

FINISHED FILE
MAI-COC VIRTUAL MEETING
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BREAKOUT SESSION 2: BUILDING HIGH PERFORMING
MULTI-DISCIPLINARY TEAMS

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>> PAM PIETRUSZEWSKI: The teams are comprised of a lot of different types of people and types of roles. And this is just three snapshots of what a high performing team might look like toward the idea of HIV prevention and intervention and engagement. Certainly there is lots of varieties. As you are looking at this slide I would love to hear if you want to type in to the chat box what would you say are the key roles on your core team when it comes to this work around HIV, minority AIDS initiative. You know, I put together some examples of what it could look like. Think of what it is in the center there. Do you refer to the person coming in as a client, as a patient, as a consumer. A lot of different ways that we identify that person coming in for services. Some teams have a pharmacist as a core member of a team. Others employ peer specialists or community health workers. I have seen some really strong teams say, you know, our receptionist is a vital part of our work because they are the person that greets that client as they are coming in. So we really see them as a key team member. So lots of different versions of what a team could look like. So as I go through some of the next slides would love to see and hear and

you want to type in to the chat box who would you say is on your core team.

So what I am going to focus on today we are going to play a little game of Connect 4. I'm going to connect what I think are four key characteristics and this comes from a document that I provided the link at the bottom. There is actually more than four in this particular document. And four at a time so that we can focus. I chose these four to really spend the time for the rest of the session today.

So first practice based learning and QI. What this is reminding us of is that it is a process of developing a team that is going to be high functioning. And that we have to start with a vision and then we move forward goals and setting small tests of change but also the vision isn't forming the sustainability. That you think of Oceans 11, what were they trying to accomplish. And this vision sets the stage for choosing the right people and certainly those early tests come long before we develop any policies and procedures ideally. Ideally we can articulate what the goals are, do some small tests of change before we implement any policies and practices.

So a little bit more about setting the vision. It is very critical especially when we are in such a dynamic change in health care. Are we clear on what our vision is and are the team members and the staff clear as well and not just clear but are they engaged in that same vision. Are they working in that same vision. Is it being reflected in what they do every day. Does it resonate with them. And then as I mentioned before really making sure that we also work backwards so that we set forth a vision and we start in on some goals. Are they going to lead us towards the end goal which is sustainability.

Some things to think about when it comes to defining team goals, some people like to think about a dashboard. I love the idea of things that are measurable but I always add what you see in the first bullet here which is that it also needs to be meaningful. Different people need to know different things. So what is it that leadership needs out of measurement and how does that play out to the staff members that are carrying out those actions. What would be meaningful to your peer specialists when it comes to measuring their process or measuring their outcomes. That might be very different than what is meaningful to a pharmacist. It might be different than what is meaningful to a patient or to leadership. So to be thinking about how any of these particular measures around goals relate to the broader process and then to be testing those and I can't emphasize enough how useful it is to do some small tests of change. We can't go from starting to running. We have to do something in between. Try a new team process for a week and then come back and talk about it. And then tweak it and try it and for a second iteration. Make sure to put your phone on mute until we ask for questions but certainly can enter text in the chat box at any time.

So one thing to think about this comes from -- if you are familiar with the model for improvement from Langley and Nolan these are some questions to

ask. What are we trying to accomplish. Why are we all here together. It would be interesting to ask your team members there. You may find some different variations on the answer. Another way of doing team building is having what people talk about what they see as the goal. Secondly how will we know that any change we are implementing is leading to an improvement and then what changes can we make to result in that. So how will we know is a nice way to keep the team members accountable by asking how are we going to know that if we do that it is going to make a difference. So this is how we set ourselves up for measurement and there is a lot more I could say about measurement, but in the essence of time I keep it simple to give you some things to think about. So, of course, when this project in particular there is a real focus and vision around engagement and retention. And so we are thinking about how substance use disorders play in to that. Certainly about how HIV care plays in to that. Screening, referral, mental health conditions or concerns all contribute to this engagement. And it is a perfect run why we are looking to have multi-disciplinary teams that can address those different areas.

