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Interprofessional Collaborations: Delivering Quality Home Care Services to Patients who are Elderly

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Abstract

This article underscores the importance of interprofessional collaborations when providing home care services to patients who are elderly. The extant research literature illuminates the advantages of interprofessional collaborations in healthcare settings. Benefits such as patient satisfaction, seamless care coordination, and improved health outcomes have long been acknowledged. However, when these care collaborations occur within the home milieu, other patient benefits are evident to include: (a) decreased hospital readmissions; (b) improved daily functioning; (c) reductions in health costs; (d) better informed decision making by providers; and (d) more accurate patient assessments. This review article accentuates interprofessionalism and best practices when caring for persons who are elderly in their home environment.

Keywords: Interprofessional, Home Care, Home Care for the Elderly

Objective: To educate the readership on the benefits of using an interprofessional approach when providing home care to patients who are elderly.

Method: A systematic review of the literature is presented which examines interprofessional home care practices with patients who are elderly. The author conducted an electronic literature search for peer-reviewed articles published between 2001and 2021 using the following data bases: EBSCO Host, E-Journal, Academic Search Premier, ERIC, Academic Search Complete, and ScienceDirect. Eighty percent of the articles reviewed were published within the last seven years. The delimitation of extending the review to the past 20 years ensures relevance to the population being studied and health system contexts. The search strategy included select key words (interprofessional approach, home care, home care for the elderly), either separately or in combination. The literature selection process resulted in the inclusion of 49 journal articles in this review.

Results: The extant literature provides a clear rationale for using interprofessional collaboration when serving patients who are elderly in the home setting. More inclusive research is needed in order to better delineate the notions and needs of diverse disciplines (e.g., pharmacy, nutrition, speech pathology, physical therapy, occupational therapy, counselors, psychologists, etc.) and to guide more meaningful collaborations. Lastly, a more inclusive theoretical model capturing the key workings of interprofessional collaboration processes is needed.

Conclusion: This review article accentuates quality components and best practices for serving elderly persons (interprofessionally) in the home environment. A number of key recommendations are made to more systematically improve team-based care. This article will serve as the foundation for a professional book on interprofessional collaboration. At least 8 disciplines will be invited to contribute a chapter to the book. These contributions will provide a medium for formal interprofessional education.

Introduction

The term interprofessional is a relatively new catchphrase signifying healthcare collaborations. In recent years, the term has replaced or been interchanged with longstanding terms such as interdisciplinary and multidisciplinary. Interdisciplinary and multidisciplinary principles of care have significantly advanced patient care and solutions. Therefore, these expressions should not be devalued. In fact, they serve as the foundation for the more progressive term "interprofessional". This article highlights interprofessionalism as a preferred practice for delivering quality home care services to patients who are elderly.

Interprofessionalism fosters a care delivery context wherein healthcare professionals can cooperatively exchange knowledge for the betterment of home care patients. Interprofessional practices facilitate shifts from fragmented (silo) services to well-informed collaborative interventions. The use of interprofessional teams connotes a high level of coordinated interprofessional collaboration. According to Steffen et al. [1], interprofessional teams "develop unified plans for patient assessment and treatment, and all members are considered to be colleagues who have a range of both unique and overlapping skills that contribute to patient care and team functioning. Team members share responsibility for the effective functioning of the team, and share leadership functions [1] (p, 735)". The Interprofessional Education Collaborative (IPEC) introduced four core competencies for promoting collaborative care. Those who embrace the principles of interprofessionalism: (a) work with individuals of other professions to maintain a climate of mutual respect and shared values; (b) use knowledge of one's own role and those of other professions to appropriately assess and address healthcare needs of patients and to promote and advance the health of the population; (c) communicate with patients, families, communities, and professionals in health and other fields in a responsive and

responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease; and (d) apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient-centered care and population health programs and policies that are safe and timely [2] (pp. 10-11). These competences provide a framework for interprofessional practice. This article renders a systemic review of the published literature that supports interprofessional collaboration as a best practice approach to delivering quality home care services to patients who are elderly.

