Module V: Interdisciplinary Care – Building Relationships Among Providers and Agencies

Table of Contents

Introduction

Background and Purpose

Client-centered care challenges providers, agencies and systems of care to collaborate in a productive manner to meet the goals of the client. The purpose of this interdisciplinary module is to provide participants with strategies for fostering more collaborative relationships among the various providers involved in the care of HIV-infected substance users. This module describes and explores different techniques for improving the coordination of care between agencies. It also helps to clarify the roles and expertise levels of medical providers, substance abuse treatment providers, mental health professionals, case managers, and outreach workers.

A variety of participants may benefit from the trainings described in this module, including medical providers, substance abuse treatment providers, mental health providers, case managers, outreach workers, administrators, and people in recovery. The activities and presentations have been structured to accommodate persons with educational levels ranging from high school to advanced graduate degrees. For the small group exercises described in the module activities, it is important that the groups contain a balanced number of persons representing each discipline. This balance will help reinforce the theme that the interdisciplinary model of care requires representation from multiple disciplines. Instructors should invite additional team members, as needed, to ensure that workshop groups are balanced, with practitioners from each discipline.

The instructors who use this module should have professional experience in HIV or substance use and knowledge of human relations and group dynamics. They should also have expertise in working as part of an interdisciplinary team. A basic understanding of group dynamics within a workshop setting is also necessary to manage individual and group responses to challenging materials.

Parts of this module are adapted from the book *Wisconsin Partnership Program/Quality Research*, by B. Bowers, published in 1999 by the University of Wisconsin-Madison School of Nursing, Providing Consumer Centered Care in Integrated Programs, Madison, Wisconsin.

Resource Materials

- Handout V-1, “Assessment of Professional Identification”, (Page 8)
- Handout V-2, “HIV and Substance Use Case Study” (Page 15)
- Handout V-3, “Individual Assessment Worksheet” (Page 24)
- Handout V-4, “Group Assessment Worksheet” (Page 28)
- Handout V-5, “Case Study: Brooklyn Hospital Center Path Program” (Page 39)
- Handout V-6, “Case Study: AIDS Services Center” (Page 41)
- Handout V-7, “Case Study: Special Health Resources of East Texas” (Page 42)
- Handout V-8, “Case Study: Project Bridge” (Page 44)
- Handout V-9, “Community Linkages Assessment Guide” (Page 46)
- Handout V-10, “Agency Linkages Evaluation Tool” (Page 48)
- Handout V-11, “Sample Confidentiality Agreement” (Page 50)
- Slides V-1 to V-24
- Four flipcharts
- Colored markers
- Self-stick note pads
- Slide projection equipment

Objectives

By the end of this module, participants will:

- Be able to state at least three ways in which their work is representative of a particular discipline
- Be able to describe at least three functions of the role of medical, substance abuse, mental health, and social service providers, and outreach workers and health educators
- Be able to explain how different providers define, provide and evaluate client care
- Be able to describe at least three strategies to overcome communication barriers among the members of an interdisciplinary care team
- Be able to describe at least two strategies to create agency linkages within their communities

Training Tips:

When participants enter the room, find out who they are and seat them in working groups of six to ten people each. The groups should be comprised of various disciplines. Ask each working group to sit at a different table. This will save time later when the groups work on the case study and the team communication exercise.

Training of Trainers Teach Back Opportunities:

Throughout this module in the Instructor Notes for most activities are boxes like this in which you will find suggestions for how to structure a teach back in a Training of Trainers setting. These teach backs are NOT factored into the time allotted for the sessions. While teach backs will put only one or two participants on the "hot seat" at any time, they should also provide opportunities for you to ask other members of the group how they would have handled a situation differently.

Session 1: Icebreaker/Introductions

Activity: Participant Introductions

Purpose

- To come to an understanding of goals and expectations with participants
- To obtain information about the diversity of participants and their experience in working with HIV-infected substance users
- To demonstrate that each participant can fit into many roles in treating HIV-infected substance users and that each person brings a spectrum of experiences to his or her work
- To help participants get to know each other and become comfortable in the group

Time: 45 minutes

Materials

- Flipchart and colored markers
- Enough pens and pencils for each participant
- Self-stick note pads with notes of two different colors
- Long sheet of newsprint paper hung on wall with a timeline dating from 1960

Instructor Notes

1. In preparation for this activity, prepare and post a long sheet of newsprint paper containing a timeline date from 1960 to the present.

2. Trainers should introduce themselves to the group.

3. Ask participants what they want to get out of the workshop, and write their responses on a sheet of flipchart paper. Let participants know if something they expect to be covered will not be available or discussed during the workshop. (This list can also be generated during Session 3, "Key Components of Interdisciplinary Care.")

4. Ask participants to write down either "HIV" or "Substance Use" (SU) (whichever they prefer) on a self-stick note; everyone should use the same color note for this. Then ask the participants to place their notes on the timeline according to when they began working in that field.

5. Ask each participant to write down "HIV/SU" on another self-stick note; again, everyone should use the other color note for this. Ask the participants to place their second notes on the timeline according to when they began working in both disciplines or first had exposure to the issues involved in both.

6. Point out that the timeline demonstrates the wide range of experience that people in the room have in HIV, substance use, and the overlap between the two.

7. Now ask each person in the room to introduce himself or herself to the group. This brief introduction should include answers to the following questions:
   - What is your professional role now?
   - How did you get started in HIV and substance use work?
   - What is your experience working with interdisciplinary teams?

8. Summarize this activity by again recognizing the experience that each person brings to the group. Note that the participants' broad spectrum of experience will help inform the discussions of interdisciplinary care throughout the day.

Training Tip:

For Option 4 (in which the timeline is displayed and added to in each of 4 separate training days) it might make more sense for participants to write their names directly on the timeline – in red for HIV, blue for SU and purple for HIV/SU.

Session 1A: Icebreaker/Introductions (Short Version)

Purpose

- To help participants to get to know each other and become comfortable in the group.
- To explore thoughts, feelings, and impressions about the word "trust".
- To incorporate actions and behaviors that promote trust and that are agreed upon by the group into the rest of the training.

Time: 20 minutes

Materials

- Blackboard or a pad of newsprint
- Chalk or a marker
- Masking tape

Instructor Notes

1. Request the participants to think about what the word "trust" means to them.

2. After several minutes, ask the participants to brainstorm actions or personal characteristics that they feel build or promote trust. For example: maintaining confidentialities, being dependable, having a caring manner, being understanding, etc.

3. List these actions and characteristics on a blackboard or newsprint.

4. Ask the participants to brainstorm *specific* actions and characteristics that can help them build trust in one another during this particular training session.

5. List these on the blackboard or newsprint and ask the participants to incorporate some of the actions or behaviors into the remainder of the training session.

6. Ask each person in the room to introduce himself or herself to the group giving their name and current professional role, e.g. social worker, nurse, physician.

7. Summarize this activity by concluding with a brief discussion of the trust required between members of the interdisciplinary team.

Session 2: Professional Identification

Activity: Assessment of Professional Identification

Purpose: To explore and distinguish the perspectives and stereotypes that participants have about different professions and providers

Time: 10 minutes

Materials: Handout V-1, "Assessment of Professional Identification"

Instructor Notes

1. Background: Each of us has particular ideas about why people choose the types of work they do. Although these ideas may have some basis in truth, they can also be exaggerated or based on stereotypes. Whatever their origins, our impressions and perspectives about providers in our own practice and in other fields can affect our daily interactions with each other. This exercise is designed to allow participants to explore and distinguish their perspectives and stereotypes about different professions and providers.

2. Ask the participants to fill out Handout V-1, "Assessment of Professional Identification."

3. After they have filled out the assessment, ask them to fold it up and put it away for now. Issues related to professional identification will be revisited later in the module.

Handout V-1

Assessment of Professional Identification

For each of the professions listed below, please list some of the things that you think might motivate a person to become a member of that profession. Think about and note the different skills you think people in these professions need in order to be successful in their work. Please be as specific and detailed as you can be about each profession. Use the back of this sheet if you need more room. Your responses on this sheet are meant for you alone and will not be shared with the group.

Physician

Nurse Practitioner

Physician's Assistant

Registered Nurse

Mental Health Professional

Substance Abuse Treatment Provider

Outreach Worker

Health Educator

Adapted from the *Interdisciplinary Collaborative Teams in Primary Care Handbook*, published in 1997 by the Pew Health Professions Commission.

Session 3: Key Components of Interdisciplinary Care

Presentation: Defining Interdisciplinary Care

Purpose

- To understand that there is no single definition of interdisciplinary care
- To recognize the key components of the interdisciplinary care team

Time: 20 minutes

Materials

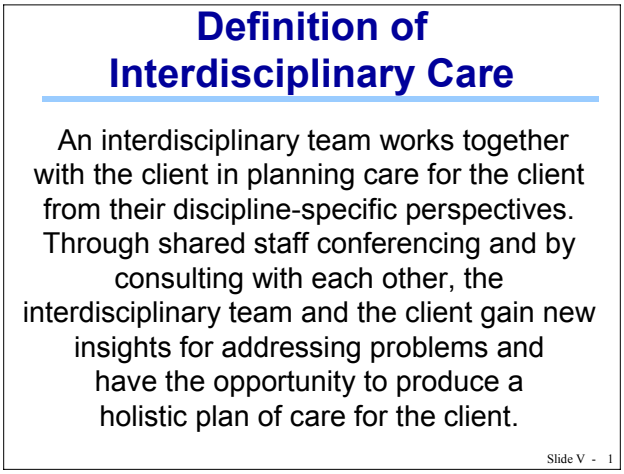
- Flipchart and colored markers
- Slide V-1, "Definition of Interdisciplinary Care"
- Slide V-2, "Key Components of the Interdisciplinary Care Team"
- Slide V-3, "Key Components of the Interdisciplinary Care Team (continued)"

Instructor Notes

1. If you did not do so as part of the Session 1 or 1A, "Icebreaker/Introductions," ask the participants what they want to get out of the workshop, and write their responses on a sheet of flipchart paper. Let participants know if something they expect will not be available or discussed during the workshop.

