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Abstract:

This clinical review describes the utility of the physician assistant in the care of the demented geriatric patient through interdisciplinary teamwork in the extended care setting. Recent relevant articles obtained from appropriate databases including MEDLINE, PubMed, CINAHL and the Electronic Journal Center were analyzed and synthesized. The literature suggests that physician assistants can play an extremely important role in the health care of the demented elderly in the extended care setting as part of an interdisciplinary team. Physician assistants, through their versatility of experience, cost effectiveness and their role as the physician extender can greatly benefit the care of the demented geriatric patient in the extended care setting through interdisciplinary teamwork.
Introduction:

The geriatric population is a unique and special group of individuals. Intrinsic to their well being is their need for satisfactory health care as they age. This is especially true for the individuals who reside in long-term care facilities and suffer from dementia. These individuals require more attention and creative healthcare than their counterparts who do not suffer from dementia. The physician assistant profession has a unique opportunity to assert itself as a part of a dynamic interdisciplinary team designed to address and manage geriatric mental health needs. Physician assistants can especially prove useful as the baby boomer generation, or those born between 1946 and 1964, ages, which will cause the older adult population to grow continually in the U.S (Halpain et al., 1999). By 2030, when the last of the baby boomers reaches the age of 65, the U.S population aged 65 and older will exceed 70 million (Besdine et al., 2005). Naturally, as the population of older adults increases, so will the numbers of those affected by chronic diseases, such as dementia, increase.

Dementia affect the older adult population the most with the prevalence ranging from 3% to 11% for those aged 65 and older (Boustani et al., 2005). Healthcare providers are grappling with the problem of how to best care for this burgeoning population. Some, such as Burbank and colleagues, believe that geriatric care should rely on interdisciplinary care because older adults offer the most complex challenges in health care at all levels and they feel interdisciplinary care is the most effective way of handling these challenges (Coogle et al., 2005).

Interdisciplinary care stems from the idea of multidisciplinary care. Multidisciplinary care is the concept that health care is delivered by a team with each member having different professional training and has different skills to bear (Nolan, 1995). With multidisciplinary care the main task is to coordinate the team effort, however, interdisciplinary care seeks to blur the professional boundaries requiring trust, tolerance and a willingness to share responsibility (Nolan, 1995). The physician assistant has a unique opportunity to participate in the interdisciplinary role. This is largely due to
their ability to extend a physician’s breadth of practice, their varied backgrounds within the healthcare field and their cost effectiveness.

**Demographics**

Population dynamics and demographics are not static and will tend to shift in the U.S. and elsewhere across the globe. According to the World Health Organization, there are approximately 600 million people worldwide aged 60 years and older in 2007 with the population estimated to increase to 1.2 billion by the year 2025 (Slingerland et al., 2007). The U.S. population of older individuals aged 65 and older is growing rapidly with the population doubling between the beginning and the middle of the century (Halpain, Harris, McClure & Jeste, 1999). Aging of the baby boomer generation, or those born between 1946 and 1964, is the driving force behind the growth of the older adult population (Halpain et al., 1999). By 2030, when the last of the baby boomers reaches the age of 65, the U.S. population aged 65 and older will exceed 70 million (Besdine et al., 2005). As of 2003, 13% of the U.S. population is 65 and older (Palmer et al., 2003).

As the population demographics change, so do the number of individuals affected by dementia. One study estimated that the number of people with dementia worldwide was 24.3 million in 2001 with an estimated growth of 4.6 million cases every year (Ferri et al., 2005). At this rate, the population of people with dementia will double almost every 20 years (Ferri et al., 2005). Dementia affects older adult population the most with the prevalence ranging from 3% to 11% for those aged 65 and older (Boustani et al., 2005). For those who are 95 and older, the prevalence of dementia jumps to 42-68% (Bornebroek & Breteler, 2004). The population’s changing demographics is also expected to affect health care spending. The percentage of the gross domestic product spent on health care is estimated to increase from 6.7% to 13% by 2050, largely due to the health care demands of the aging population (Slingerland et al., 2007). Dementia has a huge financial burden with an annual estimated cost of $100 billion (Boustani et al., 2005).
**Dementias**

