

The Lewin Group
Interdisciplinary Team Building, Management and Communication
March 21, 2018
2:00 p.m. EDT

Jessie Micholuk: Good afternoon, everyone. Welcome to the Disability-Competent Care webinar, *Interdisciplinary Team Building, Management and Communication*. My name is Jessie Micholuk, and I'll be getting us started today.

Should you have any questions now or throughout the presentation, please feel free to enter them into the Q&A feature on your platform. We'll be addressing your content-related questions during the discussion portion of this webinar.

The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, has partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This webinar series builds on the 2017 DCC webinar series but introduces the model of care and its seven foundational pillars. You can view this series and other related resources at our website, ResourcesForIntegratedCare.com.

As I mentioned, this webinar will be interactive, with 45 minutes of presenter-led discussion followed by a 15-min presenter and participant question-and-answer session. Also, video replay and the slide presentation will be available after the session at our website on the screen in front of you.

This webinar is supported through MMCO to help beneficiaries enrolled in Medicare and Medicaid to 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 Medicare and Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations in care models, such as this webinar.

To learn more about these current efforts and of course to access our resources, again, you can visit our website, ResourcesForIntegratedCare.com.

We are also pleased to be able to offer credits for continuing education units and continuing medical education for this webinar. For information on how to obtain the credits, please access the CMS Continuing Education Credit Guide, which is located on the left-hand side of the platform in the Resource Library. To receive credit, the process must be completed through the CMS learning management system with a score of 80% or higher by midnight on April 9, 2018. Further information is available at the Resources for Integrated Care website, too.

I'll now hand this over to your moderator for today's webinar, Chris Duff.

Chris Duff: Thank you, Jessie. I appreciate the background there. I would also like to welcome everyone to this fifth webinar in the 2018 series. I am a disability practice and policy consultant who has been working with the Lewin Group to develop the Disability-Competent Care model and related webinars and material.

I will be joined today by two phenomenal presenters who have decades of experience with IDTs, interdisciplinary teams. First will be Mary Glover. She is a nurse practitioner with over 35 years of clinical experience working with individuals with disabilities and complex medical conditions. She was a practicing primary care clinician with Boston Community Medical Group since inception in 1988 until March of 2016. Boston Community Medical Group, known as BCMG, is an

interdisciplinary group practice specializing in the care of adults with physical and developmental disabilities, serious mental illnesses and complex care needs.

In 2004, Mary assumed the role of executive director of Boston Community Medical Group when the corporation was restructured as a non-profit group practice and clinical affiliate of Commonwealth Care Alliance. Mary provided clinical leadership to Commonwealth Care Alliance's senior care options program and, beginning in 2007, served as the senior vice-president for clinical services, in 2015 and 2016 overseeing the statewide expansion of the clinical model to serve the under-65 dual population, opening primary care practices in Western Massachusetts and Merrimack Valley.

Mary received her Bachelor of Science degree in nursing from Saint Anselm College in New Hampshire and her Master's degree in adult primary care nursing from Boston University. She is board certified as an adult nurse practitioner.

Next, Cindy Guddal brings over 25 years of experience providing community-based services to individuals with a range of disabilities. Cindy is the manager for community services at Courage Kenny Rehabilitation Institute, which includes independent living skills services, adult rehabilitation and mental health services, known as ARMS, and community behavioral services.

Cindy has presented regionally and nationally on the topics of brain injury, mental illness and community integration for individuals with moderate to severe disabilities. Cindy is a licensed independent clinical social worker, certified psychiatric rehab professional and a certified brain injury specialist. She holds a Master's degree in social work from the University of Minnesota.

Today we will be focusing on interdisciplinary teams. The interdisciplinary team is the functional core of the disability-competency model. You will hear in these presentations today about the composition of various teams and how they benefit the participants. As this agenda shows, we will introduce the concept and purpose of the IDT and its application in several diverse settings. Our focus will be on the role, functioning and communication of the IDT. We will save 15 minutes at the end of the presentation for Q&A.

IDTs are a fairly well-known concept in health care delivery today, being used in a wide variety of settings. They have been proven to be effective in bringing a range of competencies together to focus on particular populations or individuals. It is interesting to note that the concept of interdisciplinary teams first started in the field of rehabilitation with the population that we're talking about today, where the focus demonstrated that these complex populations needed a multi-disciplinary approach. Physical medicine and rehabilitation physicians, PM&R, realized a team was needed to address the multiple physical symptoms and functional retraining needs of the population they were serving.

