

The Lewin Group
Interdisciplinary Care Teams for Older Adults
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Caroline Loeser: My name is Caroline Loeser. I am with The Lewin Group. Welcome to the webinar, *Interdisciplinary Care Teams for Older Adults*. This is the fifth webinar in the 2017 Geriatric-Competent Care Webinar Series.

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Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for discussion among the presenter and participants. This session will be recorded, and a video replay and a copy of today's slides will also be available at <https://www.resourcesforintegratedcare.com>.

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This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) at the Center for Medicare and Medicaid Services. MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time I'd like to introduce our moderator. Carol Regan is a Senior Advisor at Community Catalyst's Center for Consumer Engagement and Health Innovation, and she has over 30 years of experience with national and state-based public policy and advocacy organizations. Carol?

Carol Regan: Thank you, Caroline, and welcome, everyone. Good morning or good afternoon, depending on where you are. I'm delighted to be moderating again one of the Geriatric-Competent Care webinars and working with The Lewin Group through the Centers for Medicare and Medicaid Services.

Community Catalyst is interested in this work because one of our goals at the center is to work on policies and practices that improve the care for older adults and other vulnerable populations. The Geriatric-Competent Care series is part of our educational efforts around improving those models of care.

Today I am pleased to introduce our four speakers. First, I want to introduce Dr. Gwendolyn Graddy-Dansby. She's been the Medical Director for the PACE program of Southeastern Michigan since 2001. She's Board Certified in Internal Medicine and Geriatrics and is a Fellow at the American College of Physicians. Dr. Graddy graduated from Wayne State University School of Medicine and joined the Henry Ford Health System in 1987 before joining PACE.

Dr. Graddy speaks extensively on healthy aging, caregiving and Alzheimer's dementia. She's also begun to study the role that PACE has on facilitating controlling hospital utilization through understanding the role of care coordination. She's been consistently named top physician in her field, and in 2015, she was the winner of the Detroit Business Healthcare Hero Award in the Physician category. The Henry Ford Health System presented her with the Diversity Hero Award. We are thrilled to have Dr. Graddy leading us off here.

Then, we will hear from Sandra White, who is the Director of Operations-East for PACE of Southeastern Michigan and Detroit, where she manages and oversees the Social Work Department at three, soon to be four, centers. She currently leads the day-to-day operations for two fully operating centers in Detroit, and she's also a liaison for other senior community organizations that partner with PACE to ensure quality services and care for its members. She leads the partnership with the Presbyterian Villages of Michigan and the Greenhouse Project Staff to develop the Weinberg Greenhouse Homes for Seniors to reside in as an alternative to a nursing home setting. Sandra's got a Master's degree in Social Work and has been a clinical social worker in medical settings for 26 years.

Ellen LaSalvia will be our next speaker. She's the Director of Long-Term Services and Support and Home and Community-Based Services for Buckeye Health Plan in Ohio, an affiliate of Centene. At Buckeye, she's responsible for the development and maintenance of quality coordination of care initiatives for the Medicare Advantage, Medicaid and MyCare products. She also served as their manager for service coordination, and before that, did discharge planning and education for their care management team. Ellen has also worked as a Substance Use and Mental Health Case Manager and a community psychiatric support provider. Ellen is a licensed social worker and a certified case manager.

Finally, we are pleased to have Olivia Richard join us. She's a consumer who's been enrolled in the One Care financial alignment demonstration in Massachusetts since it started. She's a member of the Commonwealth Care Alliance Health Plan and has had firsthand experience working with a care team.

So you can see we have an incredible group of speakers that will follow. Now, we can turn it over to the presentation. I would like to introduce Dr. Gwendolyn Graddy.

Gwendolyn Graddy: Hello. This is an exciting opportunity, and I'm glad to be able to talk about an area that I think is extremely important simply because we are seeing a changing demographic, especially as it relates to this aging population. As a result of that, we are going to need to start thinking a little differently about how we provide services.

So I'm going to start this morning talking about what I call the WWWs of the interdisciplinary care team. I'm going to talk about why these care teams are important and will continue to be important in the 21st century. I'm going to talk about what they are, and then we're going to end up with who is included in the interdisciplinary care team.

We will start with the why. There was an article in The New York Times in September of this year titled "The High Cost of Failing America's Costliest Patients." As you might imagine, many of those costliest patients are our aging population as well as the dual-eligible population. Dr. Khullar had a powerful quote as a part of that article, and it states, "People want health, not healthcare. And those who require the most healthcare get the least health...high need, high-cost patients with multiple or severe medical conditions feel this most acutely."

The article went on to state that we need to look at methods, systems, and models to provide better care, and this will provide some innovation. It goes on to talk about models that can provide that type of care, especially integrated care. One of the models that it referenced was PACE. There are other models, obviously, that provide the integrated model of care. So what we're going to focus on this morning, or today, is extremely important as it relates to what does the model of care, or in this particular case, the integrated care team model, look like, and how can that model provide the best care to this population.

So, why is this important? By 2020, more than 25 percent of the population will be over the age of 65. Think about that for a few seconds. Of those over the age of 65, the greatest percentage of growth will occur among women and those over the age of 85. The other thing that we're going to be seeing in terms of what are now considered minority populations will continue to grow, as well.

With age, we know that there is a greater prevalence of chronic diseases and dementia, and about one-quarter of Medicare outlays are for the last year of life. This is unchanged from 30 years ago. In addition, availability of healthcare providers will decline significantly after 2020. And why is that? Because many baby boomers will be retiring in 2020, and so what we're going to see is that the workforce for those who are presently providing care for this population will decline. That's going to also significantly impact how we provide care.

Additionally, when we look at chronic diseases in this older population, the leading cause of death in 1900 was acute infections and acute illnesses. In the 21st century, the leading causes of death are chronic diseases and degenerative illnesses. Among those over the age of 65, 80 percent have at least one chronic disease, and 50 percent have at least two chronic diseases.