As the body ages, neurologic functions are not immune to the aging process and decline as a result of several biological processes. To begin with, neuronal death occurs along with decreased interconnections between dendrites, degeneration of nissl substance, decreased nerve conduction velocity and decreased blood flow to the brain (Rakel, 2002). Adding to the aforementioned natural aging processes, are many chronic neurologic diseases that affect the aging mind in the elderly and are grouped together as dementias. The main categories of dementia include Alzheimer’s, Parkinson’s, vascular disease with dementia, frontotemporal dementia and normal pressure hydrocephalus (Bornebroek & Breteler, 2004). Alzheimer’s disease is the most prominent and most prevalent of all dementia types constituting 50% of all dementias (Rakel, 2002). The pathophysiology of Alzheimer’s disease is not entirely understood and several different theories are currently being investigated. The foremost theory contends that the disease develops when there is pathological processing of Alzheimer amyloid precursor protein (Blass, 2002). This view is named the “amyloid cascade” and it is thought that metabolism abnormalities either lead to amyloid precursor protein dysmetabolism or result from it (Blass, 2002). The main medical treatment for Alzheimer’s is cholinesterase inhibitors (Schmitt & Wichems, 2006). Alzheimer’s patients often must be cared for in long-term care facilities. It is estimated that as of 1999, Alzheimer’s disease affected 2.44 million individuals (Brookmeyer & Gray, 2000). Within 50 years, the prevalence is expected to almost quadruple to 8.94 million cases (Brookmeyer & Gray, 2000). Of all the individuals affected by Alzheimer’s disease who are cared for in long term care facilities, 90% have moderate to severe disease (Schmitt & Wichems, 2006).

Another common dementia is Parkinson’s disease, or more specifically Parkinson’s disease with Lewy body dementia. Parkinson’s disease affects 1/1000 of the world’s population with symptoms appearing at around age 50 for both men and women
In the United States there are around 1.5 million people with Parkinson’s disease with approximately 40,000 new diagnoses each year (Poewe & Wenning, 2002). The major symptoms of Parkinson’s include a resting tremor and gait abnormalities later in the disease process and the main treatment is levadopa preparations (Popescue & Lippa, 2004). On average, the prevalence of dementia in Parkinson’s disease is 40% (Popescue & Lippa, 2004). There are several types of dementias associated with Parkinson’s disease, Parkinson’s disease with dementia, dementia with Lewy bodies and progressive supranuclear palsy (Popescue & Lippa, 2004). Lesions called Lewy bodies are the pathologic hallmark of Parkinson’s disease and Parkinson’s disease with Lewy bodies (Popescue & Lippa, 2004). The cause of Lewy body formation is unclear and whether they cause the disease is unknown (Popescue & Lippa, 2004). Cognitive symptoms of Parkinson’s disease dementias include visual-spatial impairment, hallucinations, aphasia and apraxias (Popescue & Lippa, 2004). Dementia with Lewy bodies has symptoms including fluctuations, visual hallucinations and spontaneous parkinsonism (Popescue & Lippa, 2004). Ophthalmoplegia, postural instability/ Parkinsonism and mild dementia are the common symptoms found in progressive supranuclear palsy (Popescue & Lippa, 2004).

Vascular dementia is another disease that plagues the elderly and is difficult to distinguish from other dementias. It is estimated that vascular dementia is the second most common cause of dementia (Erkinjuntti, 2005). The risk factors for vascular dementia are the same as risk factors for cardiovascular disease because vascular dementia is almost always the result of cardiovascular disease. These risk factors include hypertension, diabetes, hyperlipidemia, coronary heart disease, smoking, genetic factors and atrial fibrillation (Laukka, Jones, Fratiglioni & Backman, 2004) (Erkinjuntti, 2005). Cognitive deficits are caused by transient ischemic attacks, strokes, multiple cortico-subcortical infarcts, silent infarcts, small-vessel disease with white- matter lesions and lacunae (Erkinjuntti, 2005). Manifestations of vascular dementia include slowed information processing, memory deficit, and behavioral and psychological symptoms.
One study looking at autopsy results of elderly patients who suffered from dementia found that 18% had vascular dementia by the Mayo Clinic criteria (Knopman et al., 2003).