Today, virtually all health and social service professionals have been schooled, trained and licensed within the discipline. The benefit of the IDT is that it brings diverse knowledge and perspectives to the team for the benefit of the participants. The two presenters today will describe a unique health plan-based primary care-focused model, while the other presenter will describe an IDT model with an outpatient primary care clinic and an IDT model of coordinating LTSS services.

All programs serve very similar populations: seniors and persons with disabilities and primarily on Medicaid or dual-eligible beneficiaries. The difference in the IDTs are the settings in which they operate.

At this point, I will hand it over to Mary for her presentation.

Mary Glover: Okay. Thanks so much, Chris. I really appreciate the opportunity to participate in this discussion about the interdisciplinary care team. I feel those with complex needs such as the duals population are uniquely suited to be served by and to benefit from this model. Next slide.

Individuals with disabilities are much more likely to experience worse health outcomes and to experience difficulties or delays in receiving necessary health care. The unique challenges of individuals with disabilities will often to health disparities. Several common challenges are the lack of strong primary care relationships or often PCPs lack the skills or the infrastructure required to meet the needs of those with disabilities.

Some examples of this are a PCP may be unfamiliar with a disability; may tend to focus on that disability exclusively and perhaps not take as holistic an approach as usual; might fail to do routine screenings, diabetes screenings, cholesterol, etc; or may not understanding perhaps the individual's disability and how that might impact or increase risk in those situations.

The infrastructure issues, the PCP often may lack necessary equipment such as high-low exam tables, mechanical lifts, wheelchair scales, or even if they're present, are all the staff trained to use them safely? Is there any special accommodation for mammograms, support for colonoscopy preps or knowledge about alternative positioning for Pap smears for women with spasticity or other physical issues? Is there flexibility in scheduling that allows for additional time or additional staff to be present? These are all very tangible issues that can really impact someone with a disability the ability to access primary care.

There's sometimes a lack of communication or coordination between specialists, which may lead to hospitalization for otherwise preventable complications.

So the use of an interdisciplinary team can address these challenges by creating a team that assumes responsibility for the totality of a participant's care. Next slide.

I think all practicing clinicians, as Chris mentioned, are accustomed to working within a multi-disciplinary approach, but there is a difference between multi-disciplinary and interdisciplinary. As DeLisa notes in *Rehab Medicine*, the interdisciplinary approach brings professionals together for a common goal where team members not only need expertise in their respective disciplines, but they also must be able to contribute to a group effort. The disciplines are not siloed as they may be in a traditional approach, but they are, rather, synergistic. Key activities of the team include evaluation, communication and collaboration in order to develop an individualized care plan that is actionable, subject to evaluation of outcomes and goals. Next slide.

Because of the complex needs of the duals population, the team must represent many aspects of care, not just medical, but must include behavioral health, social services, rehab needs, etc. Each discipline bringing their unique skills to the team.

Another key requirement is the ability to rapidly respond to an urgent need. It may be a medical need, someone developing urinary tract infection symptoms. Can you respond quickly, get a sample, start someone on antibiotics, do an evaluation? Being able to intervene quickly could avoid urosepsis or a hospitalization.

But it doesn't have to be a medical complication. It could be housing. Someone could be being evicted. They could be involved in a domestic violence situation. There could be a sudden loss of a

caregiver or a personal care attendant. So a different member of the team may be the most equipped to handle a housing situation, a caregiver situation, so you need to be able to mobilize the most appropriate resource on your team and to do it quickly in order to manage the crisis. This is really critical to working with this population. Next slide.

The goal of the interdisciplinary team is to help participants receive the care they need and to achieve their identified goals. The team facilitates the participant's goal setting, problem solving and care in a coordinated and cost-effective manner. The team also fosters communication among its different members, which is an essential key component to the participant's success. Communication must be frequent, structured and documented. The team brings together the knowledge and specialties from various disciplines. Team members are responsible individually as well as collectively for the participant's care.

Obviously the participants shared decision-making is critical. A key element of disability-competent care is the recognition that the participant is central to the team. What is required by the team is an embracing of a person-centered approach that values the principles of self-determination and promotes individualized care. Next slide.