And someone is advancing the slides. So you may not realize others are seeing it. Thank you. All right. Next slide, so that was the first piece. So it was a bit about quality improvement, planning for your multi-disciplinary team. The second element is care planning and coordination. And this is where we are thinking about okay, we've outlined our goal. Now who is going to be receiving these services. What are the services we can offer now that we have loosely at least identified different team members and what's going to be the intensity or the need there. And this is where we are linking those different services together. We are creating ideally some integrated care plans and doing some warm handoffs. And the last bullet on this slide I think is most important and really hard to do. So it takes some effort and it is worth the effort. It is how do we as a team prioritize the treatment goals. Who decides what's going to be the main goal. Who is going to decide what the secondary goal is. You know, think of how that can play out, that you may have a staff person that is an expert in addictions and they are going to be obviously very good and very tuned in to wanting to address and work towards harm reduction or getting that person in to specialized treatment for that addiction.

Another team member might be really tuned in to this person's medication regimen and wanting to help them think through, you know, are they taking the meds at the right dose. So everyone is naturally coming in with different priorities because of their areas of expertise and let's not forget the client or patient may have priorities as well. So being able to negotiate and discuss what the various treatment goals are so that we are truly prioritizing them based on the best need of the patient. And just a reminder to put your phone on mute. We are hearing a little background noise again.

All right. I have a couple more slides and then I would like to pause and see what questions are arising or certainly comments, too. I would love to hear more about the work you are all doing. So this one, if it is small on your screen I apologize, should be able to make it bigger with one of those functions at the top right. If you haven't seen it before this is the four quadrant model that gives you a way of thinking about integration. And if you are thinking now about HIV care, medical care, mental health care, substance use, we are thinking about how to right size the care based on the needs and complexities of that particular patient. So the bottom left is -- just a reminder, we are still hearing some background noise. Someone just said we are muted but you are not.

(Laughter).

>> PAM PIETRUSZEWSKI: Thank you. Got to love technology. It is fun, isn't it? Thanks. I appreciate it. So the bottom left is quadrant 1 which is probably the least complex of the four. I was going to say simple but we know that nobody comes in really with anything simple. We are all very complex human beings. But that first quadrant on the bottom left we may have someone who -- their physical health status may be very stable or they are in a very healthy place, medications are going well. Whatever physical treatments are making good progress. Similarly their behavioral health status is also in a very healthy place. They are at relatively low risk. That kind of person can probably be managed by just one or two team members. This model shows that it could be a primary care physician or provider of some type or a behavioral health based on a primary care office. Behavioral health person. And you can see the advancement through the different quadrants and how the opposite of that would be the top right where we may need to pull in more team members and we may need to stop and think what team members do we need. What gaps do we have in care for someone who has a high risk status or a physical or behavioral health. And this is one way of thinking about what is our general population. Do we tend to see a lot of people in quadrant 2 and a few in quadrant 4. Are all of our patients in quadrant 4. Do we have a pretty big mix of these? And it is another way of thinking about who you need on your team and what would be the best way to provide services.

One more slide I want to share with you and then I have a polling question and then want to see if you have questions. This is what we call standard framework for integration and it is another way of looking at integrated services. We have got in blue in the middle there are different levels associated with integrations status. So on the far left we may have -- you may be an organization that collaborates a little bit with other services or other health care providers but they are in separate facilities. And it is more of an as-needed basis and it may be more of a referral relationship. Moving towards the middle there of level 3 or 4, perhaps you are collocated. You are in the same office. And you have got a medical provider down the

hall and social worker and there is some collaboration more than in those earlier levels, same space, same facility. You are physically closer which makes it a little easier to collaborate. And then on the far right is a more fully integrated practice where there is shared care plans and negotiated priorities for patients and it is truly a transformed practice.

