Interdisciplinary Team Building, Management, and Communication

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The 2018 Disability-Competent Care Webinar Series:
Interdisciplinary Team Building, Management, and Communication
Webinar Overview

- The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This is the fifth webinar in the series.
- This webinar series builds on the 2017 Disability-Competent Care webinar series, that introduced the model of care and its seven foundational pillars. To view this series, please visit: https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2017_DCC_Webinar_Series/Series_Overview
- Each session will be interactive (e.g., polls and interactive chat functions), with 45 minutes of presenter-led discussion, followed by 15 minutes of presenter and participant discussions.
- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com
This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com
Continuing Education Accreditation

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET) for Continuing Education Units (CEU) and by the Accreditation Council for Continuing Medical Education (ACCME) for Continuing Medical Education (CME, AMA PRA Category 1 credit for physicians and non-physicians).
Obtaining Continuing Education Credit

- Complete the post-test through CMS’ Learning Management System and score a 80 percent or higher by midnight April 9, 2018.

- [https://resourcesforintegratedcare.com/sites/default/files/DCWebinar5_CE_Credit_Guide.pdf](https://resourcesforintegratedcare.com/sites/default/files/DCWebinar5_CE_Credit_Guide.pdf)
Introductions

Christopher Duff
Disability Practice and Policy Consultant

Mary Glover
Founder, Boston Community Medical Group

Cindy Guddal
Manager, Allina Health Courage Kenny Rehabilitation Institute
Webinar Learning Objectives

This webinar will emphasize:

- The structure of the interdisciplinary team (IDT) and how it benefits people with disabilities
- Approaches to effectively facilitate IDT meetings to ensure they meet the unique needs of people with disabilities
- The utility of the IDT and how it can be applied in different care settings
- Strategies to facilitate communication between internal and external IDT members
Agenda

- Introduction to the interdisciplinary team (IDT)
- The IDT at the Boston Community Medical Group
- Using the IDT in alternative care settings
- Applying the IDT in alternative models of care and services at Courage Kenny Rehabilitation Institute
  - An IDT within the advanced primary care clinic
  - An IDT within in-home community services
- Audience questions
Introduction to the Interdisciplinary Team

Mary Glover
Founder, Boston Community Medical Group
Health Disparities

Individuals with disabilities are more likely to:¹,²

- Experience worse health outcomes
- Experience difficulties or delays in receiving necessary health care

The unique challenges individuals with disabilities face often contribute to health disparities. Several common challenges are:³

- The lack of a strong primary care provider (PCP) relationship. Often PCPs lack the skills or infrastructure required to meet the needs of those with disabilities.
- The lack of communication and coordination between specialists which may lead to hospitalization for otherwise preventable complications.

The use of an IDT may help to address these challenges by creating a team that assumes responsibility for the totality of the participant’s care.

Sources: 1) Office of the Assistant Secretary for Planning and Evaluation; 2016
2) Disability and Health. Healthy People 2020
3) Health Affairs Blog; 2012
Health care is a multi-disciplinary profession in which doctors, nurses, and other providers from different specialties work together, communicate often, and share resources and accountability.

Bringing together health care professionals from different disciplines is a central theme woven throughout the disability-competent care (DCC) model and allows for better outcomes.

The core members of the DCC interdisciplinary team (IDT) include a primary care practitioner, a nurse, a social worker, and a behavioral health specialist.
Interdisciplinary Team within DCC

- The complex needs of the dually eligible population make the use of an IDT a key mechanism for delivering quality health outcomes. In particular, dually eligible beneficiaries often require:
  - Multiple medical specialists (e.g., physicians, occupational therapists, physical therapists, etc.)
  - Complex health and social services (e.g., mental health therapists, housing supports, in-home personal care, eligibility for financial assistance)
  - Immediate responsiveness to prevent the development or escalation of episodes of illness
Purpose of the Interdisciplinary Team

The goal of the IDT is to help participants receive the care they need and achieve their identified goals. The IDT:

