

Effective Interdisciplinary Team Meetings

The Disability-Competent Care (DCC) model is participant-centered and focuses on achieving and supporting maximum function for the dually eligible population with disabilities.¹ The model encourages health care professionals to collaborate across disciplines and care settings, and to engage in meaningful partnerships with participants to develop their individualized plan of care (IPC).

Participants who are dually eligible for Medicare and Medicaid, who also live with disability, commonly experience functional limitations and multiple medical and/or behavioral health issues. These issues are often compounded by social determinants of health, such as poor access to transportation and employment, housing and food insecurity, and communication barriers. While the participant may be medically stable and healthy, the participant's experienced social determinants of health can compound functional limitations in day-to-day activities.

The Interdisciplinary Team (IDT) is designed with the purpose of supporting the health and well-being of participants in a collaborative, structured, and person-centered way. An IDT brings together providers from various specialties with diverse knowledge to respond to the participant's physical and clinical needs while also considering the participant's emotional, social, intellectual, and spiritual needs. Responsibilities of the IDT include addressing acute episodes of care, proactively managing emerging needs, tailoring services and supports, and managing care transitions.²

Team meetings have five key purposes:

- 1) Communicating administrative information;
- 2) Reviewing utilization, including emergency room (ER) visits, acute/sub-acute hospitalizations, and authorizations and service decisions;
- 3) Preparing for care transitions;
- 4) Conducting routine quarterly/biannual care reviews; and
- 5) Conducting requested participant care review/consultation.

Successful IDTs are structured to address the needs of participants through frequent, organized, and documented communication across disciplines and with the participant. Regular IDT meetings allow team members to share information and updates, collaborate to solve problems, and develop and update the participant's IPC. The purpose of this resource is to assist health care professionals working with dually eligible individuals who have disabilities in effectively preparing for and managing IDT meetings. This resource includes tips for effective IDT meetings, templates for use during IDT meetings, and instructions on how best to use those templates.

¹ For more information about the DCC model, visit the Resources for Integrated Care website at <https://www.resourcesforintegratedcare.com/concepts/disability-competent-care>.

² For more in-depth information about IDTs, view the recording of the Interdisciplinary Team Building, Management, and Communication webinar at https://resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Interdisciplinary_Team_Building

General Practices for Effective IDT Meetings

- **Composition:** In the DCC model, the core members of the IDT include the participant, a primary care provider, a care coordinator, a nurse, a social worker, and a behavioral health specialist. Other health care providers, such as rehabilitation specialists, durable medical equipment (DME) specialists, and hospitalists, may also be included as needed. These team members bring an understanding of the participant's specific physical limitations and knowledge about accommodations to meet their needs. As members of the IDT, these multidisciplinary providers are responsible, individually and collectively, for the participant's care. Participants are invited to all IDT meetings, but may choose not to attend; in these instances, the care coordinator usually represents the participant's perspective and emphasizes the need to continually consider the participant's preferences and goals. Decisions are not finalized until the participant has been consulted.
- **Frequency:** Team meetings can be held weekly or bi-weekly, and members can attend in-person or virtually.
- **Duration:** The length of the meeting will vary based on the number of participants to be discussed and the complexity of the participant's needs. Generally, meetings run 60-90 minutes. Due to patient confidentiality issues, the designated IDT lead (commonly the care coordinator) will need to carefully coordinate participant attendance such that each participant is only present during their portion of the discussion. IDT members are encouraged to use their electronic health record (EHR) to provide team members with participant-specific updates prior to the meeting. This allows the team to prioritize items requiring discussion during the meeting time.
- **Number of Participants Discussed:** This will vary depending on meeting frequency and the intensity of the needs being addressed.

The following templates are available at the end of this resource to assist with preparing for and managing IDT meetings:

1. IDT Meeting Agenda Template
2. Participant Care Review and Consultation Template

How to Use the IDT Meeting Agenda Template³

Effective IDT meetings have a clearly defined purpose, agenda, and leader. The designated IDT lead is tasked with preparing and populating the meeting agenda; collecting, summarizing and including participant information in the agenda; and distributing this information to IDT members prior to each meeting. This allows team members to arrive at the meeting prepared to discuss the identified participants. The IDT meeting agenda template helps to define the purpose of each meeting and prepares members by including topics or questions that require team discussion; it also serves as a location for the IDT lead to track notes, action items, and assignments during the meeting. Effective time management is helpful to ensure all topics are covered within the available time. While the IDT lead is responsible for keeping the discussion on track, all team members should be mindful of the time. Content for each meeting may include:

³ Completed agendas will likely contain Personally Identifiable Information (PII) and Protected Health information (PHI). It is the organization's responsibility to comply with Health Insurance Portability and Accountability Act (HIPAA) and other health-related laws and regulations concerning participant information. In addition, if information on multiple participants is included on the same agenda, it should not be shared with participants. The IDT lead may want to develop a separate agenda for each participant to be discussed.

Administrative Information:

- Communicate revised policies, processes, benefits, staffing changes, or other organizational information relevant to team members or the participants. Be sure to fully explain how this will impact the care or daily life of the participant.