Now one note about this that I would like to share is one of the people that created this framework I was speaking with recently and she said it is really important to think about not just advancing in the levels but before you advance to the next level or feel you have hit the next level, being as masterful as you can in the existing level. So what that means is that if someone feels that they are at a level 5, but it is -- they are just starting it or it is not a very well done level 5, being a good level 4 is wonderful. So it is not just about moving up the ranks so to speak but being really good and mastering the level that you are at. So there are different tools that can help you assess this level in much more detail but I wanted to give you a snapshot of that because as I am sure you are looking at this you probably have a little self-dialogue about I think we are probably a 2 or a 3. Maybe we are a 4. Maybe we are a 3 because we are a pretty good 3. I want to invite you to respond to the poll question about what level you feel that you are at just to get a sense of the audience. Majority of people are in one bucket or another. So Rose, I will turn it to you to initiate the poll question.

>> Rose: Pam, at this time your poll questions aren't loaded yet. So we can get back to this one.

>> PAM PIETRUSZEWSKI: Okay. I only had one. Not a problem. Now you can ask some questions. Particularly related to these first two elements of multi-disciplinary high functioning teams? Rose, you don't see more than what my screen looks like?

>> Rose: Yes.

>> PAM PIETRUSZEWSKI: Let's keep moving. Welcome questions throughout and I would say, too, about these levels of care, another way to look at them in relation to this project is, you know, you could sit down with this as a team and say, you know, what does it take for us to be at a level 2 when it comes to HIV testing and having good processes for that. Or we think we are at a level 1. What would it take to move to level 2 on the goal of helping our clients be aware of their HIV status. I was looking back at the goals of this collaborative and you could really align those goals with and turn those in to questions when it comes to assessing your level.

Move on to No. 3, collaboration and teamwork. This is a section that's about clarifying those roles and tasks, determining how we can do handoffs or huddles, leading to that fourth element which will be interpersonal communication. Clear role expectations are super critical and we know that roles or changes or tasks certainly can change a lot. So revisiting what people are establishing or expecting from their own roles is really, really an important piece here. Looking at my first bullet I think it is missing some

words. The more -- the clearer the roles must be. Truly the case. Again I will go back to the Oceans 12 analogy if you think about what everyone's tasks were, they are very clear why they were recruited in to the group and why they are working on that particular team. Also people had to be prepared to back up other people. Are there certain roles that only one person can fulfill and are there tasks that need to be filled by more than one person. All of the tasks necessary to complete a particular goal. There are some clear goals. Linking people to medical care, adherence. So I put some things on the left-hand side.

Screening for substance use, providing med REC, using motivational interviewing and other tasks. Along the top then is the opportunity to have your staff fill this out and have them identify is this my role as a member of this team. Do I think it is my role to do the screening.

If it is not my role -- oh, someone is forwarding the slides. Please know that when you are touching those buttons it forwards it for everyone.

Almost there. Okay. So the middle section there is whose role is it. So if it isn't your role whose role do you think it is or could it be. Because the far right column is saying that perhaps it could be the receptionist role if they had more training and proper support. Maybe there are certain things here that only a prescriber could do. Maybe there are things that someone thinks it is their role but it really isn't. I have often had people use this worksheet and there will be some gaps. So someone will think it is one person's role. Someone else will think it is another person's role and it turns out that nobody is actually doing that particular task. So again this is a very simplified version of this but it is a very useful way to talk as a team and figure out who is doing what and who could be doing what and what people's expectations are.

Some success strategies in particular, and these are some things I have been hearing and seeing in my time of doing collaborative care and facilitation. The first top left there is a cross-training. So knowing what tasks need to have more than one person trained in. Certainly may not be all of them. But there may be some. So knowing which ones those are, and in the middle right there about creating redundancy is a related item. There are some things that we know we need to have more than one person looking at or asking about or doing. Perhaps in relation to this work it is discussing treatment barriers. Maybe that's something that a physician brings up and it is something that a nurse or a peer support specialist follows up on.