Some responsibilities of the team include, as we mentioned, addressing urgent and acute episodes of care; proactively managing emerging needs as people are always changing; managing care transitions, which we'll talk a little bit more about later; assessing and creating the participant's individualized care plan; implementing and managing and overseeing the care plan; assuring that goals are being met and if not, why not, what are the barriers, how can they be overcome; allocating care management resources; facilitating access to services that the individual needs; and tailoring those services and supports to the unique needs of that individual. Next slide.

One of the key elements of a successful team is team meetings. To accomplish this, team meetings really need to be a critical and essential tool for the team. It's important for the team to come together either virtually or in reality to build relationships, to share information and to work together to identify and solve problems. Many of these problems are participants present with many complex issues and needs, and it may take a village to come to consensus about the best approach. And so, it's really important for the team to work together and to pool their knowledge and resources.

Also it's a learning opportunity for members of the team. We can learn from each other, and it creates a continuous learning environment. There's also a tremendous amount of support that occurs in team meetings. Sometimes it can be a lonely situation where a provider may really feel responsible, may feel the weight of the responsibility of the care for the participants that they're working with, and so it's important to be able to share that and to get support from your fellow team members. Next slide.

Some key concepts that are critical for an effective team meeting is, first of all, to identify a facilitator and a leader of the meeting. The facilitator really needs to provide for all members a clear understanding of what the goals are of the meeting and to make sure that it's the participant's goals that are being addressed. The meetings need to include all appropriate team members. There needs to be an agenda and structure for the meeting. The meeting should start on time. And the facilitator really needs to manage time during the meeting. Frequently the facilitator really needs to step in and suggest that a discussion, for example, be taken offline. It may be getting too detailed or too lengthy for it to have value within a team meeting format, and so I think the facilitator really needs to be a very active participant along those lines.

It's very helpful to have minutes taken and distribute them promptly, usually within 24 hours. The meetings also serve a purpose of developing rapport between team members. Consensus can be developed on key decisions. Action plans are developed and responsibility assigned so that everyone knows their role and who's expected to do what.

And most importantly, this is a dynamic process and team meetings need to be constantly re-evaluated and structure perhaps changed as your team evolves, as your practice evolves. So it's very important to constantly keep that in mind, that there may be a better way of doing things.

A little bit of my experience at Boston Community Medical Group. As Chris mentioned, it's an interdisciplinary care practice. Originally the focus of the practice was really on people with physical and developmental disabilities, but as the practice evolved and served members of Commonwealth Care Alliance's duals program, both the senior program and the under-65 program which started in 2013, the population began to change and diversify.

The under-65 duals program for us brought in a much higher percentage of people who presented with serious mental illness, so that required us to change the participation in our team. We had to expand our behavioral health services. We integrated community outreach workers and expanded the scope of community services that we liaised with in order to make sure we were meeting the needs of our new population. We developed three primary care centers throughout Massachusetts, all focused on this population.

At BCMG, our team is comprised of nurse practitioners, physician assistants, physicians. Oftentimes because we were primary care providers, our nurse practitioners and PAs were really the team leaders and sort of functioned also as the care managers for the participants. We had physician support, social workers, outreach workers, behavioral health specialists, rehab and durable medical equipment specialists, administrative support staff and obviously external specialists and consultants as needed.

One of the newer developments for our practice was the development of our hospitalist team. We were able to partner with our primary hospital to designate a specific unit where our participants would be hospitalized if they required hospitalization, and unless they were in ICU, they would go to this unit. We had our own hospitalist team, which included a physician and either a nurse practitioner or a PA.

Because of this, we were able to develop much closer relationships and have much greater communication around hospitalizations and transitions of care. The hospitalist team would actually come to our team meetings weekly, and if they couldn't physically come, they would call into the meeting, which really was a great benefit to our participants to really ease the transition in and out of the hospital and to make sure that both inpatient team and outpatient team were knowledgeable about what was going on.

Our team meetings occurred weekly for two hours. All of the clinical team members participated or sent a representative, so it was truly an interdisciplinary discussion. We had a standardized agenda where we would make announcements that were important for the whole team to know. We discussed enrollment activity. Any new participants in the program were presented by their primary clinician so that the whole team was aware. It helped with being on call, etc., to have at least heard the story of people coming into the practice. Mostly clinical coverage and scheduling things were taken offline. We would always review all hospitalized participants, whether they were in acute or sub-acute situations, any emergency room visits in the last week.