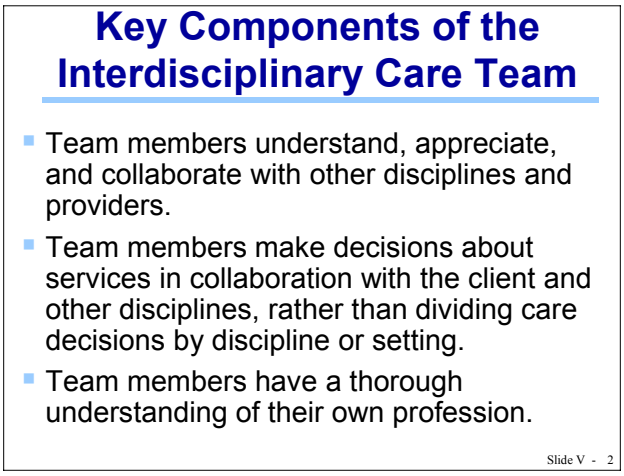
2. Ask the participants to define "Interdisciplinary Care." Summarize the key themes of their responses on a sheet of flipchart paper.

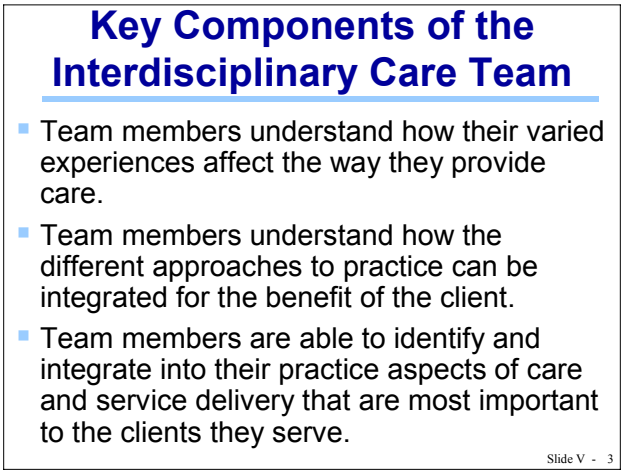
3. Present the definition of interdisciplinary care given in Slide V-1, and reflect with the group on its main points, focusing on the following:
   - Knowledge of the expertise and role of other team members and how these interrelate
   - Trust between team members
   - Recognition of and respect for the specialized skills and contributions of each team member



4. Emphasize that HIV and substance use services are often provided to the client in separate settings by separate agencies, and that these settings and agencies are often not linked. If the various providers who serve HIV-infected substance users don't work together, they neither share critical information about the client nor achieve improved outcomes.

5. Acknowledge that everyone brings a different perspective of interdisciplinary care into the room. Use Slides V-2 and V-3 to highlight the key components of the interdisciplinary care team.





6. Ask the participants whether they have any questions, and summarize the key points of the activity.

Session 4: Discipline Awareness and Understanding

Activity: Team Member Professional Identification

Purpose

- To encourage participants to think of themselves as members of a particular discipline and understand the discipline-specific orientation that guides their work
- To increase participants' awareness of the common values, attitudes, logic, and priorities of providers in their discipline, as well as individual differences in experience and perspective
- To see how these values, attitudes, logic, priorities, and approaches to practice play out in a case study involving an HIV-infected substance user

Time: 45 minutes

Materials

- Breakout tables large enough to accommodate six to ten people each
- Flipchart and colored marker
- Handout V-2, "HIV and Substance Use Case Study" (urban and rural versions)
- Handout V-3, "Individual Assessment Worksheet"

Instructor Notes

1. Background: As noted above, an important goal of this exercise is to encourage participants to think of themselves as members of a particular discipline and to understand the discipline-specific orientation that guides their work. This exercise will also help increase the participants' awareness of the common values, attitudes, logic, and priorities of providers in their discipline, as well as individual differences among providers in their discipline. These differences may include identity, personal experiences, professional perspective, and credentials.

   This exercise will also encourage participants to recognize and be confident about their competence in their work.

   Throughout this activity, it will be important to keep the participants focused on their own discipline and role, rather than on other disciplines. It is very likely that some participants will shift their focus to other disciplines. If this occurs, you should direct them back to examining the values and logic of their own practice. Participants who are unable to stay on task may be experiencing a high level of tension with their team or may lack a clear understanding of their own discipline or role.

2. If you haven't already, divide the participants into working groups of six to ten people each. The groups should be comprised of various disciplines. Ask each working group to sit at a different table.

3. Pass out a copy of the case study and the "Individual Assessment Worksheet" to each participant. Note that there are two settings (urban and rural) and two lengths (full and condensed) of case studies included in this module.. Please use the case study that is most appropriate for your region, audience, and time limitations.

4. Review with participants the worksheet instructions as well as the objectives listed at the beginning of this activity.

5. Ask the participants to read the case study and complete the worksheet. Allow 20 minutes if using the longer case study, 15-20 minutes if using the shorter version.

6. Ask each participant to look at Item 1 on the worksheet, in which they identified and prioritized the client's needs. Have them discuss their answers to this question with other participants of their small group and circle the areas where their answers varied from others. Ask the group to consider and discuss the questions below. Ask one member of the group to serve as a recorder to capture the key themes from their discussion. Allow 10 minutes.

   - How did you make a decision about what the client needed?
   - What assumptions guided your assessment of the client's needs? These may include assumptions about the population, the urgency of the situation, and the things that you feel are most troubling to the client. Your assessment may also reflect your past experiences, your work philosophy, and your ideas about providing care to clients. Try to consider all of the things you are bringing to the situation that are not coming from the client.
   - How did you prioritize the needs in Item 1 on the worksheet? What was the logic behind your thinking? What made you think that some needs were more important than others?

7. Ask the recorder from each working group to summarize their group's discussion to the larger group. If there were differences in the thinking among the participants, identify these for the group and examine them. If the people in the working groups all thought alike, what common logic guided them? Allow 15 minutes for steps 7-9.

   At this point, introduce the idea of "advocacy" if the participants have not already mentioned it. Consider what can happen when a single person or more than one person of the same discipline identify as the client's *only* advocate. This can set up a conflict between disciplines. Emphasize to the group that every provider is an advocate for his or her client.

8. Continue a guided group discussion with entire group, using the following questions:
   - How did you select the criteria for evaluation (Item 6 on worksheet)? What do these sets of criteria tell you? What don't they tell you? Do the criteria you selected correspond to the responsibilities you assigned in Item 5 on the worksheet?
   - Think about your personal history and your professional experiences. How might these have influenced your approach to this case study?

9. Summarize the highlights of this activity.

Training Tip:

Change the case study you use to make it culturally and regionally appropriate as well as to fit time restraints. The condensed version has already been stripped down to the essentials.

Training of Trainers Teach Back Opportunity:

Objective: Facilitating a Group Discussion When a Difficult Person is Present

After completing steps 1-9, stop the group and explain that you are going to ask 2 of them to teach back to the group as "Teach Back Co-Facilitators." Have them repeat steps 7-9. Slip a 3x5 card to another group member, asking him/her to take the part of case manager who believes that case managers are the only "true advocates" of a client, putting off group members from other disciplines. The Teach Back Co-Facilitators should turn this conflict into a learning opportunity.

Handout V-2

HIV and Substance Use Case Study

Introduction

The following case study is a teaching tool to describe and promote the use of an interdisciplinary model of care in addiction treatment settings. Tom Gates is a patient who is HIV-infected and has a substance use disorder. Tom's story includes a variety of typical, but challenging, situations seen among HIV-infected substance users who receive care in addiction treatment programs. Although circumstances and available resources vary from program to program, this case presents many of the challenges facing providers in this practice setting. In working with this case study, the primary objective is to encourage you to work with other group members as a team. In this way, you will learn to apply an interdisciplinary approach to care that can address the myriad and complex issues common to HIV-infected substance users.

In the context of this case, the term "health care" includes a broad range of health care needs, including nursing, medical care, mental health and substance abuse treatment, as well as social services and other nonmedical needs. The term "interdisciplinary team" is used to describe the group of providers from many disciplines who are providing services to the client. It is important to recognize that all of these providers may not necessarily work for the same organization or at the same site.

We have presented two different versions of this case study to highlight the different types of issues that might be encountered in urban and rural locations. The first version takes place in a major city with significant medical and substance abuse treatment resources, while the second version takes place in a rural location with fewer resources in the immediate vicinity.

Case History (Urban Version)

Tom Gates, a 56-year-old male, has been a patient at TriCity Community Health Center for the past three months. Tom originally came to TriCity with the complaint of mouth sores and diarrhea. He was seen by the physician, Deborah Kavanagh, and treated for oral thrush and hypertension. After appropriate testing, he was diagnosed as coinfected with HIV and the hepatitis C virus (HCV). His CD4 count is 350, with a viral load of 635,000. Deborah would like to start Tom on antiretroviral medications but is reluctant, because she is concerned about his substance use.

Tom admits to drinking a pint of liquor daily and smoking crack "with buddies on the weekends." Tom states he started drinking heavily when he was 18 years old. At the time, he was in the Navy and stationed in Southeast Asia. Tom states that he has used heroin in the past and has injected it along with cocaine. He says he has "laid off that stuff" over the last few years.

Tom does not have health insurance and is paying a sliding scale fee at TriCity Community Health Center. Deborah gives Tom sample medications for the oral thrush and hypertension and asks him to return in two weeks for follow-up. Deborah also refers Tom to Jan Harris, a licensed social worker, for a psychosocial assessment and to determine what benefits he may be eligible

for to cover the costs of medications. Jan meets with Tom briefly that day, talks with him about how he feels about being infected with HIV and HCV, and begins establishing a relationship with him. Tom has a quiet demeanor and has very few questions regarding his new diagnosis. He agrees to meet with Jan again, and they set up an appointment a week later to conduct a psychosocial assessment.

Tom misses his follow-up appointments with both Jan and Deborah and arrives at TriCity a month later out of medications and smelling of alcohol. He avoids eye contact with Laura Curran, the triage nurse, and his clothes are dirty and his hair disheveled. When he speaks with Laura, Tom becomes teary-eyed, saying he doesn't want to die. She takes his blood pressure and finds that it is high, with a reading of 186/100. Deborah examines Tom that morning and discusses his treatment options with him again. Tom agrees to go into substance abuse treatment, and Deborah refers him directly to Jan, the social worker, to set up arrangements for admission to a program.

Jan explains to Tom that TriCity has a collaborative agreement with Second Genesis, an out-patient substance abuse treatment program located six blocks from the health center. Jan calls Second Genesis and gets an intake appointment for Tom that afternoon. She faxes a summary of his health history and current medications to Second Genesis. Tom arrives for his appointment at Second Genesis two hours later. He is met by Louise Brown, a licensed social worker and certified addiction counselor, who conducts the intake assessment. She then refers Tom to Sandy Hale, a psychologist, for further mental health assessment.