Normal pressure hydrocephalus is a type of dementia that is characterized by gait disturbance, memory deficit, and bladder incontinence (Mararo et al., 2006). The gait disturbance is characterized by hypokinetic gait, reduced gait velocity and a diminished and highly variable stride length (Nowak & Topka, 2005). Other symptoms present include hypokinetic motor disabilities of the upper extremities, which include tremor, akinesia and rigidity (Nowak & Topka, 2005). It is caused by ventricular dilation and hydrocephalus at a normal cerebral spinal fluid pressure (Mararo et al., 2006). Normal pressure hydrocephalus is one of the few dementias that can be treated with surgery making early diagnosis and treatment extremely important.

Frontotemporal dementia is another type of dementia that effects the elderly population. Symptoms typically have a pre-senile onset and consist of chronic progressive behavioral changes and have disturbances of language and frontal functions (Bornebroek & Breteler, 2004). The disease is characterized by bilateral atrophy of the frontal and anterior temporal lobes with degeneration of the striatum (Bornebroek & Breteler, 2004). The average length of time for the disease from onset to death is 8 years and nearly half of the victims have a family history of dementia (Bornebroek & Breteler, 2004).

There are numerous other dementia types resulting from numerous diseases and syndromes including multiple sclerosis, Hashimoto’s encephalitis, systemic lupus erythematosus, cerebral vasculitis, sarcoidosis, limbic encephalitis, HIV-, Whipple’s disease and syphilis that affect the elderly and eventually necessitate the need for extended care (Thompson & Lennox, 2005). These diseases are relatively rare when compared to the main dementia diseases discussed above.
Geriatrics- A History

Geriatrics as a specialty in medicine is a relatively new concept with clinical geriatrics beginning in the 70’s and 80’s (Reuben et al., 2004). Geriatrics is the medical specialty that specifically deals with the health care management of older adults (Besdine et al., 2005). The mission of geriatrics is concentrated on improving the health, functioning, and well-being of older persons and, when this is not possible or is not the patient’s wishes, to provide palliative care that is consistent with the patient’s wishes (Besdine et al., 2005). Since its inception, geriatrics has strived to fulfill its mission. Proponents and advocates have strengthened the geriatric field by establishing the National Institute of Aging and by creating a body of scientific knowledge that directs the clinical care of older persons and establishes a foundation for future research (Besdine et al., 2005). Research devoted to geriatrics has resulted in significant findings including the identification of new clinical interventions for geriatric syndromes and for many other diseases common in older adults. (Besdine et al., 2005). Geriatric proponents have accomplished and continue to increase geriatric education in general and post-graduate education for physicians (Besdine et al., 2005). In addition, they have developed fellowship programs and certifications for training physicians in geriatric medicine (Besdine et al., 2005). In the future, geriatric proponents hope to improve geriatric care by increasing the amount of clinicians who apply the principles of geriatric medicine when caring for older adults, expanding geriatric knowledge to guarantee high quality care for all older adults, increase the amount of physicians and other healthcare professionals who specialize in geriatrics, and by influencing public policy to improve health care for older adults (Besdine et al., 2005).

