N.C. Department of Health and Human Services

Interdisciplinary Care Planning

Stepping up to the plate to meet holistic needs of CAP beneficiaries

What does Interdisciplinary Team Planning mean for CAP/DA Program

- Reduces Redundancy & Wasteful processes
- Decreases cost
- Increases Communication
- Assures Continuity of Care

Reference: Medicaid and Health Choice Clinical Coverage Policy No: 3K-2 (6.3, g)

Interdisciplinary Teams

Interdisciplinary teamwork is an important component in:

- Reducing health care costs,
- Promoting beneficiary safety through more effective communication
- Helping reduce workload through shared responsibility

Interdisciplinary Teams

- Well-coordinated collaboration across professions (specialists outside program, home service, contracted services, hospitalization)
- Potentially allows comprehensive, population-based, cost-effective care
- Places emphasis on health promotion and disease prevention

Interdisciplinary Teams

- Consist of providers from different professions who share a common population and care goals and have responsibility for complementary tasks.
- Each team member puts forth their knowledge individually and collectively

Interdisciplinary Teams

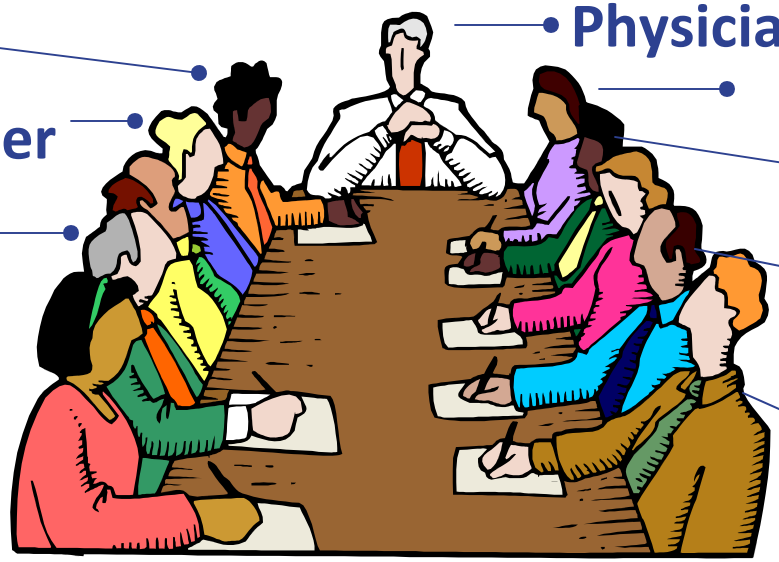
The team is actively interdependent, with an established means of ongoing communication among team members, the beneficiary and their families to ensure that various aspects of the beneficiary's health care needs are integrated and addressed.

Common Key Players

Can include, but are not limited to:

- Physician
- Beneficiary and/ or Responsible Party
- Case manager
- Medicaid Eligibility
- IHA agency
- Home Health
- Pharmacist

Interdisciplinary Teams manage the care and services provided to each CAP/DA Beneficiary



Core Components of Interdisciplinary Teams

Person-Centered Care

- Inform and involve beneficiaries and their families in medical/treatment decision making and self management;
- Coordinate and integrate care;
- Apply principles of disease prevention and behavioral change appropriate for diverse populations

Core Components of Interdisciplinary Teams

Quality Improvement

- Continually understand and measure quality of care in terms of structure, processes, and outcomes;
- Design and test interventions to change processes and systems of care

Tasks of the Interdisciplinary Team

Coordination

- The goals of the beneficiary determine the composition of the team or team subset that will be responsible for addressing specific problems encountered by the beneficiary.

Reference: Medicaid and Health Choice Clinical Coverage Policy No: 3K-2 (Section 6.3 g, s7 & t10)

Tasks of the Interdisciplinary Team

Communication

- Effective communication is needed to facilitate coordinated care.
- An ideal communication system would include a well-designed case file, regularly scheduled meetings to discuss beneficiary care issues, and a mechanism for communicating with external systems.

Reference: Medicaid and Health Choice Clinical Coverage Policy No: 3K-2 (6.3, f4 & 6)

Tasks of the Interdisciplinary Team

Shared Responsibility

- Interdisciplinary teamwork is an important component in reducing health care costs, promoting the safety of the beneficiary through more effective communication and helping reduce workload through shared responsibility.