Any discharges that occurred within the last week, the following clinician would present how that went. This was good information for the hospital team to hear as well so that they could understand. If there were any hiccups along the way between transitioning from inpatient to outpatient, we could talk about it.

We had a 48-hour post-hospital discharge policy where we were required to see someone within 48 hours of discharge. Often it was sooner than that. And the clinician that would see the person was the most appropriate person. If it was medical, it would obviously be probably the NP or the PA, but sometimes if it was a behavioral health issue, it would be the behavioral health clinician who would make that follow-up visit to ensure that everything went smoothly.

We had a very open forum and a problem-oriented approach where any team member could really identify a situation, a participant, that they wanted to discuss. We also implemented morbidity and mortality rounds. Anytime a member died or had a serious complication, our medical director would do a complete chart review of the situation and would do a formal presentation at our team meeting. It was a very good opportunity for us as a quality check to be sure that everything that was done should have been done, that there wasn't anything not done that should have been done. And often it would also be an opportunity to really support the caregivers on the team who had perhaps lost a member. Our members we had for many, many years, and so sometimes that would be a very difficult thing for our caregiver team members, so it was an opportunity to provide support for them as well.

I know I'm running over, so I want to make sure Cindy gets her share of the time here, so I will just close really by saying that, again, the team meeting is always an evolution. It's important to constantly be re-evaluating where you are. There's now more technology involved, so that might allow for more flexibility with remote monitoring, telemedicine, EMRs, Skyping, etc. I think it allows for perhaps more creativity in bringing teams together.

So just in summary, I just think the interdisciplinary approach where we can integrate various discipline in a coordinated and non-fragmented manner achieves really positive outcomes that would not otherwise be possible for very complex members.

Thank you. I will hand it over to Cindy Guddal now. Thanks.

Cindy Guddal: Thank you, Mary, for your presentation. Fascinating stuff.

My name is Cindy Guddal, and I'm the manager of community services at Courage Kenny Rehabilitation Institute, and we are part of Allina Health, which is a large health system in Minnesota and Western Wisconsin. We have a unique combination of rehabilitation support and lifestyle services to meet the needs of the people that we serve who have disabilities of all kinds, and we take a look at the whole person to address their needs. Courage Kenny Rehabilitation Institute served over 94,000 individuals in 2016.

We have a broad spectrum of services, but I'm going to be focusing in on two of our services that have worked together to address some common needs of the people that we serve and have been able to achieve some great outcomes with them.

The first program I wanted to talk about is our advanced primary care clinic. That is a primary care clinic that's housed at our Golden Valley site, which is kind of our hub site with lots of different services offered there, and so it's kind of a one-stop shop for the people that we serve. They can get their primary care, their rehabilitation like physical therapy, occupational therapy, fitness services,

pool, our community services, vocational services, mental health services, a wide spectrum in one place. And then they can get their primary care there also.

The goal of the program for the advanced primary care clinic is to help the person manage their complex neurological condition. The people served in the APC are folks who have complex neurological conditions such as spinal cord injury, brain injury with neurological effects, muscular sclerosis, those types of conditions.

Our in-home community services, which is a service that I am responsible for, is our long-term services and supports for individuals with disabilities of many different kinds, mostly individuals with physical disabilities, including brain injuries, and mental health disabilities. As Chris mentioned, there's three different services that are provided for people in their homes, and we partner with the person's care team, whoever that may be. Oftentimes the care team are other Courage Kenny staff members or are part of the advanced primary care clinic, or they might be part of other organizations and care providers.

The goals for our community services are working with participants to build a life that is important and meaningful to them, to identify and pursue goals, develop skills remove barriers and connect with resources so that they can achieve those goals. And as I mentioned, those services are provided to the person in their home. Next slide, please.