Independence vs. Assisted Care

There is a significant difference in medical care and other characteristics between the elderly who are living independently and those residing in long-term care facilities. One survey study found that in respondents aged 65 to 74 years in age who lived in the
community, rates of dementia ranged from 1.9% to 8.3%. For respondents over the age of 85 years still living in the community, the dementia rate was 8.6% to 29.9% (Pressley, Trott, Tang, Durkin & Stern, 2003). In terms of the most prevalent dementia, Alzheimer’s disease, for community-dwelling patients diagnosed with Alzheimer’s, it is estimated that over half are in the moderate to severe stages of Alzheimer’s (Schmitt & Wichems, 2006). Institutionalized persons fare worse with up to 90% of those diagnosed with Alzheimer’s disease in the moderate to severe stages (Schmitt & Wichems, 2006). The percentage of elderly suffering from dementia increases significantly in the nursing home with about half of all nursing home residents suffering with dementia (Magaziner et al., 2005). One study compared inappropriate medication use between nursing home residents and community dwelling patients and found a rate of inappropriate medication use of 21% in ambulatory patients while nursing home residents had a rate of 38% (Rigler et al., 2004). The same study also found that community dwelling patients had lower rates of disease burden and fewer total medications than nursing home residents (Rigler et al., 2004). Interestingly, one study found that nursing home residents were less likely to exhibit hoarding behaviors than community-dwelling individuals, with 15% of nursing home residents and 25% of community dwelling individuals with hoarding behaviors (Marx & Cohen-Mansfield, 2003). Preventive home visits with medical and social care incorporated with case management has been shown to delay the onset of disability and reduce nursing home placement (Counsell et al, 2006).

**Need for interdisciplinary teamwork:**

Interdisciplinary care stems from the idea of multidisciplinary care. Multidisciplinary care is the concept that health care is delivered by a team with each member having different professional training and has different skills to bear (Nolan, 1995). With multidisciplinary care the main task is to coordinate the team effort, however, interdisciplinary care seeks to blur the professional boundaries requiring trust, tolerance and a willingness to share responsibility (Nolan, 1995). With the advent of clinical geriatrics during the 1970’s and 1980’s, healthcare workers and systems began to
recognize that no single health profession could possibly possess the knowledge and skills needed to manage the care of older adults (Reuben et al., 2004). One study that examined the effects of integrating mental health care into residential homes for the elderly found that the most successful model was one in which continuing mental health training and expertise was available (Train et al., 2005). Other studies have also reported much success when instituting interdisciplinary care into the nursing home (Besdine et al., 2005). Some experts, such as Burbank and colleagues, believe that geriatric care should rely on interdisciplinary care as older adults offer the most complex challenges in health care at all levels and interdisciplinary care is the most effective way of handling these challenges (Coogle et al., 2005). As interdisciplinary care broadens its participation, the more likely it will improve continuity of care, especially where teams work across settings (Macdonald, Herrman, Hinds, Crowe & McDonald, 2002).

Interdisciplinary care is advantageous because of the characteristics of dementia. One study came to the conclusion that it should be recognized that most long-term care is explicitly for people with dementia (Train et al, 2005). Individuals with dementia offer many challenges to health care provider. Among these challenges include the possibility of paranoid delusions, which occur in up to 50% of patients with Alzheimer’s, poor personal hygiene, wandering or getting lost while doing routine activities, incontinence and difficulties feeding themselves (Rakel, 2002). For these reasons, demented individuals are at a much greater risk to do harm to themselves also in addition to not maintaining a basic level of self-care. The burden for their safety and care is transferred to the caregivers, whether in an institution or at home. Part of interdisciplinary care of the geriatric patient includes care of their family members and caregivers. Families tend to report a need for education rather than emotional support and respite services (Kuhn, King & Fulton, 2005). Caregivers who are part of or connected to an interdisciplinary team have access to knowledge and education on the myriad of issues they face when caring for an elderly demented adult.
Geriatric health care is also facing financial difficulties. The Medicare trust fund is predicted to be exhausted by 2019, well before the population of older adults peak (Besdine et al., 2005). This challenge necessitates major revamping of the healthcare delivery and financing systems (Besdine et al., 2005). The healthcare delivery system is currently an ill-prepared, poorly organized physician workforce that inevitably means expensive and fragmented health care (Besdine et al., 2005). Some studies have shown reduction in costs through use of interdisciplinary teams by reduction in patient readmission rates and mean office visits (Leipzig et al., 2002). The solution may perhaps include the increased use of highly organized interdisciplinary health care teams to deliver care while decreasing the cost burden.