Interprofessionalisms can only increase the number of positive outcomes associated with home care services. Favorable outcomes include decreased medical costs and decreased hospital use or nursing home placement [3]. Kao et al. [4] discussed other notable outcomes such as more accurate and relevant identification, assessment, and follow-up, as well as better processes and patient outcomes resulting from collaborative approaches to medical, functional, and social conditions. Kao et al. noted the shift to team-based care is challenging, however, it is imperative that healthcare providers be equipped with the necessary competencies to work together to accomplish the best possible outcomes for patients who are elderly.

Methodology

A systematic review of the literature is presented which examines interprofessional home care practices with patients who are elderly. The author conducted an electronic literature search for peer-reviewed articles published between 2002 and 2021 using the following data bases: EBSCO Host, E-Journal, Academic Search Premier, ERIC, PubMed, Academic Search Complete, and ScienceDirect. Eighty percent of the articles reviewed were published within the last seven years. The delimitation of extending the review to the past 20 years ensures relevance to the population being studied and health system contexts. The search strategy included select key words (interprofessional approach, home care, home care for the elderly), either separately or in combination. The literature selection process resulted in the inclusion of 49 journal articles in this review.

Review of the Literatures

The elderly population comprises the proportion of individuals age 65 years or older out of the total population. The World Health Organization (WHO) and the United Nations define an "aging society" as one in which more than 7% of the population is 65 years or older; an "aged society" as a society in which more than 14% of the population is 65 years or older; and a "super-aged society" as a society in which more than 21% of the population is 65 years or older [5]. The United Nations (Department of Economics and Social Affairs, Population Division) [6] projected that a person aged 65 in 2015-2020 could expect to live, on average, an additional 17 years. By 2045-2050, that figure will increase to 19 years (World Population Ageing, 2019). According to Lanoix [7], as the population ages, many individuals will require more (yet different types of) supportive medical services to help them manage medications, perform necessary activities of daily living, and enjoy the highest quality of life possible. Lanoix also postulated that the changing nature of disease management is reflective in the aged population, and that home care is a medical necessary in order to maintain the health and survival of older persons (p.169). Well-coordinated, integrated home care services allow older persons with diverse health conditions to maintain their health, quality of life, dignity and independence as long as possible. Extant research findings point to inadequate collaborations between physicians and other medical professionals. This lack of effective communication between physicians and other medical professionals can lead to a high patient mortality rate in hospitals and home care settings [8,9].

Hayashi et al. [3] posited that most older citizens prefer to age in place rather than reside in facilities with on-site medical personnel. They proclaimed the Independence at Home Model (IHM) as a means to ensuring interprofessional home care services for elderly patients with chronic illnesses. IHM is a medical house call paradigm piloted by Centers for Medicare and Medicaid Services (CMS) and endorsed by the Independence at Home (IHM) Act and section 3024 of the Patient Protection and Affordable Care Act of 2010. The goal of the demonstration as described in the Federal Register is:

- to test a service delivery model that utilizes physician and nurse practitioner directed primary care teams to provide services to high cost, chronically ill Medicare beneficiaries in their homes. Participating practices will be accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinate health care across all treatment settings. The participants in the Demonstration will be multidisciplinary teams composed of various members such as physicians, nurse practitioners, physician assistants, pharmacists, social workers, and other supporting staff.

Hayashi et al. determined medical house calls to be a comparable source of primary care for elderly patients who cannot attend on-site medical appointments. Effective house-call models such as IHM require integrated interprofessional teams that are capable of addressing medical, functional, and social problems.

Given the growing number of elderly individuals with chronic diseases, there is a push to decrease the number of inpatient admissions and to increase the percentage of in-home rehabilitation. Rehabilitation or recuperation initiatives in the home setting fosters improved patient outcomes because care interventions are better aligned with activities of daily living and local services and resources. Home-based care has proven to be effective for survivors of strokes, patients with dementia, and patients with musculoskeletal conditions, where coordinated services among interprofessional teams are necessary [10-16].