Our advanced primary care clinic was created to bring coordination between the acute care setting and other providers of care, including rehabilitation, specialty services, home health services, long-term services and support or other kinds of services that the person may need. It started because many of the people who were getting other kinds of services within Courage Kenny were having difficulty finding primary care that was understanding and knowledgeable about their disability and had the capacity to meet their needs, including accessible exam rooms with accessible tables, the ability to transfer them, many of the things that Mary had mentioned in terms of meeting their unique needs with their physical disabilities. And then also flexibility in terms of length of appointment scheduling and those types of things.

Our in-home services were designed to work with participants to teach them skills that they would need in order to work and live in their home and in their community and to participate as they choose. It was also started because there were limited options for people that we served to be able to help them to build a life that they desired after they acquired the disability or after living with a disability throughout their childhood and then transitioning into adulthood.

As I mentioned, the program populations that we serve are similar in terms of their makeup for insurances. About 42% in both our advanced primary care clinic and our in-home services are dually eligible with Medicare and Medicaid. And then with the primary care clinic, it's about 34% are Medicaid only and then 11% are Medicare only or other insurance. Our in-home service is about 55% are Medicaid only and with just a handful percentage with other kinds of payers.

In the advanced primary care clinic, it's individuals with physical disabilities and complex medical conditions who need the intensive care coordination that is offered in the clinic. Many of them have numerous co-occurring conditions, and I think the average is 11 active medications that they're taking at one time in that population in the clinic.

For our in-home services, the largest group of individuals that we serve are individuals who have had a brain injury, and then also other physical disabilities, and then many of them also have co-occurring behavioral health conditions and disabilities. Next slide.

Both kinds of services rely on the interdisciplinary team to provide effective services and coordination for the people that we serve. However, it looks a little bit different in each of them, and that's because of the nature of the way the service is provided and the interactions with the participant.

For the primary care clinic, the composition of the industry team is led by the care coordinator with representation by the primary care provider, the physical medicine and rehab doctors, and then also ad hoc members, if they're involved with the person, from the rehab therapies, physiatrist and mental health providers. As I mentioned, the care coordinator, who is a registered nurse, is the person who is responsible for coordinating the teams and is also the point person for the participant in accessing the team.

With our in-home community services, it's a little bit different because many of our people have their own circles of support that may or may not be exclusive to Courage Kenny Rehab Institute. They may be represented by many multiple different agencies. And also depending on the person and their needs, the team can be very fluid. Some people don't have a need for interdisciplinary team interactions a lot, and some have a lot more need for that just based on their disability, their ability to manage their services and care themselves, or kind of what they have going on, what their problem list. Oftentimes this team is led by an external case management agency or case manager.

So kind of in practice, the differences are, one, that the clinic is much more formal and standardized, probably looking a lot more like the type of IDT that Mary described at the Boston program, where within the in-home community services, it could be more fluid, more informal, more on an as-needed basis. They're not scheduled meetings, but they oftentimes come up and are put into place when there are problems taking place. Unfortunately we don't get together to celebrate successes, which I think we probably should do more of, but oftentimes the teams come together to address a problem. With the clinic, it's much more standardized. It's on a weekly basis with an hour-long, it's centralized and the care coordinator is running it and documenting that meeting.

The communication methods within the clinic, the main communication method is obviously the electronic medical record that is shared by all members of the team and all members of the team would have access to the records of the other team members. Where in the in-home services, we have to rely on some other strategies that oftentimes center around the participant rather than having an existing centralized place.

The goals, however, I think are similar in terms of coordinating care and aligning goals and services and sharing updates with the team so that the person is getting their needs met and are achieving their goals. Next slide.

With coordinating communication, some strategies that we have found to work really, really well are similar in some ways with the Boston program, but I have a few other strategies, too. Oftentimes because the need to have some team interaction is somewhat ad hoc, that's where phone calls or secured emails, secured messaging within the electronic medical record would be used. Some strategies that are around and focused on the participant are the use of communication books and planning sheets and communication sheets from community service providers to their medical providers or other kinds of providers so that the participant can carry along a record with them of what it is that they've discussed with their various providers and the recommendations, so that they can gain support to follow through with those recommendations.

Other written instructions for that person's supports are really crucial and helpful in helping that person to follow through with what they are expected to follow through. Oftentimes people with disabilities need some support from others, whether it might be family members, it might be our community services workers, to accomplish those tasks, and so some specific instructions written down can make it helpful for the team to be involved with that.