So knowing what are the things that we do want to see redundancy in and then, of course, eliminating unnecessary redundancy where we don't need it. Knowing we need to periodically revise because work changes and that is -- health care changes. And then just a reminder to put your phone on mute if you just joined us. Hearing a little bit of conversation. Thanks.

I will mention bottom left corner because that says planning meeting

versus work meetings. So know the intent of when we are bringing people together, when we are taking them out of patient care for a day, for a half day for a meeting like this. What is expected. Is this an opportunity to do some planning. Is this an opportunity to do some actual hands-on work. Are we reviewing a case. Are we planning for how we are going to review cases, and having it be real clear helps people be the most efficient in the time.

I mention, too, at the bottom about creating contingency plans. There are certain days where clinic flow just doesn't go the way we intended and sometimes we have to ditch our plans and everyone has to roll up their sleeves and make it through the day because we were swamped or someone called in sick or a crisis came up. So having plan B and having a backup plan where we need it really will help with the team as well.

So the fourth one in this list here is about interpersonal communication. Personally love this picture because it makes me think of how communication weaves in and out, can create something rather beautiful or it can create something really messy depending on your perspective. But what we are looking to do in multi-disciplinary teams is create an environment of trust. And we know that trust doesn't just happen. So how do we encourage it. How do we allow for mistrust to be aired so that we can get to a place of trust with each other. When people are working, coming from different disciplines they come with very different perspectives, different language, different acronyms. And we have to break down those silos and allow a little space, a little time to figure out what is needed in order to trust that other person. I have seen it play out a lot and I have seen this look beautiful when it can be done well. I have seen some physicians that literally roll up their sleeves and sit down next to their medical assistant and say help me understand the work you do. I would like to know what you do when you sit down with one of our clients and you talk with them about the results of a screening test. So that kind of messaging and demonstration are saying I am going to trust you and then learning what the other person does also helps to enhance that trust. So clearly we have got to be pretty flexible when it comes to making decisions as a team and as individuals within a team. And knowing what that is and really as it says here relevance and appropriateness is how we will know which way a decision-making process is going to play out. So Rose, I have seen that we have our poll loaded. Should I pause now and we allow people to take that?

>> Rose: Yes, I will go ahead and launch that for everyone to put their responses.

>> PAM PIETRUSZEWSKI: I don't mind giving a few extra moments because I know this can take some thinking through and talking as a team to say well, roughly where do we think we fall. So go ahead and take a minute, talk as a team and we'll give you one more minute.

So Rose, is the poll still open?

>> Rose: I have closed it. It looks like no one else is submitting their responses.

>> PAM PIETRUSZEWSKI: Got it. Okay. So we have got roughly the majority are at about a 4. So that's wonderful. And we have got some people at 3 and 5 and -- even someone at 6. Very few 6s out there in the world. So if you are a 16, we would love to hear from you. That's helpful to know that everyone is doing some elements of collaboration. And I'm guessing you wouldn't be here if you weren't. This is something I think you have been working towards at least with this initiative, if not with other things. So great, thank you.

All right. One last slide I want to mention and then I will pause again and see if we have any questions or comments. There is an outer ring. Thinking about what makes sense for you and if you design and articulate who is on the team. So when I talk about teams choosing their decision-making process that's another piece that's really critical, right? So if we are going to do something by majority vote, is it clear who gets to vote. If certain things are decided because there is nobody deciding in the group, that's a very different way in which we make decisions. So this might be another thing to add to that worksheet if you are thinking of using it as a what way do you think is the way we make decisions most of the time. And to see if there is a good understanding of how that works and it tells leadership if there isn't, that it is something to talk about.

Let me pause again. I certainly want to not just have it be me talking to but talking with others and sharing. Are there any questions, comments, feel free to unmute your phone or type in the chat box. Everyone has this little feature along the top, they can check if they disagree or agree. They want me to slow down, speed up. Is everyone able to play with that if they want to?