When you couple chronic diseases with functional decline, that is actually an increased need again for the types of services that we're talking about as a part of the team.

When we look at Medicare-Medicaid enrollees, 59 percent of those will have arthritis, as well as the percentage of chronic diseases, 20 percent have diabetes, and the largest incidence occurs in those over the age of 75. That's a staggering statistic. Thirteen percent of this population will have a mental illness, and it is estimated that 65 million have a diagnosis of depression. The risk of Alzheimer's dementia doubles every five years. Dementia is actually a disease of the elderly. And so the highest incidence of Alzheimer's will be in those over the age of 80.

Among Medicare-Medicaid enrollees, an average have 25 percent more chronic diseases than non-Medicare-Medicaid enrollees, and they are more likely that non-Medicare-Medicaid enrollees to have diagnoses of depression, Alzheimer's dementia, diabetes, heart failure, chronic kidney disease, COPD, asthma, stroke, and coronary artery disease.

So, what are the interdisciplinary care teams? How do we define them?

When we think about an interdisciplinary care team, the operative word for me that comes to mind is collaboration, collaboratively working together. The collaborative model is an arrangement between multiple disciplines and multiple professions. There are multiple terms that are used for this: interdisciplinary, interprofessional, multiprofessional, multidisciplinary, but basically it all boils down to professionals being able to come together, work collaboratively, be able to interchangeably effect and coordinate the care of those that they're providing services for.

In addition, when you think about teamwork, it's a dynamic process involving two or more health professionals. What I like about this definition is "dynamic." When you think about interdisciplinary teams coming together, they are not static. The need of that aging adult determines which team members are important, and at the end of the day, the intent is to be able to add value-added patient, organizational and staff outcomes.

Now I'd like to talk about what I consider to be the 10 characteristics of a high-functioning, interdisciplinary care team. There are 10 characteristics that we consider. I am not going to highlight each of these because you'll have the opportunity to review these at a later time or if you have additional questions, we can cover those at the end.

So, number 1, leadership and management. For a high-functioning interdisciplinary team to operate and to maximize the benefit, you must have clear definition around a leader. There has to be a clear leader. That leader has to give clear direction, and that leader should be a leader who listens, and based on what they hear, acts.

Number 2, communication and good communication skills. We have a saying here in our organization that good communication consists of open communication, direct communication, honest communication and respectful communication. For any interdisciplinary care team to function its best, there must be good communication.

Number 3, personal rewards, training and development. Again, this emphasizes the importance of training and giving people the tools that they need to be able to perform the task.

Number 4, appropriate resources and procedures. It is extremely important to have structures in place, and Sandra's going to touch on this a little bit more in terms of meetings, organizational factors, and team members being able to come together in a general location to talk about what those needs are. Being at the same table is actually much more effective than being on a phone. We've found that out.

Number 5, an appropriate skill mix. You have to have sufficient and appropriate skills and competencies. Do not assume that people have the competencies that they need. Ask. Have ways of testing whether or not they have the competencies, and then provide those tools for them.

Climate: It's important to have a team climate of trust. That must be the culture for a high-performing interdisciplinary team.

Number 7, individual characteristics. What I'd like to pull out of this particular characteristic has to do with reflective practice. Some of you may be familiar with reflective practice, but we have found that reflective practice allows a team to come together and look at what happened, what went well, what did not go well, why didn't it go well, and what are we going to do differently so that this doesn't happen again. If it went well, let's figure out what we're going to do make certain that we continue to do that, and if it did not, what do we need to do differently?

Clarity of vision, Number 9, quality and outcomes, and Number 10, respecting and understanding the roles. That is shared power and joint working together.

Who makes up that interdisciplinary care team?

There are a list of individuals that make that up, but what's extremely important to emphasize here is that it is dynamic. The subset of interdisciplinary team members that are needed for one participant or patient, for one set of problems, may be completely different based on what the need is. We have to be sensitive enough to understand that the need will really drive which interdisciplinary team member is indicated, or which interdisciplinary team member is important.

I've talked about why, the what and the who, so I am going to turn it over to Sandra to talk about how we implement this interdisciplinary care team. Sandra?

Sandra White: Thank you, Dr. Graddy. Making a Team Work: Strategies for Implementing Care Teams.

Phil Jackson is right when he states, "The strength of a team is each individual member, and the strength of each member is its team." The interdisciplinary care team must work together collaboratively to make that team strong.

Let's look at some of the key strategies for making the interdisciplinary care team work. We will look at team leadership, small meetings, creative thinking, and interdisciplinary thinking.

Key strategies for making interdisciplinary care teams work: team leadership. Having a knowledgeable and competent team leader is a must. This is one who effectively works collaboratively with the team to help make and achieve the patient-centered care that is needed. This team leader is able to provide that ongoing support, guidance, instruction and direction while building a cohesive integrated team and a working environment.

The team leader must be knowledgeable of its team, and that team leader is capable of identifying the strengths of the interdisciplinary care team members and knowing when to involve a particular discipline based upon whether that need is psychosocial or medical. In summary, the team leader helps the interdisciplinary care team stay focused on what I like to call what's important. That creates a winning team.

Now, let's look at some small meetings. Oftentimes, it is important to take a larger group and break it into a smaller, interdisciplinary group based upon the needs of the beneficiary or that patient. The meeting should consist of meeting around a particular problem or concern that that patient sees as the problem; building trust; clarifying roles; communicating openly and effectively. Appreciating diversity of ideas is very important in these small teams, and making certain that the interdisciplinary care team stays focused on the task at hand.

