



## IssueBrief

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A photograph of a soccer team in red and white jerseys huddled together on a field. The players are seen from behind, with their arms around each other's shoulders. The background shows a blurred crowd of spectators.

# Communicating for success: Case managers on transdisciplinary teams

Let's get the cliché out of the way: Anyone who has tried to facilitate a cross-discipline health care team will tell you it's sometimes like herding cats. Cats are not generally team players, and there's always a tomcat who wants to take charge.

This doesn't faze professional case managers, who not only understand the value of integrated care, but also have the tools to make it happen.

Still, it's been a bit of a journey. As health care leaders have learned the value of bringing disciplines together around care, many different models have evolved.

Over the last decade or so, various models of integrated care have emerged. As a result, there have been multiple definitions and understandings of what an integrated model should look like. And each may be perfectly appropriate for a given setting. So how do you pull it all together when you are dealing with a diverse population of health care professionals and clients?

Virna Little, PsyD, LCSW, MBA, CCM, SAP, associate director for clinical innovation at the Center for Innovation in Mental Health, CUNY School of Public Health, has the answer. "The overarching model that many organizations are considering a gold standard is called 'transdisciplinary care.'"

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## Differentiating modes of team collaboration

**T**eam collaboration to support complex patient care may involve participants from primary care, specialists, behavioral health, case management and others. While the terms “multidisciplinary,” “interdisciplinary” and “transdisciplinary” are often used interchangeably, there is a real difference between the modes of team-based care.

Members of the **multidisciplinary team** each approach the patient care issue from their own disciplinary viewpoint; for example, the behavioral health clinician brings a plan to deal with behavioral issues, the primary care clinician plans to address the patient’s chronic condition, the social work case manager brings a plan to address social health needs, etc. Although the multi-disciplinary approach brings expertise to the plan, it invites individual members to focus on only a narrow part of the patient’s overall needs.

The **interdisciplinary team** model assumes interaction among the team members and transfer of knowledge across the team. It’s expected that each member informs the others of their work and there is collaborative discussion of progress towards goals.

The **transdisciplinary team** is the gold standard in team collaboration. Individual members contribute their expertise to an overall plan with shared goals. Team members from multiple disciplines collaborate and share knowledge and ideas from the start to develop a total care plan that covers all necessary support for a patient. They continue to meet and share progress toward goals, collaboratively revisiting the plan for updates and followup.

It started, she says, with the recognition that a team needs to have multiple disciplines represented, which led to multidisciplinary teams that included primary care, behavioral health care management and other specialty clinicians, such as a diabetes educator.

But that model still wasn’t adequate. “So then we talked about *interdisciplinary* teams. We really wanted the disciplines represented to be able to interact with each other, to be able to have a shared record, to be able to *really* communicate with each other.”

That represented a major step forward. But communication itself wasn’t enough, either. How do you get all the team members to communicate *meaningfully and thoughtfully* with each other?

*Transdisciplinary* care provides that final element: meaningful, thoughtful communication.

### Equal voice, shared responsibility

“We’ve come to learn that it is really important to have everyone present who cares for patients,” says Little. That will vary by setting and client, of course. But at a minimum, it includes primary care, behavioral health and case management. It may also involve many others who are involved in a client’s care—physical therapists, chaplains, public health and community health workers who are helping individuals with social needs such as food or housing.

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Such an approach requires a shared care plan—one that everyone on the team can access and read. It needs to be comprehensive and include not only the clinical issues, but social ones as well.

But once everyone is on the same page about the client, what next?

In a transdisciplinary model, members know what their colleagues are doing; they understand the other disciplines and everyone's role. And that, Little says, is what truly separates transdisciplinary teams from multidisciplinary or interdisciplinary teams.

Case managers, in particular, need to know a little bit about what everyone else on the team does, to manage and keep communication flowing. But she also emphasizes that regardless of who leads the team, everyone is accountable for all the measures.

"If I'm a behavioral health provider and I'm seeing a client for anxiety,

I'm just as responsible for their flu shot and their mammogram as the primary care provider. I should be able to see those preventive measures in the record and say 'Hey, I see you haven't had your flu shot. Let me walk you down to the nurse before you leave and get that taken care of.'"

By the same token, the primary care provider may be responsible for depression screening and care, and for having access to a client's safety plan if they're at risk for suicide.

This shared accountability not only helps accomplish goals and engage clients; it also helps bring the team together because *everyone* is responsible for *everything* that needs to happen, Little explains.