Reference: ***http://www.emergingrnleader.com/why-interdisciplinary-teamwork-in-healthcare-is-challenging/#sthash.rF1RJc7Z.dpuf***

Activities of the Interdisciplinary Team

- Define the problem and decide on goals,
- Gather information about the problem,
- Seek opinions about the problem from appropriate team members,
- Discuss and expand the problem, each contributing his or her own unique professional perspective

Activities of the Interdisciplinary Team (continued)

- Develop potential solutions
- Offer opinions about each potential solution,
- Evaluate potential solutions and choose the best one or integrate several into one,
- Summarize the plan and agree on distribution of tasks across team members.

Advantages of Interdisciplinary Team Care

For beneficiaries:

- Improves care by increasing coordination of services, especially for complex problems
- Integrates health care for a wide range of problems and needs
- Empowers beneficiaries as active partners in care
- Resourceful in serving beneficiaries of diverse cultural backgrounds
- Uses time more efficiently

Advantages of Interdisciplinary Team Care

For case managers:

- Increases professional satisfaction
- Facilitates shift in emphasis from acute, episodic care to long-term preventive care
- Enables the case manager to learn new skills and approaches
- Encourages innovation
- Allows providers to focus on individual areas of expertise

Advantages of Interdisciplinary Team Care

For Lead Agency and DMA:

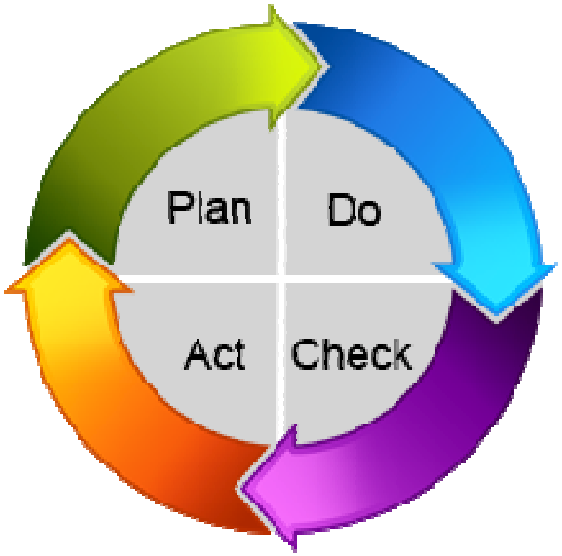
- More efficient coordination of care
- Reduces short-term NF or hospitalization as a result of increased preventive care
- Facilitates continuous quality improvement efforts

Reference: Medicaid and Health Choice Clinical Coverage Policy No: 3K-2(6.3,g)

Monitoring Using the Plan-Do-Check-Act Approach

Plan-Do-Check-Act (PDCA)

PDCA is an interactive ***four step problem solving process***



Plan-Do-Check-Act (PDCA)

Plan

Establish the objectives and goals according to the beneficiary's needs, the assessment and program policies.