Now, here's a slide I like a lot focusing on creative thinking. This is thinking beyond the ordinary, thinking beyond what each discipline would normally do in a particular case, and I like to call this thinking outside the box. So, when the team is thinking outside the box, keep in mind that they're thinking differently. They're thinking unconventionally. They're thinking of a new way and a new perspective of handling the problem at hand.

Key strategies for making interdisciplinary teams work. This is interdisciplinary thinking at its best, when you have all of the disciplines coming together and everyone is focused in on the problem and everyone has one mindset. That mindset is to solve the problem at hand. That creates for a winning team. You have many players. You have many hands, but you only have one mind to address the issue at hand.

This slide is on good team-building and problem solving skills. A couple of things that a good team wants to know when they're problem-solving is evaluating the problem; what is it that we're here for? Gather all the information from each discipline, and then break that problem down into smaller pieces, if you can, or smaller situations. Identifying solutions is also a good thing too. When you identify solutions, figure out what the best solutions are, and then take action. Examine results, and then after you examine your results of the problem, test it, review it, and see if it works. Bring the team back together and figure out what worked and what did not work.

Now, Dr. Graddy and I will work together on the case studies. I would like to focus on case studies and demonstrate how the interdisciplinary team's approach to a particular case is based upon the medical needs, the social needs and the specialty needs.

So, I'm getting ready to turn it back over to Dr. Graddy.

Gwendolyn Graddy: Thank you, Sandra. The first case we're going to examine is Ms. S.W.H., a 66-year-old female who presented to us with a history of metastatic lung cancer, chronic pain, malnutrition, functional decline, polypharmacy, and also a history of mental illness. When this person presented to us initially, a large amount of our emphasis was really on her medical conditions.

Her metastatic lung cancer was actually terminal, so there was no additional treatment that was going to change the outcome in terms of her cancer. So we began to look at several areas from a medical perspective. Number one, how should we treat this cancer? We finally identified that the best way to treat this was to have a discussion with the participant, or the patient, regarding end-of-life care. That's what we did, and she was actually enrolled into a comfort care or an end-of-life care program.

The next thing we needed to do is address her chronic pain. We recognized early that her chronic pain was not just physical. Yes, there was a medical component, but there was also a spiritual component, and there was an emotional component. If we did not address each of those components, we were not going to adequately address her chronic pain. So, the providers looked at medications and identified the appropriate medications.

Behavioral health intervened and started talking about the mental illness issues that were also contributing to the pain and provided support and interventions. We had our chaplain come aboard and talk about some of the areas that she needed to resolve that she hadn't had a chance to talk about, but she needed to. We had the social workers come aboard and help us with the emotional aspects. That was how we used an interdisciplinary approach to address her pain.

Malnutrition was another issue. We had a nutritionist talk about supplements, but it was more than that, and Sandra will address this in more detail. We needed to go into the home and see what was needed in the home to be able to address the issues of her nutrition. We also understood that her malnutrition and pain in some ways was impacting her function, so rehab got involved and talked about durable medical equipment and what other things we could do.

Then there was polypharmacy. When she came into our program, she was on 22 medications. We gathered as a team to discuss this lady on a regular basis and were able to reduce her medications down to approximately 10 to 12 medications. At some point, the interdisciplinary care team was uncomfortable with her ability to be in the community, but after coming together and talking on a regular basis, we were able to resolve this.

Sandra will talk about some of the psychosocial issues and some of the other things we did.

Sandra White: Absolutely. One of the things we recognized right off the bat was this individual's lights, gas, and water was scheduled to be cut off, so quickly the social worker was able to go out in the community and work and provide resources to make sure that the gas, lights and water were not cut off. We also realized that she did not have a functioning stove in her home, so we decided to buy her a new stove. We provided the resources for that. We hooked the stove up in her home, and everything was great from a social work point of view at that time.

The registered dietician made sure she provided daily frozen meals to go out to the home, and our transportation team made sure those meals arrived, as well. The dietary team worked closely with the transportation team on that. Now, in terms of the transportation team, they did a lot more, too, because they took her to all of her specialty appointments. They made sure that all of her medications were delivered to her home, as well as her incontinence supplies. Her days for coming into the center were increased from two to four days, so transportation picked her up from her home. A certified nursing assistant (CNA) was at the home to make sure that she was bathed, clean, and assisted on the bus, and we made sure that everyone had an opportunity to get her to the building or our day center safely.

The RN case manager made weekly visits to the home, and then the RN case manager talked to her and she told her, you know what? I feel like I'm losing my dignity. My hair is coming out, so the nurse went out and not only provided medical care for her, but also provided her with a wig to help keep her self-esteem up and keep her pride. The social worker and RN case manager went out on a weekly basis to the home and worked with the son to see how they could help him, as well.

The rehab team went to the home. As Dr. Graddy stated, spiritual care was involved. Behavioral health team worked very closely with us. The day health center engaged her in all of the activities. It was wonderful when she was in the day health center, and we kept communication going with her and her son.

The integrative slide is right there, and it just shows you how the team works together.

Now, I'll turn the Case No. 2 over to Dr. Graddy.

Gwendolyn Graddy: To try to stay on track, because I know there are other speakers, we're going to go ahead go to the next slide, and talk about lessons learned.

Sandra White: Number 1, do not assume that another person heard and understood the same thing you did. Allow for mistakes. Make it safe for people to be transparent. It is okay to agree that you disagree. Constantly educate each other. Education, education, education is extremely important. Remember that we are here for the patient. Do not forget to ask the patient and caregiver for their input. That's very valuable. When in doubt, ask for another opinion. Include the frontline staff. It could be home health aides, nursing assistants, drivers or whoever. Decisions can be changed. We can always change decisions that we made. Follow up and debrief. Dr. Graddy?

