INTERDISCIPLINARY CARE TEAMS FOR OLDER ADULTS: RESOURCE GUIDE

This is a supplemental resource guide to the Resources for Integrated Care (RIC) webinar hosted on December 7, 2017, ***Interdisciplinary Care Teams for Older Adults***. The work of interdisciplinary care teams (ICTs) is a dynamic process that involves two or more health professionals with complementary backgrounds and skills. These professionals share common health goals and engage in a concerted effort to assess, plan, and evaluate patient care. Through interdependent collaboration, open communication and shared decision making, ICTs generate improved patient, organizational, and staff outcomes. By utilizing ICTs, providers can deliver comprehensive assessments and manage the care of older adults more effectively. Successful ICTs use a person-centered approach that prioritizes the individual's needs. A number of resources for providers and health plans to support ICTs are included below. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website: https://resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/ICT.

Please note that some of the resources listed below may have an associated cost.

PUBLICATIONS AND ARTICLES

Center for Health Care Strategies' **Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States** provides considerations for ICT development and oversight, and gives examples of strategies used by states integrating care for beneficiaries dually eligible for Medicare and Medicaid.

https://www.chcs.org/media/INSIDE_ICTs_for_Medicare-Medicaid_Enrollees-012216.pdf

Ten Principles of Good Interdisciplinary Care Teamwork describes characteristics underpinning effective interdisciplinary team work and competency statements that an effective ICT functioning at a high level should demonstrate.

https://www.ncbi.nlm.nih.gov/pubmed/23663329

The Interdisciplinary Care Team in Geriatric Care defines a number of diverse team models and evidence of their efficacy. The article provides thoughts on the position of geriatric teams within the more general emergence of primary, managed care models of health services delivery.

http://journals.sagepub.com/doi/abs/10.1177/0002764296039006003

PUBLICATIONS AND ARTICLES

Core Principles & Values of Effective Team-Based Health Care is a discussion paper that provides common reference points to guide coordinated collaboration among health professionals, patients and families – ultimately helping to accelerate inter-professional team-based care. The discussion paper includes identified core principles to enable health professionals, researchers, policy makers, administrators and patients to achieve appropriate, high-value team-based health care.

https://www.nationalahec.org/pdfs/vsrt-team-based-care-principles-values.pdf

Interdisciplinary Collaboration Improved Safety, Quality of Care, Experts Say is a first-person account of an individual patient benefitting from interdisciplinary care program in Philadelphia's Living Independently for Elders (LIFE). It describes aspects of this program and how LIFE improves care through testimonies from administrators and leaders of the program. These testimonies serve as guides for health professionals to begin working collaboratively to treat patients.

https://www.rwjf.org/en/library/articles-and-news/2010/11/interdisciplinary-collaboration-improves-safety-quality-of-care-.html

HANDBOOKS AND GUIDES

TeamSTEPPS® 2.0 is an evidence-based program that optimizes performance among teams of health care professionals, enabling them to respond quickly and effectively to whatever situations arise. The Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD) have developed TeamSTEPPS®, a teamwork system that offers a powerful solution to improving collaboration and communication within your institution.

https://www.ahrq.gov/teamstepps/instructor/index.html

Implementing Care Teams, Practice Facilitation Handbook describes the make-up and function of care teams. It also provides guidelines for how a practice facilitators can help healthcare practices implement team-based care. This handbook lists steps to take and task management activities for successful care team models.

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod19.html

Geriatric Care by Design is a clinician's handbook available for purchase that describes how to meet the needs of older adults through environmental and practice redesign. The handbook features case studies and lessons learned from experts in the fields of both primary and specialty care, and provides information and clear insight on how to design an environment that meets the needs of physicians, patients and office staff.

http://amascb.pdn.ipublishcentral.com/product/geriatric-care-by-design

RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration

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The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries enrolled in both Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This guide is intended to support health plans and providers in integrating and coordinating care for Medicare-Medicaid beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com. Please submit any feedback on this guide or topic suggestions for other resources to RIC@Lewin.com.