Interdisciplinary Care Teams for Older Adults

Credit Information

- If you are a **physician** or **social worker** in a National Association of Social Workers (NASW) state and would like to receive CME credits through the American Geriatrics Society or CE credits through NASW for this event, please complete the pre-test posted here: https://www.research.net/r/pre_interdisciplinaryCare
  - You will also be required to complete a post-test; a link to this test will appear at the end of the presentation.

- For more information about obtaining CEUs for **social workers in non-NASW states**, **psychologists**, **PAs**, **nurses (NP, APRN, RN, LPN)**, **pharmacists**, **marriage and family counselors**, etc. via the Centers for Medicare & Medicaid Service’s Learning Management System, please visit: https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/ICT

Audio and Platform Information

- The audio portion of the presentation will automatically stream through your computer speakers. If you experience challenges with the audio, please click the phone icon at the bottom of the screen for dial-in information.

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Interdisciplinary Care Teams (ICTs) For Older Adults
Overview

- This is the fifth session of a five-part series from the “2017 Geriatric-Competent Care Webinar Series.”

- Each session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.

- Video replay and slide presentation are available after each session at: www.resourcesforintegratedcare.com.
Accreditation

- The American Geriatrics Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians and by the National Association of Social Workers (NASW) to provide continuing education for social workers.

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET). The Centers for Medicare & Medicaid Services complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the Centers for Medicare & Medicaid Services is authorized to issue the IACET CEU.
## Continuing Education Information

<table>
<thead>
<tr>
<th>If You Are A:</th>
<th>Credit Options</th>
<th>Requirements</th>
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<tbody>
<tr>
<td><strong>Option 1: American Geriatrics Society</strong></td>
<td><strong>Please note:</strong> other health care professionals can receive certificate of participation from AGS</td>
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| Social Worker                          | The American Geriatrics Society designates this webinar for a maximum of 1 Continuing Education (CE) credit hour  | 1. Complete the pre-test at the beginning of the webinar  
2. Complete the post-test with a score of 80% or higher by midnight January 7, 2017 |
| **Please note:** New York, Michigan, and West Virginia do not accept National CE Approval Programs for Social Work. New Jersey, Idaho, and Oregon do not recognize NASW National Approval |                                                                            |                                                                                                                                 |
| Physician (MD or DO)                   | The American Geriatrics Society designates this live educational activity for a maximum of 1 AMA PRA Category 1 CreditTM | 1. Complete the pre-test at the beginning of the webinar  
2. Complete the post-test with a score of 70% or higher by midnight January 7, 2017 |
| **Option 2: Centers for Medicare & Medicaid Services**                                                |                                                                                     |                                                                                                                                 |
| Other (social worker in non-NASW states, psychologist, PA, nurse (NP, APRN, RN, LPN), pharmacist, marriage and family counselor, etc.) | The Centers for Medicare & Medicaid Services (CMS) is authorized by IACET to offer CEUs. CEUs will be awarded to participants who meet all criteria for successful completion of this educational activity | Complete the post-test through CMS’ Learning Management System with a score of 80% or higher by midnight January 31, 2017 |
Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to help ensure beneficiaries enrolled in Medicare and Medicaid 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-Medicaid enrollees, MMCO develops technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.
Introductions

- **Gwendolyn Graddy-Dansby, MD, FACP**  
  Medical Director, PACE Southeast Michigan

- **Sandra White, LMSW**  
  Director of Operations-East, PACE Southeast Michigan

- **Ellen LaSalvia, MSW, LSW**  
  Director of Long-Term Services and Supports and Home and Community Based Services, Buckeye Health Plan

- **Olivia Richard**  
  Care-Recipient
Webinar Outline/Agenda

- Polls
- The Role of an Interdisciplinary Care Team
- Strategies for Implementing Care Teams
- Successful Clinical Care = Interdisciplinary Care Team
- Perspective of a Care-Recipient
- Q&A
- Evaluation
It Takes a Village to Care for Older Adults: The Role of an Interdisciplinary Care Team

Gwendolyn Graddy-Dansby, MD, FACP
The Why, What, and Who of Interdisciplinary Care Teams (ICTs)
Why are ICTs Important?
“People want health not healthcare. And those who require the most healthcare and get the least health- high need, high-cost patients with multiple or severe medical conditions - feel this most acutely.”