We've also found it really, really helpful to have lists of care providers for the participants and also for the other team members, and written in a way that the participant can make the most use of it. So you would say, "This is your psychiatrist and this is the name, the clinic, the phone number, and this person helps you with managing your mood." And then you could say, "This person is your primary care physician, the name, their phone number, their clinic, and you can call this clinic when you are feeling ill. This is your community support, you can call this person when you're having a problem with day-to-day tasks." So they will know who they need to contact with what kind of problem that they're having.

I think also especially if people have a lot of specialists, it's really difficult to understand who they need to call. The care coordinator certainly plays a role in that, but I think it's important for the person to also have some written materials about who their teams are so that when the care coordinator says, "This is an issue related to heart; you should call your cardiac specialist," they understand. They have that written down, and that's not new information.

Preparing the participant to communicate with their team is really an essential service that we provide within our community services and are supported within the clinic, and that is to have the community services staff work with the person to plan for their appointments with their care providers, to write down the concerns and issues that they have about their health or their questions that they have about their treatment regimens or the problems that they might be having with their health or questions that they might have about their medications or their therapies. And write all of those down, maybe do some rehearsing of that and practicing how they're going to ask the questions. And then following through on the recommendations.

I know we've all been in the situation where you get in the room and even if you have a long period of time to speak with your practitioner, it is really difficult to get through all of the things that you want to discuss, and you can very easily forget those. So we find that preparation really makes a big difference in terms of them being involved in their care and having that care be coordinated. Next slide, please.

With involving the participant, it's important to be clear on roles. Oftentimes the people that we serve, they'll have a case manager for their long-term services and supports, they'll have a care coordinator at their clinic, they'll have a care coordinator at their health plan, and again, to be really clear, to delineate the roles, to give examples about the kinds of things that they would talk to that person about. So, "The care coordinator will help you find other medical resources such as—the care coordinator at the health plan will help you find other resources like a dentist," or something like that so that they have some clear examples about who they need to contact and ease their frustration with that.

And then also the other thing that's really important in terms of involving the participant is for all of the team members to be understanding about the barriers that people face. People with disabilities have many barriers to accessing their health care, including their own mobility, their transportation and the availability of transportation, the availability of their supports. Oftentimes people can't make it to the clinic because their personal care attendant didn't show up to get them up and out of

bed and into their wheelchair and onto the van to take them to the provider. And so, just some understanding around that is crucial for the participant to feel involved.

I talked about conflicting priorities or goals with the various care providers and the person served. The person served might just want to have an enjoyable life and the care providers feel like it's important for them to manage their diabetes, and how do those two things go together and how can one have an enjoyable life and yet still make progress in managing your diabetes? And to take their goals into consideration with the things that care providers might feel are important for them.

With involving the participant at Allina Health, we found some success and some interest in using shared decision-making tools. There's a link, and you can see some of the ones that Allina Health has developed. Those are around helping the person to make a decision about different kinds of care options for them, like around low back pain, breast cancer treatment, options for different ways to do colorectal screening, cancer screenings, which might be easier for people with disabilities or people from different cultures, it might be an easier way to do that. So it kind of just lays out what all the different options are in a way that's really easy to understand so the person can make an informed choice. Next slide. Thank you.

Another tool to support teamwork, coordination and communication is clearly defined care plans that are shared with the participant and identify the goals and who's going to do what, and then possibly have those all collected into a communication book that the person can carry with them and can be available to all their different providers. Also summary visits with clear directions for follow-up that they can use for themselves or use with their supports to do the necessary follow-ups.

And then at the clinic, what we found is developing protocols for common medical issues. Many of the people that we serve in the clinics have a spinal cord injury, and you may or may not know, but urinary tract infections are very common in individuals with spinal cord injury, and they've developed protocols around that where if a person is at risk for that, they'll send home clean catch kits with the person even before they need them so that if they're feeling symptomatic, they can call the care coordinator, they can do the clean catch at home, and then a family member or a care provider can bring the sample to the clinic for testing to see if that's truly what the case is. And so that just removes some of the barriers to accessing their care. It's easier to get the sample to the clinic than it is to get the person to the clinic to give the sample. Next slide.

Just communication is essential within the interdisciplinary team, and some flexibility around how that communication happens is crucial. And then, there has to be kind of a focus on the person served and what their needs and goals are. And then, if somebody is having ongoing care coordination needs, then to have that be more systematized and standardized is helpful to them. Next slide.