Sandy diagnoses Tom with depression, post-traumatic stress disorder (PTSD), cocaine abuse, and alcohol dependence. She confers with Jeffrey Frank, the consulting psychiatrist for Second Genesis, and starts Tom on the antidepressant bupropion (trade name Wellbutrin). Sandy and Jeffrey observe Tom for any signs of alcohol withdrawal. They also teach him what signs and symptoms to watch for and ask him to contact them if symptoms develop.

From the intake assessment, the staff at Second Genesis learns that Tom was a machinist working in a tool and dye shop after he was dishonorably discharged from the Navy due to substance abuse. He has had various laborer jobs over the past 30 years, with periods of unemployment. For the past two years, Tom has been working as a janitor at a local steel factory. He lives alone in a one-room apartment downtown and takes the bus to work. Tom is divorced and has two grown children who live out of state. His ex-wife remarried two years after their divorce 23 years ago. Tom says that she and her new husband didn't "want me around my kids... I saw them once in a while when they were young," but he has "lost track of them" over the years. Tom's parents are both dead. He relates that he has a younger brother in town whom he talks to occasionally, but "we don't get along that well." Tom reports that he was incarcerated five years ago for "hitting a guy over the head with a bottle" in a street fight. He has a scar over his right temple and says he has had seizures in the past.

Tom relates that he has been in treatment before – several times in outpatient treatment and through detox "a couple of times." He states that he was once in an inpatient treatment program for three weeks, "but that was a few years back." He denies using heroin or injecting drugs for the past three years. He drinks a pint of liquor a day and has for a "long time."

Sandy Hale and Louise Brown consult on a plan of care, and Louise then reviews it with Tom. Tom agrees to start individual counseling with Sandy once a week, attend the TriCity's Addiction Groups for one hour each day, and go to at least three AA meetings per week. Louise Brown also meets with Tom on a weekly basis to see how he is doing and to manage his plan of care at the substance abuse treatment program.

Over the next five weeks, Tom follows his treatment plan at Second Genesis and participates in the groups. He also returns to TriCity Community Health Center and is started on antiretroviral medications by his physician Deborah Kavanagh. Although Tom has some side effects – nausea and diarrhea – he takes his medications as directed. Deborah is concerned about Tom's nutritional status, since he is about 20 pounds below normal body weight and his blood pressure remains uncontrolled. Tom is referred to a gastroenterologist for a consult regarding his HCV infection and poor nutritional status. A liver biopsy is ordered and scheduled for two weeks later.

Tom continues to meet periodically with Jan the social worker and obtains a pharmacy entitlement that pays for his prescriptions. She also helps him access nutritional supplements. Jan completes the psychosocial assessment with Tom and learns that he is the oldest of four children. Although his brother and his family live in town, his two sisters moved to the East Coast 20 years ago. He admits that his relationships with his siblings are "not very good." He also split up with a woman friend six months ago. Tom states that she "left me for someone else" and confides that he misses her. Tom started using heroin and speedballing cocaine in his late twenties after returning from Vietnam. He has had several periods of homelessness over the last 30 years and has moved in and out of town.

During his sixth week at Second Genesis, Tom has a urine test that is positive for alcohol. Louise discusses with him what triggered his use of alcohol. Tom states that an old girlfriend of his came to his apartment last night and they had a "few drinks together." He relates that she is going to be staying with him for a while, because she lost her job and can't pay the rent for her apartment. Louise strongly recommends to Tom that he make his sobriety the priority in his life. She tells him that if he has another positive urine test, he will be asked to leave the program. Five days later, a random urine sample from Tom returns positive for alcohol, and he is discharged from Second Genesis.

A week later, Tom presents to TriCity for both his medical appointment with Deborah, and his case management appointment with Jan. In meeting with Jan, Tom tells her what has happened at Second Genesis. He admits to Jan that he is drinking daily but states that he is not doing any crack. He has continued taking his medications, and he says that his girlfriend is "helping me to remember to take them." Tom says he told his girlfriend he is HIV-infected and that she doesn't have "it." Jan discusses with Tom the risk reduction behaviors he needs to take when having sexual relations with his girlfriend.

Jan congratulates Tom on maintaining sobriety from crack cocaine for a whole month. She discusses with Tom what he did during his one month of sobriety that helped him stay sober. Jan also reviews the medical treatment plan with Tom and asks him what part of the plan he thinks

he can do at this time. Tom states that he can take his HIV medications but does voice concerns about side effects. He says he can stay off cocaine, and will try not to drink.

Jan discusses the situation with Deborah, and they decide to ask Second Genesis to take Tom back into their program. Jan calls Louise, the substance abuse provider, and relates her conversation with Tom concerning his desire to re-enter their program. Louise and Sandy Hale, the psychologist, remind Jan that clients at Second Genesis have to make a commitment to abstinence and maintain negative urines to stay in the program. They give Tom an appointment for the next morning, and he is readmitted into Second Genesis. Two weeks later, he is discharged again after a positive urine test. Jan tries to get Second Genesis to take Tom back into the program again, but they refuse. There are no other addiction treatment programs in the community. Over the next month, Tom continues to be engaged with TriCity, although he misses some appointments and shows up as a walk-in. He continues to drink, denies using cocaine, and is taking his antiretroviral medications.

Case History (Rural Version)

Tom Gates, a 56-year-old male, has been a patient at Rural Community Health Center for the past three months. Tom originally came to Rural with the complaint of mouth sores and diarrhea. He was seen by the physician, Deborah Kavanagh, and treated for oral thrush and hypertension. After appropriate testing, he was diagnosed as coinfected with HIV and hepatitis C virus (HCV). His CD4 count is 350 with a viral load of 635,000. Deborah would like to start Tom on antiretroviral medications but is reluctant, because she is concerned about his substance use.

Tom admits to drinking a pint of liquor daily and smoking crack "with buddies on the weekends." Tom states he started drinking heavily when he was 18 years old. At the time, he was in the Navy and stationed in Southeast Asia. He states that he has used heroin in the past and has injected it along with cocaine. He also claims he has "laid off of that stuff" over the last few years.

Tom does not have health insurance and is paying a sliding scale fee at Rural Community Health Center. Deborah gives Tom sample medications for the oral thrush and hypertension and asks him to return in two weeks for follow up. Deborah also refers Tom to Jan Harris, a licensed social worker, for a psychosocial assessment and to determine what benefits he may be eligible for to cover the costs of medications. Jan meets with Tom briefly that day, talks with him about how he feels about being infected with HIV and HCV, and begins establishing a relationship with him. Tom has a quiet demeanor and has very few questions regarding his new diagnosis. He agrees to meet with Jan again, and they set up an appointment for a week later to conduct a psychosocial assessment.

Tom misses his follow-up appointments with both Jan and Deborah and arrives at the health center a month later out of medications and smelling of alcohol. He avoids eye contact with Laura Curran, the medical assistant, and his clothes are dirty and his hair disheveled. On talking with Laura, Tom becomes teary-eyed, saying he doesn't want to die. She takes his blood pressure and finds that it is high, with a reading of 186/100. Deborah examines Tom that morning and discusses his treatment options with him again. Tom agrees to go into substance abuse treatment,

and Deborah refers him directly to Jan, the social worker, to set up arrangements for entry into a program.

Jan explains to Tom that Rural has a collaborative agreement with Second Genesis, an outpatient substance abuse treatment program located 30 miles away in the next town. Jan calls Second Genesis and gets an intake appointment for Tom the next day. She faxes a summary of his health history and current medications to Second Genesis. Tom arrives for his appointment the next morning. He is met by Louise Brown, a licensed social worker and certified addiction counselor, who conducts the intake assessment. She then refers Tom to Sandy Hale, a psychologist, for further mental health assessment.

Sandy diagnoses Tom with depression, post-traumatic stress disorder (PTSD), cocaine abuse, and alcohol dependence. She confers with Jeffrey Frank, the consulting psychiatrist for Second Genesis, and starts Tom on the antidepressant bupropion (trade name Wellbutrin). Sandy and Jeffrey observe Tom for alcohol withdrawal. They also teach him what signs and symptoms to watch for and ask him to contact them if symptoms become apparent.

From the intake assessment, the staff at Second Genesis learns that Tom was a machinist working in a tool and dye shop after he was dishonorably discharged from the Navy due to substance abuse. He has had various laborer jobs over the past 30 years, with periods of unemployment. For the past two years, Tom has been working as a janitor at a local meat factory. He lives alone in a trailer that he rents about two miles outside of town. He has an "old car that I keep together" and uses it to get around. Tom is divorced and has two grown children that live out of state. His ex-wife remarried two years after their divorce 23 years ago. Tom says that she and her new husband didn't "want me around my kids… I saw them once in a while when they were young," but he has "lost track of them" over the years. Tom's parents are both dead. He relates that he has a younger brother who lives in the next town whom he talks to occasionally, but "we don't get along that well." Tom reports that he was incarcerated five years ago for "hitting a guy over the head with a bottle" in a bar fight. He has a scar over his right temple and says he has had seizures in the past.

Tom relates that he has been in treatment before – several times in outpatient treatment and through detox "a couple of times." He states that he was once in an inpatient treatment program for three weeks, "but that was a few years back." He denies using heroin or injecting drugs for the past three years. He drinks a pint of liquor a day and has for a "long time."

Sandy Hale and Louise Brown consult on a plan of care, and Louise reviews it with Tom. Tom agrees to start individual counseling with Sandy once a week, attend Rural's Addiction Groups for one hour each day, and go to at least three AA meetings per week. Louise Brown also meets with Tom on a weekly basis to see how he is doing and to manage his overall plan of care.

Over the next five weeks, Tom follows his treatment plan at Second Genesis and participates in the groups. He returns to Rural Community Health Center and is started on antiretroviral medications by his physician Deborah Kavanagh. Although Tom has some side effects – nausea and diarrhea – he takes his medications as directed. Deborah is concerned about his nutritional status, since he is about 20 pounds below normal body weight and his blood pressure remains

uncontrolled. Tom is referred to a gastroenterologist at the medical center located 40 miles away. He keeps the appointment for a consult regarding his HCV infection and poor nutritional status. A liver biopsy is ordered and scheduled for two weeks later.