There exists segments of geriatric care where the method or approach of health care has not been solidified, in particular the assisted living patient. There has been a rapid growth of the assisted living-type residential living for older adults, and in the midst of this growth, the role of the physician has remained largely undefined (Schumacher, 2006). This is due partly to the industry’s strong promotion of a social model of care that is sharply delineated from medical models of care (Schumacher, 2006). Many physicians manage patients living in assisted living type facilities as they would community dwelling patients requiring office visits, interacting with only the patient or offering only off-site diagnostic testing (Schumacher, 2006). This may be egregious to the health care of those who live in assisted care because the physician is isolated from the other health care workers, social workers and other professionals who contribute to the individual’s care. With a large segment of the elderly population living in assisted living type settings and growing in number, an interdisciplinary approach to treatment should be developed while the method of health care for these individuals is still being molded. Another example supporting the need for interdisciplinary care is that the health care system is designed to provide acute care with the focus on treatment of a specific illness or symptom while, in reality, most health care is utilized by patients with chronic conditions and multiple comorbidities (Connor et al, 2002). This is especially true of the demented
elderly because not only do they suffer from dementia, a chronic disease; they are prone to many other chronic diseases such as arthritis, diabetes, and cardiovascular disease.

Unfortunately, the quality of care in extended care facilities, particularly in the nursing home, is lack luster. Quality problems in nursing homes remain even after the passage of the Nursing Home Reform Act fifteen years ago (Castle, 2005). A recent study by the US General Accounting Office reports that although nursing home quality has improved in recent years, there yet remains major quality problems (Weech-Maldonado et al., 2006). Other government reports identify up to 25% of the nursing homes in the U.S. having serious quality problems that can harm residents (Castle, 2005). One study that compared inappropriate medication use between nursing home residents and community dwelling patients found a rate of inappropriate medication use for 21% in community dwelling patients while nursing home residents had a rate of 38% (Rigler et al., 2004). By developing a team of interdisciplinary care workers that incorporates workers in the extended care facilities and community professionals, such as physician assistants, initiatives to improve care can be created, communicated amongst the team, implemented and evaluated. Also, by involving professionals who are not solely connected to the facility, such as the physician assistant, fresh insight may occur for quality care issues that might have been overlooked or undervalued.

**Advantages of Interdisciplinary Care:**

Multiple studies have shown the benefit to interdisciplinary approach for elderly care. For example, one study compared the mortality and morbidity of geriatric patients cared for by an interdisciplinary team or usual care after hip surgery. They found, for patients with mild to moderate cognitive impairment, 47% receiving interdisciplinary care demonstrated no decline in ambulation, transfers or residential status compared to 24% of patients receiving the usual care (Naglie et al., 2002). An interdisciplinary, collaborative practice intervention that included a primary care physician, a social worker and a nurse decreased hospitalizations in community-dwelling seniors with chronic
illnesses (Counsell et al., 2006). Another study looked at the geriatric patient in acute care and compared interdisciplinary care to the usual-care treatment. They investigators found that patients under the care of the “ACE intervention”, an interdisciplinary team of physicians, occupational therapists, physical therapists, and dieticians, had significantly better mobility, less physical restraints used and more satisfaction with the care they received (Palmer et al., 2003). In addition, recent studies suggest that the quality of care improves when interdisciplinary teams treat hospitalized geriatric patients (Coogle et al., 2005). One study found that outpatient comprehensive geriatric assessment combined with an intervention to guarantee compliance to recommendations or interdisciplinary primary care has been shown to prevent functional decline. Also, preventive home visits with medical and social care, incorporated with case management, have been shown to delay the onset of disability and reduce nursing home placement (Counsell et al., 2006).

