2005 MCHB Joint Meeting
On Interdisciplinary Training & Care

LAURA KAVANAGH – Context for what's going on in Federal Gov't now.
Presidential and DHHS Priorities:

- 2006 DHHS Priorities
  - Providing access to quality health care
  - Enhancing PH and protecting America'
  - Supporting a compassionate society
  - Improving HHS Management, including the President's Management agenda
- Link between performance and budget must be strong
  - 3 zeroed out – TBI, Newborn hearing, emerg med svcs for children
- Changes within HRSA
  - Office of Data and Program Development combined
  - Abstinence ed moved to ACF

MCHB and MCH TRAINING PRIORITIES

- Leadership, Performance, Accountability priorities
  - Surveys CSHCN and Child Healthdata avail soon – use the data for fac and trainees
  - Electronic Progress Reports are now electronic. MCHB working to fix glitches.
- Training Program Priorities: Developing competencies
  - CC and FCC – LEND FamFac Meeting good. Keep the exchange going.
  - Examining Leadership with Ginny
  - Research to Practice meetings between HRSA bureaus
- New Staff – PO's and new Grants Mgt staff – Jose Aviles and Jamie King
- Genetics and LEND
- Diversity projects and Bureau of Health Professions
- DBP and the Commonwealth Fund
- Meetings with Consortium on AfAm PubHealth Programs – at Morgan State
- Medical Subspecialties workgroup formed by Merle - #1 rated need based on survey of TV Dirs was DBPeds

PROGRESS REPORTS AND PERFORMANCE MEASURES

- 3 Leadership Institutes available – are Inter D faculty interested in attending? ~3/program. Out of UAB. AnnMichele presents. Program eval to conflict negotiation topics. 3-day institute @ St. Louis. Suggestion from floor – enhance commun between TV Dirs by getting TV Dirs to Joint etc meetings.
- Workgroups from All Grantee Meeting. Workforce Issues are prominent, so you'll be seeing increased emphasis on workforce efforts. Leadership connects with workforce by retaining leaders produced.
- Be sure you're using the HRSA and MCHB logos correctly – the policy has changed. To use logo must go thru office of communications. Instead, cite "this product/website etc was supported in part by HRSA"
- Office of Performance Review: Laura's a part of a unveristy grant review pilot to tell others what's important to university grant programs vs. local/regional programs

MCHTRAINING PROGRAM GOALS

- Workforce
- Diverse workforce
- Improve

CONTINUATION APPLICATIONS

GUIDANCE IS COMING ASAP

- Budget Information (same as before form 6025)
  - More about leveraging funds – only related to training
  - Budget vs. Exp – same
  - Form 3 - Levels of the pyramid – put everything in infrastructure.
  - Form 5 - # Indiv served – only LEND PPC, LEAH do form 5
  - Form 7 – Summary data mostly checkboxes
- Project Details = Narrative (same)
  - Admin changes
  - Project plan amendments, updates, collab, lship, mktg, eval – all the same.
  - CE/TA pulled out
- Assurances and Certifications – check list
- Appendices – new fac members, include bio, new collaborations – nothing else really
- Program Specific Information – covered in webcast. Archive avail. Staff avail before and during.
- PERFORMANCE MEASURES
  - PM07 – self rated scale
  - PM 08 – seen before

        - PM 09 –
        - PM – 11 – self assessment
    - PPMs = LEND, LEAH, PPC
        - Overlap between some program's PPM's
        - PPM 59 –
        - PPM 60 -
        - PPM 62 -
        - LEAH – PPM 64 –
        - LEND – PPM 61, PPM 63
        - PPC – Medium Term trainees, faculty leadership
        - Other training prgm data – same forms, just electronic
            - fac staff,
            - long term trainees
            - Former Trainees
            - Short/Med
            - TA/Collab
            - CE

LESSONS LEARNED FROM PPCs –

Start Early!!
West coast – call center is open 9-5 EST
Mac vs. PPC – not Mac compatible, no matter what they say
Printing –
Narrative ok offline, sent as attachments
Budget, PMs, PPMs need to be entered online
Internet browsers make a difference

Ann said – all future competitions may/probably be competed on www.egov.com, while progress reports will be done through EHB. Possibly ready for fall 2005.