Tom continues to meet periodically with Jan the social worker and obtains a pharmacy entitlement that pays for his prescriptions. She also helps him access nutritional supplements. Jan completes the psychosocial assessment with Tom and learns that he is the oldest of four children. Although his brother and his family live in the next town, his two sisters moved to the East Coast 20 years ago. He admits that his relationships with his siblings are "not very good." He also split up with a woman friend six months ago. He states that she "left me for someone else" and confides that he misses her. Tom started using heroin and speedballing cocaine in his late twenties after returning from Vietnam. He has had several periods of homelessness over the last 30 years and has moved in and out of town.

During his sixth week at Second Genesis, Tom has a urine test that is positive for alcohol. Louise discusses with him what triggered his use of alcohol. Tom states that an old girlfriend of his came to his apartment last night and they had a "few drinks together." He relates that she is going to be staying with him for a while, because she lost her job and can't pay the rent for her apartment. Louise strongly recommends to Tom that he make his sobriety the priority in his life. She tells him that if he has another positive urine test, he will be asked to leave the program. Five days later, a random urine sample from Tom returns positive for alcohol, and he is discharged from Second Genesis.

A week later, Tom presents to Rural for both his medical appointment with Deborah, and his case management appointment with Jan. In meeting with Jan, Tom tells her what has happened at Second Genesis. He admits to Jan that he is drinking daily but states that he is not doing any crack. He has continued taking his medications, and he says that his girlfriend is "helping me remember to take them." Tom says he told his girlfriend he is HIV-infected and that she doesn't have "it." Jan discusses with Tom the risk reduction behaviors he needs to take when having sexual relations with his girlfriend.

Jan congratulates Tom on maintaining sobriety for crack cocaine for a whole month. She discusses with Tom what he did during his one month of sobriety that helped him stay sober. Jan also reviews the medical treatment plan with Tom and asks him what part of the plan he thinks he can do at this time. Tom states that he can take his HIV medications but does voice concerns about side effects. He says he can stay off cocaine, and will try not to drink.

Jan discusses the situation with Deborah, and they decide to request that Second Genesis take Tom back into their program. Jan calls Louise, the substance abuse provider, and relates her conversation with Tom concerning his desire to re-enter their program. Louise and Sandy Hale, the psychologist, remind Jan that clients at Second Genesis have to make a commitment to abstinence and maintain negative urines to stay in the program. They give Tom an appointment for the next morning, and he is readmitted into Second Genesis. Two weeks later he is discharged again for a positive urine test. Jan tries to get Second Genesis to take Tom back into the program again, but they refuse. There are no other addiction treatment programs within 100 miles of Rural Community Health Center. Over the next month, Tom continues to be engaged

with Rural although he misses some appointments and shows up as a walk-in. He continues to drink, denies using cocaine, and is taking his antiretroviral medications.

Case History (Urban Version Condensed)

Tom Gates, a 56-year-old male, has been a patient at TriCity Community Health Center for three months and is newly diagnosed with HIV with CD4 350 and viral load 635,000. Deborah Kavanagh, M.D. wants to start Tom on antiretroviral medications but is reluctant due to his substance use. Tom admits to drinking a pint of liquor daily and smoking crack "with buddies on the weekends." Tom states that he has used heroin in the past and has injected it along with cocaine. With no health insurance, Tom is getting sample medications for oral thrush and hypertension. Deborah requests Tom to return in two weeks for follow up and refers him to Jan Harris, social worker, for case management services. Jan meets with Tom briefly that day and begins establishing a relationship with him. Tom has a quiet demeanor and asks few questions regarding his new diagnosis. He agrees to meet with Jan again a week later for a full assessment.

Tom misses his follow-up appointments with both Jan and Deborah and arrives at TriCity a month later out of medications and smelling of alcohol. When he speaks with Laura, the triage nurse, Tom becomes teary-eyed, saying he doesn't want to die. His blood pressure is 186/100. Deborah examines Tom, discusses his treatment options, and Tom agrees to go into substance abuse treatment. Deborah refers him to Jan to set up arrangements for admission to a program.

TriCity has a collaborative agreement with Second Genesis; an outpatient substance abuse treatment program located within six blocks from the agency. Jan calls Second Genesis, gets an intake appointment and two hours later, Tom arrives for his appointment. Louise Brown, addiction counselor, conducts the intake assessment and refers him to Sandy Hale, a psychologist, for further mental health assessment. Sandy diagnoses Tom with depression, post-traumatic stress disorder (PTSD), cocaine abuse, and alcohol dependence. Jeffrey Frank, the consulting psychiatrist, starts Tom on the antidepressant bupropion (Wellbutrin).

The Second Genesis staff learns that Tom was dishonorably discharged from the Navy due to substance abuse. He is a janitor in a local factory and lives alone in a one-room apartment downtown. He is divorced, has two grown children who he has lost contact with and a brother in town but "we don't get along that well." His parents are deceased. He was incarcerated five years ago after a "street fight" and reports he has had seizures in the past.

Sandy and Louise consult on a plan of care and Tom agrees to start individual counseling with Sandy weekly, attend Second Genesis Addiction Groups every day and at least three AA meetings weekly. For the next five weeks, Tom follows his treatment plan. He returns to TriCity and Deborah starts him on antiretroviral medications. Although he voices concerns about the side effects, he takes them as directed. Tom continues to meet periodically with Jan and he obtains a pharmacy entitlement that pays for his prescriptions. Tom confides to Jan that he split up with a woman friend six months ago and that he misses her.

During his sixth week at Second Genesis, Tom has a positive urine test for alcohol. Louise discusses with him what triggered his use of alcohol and Tom admits that he had a "few drinks"

with an old girlfriend and that she is going to be staying with him. Louise strongly recommends that he make his sobriety the priority in his life. Five days later, a random urine sample from Tom returns positive for alcohol, and he is discharged from Second Genesis.

A week later, Tom presents to TriCity for both his medical appointment with Deborah, and his case management appointment with Jan. Tom tells Jan what happened at Second Genesis and admits to Jan that he is drinking daily but states that he is not doing any crack. He has continued taking his medications, and he says that his girlfriend is "helping me to remember to take them." Tom says he told his girlfriend he is HIV-infected and that she doesn't have "it." Jan discusses with Tom the risk reduction behaviors he needs to take when having sexual relations.

Jan congratulates Tom on maintaining sobriety for crack cocaine and she discusses with him what he did during his one month of sobriety that helped him stay sober. Jan also reviews the medical treatment plan with Tom and asks him what part of the plan he thinks he can do at this time. Tom states that he can take his HIV medications, stay off cocaine, and will try not to drink. Jan calls Louise at Second Genesis requesting that Tom be readmitted to the program. Louise reminds Jan that clients have to make a commitment to abstinence and agrees to take him back into the program. Two weeks later he is discharged again after a positive urine test. Jan tries to get Second Genesis to take Tom back, but they refuse and there are no other addiction treatment programs in the community. Over the next month, Tom continues to be engaged with TriCity, although he misses some appointments and shows up as a walk-in. He continues to drink, denies using cocaine, and is taking his antiretroviral medications.

Case History (Rural Version Condensed)

Tom Gates, a 56-year-old male, has been a patient at Rural Community Health Center for three months and is newly diagnosed with HIV with CD4 350 and viral load 635,000. Deborah Kavanagh, M.D. wants to start Tom on antiretroviral medications but is reluctant due to his substance use. Tom admits to drinking a pint of liquor daily and smoking crack "with buddies on the weekends." Tom states that he has used heroin in the past and has injected it along with cocaine. With no health insurance, Tom is getting sample medications for oral thrush and hypertension. Deborah requests Tom to return in two weeks for follow up and refers him to Jan Harris, social worker for case management services. Jan meets with Tom briefly that day and begins establishing a relationship with him. Tom has a quiet demeanor and asks few questions regarding his new diagnosis. He agrees to meet with Jan again a week later for a full assessment.

Tom misses his follow-up appointments with both Jan and Deborah and arrives at Rural a month later out of medications and smelling of alcohol. When he speaks with Laura, the triage nurse, Tom becomes teary-eyed, saying he doesn't want to die. His blood pressure is 186/100. Deborah examines Tom, discusses his treatment options, and Tom agrees to go into substance abuse treatment. Deborah refers him to Jan to set up arrangements for admission to a program.

Rural has a collaborative agreement with Second Genesis; an outpatient substance abuse treatment program located 30 miles away in the next town. Jan calls Second Genesis and gets an intake appointment for the next day. Tom arrives for his appointment the next morning. Louise Brown, addiction counselor, conducts the intake assessment and refers him to Sandy Hale, a

psychologist, for further mental health assessment. Sandy diagnoses Tom with depression, post-traumatic stress disorder (PTSD), cocaine abuse, and alcohol dependence. Jeffrey Frank, the consulting psychiatrist, starts Tom on the antidepressant bupropion (Wellbutrin).

The Second Genesis staff learns that Tom was dishonorably discharged from the Navy due to substance abuse. He has been working as a janitor at a local meat factory. He lives alone in a trailer that he rents about two miles outside of town. He has an "old car that I keep together". He is divorced, has two grown children who he has lost contact with and a brother in the next town but "we don't get along that well." His parents are deceased. He was incarcerated five years ago after a "street fight" and reports he has had seizures in the past.

Sandy and Louise consult on a plan of care and Tom agrees to start individual counseling with Sandy weekly, attend Rural Addiction Groups every day and at least three AA meetings weekly. For the next five weeks, Tom follows his treatment plan. He returns to Rural and Deborah starts him on antiretroviral medications. Although he voices concerns about the side effects, he takes them as directed. Tom continues to meet periodically with Jan and he obtains a pharmacy entitlement that pays for his prescriptions. Tom confides to Jan that he split up with a woman friend six months ago and that he misses her.

During his sixth week at Second Genesis, Tom has a positive urine test for alcohol. Louise discusses with him what triggered his use of alcohol and Tom admits that he had a "few drinks" with an old girlfriend and that she is going to be staying with him. Louise strongly recommends that he make his sobriety the priority in his life. Five days later, a random urine sample from Tom returns positive for alcohol, and he is discharged from Second Genesis.

A week later, Tom presents to Rural for both his medical appointment with Deborah, and his case management appointment with Jan. Tom tells Jan what happened at Second Genesis and admits to Jan that he is drinking daily but states that he is not doing any crack. He has continued taking his medications, and he says that his girlfriend is "helping me to remember to take them." Tom says he told his girlfriend he is HIV-infected and that she doesn't have "it." Jan discusses with Tom the risk reduction behaviors he needs to take when having sexual relations.