Utilization Review:

- **ER Visits:** Review the participant's ER visit(s) since the last team meeting and whether this would indicate that they should be classified as a "high utilizer"; include location of ER, diagnoses, outcomes, follow-up recommendations, and medications. Encourage the participant to share their experience from this visit and consider the participant's perspective as to why they visited the ER when determining classification as a "high utilizer."
- **Acute/Subacute Hospitalizations:** Review new and ongoing hospitalizations and institutionalizations since the last meeting, and discuss discharge planning. Seek the participant's perspective on their care setting and desires for discharge planning.
- **Authorization and Service Decisions:** Discuss decisions that are out of the ordinary or require review and authorization. For those participants affected by these decisions, seek their perspective and preferences prior to the meeting so the participant's input can be appropriately prioritized for effective time management during the meeting.

Care Transitions:

- Review care transitions and the participant's preferences for transitioning, whether in process or planned. This includes all forms of transitions in which gaps commonly occur, including changes in care supports and residence.

Quarterly/Biannual Care Review/Care Planning:

- Care reviews are routinely conducted on either a quarterly or biannual basis. Prior to the meeting, the IDT members, individually or as a group, meet with the participant to complete a reassessment and develop recommendations for care plan or service changes. These are reviewed and finalized at the team meeting.

Participant Care Review and Consultation:

- IDT members or a participant commonly request care reviews and consultations to update the IDT on significant changes with a participant, or discuss a situation that is particularly challenging for a team member. This is an opportunity to obtain new perspectives about a participant's care from other members and to problem solve together. The participant should be made aware of these challenges and given the opportunity to provide their perspective or preferences for care planning. The IDT should be sure to consider this perspective and prioritize participant values and desires for person-centered care planning. Example topics that might be addressed include housing challenges, ethical dilemmas, complex clinical decisions, conflicts with the participant, dignity of risk, safety issues (either for the participant or the care team), and other challenges faced by the provider. See the *Participant Care Review and Consultation Template* for further information about preparing for this discussion.

Action Item Follow-up:

- Review action items from previous meetings, as needed.

IDT Administrative Items/Preparation for Future Meetings:

- Review upcoming meeting information, topics to be discussed, and other IDT or organizational announcements. This will be the initial draft of the agenda for the next meeting.

How to use the Participant Care Review and Consultation Template⁴

IDT members complete the *Participant Care Review and Consultation Template* to prepare for and facilitate the care review/care planning portion of the meeting. Additionally, each participant should be invited to join this discussion. Prior to the meeting, the IDT lead should identify the participants for review and collect pertinent information related to each case, prioritizing the participant's perspective and preferences around their care. If time allows, multiple participants can be reviewed during one meeting; however, separate templates should be completed for each participant. The care review and consultation template focuses the discussion to ensure key information is captured and shared with IDT members. The review and consultation should be concise and focused on addressing critical participant issues, such as ethical dilemmas and challenging clinical situations. The following information can be included in the participant care review and consultation⁵:

- **Participant Name and History:** A brief summary of the participant and pertinent history for the purpose of the care review, including care needs.
- **Participant Assessment and Goals:** A summary of the participant's most recent assessment and their goals.
- **Issue(s) for Discussion and Care Coordinator Recommendation:** Identification of issue(s) for discussion with the IDT, initial recommendations from the participant's care coordinator, and consideration of the participant's preferences. Examples include clinical or ethical concerns, referral resources, and participant relationships with IDT members or care partners. Due to time considerations, include a few key priority issues, as well as the participant's perspective, rather than an all-encompassing list.
- **Action Plan and Follow-up:** A detailed summary of the IDT discussion and recommendations for follow-up. These may not be decision points, but rather, issues for further exploration and review with the participant.
- **Responsible Team Member(s):** Identification of the IDT member(s) who will provide leadership and assistance to the care coordinator moving forward on matters discussed during the meeting. This may include overseeing referrals to specialists or other organizations, interventions, and any follow-up.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to ensure that beneficiaries enrolled in both Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This resource is intended to support health plans and providers in integrating and coordinating care for Medicare-Medicaid enrollees. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to <https://www.resourcesforintegratedcare.com/>.

⁴ Completed templates will likely contain Personally Identifiable Information (PII) and Protected Health information (PHI). It is the organization's responsibility to comply with Health Insurance Portability and Accountability Act (HIPAA) and other health-related laws and regulations concerning participant information.

⁵ Note: The Participant Care Review and Consultation Template generally follows the "Situation, Background, Assessment, and Recommendation" or SBAR format. For more information about this format, please visit the SBAR tool available here: <https://www.resourcesforintegratedcare.com/sites/default/files/DCCSBARTool.pdf>.

Interdisciplinary Team Meeting Agenda Template

Date & Time: _____

IDT Lead: _____

Location: _____

Note Taker: _____

Call in Number: _____

In-person Attendees:

Remote Attendees:

Topic	Discussion	Action Plan / Follow-up	Responsible Team Member(s)
Administrative Information			
ER Visits <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			
Acute/Subacute Hospitalizations <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			
Authorization & Service Decisions <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			

<p>Care Transitions</p> <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			
<p>Quarterly/Bi-Annual Care Review/Care Planning</p> <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			
<p>Participant Care Review and Consultation (complete template for each Participant)</p> <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) 			
<p>Action Item Follow-up</p> <ul style="list-style-type: none"> • Participant name (1) • Participant name (2) • Non-participant related action items 			
<p>IDT Administrative Items/Preparation for Future Meeting(s)</p>			

Participant Care Review and Consultation Template

Participant: _____

Meeting Date: _____

Participant History (including care needs):

Participant Assessment and Goals:

Issue(s) for Discussion and Care Coordinator Recommendation:

Action Plan and Follow-up:

Responsible Team Member(s):