Do

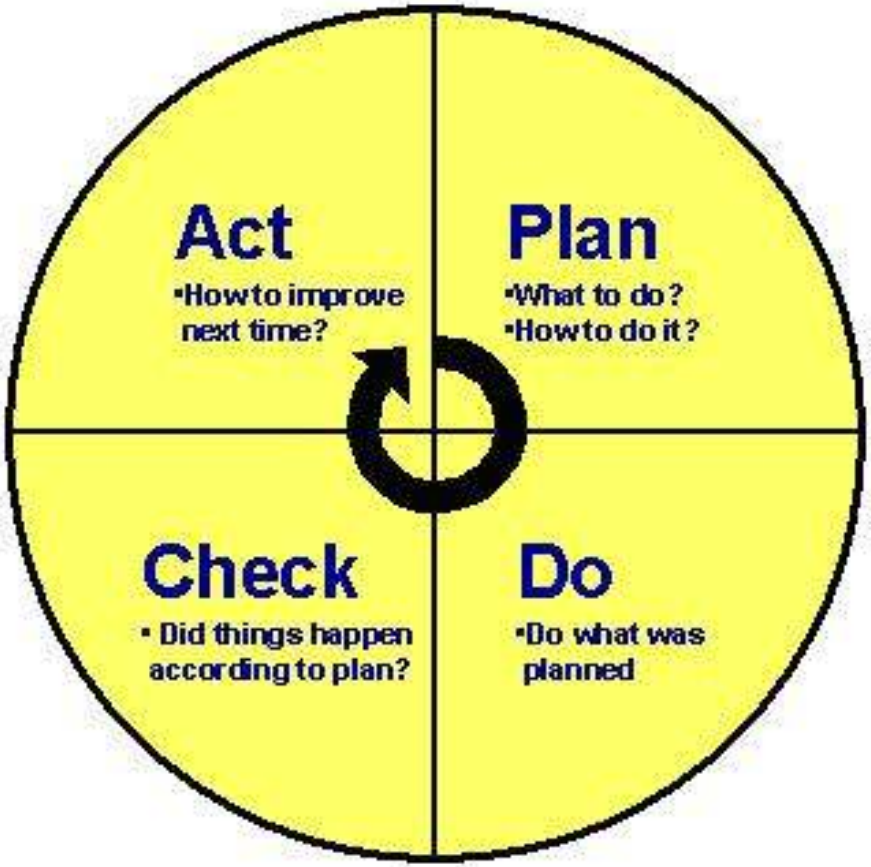
Coordinate the services to be provided according to the Plan of Care.

Check

Monitor and measure services against policies, goals, and the documented needs of the beneficiary.

Act

Take actions to continually improve the provision of services, if applicable.


Act
•How to improve next time?
Plan
•What to do?
•How to do it?
Check
• Did things happen according to plan?
Do
•Do what was planned

IDT & the CAP/DA Process

CAP/DA Assessment

The lead agency social worker and registered nurse shall complete an initial and annual interdisciplinary comprehensive needs assessment on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs.

CAP/DA
Interdisciplinary Team (IDT)

IDT Key Players:

- Physician
- Case Manager
- CAP RN
- Beneficiary
- Responsible Party
- Medicaid Eligibility

Frequency of Assessments

- Initial and Continued Need Review Assessments require all six team members.
- Other assessments that may result in an intervention of all six team members are: change in status assessments, short term rehabilitation stays, initial returns and transfers from another county.

Example of CAP/DA Assessment Basic Interdisciplinary Team (IDT)

Plan of Care

A plan of care is:

A comprehensive and person-centered interdisciplinary framework for managing the overall health status of each beneficiary. It specifies the care needed to meet the beneficiary's medical, physical, emotional, and social needs, identifies measureable outcomes, and is developed in collaboration with the beneficiary and/or caregiver.

Frequency of Plans of Care

- Developed annually and updated when warranted due to status changes in the waiver beneficiary's condition.