Jan congratulates Tom on maintaining sobriety for crack cocaine and she discusses with him what he did during his one month of sobriety that helped him stay sober. Jan also reviews the medical treatment plan with Tom and asks him what part of the plan he thinks he can do at this time. Tom states that he can take his HIV medications, stay off cocaine, and will try not to drink. Jan calls Louise at Second Genesis requesting that Tom be readmitted to the program. Louise reminds Jan that clients have to make a commitment to abstinence and agrees to take him back into the program. Two weeks later he is discharged again after a positive urine test. Jan tries to get Second Genesis to take Tom back, but they refuse and there are no other addiction treatment programs in the community. Over the next month, Tom continues to be engaged with Rural, although he misses some appointments and shows up as a walk-in. He continues to drink, denies using cocaine, and is taking his antiretroviral medications.

Handout V-3

Individual Assessment Worksheet

After you have read the case study narrative, please answer the questions below. During the group discussion about this exercise, please circle the areas where your answers vary from those of participants in the group who represent other disciplines.

1. Think about the client's most pressing concerns. Develop a problems or issues list, prioritizing the strategies, interventions, and services that the client needs. Please list the top three priorities below in the order of urgency or importance:

   - First priority issue:_____
   - Second priority issue:_____
   - Third priority issue:_____

2. Can you think of any things you don't know, but would need to know, about this client?

3. Why do you need to know these things?

4. Answer the following questions about the client's goals:
   - How do you determine the goals for this client?
   - Based on what you know, what are the goals for this client?
   - For each of the priority items listed in Item 1 above, what is the client's role or responsibility?

Adapted from the *Wisconsin Partnership Program/Quality Research*, by B. Bowers, published in 1999 by the University of Wisconsin-Madison School of Nursing, Providing Consumer Centered Care in Integrated Programs, Madison, Wisconsin

Activity: Cross-Discipline Awareness

Purpose: To increase participants' knowledge, understanding, appreciation, and respect for other disciplines and for their colleagues in those disciplines

Time: 40 minutes if done in conjunction with "Team Member Professional Identification" Activity (45 minutes if done alone and participants need to read the case study)

Materials

- Flipchart and colored marker
- Handout V-4, "Group Assessment Worksheet"

Instructor Notes

1. Background: The earlier exercises were designed to help each participant review the values and perspectives of their particular discipline and gain a deeper understanding of how personal and professional experiences influence their approach to care. Building on this foundation, the current activity shifts the participants' focus of attention to the roles, values, and perspectives of other disciplines.

   It is important to note that this activity is concerned with the *integration* of the work of different disciplines rather than on a mutual understanding *between* the disciplines. This activity will succeed only if the participants have a mutual respect for and appreciation of the roles played by all disciplines represented in the interdisciplinary team. The exercises in this activity are designed to promote and enhance this mutual respect and appreciation.

2. Ask each workshop participant to choose one of the roles below to assume for the activity. They should choose a role other than their current professional role.
   - Registered nurse
   - Physician, nurse practitioner, or physician assistant
   - Social worker
   - Mental health counselor
   - Substance abuse treatment provider
   - Health educator
   - Outreach worker

3. Ask the "interdisciplinary team" at each table to complete the "Group Assessment Worksheet" together, each member voicing the perspectives of the discipline or role he or she has chosen. Allow 20 minutes for this part of the activity.

4. Ask a representative from each table to share with the large group what their table identified on the worksheet. They should summarize the different perspectives, observations and conflicts that arose. Highlight the key points, noting them on a sheet of flipchart paper, and discuss them with the group. Allow 20 minutes for this part of the activity.

Training Tip:

If the participants seem to have a high level of conflict or a low level of trust among them in this large group discussion, then the large group should be divided into smaller working groups comprised of individuals from the same discipline for the completion of this activity.

Training of Trainers Teach Back Opportunity:

Objective: Resolving a Personal Conflict that Emerges between Participants:

After completing steps 1-4, stop the group and explain that you are going to ask two of them to teach back to the group as Teach Back Co-Facilitators. Have them repeat steps 2-3. Slip 3x5 cards to two group members sitting at the same table. One card calls for the first group member to play the role of a physician who does not appreciate the hard work that goes into outreach, specifically the work done by the outreach worker at the table; the other 3x5 card calls for the second group member to be an outreach worker who feels unvalued by the physician at the table. Both are from the same clinic. This will create a personal conflict among group members that the Teach Back Co-Facilitators must overcome.

Handout V-4

Group Assessment Worksheet

Review the "HIV and Substance Use Case Study" (Handout V-2), assuming the perspective of someone in a role or discipline different from your own. Each group should be comprised of members assuming a variety of different roles. You may choose from any of the following roles or disciplines:

- Registered nurse
- Physician, nurse practitioner, or physician assistant
- Social worker
- Mental health counselor
- Substance abuse treatment provider
- Health educator
- Outreach worker

Then, as an "interdisciplinary team," answer the questions below together.

1. Think about the client's most pressing concerns. Develop a problems or issues list, prioritizing the strategies, interventions, and services that the client needs. Please list the top three priorities below in the order of urgency or importance:

   - First priority issue:_____
   - Second priority issue:_____
   - Third priority issue:_____

2. What other information would you need to know about this client from the perspective of a person in the discipline or role you've chosen?

3. Why would you need to know these things?

4. Discuss the logic behind your identification of particular issues above as priority areas.

Adapted from the *Wisconsin Partnership Program/Quality Research*, by B. Bowers, published in 1999 by the University of Wisconsin-Madison School of Nursing, Providing Consumer Centered Care in Integrated Programs, Madison, Wisconsin.

Session 5: Team Communication

Activity: Communication Strategies for the Interdisciplinary Team

Purpose

- To identify the barriers to communication among the interdisciplinary team members
- To share strategies that can break down the barriers and foster communication

Time: 35 minutes

Materials

- Flipcharts, colored markers, and tape
- Breakout tables for working groups of six to ten people

Instructor Notes

1. If you haven't already, divide the participants into working groups of six to ten people. Make sure that the participants in each working group come from a range of different disciplines.

2. Ask each working group to brainstorm for 15 minutes. Have them designate a person to record on a flipchart the barriers to communication among interdisciplinary team members. Allow 15 minutes for steps 2-3.

3. Ask the working groups to think specifically about the barriers that are encountered when members of the interdisciplinary team work in different agencies.

4. Ask a spokesperson from one working group to share the list of barriers that his or her group identified. Then ask participants from the other working groups to expand that list by adding any other barriers they identified. Allow 20 minutes for steps 4-8

5. Post this expanded list of barriers on the wall where all participants can easily see it.

6. For the remainder of the 20 minutes, conduct a guided discussion with the entire group of participants. Ask participants to share the strategies they have devised or used in their interdisciplinary work to overcome barriers to communication both within their agency and in working with other agencies.

7. Record these strategies on one or more sheets of flipchart paper, and then post the list on the wall where it can be easily seen. If possible, create a new handout containing the participants' list of strategies. Distribute copies of this new handout to all participants after they've completed the activities in this module.

8. Ask the participants if they have any questions. Answer these questions, and then summarize the key points of the session.

Training of Trainers Teach Back Opportunity:

Objective: Managing Time, Facilitating a Discussion, and Talking about Barriers without Placing Blame

After the first spokesperson has presented to the entire group (step 4), stop the group and explain that you are going to ask two participants to teach back to the group as Teach Back Co-Facilitators. They should continue where you leave off, adding to the expanding list of barriers and facilitating the discussion on strategies used in interdisciplinary work. You should step in at the end of step 6, wrapping up the guided discussion and touching upon any points missed by the Teach Back Co-Facilitators.

Note that unlike the previous teach back opportunities, this one does not complete the entire session first; instead the teach back is incorporated into the session during its first run, so there is no repetition.

Session 6: Models of Care

Presentation: Innovative Models of Interdisciplinary Care

Purpose

- To demonstrate how linkages can be created among the providers and service agencies throughout a community to better serve HIV-infected clients
- To highlight the key features of innovative, successful models of interdisciplinary care implemented at various sites across the country

Time: 45 minutes

Note: The slides and descriptions used in this session are meant as examples. You should substitute or add slides and descriptions about local models that will be familiar and more meaningful to your audience.

Materials

- Slide V-4, "Innovative Models for Interdisciplinary Care and Community Linkages"
- Slide V-5, "The Need for Interdisciplinary Care"
- Slide V-6, "Brooklyn Hospital Center Path Program"
- Slide V-7, "Path Program: Program Design"
- Slide V-8, "Path Program: Innovative Features"
- Slide V-9, "AIDS Services Center"
- Slide V-10, "AIDS Services Center: Program Design"
- Slide V-11, "AIDS Services Center: Innovative Features"
- Slide V-12, "Special Health Resources of East Texas"
- Slide V-13, "Special Health Resources of East Texas: Program Design"
- Slide V-14, "Special Health Resources of East Texas: Innovative Features"
- Slide V-15, "Project Bridge"
- Slide V-16, "Project Bridge: Program Design"
- Slide V-17, "Project Bridge: Innovative Features"
- Slide V-18, "Common Themes and Success Factors of Interdisciplinary Care"
- Slide V-19, "Common Themes"
- Slide V-20, "Common Themes (continued)"
- Slide V-21, "Common Themes (continued)"
- Handout V-5, "Case Study: Brooklyn Hospital Center Path Program"
- Handout V-6, "Case Study: AIDS Services Center"
- Handout V-7, "Case Study: Special Health Resources of East Texas"
- Handout V-8, "Case Study: Project Bridge"
- Handout V-9, "Community Linkages Assessment Guide"

- Handout V-10, “Agency Linkages Evaluation Tool”
- Handout V-11, “Sample Confidentiality Agreement”

Instructor Notes

1. Introduce the presentation topic, and explain that participants will hear a presentation about the design and key features of innovative interdisciplinary care programs involving HIV and substance use providers.

2. Spend 20 minutes presenting Slides V – 4 through V– 21, which describe the innovative models of interdisciplinary care and their common success factors. Distribute the case studies, Handouts V-5 through V-8, to supplement the presentation.

Brooklyn Hospital Center Path Program

New York, NY

Slide V - 6

Program Design

- Hospital-based infectious disease clinic expands traditional HIV medical care delivery model to provide full spectrum of services
- On-Site Services – HIV medical care, mental health treatment, case management, peer ed, nutrition, support services
- Linkages with external providers for additional services – outpatient SA counseling, methadone maintenance, detox, mental health counseling
- Each patient assigned to a medical panel, case manager, and social worker

Slide V - 7

Innovative Features

- Case conferencing key feature of model
  - Interdisciplinary team members meet 3-4 times per month to discuss patient cases
- Strong collaboration between medical care providers and detoxification program
- Peer educators are critical to the success of the program
- Community-based organizations from African immigrant and Haitian communities provide case management on site
- Service agencies that link to Path are invited to be part of a Community Advisory Board and play an active role in shaping program operations.