That sort of team work doesn't emerge organically, and it certainly doesn't happen by chance. It takes effort and intention. Some of the best practices she identifies, such as the team huddle and warm handoffs, are already familiar to professional case managers.

## **Meaningful huddling**

By now, thanks to the emergence of the patient-centered medical home and standards from URAC, NCQA, the Joint Commission and many others, every health care professional knows what a huddle is.

As a result, there's tremendous interest, says Little. Unfortunately, interest doesn't always translate into success. "I think a majority of organizations are still trying to

figure out how huddling can work for them."

Too often, she says, huddles focus on the timing of patient appointments, staffing and other administrative issues. While those may be important, they're not the point of the huddle. The focus needs to be on the client. Who's coming in? What do we need to make sure we cover? Who's at risk?

She offers some examples:

- A behavioral health clinician has someone coming in who has missed several specialist appointments. The huddle is the time the case manager can coordinate with the behavioral health team to make sure the case manager speaks with that client.
- A client coming in struggles with sitting in the waiting room. The huddle is the time to get everyone on board, agreeing to get them in and out quickly.

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It's also an opportunity for triage. One approach that's helped Little is to develop staffing models for her teams using a quadrant model she developed. (See Figure 1.) It's a way to identify the "house on fire" needs of particular clients.

The clients in the top right quadrant have the greatest behavioral and physical health needs. They are the ones who need the

most immediate attention on any particular day. "This model helps you think about how you may assign staff. It also allows you to bring disciplines together and decide who will take the lead in a particular situation."

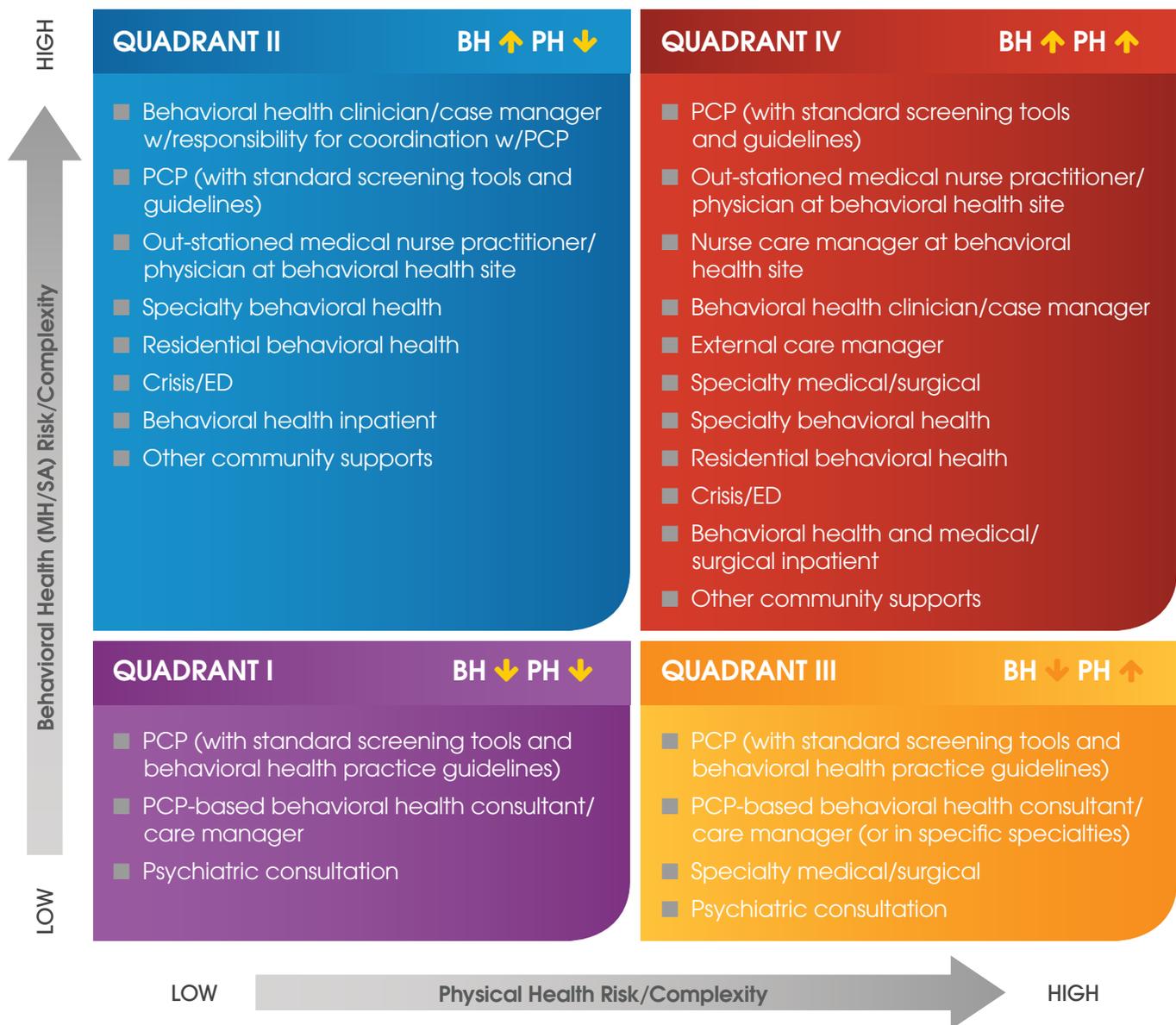
For example, the huddle is the place for the behavioral health clinician to say, "You know, we're not going to get Jack's diabetes