Plan of Care

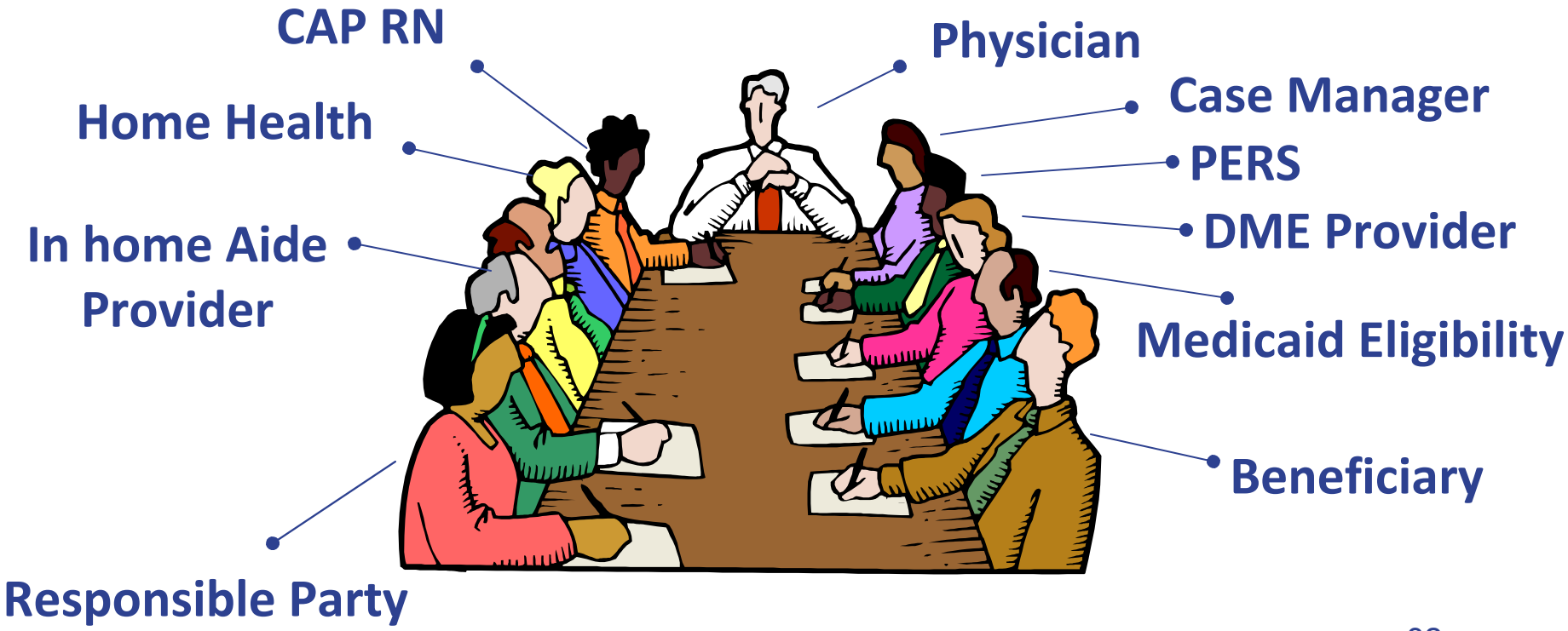
- Is developed with input from the IDT
- Is driven by the assessment
- Addresses the beneficiary's medical, functional, emotional, and cognitive needs

Reference: Medicaid and Health Choice Clinical Coverage Policy No: 3K-2 (5.3.2)

Plan of Care Components

- Identified Needs
- Person-centered goals and objectives to meet identified needs
- Comprehensive listing of waiver services, medical supplies and durable medical equipment (DME), other community services used to meet the beneficiary's needs
- Detailed listing of formal and informal social support available to meet beneficiary's needs

Example of CAP/DA Plan of Care Interdisciplinary Team (IDT)