Another major concern for the elderly in the long term care setting is medication use. Interdisciplinary teams have been shown to have the potential to help prevent adverse drug reactions (Levenson & Saffel, 2007). Some studies have demonstrated a reduction in costs through the use of interdisciplinary teams by a reduction in patient readmission rates and the mean number of office visits (Leipzig et al., 2002). Other studies examining the benefits of interdisciplinary care reported improvements in social activities, Mini-Mental State Examination, depression scores, functional status and perceived well being (Leipzig et al., 2002). Overall, it appears the geriatric population stands to benefit from an interdisciplinary approach to their care.

Advocates of Interdisciplinary Care:

There are many individuals and associations associated with the geriatric field who advocate interdisciplinary care for the elderly. A key supporter for interdisciplinary care for the elderly is the American Geriatrics Society (Mion et al., 2006). Their position is that interdisciplinary care better addresses the complex needs of older adults, improves
healthcare processes and outcomes for geriatric syndromes while benefiting the healthcare system and the caregivers (Mion et al., 2006). Another example is the Veterans Administration, which uses the team approach in primary and ambulatory care to expand the comprehensiveness of geriatric assessment and treatment (Coogle et al., 2005). Organizations and foundations are recognizing the need for interdisciplinary care for the geriatric patient and are providing monetary support. The John A. Hartford Foundation is one such organization, providing $10 million in 1995 under the Geriatric Interdisciplinary Team Training (GITT) program initiative (Coogle et al., 2005). The initiative was started because they recognized that health trainees received little, if any, explicit instruction on teamwork (Coogle et al., 2005). Some other examples of supporters of interdisciplinary care include a falls management program developed in 2002 by an interdisciplinary team at Emory University (Capezuti et al., 2007). This team included geriatricians, geriatric APNs, occupational therapists, and a geropsychologist whose goal was to work together to help prevent falls in the extended care setting (Capezuti et al., 2007). The concept of interdisciplinary teamwork extends beyond healthcare with many different fields and professions adopting the interdisciplinary approach. The National Institute for Science Education seeks to create interdisciplinary teams to improve the education in science, mathematics, engineering and technology (Derry et al., 1998). Researchers have also adopted the interdisciplinary approach and have created institutes, such as Rockefeller University, California Institute of Technology and Harvard’s Bauer Center for Genomics Research, devoted to interdisciplinary research (Robertson et al., 2003).

**Barriers to and Critics of Interdisciplinary Care:**

Unfortunately, there are many barriers to effectively utilizing physician assistants as part of the interdisciplinary management of the demented elderly. One problem is, there has been little study performed that examines the physician assistant’s role in elderly care. This is most likely due to the relative newness of the PA profession and a lack of understanding of the physician assistant’s role. Primary care physicians are also
found to be lacking training in geriatrics. Multiple studies have shown that many primary care physicians are unprepared or under prepared to deal with geriatric mental disorders because most receive little training in mental disorders of elderly patients (Halpain et al., 1999). Of the 100,000 practicing internists, only 4500 have certifications for geriatrics (Warshaw et al., 2006). The state of knowledge, or lack of it, by physicians, is also detrimental to the physician assistant who is employed by a primary care physician because many physician assistants model their treatment style after their employers. The knowledgeable and astute physician assistant should employ every opportunity to educate the primary care physicians they work with about the benefits of interdisciplinary care and reinforce the PA’s role in interdisciplinary practice.

The lack of education in the mental health dimension of geriatric interdisciplinary care may be exacerbated by the increasing need for care. The increase in the number of older adults will continue slowly and steadily until around 2010 when the population will rapidly swell and produce the largest age wave in history (Halpain et al., 1999). Sadly, interdisciplinary teams cannot be formed when there are not enough team members trained to meet the needs of the geriatric population. The number of geriatric and gerontologic specialists in mental health available across the disciplines is exceptionally small given the need (Halpain et al., 1999). It is estimated that 400 to 500 academic geriatric psychiatrists along with 1,221 physician faculty members and 919 non-physician faculty members will be needed by 2010 to provide adequate training in geriatric psychiatry (Halpain et al., 1999). This will be confounded by a predicted severe shortage in physicians by the year 2020 (Berlin & Hooker, 2002). Limitations in basic manpower will likely affect the capability of potential team members to explore new treatment methods such as the interdisciplinary team approach.

