

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 nurse, dietitian, occupational therapist, orthotist, physiotherapist, social worker, psychologist and speech pathologist) and local primary, palliative and community care workers. Other team members who have particular expertise are involved as needed, such as a neurologist, respiratory specialist and gastroenterologist.
- You can live better for longer with motor neurone disease when health professionals have a coordinated, multidisciplinary approach to your care. (Hogden, et al, 2017, Martin et al 2017).
- In many areas of Australia, the MND Advisor from your MND Association liaises with the team, assisting you get information, support and referral to other services when needs change.

About the multidisciplinary care team

Multidisciplinary 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 various health professionals and specialists to support you, and it is ideal to have a coordinated and integrated multidisciplinary approach to your care.

Your multidisciplinary care team key worker

Importantly, multidisciplinary care can provide you with a direct link to one person (key worker), who is a member of the team, usually referred to as a clinical nurse coordinator, care coordinator, support coordinator or team coordinator. The key worker can be your GP, your MND Association Advisor or any member of your multidisciplinary care team.

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.

Members of a multidisciplinary care team

Community aged care workers provide general household assistance, emotional support, care and companionship to people in their homes.

Dietitians provide dietary and nutritional advice including advice about modified meals, hydration and timely nutritional support.

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 Advisors help people with MND connect to the services they need. MND Advisors also offer ongoing information to families and service providers as questions arise or needs change.

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

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

An **orthotist** can assist with the advice and timely provision of artificial or mechanical aids, such as braces to prevent or assist movement of weak or injured joints or muscles to help prolong function of the patients. It is recommended that the orthotist be visited early on to provide prompt access to orthotics.

The **palliative care team** specialises in interventions that can improve quality of life for people with life limiting conditions. Palliative care services may also provide emotional support for people living with MND and can assist you to plan your future care.

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.

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 including timely access to non-invasive ventilation.

The role of the **Registered nurse, MND nurse, clinical nurse consultant or clinical nurse specialist** 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.

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

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

Support coordinators assist people who are diagnosed with MND when aged 64 or younger who have an NDIS plan that includes support coordination. The coordinators assist people to enact their NDIS plan and find suitable local services.

References

- Hogden A, Foley G, Henderson RD, James, Aoun SM 2017, 'Amyotrophic lateral sclerosis: improving care with a multidisciplinary approach', Journal of Multidisciplinary Healthcare 10
- Martin et al, 2017, "The benefit of evolving multidisciplinary care in ALS: a diagnostic cohort survival comparison", Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration 18(7-8)
- 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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