>> No, the icon that Pam is referring to is at the top where it says meeting. If you move down you will see a sound icon, a phone icon, a webcam icon and then that very last icon is where you would hit and see options to submit your overall responses for this breakout session. Click that dropdown and you will see a few options there.

>> PAM PIETRUSZEWSKI: Great. Yeah, I -- that's a fun one. I haven't seen that in a lot of these slide sets or these webinar features. So feel free to play with that as well. Okay. I'm going to carry on with a few more slides and now is the bonus round. I am excited to share this with you. It is not part of that document or those four components that I shared with you but it is something I have learned and I found it to be really transferrable information. It is the idea of what is called technical versus adaptive change. And this comes from Ron Hyfeds. Want to give credit where credit is due. It is the idea that there are different types of change and we need to attend to them differently by recognizing the type of change they are. So a problem in need of change that is very well defined would be

more likely a technical change versus on the right there something that is very complex is more -- is requiring more adaptive change.

Just to carry through on this list, so something where the answer is out there. We just have to find it because we know it is within the structure or it is within the plan. I just got to look it up or I need to ask the right person. It is technical versus the answer is not so straight forward and it is more about addressing deeply held beliefs and values and thinking about loss. And it is a really interesting thing that Dr. Hyfeds have come up with that change inherently involves some loss and those that are behavioral health, behavioral health providers on the phone we know this. We know this from our studies. So if something is adaptive, going to require adaptive change we need to recognize the loss. It is where something that is much more organic in the work that we are doing and we need to help it grow and process. Oh, cool. Someone is pointing with the arrow. Thanks. I like that.

On the left side the opposite there is where it is very clear. We just need the time to get there. And we can fix the problem because it is a technical one. We tend to treat a lot of challenges as technical challenges when there is usually much more adaptive work to be done. So let me share on the next slide what I mean by this. So in yellow here is identifying some technical challenges or some technical solutions actually. It is not the challenges. Elements such as implementing an EHR. Having the right tools in front of you. If you are screening for substance use do you have a screening tool that you can use. That is a technical challenge that only needs a technical change. So it is just a matter of researching good screening tools and identifying the best one for our clinic and for our population. Where we are often forgetting bigger in red there, underlying foundation of change which is the adaptive changes. So it is things like leadership supporting clinical champions. We will ask people go to this training or attend this meeting or we are going to start implementing this and I would like you to lead it. And what is the support for that person to be that clinical champion. Getting staff engaged in any difficult challenging work involves -- involves thinking about what are their beliefs and values.

So when we bring a team together, a multi-disciplinary team, is this impacting in any negative upon their values or beliefs in how they work and that's also where loss really comes in. I worked a lot with primary care physicians in the past and a lot of primary care physicians are very smart, very independent thinkers in traditional medicine per se allowed for that and really encouraged that because we weren't doing team-based care the way we are now. We needed physicians that could think on their own and make quick decisions. And there are certainly things with other professions, too, that create some loss. So having to either slow down the way we work because we are used to a busier environment or we have to work faster because we have to see more patients every day. Whatever those things are that are impacting your environment there is some room to know that

there is some loss and some perhaps challenges to our beliefs and values. So knowing that and spending time on that is really important.

Allows staff to work up to their potential having people work at the top of their license so to speak. Really maximizing what people are trained to do and having them do that work and then shared vision and accountability. So this is a model that says there are things that are technical and things that are adaptive and we have got to spend the right amount of time on each and not assuming that a technical solution will resolve all of the adaptive challenges.

A few more things to think about. What this quote is saying here teams with greater occupational diversity reported higher overall effectiveness. And that the innovations introduced by these teams were more radical and will more impact both on the organization and on patient care. So if we allow, if we make the room for and we encourage more occupational diversity where it might have been previously thought that that would create more chaos or be more challenging for delivering good care. We are learning more and more that that's actually a good thing and it is having some positive impact on health care. Now, of course, it has to be designed, and we have to pay good attention to all of those core components that I described earlier but there could be some positive that comes from that.