Another barrier is what one study termed the “disciplinary split” (Reuben et al., 2004). This is described as the situation that occurs when several different professions are brought together to learn how to work as a team in the care of older of adults but have
difficulty coming together because each profession has its own tradition, culture, and regulatory requirements (Reuben et al., 2004). This study examined several geriatric interdisciplinary team training programs and evaluated some of the potential causes for disciplinary split through interviews with participants and questionnaires. They found that medical doctors had great difficulty with the interdisciplinary training programs. Data from interviews plainly showed that medicine was perceived as the least enthusiastic among the disciplines (Reuben et al., 2004). Medical doctors also had the poorest attendance and were viewed as being the top of the hierarchy among the healthcare disciplines (Reuben et al., 2004). It is difficult to form a cohesive interdisciplinary team when the team player who is considered to be at the top of the hierarchy is perceived as being the least enthusiastic and demonstrates poor attendance. This idea is reinforced by a survey study that compared the attitudes about interdisciplinary care of post-graduate internal medicine or family practice residents, masters-level social work students and nurse practitioner students. Eighty percent of post-graduate physicians agreed with the notion that physicians have the right to alter patient care plans developed by the team and to have ultimate legal responsibility for the team (Leipzig et al., 2002). This contrasted with only 35-40% of nurse practitioner and masters of social work students who agreed that physicians can alter the team’s patient care plan and should have ultimate legal responsibility (Leipzig et al., 2002). Student’s perceptions and views are also a possible source of team conflict as team conflict may be manifest by differing professional and personal perspectives, role competition and differing interprofessional perceptions of roles (Leipzig et al., 2002). As these students become professionals, they tend continue their perceptions and views about their roles and the roles of other professions.

Communication is also vital to the survival of an interdisciplinary team. An initiative called the National Strategic Framework for Older People in the UK found that to give effective care, information about older people must be transferred between professions and organizational service boundaries (Payne et al., 2002). Though
technology has provided the healthcare worker with many more options for effective communication, it is still limited by time and work constraints.

**Physician Assistants as an Interdisciplinary Team Member**

PA’s have a unique opportunity to assert themselves as a viable and important interdisciplinary team member, helping to manage the care of the demented elderly in long-term care facilities. Numerous studies clearly show that the physician assistant’s quality of care is at the level of the care given by physicians in comparable situations while also resulting in high levels of patient satisfaction (Mittman, Cawley & Fenn, 2002). Actuary data also failed to show any increased liability as a result of utilizing physician assistants (Mittman et al., 2002). In the mid-1990’s renewed interest in the physician assistant profession was prompted by a perceived shortage of primary care physicians and the physician assistant profession subsequently grew (Berlin & Hooker, 2002). With the growth of the profession, access to care for some patients was improved suggesting that physician assistants are providing services, especially in primary care, to populations that otherwise would receive minimal services by physicians or no services at all (Berlin & Hooker, 2002). Unfortunately, due to the newness of the profession, not much literature is available that documents the advantages of incorporating the PA in the management of patients within an interdisciplinary team. However, because the PA often takes on much of the responsibility of the physician, the PA’s role will be similar to that of the physician’s with some minor limitations in practice. Also, the PA often functions in a similar role as the nurse practitioner because both professionals are considered mid-level practitioners. Therefore it can be argued that the research examining the APN’s role in the interdisciplinary team may be generalized to the PA (Mittman et al., 2002).