Gwendolyn Graddy: In summary, the interdisciplinary care teams for older adults require certain skill sets. You must have positive leadership in management. Number 2, commitment to think outside the box. Number 3, the ability to collaborate, which simply means to work together. Number 4, willingness to get out of your comfort zone. Number 5, know where and when to ask for help. Number 6, communicate, communicate, communicate. We have a saying in our organization, eight times, eight ways. Finally, keep what's important first, and that is the aging adult.

Sandra White: Thank you, Dr. Graddy. Keep in mind that the interdisciplinary care team, when it comes together, works together, it creates a wonderful life for our patients. Now, I will turn it over to Ellen.

Ellen LaSalvia: Thank you. Good afternoon, everyone. Today I'm going to talk about the successful clinical care of an interdisciplinary care team (ICT) as we talk about those individuals that benefit from LTSS services.

LTSS, what is it? If you're not familiar with LTSS services, LTSS stands for long-term services and supports. These services are provided to Medicare and Medicaid members of all ages who need ongoing help with activities of daily living, both ADLs and IADLs, due to either aging or disability. The purpose of these particular services is to support that member to live and work in the setting of their choice. Settings may include a member's home, or it may be a provider-owned or controlled residential setting, such as a nursing facility or other institutional settings if you're an individual that might have developmental disabilities.

In looking at LTSS, you can look at it in two models. One would be HCBS, and those are your home and community-based services. Our second model would be those that belong to the LTC, or long-term care, model. Individuals that associate with the HCBS model are individuals that reside within their homes within the community. These can be older adults and/or persons with disabilities. With our HCBS membership, care managers work to ensure, right along with the member, that the right level of services are in place to maximize independence within their home and communities and to assure that they are able to achieve the quality of life that they desire.

They do this through working to address the needs of that particular individual as it pertains to functional limitations and assistance that may be needed with activities of daily living or instrumental activities of daily living. Services within the HCBS model can include services such as additional personal care attendant services to assist with daily bathing. They can also include services such as transportation, and, at times, pest control in order to ensure that the homes in which individuals reside are free from any pests that may be making that home unlivable.

In our second model, the long-term care model, care can be administered within an assisted living, though, depending on the particular state in which you're in, that assisted living can also be considered an HCBS model. So that is very specific to the waiver within the state. In the long-term care model itself, providers offer skilled nursing care, occupational therapy, speech therapy, physical therapy, dietary management, dialysis, and/or hospice and palliative care in house, which would be within that residential facility that the individual considers their home.

If we are comparing the two LTSS models, you can see that from a home- and community-based perspective, the services that I spoke of previously can include personal services, personal care attendant services, medical and nonmedical help with daily living tasks, emergency home response system, home-delivered meals. These particular services are provided in the home of an individual's choosing. It could be an apartment. It could be in a home that they own. It could be a home that they reside in with a family member or a primary care giver, and, depending upon the waiver, could be an assisted living facility, as well.

If we are looking at our long-term care or facility-based model there are medical and personal services to help specifically with daily living tasks. The facility is designated to provide the LTSS to the residents within that nursing facility. Services are provided by staff and caregivers who work directly with the facility, whereas in the home and community-based model, those services are provided by agencies within the community, and they can also be provided by independent providers, so those individuals that are independently employed to provide a particular service, such as personal care attendant services.

Now if we bring in our previous discussion from Sandra and Dr. Graddy and bring and layer on our ICT process within the LTSS area, we can see that ICT participants are included based on the type of services the member is receiving. So, those ICT participants can be different based on being in an HCBS model or a in a long-term care model. If you're looking for recommendations based on ICT composition that are a little more in depth than we have been able to previously share, if you're looking at an individual that is receiving HCBS services, the ICT participants would include the member, a caregiver, a primary care physician, a psychiatrist, if applicable, and in-home HCBS providers. These could be personal care attendants, nurse, social workers, counselors, based on the services available for the particular HCBS waiver within your state.

Within the long-term care model, you would look at a member and a caregiver. The caregiver could be a friend or family, or it could be somebody who has a power of attorney or a guardian, the PCP, a psychiatrist, if applicable, the facility social worker, the nurse, physical therapist, occupational therapist, and dietician there at the facility, and any community-based provider that individual may still elect to see.

Optional participants may include but are not limited to specialists, friends, or social network support. One example of that could be a church pastor. One of the things about the ICT is if you have a larger group, and Sandra spoke of this, is if you have an identified particular issue it may be necessary to take that larger group and make it into a smaller group to address a very particular issue that a member may want to address in order to achieve the goals that they have set for their ICT team. The ICT team should be a collective body that represents and supports the goals identified by the member to achieve a quality of life desired by that individual.

The inclusion of both HCBS providers and long-term care providers is an essential piece for the ICT success puzzle from a clinical perspective. HCBS providers can often be the eyes and ears in the home for an ICT group. Specifically in Ohio, our care managers do home-based visits with our members so they can also be eyes and ears, but they're not there every day, whereas a personal care attendant can be there every day and may bring additional insights into that ICT discussion through observation and daily interaction with an individual.

From a long-term care provider, they're the eyes and ears of the facility. One example of this could be that as an activities coordinator you have the ability, the unique ability to be able to engage on a social aspect with individuals and hear the conversations that occur in a non-pressurized situation, so the ability to bring forth information that is relevant that may not necessarily seem relevant to, say, a primary care physician, or to the member themselves and being able to link those items that might not seem linkable at first.

HCBS and long-term care providers both connect on a personal level with individuals, and they supply perspectives that might not otherwise be known, and they also have the ability to, on a day-in and day-out basis, support and reinforce member-selected plans and actions.

LTSS services are unique, so education for the overall ICT is recommended. Ensuring that the LTSS benefits are known and understood by the team allows individuals to be able to come up with those out-of-box solutions. So what benefits are available? Benefits are dependent on the LTS waiver that an individual participates in. Some common benefits include but are not limited to personal care attendant services, transportation, home-delivered meals, emergency response systems, home modification, and, in some states, assisted living, items that we have covered before but they may not be readily known to all ICT participants. So having a full view of the benefits available to an individual allows for creative solutions when problems arise.

