

## Multidisciplinary care team

### What you should know

- A multidisciplinary care team for people with motor neurone disease usually includes a doctor, allied health professionals (such as a dietitian, occupational therapist, physiotherapist, 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 respiratory specialist.
- You can live better for longer with motor neurone disease when health professionals have a coordinated, multidisciplinary approach to your care.
- In many areas of Australia, the regional/care advisor from your MND Association liaises with the team, assisting you and the team get information, support and referral to other services when needs change.

### About the multidisciplinary care team

Multidisciplinary teams are also known as primary health care teams. Team members communicate with each other about your care and help you get care from other members of the team when you need it. Professionals providing multidisciplinary care can be from the same organisation, a range of organisations or from private practice. They can work in the community, hospital, clinic, residential and other care settings. Each discipline-specific team member enriches the knowledge-base of the team as a whole and, over time, the multidisciplinary team composition can change to reflect changes in the person's needs (Mitchell et al 2008).

### Multidisciplinary care and MND

Over the course of your disease progression you may find you need to talk with a respiratory specialist about breathing, an occupational therapist about equipment, a speech pathologist about communication, a physiotherapist about joint stiffness, a palliative care team about support and your general practitioner and neurologist for regular symptom review. You can live better for longer with motor neurone disease when these health professionals have a coordinated, multidisciplinary approach to your care (Traynor et al 2003, Van den Berg et al 2005).

Importantly, multidisciplinary care provides you with a direct link to one person, who is a member of the team, usually referred to as a key worker, case manager, care coordinator or team coordinator.

### Your multidisciplinary care team key worker

Your key worker:

- maintains regular contact with you
- initiates effective and timely response when your needs change
- liaises with other team members and services
- organises regular case conferences and team meetings.

Who your key worker is depends on:

- where you live in Australia
- local health and community care service availability
- the professional interests of individual health and community care professionals in your area.

Your key worker may be a:

- case manager
- general practitioner
- local occupational therapist, physiotherapist or speech pathologist
- MND clinic nurse
- MND regional/care advisor
- MND shared-care worker
- neurologist
- palliative care professional
- other health or community care professional with particular expertise in MND symptom management.

## Members of a multidisciplinary care team

### **Community/aged care worker and case manager**

Community/aged care workers provide general household assistance, emotional support, care and companionship to people in their homes. Case managers assist people to access health and community services.

### **Dietitian**

Dietitians provide dietary and nutritional advice.

### **General practitioner**

The general practitioner (GP) is a doctor providing general medical care. GPs are usually your first point of medical contact. The GP liaises with the neurologist and other health and community care providers.

### **MND Association regional/care advisor**

MND Association regional/care advisors help people with motor neurone disease connect to the services they need. Regional/care advisors also offer ongoing information to families and service providers as questions arise or needs change.

### **Neurologist**

The neurologist is a doctor who specialises in disorders of the nervous system. The neurologist coordinates the tests you need for diagnosis. The neurologist also monitors the progress of the disease and management of your symptoms.

### **Occupational therapist**

An occupational therapist (OT) helps to maintain mobility, function and independence. OTs provide advice about home modification, different ways of performing tasks and on selecting, acquiring and adapting specialised equipment.

### **Palliative care team**

The palliative care team specialises in interventions that can improve quality of life for people with eventually fatal conditions. Palliative care services can also provide emotional support for people living with motor neurone disease.

#### References

- Mitchell GK, Tieman JJ, Shelby-James TM 2008, 'Multidisciplinary care planning and teamwork in primary care', *Med J Aust* 188(8 Suppl).
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- van den Berg JP, Kalmijn S, Lindeman E, Veldink JH, de Visser M, der Graaff MMV, Wokke JHJ, van den Berg LHV 2005, 'Multidisciplinary ALS care improves quality of life in patients with ALS', *Neurology* 65(8).

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Multidisciplinary care (EB2)

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Riluzole (EB4)

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Breathing and motor neurone disease: what you can do (EB6)

Breathing and motor neurone disease: medications and non-invasive ventilation (EB7)

Considering gastrostomy - PEG and RIG (EB8)

### **Physiotherapist**

A physiotherapist helps you maintain physical activity and mobility. Physiotherapists can also show your family or carer how to safely help you move from one position to another, for example, moving from a chair to a bed.

### **Respiratory specialist**

The respiratory specialist is a doctor who specialises in disorders of the lungs and breathing. The respiratory specialist provides information and advice about breathing and motor neurone disease.

### **Registered nurse, MND nurse, clinical nurse consultant or clinical nurse specialist**

The role of the nurse is varied and can include ongoing care and care coordination, often for people in their own homes. Specialised MND nurses usually work in MND clinics and have particular expertise in motor neurone disease symptom management.

### **Social worker, psychologist, or accredited counsellor**

A social worker, psychologist or accredited counsellor provides counselling on the psychological and emotional aspects of living with motor neurone disease. In addition, a social worker can provide information on community services that may assist you with accommodation, legal, financial and other issues.

### **Speech pathologist**

A speech pathologist helps in the management of communication and swallowing. They can advise about communication aids and devices and also about swallowing techniques and food consistency.

To find out about motor neurone disease and other fact sheets in this series contact the MND Association in your state or territory ph. 1800 777 175 or visit [www.mndaust.asn.au](http://www.mndaust.asn.au)