–Dr. Dhruv Khullar, September 2017

Why ICTs: Older Adult Demographics

- By 2020, more than 25 percent of the population will be over the age of 65
- Of those over 65 years, the greatest percentage of growth will occur among women and those over 85 years
- With age, there is a greater prevalence of chronic diseases and dementia
- About one-quarter of Medicare outlays are for the last year of life, unchanged from thirty years ago
- Availability of health care providers will decline significantly after 2020 due to baby boomers retiring from the workforce
Chronic Diseases in Older Adults - Statistics

- **Leading causes of death:**
  - In 1900 – infections and acute illness
  - In the 21st century – chronic diseases and degenerative illness

- **Among individuals over 65 years:**
  - 80 percent have at least one chronic disease
  - 50 percent have at least two chronic diseases
  - Medicare-Medicaid Enrollees (MMEs)
  - 59 percent have arthritis
  - 20 percent have diabetes (largest incidence occurs in individuals over 75 years)
  - 13 percent have a mental illness; 65 million have depression
  - The risk of Alzheimer’s doubles every 5 years
  - The highest incidence of Alzheimer’s is in those over 80 years

- **Among Medicare-Medicaid Enrollees (MMEs)**
  - On average have 25 percent more chronic conditions than non-MMEs
  - More likely than non-MMEs to have depression, Alzheimer’s disease, diabetes, heart failure, chronic kidney disease, COPD, asthma, or stroke
What are ICTs?
Terminology

- A wide range of terms are used to describe **collaborative working** arrangements between professionals.

- Terms such as **interdisciplinary, interprofessional, multiprofessional, and multidisciplinary** are often used interchangeably in the literature to refer to different types of teams and different processes within them.
“A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physician and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision making. This in turn generates value-added patient, organizational, and staff outcomes.”

### Characteristics of a Good Interdisciplinary Care Team

| 1. Leadership and management | • Clear leader of the team with clear direction and management; leader who acts and listens  
|                             | • Democratic with shared power and support/supervision structure  
|                             | • Personal development aligned with line management; leader who acts and listens |
| 2. Communication             | • Good communication skills  
|                             | • Appropriate systems to promote communication within the team |
| 3. Personal rewards, training and development | • Training and career development opportunities  
|                             | • Incorporates individual rewards and opportunity to increase morale and motivation |
| 4. Appropriate resources and procedures | • Structures (for example, team meetings, organizational factors, team members working from the same location)  
|                             | • Appropriate procedures are in place to uphold the vision of the service (for example, communication systems, appropriate referral criteria) |
| 5. Appropriate skill mix     | • Sufficient/appropriate skills, competencies, practitioner mix, balance of personalities  
|                             | • Ability to make the most of other team members' backgrounds  
|                             | • Full complement of staff, timely coverage for empty or absent posts |
# Characteristics of a Good Interdisciplinary Care Team

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| 6. Climate | • Team culture of trust, valuing contributions, nurturing consensus  
• Interprofessional atmosphere |
| 7. Individual characteristics | • Knowledge, experience, initiative, identifying strengths and weaknesses, listening skills, reflexive practice  
• Desire to work on the same goals |
| 8. Clarity of vision | • Clear set of values that drive the direction of the service and the care provided  
• Portray a uniform and consistent external image |
| 9. Quality and outcomes of care | • Patient-centered focus, outcomes and satisfaction, encouraging feedback  
• Capture and record evidence of the effectiveness of care that is used as part of a feedback cycle to improve care |
| 10. Respecting and understanding roles | • Shared power, joint working, autonomy |
Who makes up an ICT?
Who?

- Home care
- Transportation
- Recreation therapy
- Physical therapy
- Occupational therapy
- Social work
- Nursing care
- Chaplain

- Physician
- Nurse practitioner
- Pharmacist
- Dentist
- Audiologist
- Podiatry
- Behavioral health
- Nutritionist
Making a Team Work: Strategies for Implementing Care Teams

Sandra White, LMSW
ICT Working Together

- “The strength of the team is each individual member. The strength of each member is the team.”
  - Phil Jackson
Key Strategies for Making ICTs Work

1. Team leadership
2. Small meetings
3. Creative thinking
4. Interdisciplinary thinking
Key Strategies for Making ICTs Work: Team Leadership

- **Knowledgeable and competent team leader**
  - Who effectively works collaboratively with the team to help achieve patient centered-care plans
  - Who is able to provide team support, guidance, instruction and direction while building a cohesive integrated team and working environment
Key Strategies for Making ICTs Work: Team Leadership

- Knowledgeable and competent team leader:
  - Who is capable of identifying the strength of the ICT members and knowing when to involve particular ICTs, based on whether the need is psychosocial or medical

- In summary, the team leader helps the ICT stay focused on “what’s important now”
Key Strategies for Making ICTs Work: Small Meetings

- Meetings around a particular problem/need
  - Building trust
  - Clarifying roles
  - Communicating openly and effectively
  - Appreciating diversity of ideas
  - Making certain ICT stays focused
Key Strategies for Making ICTs Work: Creative Thinking

Thinking

OUTSIDE OF THE BOX
Key Strategies for Making ICTs Work: Interdisciplinary Thinking

A team is...