- Facilitates participant goal setting, problem solving, and care in a coordinated, cost-effective manner.
- Fosters communication among its different members - an essential and a key component to the participant's success.
  - Communication among the different disciplines is often frequent, structured, and documented.
- Brings together knowledge and specialties from different disciplines. Team members are responsible individually and collectively for the participant’s care.
- Depending on the context of the IDT, participant’s input is facilitated by a designated team member.
  - Shared decision making between the participant can add value.
Responsibilities of the IDT

The IDT maintains several responsibilities, including:

- Addressing urgent and acute episodes of care*
- Proactively managing emerging needs*
- Managing care transitions*
- Assessing and creating the participant’s individualized plan of care (IPC)
- Implementing, managing, and overseeing the IPC
- Allocating care management and resources
- Tailoring services and supports

*Those with functional limitations are especially vulnerable during these situations and require timely and time intensive intervention.
Purpose of IDT Meetings

Effective IDT meetings are centered around meeting the needs and goals of participants. To accomplish this, regular IDT meetings* can be used as a successful tool. They allow its members to:

- Build relationships
- Share information (e.g., participant medical updates, and administrative updates)
- Work together to identify and solve problems
- Develop IPCs with input from all disciplines
- Disseminate learning experiences and foster a continuous learning environment
- Support other team members

*Meeting frequency is dependent on the complexity and unique needs of the participants served by the IDT
Elements of Effective IDT Meetings

- Provide all members of the IDT a clear understanding of the team and participant’s goals
- Include appropriate team members
- Develop an agenda for the meeting
- Start the meeting on time
- Take minutes and distribute them promptly after the meeting
- Build rapport between team members, and include input from the participant
- Strive for consensus on key decisions
- Develop action items and assign responsibility
- Revise the meeting process and structure, as necessary
IDT at the Boston Community Medical Group

Mary Glover
Founder, Boston Community Medical Group
The Boston Community Medical Group (BCMG) is an interdisciplinary practice that provides primary care to adults with disabilities and seniors.

BCMG was structured as an independent practice group to serve members of Commonwealth Care Alliance (CCA), a health plan serving dually eligible beneficiaries in Massachusetts.

All BCMG participants are enrolled in a health plan are dually eligible, except for a small number who have been grandfathered into the plan but who do not qualify for Medicare.

BCMG’s three primary care center locations provide comprehensive DCC to adults of all ages, including those who may have complex physical, developmental, intellectual, and behavioral health conditions.
The BCMG Interdisciplinary Teams

- IDTs at BCMG are comprised of:
  - Nurse practitioners
  - Physicians and physician assistants
  - Social workers
  - Behavioral health specialists
  - Rehabilitation specialists: physical therapy and occupational therapy
  - Durable medical equipment (DME) specialists
  - Administrative support staff
  - Hospitalist
  - External specialists and consultants, as applicable

- The IDT must be flexible to include additional team members as needed to be responsive to each participant’s unique care needs and goals.
BCMG Team Meetings

- The IDT at BCMG meets for two hours each week to discuss the panel of participants assigned to the team. On average, 25 percent of the panel will be discussed in one meeting.

- Weekly meeting attendees include all team members, such as:
  - Nurse practitioners/physician assistants, physicians, and social workers
  - Administrative staff participate in the non-clinical portion of the meeting to discuss operational issues
  - Rehabilitation coordinator: answers questions related to speech, occupational and physical therapy
  - Behavioral health (BH) specialist: offers input regarding BH questions and plans
  - Psychiatrist: provides consultation for complex BH needs (e.g., medication changes)
A standard agenda at an IDT meeting includes the following items:

- Announcements
- Enrollment activity: new cases assigned and presented
- Clinical coverage and scheduling updates
- Review of hospitalized participants, including acute, sub-acute, emergency room visits, and recent discharges
- Clinical presentations and review of guidelines
- Case discussions with a problem-oriented approach
  - Team members identify cases for discussion
- Morbidity and mortality rounds
A meeting facilitator for the IDT is identified to organize the agenda, take notes, and monitor the time. However, different team members will take turns leading the discussion.