Slide V - 8

AIDS Services Center

Anniston, AL

Slide V - 9

Program Design

- Rural, non-profit HIV clinic – 85% of clients are current or former substance users
- On-Site Services – primary medical care, mental health counseling, community outreach, case management, substance abuse assessment and treatment, nutrition counseling

Slide V - 10

Innovative Features

- Accommodates walk-in appointments for same-day medical care, mental health, and substance abuse services
- Mobile van for home visits to provide medical care, mental health counseling, outreach, and client follow-up
- Resource-scarce area – set up 5 satellite clinics with a full complement of services
- Strong collaboration between medical director and substance abuse treatment coordinator

Slide V - 11

Special Health Resources of East Texas

Longview, TX

Slide V - 12

Program Features

- Community-based agency with three major divisions:
  - Substance Abuse Services Division – provides detox, case management, substance abuse counseling, and support services
  - HIV Division – provides full spectrum of medical care, dental care, mental health counseling, and support services in four different clinics
  - Wellspring Recovery Center – 18 bed inpatient substance abuse treatment program exclusively for HIV-infected substance users

Slide V - 13

Innovative Features

- Early intervention program provides intensive case management to HIV-infected substance users
- Wellspring staff is trained to treat clients with HIV, substance abuse, and mental health disorders through a harm reduction approach
- Case conferencing takes place informally everyday and formally once weekly to discuss patient cases
- Careful discharge planning involves case management and support services

Slide V - 14

Project Bridge

Providence, RI

Slide V - 15

Program Design

- Outreach and intensive case management program for HIV-infected ex-offenders; affiliated with ID clinic of hospital
- Provides 18-24 months of services post-release, goal is to integrate clients into community in that time
- Model consists of two intensive case management teams, each with a LICSW, case manager, and outreach worker, with infectious disease physicians, psychiatrists, and nurses available for consultation
- Physicians who provide HIV medical services in prisons refer their clients to Project Bridge and continue to provide medical care to same individuals after prison release

Slide V - 16

Innovative Features

- Project Bridge does not provide medical services or substance abuse treatment directly, but case managers accompany clients to all medical and non-medical appointments
- Intake process identifies needs of client, such as methadone treatment, residential treatment, and ADAP, to ensure continuity of HIV medications
- Weekly meetings between medical providers and case managers at Project Bridge ensure integration between medical and non-medical care

Slide V - 17

Common Themes and Success Factors of Interdisciplinary Care

Slide V - 18

Common Themes

- Program Structure
  - One agency or multiple, linked agencies providing full spectrum of services to clients
  - Linkages and communication among both internal and external providers
  - Short waiting times for appointments
  - Intensive case management
  - Mobile services
  - Staff accompany clients to appointments
  - Discharge planning with patient involvement
  - Management support

Slide V - 19

Common Themes

- Confidentiality
  - Highly sensitive issue for clients
  - Communicate confidentiality protocols to clients to ensure their protection
  - Utilize standard memoranda of understanding and confidentiality agreements with partner agencies
  - Find strong methods for locating clients that do not break confidentiality

Slide V - 20

3. After you've completed the presentation, spend 20 minutes on a group discussion about interdisciplinary care models. Encourage participants to ask questions about the models presented and to describe any other models that they are familiar with from their work.

4. Summarize the main points of the presentation and subsequent discussion. Be sure to mention that interdisciplinary care can be achieved through many different kinds of models, but that all of these models share common themes and success factors.

5. Set aside five minutes at the end of this activity to mention three additional tools that may be used to facilitate and support an interdisciplinary process. These tools are listed below:
   - Handout V-9, "Community Linkages Assessment Guide"
   - Handout V-10, "Agency Linkages Evaluation Tool"
   - Handout V-11, "Sample Confidentiality Agreement"

   Briefly describe each tool, and encourage participants to use them in their interdisciplinary work.

Training of Trainers Teach Back Opportunity:

Objective: Learning How to Present PowerPoint Materials and Engage the Audience

After completing steps 1-5, stop the group and explain that you will ask several of them to teach these slides back. Have the first volunteer do step 1 and present slides V-4 and V-5. A separate volunteer can present each model. Separate Teach Back Co-Facilitators can do steps 3-5.

Handout V – 5

Case Study: Brooklyn Hospital Center, Path Program New York, NY

The PATH (Program for AIDS Treatment and Health) program is a multidisciplinary HIV primary care and case management program at two different campuses of Brooklyn Hospital in New York City. The hospital is designated as an AIDS Center by the New York Department of Health. This designation has allowed the hospital to establish the PATH program, a multi-disciplinary, full-service model of care for individuals living with HIV and AIDS. There are HIV clinics on both hospital campuses.

During 2001, the hospital served over 700 people living with HIV. Approximately 25-50% of these individuals are substance users. Over 70% of patients are Black and 26% are Hispanic; there are much smaller populations of White and Asian/Pacific Islander patients. PATH also serves growing Haitian and African immigrant populations.

A key aspect of the PATH program is the extensive multidisciplinary team. PATH has expanded the traditional HIV medical care delivery model to include physicians, residents, nurse practitioners, physician assistants, nurses, social workers, case managers, an adherence counselor, a nutritionist, a psychiatrist, an outreach worker, an HIV counselor, and peer educators. Each patient is assigned to a medical panel, a case manager and a social worker, with the other services available as needed.

Many substance abuse services are available on site; for those that are not a variety of service integration and linkage strategies are used. For example, to supplement the HIV medical care and mental health treatment available on site, one of the campuses houses a medical detoxification program directly adjacent to the HIV clinic. Outpatient substance abuse counseling, methadone maintenance and additional mental health therapies are available through external providers; PATH case managers provide the linkage to and coordination of services. According to the medical director, this full complement of services has made a significant difference in the program's ability to engage substance users in effective treatment.

Another unique aspect of the PATH model is the movement of multidisciplinary provider teams between the two hospital campuses for separate HIV clinic sessions. Patients at both sites have full access to medical and mental health care, case management, peer education, nutrition, and other support services. While the core of the team is conducting clinic work at one site, a social worker, case manager, and front desk staff remain at the other site to address psychosocial and administrative issues that arise out of, and between, clinic sessions.

Case conferencing is also a key part of the PATH model. The multidisciplinary team members meet formally as a group three times each month; once for a patient flow meeting, once for a journal club and once for a case management meeting. In formal case conferences, the staff discusses the patients who present the greatest challenges for any one of the providers. In addition to the formal meetings, informal conferencing occurs during and after each clinic session, when the multidisciplinary needs of each patient are discussed.

Another innovative aspect of the PATH program model is the partnership between the PATH program and the detoxification program. Although the detoxification unit serves a diverse population, including individuals who are not HIV positive, and its length of stay is only five days, PATH program staff work with the detoxification staff to ensure that all HIV-infected clients receive the spectrum of HIV-related services. These include ongoing medical monitoring and maintenance of HIV medication protocols if the client is known to be HIV positive, HIV education and risk reduction, and the opportunity to access HIV counseling and testing services. The detoxification unit also allows people to remain on methadone, anti-anxiety, and psychotropic medications if clients have prescriptions for these medications. Staff at the detoxification program work closely with the PATH staff, especially the psychiatrist, to determine doses and usages of these drugs.

Peer educators from PATH visit the detoxification unit weekly to talk with detoxification clients and share their own experiences as former substance users. They encourage people to get tested, or if already positive, to reveal their status and enter care. Above all, they let people know they are available to talk and listen. Every Thursday, the HIV counselor goes to the detoxification unit to provide counseling and testing to anyone who wants to participate. They encourage individuals to return for counseling and testing after their discharge from the detoxification unit, and have been successful in some cases.

Referral relationships are also critical to the interdisciplinary model and the success of the program. Since the PATH program only has two case managers and one case manager technician for over 700 patients, they work very closely with community-based agencies to support their patients. The PATH program has formal linkages with twenty agencies for supported housing and community-based case management. Case managers from three of the community-based organizations attend clinic sessions at Brooklyn Hospital Center to provide case management services for patients. Some of these agencies have staff who provide specialized assistance to monolingual patients and work hand-in-hand with clinic staff.

The agencies with formal linkages with the PATH program are invited to be part of the hospital's Community Advisory Board and play an active role in shaping PATH program operations. In addition to formal linkages, informal relationships are also important, particularly for mental health and substance abuse treatment. Because the closely affiliated detoxification program only accepts individuals with insurance, the PATH program works with other detoxification and substance abuse treatment programs that accept the uninsured. There are numerous referral agencies for ongoing mental health treatment. For each patient, all of these external services are identified and coordinated through the initial case management assessments and at six-month intervals thereafter.

Handout V – 6

Case Study: AIDS Services Center, Inc. Anniston, AL

AIDS Services Center, Inc. (ASC) is a free-standing, private non-profit clinic located in rural Anniston, Alabama. The ASC service area covers fourteen counties with five satellite offices. Northeastern Alabama is a rural area where the main employment is textile factories and chicken farming, including large chicken processing plants.

ASC was founded as a support group in 1987. Their target population is people living with HIV/AIDS and affected others. Last year, they served 247 people with HIV/AIDS, of whom 80-85% are substance users or have a history of substance abuse. Of the persons served, approximately 53% are White, 42% are African American, 4% are Hispanic, and 1% are Asian or Pacific Islander.

AIDS Services Center provides on-site primary medical care, mental health and support services, community outreach, case management, substance abuse assessment and treatment. ASC accommodates walk-in appointments for same-day medical care, mental health or substance abuse services. They use a mobile van for home visits of medical care or mental health services and conduct community outreach for client follow-up or to locate clients who are lost to care. In addition, ASC provides outreach and health education at a juvenile detention center, a women's domestic violence shelter, and various civic, church and self-help groups. ASC also has a Palliative Care Program through a HRSA SPNS grant for clients who are ill and in need of homecare services or who are at the end-stage of AIDS. An intensive substance abuse treatment outpatient program was launched by the ASC substance abuse coordinator in August of 2000, adapting a National Institute of Drugs and Alcohol protocol.

