CareForum 2022

The WellSky® Conference

Reformulating the IDT to increase morale and reduce risk

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Today's speaker

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Disclosures

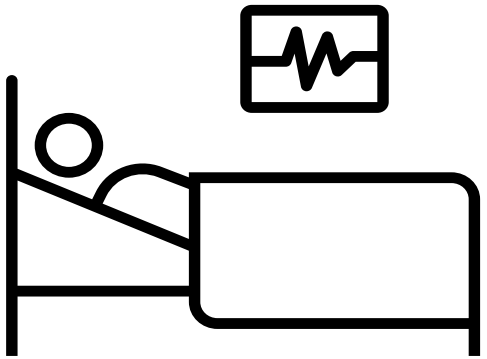
- I have no financial or ethical disclosures other than being supported by WellSky to make this presentation
- I disclose that I am impatient with inefficiency and being disrespectful towards patients, families, and teammates
- I also disclose that IDT has been one of the most potentially fruitful, but often wasted opportunities in my 29-year experience in the hospice industry
- I disclose that I assume you already know the regulations, such as timing, associated with IDT – MOST of these are not covered in this talk
- Finally, I disclose that I believe in checklists – as PROMPTS – to ensure effective care and reporting

Audience survey: Who is in the room?

- Patient or family member
- Hospice aide
- Nurse case manager/other nurse
- Hands on caregiver affiliated with home health, sitter services
- Social worker, counselor, psychologist
- Pharmacist
- Team physician/medical director/other physician
- Chaplain
- Bereavement professional
- Volunteer coordinator/volunteer
- Owner/Administrator of hospice, home health, hospital

IDT purpose and associated regulations

IDT purpose and opportunities



To create a forum for INTERdisciplinary collaboration to ensure the patient and family receive the benefit of our collective wisdom, knowledge, and experience in designing a Plan of Care (POC) to meet their goals

To enable each other to feel useful and valued, part of something larger than ourselves, in the service of our patients

To learn from each other so that we can provide effective TRANSdisciplinary care when called on to do so

CFR **418.56 refers to "Group", BUT…**

CFR 418.56 requires COLLABORATION among patients, their family caregiver, attending physician, and hospice TEAM members, including at least physician, nurse, spiritual/counselors and psychosocial experts.

What is the difference between TEAM and GROUP? (Cambridge on line dictionary)

TEAM: a number of people who ACT TOGETHER IN ORDER TO ACHIEVE SOMETHING

GROUP: a number of people or things that together are considered as a unit

CFR **418.56**

- The TEAM is called on to:
  - Agree on **individualized GOALS specific to each patient and family** for the remainder of the patient's life
  - Develop strategies and plans to accomplish them
  - Identify causes of distress for the patient and family
  - Create and execute plans for their resolution

Together, this is called the **Plan of Care** (POC)

Managing the Plan of Care

- The POC is often multifaceted, requiring stepwise management, and thus needs to be revisited and updated regularly
- The POC must include documentation about education that will be/has been provided to the patient/family regarding
  - The nature of hospice services, hospice philosophy, forgoing standard Medicare Benefits
  - The expected trajectory of illness
  - Ways to enhance comfort when the team is not present
  - How to enable the achievement of the patient's and family caregiver's goals
  - The futility of resuscitation attempts and the outcome if they are attempted
  - Recognizing, understanding and being prepared for the dying process
- **Failure to follow the POC is one of the top reasons for citations of hospices, resulting in repayment of earned income**

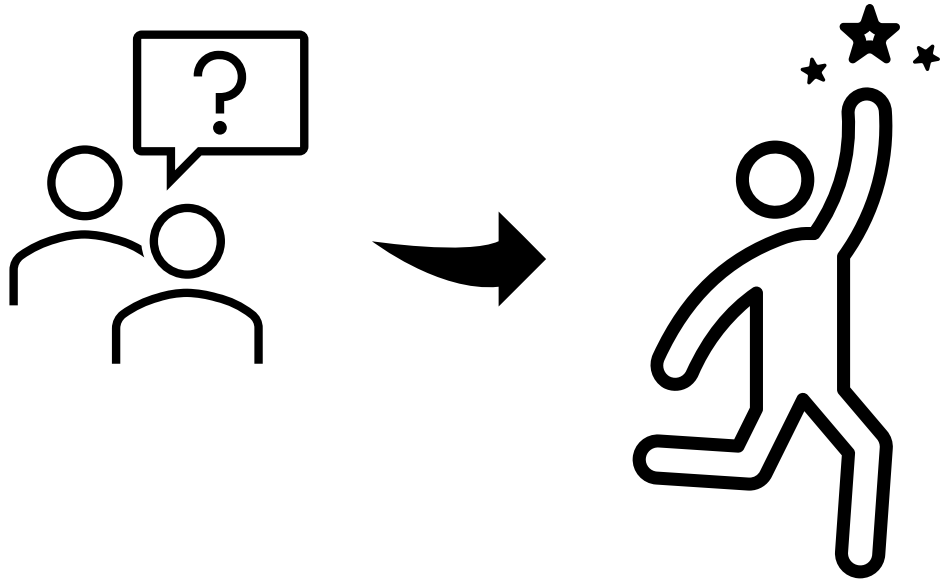
IDT meetings are not required.

Collaboration in creating and accomplishing the ever-evolving POC **is** required.