Participants and any external specialists are consulted outside of routine IDT meetings due to the large amount of information discussed during settings. A designated team member will be responsible for coordinating consultation.

- Usually, it is the care coordinator’s responsibility to relay information to and from the participant and their specialists.
IDT Meeting Challenges

- During weekly meetings, the IDT routinely reviewed the care plans of participants assigned. However, time efficiency became a challenge as the program grew and more participants were being managed by each IDT member.
- The BCMG team adopted a more problem-oriented approach for the IDT meetings.
  - IDT members were expected to come prepared with participant updates and key questions.
  - IDT managers reviewed the standard agenda to see what could be taken off-line, e.g. regular reassessments.
  - Meetings focused on hospitalized participants and those with urgent needs.
  - An increased focus on relaying information rather than in-depth case discussions.
IDT Meeting Best Practices

- Value the diversity of opinions among team members.
  - Encourage an environment where providers are comfortable requesting advice from other specialists.
- Maintain positive group dynamics.
  - Establish reliable, positive working relationships and regular communication exchanges between providers, e.g., between primary care providers (PCPs) and behavioral health specialists.
- Encourage smooth hand-offs between providers with routine discussions of participant care issues prior to and after same-day visits. PCPs can keep half of their daily schedule available to respond to urgent needs.
- Encourage the use of new technology and techniques to expand participation and improve efficiency.
  - Offer periodic training and education for staff on specialized topics that are of particular relevance to the participant population,
  - New technologies can include telemedicine and remote monitoring.
Applying the IDT in Alternative Models of Care and Services at Courage Kenny Rehabilitation Institute

Cindy Guddal
Manager, Allina Health
Courage Kenny Rehabilitation Institute
Courage Kenny Rehabilitation Institute

- Courage Kenny Rehabilitation Institute (CKRI), part of Allina Health, provides rehabilitation services for people with short- and long-term chronic conditions, injuries and disabilities. Facilities are located in Minnesota and western Wisconsin.

- CKRI’s unique combination of rehabilitation, support, and lifestyle services address the needs of the whole person. More than 94,000 lives were touched in 2015.

- Two CKRI programs referenced in this webinar are:
  - Advanced primary care clinic
  - In-home community services
Program Descriptions

Advanced Primary Care

- The Advanced Primary Care (APC) clinic is a state-certified medical home where participants are managed by an IDT. Services include:
  - Primary care services

- Program goals center on helping the participant manage complex neurological condition(s) in an effort to maximize function and achieve life goals.

In-Home Community Services

- The in-home community services program consists of several unique LTSS programs. Services include:
  - Independent living skills
  - Community behavioral services
  - Adult rehabilitative mental health services (ARMHS)

- Program goals center on working with the participants to build a life that is important and meaningful; identify and pursue goals; develop skills, remove barriers, and connect with resources.
Program Objectives

Advanced Primary Care

- The APC clinic was created to bring coordination between acute care settings and other providers of care; helping to address three immediate challenges.
  1. Limited PCP understanding and knowledge of participants with disabilities
  2. Limited capacity to meet the populations needs within a traditional primary care clinic context
  3. Greater responsiveness / flexibility to meet the needs of participants with disabilities.

In-Home Community Services

- The in-home community services program was designed to work with participants to teach the skills required to work / live within the community and to help address immediate challenges, as they arise.
  1. Limited services were available to support participants in achieving goals within:
     - Their home
     - The community
Program Populations

**Advanced Primary Care**
- Participants generally have a primary neurologic or other physically disabling injury that limits their ability to obtain primary medical care in a typical clinic setting.
  - 42 percent are dually eligible beneficiaries
  - 34 percent Medicaid-only beneficiaries
  - 11 percent Medicare-only beneficiaries
- On average, participants have a total of seven co-occurring conditions and 11 active medications.