under control until he's on medications for schizophrenia." And beyond that, the behavioral health clinician shares some of her goals for Jack with the team, so everyone can help reinforce them.

### Who's in charge of the huddle?

The huddle is the place to plan who is going to throw the ball and

**Figure 1.** Quadrant Model for Case Manager Staffing, Integrated Behavioral and Physical Health



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who is going to catch and carry it. To make sure that happens, everyone needs to know where the ball is in play—and should participate in the huddle.

But the nature of integrated behavioral care delivery varies widely. Case managers may be embedded within the primary care team, or they may work with multiple primary care teams at diverse locations—each of which plans a morning huddle. Some case managers spend the majority of time in the field, working with clients face to face. Others work telephonically with clients and other clinicians. "If we want to have everyone on our transdisciplinary team participate in these huddles, it's critical to ask: How can we best do that?" Little says.

The solution could be as simple as changing the huddle time to accommodate all members of the team. Often, however, a more creative solution is required. For instance, if two huddles are being

held at the same time, a case manager may need to attend part of each huddle and then get updated on what they missed. Skype, FaceTime or other technology tools can provide another option to join the huddle remotely, she says.

But timing may be the least of the problems, warns Little. "Many in health care today were not trained to work on teams."

In contrast, professional case managers *are* trained to work on and lead teams. "This is where professional case managers really shine," says MaryBeth Kurland, CAE, chief executive officer, Commission for Case Manager Certification. After all, she adds, case management is a transdisciplinary practice.

One of the issues case managers may need to deal with on these teams in general—and the huddle in particular—is power dynamics, Little says. One member may take the lead around a certain diagnosis or issue, of course. But each member—from physician to community health worker—has an equal role on the team.

That can sometimes be difficult for physicians or others who aren't completely comfortable with being an equal member of a team.

That, of course, leads to the question of who leads the huddle. "The answer is, it should be the person who can lead the huddle best," says Little. That means someone who

- is organized
- will take the time to create a list of each client who needs to be discussed
- can consistently attend huddles
- is committed to including client goals in the care plan
- can then follow up with people who are not at the huddle
- can follow up with people around tasks that were assigned during the huddle
- is responsible for making sure everything—including the fact of the huddle itself—is documented in the EHR, in the care plan and wherever else it's appropriate.

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In her experience, the team itself generally arrives at some consensus about who the leader should be—and it's not necessarily the physician. It needs to be the person who can pull all those pieces



## Implementing Warm Handoffs

The warm handoff has its roots in customer service, when one agent helping a customer makes a transfer to another agent who can better address an issue, while staying connected until everyone is assured the transfer is successfully made. In health care it's defined as "a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present). It includes the patient as a team member so that he or she can hear what is being discussed about the clinical problem, current status, and plan of care."<sup>1</sup> The Agency for Healthcare Research and Quality includes the warm handoff as part of an overall patient safety strategy, and provides a range of practice resources for practices, clinicians and patients at [www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfepriarycare/interventions/warmhandoff.html](http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfepriarycare/interventions/warmhandoff.html)

<sup>1</sup> "The Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families: Implementation Quick Start Guide, Warm Handoff." 2017, Agency for Healthcare Research and Quality, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfepriarycare/warm-handoff-qsg-brochure.pdf>.

together and run that huddle, she says, adding that the professional case manager can be ideally suited for the role.

Kurland agrees, noting that if anyone can align team members across disciplines, it's the professional case manager. "Integrated physical and behavioral health care requires ongoing communication and care coordination," says Kurland. "These are key areas where professional case

managers excel and can provide team leadership."