What is also helpful is when can LTSS benefits be accessed once qualification for a waiver is determined and an individual has accepted a waiver. For example, there are times if an individual has a skilled stay at a nursing facility and in order to return home they have to have some pests removed from their home, let's say they have an infestation of bedbugs and they need that taken care of, there are some waivers that don't allow those waiver services to take place until that individual is no longer receiving those skilled services. So it's important to recognize those when the ICT team is working to overcome barriers to meet the goals of the individual.

This can be easily accomplished through the development of a frequently asked questions document. Basically, it's a one-page sheet that summarizes the benefits that are very pertinent to LTSS so everybody has that same information when the ICT team is meeting.

Another area is to ensure that the care manager is prepared and is a subject matter in those particular areas. So any barrier resolution can be streamlined through that individual.

The ICT team, because you can go from a large team to a smaller team, should have agreement on preferred communication methods and how those communication methods work.

I want to provide a case study on how an ICT team with the inclusion of LTSS providers has shown to be successful in clinical practice. Our case study is of a 66-year-old male. He had a history of depression and paralysis at the waist level. His ICT consisted of himself, the care manager, a waiver service coordinator, his primary care physician, and his personal care attendant.

The identified need in the discussion with the ICT was that he was in need of a new electric wheelchair and that he also had flooring concerns. He had carpet within his residence, which was making it difficult to navigate in his electric wheelchair. Through the inclusion of that personal care attendant we were able as an ICT to be able to identify the barriers of the particular carpet throughout the home, and in those specific rooms, and be able to share that very specific information regarding that.

We were able to come together as a team to utilize the benefits related to his Medicare coverage for his new electric wheelchair and then, from an LTSS perspective, he had access to home

modification services, and we were able to utilize those to replace that carpet with floors, and then through the personal care attendant and the partnership with the member were able to be able to test out flooring to make sure that they would in the long term meet the needs of the new electric wheelchair that was coming in.

I am now going to turn it over to Olivia Richard.

Olivia Richard: Hi. My name is Olivia Richard. I am a member of the One Care Program who receives coordinated care through Commonwealth Care Alliance. I enrolled in Commonwealth Care Alliance, the health plan, at the very beginning of the demonstration in 2013 basically because I was getting bad healthcare in fee for service, and the Medicare-Medicaid fee-for-service system was just not working for me.

I was at the point where I repeatedly designed a new manual wheelchair and was trying to maintain my own chair out of my own pocket. I pulled out some of those high school trade skills, welded a little bit to try to get it working. I was getting little to no community support within LTSS. I was in an agency model where I was receiving very few PCA hours. As a result, my apartment become unhealthy to live in. I had a lot of infestations. I had bedbugs. I didn't know I had bedbugs until I enrolled in the plan.

After I enrolled, the care coordinator came to my apartment and evaluated me. It was then that I realized I had a lot of unmet needs. I'm a pretty sharp tack, but it's really hard to look at yourself and say, hey, I'm not getting a lot of what I should get, because I had just become so used to being underserved. I mean, I was an advocate involved in setting up the demo to begin with, so I knew a lot about the fact that there was going to be a physician called the LTS coordinator, and as soon as I enrolled, I asked for a long-term service coordinator to be assigned to me to help.

They came to my home and did an assessment. We clicked immediately. For me, I knew she was someone I could trust. She saw my living conditions and all the challenges I was experiencing firsthand. She even saw things I didn't. I didn't realize some of the practices that I was experiencing were abusive. She assisted me in changing out of the agency model into the consumer-directed model where I'm able to hire my own PCA. She assisted me and my care team assisted me, because my care team included a physical therapist, in getting a new custom wheelchair, which was huge. It increased my mobility tenfold.

They approved a deep cleaning of the apartment. I was able to get more PCA hours in the consumer-directed model. I have one PCA that I rely on. Just by luck, she lives in the apartment above me. I have the per diem PCA, which is one of the college kids. If my regular PCA is sick, she'll come on over and help me out. My PCA is considered part of my team. She's put input in on some things, like I didn't realize how bad my shower chair had gotten, so my PCA threw in her two cents on that.

I don't get my primary care from Commonwealth Care Alliance, because Commonwealth Care Alliance. I go to Fenway Health, because it's nationally renowned for LGBTQIA culture and services. It was the one part of my healthcare that was working for me before the demonstration,

so I decided I'm just going to keep this part, and we'll see what happens with the rest of it. It's worked really well.

I was recently admitted to the hospital for a behavioral health issue. My long-time service dog passed away. It hit me really hard. I ended up with severe depression. When I was in the hospital, my care coordinator introduced me to a behavioral health specialist from my care team who is a licensed social worker. She's actually now become my care partner in that she coordinates a lot of my care. She has a nurse practitioner that oversees my care within the PCA model, and they will talk with Fenway. They'll talk with the Boston Center for Independent Living, where my long-term service coordinator is at. Everyone talks to everyone. Sometimes it's bad, because it doesn't let me get away with stuff. Most of the time, it's absolutely fantastic, and I love it.

I was diagnosed as pre-diabetic recently, and during my reevaluation, I said I needed to work on my nutrition as my number one goal. Ultimately, that's what Allie, the behavioral health specialist, and my social worker, is going to help me with. They set me up with nutrition and all that stuff.

In my opinion, a good team means listening to the member, having the member be a part of the team, being attuned to when there are significant changes in the member's life that could trigger something, and being flexible. I want to thank all of you out there who do what you do because ultimately it allows people to live happy and fulfilled lives. Thank you.

Caroline Loeser: Wow, all right. Thank you so much, Olivia, and to the rest of our speakers. Dr. Graddy, Sandra and Ellen, for your presentations. This has been incredibly informative, and thanks so much for joining us today.