Ryburn et al. [17] emphasized in their research the value of multicomponent restorative home-based services. Some advantages included improvements in morale, self-care and mobility, and activities of daily living/home management. Overall, multicomponent restorative home-based services resulted in a reduced need for extended services (p. 230). Additionally, Ryburn et al. surmised that multicomponent restorative services must be timely, educational, and include assistive technologies to encourage patients to continue independence and former activities. Multicomponent restorative home-based services "align more closely with recent models of healthy ageing and the progressive principles of service provision already well-established among other disabled groups, with their emphasis on independence, empowerment and community-based treatment" (p. 232).

Noteworthy is a bipartisan Senate bill introduced in July 2021. The bill supports an increase of Medicare beneficiaries' access to home health after hospitalization. The Choose Home Care Act (CHCA) was introduced by Senators Debbie Stabenow (D-Michigan) and Todd Young (R-Indiana), with Senators Ben Cardin (D-Maryland), Bob Casey (D-Pennsylvanian), Susan Collins (R-Maine), Maggie Hassan (D-New Hampshire), and James Lankford (R-Ohio) signing on as co-sponsors. If enacted, CHCA would enable eligible Medicare patients to receive extended care services as an add-on to the existing Medicare home health benefit for 30 days after hospital discharge. The act would help patients who are seriously ill and elderly recover safely at home, increase patient and family satisfaction, and reduce the risk of exposure to COVID-19 or other infectious diseases. The act also saves the Medicare Trust Fund money by avoiding nursing home and skilled nursing facility costs [18]. Many advocacy groups such as American Association of Retired Persons (AARP), National Association for Home Care & Hospice (NAHC), and National Council on Aging (NCA) have endorsed home care services as a key strategy in improving the health and safety of older Americans.

Salerno [19], stressed that successful healthcare change management would require professionals working to ensure continuative care within integrated interprofessional care systems (ICTs). Older persons with complex medical conditions often have needs that cannot be met by one single home care provider. Thus, interprofessional collaboration becomes a care necessity. An ethical and accountable component of health care is ensuring that care is arranged according to the needs of the patient. Larsen et al. [20] discussed care providers' collaborative experiences. These experiences were manifested by both feelings of distrust and trust and by insecurity and security. This relational dissonance was reduced when the focus remained on the patient needs (vs. diagnoses), and professionals demonstrated a reflective and questioning approach to collaboration. Such dispositions brought about more secure and trusting relationships and less boundary drawings (silos) between care providers.

Davison et al. [21] highlighted the appropriateness of home-base behavioral health services for patients who are elderly, particularly those experiencing depression, anxiety, and dementia. They suggested that age-specific psychological assessments and interventions would enhance the delivery of home care services for the elderly. Yet, these services are often not funded due to a lack of promotion of evidence-based non-pharmacological approaches to care. Home-based behavioral health services are often overlooked in the continuum of services for patients who are elderly. Peritogiannis et al. [22] noted a negative correlation between age and the utilization of mental health services with advancing age appearing to decrease the likelihood of consuming mental health services. Peritogiannis et al. [22] posited that underutilization of mental health services could be effectively remedied by the use of mobile mental health units. They cited evidence of the effectiveness of home-based mental health services in alleviating psychiatric symptoms of patients who are elderly (p.458).

Larson, et al. [20] emphasized the importance of providers shifting their attention from (organizational or administrative) structures to interpersonal relations and interactions. According to Vangen et al. [23], health care is designed on the principle of boundary drawing with accentuation on role divisions and responsibilities. According to Samverkan (2009), effective teamwork among disciplines has a more positive effect on patient outcomes than other quality improvement strategies. Sims et al. [24] described teamwork as involving two or more care providers with concrete goals surrounding assessment, planning, performing, and evaluating with defining attributes of interdependent collaboration, open communication, and shared decision-making (p. 20-25). Bronstein [25] defined teamwork as an interpersonal process leading to the achievement of goals that cannot be attained by a single member. Bronstein identified five key components of interdisciplinary collaboration: interdependence; newly created professional activities; flexibility; collective ownership of goals; and reflection on process. Vangen et al. [23] identified other essential ingredients to successful interprofessional collaborations. These include respecting the competencies of others, maintaining close interactions, and being flexible and creative. They posited that a climate of trust must be continually nurtured for optimal interprofessional collaborations. According to Larsen et al. [20], having no experience and understanding of interprofessional collaborations can hinder members' ability to identify deficiencies while caring for older persons with multi-morbidity.