**In-Home Community Services**
- Participants have a physical disability such as an acquired brain injury, stroke, spinal cord injury or Cerebral Palsy that limits their ability to be successful in community living.
  - 42 percent are dually eligible beneficiaries
  - 55 percent Medicaid-only beneficiaries
- Many participants present with co-occurring behavioral health disabilities.
## Program IDTs in Practice

<table>
<thead>
<tr>
<th>IDT Components</th>
<th>Advanced Primary Care</th>
<th>In-Home Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDT Composition</td>
<td>Internal team members</td>
<td>External team members</td>
</tr>
<tr>
<td>IDT Members</td>
<td>Care coordinator (registered nurse), primary care provider, PM&amp;R*, occupational and physical therapists, speech therapist, physiatrist, and mental health provider</td>
<td>Composition is fluid, includes: case manager (from referral source), provider (from CKRI program), and the participant</td>
</tr>
<tr>
<td>IDT Leader</td>
<td>Led by the care coordinator</td>
<td>Led by the external case manager</td>
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*Physical Medicine and Rehabilitation (PM&R) Physician*
## Program IDTs in Practice

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<th>IDT Components</th>
<th>Advanced Primary Care</th>
<th>In-Home Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Structure</td>
<td>Formal / standardized</td>
<td>Informal / when problems arise</td>
</tr>
<tr>
<td>Meeting Frequency</td>
<td>Weekly</td>
<td>Ad-hoc</td>
</tr>
<tr>
<td>Meeting Duration</td>
<td>1 hour</td>
<td>As needed</td>
</tr>
<tr>
<td>Communication</td>
<td>Centralized medical record, team meetings, and messaging</td>
<td>Communication books, phone calls, and planning forms</td>
</tr>
<tr>
<td>Methods</td>
<td></td>
<td></td>
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<tr>
<td>IDT Goals</td>
<td>Coordinating acute and primary care, aligning goals and services, and sharing updates</td>
<td>Coordinating care, aligning goals and services to improve functioning within the community, and sharing updates</td>
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Coordinating Communication

- Methods for managing team communication to reduce silos of care include:
  - Using effective communication methods such as
    - Phone calls
    - Secured email messages
    - A communication book carried by participant to prepare for and make notes during the visit
    - A communication book kept in the participant’s home that is filled out by home care or service providers when they interact with the participant
  - Written instructions for support persons e.g. a personal care attendant
  - Shared appointments for in-person meetings to include multiple providers in one visit with the participant
  - Keeping an up-to-date list of care team providers and their roles and shared with the participant
  - Routine prioritization of care plan goals and outcomes
Coordinating Communication

- Preparing the participant to communicate with their team and providers can improve care coordination. Providers can help build skills that support the participant's effective self-advocacy:
  - Plan for appointments, e.g. identify questions to be addressed during the appointment
  - Rehearse the appointment to help with assertiveness and encourage active participation
  - Identify recommendations and follow-ups post-appointment and review these with the case manager
Involving the Participant

- Provide participants clarity about the various roles of their IDT members and providers:
  - Case manager vs. care coordinator
  - Clinic vs. health plan
  - Which community service provider helps with which health issues
  - Care coordinators from the physician clinic vs. the care coordinator from the health plan
    - Which community service provider provides support for health issues
    - Which provider to contact for support regarding BH issues
- Respond to the participant and those involved in their care in a timely fashion
- Understand the barriers people face
- Address conflicting priorities among the participant, payors, and providers
Involving the Participant

- Shared decision making is a process that involves two experts: the provider and the participant.
  - The provider knows the evidence-based medical options
  - The participant knows his or her values, preferences, and particularly, their experience with their disability
- Together, they choose a treatment, test, or screen after reviewing decision aids/documents that detail options in an unbiased manner.
- The process of shared decision making helps to ensure that participants are well-informed, and choose a course of care consistent with their values and preferences.
- Decision aid examples can be found: [https://www.allinahealth.org/Health-Conditions-and-Treatments/Health-library/Patient-education/Shared-decision-making-decision-aids/](https://www.allinahealth.org/Health-Conditions-and-Treatments/Health-library/Patient-education/Shared-decision-making-decision-aids/)
Tools to Support Teamwork, Coordination and Communication