Before we jump into our Q&A, we first wanted to point out, that any key takeaways from this webinar can also be applied to populations beyond older adults, such as individuals with disabilities or individuals with intellectual and developmental disabilities.

Resources for Integrated Care would like to highlight two tools in particular that may assist providers and health plans with providing interdisciplinary care. We have the Disability-Competent Care Self-Assessment Tool available to help health plans and health systems evaluate their present ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement. You can also check out the My Health, My Life Toolkit for individuals with intellectual and developmental disabilities, their family members or guardians, and their provider support team.

With that, we now have a few minutes for questions from the audience. At this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left of the presentation. You can type your comment at the bottom of the Q&A box, and then press submit to send it in.

All right, we received several questions throughout the course of the presentation, so I'm going to start with one of the first questions that we received, and this was during the first case study that Dr. Graddy and Sandra presented. The question is, in the over-65 age group, 50 percent have

several visual impairment or one of the major causes of visual impairment. Does the ICT's format recognize a role for connecting either to the local organization for the blind, visually impaired who employ the specialized certified vision rehabilitation professionals, or to employing them?

Gwendolyn Graddy: Hi. Thank you. I'd really like to start off by thanking Olivia. That was an excellent overview, and to be able to see the impact that the ICT had on her quality of life is amazing, and that's really what this was all about. So, Olivia, thank you. That was an excellent overview.

Then to comment on the question regarding visual impairment and what the organizations can do to make connections with organizations that can support individuals with visual impairment. So, there are two answers to that. First of all, from a medical perspective, there will be a need to actually have an evaluation to identify what the actual disability is as it relates to a visual impairment

So we start with that, whether it's an ophthalmologist or whether it's an optometrist, identifying that there is a visual impairment and the reason for it, because the cause of the visual impairment will also impact what the interventions are.

We have used other resources in the community for people with visual impairments, and Sandra will comment on that.

Sandra White: Thank you, Dr. Graddy. We are familiar with visually impaired organizations, and we use them and incorporate them into the ICT. When we incorporate them into the ICT, we make sure that the patient is involved in the care as well as making sure that that social worker is providing ongoing communication about the needs in the home, and then the rest of the team members assist in the home, as well. So, yes, we make sure that anyone who comes into our organization or program is linked to the proper resources, and that helps build our team and make it stronger for our participant or patient.

Caroline Loeser: Wonderful. Thank you. We'll turn now to a question for Ellen. There was a question during your presentation that asked if you could speak to the health plan care coordinator's role in helping with LTSS planning, especially finding appropriate placement for patients discharging from hospitals to lower levels of care and/or home care for LTSS patients.

Ellen LaSalvia: So, just so I'm clear for the term care coordinators, is that equivalent to a care manager? Within our organization we have care coordinators that support care managers, so I want to make sure that I'm speaking from the perspective of what the intent of the question was.

Caroline Loeser: The question didn't specify, so if you want to maybe speak to both perspectives.

Ellen LaSalvia: Certainly. Within our plan, we have specialized care managers that receive additional education and training in LTSS specifically in regards to being able to place individuals with the right agency or independent providers. One of the other items that we

attempt to do is engage with our providers, as well, so we can learn what specialties they have and what specialties that their individualized staff can provide.

So we have a data registry that's available to our care managers to be able to link those specialized services that an individual needs with the provider that is able to provide those services. It really is incumbent upon the networking with the providers in order to understand the skill set down to that very specific level, and we do that in combination with our provider relations department that works most closely with our providers, but also our care managers, who are the referral source for any of our LTSS services that individuals may receive.

Caroline Loeser: Great. Thank you, Ellen. That's helpful.

One webinar participant asked us to speak more about including psychologists in the interdisciplinary care team. Has anyone tried to include psychologists, and if so what are some barriers to doing so?

Gwendolyn Graddy: That's an excellent question, and I'll chime in, and then may be other presenters would like to have something to say. One of the things that we found in our organization is that an extremely important member of the ICT basically is behavioral health. There are a couple of reasons for that. Number one, as we're looking at the demographics of this aging population, we're seeing a larger percentage of that population having mental illness diagnoses. Number two, what we're finding is resources in many communities for providing that type of help or assistance is basically limited, whether it's limited based on availability or whether it has to do with insurance or coverage. We are finding that there is a greater and greater need demographically for people who have a mental illness diagnosis and the need to make behavioral health a part of the interdisciplinary team.

So they are a part of the interdisciplinary team. When there are issues, challenges or concerns, that is actually a formal process whereby behavioral health is a part of reviewing what the concerns are, reviewing what the solutions are, and also following in managing, because you can't put a process in place without a way to be able to follow and identify whether or not whatever you've put in place works.

As it relates to the barriers, I think a couple of barriers. Based on geographically, where a particular program is located determines the availability. We recently had a sister organization where there is no availability of behavioral health. One of the ways that actually help with that barrier is to look at having virtual visits. That is going to be something I think going into the future that we're going to look at more and more.

So you don't have availability of behavioral health specialists, whether it's a social worker or psychologist, being able to partner with organizations and entities that can provide those visits virtually, will still be able to offer the resources and the services that you need to be able to service that particular population. I hope I answered that question, and if not, maybe they can chime back in.

Caroline Loeser: Wonderful. Thank you.

Sandra, during your portion when you were discussing key strategies for making interdisciplinary care teams work, one of our participants was wondering if the client attends his or her own team meeting.

Sandra White: That is an excellent question. Thank you for asking. Yes. We make sure that the participants or patient is involved in all of the meetings. Now, if they can't make it for some reason, be it medical or social, it's okay. What we do if we can't see them face to face, then we move to the next thing. Can we talk to them via conference call? If we really need to do a face-to-face with them and if they need, let's say, social worker, RN case manager or the rehab department or another person, we will go to their home.