...many hands & one mind
Good Team Problem Solving Skills
The following case studies will demonstrate how the team’s approach changes based on beneficiary’s needs:

- Medical care needs
- Social service needs
- Specialty needs
Case Study 1: Ms. S.W.H., 66 year old female

- **Medical History:**
  - Metastatic lung cancer
  - Chronic pain
  - Malnourished
  - Polypharmacy

- **Social:**
  - Living in home with son
  - Lacks basic necessities, i.e., stove to cook

- **Psychosocial:**
  - Bipolar
  - Traumatic life
Integrated Care Model
Case Study 2: Ms. D.R., 89 year old female

- **Medical History:**
  - Coronary artery disease, degenerative joint disease, atrial fibrillation, dementia, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and pseudogout, and multiple falls

- **Social:**
  - Lives in community with her daughter who has a high level of stress
  - Home is cluttered: Question – is Daughter a “hoarder”?

- **Challenge:**
  - Safety in the community
  - Addressing participant’s behaviors
  - Caregiver support

- **Question:**
  - Adult Protective Services Referral?
Case Studies - Lessons Learned

- Do not assume that another person heard and understood the same thing that you did.
- Allow for mistakes.
- Make it safe for people to be transparent.
- Agree to disagree.
- Educate, educate, educate.
- Remember that we are here for the patient.
- Don’t forget to ask the patient and caregiver for their input.
- When in doubt ask for another opinion.
- Include the front line staff (i.e., home health aide, nursing assistants, drivers).
- Decisions can be changed.
- Follow up and debrief.
Summary

- Interdisciplinary Care Teams for older adults require:
  - Certain skill sets - (i.e., positive leadership and management attributes, clarity of vision, problem solving, strong communication, staff training and development, understanding appropriate resources and procedures, supportive team climate)
  - Commitment to think outside the box
  - Ability to collaborate
  - Willingness to get out of your comfort zone
  - Know where and when to ask for help
  - COMMUNICATE, COMMUNICATE, COMMUNICATE
  - Keep what’s important first: Aging Adult
It’s a Wonderful Life
Successful Clinical Care = Interdisciplinary Care Team

Ellen LaSalvia, MSW, LSW
LTSS? What is it?

- **LTSS = Long Term Services and Supports**
  - LTSS are provided to Medicare and Medicaid members of all ages who need ongoing help with activities of daily living (e.g. bathing, dressing, cooking) due to aging or disability
  - The purpose of LTSS is to "support the member to live or work in the setting of their choice, which may include the member's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting" (CFR 438.2)
Two LTSS Models

1. Home and Community-Based Services (HCBS) Model
   - Works to address the needs of individuals with functional limitations who need help with Activities of Daily Living/Instrumental Activities of Daily Living
   - This model aims to support older adults and persons with disabilities in their homes and communities
   - Care managers work to ensure the right level of services to maximize independence and quality of life

2. Long-Term Care (LTC) Model
   - Care can be administered in assisted living (though this can be an HCBS as well), adult family homes and/or nursing facilities
   - In this model providers may offer skilled nursing care, occupational therapy, speech therapy, physical therapy, dietary management, dialysis, and/or hospice and palliative care “in house”
## Comparing LTSS Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Home- and Community-Based Care</th>
<th>Facility-Based Care</th>
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<tr>
<td><strong>What LTSS services can be provided?</strong></td>
<td>Personal services, medical/non-medical to help with daily living tasks, Emergency Home Response, Home Delivered Meals</td>
<td>Medical and personal services to help with daily living tasks</td>
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<td><strong>Where does the individual live?</strong></td>
<td>In own home, with a family member, Assisted Living Facility, or other setting of choice</td>
<td>In a facility designed to provide LTSS to residents</td>
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<td><strong>Where are the services provided?</strong></td>
<td>Typically in the home, some services may be provided in the community</td>
<td>Services are provided by staff/caregivers who work for the facility</td>
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<td><strong>Who are the paid or reimbursable caregivers?</strong></td>
<td>Agency based home care aides or personal care workers (including self-directed). Family members may be certified as live-in or visiting caregivers, depending on state's requirements. Other care can be provided by non-medical/medical providers in the community. (IE: Adult Day Services, Respite, Therapists)</td>
<td>Caregivers include facility staff (dietary aides, CNAs, and licensed staff)</td>
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ICT participants are included based on the type of services the member is receiving (HCBS or LTC)

