Facilitated Mini Training – "Using Telehealth to Support Interdisciplinary Care Delivery for CYSHCN Within the Medical Home" Story

Instructions: The story below presents an example of using telehealth to support interdisciplinary care delivery for CYSHCN within the medical home. Throughout the story, components of interdisciplinary care delivery (as outlined in the accompanying raining slides) are identified in violet. It is recommended that this story be presented and discussed during the training. Refer to the discussion questions/possible answers in the training on page 2 below to guide the conversation in your practice.

Components of Interdisciplinary Care Delivery for CYSHCN through Telehealth:

1. Preparation
2. Team Roles
3. Team Communication

Jane is a 10-year-old female with an acquired brain injury secondary to a high speed MVC with subsequent left hemiparesis, visual impairment, spasticity and cognitive impairment. She was recently discharged from acute inpatient rehabilitation and presents today for follow up with her primary care physician. Her parents mention that she will be seen in the hospital's interdisciplinary Acquired Brain Injury Clinic next month via telehealth. At that visit she will see a Rehab. Physician, Rehab. Psychologist, Learning Specialist, Nurse, Physical Therapist, Occupational Therapist and Speech Therapist. Her parents need help with navigating through her new services and communicating recommendations with the PCP and her school. They ask how they might best include the PCP and/or a school representative in the discussion to ensure all of her care team is on the same page as she re-enters school and adjusts to life at home.

[Component 1 &2] The PCP ensures there is a designated care coordinator within their practice to act as a point of contact to discuss and address interdisciplinary care. The care coordinator finds out that the interdisciplinary clinic is a team-based model, with successive visits between providers; there will be one report assembled by the interdisciplinary clinic "lead" staff.

[Component 1 &2] The scheduler sets a follow up telehealth or in-person appointment with PCP after the interdisciplinary hospital clinic appointment to review the recommendations. Regular telehealth follows ups are continuing to be held to discuss readjustment to home, transition to school, mental health needs for child and family, and connection with local services.

[Component 2 & 3] Social/worker and care coordinator work to support parents' knowledge base and partnering and refer the family to support groups including the local Family-to-Family Health Information Center (F2F) and the Parent and Training Information Center (PTI) to help them understand navigating the health care system and the school system, respectively.

[Component 3] Team/partners communication occur in several ways. The family is an essential part of all teams. The PCP, care coordinator, and family work together as a team, using regular telemedicine visits, to ensure Jane thrives at home, connects to community-based services, and adjusts to school. The Acquired Brain Injury Clinic staff work with the family to provide an integrated care model,

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addressing medical, rehabilitation, and therapy needs, utilizing telemedicine to enable Jane to be evaluated while in the home setting and minimizing travel. Finally, telemedicine enables the PCP to communicate with the Acquired Brain Injury Clinic lead staff person in real time while recommendations are being made with the family.

Case Study Questions & Answers

Use the questions below to guide conversation following the story. Possible answers are bulleted below each question. The responses are by no means exhaustive.

1. **How do you determine utility/appropriateness of telehealth to provide care in between in person visits?**
   - Immunizations are up to date
   - Consistent growth and stable physical exam findings in past
   - Knowledge of telehealth capability by family

2. **Are there any additional types of activities you would engage in related to:**
   - **Preparation before the interdisciplinary team telehealth appointment?**
   - **Clarification of roles/responsibilities during the team telehealth appointment?**
   - **Discussing team communication during and after the telehealth appointment?**
   - Knowledge of interdisciplinary team flow
   - Scheduled follow up with PCP
   - Empowering family with support and resources about school

3. **What additional support would you need?**
   - IT support
   - Equipment

4. **What other barriers or challenges to consider, and how could those barriers be mitigated?**
   - Family connectivity. Discuss importance of preparation and equipment needs
   - Family knowledge and understanding of system. Refer to outside support
   - Regular follow up including telehealth

5. **How can [your/our] practice use telehealth to support interdisciplinary care delivery for CYSCHN?**
   - Regular communication with partners
   - Training care coordinators and practice staff to support telehealth
   - Knowledge of interdisciplinary care clinic flow

6. **Do you anticipate any changes to processes or workflow?**
   - Knowledge about whether interdisciplinary care is team visit with an integrated care plan or a co-location model with different reports
   - Telehealth and in-person visits have different work flow (e.g. telehealth visit with physician tends to start at exact time, whereas in-person visit tends to start with registration, then triage, then weight etc.

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