Reminder - use training website

JOHN REISS – INSTITUTE FOR CHILD HEALTH POLICY – Resources available to all training programs FOR FREE

- Walk you through some websites
- Contract from DRTE to provide support and TA
- Institute has been doing technology-based projects and services since 1985. Goal – enhance capacity of MCHB programs, grantees and greater MCH community to effectively utilize IT to address goals and priorities.
- Contract activities – MCHB Training website, grantee websites, listservs, TA, distance learning training materials and resources.
- www.mchb.hrsa.gov/training - Provides information about programs, contact information, resources, etc.
- www.mchtraining.net – training project home. Project information links throughout network, tech support request form.

- Websites – to enhance collaboration among grantee groups with group-oriented webs and listservs. Group-oriented "subwebs" – nutrition.mchtraining.net, etc
- Uses Mambo content management systems
- E-learning system "Moodle", like Blackboard or WebCT but easier to use
- Listservs –
- www.Workgroups.mchtraining.net
- Working on web-surveys, peer-peer consultations
- John Reiss jgr@ichp.ufl.edu;
- ***Key for LENDs that are happy with website, listservs – check out elearning to distribute distance ed/CE content.

INTERDISCIPLINARY TRAINING AND CARE

After performing a quick literature review, the data on interdisciplinary training and care appears to be limited. There is some in geriatrics and HIV/AIDS.

MCHB appears to be committed as a funding agency to providing interdisciplinary (ID) care. We've done a good job of documenting immediate outcomes, but haven't yet continued on to the ultimate question - are health outcomes improved when children and families receive ID care? Data is important to defend the program over time, and capacity building is always good. We need more data and information to talk about our programs with policy makers.

This research might look at better integrated service systems, improved health outcomes, intermediate outcomes of perceived benefit on part of trainees, faculty, youth and families receiving ID services.

There are few federal agencies that fund ID training. Looking to the future, what does the workforce look like? We keep coming back to an ID model. Now we need to connect our experiences with what policy makers think is true.

Meeting attendees were split into groups, each addressing the following:

1. What are the critical elements of ID training?
2. How do you defend ID training and/or care to administrators?
3. What are potential measurements and outcomes of ID training & care?

To set the stage:

Steve Contompasis, Director of the VT ILEHP discussed his program's new book, *Ccaring for Children with Neurodevelopmental Disabilities and Their Families*. He stated that the new model of interdisciplinary, community-based assessment involves all faculty and trainees within their program. They do action planning with their community to determine what's feasible, and as a training

model, it works. He said that their book is one big qualitative study (key points are bolded in the packet handout). To generate proof of the effectiveness of ID care, Steve said that MCHB may need to develop more instruments to measure the effect on teaming, families, family centered care and ID practice. Activities in Vermont that demonstrate interdisciplinary-ness include:

- Birth-to-3 is developing a transdisciplinary model of assessment. Planning includes 4 trainees, faculty and 6 disciplines.
- Autism task force is working on creating a toolkit to address evidence based practice – trainees, fac and 5 disciplines are creating it.
- Outcomes of ID training on faculty, faculty development and factulty retention.

Julie McDougal of the WI PPC summarized the leadership training outcomes survey and article the PPC programs had published in an MCH journal. Their survey identified the PPC needs to develop competencies and outcome measures for ID training, care and leadership. Their survey asked former trainees to describe their career paths to determine whether they are now expressing leadership and continuing to express MCH values in their work. One limitation to their article was the PPC's did not have the mechanism of comparing non-interdisciplinary leadership trainees. They did however find that the PPC program IS producing leaders. Trainees are staying in the MCH field, continuing to work with the MCH population and with racial and ethnic minorities, are highly published and many act as administrators. Trainees are not only functioning in the manner in which they were trained, but are also teaching others in same manner.