Important linkages between HIV treatment and substance use services happen within ASC. The medical director and the substance abuse treatment coordinator work very closely to identify and support individuals who are having difficulty with substance abuse. The medical director makes numerous referrals to the substance abuse treatment coordinator. In addition, when clients first come to ASC they see a case manager who conducts a psychosocial assessment. In addition to all of the medical services provided during the initial appointment, clients also see the mental health counselor for a mental health history. The physician, nurse practitioner, nurse, and mental health counselors can make a referral to the substance abuse treatment counselor or the nutritionist if needed.

An all-staff case conference is held weekly, and since ASC uses a team approach, many informal conferences are held as needed. Since the satellite offices are located one to two hours away, staff members use the driving/riding time to review and discuss cases and any emergent problems.

Handout V – 7

Case Study: Special Health Resources of East Texas Longview, TX

Special Health Resources of East Texas, Inc. is a non-profit agency based in Longview, Texas. The agency is comprised of three main divisions. *The Substance Abuse Services Division* serves the 11 counties of East Texas. The *HIV Division* provides HIV services in 23 counties. These two divisions emerged from predecessor community agencies to form Special Health Resources in 1994. The third division is *Wellspring Recovery Center,* an 18-bed inpatient substance abuse treatment program for people with HIV. Wellspring is the only inpatient facility in Texas exclusively treating HIV positive substance abusers. The HIV division and Wellspring are entirely dedicated to working with those with HIV. Although the Substance Abuse Division serves a broader population, they work very closely with the other two divisions to provide specialized services to people living with HIV. All Special Health Resources services are available to HIV positive individuals in the 23 counties without regard to income. In addition, Wellspring services are available to any HIV positive substance user in the state. There is a strong interdisciplinary as well as cross-division focus and collaboration.

Special Health Resources serves approximately 900 HIV positive individuals on an annual basis and estimates that 20-25% are substance users. In the year 2000, 41% clients were Caucasian, 53% were African American, and 6% were Hispanic. Women represented 34% of the total population served. Among substance users, the primary drugs of choice were: 69% cocaine, 16% alcohol, 6% cannabis, and 78% poly-drug use. Approximately 59% of clients have a history of IV drug use.

The HIV Services Program provides medical care, dental care, medication, insurance assistance, massage therapy, professional individual and group counseling, housing and utility assistance, food vouchers, transportation assistance and case management services. These services, including dental care, are available at four separate clinics. Approximately 80% of clients have concurrent mental health issues, and most are medically compromised and in need of dental, nutritional and prescription medication services. Approximately half of clients tested positive for Hepatitis A, B or C, and a small number suffer from significant complications due to Hepatitis C.

Staffing of the *HIV Services Program* includes a physician, nurses, a certified acupuncturist, detoxification (acudetox) technicians, case managers, social workers, licensed chemical dependency counselors, and licensed professional counselors. To provide completely holistic care, the agency also has subcontracts with massage therapists, mental health providers, a psychologist, and alternative therapists. Because the service area is so vast, the agency maintains contracts with other agencies to ensure collaboration. They have an extensive informal network ranging from the Louisiana state line to Dallas, and from the Oklahoma border to the Arkansas border to cover their entire service area. Within this division, the HIV Early Intervention Program (HEI) provides intensive case management to HIV positive substance abusers. Specialized case managers work closely with clients to assess their healthcare needs and provide an informed and concerted effort to address the barriers of care for this population. Case managers conduct support groups and field trips. They see clients in the clinic facilities, but they

also travel to their homes and often provide transportation to care. Clients are seen as often as necessary to maximize recovery and adherence to care.

Case conferencing takes place on an informal basis every day, and formally once a week. Difficult situations are discussed, new information is shared, medical updates are given, policies and procedures are reviewed and changes are made, as necessary. These meetings often include staff from other programs in the agency. A representative from the medical clinic, the substance abuse program and all the case managers attend all case conferences.

The Substance Abuse Services Division provides outpatient substance abuse services and works closely with the other programs. One area of special focus is trauma counseling for people living with HIV.

Wellspring Recovery Center is a 60-day residential program for people with HIV and substance abuse issues. Wellspring staff is trained to treat clients who are triple-diagnosed with HIV, substance abuse and mental health problems. The center provides a well-rounded array of traditional and nontraditional health care. The Wellspring staff consists of one part-time physician who shares time with the *HIV Services Program,* nurses, a licensed professional counselor, a licensed chemical dependency counselor, substance abuse clinicians, a case manager, and cooks. *Wellspring* provides medical and psychological evaluations, medical care and substance abuse treatment, social stabilization, crisis intervention, and case management. Nurse monitoring of clients is provided 24 hours per day. The program offers an array of therapeutic options including traditional individual and group counseling, support groups, life skills groups, and skills necessary to manage addiction while following a prescribed medical regime. Additionally, some less traditional treatments are incorporated into their programs. Group and individual sessions of Acudetox (auricular acupuncture) and neuro-feedback are offered daily to clients. Other therapies include yoga, massage therapy and other bodywork techniques known to enhance the immune system and general health, wilderness experiences, equestrian therapy (horseback riding once a week), and additional outings which promote socialization and cooperation.

Throughout stays at the facility, there is careful discharge planning. The HEI team provides intensive case management and support services upon discharge. Follow-up assessments are done by Wellspring staff at 30 day, 60 day, and one year intervals following completion of the program. Many clients have formed such a strong sense of community while at Wellspring they choose to remain in East Texas and under the care of the *Substance Abuse Division* outpatient services.

In addition, all Special Health Resources outpatient case managers are trained to follow up on clients lost to care. At the time of intake, clients are asked to provide the name and phone number of someone who might know where they are if the agency cannot locate them. In addition, all case managers carry pagers and cell phones and can be reached at any time through a 1-800 number to facilitate communication with their clients and between providers.

Handout V – 8

Case Study: Project Bridge
Providence, RI

Project Bridge is an outreach and intensive case management program for HIV-positive ex-offenders operated by The Miriam Hospital in Providence, Rhode Island. Project Bridge provides clients with 18 months of services post-release, and has served approximately 130 HIV positive individuals over the past five years.

Similar to the prison population, the Project Bridge client population is 75% male and 25% female. Fifty-two percent of their clients are Black, 35% are White and 13% percent are Hispanic. These percentages are not reflective of the state population, but are indicative of the high incidence of HIV in populations of color. Almost all of Project Bridge clients have a substance abuse history, with 74% having used injection drugs and 73% of the injection drug users sharing syringes and equipment. Clients have long histories of incarceration, with an average four previous prison terms.

Project Bridge's service model consists of two intensive case management teams, each of which includes a licensed social worker and a paraprofessional case management assistant. The social workers coordinate the clinical aspects of care while the paraprofessionals coordinate support services and conduct community outreach to keep people engaged in care. Several infectious disease physicians, a psychiatrist, a clinical social worker, nurses and a psychologist from Miriam Hospital also work closely with the program clients and the Project Bridge intensive case management team. Project Bridge has a major focus on interdisciplinary care and referrals and service linkages.

The physicians who provide HIV medical services in prison refer their patients to Project Bridge. As the client prepares for prison release, the physician or correctional facilities nurse gives the client a brief introduction to the program and asks if he or she is interested in participating. Interested individuals then meet with a social worker several times for intake prior to prison release. At this time, these prospective clients provide the case manager with the names, addresses and telephone numbers of at least two individuals who will always know how to locate them once they are released from prison. During the intake process, the future needs of the clients are considered, such as housing, methadone treatment, a bed in a residential facility, and ADAP to ensure continuity of HIV-related medications. The case manager works to get many of these services in place prior to prison release. Case managers also ensure that a post-discharge medical appointment and Project Bridge appointment are scheduled. The first Project Bridge appointment is typically scheduled within 24 hours of prison release.

Although Project Bridge does not provide medical services or substance abuse treatment directly, case managers accompany clients to all medical appointments. The case management assistants accompany clients to all non-medical appointments, such as appointments to apply for housing or social security benefits. This accompaniment ensures that clients make and keep their appointments, and are able to keep in touch with a member of the team about the implications of these visits and next steps.

The case management team assists clients who express readiness to arrange for substance abuse treatment. In addition, both the case managers and the medical staff have formal training and practical experience in recognizing signs of substance abuse. Medical providers have a congenial relationship with clients and are non-judgmental, which facilitates discussions about substance use between providers and clients.

All employees of an outpatient clinic, Project Bridge staff, nurses and doctors are all part of the same structure, significantly facilitating medical care and cooperation. To ensure integration between medical and non-medical care, case managers attend a weekly meeting with medical staff that focuses on patient care. In addition to team meetings and meetings with the medical staff, there are quarterly case conferences for each client. At the quarterly case conferences, the key people providing services to a particular client from all involved agencies exchange information regarding the client's treatment, progress and goals. Clients attend these conferences and provide input.

At Project Bridge, the goal is to integrate clients into the community in 18 months. Before discharge from the program, Project Bridge staff contact other HIV case management providers in the community to arrange for client transfer.

Handout V-9

Community Linkages Assessment Guide

1. What does HIV and substance use look like in your community or county? What is the extent of the problem and whom does it primarily affect?

2. Who knows most about the HIV and substance use cases in your community? In what ways are you linked to them?

3. What are the needs of the HIV-infected substance users in your community?

4. Which providers in your community take care of HIV-infected substance users? Does your community have any government-funded health services? In what ways are you linked to these services?

5. Are there any other health and human services agencies in your area that attract or serve similar populations? In what ways are you linked to those agencies?

6. How do privacy and confidentiality concerns play out in your community? Do these concerns create barriers to service?

7. How does stigma play out in your community? How should you address it?

8. How do people access public assistance and drug assistance programs in your area? In what ways are you linked to these programs?

9. Is public transportation or transportation assistance available in your community? How do you coordinate these services?

10. What are the ways and in what settings do people in your community communicate? In what ways are you linked to these communication systems?

11. What kinds of public awareness efforts are happening in your community? In what ways are you linked to these efforts?

12. Who does the HIV and substance use education in your community, and where does this education take place? In what ways are you linked to these educational forums?