So, to answer the question, yes, we try to make sure that the person we're talking about working with and trying to help solve problems with are partnering with us. Thank you.

Caroline Loeser: Great, thank you. We have a lot of questions coming in. We really appreciate the discussion.

Ellen, I'll turn to a question for you, and this came up during your case study. So one of our participants on the webinar was wondering what steps you find helpful to get the primary care physician to the meeting.

Ellen LaSalvia: Excellent question. I think it's something that we're constantly challenged with. I will say that the successes that we have seen are a few things. One, we have a partnership with a physician group that does home visits, so they're visiting physicians and they go to the homes. So we schedule our care management visits at the same time that the visiting physician will be there and conduct our ICTs with that already-established and scheduled visit.

In addition to that, we also have onsite ICT meetings with the entire team from those particular offices in each of the regions that we work with on a biweekly basis for urgent issues that may arise or complex issues that are ongoing that we're able to then discuss and we're able to patch in the member via telephone for those particular meetings. We have also seen success in having our care managers work with our members in scheduling those primary care physician appointments so that they can attend those together and potentially telephoning in or bringing forth the other ICT members' questions via writing them down, bringing them in and then communicating with the remainder of the ICT team post that particular meeting.

We also opened up the availability to establish telephonic ICT meetings that we hold on a regular and consistent basis. So we have them scheduled Monday, Wednesday, Friday from 10:00 a.m. to 2:00 p.m. So there are established times that our provider network would be aware that they can participate at those particular times if their schedules allow. We also do a lot of work with potentially the nurses that support the physicians within their offices participating in the ICT on behalf of the physician or the specialty physician that an individual may see. But they do require creative solutions in order to work at the engagement at that level.

Caroline Loeser: Great. Thanks for providing that extra detail. All right. We have another question. Dr. Graddy, I'm wondering if you may know a good response to this. The question is

some of our team members are used to a medical model where the doctor is "in charge and directs the discussion and makes the decisions." How do we encourage them to engage in a person-centered perspective and to respect and acknowledge everyone's expertise as well as the patient's wishes?

Gwendolyn Graddy: Yes, actually that's a great question, and I'm going to start the commenting on that, but then I'm also going to let Sandra chime in. It is true that in healthcare many people are used to a medically driven model, but what we are finding, as the population ages and we're seeing more aging adults, that the medical model or the medical component of the model is so important there usually does need to be a medical intervention, because we're talking about people with chronic diseases. Remember when I showed the statistics, that as the population ages the number of chronic diseases also increases. So there needs to be a medical component.

However, if we only do the medical component what happens is we actually miss the opportunity to really influence from a holistic approach that aging adult -- that aging individual's life. And so one of the things that we've done as a part of our team is that even though there is a physician or a midlevel or an advanced practice provider as a part of that ICT, we encourage participation from each discipline. And what that does is that allows them to feel that their input is being heard, and that that input is valued. If when an individual gives an input it always comes back to the physician making the final decision, then the other disciplines will feel that their input is not valued, and that's what we don't want to happen.

So it's important to encourage other interdisciplinary members to have input. It's important for the team, including the physician, to acknowledge the value of that input. And at the end of the day, if what their input is actually influences what you do for that individual and the outcome, then people will feel the -- they will feel the comfort to be able to have their input, and then they'll feel like their input is valued. It's just important for people to feel like what they have to say is important and that it's valued.

Sandra White: So when we have care plan meetings or we're focusing in on all of the aspects, the medical, the social issues of our patients, we look at who is around the table, as we stated before. As Dr. Graddy stated, it's not just medical. We're pulling in the other aspects. So if it is from a psychosocial area, then we break that down even further. Does that relate to behavioral health? Do we need to pull in all of the players?

So one of the things that we do for care plans is we go through each discipline and make sure that their interventions are heard. Does it fit what we're trying to solve? When I say that is when there is a problem, is that discipline looking at that problem and saying this is my input for that, this is how I can help? So we go around the table, and we do not leave any discipline out. So if it is our CNA, their input is just as valuable as the home care team, which is just as valuable as the recreational therapy team or the dietary or the rehab. We make sure that everyone is heard. And that goes back to that leader. That leader needs to make sure that everyone is heard, respected, and they have a voice in the problem solving.

Caroline Loeser: Great. Thank you both. All right. The next question in the queue is coming from an independent practitioner. So this participant wants to know how do I get the ICT to visit

with my clients in the home on the same day at the same time? Three physicians, outpatient therapist, administrators, family friends, etc., all have to meet together at the same time. Any suggestions, or is there any model for this sort of arrangement? I'll open that up to the group, or, Ellen, I don't know if you have any thoughts to start.

Ellen LaSalvia: I would say that that is certainly a challenge. While in person, all together, is a good goal, I think when trying to balance and organize so many different individuals, the ability to be flexible in how participation can occur will make that an easier task to accomplish. If the ultimate goal is all in person, then identify a handful of potential dates and times of when this could occur and provide a personal invite and see if any of those particular times can work. If you start out by saying when can you do it versus narrowing it down to options available and selecting, you may see better luck there. We've seen more success in having the flexibility of attendance be in multiple forms of participation and not only face to face.

Caroline Loeser: Great. Thanks, Ellen.

So, Dr. Graddy, you touched on this a little with the psychologists and some future in terms of telehealth. So we have a more broad question I'm wondering if you can respond to. The question's just simply how has technology impacted the interdisciplinary care team, if there are any examples you may want to provide or just speak to it generally.

Gwendolyn Graddy: That's another great question, and one of the things that I referenced had to do with behavioral health and how you can now do virtual visits, which basically is telehealth. One of the other things that our organization is looking at is we're looking at ways that we feel that we can best impact utilization. One of the places you don't want an aging elderly or an aging adult to be is in the hospital when you can help it. When you look at the Medicare beneficiaries, and especially when you look at the Medicare and Medicaid, unfortunately, these people often end up in the hospital.