This is another thing that is related. It is a study that was done in 2010 about adaptive reserve. Think about the adaptive reserve of your organization and it comes from those things in the bullets there is their shared vision. Is everyone able to shift the way they think about it and understand their role in an ever changing environment. Needing to be flexible. Needing to support the overall vision and are we able to think about different mental models. So am I as a social worker able to at least for a little while understand the world that a nurse practitioner is coming from enough to appreciate what they are bringing to this multi-disciplinary team and vice versa. The peer health worker, are they able to think through how they fit in to the team and how their role plays a key piece of making the success happen. Everyone to adapt different mental models as needed. The quote in blue, transformation occurs not at a steady space but it fits and starts. Things may be smooth for awhile and they get bumpy and hopefully they smooth out again.

Another way of thinking about this is another philosophy or another model for change which is called Theory U and it comes from this U-shaped curve. So if we take a problem and we try to quickly identify a solution and it turns out it is more than just a technical problem. It is actually an adaptive problem. We are really shortcutting the process and probably not getting to the most sustainable solution. So what Theory U says we have got to allow the time for the team to focus, figure out what is it that we are working on doing here. Sometimes the focus is clear from the start and sometimes it takes a while to get in to focus. And we need to allow the time

to both broaden and deepen the perspectives, problem and the issue and in this downward slope of the U is often where people get frustrated or a little freaked out or jump ship or just aren't sure that this is going to fit. But if they stay with it, they start to get on the upward side of the U and if we allow for that broadening and deepening what can come from that based on Otto Scharmer's research at MIT is new ways of thinking, creativity and new structures that we never could have envisioned if we had shortcutted this and gone for problem to quick solution.

So it is a way of thinking about this work and thinking about where we are in the process of this U, in this project in particular. Have we started to determine some new creative processes. Are we still trying to focus. Maybe we are still in that focus stage and we need to know that that's where we are at. A few notes on team care and persistence because I think that last slide is all about persistence?

>> Rose: This is Rose. Before you move to this slide I had a question come in that I wanted to ask regarding your previous slide. You mentioned creating redundancy as a success strategy. How do you balance creating redundancy without having stay feeling like they are wasting time doing services?

>> PAM PIETRUSZEWSKI: That's a good one. I think the latter part of that is the key. What is staff's understanding of the reason for the duplicity and something that is leadership's perspective that we need to do that more than once and what does that look like versus a staff person saying, you know, we really don't need to do that more than once and here is why. So it comes back to the shared goals and the same vision. It relates to this slide that I have up. So I think having those conversations is the broadening and deepening phase that could be messy and yucky. This U, another way I have seen it is more of a wiggly line where it isn't just this smooth line up and smooth wave up. So if we have got some things that we are duplicating, are we spending the time having the discussion in these broadening and deepening phases to understand everyone's perspective. I might not realize how it fits in to the next person's work. So am I asking the question, gosh why am I doing this when the person before me already did it. Or you know someone else needs to check this. This seems to be a necessary check and balance opportunity because we have had some mistakes before. So how do we in my world I see that we need a redundancy. So it is really an opportunity for a conversation to say do we need this. Who thinks we do, why do you think we do. And knowing more than just your part of the work flow. It is a great question. And spending that time in the messy phase to understand it. Thanks for the question. I would love to hear more if there are some.

I will just say at this slide about persistence, that, boy, that's an example of how do we be persistent on that, right? So how do we figure out and think about how teams are inevitably emotionally laid in. We need to give

them constant attention. We need to revisit questions like that. If we set up a process where there is going to be a redundancy here and someone comes in and asks us why ponder that question. If you have any new team members they are your best asset right now because they are seeing everything with fresh eyes which is another QI phrase if you are familiar. Those fresh eyes this is someone who is coming in who isn't so engrained in the process that they aren't maybe any longer questioning things. If a new person comes up and says why do we do that, great opportunity to revisit and say why do we think about that. If there isn't a good reason because it is the way we have always done it, opportunity to do some changing, right?