Jan Moss, the Family Faculty member from the OK LEND discussed her experience receiving care in the past for her son in both a uni- and inter-disciplinary manner. Her son has multiple challenges and in talking with providers, Jan realized she needed to get them all in one room. In doing this the family used up all of their work leave and was constantly stressed as they had to travel over 1,000 miles to find a place that would let everyone meet together. The family couldn't get their doctors together at their local care provider because those doctors didn't appear to believe the family had expertise, was reliable or had a desire to work together with them. The total cost of the visit to get a team together was over $12,500, none of which was reimbursed. After their meeting they got a "diagnosis" (their son was going through puberty) and went home with good recommendations. Now that Jan works at an interdisciplinary (LEND) program she is teaching these future practitioners that the family does have expertise, wants to work with the medical team, and is reliable. In her family's experience, interdisciplinary care provides better outcomes and increased satisfaction, which creates better care and better families.

George Jesien, Executive Director of AUCD talked about the policy perspective of ID care. While this model of care has been traditional for many people attending the meeting, there is now a resurgence of interest from the policy and

research perspective. The new NIH roadmap uses the premise of team ID science to look at health problems in the US. The National Science Foundation and others are identifying the interdisciplinary model as the way to address social problems. AUCD's SSA project has identified team evaluations (typically at LEND programs) of children who would have either lost their benefits or not been granted benefits given the information in their SSA files. After the ID group reviewed the cases, over 40% of the cases were reversed and the children received the SSA benefits. When the review teams were asked, "What changed your mind?" they stated that the ID review focused on the WHOLE child and looked at various body systems impacts on each other. They spoke about how kids can function in multiple environments, and the ID reports resolved conflicting information – discrepancies from many uni-disciplinary exams were resolved in a team assessment. As well the interdisciplinary reports provided information on the impact of disabilities on the functional behavior of a child in the child's daily life – real world, practical impact on life.

Meeting attendees were then broken up into their discussion groups and addressed the questions posed above. Their comments were as follows:

CRITICAL ELEMENTS OF INTERDISCIPLINARY TRAINING:

- Family is a member of the team!
- Getting to know and appreciate other disciplines – jargon-busting
- Comprehensive, coordinated, family-centered, culturally competent
- Self-awareness
- Collaborative awareness
- Models of training need be converted to models of practice
- Models of teaming (partnership and collaboration)
- How to effect change as a leader: develop attitudes of communication, mutual respect, problem solving, humility, systems change (advocacy)
- "Its not your dad's Buick"-different definition of interdisciplinary training
- What are the competencies and what are the outcomes? (change in the community)
- Processes and competencies (rather than the model)
- "You don't have all the answers" -- novel thinking and find others to help
- Broadening of knowledge. Pre- & post-tests find the relationship of time spent on a complicated case with individual treatment vs. interdisciplinary in care coordination.
- Can hone down to the key issues by using interdisciplinary approach

CHALLENGES FOR INTERDISCIPLINARY TRAINING

- Is there Common Vision of Interdisciplinary?
- At what level of the MCH Pyramid are we thinking? Delivery? Infrastructure?
- Why have insurers found case management effective? – use this argument to back up ID training
- Early intervention model of teaming – transdisciplinary models. Why has Early Intervention found this to be effective?
- Reimbursement for the process
- Waiting lists
- Flexibility: team must be structured to meet the needs of the child
- Intake Staff skills
- University often discourages team practice
- Lack of care coordination POST assessment
- Value of timely access – how can we put a price tag on it?
    - ID teaming results in more access to services
    - Family outcomes, quality of life
- Decreased support for interdisciplinary care in health care vs. in schools
- Report writing format- ID teams need electronic medical records. (watch HIPAA issues)
- Physical location of programs
- Not everyone is trained in teamwork
- Does the definition of medical home *really* touch on ID care? We need to make sure it does.