I wanted to share briefly a story about an individual who has been served in a coordinated fashion between the clinic and our community services, and that is the story of Mary Jo, who has multiple sclerosis and bipolar disorder. In the clinic, she was having a lot of difficulty managing her medical condition, so they recommended that she participate with some community services, and we were able to see her in her home and then help her to compensate for some of the cognitive deficits that she was having with her multiple sclerosis.

Coordination efforts included keeping track of appointments, planning for appointments, using memory aids, cuing her to contact her providers when she was feeling ill. And then the care coordinator would actually call her when her community supports were at her home, so then they

could have a joint conversation to address her needs and what's going on with her. You can go to the next slide, too. Thank you.

And then the community supports were able to help her to follow through on the recommendations of the care team. Without that type of coordinated care, she was at risk of not being able to stay in her condominium anymore, which was very important to her, and having to move into a more supported housing setting, but she really wanted to stay as independent as possible, and this model of care really worked to help her address her medical needs while maintaining her housing of choice.

And then, you can kind of see in the next slide some of the strategies that were used were a common medical record, frequent communication with the care coordinator, including when their supports were present with them, and also having the supports attend appointments with their medical providers.

And I think I'm done. I will give it back to Chris for our questions and answers.

Chris Duff: Thank you, Cindy and Mary, for your great presentations. I appreciate it. A bunch of questions have come in, and they're kind of around a couple issues. One is involvement of outside providers, especially primary care. And another is, How do you keep the team together, especially when they're not all on site? But I'm going to start with a question that I think is very important. It's a little outside of those two areas, and it comes from Rose at Kindred at Home in Texas: How do you ensure the participant's voice is not lost in the IDT process? Why don't we start with Mary and then we can go to Cindy.

Mary Glover: Okay, great. Chris, thank you. That's a good question and something that has to be at the forefront of all team members' minds at all times. Because of the format of the official team meeting, the participant is not present generally at that meeting. It doesn't mean that the participant's voice isn't heard there. All of the team members who have direct interface with the participant represent the voice of the participant. During the assessment process and the reassessment process, the participant is always—obviously that's a direct assessment with the participant. They are asked what their goals are. Their goals are identified in the care plan. And as Cindy alluded to, the participant's goals may not be our goals, but this is definitely a participant-driven care plan, and so what they prioritize is what we address in the care plan and in our care structure.

There are oftentimes meetings that are outside of this interdisciplinary meeting that I described at the office. We often have meetings in the member's home or in the office with either caregivers, family, our own team members, who is appropriate. Sometimes if they're living in a residential place, we might meet there. But certainly there are also team meetings and one-on-one meetings with the participant where the participant's voice is definitely front and center.

And also, many of our longer-term patients were very aware of our weekly team meetings and would often say to me, "Are you going to talk about me at the team meeting this week? Are you going to bring this up or that up?" They knew about the meetings, and they actually would ask us, "What happened at the meeting? What did people think of this or that?"

Anyway, it was pretty interactive. I think we can always do better. We always have to strive to improve access for people to have their voice heard. As Cindy mentioned, they get a copy of their care plan. When I left, they were working on member access to the medical record or aspects of the medical record. I'm not sure where that stands now, but that's certainly something I see when I'm—I still do a little bit of work on the assessment side, and many people will log into their medical

record and will show me their test results and all of this stuff. People really like to be a part of it and need to be a part of it.

Chris Duff: Cindy, do you have further comments?

Cindy Guddal: I agree with everything that Mary said. I would just add to make sure that the participant's goals are written in their own language and in the way that they say that, and not sort of doctored up and flowered up the care provider's language. To make sure that that voice is heard.

Chris Duff: I haven't practiced with people for quite a while, but I really want to pull out two things that both of you talked about that I did not do. One is in the person's language. We were very good at doing all of our shorthand in our professions, so I'm thrilled to hear you talk about the care plans being written in their language. And then, Mary, I think it's great that they were so aware of the team meetings that they would inquire, "Okay, so what did you guys talk about today?" and stuff like that. I think that transparency is absolutely wonderful and I think very, very helpful.

