Interdisciplinary Team Building, Management, and Communication

Using an interdisciplinary team (IDT) can be a helpful tool to deliver quality health care and outcomes for the dually eligible population with disabilities. Individuals with disabilities face unique challenges that contribute to health disparities. In particular, this population often requires multiple medical specialists, a range of health and social services, and immediate responsiveness to prevent the development or escalation of acute conditions. For instance, participants with disabilities frequently lack a strong primary care provider (PCP) relationship due to PCPs' limited resources to meet the needs of those with disabilities. Additionally, the lack of communication and coordination among a participant's multiple specialists and ancillary providers may lead to hospitalizations for otherwise preventable complications. The IDT can help to address these needs by assuming responsibility for the totality of the participant's care.

An IDT brings together the knowledge and specialties from different health care disciplines to help participants receive the care they need. In the disability-competent care (DCC) model, the core members of the IDT include a PCP, 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 then responsible, individually and collectively, for the participant's care. Responsibilities of the IDT include addressing urgent and acute episodes of care, proactively managing emerging needs, tailoring services and supports, and managing care transitions.

An essential component to the IDT's success in addressing the needs of participants is frequent, structured, and documented communication across disciplines. For this reason, effective teams have regular IDT meetings. Such meetings allow team members to share information and updates, collaborate on problem solving, and develop the participant's individualized plan of care (IPC). Additionally, regular team meetings allow members of the IDT to build relationships, support one another and the participant, and foster a learning environment. The following steps help structure effective IDT meetings:

- Include appropriate team members, including the participant(s).
- Provide all members of the IDT a clear understanding of the team and its goals.
- Develop an agenda for each meeting, and start meetings on time.
- Take minutes, and distribute them promptly after each meeting.
- Build rapport among team members and participant(s).
- Strive for consensus on key decisions.
- Develop action items, and assign responsibility.
- Revise the meeting process and structure, as necessary.

While the IDT structure includes the participant, participants may choose not to attend due to scheduling and other conflicts. Because the input of the participant is crucial and must be incorporated to allow for shared decision making, a designated point of contact, commonly the care coordinator, should consult with the participant prior to and following the IDT meeting and relay information to and from the participant and the IDT. Clear communication and shared decision making ensure that participants are well-informed and that the chosen course of care is consistent with their values, preferences, and goals.

For more information and resources on Disability-Competent Care, please visit https://www.resourcesforintegratedcare.com/concepts/disability-competent-care

To view a webinar related to this topic, please visit https://resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Building_Partnerships

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