Interprofessional Collaboration: A Team Approach To Assure Person-centered Decision-making

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Learning Outcomes

- List at least two key elements of the ACP team approach that foster competent clinical practice; clinician-patient communication, person-centered and family-oriented planning.
- Describe core concepts to build an interprofessional collaborative model fundamental to the advance care planning process, advanced illness care, and care coordination.
- Identify potential barriers to interprofessional collaboration as demonstrated in a case study.
- Define three best-practice strategies that strengthen teamwork and keep individuals at the center of all care decisions.

Knowing and Honoring Preferences and Decisions

“Care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions.”
The desired outcome of Person-Centered Decision Making (PCDM) is to know and honor individuals’ well-informed preferences and decisions by...

- **Creating** an effective process to plan for future decisions.
- **Making plans available** to treating health professionals.
- **Assuring plans are incorporated** into current medical decisions.

Changing the Culture

Organizational culture that promotes

• Collaboration to improve service delivery and client outcomes.
• Interprofessional collaboration as a ‘partnership’ and coordinated approach.
• Interprofessional collaborative practice as a process which includes communication and decision-making.

Interprofessional Practice

Multiple health workers from different professional backgrounds providing comprehensive services working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.

Learning together to work together for optimal health-services and better health outcomes

Framework for Action on Interprofessional Education and Collaborative Practice, 2010
Interprofessional Collaborative Practice

Core Competencies: Four Domains

Values/Ethics  Work in IP Teams → Core Competencies  Roles/Responsibilities
Communication  Teamwork Processes

(Interprofessional Education Collaborative, 2016)

Interprofessional Collaborative Team Practice

The Missing Aim

- Better Outcomes
- Improved Clinician Experience
- Lower Costs
- Improved Patient Experience
Why is IPC needed?

• Population is aging
  – >10,000 people turn 65 every day in U.S.
  – Largest increase in Age >85
  – Active older adults
• Chronic disease mgmt., complex care needs
• Patient-centered team-based care
• Population health management

Possible Risks/Barriers

Current Practice:
• Create work-arounds
• Unclear roles and expectations
• Lack of accountability
• Refuse to relinquish hold:
  “Only I can do this” or “I do it best”

Unintended Consequences:
• Ripple effect beyond “me”
• Any others?
Case Study Example

- Patient arrives at specialty clinic for first appointment after a “mild MI”
- A team approach to care
- Person-centered and family-oriented care
- Accountability by ALL who touch the patient

Follow-Up Clinic Visit

- Advance Disease Management
- Cultural Competence & Humility
- Community Support System
- Caregiver Support
- Health Promotion
- Strength-Based Care
- Communication
- Care Setting Practices
- Shared Decision Making
- Care Coordination

Person-Centered and Family-Oriented Care
**Strategies that Strengthen Interprofessional Collaboration**

- Leaders that support collaborative practice and team effectiveness.
- Establish team work communication principles.
- Honest appraisal of skills, barriers, biases and behaviors.
- Collective willingness to improve.
- Implement team processes and workflows with consistent expectations.

**Small Group Activity**

- Specific habits, biases, and behaviors.
- What needs to change?
- What skills are needed to improve interprofessional collaboration practice?
Strategies that Keep Individuals at the Center of Care Decisions

• Individualize the care model.
• Full team owns embedding ACP into routine of care.
• Engage in shared decision-making.
• Assure individuals receive care that matters most.
• Goals of care discussions available across care settings.

Power of Enduring Conversations

“One of the most important conversations we had,” by Greg Loomis

• “The conversation was eye-opening to me… I learned things I never knew about my dad.”
• “The meeting triggered multiple follow-up conversations… We had more father-son talks than we did for the first 60 years of my life.”
• “The choice was his; the facilitation just provided the road map.”
• “We all knew he did not want life-sustaining treatment. The decision was not up to us; our father made it very clear what he wanted in advance.”
• “This experience with my father allowed me to develop my own advance directive and share my wishes with my family.”
• “It’s a lesson I learned from my dad, and for that, I will always be grateful.”

QUESTIONS

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References


Framework for Action on Interprofessional Education & Collaborative Practice (WHO/HRH/HPN/10.3)