The last thing I will say about this and then we'll see if there is last questions before we have you move in to the other meeting room is to hire -- the third bullet there, hire team members, not positions. And my interpretation of this is, you know, positions change and health care is changing so much. So we are really looking for hiring the right people. We can train them on positions. Of course, there is licensure and there is all those things. But hiring people for a set type of work and hiring the right people that could be trained to expand on that and to grow. I mentioned earlier receptionist. Receptionist is the key person. That's the person that I first see when I walk in and I'm awaiting my test results from my HIV test. How are they responding to me? Did we hire the right person for that job. Might they with good training and support be able to do some patient care beyond just saying great, you are checked in now. A lot of opportunity to really enhance people's work if we hire the right team members.

So that is what I have for slides. I put my contact info up there as well as some other folks in the SAMHSA-HRSA website. If there are any other questions I welcome hearing them or seeing them in the chat box. So I see a general comment. Thanks Nicole. I think hiring is a successive part. Isn't that true. I just lived that not long ago where we couldn't hire until we knew we got the right grant. We wanted to hire the right people. We did some outreach and told people we hope you think about taking this but we can't right now. We have come a long way with -- way to anticipate how people will perform in the work world. But certainly love to hear if other people have comments on that. Hiring is tough and hiring the right person, especially in the world of such demanding health care and, you know, some schools of thought is that in health care we have to hire people that are willing to be flexible and nimble and deal with uncertainty. Someone that's able to embrace ambiguity. Not easy but that's probably the kind of person we are looking for when it comes to health care these days.

>> There is one question coming in from Ruth Ann. If you want to open your phone line you can do that as well.

>> PAM PIETRUSZEWSKI: Ruth Ann, can't hire admin help on federal grants. Another person saying the grant world is tough. Not enough funding and people are doing multiple jobs. Setting up for the project work

in a grant and allocating ahead of time and anticipating what you are going to need, that's not easy, is it? That's something I could bring back to Rose, we could bring that back, that might be a good target topic for the future. How to plan your staff and your team when you are doing grant planning. I know we are getting a message that we need to return to the main room. Thanks for those who did submit those comments. Those are good. And I hope this was helpful to you and look forward to working with you again and good luck on the rest of the meeting.

>> Thank you, Pam. And just a reminder to everyone, Pam's slides will be available on the MAI-CoC on this webinar under the virtual meeting tab. You will be able to get these slides if you did not get a chance to download them as a file on the right-hand side of your screen. Thanks, everyone.

>> JAKE BOWLING: Welcome back. We hope they are helpful with the integration efforts. So to close out today we are going to use a continuous quality improvement method called stop, start, continue. And this is a way to really think through how you are going to use the information that you have learned today to enhance your integration efforts. So I want you all to think about after this virtual meeting and given what you have learned today, what is one thing that you plan to stop doing, what is one thing that you plan to start doing and what is one thing that you plan to continue doing given the information that you have learned today.

So at this time if you would like to share your reflection on stop, start, continue you can either type it in to the chat box and I'll be glad to read it out loud to the group or you can raise your hand so we can unmute your line and you can share it with us verbally. So who would like to get us started? Who is going to be our brave first report out person?

>> Point to the GPO. Volunteer.

>> JAKE BOWLING: And also feel free if you are not prepared to share all three stop, start, continue to select one based on what you have learned today, one thing that you would like to start doing or one thing that you are going to stop doing. You don't have to necessarily do all three.

>> To be honest, we are asking each grantee to share something. We want to make so you can all kind of learn from each other. So it would be really helpful for everyone regardless of your physician or where you are at to share your stop, start or continue.

>> JAKE BOWLING: It looks like we have multiple attendees who are typing. We look forward to hearing the information. So we have Patricia and she says that we are going to develop and implement cross-training. In addition from yesterday we are going to institute a wellness report card for clients to review with clinicians. I would imagine you were in Aaron's breakout session.

This is being provided in rough-draft format. Communication Access

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