According to Toth-Pai et al. [26], interprofessional collaboration can increase job satisfaction and reduced stress levels. Interprofessional collaboration also affords opportunities for members to resolve stereotypes or preconceptions about other professions. Toth-Pai et al. emphasized the need for healthcare organizations to not only provide interprofessional education, but to afford opportunities for application. Education provides the foundation for building trust among professionals; trust must be developed before cooperative processes can be established and implemented. Historical impediments to interprofessional collaboration comprise physician qualities (knowledge, skills, emotions); relational factors (levels of communication and collaboration); and structural factors (organization of care, compartmentalization) [27,28,29]. Care deficiencies resulting from a lack of interprofessional collaboration has focused attention on the value of interprofessional teamwork and facilitated initiatives to reduce care gaps [30,31]. Poor communication and interaction between care team members can adversely influence the knowledge and understanding of other professions, as well as the quality of community care [32-34].

Yamamoto-Mitani et al. [35] described how Japan's traditional hierarchy in the field of medicine—with physicians at the top—impedes conversations among various disciplines. This hierarchy and trend is often apparent in rural areas [36]. This traditional professional hierarchy inhibits home care workers from collaborating freely with colleagues in other medical fields. Increased collaborations can only strengthen mutual respect and improve interprofessional education and rural community care [37]. A significant portion of the literature is devoted to interprofessionalism in rural communities. Ohta et al. [38] solicited the feedback of physicians providing rural medicine. These physicians often assumed the role of medical team leader in an effort to integrate patient care in interprofessional teamwork. Efforts were often unproductive due to the psychological distance imposed by the traditional administrative hierarchy. Ohta et al. [38] emphasized that many modern day medical students are required to participate in interprofessional education. However, for many older rural physicians such education and awareness opportunities were not available. There is a need for all physicians, but particularly those in rural communities, to become proficient in using interprofessional teams effectively.

Ohta et al., [38] identified several challenges faced by rural physicians: (1) poor awareness of changing social conditions; (2) paternalistic position in the community; and (3) subpar interprofessional education and collaboration. Solutions posed included effective clinic-hospital collaborations, constant skill- and knowledge- sharing among medical and care professionals, mutual understanding between physicians and citizens, and educating the community about appropriate help-seeking behaviors (p. 5). Ohta et al. underscored the need for home care professionals to enhance their understanding of care team members' working conditions, roles, and competencies. Such understanding maximizes connectedness and continuity of care, promotes the best possible use of expertise, and reduces unnecessary knowledge gaps. Interprofessional collaborations afford rural physicians opportunities to delegate to capable professionals, thereby reducing stress levels and patients' tendencies to overly depend on physicians for care and sole decision-making.

Understanding a colleagues' competencies is necessary for effective interprofessional collaboration. If workers from different fields understand each other's skills, then patient information can be shared and practical help received [39]. Le´gare´ et al. [40] emphasized that a prerequisite for interprofessional collaboration is knowledge of others' expertise, roles, and responsibilities. Presently, many healthcare workers perform their tasks independently because there is a lack of sharing (and understanding) in terms of professional abilities. Patients—especially older adults—with multimorbidity face risks such as polypharmacy, frequent hospitalization, or high mortality rates when interprofessionalism is lacking [41]. Exchanging information about patients' medical conditions is necessary for smooth multiprofessional cooperation. Morris et al., [37] (p. 6) outlined four problems commonly encountered by home care workers: biomedical, social, psychiatric, and interprofessional. Interprofessional problems stem from inadequate information sharing, vaguely defined roles, and hierarchy conflict.

Patients who are elderly and in the chronic stage of disease may require the collaborative skills of various home care professionals such as physical therapists, occupational therapists, nurses, social workers, and dietitians. Interprofessional teams are deemed the universal gold standard of healthcare for patients who are elderly with complex medical conditions and medical frailty [1]. These teams can play an important role in best practices for geriatric care. Professional disciplines, working interprofessionally, can provide the expertise needed to allow elderly patient to receive quality care at home [42-44].