OUTCOME MEASURE IDEAS

- Measurement is important! We believe, now must prove interdisciplinary training and care is better for everyone (providers, trainees & consumers)
- The interdisciplinary model seems financially logical...how can we document the long-term cost benefit?
    - Look at CSHCN data on insurance… is there data on care too?
- Use objective measures
    - Health outcomes:
        - Blood levels, height/weight changes
        - Caregiver/casemanager satisfaction in care received: CSHCN survey data
        - Optimal medical management/errors in management. (Poly-pharmacy)
        - Ability of parents to advocate for child (clarity of message)

        - Placement stability (foster care, least restrictive environment)
        - School attendance
        - Child Safety, CPS referrals
        - ER visits, LOS, Mental Health admissions, mortality rates
        - # of identified medical homes
    - Financial outcomes: health care costs – Medicaid data, SSI enrollment
        - Family stress & satisfaction (measurements: time off work, economic impacts to family, family stress, divorce)
    - Trainee outcomes
        - Compare trainees (within discipline) uni- vs. inter-disciplinary training…employer surveys, consumer surveys, satisfaction self-reports.
        - Do trainees know what other disciplines are, do they screen patients to be seen by other disciplines
        - Breadth of knowledge/skills of trainees – measure thru case scenarios, standardized "virtual patient" exercises; qualitative data
        - Compare interdisciplinary leadership training grads to other training grads. Look at leadership indicators to see what outcomes are different and effectiveness.
- Make the comparison of groups served or trained in uni- vs. inter-disciplinary models –
    - Medical home connection vs. none
    - Satisfaction with previous uni-disciplinary care
    - Satisfaction data – what are common questions across groups
- Measure how well uni- vs. inter- disciplinary trained disciplines interpret other discipline reports

- Process Issues: what recommendations made to a family were later were implemented? Do families get a clearer message from an ID team?

- Systems – BIG system changes: what do state/local policies need to say, working better with community systems
- need to demonstrate better care by multimodal approaches
- evidenced based medicine and use of pathways
- Use population outcomes rather than individual outcomes
- Developmental disorder outcomes
- International classification of functioning-has change occurred
- Child health questionnaire-measure before and after interdisciplinary care
- Improvement in chronic care-cost analysis

- Critical element-teaming time and getting paid for it

NEXT STEPS:

- Define the level of MCHB commitment to measuring outcomes of interdisciplinary training and care – resources available through the Training Bureau or Programs. What discussions are happening on research commitment within MCHB; is NICHD interested in $, or Commonwealth Fund?
- Create a competition in which many apply, then bring the top 3 together to form 1 project. MTA, CDC, others are national models for this cooperative agreement already (but it might be a challenge if this is funded across agencies)
    - Look for potential partners or research networks formed around training issues
- Is this tied to the performance measure on medical home? What about the CSHCN performance measures?
- Find artifacts from 70's "golden era of ID Training" (Merle, Woody, Vince). Did they have demonstrations or research produced?
- Interest areas or mechanisms we might have MCHB pursue…
    - Find or include language in other programs on the need to be and how to be interdisciplinary
    - Can we fund a project of outcomes in one disability when approached from uni- inter- disciplinary approaches – would be hard proof, but may be hard to fund.
    - Systems change comparisons
    - Can we create an MCHB competition as a follow-up to Training Strategic Plan, as a special category, targeted RFA.
- Compare trainees doing uni-disciplinary work who have a uni-disciplinary background vs. those with an inter-disciplinary background
- Do a systematic review of Mgt/HR literature on the interdisciplinary approach
- It's in everyone's interest to pursue research: Bureau, Congress, Families.
- Keep the lifespan perspective
- We must make the research/work inter-program-disciplinary (SPH, PPC, LEAH, LEND)!