

## Multidisciplinary care

### What you should know

- Multidisciplinary care helps you live better, and may help you to live longer, with MND.
- Research has shown that the health professionals you consult can give you better care and advice when they are knowledgeable about MND and have a coordinated, multidisciplinary approach to your care.
- Multidisciplinary care occurs when health professionals, from different disciplines, work together to address as many of your health and support needs as possible.
- Ideally you should be reviewed every 2–3 months, with the health professional team maintaining regular contact with the patient and family between visits (Hogden et al 2017).
- Multidisciplinary care is available:
  - at several MND-specific clinics in Adelaide, Brisbane, Canberra, Melbourne, Sydney and Perth
  - in the community

### What is multidisciplinary care?

Multidisciplinary care is delivered by professionals from a range of disciplines who work together to address as many of a person's health and other needs as possible (Mitchell et al 2008). Each discipline-specific team member enriches the knowledge of the team as a whole. Over time, the multidisciplinary team composition can change to reflect changes in the person's needs (Mitchell et al 2008).

While we know that the multidisciplinary approach is best practice, we also know that how this is accessed may vary from person to person and from region to region due to the availability of services in a person's local area. In Australia coordination of care is difficult because of service boundaries, distance, funding and health sector accountability to different levels of government (Powell Davies et al 2006). It can be very hard for people with complex disorders, including progressive neurological diseases, to get timely access to care and services that meet their needs. For expert advice contact your MND Association.

### Multidisciplinary care and MND

People living with motor neurone disease are likely to need advice about mobility, communication, breathing, nutrition, managing other symptoms and getting community support for themselves and their families.

Importantly though, how you manage some of your earlier symptoms can affect how other, later-developing, symptoms can be managed. However, many health professionals, such as general practitioners may only see one or two people with motor neurone disease in their working life (Al-Chalabi 2007).

Studies have also shown that the health professionals you consult provide better care and advice when they are knowledgeable about motor neurone disease and take a coordinated, multidisciplinary team approach to your care (Traynor et al 2003, Van den Berg et al 2005).

Specialist integrated multidisciplinary care that includes palliative care services, respiratory care and allied health therapists improves survival and can improve outcomes in for people with MND (Martin et al 2017).

Multidisciplinary care can provide people living with motor neurone disease:

- flexible, coordinated professional support
- referral to professionals in a coordinated way, so that any difficulties can be dealt with promptly
- regular review of symptoms
- opportunities to get specialised advice from other health and community care professionals and providers.

Ideally, multidisciplinary care should be coordinated and provide you with a direct link to one member of the team, usually referred to as a key worker, clinic coordinator, support coordinator or team coordinator. This person can advise you about regular review of symptoms and coordinates your care.

## Multidisciplinary MND clinics

Teams at MND clinics are knowledgeable about motor neurone disease and provide a coordinated, multidisciplinary approach to the care of people with the disease. An important aspect of MND clinic multidisciplinary care may be the links from an MND clinic to your local primary health care team or local palliative care team (Zoccolella 2007). MND specific guidelines available in the UK recommend effective communication and coordination between all healthcare professionals and social care practitioners involved in the person's care and their family members and/or carers... especially for those people who cannot attend the clinic, according to the person's needs [NICE, 2016]. The MND Association can provide you with contact details for multidisciplinary MND clinics.

## General multidisciplinary care

Many people live too far from an MND clinic to attend or may live outside the MND clinic's area. If this is your situation, your multidisciplinary care can be provided by a local primary health care team. In some areas local teams have established MND specific models of care with some linked to an MND specific clinic for specialist input, including the use of telehealth.

A primary health care team includes local health and community care professionals who provide a range of expertise, advice and support. Your primary health care team can liaise with your neurologist and your MND clinic, if you are attending one. For people with motor neurone disease, a primary health care team usually includes a general practitioner, nurse, allied health professionals (such as a dietitian, occupational therapist, physiotherapist, orthotist, social worker and speech pathologist) and local palliative and community care workers. Other team members who have particular expertise are involved as needed, such as a neurologist, respiratory specialist, gastroenterologist and palliative care specialist. In many areas of Australia, the MND Advisor from your MND Association liaises with the team, assisting you and the team to get information, support and referrals to other services when needs change.

## MND research in this area

In a review that examined the nature of specialised multidisciplinary care in motor neurone disease, it was concluded that there needed to be a patient/family-centric care approach, with 'strong inter-service communication; and an inter-professional team resourced and funded to provide expert care to patients and their family caregivers'. Transition of care between care settings was found to be challenging for patients and carers, with attendance rates indicating more needs to be done to improve access for them. Where the person with MND was being cared for within their own community, it was recommended that specialised MND 'multidisciplinary care services, general neurology, and primary care services network together, in order to improve access, patient care, service transition and standardized service delivery (Hogden A, et al 2017).

## More information

To find out about the roles of health and community care professionals working in a multidisciplinary team see the MND Australia fact sheet Multidisciplinary care team (EB3). For more information about multidisciplinary care contact your MND Association, neurologist, general practitioner, allied health professional, community nurse, local palliative care service, MND clinic or service.

### References

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Multidisciplinary care team (EB3)

Riluzole (EB4)

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