Currently, interprofessional care teams (IPCTs), unlike multidisciplinary teams, routinely interact and collaborate for collective decision-making. The result is less "work in silos" with a greater focus on the provision of person-centered care vs. profession-centered care [44,45]. Steffen et al., [1] (p. 737) delineated how multidisciplinary team members develop independent assessments and treatment plans, and focus mainly on patient outcomes and less on effective team functioning. These teams are likely to adhere to a hierarchy with members "from the highest status discipline most commonly identified as the team leader". IPCTs are the basis for real collaboration, promoting an environment that is complete, inclusive, and holistic for patients who are elderly [44,46]. Additionally, IPCTs' commitment to cohesion and constant dialogue fosters better care planning [44,47]. Larsen et al. [20] differentiated between multiprofessional and interprofessional teams. With the former, team roles are specialized and members concentrate on their own tasks. With the latter, team roles are specialized but everyone is expected to interact.

According to Le´gare´ et. al. [48], home healthcare providers for elderly patients demonstrated positive intention to engage in interprofessionalism and shared-decision making (IP-SDM). However, their research revealed a distinct 'behavior–intent' gap due to cognitive attitude, affective attitude, time constraints, perceived behavioral control, and lack of human resources. Steffen et. al. [1] discussed how the time factor (having enough time) is frequently an impediment to interprofessional collaboration. Moreover, collaborative work is often intensive and not billable or reimbursable. Healthcare administrators who desire to implement interprofessional principles must develop clear policies that outline the inner workings of interprofessionalism. Steffen et. al. [1] stressed the importance of developing organizational policies that take into account financial factors, as well as measures for evaluating and sustaining interprofessional team activities. Sargeant et al. [49] (p. 233) described the importance of interprofessional education and interprofessional teamwork in the passage below:

- Interprofessional education is a social learning activity in which health practictioners in different professions learn with, from, and about each other. Lack of respect for other health professions and stereotypical views can interfere with teamwork and collaboration. Effective teamwork takes work, a fact not explicitly recognized in health care. Medical education has traditionally not taught teamwork and interprofessional communication skills. Opportunities need to be created for health professionals to learn together.

Discussion

Interprofessional collaboration is an essential component in the home care delivery system. A review of the extant literature reinforces the need for, and importance of, interprofessionalism. This articles accentuates salient characteristics of interprofessional teams and provides solid evidence of how interprofessional collaboration can benefit patients who are elderly and desirous of rehabilitating, recovering, or aging at home. The population of individuals over the age of 65 is growing globally. Healthcare professionals' reluctance to collaborate interprofessionally places this high-risk population at even greater risk. All healthcare providers have an ethical obligation to provide this vulnerable population with the best possible care. This goal can be achieved by dismantling unrealistic hierarchies, stepping outside of professional silos, and engaging in meaningful discussions about patient care and team members' work tasks and challenges. Home care stakeholders, in particular, increase their respect and knowledge of other disciplines when they embrace interprofessional collaboration principles. Leaders of healthcare organizations, university programs, government agencies, and advocacy groups must push for national policies and financial incentives that normalize the concept of interprofessionalism in the home healthcare arena. The following benefits of interprofessional collaboration greatly outweigh the labor and financial costs: decreased hospital readmissions; improved daily functioning; reductions in health costs; better informed decision making by providers; more accurate patient assessments, better health outcomes, and reduced mortality rates. Interprofessionalism brings to the forefront the perils of healthcare professionals being profession-centered and diagnosis centered vs. patient-centered. Advances in technologies may facilitate the development and use of virtual interprofessional teams. Educational institutions and accrediting bodies should give consideration to mandating interprofessional education. Currently, national healthcare policies do not require healthcare professionals to be proficient in interprofessional collaboration. Hopefully, such mandates will occur in the near future.

Conclusion

This review article accentuates quality components and best practices for serving elderly persons (interprofessionally) in the home environment. This article will serve as the basis for a professional book on interprofessional collaboration. At least 8 disciplines will be invited to contribute a chapter to the book. These contributions will provide an official educational forum on interprofessional education. The forum will facilitate the creation of a theoretical model that will depict key features and inner workings of effective interprofessional collaboration. Hopefully, the construct will be adopted by healthcare professional who provide home care to the elderly.

Conflicts of interest: The author declares no conflict of interest.

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