- Minimum recommendation for ICT composition, as applicable:
  - HCBS: member, caregiver, primary care physician (PCP), psychiatrist, in-home HCBS providers (personal care assistant, nurse, social worker, counselor, etc.)
  - LTC: member, caregiver (power of attorney, guardian), PCP, psychiatrist, facility social worker, nurse, physical therapist/occupational therapist, and dietician

- Optional participants may include but are not limited to: specialists, friends, or social network support (e.g. church pastor)
- The ICT should be a collective body representing and supporting the goals identified by the member to achieve a quality of life desired by the member
The inclusion of both HCBS providers and LTC providers is an essential piece of the ICT success puzzle:

- **HCBS providers** – eyes and ears in the home
  - For example, the dialogue that occurs in the course of personal care and connects back to something shared with the PCP
- **LTC providers** – eyes and ears in the facility
  - For example, the activities coordinator can bring a wealth of knowledge on social interaction
- **HCBS and LTC providers both:**
  - Connect on a personal level with individuals and their support system
  - Supply perspectives that may not otherwise be known
  - Support and reinforce member selected plans and actions
ICT Success in Support

- LTSS are unique, so education for the overall ICT is recommended, such as:
  - Ensure the LTSS benefit(s) are known and understood by the team
    - What benefits are available? When can they be accessed? How are they used? Why are they needed?
  - Provide a Frequently Asked Questions document (FAQ)
    - A one page sheet that summarizes benefits and how to access them is beneficial when the team is attempting to remove a barrier
  - Ensure the care manager is prepared to be the subject matter expert on the HCBS benefits available within the waiver
    - For example, understanding that home modifications are for minor home modifications and not general maintenance will streamline the coordination to resolve a roof issue
- There should be an agreement on preferred communication methods:
  - Telephone, in-person, fax, letter, etc.
Case Study 1: 66 year old male

- **Medical History**
  - Depression
  - Paralysis at waist level

- **ICT Membership**
  - Member, Care Manager, Waiver Service Coordinator, Primary Care Physician and Personal Care Attendant

- **Need**
  - Wants a new electric wheelchair and has flooring concerns in current residence

- **Resolution**
  - New electric wheelchair and replacement of floors
Case Study 2: 68 year old male

- **Medical history:**
  - Non-verbal
  - Coronary artery disease
  - CCVA
  - Anoxia and aspiration

- **ICT Membership**
  - Member, member’s wife (also primary caregiver), Primary Care Physician, multiple personal care attendants and multiple skilled nurse providers

- **Need**
  - Maintain community residence with no or minimal hospitalizations

- **Outcome**
  - Hospitalization with discharge home
Resources

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2838161/
Care-Recipient Perspective

Olivia Richard
ICTs Beyond Older Adults

- The key takeaways from this webinar can be applied to populations beyond older adults, such as individuals with multiple comorbid conditions, individuals with disabilities or individuals with intellectual/developmental disabilities.

- *The Disability-Competent Care Self-Assessment Tool* is 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.

- *My Health, My Life Toolkit* is a toolkit for individuals with intellectual and developmental disabilities (I/DD), their family member(s) or guardian(s) and their provider support team.
  - [https://www.resourcesforintegratedcare.com/IDD/Care_Integration/Toolkit/My_Health_My_Life](https://www.resourcesforintegratedcare.com/IDD/Care_Integration/Toolkit/My_Health_My_Life)
Questions
Resources for Integrated Care – Upcoming Events

- Webinar on Disability Competence Resource: DCCAT
  - Date: December 13, 2017
  - Time: 2:00pm-3:00pm ET
  - To register, please visit: https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2017_DCC_Webinar/DCCAT

- Stay tuned for our 2018 Geriatric-Competent Care webinars focused on:
  - Older Adults and Substance Use Disorders
  - Safe and Effective Use of Medications in Older Adults
Evaluation Form and Post-test

- Thank you for joining our webinar. Please take a moment to complete a brief evaluation on the quality of the webinar.

- If you are applying for CME or NASW CEU, you must complete the post-test in order to receive credit: https://www.research.net/r/post_interdisciplinaryCare

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- Questions? Please email RIC@lewin.com