So one of the things that we're looking at is what will be the impact of using telehealth to prevent hospitalizations and to reduce utilization for either hospitalizations or emergency room visits. Now, we're still in the process of really putting this process together, and it's not implemented yet. However, the literature does support that there is a place for doing telehealth. You have to have the right players at the table, number one.

Number two, you have to have a way that you will be able to communicate with people, so whether that will be by providing them with a computer, whether it will be by providing them with a special telephone, whatever the mechanism is for communication, in order for it to be successful there has to be the ability to be able to communicate. There have to be ICT members that can actually then go into the community, as well, and to make certain that what we're saying is available and what we're saying we're doing is actually being done firsthand.

So when we continue to look at 21st century medicine I think we will reach a point where telehealth will be one of our primary ways of being able to provide care and one of the ways that the interdisciplinary care team will actually be able to maximize the care, not just to an aging

adult population but also to the Medicare-Medicaid or that dual-eligible population. So I think that that's something the jury is still out.

Olivia Richard: Can I throw in on this one? This is Olivia.

Caroline Loeser: Great, yes, please, Olivia.

Olivia Richard: I have to say as a member I actually use my cell phone a lot to communicate with my care team. Texting is huge. When I was entering the hospital, when I was in the emergency room, I was texting my care coordinator. It'd be like I think I'm going into the hospital, so don't be surprised if you get a call. CCA, Commonwealth Care Alliance, has a 24-hour number that you can call if you're having a behavioral health crisis where there's someone on call all the time.

They also have the Community Medic, which is basically an emergency department that comes to you, which is an innovation we have here in Massachusetts where it's a paramedic-level EMT who can draw blood, run tests, and they get in contact with the doc over the phone to authorize meds. It's one of the biggest services that has kept me from needing to go to the emergency department so much for like UTIs and stuff like that.

Gwendolyn Graddy: That's excellent. Just add on to what Olivia said, we have found that utilizing EMS to provide after-hours services is another really good way to keep people out of emergency rooms in the hospital. In essence, it's sort of a modified version of telehealth, because the patient can call, identify what the problem is. The EMS, or the ambulance service that is acting as the on-call service, can then go into the home and actually do an evaluation, similar to what Olivia said, make an assessment, and then determine whether that person actually needs to go into the hospital.

We've actually found that it has decreased the number of emergency room visits, but also what we've found is that when an emergency room visit is indicated, it's more likely to be an appropriate emergency room visit, where they actually needed to go and may have been hospitalized. So that is sort of the -- I think that's going to be the wave of the future as we're continuing to look at the role of telehealth. Thank you for bringing that up, Olivia.

Caroline Loeser: Yes, that's really interesting, Olivia. Thanks for providing that example. We have a few more minutes for questions, and so thanks for bearing with us. Ellen, this is a question that came up during your presentation. I don't know if there's one answer or a correct answer for this, per se, but we'll give it a shot. So the question is as a health plan we don't necessarily have the breadth of staff needed for the ICT. Are there any suggestions for how we can get the benefits of the ICT within our health plan context?

Ellen LaSalvia: So I do think that's a challenging question. I think from my perspective we would find it challenging to get the benefits of the ICT with only utilizing health plan-based staff, because none of us are providing direct treatment to an individual, and it's those individuals that have that hands-on direct treatment that have the ability to engage and impact the outcomes that are being sought.

That's not to say, however, that we couldn't utilize our health plan-based staff in order to do a comprehensive review with an individual and identify action items that then could be carried out if you have care management, utilization management staff from an internal plan perspective. But I do feel that the biggest benefit from an ICT is the engagement of those individuals that are community-based, providing those services, engaging in those services with the individual, that have the highest impact into outcomes.

Gwendolyn Graddy: If I can just add something quickly to that, I think that is a challenge, because we understand that there will be plans and organizations that don't have the benefit of having all of the ICT as we see the ICT. Even if you're limited to one or two, and usually there is a minimum number of folks and disciplines to really make this effective, but if there's ongoing communication, it goes back to the whole issue of what's a high-functioning team.

So you don't have all of the members of that team, but if the members of that team are adequately communicating both with the patient or the individual that's receiving the services and with the other members of the ICT, then a decision can be made at what point do we need to look for other players. In order for the plan to be able to provide the care that's needed, sometimes a decision has to be made that we're going to need to include other members for the ICT in order for us to be effective.

What does it mean to be effective? If you're reducing hospitalizations, if you're reducing visits to the emergency room, if you're increasing quality of life and quality of care for that individual, who can usually tell you how they define that, then you may find that you have to go back to the drawing board and identify that there are other members that need to be a part of that ICT. And that's something that from an organization, from a plan perspective, they have to decide how do we do it. Thinking out of the box.

Caroline Loeser: All right. Thank you guys so much. So with that we're going to wrap up for the day. If you have any additional questions or comments for our speakers or for Resources for Integrated Care, please feel free to email us at RIC@lewin.com.

The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly.

Before we close for the day, we also wanted to turn your attention to two upcoming Resources for Integrated Care webinars. We have a webinar on the Disability Competent Care Self-Assessment Tool, and that'll be held on December 13 from 2:00 p.m. to 3:00 p.m. Eastern Standard. And you can also stay tuned for our 2018 Geriatric Competent Care webinars. Those will be focused on older adults with substance use disorders as well as safe and effective use of medications in older adults.

At this time, the posttests for this webinar are now open. Additional guidance about obtaining credits and accessing the links to the posttest can be found within the Continuing Education Credit Guide in the resource guide on the left-hand side of your screen or our Resources for Integrated Care website.

Thank you again to all the speakers. Have a wonderful afternoon, and thanks so much for your participation.