One way in which the physician assistant can be advantageous to the demented elderly patient in an interdisciplinary team is simply by doing what the profession was created for: functioning as a physician extender. Along these lines, physician assistants, acting as physician extenders, can help to alleviate the workload and burden of physicians
caring for the elderly. A survey performed on large group practice physicians found that they were dissatisfied with stress-related aspects of day-to-day practice, in particular workload and patient volume (McMurray et al., 1997). The same survey was given to managed-care group participants and found that participating women physicians also emphasized concerns about workload. (McMurray et al., 1997). The physician’s role is to evaluate the nursing home resident at the time of admission, at periodic visits every 30 to 90 days, when acute problems occur, and at the time of annual review for residents who stay longer than one year (Ouslander & Osterweii, 1994). This adds up to a lot of time for the required visits and extra visits for patients with health problems. Given that most demented elderly situated in long term care facilities are not able to drive themselves to appointments, physicians must often travel to nursing homes to see the patients, making their care even more time consuming. By developing a model that uses the PA to provide patient visits and follow-up care, it may allow time for more communication among the social worker, nursing staff, physical and occupational therapists and any other specialists that are needed in the patient’s care and who may also be members of the interdisciplinary team.

Physician Assistants are also cost effective, which provides an added benefit to the interdisciplinary team as the interdisciplinary patient can be costly (Mittman et al., 2002). In one study, 26 primary clinics in a group managed care organization were examined to see the cost saving advantage of using PA and NPs. It was found that the clinics using greater numbers PAs had lower labor costs (Forrest et al., 2007). Another example is found in one study that compared physician assistants and physicians and their practice styles in occupational medicine. It was found that physicians see an average of 2.9 patients per hour while physician assistants saw 2.5 patients per hour (Hooker, 2004). However, physician assistants worked more hours and saw more patients per year than physicians but were only paid half of what the physician was paid (Hooker, 2004).
Hospitals have also found the utilization of physician assistants is cost effective while often increasing the quality of care. Harborview Medical Center, a large level one trauma center, was having financial problems in their radiology department with rapidly increasing volume of work, insufficient reimbursement and rapid increases in radiologist’s salaries (Blackmore et al., 2004). Their solution was to hire and train physician assistants (Blackmore et al., 2004). Their emergency department, which closely interacts with the radiology department, has since reported improved communication and much more consistent practice in accord with joint Emergency Department, trauma surgery and radiology protocols (Blackmore et al., 2004).

Because many physician assistants come from another health care background, their diversity in health care training makes them ideal to work and interact with other professions. Physician assistants often start out as nurses, medical assistants, paramedics, nursing assistants, corpsman, dieticians, respiratory therapists and many other professions. Most have worked in health care for an average of 24 months (Hooker, 2004). Their background and experience lends itself to the understanding of other health care professionals’ roles and skill sets, which supports interdisciplinary team members’ interactions. The PAs’ backgrounds and experiences any also help to alleviate the “disciplinary split” phenomenon discussed earlier. Building upon this diversity of backgrounds, physician assistants are very mobile amongst the different specialties and practices. Many physician assistants have worked in diverse health care settings, including hospitals, ambulatory care and in a variety of specialties and sub-specialties. Their diverse healthcare experience will serve to make the physician assistants valuable members of the health care interdisciplinary team.

**Conclusion:**

Health care for the demented elderly is facing a crisis as the amount of qualified clinicians needed does not meet the demands for care of the aging population. Because the care of the geriatric patient is so complex, many experts believe an interdisciplinary
approach is the key to proper healthcare. Interdisciplinary teamwork allows professionals taking care of different aspects of the geriatric patient’s whole care to work together, collaborate and communicate efficiently. This approach is especially valuable in extended-care as the residents are regularly in contact with nurse aids, nurses, social workers and other professionals working at the facility. The physician assistant can be a valuable part of the interdisciplinary team caring for older adults in extended care by handling their health care needs and helping to educate other caregivers. Though there are many barriers to building an efficient interdisciplinary, such as cost, difficulties collaborating between professions, and lack of education and educators, the physician assistant has the potential to overcome these barriers. This is because the physician assistant is cost effective, has experience working as other types of healthcare professionals and working in different fields of medicine and can help to extend the role of the physician. Physician assistants who share a love of geriatric medicine and a heart for geriatric patients in extended care have an opportunity to greatly increase the quality of care through promotion and participation in interdisciplinary care.
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