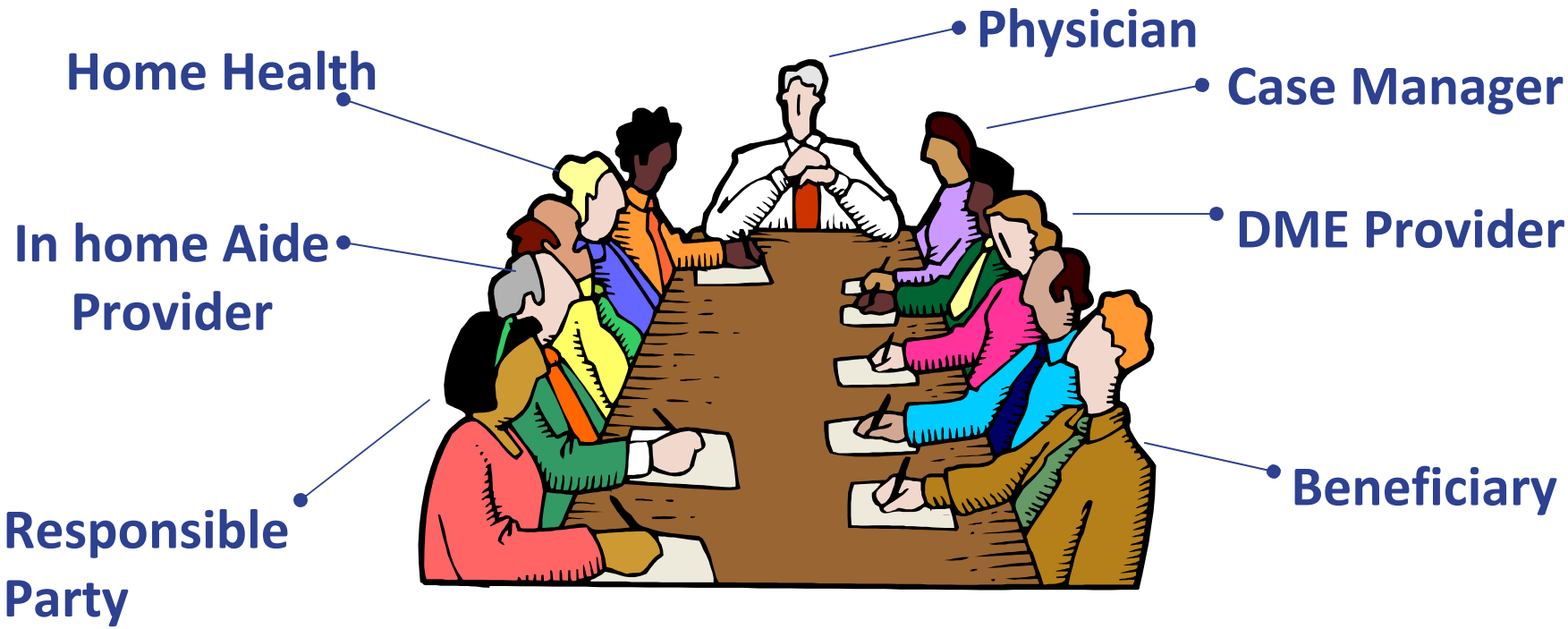


Monitoring Using the Plan-Do-Check-Act Tool

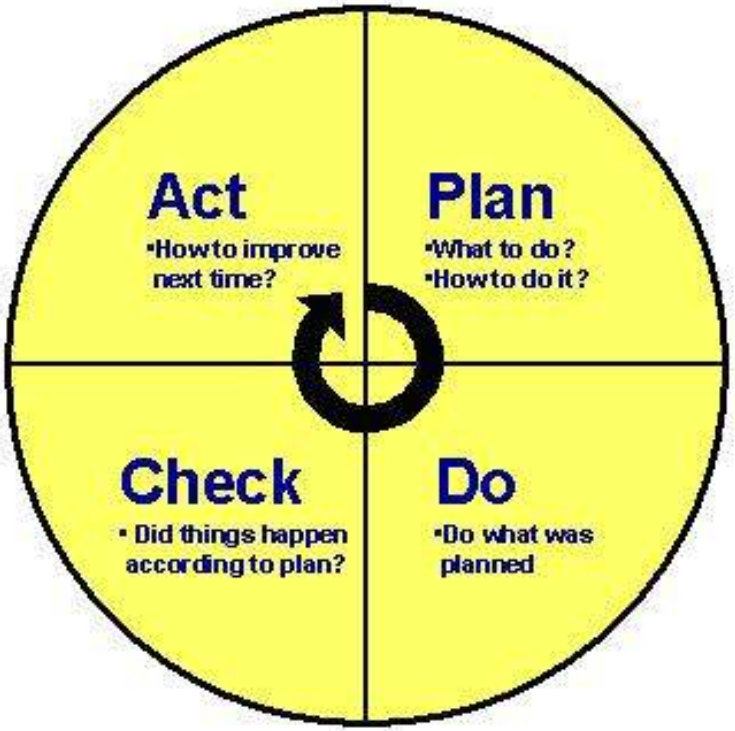
Who are Key Players for a Problem Solving IDT?

Beneficiary care needs, goals, and services determine the composition of the Interdisciplinary Team or team subset that will be responsible for a particular beneficiary problem.

Example of CAP/DA Plan of Care Interdisciplinary Team (IDT)



When problem identified, remember to use "Plan-Do-Check-Act"



Group Activity

Questions

DMA's CAP Unit Contact Information

CAP/DA Program Manager:

- WRenia Bratts-Brown
  - Wrenia.bratts-brown@dhhs.nc.gov
  - 919-855-4371

CAP/DA Consultants

- Antoinette Allen-Pearson
  - Antoinette.allen-pearson@dhhs.nc.gov
  - 919-855-4361
- Joanna Isenhour
  - Joanna.isenhour@dhhs.nc.gov
  - 828-424-1224

DMA's CAP Unit Contact Information

CAP/DA Consultants

- Edwina Thompson
  - Edwina.thompson@dhhs.nc.gov
  - (919) 855-4370

Administrative Assistant:

- Dawn Gill (primary to CAP/DA)
  - Dawn.gill@dhhs.nc.gov
  - 919-855-4309