Once it's decided who will throw the ball and who's going to catch it, the team's task is to ensure everything happens smoothly and according to plan.

That leads to another aspect of the transdisciplinary team: warm handoffs—when one member of the health care team transfers care to another through a clearly

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communicated interaction in front of the client and, when appropriate, their caregiver.

## Warm handoffs any time, every time

"We used to think about warm handoffs going from primary care providers to other team members," Little says. That way of thinking has changed: Warm handoffs should occur across all team members, all day long.

Sometimes they can be arranged during the huddle, and sometimes they may be spur-of-the-moment actions, as the need arises. "We need to trust our team members to identify people who would benefit from seeing us sooner or in the moment," Little says.

As with the huddle, logistics can be an issue. "Many times we hear, 'How can I be available for warm

handoffs if I'm out in the community?" Again, it comes down to creativity, Little says. Perhaps you can train someone who is always in the office—maybe a medical assistant—who can handle the scheduling or administrative aspects up front, and then fill you in later. Failing that, there's always Skype, FaceTime and other secure communication avenues, she says.

Regardless of how and where you do it, facilitating the handoff should be as simple as possible, she says. "I think that people tend to over-explain. It's easiest to say, 'I work with Virna; she's part of my team. She helps me care for my clients who are feeling anxious. I'm going to have her come in and you're going to finish up with her today.'"

Of course, there may be times you need to offer more detail, but generally it's advisable to stick to the basics, Little says. The words you use matter, too. For some clients,

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any mention of mental or behavioral health triggers "automatic disengagement" and may actually lower the chance they will agree to see another member of the team, she warns. Doing warm handoffs well is a skill; it doesn't come naturally. She recommends practicing them during staff meetings.

## Getting started

Neither transdisciplinary care nor working as an integrated team comes naturally to most health care professionals. It must be learned and practiced, but it's essential—especially when working with clients who have medical, behavioral and social health needs.

Little offers a revealing way to get started. When she's consulting with a team, she pulls up a long-term client's chart and identifies all the goals that had been set by the different providers over the past few years. Then she looks to see how many were accomplished.

Comparing the two can be uncomfortable, but "it really helps bring teams together to think about a way to work smarter and to bring those care plans together."

Professional case managers have the skills, talent and training to lead that effort to align goals, track progress and keep communication flowing.

"We know that the more complex the client's care needs, the more critical it is to have clear lines of communication and coordination," says Kurland. "Integrated behavioral health requires a team mindset to move the ball forward, and team execution demands practice, discipline and focus on shared goals." ■

## About the Experts



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**VIRNA LITTLE** serves as associate director for clinical innovation at the Center for Innovation in Mental Health at City University of New York (CUNY) School of Public Health. Prior to that, she served 22 years at the Institute for Family Health as senior vice president, psychosocial services and community affairs, where she oversaw delivery of social work, mental health and community-based services across 35 centers and more than 300 staff.

Little is a frequent speaker on collaborative care and the development of viable behavioral health services in community health settings. She earned a doctorate in psychology from California Coast University and a master's in social work from Fordham University. She holds a faculty appointment at Columbia University, Mt. Sinai and The School of Public Health, CUNY.

She is a member of the Zero Suicide Faculty, Advancing Integrated Mental Health Solutions (AIMS) Center and National Council for Community Behavioral Health Providers consulting teams. She serves as chair for the Association for Clinicians for the Underserved and the Hudson Valley American Heart Association Board. She is a member of the National Council for Community Behavioral Health Providers, the American Association of Play Therapists, Social Work Managers, Society for Social Work Leaders in Healthcare and the National Association of Social Workers.

**MARYBETH KURLAND** leads and sets the Commission's strategic mission and vision. She manages relationships with likeminded organizations and oversees business development as well as the Commission's programs, products and services. She works directly with the Board of Commissioners, building its corps of volunteer and subject-matter experts who directly support and evaluate certification and related services. Prior to becoming CEO, Kurland served as the Commission's chief operations officer, and was staff lead for the development and launch of the Commission's signature conference, the CCMC New World Symposium®.

Kurland brings extensive experience to her role, having served as executive director of organizations including the Association of Medical Media, Office Business Center Association International and the League of Professional System Administrators. She holds a bachelor's degree from the University of Delaware and is a member of the Institute for Credentialing Excellence, the American Society of Association Executives and the Mid-Atlantic Society of Association Executives. In 2011, Kurland was recognized as Association TRENDS Young & Aspiring Association Professional.



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