Mary Glover: Well, it was a little bit—not an out, exactly, but it was a little bit for us, if we were stymied with something, we could say to them, "You know what? I'm going to bring this up at the team meeting this week because I'm not sure the best way to handle this." They appreciated that, that you were looking to other people for help.

Chris Duff: Yeah. I think that's always good, and especially the way you introduced it. That's very cool.

So now, a question from Melissa at CMS. I hear this question all the time, and that is—and, Mary, I think this is probably a little less pertinent to you because you are in a health-plan owned—or, you were in a health-plan owned and managed physician clinic or practitioner clinic, primary care practitioner clinic. So I think this is more about Cindy, but also, Mary, for your specialists. The issue is, how do you get the primary care practitioners and specialists to participate in IDT meetings, especially if they're not on site? This has been a challenge for the Medicare/Medicaid plans, the dual plans, despite those plans having IDTs. In New York, for example, physicians or primary care practitioners have said they do not have the time to participate and they're not being adequately compensated.

So, I'll take a first shot at that. Just simply, that is a struggle across the board. There's always the strategy of doing some co-location, that you co-locate the team in a practice that has a lot of your members. But now with that as kind of a first idea, Cindy or Mary, any ideas that come to your mind?

Cindy Guddal: I could speak about it a little bit in terms of coordinating our community services with primary physicians or providing support to the person for accessing the primary physician is it works really well to just go to the appointment with them and to do it during an appointment so that the primary care physician is already engaged with the person. So if it could be during that period of time. And then also the participant is involved and active in that meeting. So that would be one strategy.

Similarly, within the clinic I think it's oftentimes the role of the care coordinator who's an RN to represent the clinic in those kinds of meetings and would participate in those on the phone or something like that so that it's not taking away from the provider who does the billable service.

That's just two strategies.

Mary Glover: Yeah, I agree with both of you. In addition, sometimes if we did have a critical number, our clinicians could go to their team meetings at the health center or the practice and they would review our patients first so that we could have a discussion. We also used to try to get EMR access even to the primary care site's medical record, and sometimes that was successful. It didn't really substitute for a meeting, but at least it facilitated some communication back and forth.

It became burdensome, though, for our staff because the primary care sites really wanted us to document all of our stuff in their records, but we had our own record, and so we really couldn't ask our clinicians—well, we did for some period of time—document it in both places, but that became totally cumbersome and untenable. And so, we keep waiting for the day when technology speaks to each other. That might help.

Chris Duff: Yeah, the only other thing—I agree with all that, obviously. The only other thing I have heard that's been tried is to purchase some time—you work with a clinic. You figure out what clinics have a lot of your members, your participants, and then you work with that clinic to get them to be seen by one or two physicians in particular. And then what you do is you buy time with those physicians.

I know we were implementing a program where we would buy two hours of that physician's time every Thursday, and we would review all of the participants in common. So the doctor wasn't stressed about a caseload of his own with all his other people waiting for him, but that time was blocked on his calendar and was pre-paid by the plan.

So I think it takes some of that creative thinking to accomplish that until more of the methodologies are in place. I know systems are now in place to do some care—for physicians to bill for care planning, but that's not really attending team meetings. I think that's an evolving science with no clear answer at this point.

A bunch more questions have come in, but our time is over. We will follow up on the questions that have come in and get back to you. Either one of the three of us will get back to you. I will need to hand this over to Jessie to wrap it up.

Jessie Micholuk: Thank you, Chris, and thank you, everyone, for attending today and for your contributions to our discussion. You can keep sending any questions via the Chat feature on the platform or, of course, to our email address that will be available at the end of the presentation.

I'd also like to thank our presenters today, Mary and Cindy. That was a great presentation and a great discussion.

The next webinar in our series will be held next Wednesday, March 28, and we'll be discussing managing transitions with adults with disabilities.

For more information about obtaining CEUs or CMEs, and of course for additional resources, please visit our website, ResourcesForIntegratedCare.com. And again, you can access the CMS Continuing Education Credit guide on your platform right now. It's located on the left-hand side in the Resource Library.

As always, your input is essential in developing new trainings and resources. Please answer our brief survey that will appear automatically on your screen when this webinar ends. You can send

additional comments to our Inbox, RIC@lewin.com. Also, please follow us on Twitter at [integrate_care](#).

Once again, thank you for attending today's webinar, and have a great rest of your day.