- Clearly defined and articulated care plans that are shared with the participant and that:
  - Identify goals
  - Describe what is to be done
  - Specify when it is to be done
  - Highlights the responsible party

- Appointment planning sheets for the participants

- Summaries of visits, including clear directions for follow-ups

- Protocols for common medical issues such as:
  - Urinary Tract Infections (UTI’s)
  - Skin Breakdowns
  - Upper Respiratory Infections
Lessons Learned

- Communication and coordination of care within the IDT is far more effective and efficient when the participant is primarily served within a single care system as compared to providing care across multiple distinct care systems.

- Regardless of where the IDT resides or functions, there must be an overall coordinator of care and access point for the participant.

- Routine systems and procedures need to be in place to ensure good communication and that updates are clearly and fluidly disseminated to all involved providers, especially upon the occurrence of an injury or hospitalization.
First Person Story: Mary Jo

- Mary Jo is a 60 year old woman with multiple sclerosis and bipolar disorder.
- She lives alone in a condominium, and her only family members are her elderly parents who live over two hours away. She values her community but has become increasingly isolated.
- Mary Jo is dually eligible and receives LTSS through a Medicaid waiver.
- Multiple sclerosis impacts her with cognitive deficits including memory loss, though her mobility is not impaired. Her services from CKRI include primary care at the APC clinic and community-based Independent Living Skills (ILS) services.
- She also receives in-home nursing and personal care attendant supports and sees medical specialists from providers outside the Allina Health system. ILS services have been instrumental in removing barriers to her receiving proper medical care.
Coordination strategies included:

- Working with Mary Jo to keep track of appointments, using memory compensation strategies, cueing her to contact providers as needed, and ensuring that she is providing accurate information to providers.
- Having the clinic care coordinator follow up with Mary Jo via phone calls and messages, and attending medical appointments when complicated information is shared.
- A shared medical record that allows each care team member access to the ICP and reinforces follow-up activities.

Without this level of coordinated care, Mary Jo is at risk of needing to move to a more supported housing setting, in turn losing her home. She values her independence and the community of people so such a loss would be devastating.
Coordinating Care Between CKRI Services

Care coordination between providers in the clinic and the multiple services offered through in-home community services is critical for achieving care goals. When Mary Jo was served through both programs, successful communication strategies included:

- A central location to view participant records and notes (e.g., single electronic health record)
- Frequent communication with care coordinators regarding the participant’s needs, preferably through regularly scheduled meetings
- Having community services staff attend the participant’s appointments
- Defining complementary goals in each service’s care plan
  - Care plans are distinct and specific to the service provided, but may have complementary goals (e.g., the clinic may have a goal of improved adherence to special diet; LTSS would have a goal involving meal planning or grocery shopping).
Next Webinar

Managing Transitions with Adults with Disabilities
Date: March 28th, 2018
Time: 2:00pm-3:00pm ET
Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at:
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Send Us Your Feedback

Help us diversify our series content and address current Disability-Competent Care training needs – your input is essential!

Please contact us with your suggestions at RIC@Lewin.com

What We’d Like from You:

- How best to target future Disability-Competent Care webinars to health care providers and plans involved in all levels of the health care delivery process
- Feedback on these topics as well as ideas for other topics to explore in webinars and additional resources related to Disability-Competent Care
Sources

1. Office of the Assistant Secretary for Planning and Evaluation. (2016). Report to Congress: Social Risk Factors and Performance under Medicare’s Value Based Purchasing Programs


Resources

- NPD Solutions: Effective team meetings:
  - [www.npd-solutions.com/meetings](http://www.npd-solutions.com/meetings)
- Allina Health: Shared decision making decision aids
  - [https://www.allinahealth.org/Health-Conditions-and-Treatments/Health-library/Patient-education/Shared-decision-making-decision-aids/](https://www.allinahealth.org/Health-Conditions-and-Treatments/Health-library/Patient-education/Shared-decision-making-decision-aids/)