Handout V-10

Agency Linkages Evaluation Tool

Partner agency: _____ Today's date: _____

Person interviewed and job title: _____

1. How much do you know about services at (name of agency)?
   - ❑ Nothing
   - ❑ Very little
   - ❑ A little
   - ❑ Moderate amount
   - ❑ A lot

2. How satisfied are you with the services provided and the quality of your interaction with the staff at (name of agency)?
   - ❑ Not at all
   - ❑ A little
   - ❑ Moderately
   - ❑ Very
   - ❑ No relationship by choice

3. How often do you have contact with the staff at (name of agency)?
   - ❑ No contact
   - ❑ Several times a week
   - ❑ A few times a year
   - ❑ About once a month
   - ❑ About once a week
   - ❑ About once a day

4. About what percent of your clients *were referred from* (name of agency) last year?
   - ❑ 0%
   - ❑ 1-25%
   - ❑ 26-50%
   - ❑ 51-75%
   - ❑ 76-100%

5. About what percent of your agency's clients *were referred to* (name of agency) last year?
   - ❑ 0%
   - ❑ 1-25%
   - ❑ 26-50%
   - ❑ 51-75%
   - ❑ 76-100%

6. Please answer **Yes (Y)**, **No (N)** or **Don't Know (DK)** to the following statements:

The staff at (name of agency) is competent.	**Y**	**N**	**DK**
Clients value the services at (name of agency).	**Y**	**N**	**DK**
The staff at (name of agency) is sympathetic to our services.	**Y**	**N**	**DK**
I have a good working relationship with the staff at (name of agency).	**Y**	**N**	**DK**
I rarely have differences or disputes with the staff at (name of agency).	**Y**	**N**	**DK**
Clients like dealing with the staff at (name of agency).	**Y**	**N**	**DK**
The staff at (name of agency) is friendly.	**Y**	**N**	**DK**
The staff at (name of agency) is open to my suggestions about working with particular clients.	**Y**	**N**	**DK**

Thank you for your cooperation!

For Office Use Only:

Type of Agency: _____

Range of Services (please circle all that apply):

Medical care	Substance abuse treatment
Mental health services	Case management services
HIV prevention/education	HIV counseling and testing

Agency ZIP Code: _____

Public or Private?: _____

Handout V-11

Sample Confidentiality Agreement

Qualified Service Organization Agreement: Promoting Care Coordination Between HIV and Substance Abuse Treatment Facilities

[Enter the name of health care facility providing HIV care – "HIV Care Provider"] and [enter the name of the alcohol or other drug treatment facility – "Substance Abuse Treatment Facility"] hereby enter into a *qualified service organization agreement,* whereby the HIV Care Provider agrees to coordinate the treatment and/or related services being provided to patients through this program with those services provided by the Substance Abuse Treatment Facility.

Furthermore, the HIV Care Provider and Substance Abuse Treatment Facility:

(1) acknowledge that in receiving, storing, processing, or otherwise dealing with any information from this program about the patients in this program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and

(2) undertake to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 C.F.R. Part 2.

Executed this ____ day of _____, 200___.

Program Director
Name of HIV Care Provider
Address

Program Director
Name of Substance Abuse Facility
Address

Adapted from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, TIPS, 2002.

Session 7: Take Home Messages

Activity: Revisiting Assumptions and Success Factors

Purpose: To summarize the key highlights of the day

Time: 15 minutes

Materials

- Flipchart and colored marker
- Slide V-22, "General Success Factors for Teams"
- Slide V-23, "General Success Factors for Teams (continued)"
- Slide V-24, "Team Building Works"

Instructor Notes

1. If applicable, ask participants to pull out the "Assessment of Professional Identification" form that they completed in Session 2 and to review what they had written.

2. Guide the group through the following questions:
   - What new things did you learn today about the roles of other providers in your group?
   - What assumptions about the other providers in your group were reinforced today?

3. Review with the list of goals and expectations generated during either the introduction or the "Defining Interdisciplinary Care" activity. Discuss whether their expectations were met.

4. Show participants Slides V-22 through V-24, "General Success Factors for Teams." Highlight key points, and answer any questions.

Training of Trainers Teach Back Opportunity

Objective: Learning how to Wrap Up Key Messages

After completing steps 1-3, stop the group and explain that you are going to ask a few of them to teach back to the group. Ask two Teach Back Co-Facilitators to teach back step 1. A third Teach Back Facilitator can teach back step 2, and a fourth can teach back step 3.

General Success Factors for Teams

- Knowledge of expertise and role of other team members and how these interrelate
- Focus on needs of clients
- Recognition of and respect for specialized skills and contributions of each team member
- Shared charts and information regarding clients
- Trust is valued

Slide V - 22

General Success Factors for Teams

- Open communication and resolution of disagreements in a civilized manner (no hidden agendas)
- Work atmosphere is relaxed and supportive
- Collaboration and cooperation are cornerstones of success
- Commitment to common goals and to team members
- Coordination of services

Slide V - 23

Team Building Works

"Team building works. It helps team members to build upon their strengths and take better advantage of opportunities. It encourages members to strengthen their weaknesses and manage their problems together. In doing so it promotes better understanding between individuals – a critical factor in the success of any team!"

(Phillips, 1989, 1-2)

Slide V - 24

Session 7A: Definition of Interdisciplinary Care and Take Home Messages

Note: Session 7A should replace Session 7 if the facilitator has cut Session 3, "Key Components of Interdisciplinary Care" from the training. Session 7A should be used in replication Options 1, 3, and 4.

Activity: Revisiting Assumptions and Success Factors

Purpose:

- To provide a definition of interdisciplinary care
- To summarize the key highlights of the day

Time: 15 minutes

Materials

- Flipchart and colored marker
- Slide V-1, "Definition of Interdisciplinary Care"
- Slide V-22, "General Success Factors for Teams"
- Slide V-23, "General Success Factors for Teams (continued)"
- Slide V-24, "Team Building Works"

Instructor Notes

1. Present the definition of interdisciplinary care given in slide V-1.

2. If applicable, ask participants to pull out the "Assessment of Professional Identification" form that they completed in Session 2 and to review what they had written.

3. Guide the group through the following questions:
   - What new things did you learn today about the roles of other providers in your group?
   - What assumptions about the other providers in your group were reinforced today?

4. Review with the group the list of goals and expectations generated in the introduction. Discuss whether their expectations were met.

5. Show participants Slides V-22 through V-24, "General Success Factors for Teams." Highlight key points, and answer any questions.

Definition of Interdisciplinary Care

An interdisciplinary team works together with the client in planning care for the client from their discipline-specific perspectives. Through shared staff conferencing and by consulting with each other, the interdisciplinary team and the client gain new insights for addressing problems and have the opportunity to produce a holistic plan of care for the client.

Slide V - 1

General Success Factors for Teams

- Knowledge of expertise and role of other team members and how these interrelate
- Focus on needs of clients
- Recognition of and respect for specialized skills and contributions of each team member
- Shared charts and information regarding clients
- Trust is valued

Slide V - 22

General Success Factors for Teams

- Open communication and resolution of disagreements in a civilized manner (no hidden agendas)
- Work atmosphere is relaxed and supportive
- Collaboration and cooperation are cornerstones of success
- Commitment to common goals and to team members
- Coordination of services

Slide V - 23

Team Building Works

"Team building works. It helps team members to build upon their strengths and take better advantage of opportunities. It encourages members to strengthen their weaknesses and manage their problems together. In doing so it promotes better understanding between individuals – a critical factor in the success of any team!"

(Phillips, 1989, 1-2)

Slide V - 24

Options for Replication Trainings

Option 1 (90 minutes)

A. Session 1A (35 minutes)
   - Solicit and discuss goals and expectations

B. Session 4, Activity 2: "Cross-Discipline Awareness" (45 minutes)
   - Use shorter version of case study

C. Session 7A, "Definition of Interdisciplinary Care and Take Home Messages" (10 minutes)

Option 2 (120 minutes)

A. Session 1A (35 minutes)
B. Session 2, "Professional Identification" (10 minutes)
C. Session 3, "Key Components of Interdisciplinary Care" (20 minutes)
D. Session 4, Activity 2: "Cross-Discipline Awareness" (45 minutes)
   - Use shorter version of case study

E. Session 7, "Take Home Messages" (10 minutes)

Option 3 (180 minutes, includes break)

A. Session 1A (35 minutes)
   - Solicit and discuss goals and expectations

B. Session 4, Activity 1, "Team Member Professional Identification" (45 minutes)
   - Use either version of case study

C. Break (15 minutes)

D. Session 4, Activity 2: "Cross-Discipline Awareness" (40 minutes)
   - Use same version of case study as in "Team Member Professional Identification"

E. Session 5, "Team Communication" (35 minutes)
F. Session 7A, "Definition of Interdisciplinary Care and Take Home Messages" (10 minutes)

Option 4 (240 minutes in four 60 minute trainings)

Part 1

A. Session 1, "Icebreaker/Introductions" (45 minutes)
   - Solicit and discuss goals and expectations
B. Session 2, "Profession Identification" (10 minutes)
C. What's Next? (5 minutes)
   - Facilitators provide a hand-out with the dates of Parts 1-4 and what will be covered

Part 2

D. Session 1, "Icebreaker/Introductions" (10 minutes)
   - Facilitators seat participants at interdisciplinary tables as they enter
E. Session 4, Activity 1, "Team Member Professional Identification" (50 minutes)
   - Use longer version of case study

Part 3

F. Session 1, "Icebreaker/Introductions" (10 minutes)
   - Facilitators seat participants at interdisciplinary tables as they enter
G. Session 4, Activity 2, "Cross-Discipline Awareness" (45 minutes)
   - Use longer version of case study, same as in "Team Member Professional Identification"
H. What's Next? (5 minutes)

Part 4

I. Session 1, "Icebreaker/Introductions" (10 minutes)
   - Facilitators seat participants at interdisciplinary tables as they enter
J. Session 5, "Team Communication" (35 minutes)
K. Session 7A, "Definition of Interdisciplinary Care and Take Home Messages" (15 minutes)

Note: Option 4 assumes the same audience from one training to the next. Session 1, "Icebreaker/Introductions" is repeated in Trainings 2-4 to allow participants who missed the first training to add their names to the HIV/SU timeline (which should be posted at each training session).

Option 5 (285 minutes, includes break)

A. Session 1, "Icebreaker/Introductions (45 minutes)
A. Session 2, "Professional Identification" (10 minutes)
B. Session 3, "Key Components of Interdisciplinary Care" (20 minutes)
C. Session 4, Activity 1, "Team Member Professional Identification" (45 minutes)
   - Use longer version of the case study
D. Break (30 minutes)
E. Session 4, Activity 2, "Cross-Discipline Awareness" (40 minutes)
F. Session 5, "Team Communication" (35 minutes)
G. Session 6, "Models of Care" (45 minutes)
H. Session 7, "Take-Home Messages" (15 minutes)