How do we know the patient’s/family's **goals** and **concerns**?

Soliciting patient and family goals

- What do you want to do with the rest of your life?
- What is your greatest concern at this time?
- What is important to you now?
- How can we help you best?
- What do you hope for?
- What are you afraid of?
- Have you known other people who have died?
  - What was it like for them?
  - How do you envision your path to be the same or different than that?
- Ideally, where would you be in your final moments?



SMART Goals

- Specific
- Measurable
- Achievable
- Realistic

(Results-focused)

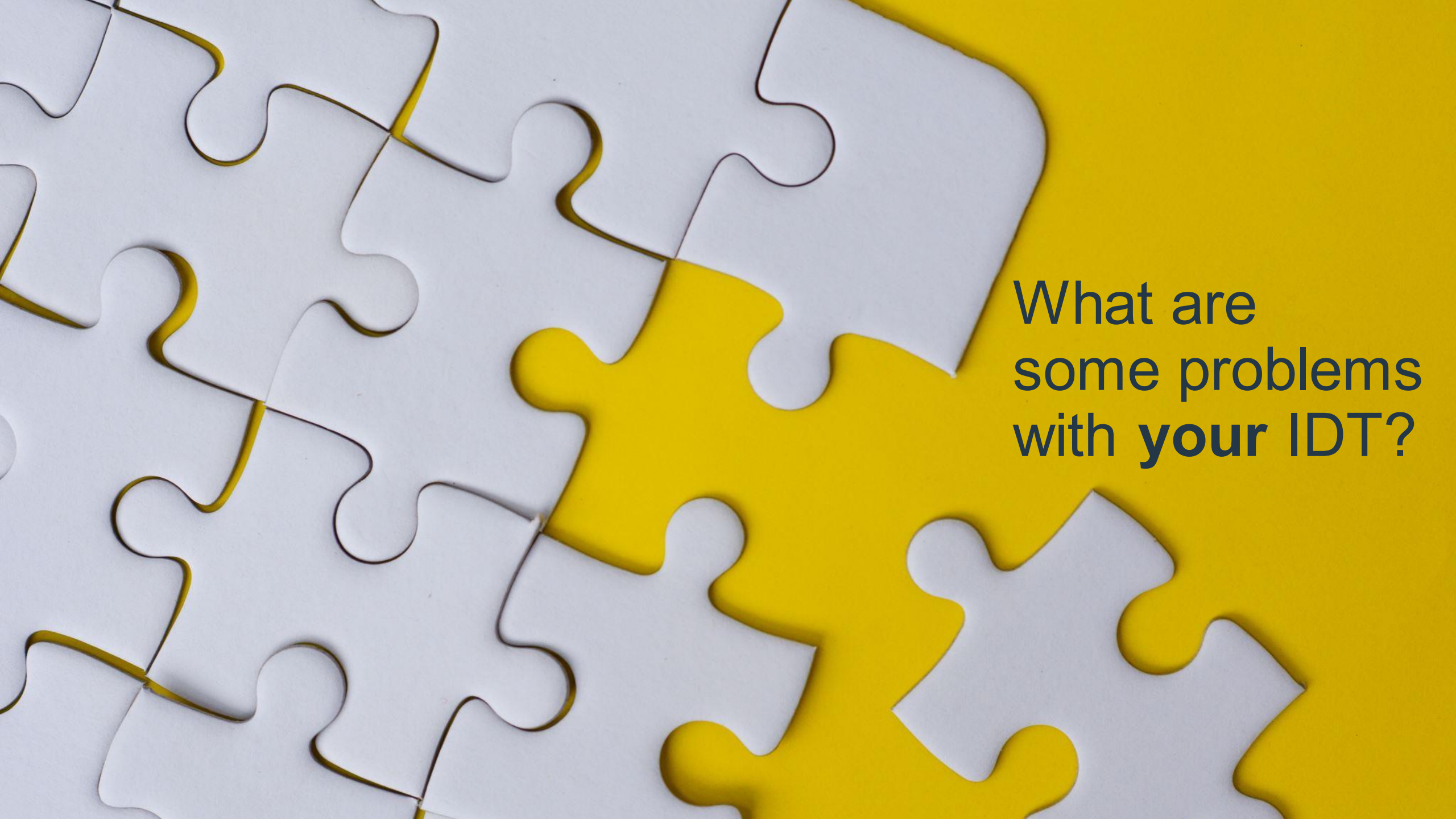
- Time-bound

Examples


What is **great**
about **your** IDT?

Audience survey:
What's **great** about **my** IDT? (Choose all that apply)

1. Our patients and families are getting the benefit of our collective knowledge and experience
2. The feeling of mutual support and camaraderie
3. I always learn something valuable
4. I feel like my time is used well
5. We know what the plan is for the next 2 weeks


What are
some problems
with **your** IDT?

Audience Survey: Problems with my IDT?

1. Inefficient, too long
2. Ineffective in accomplishing the goals
3. Some members routinely feel unappreciated
4. Some members monopolize the meeting
5. People are late all the time
6. People leave in the middle
7. People are not paying attention
8. Some people come unprepared

IDT Solution

Mutual understanding and commitment; structure; supportive policy & procedure

+

Tools and solutions to ensure mutuality of goals and responsibilities

Before IDT ever starts,
lay the groundwork for success:

Commitment tool

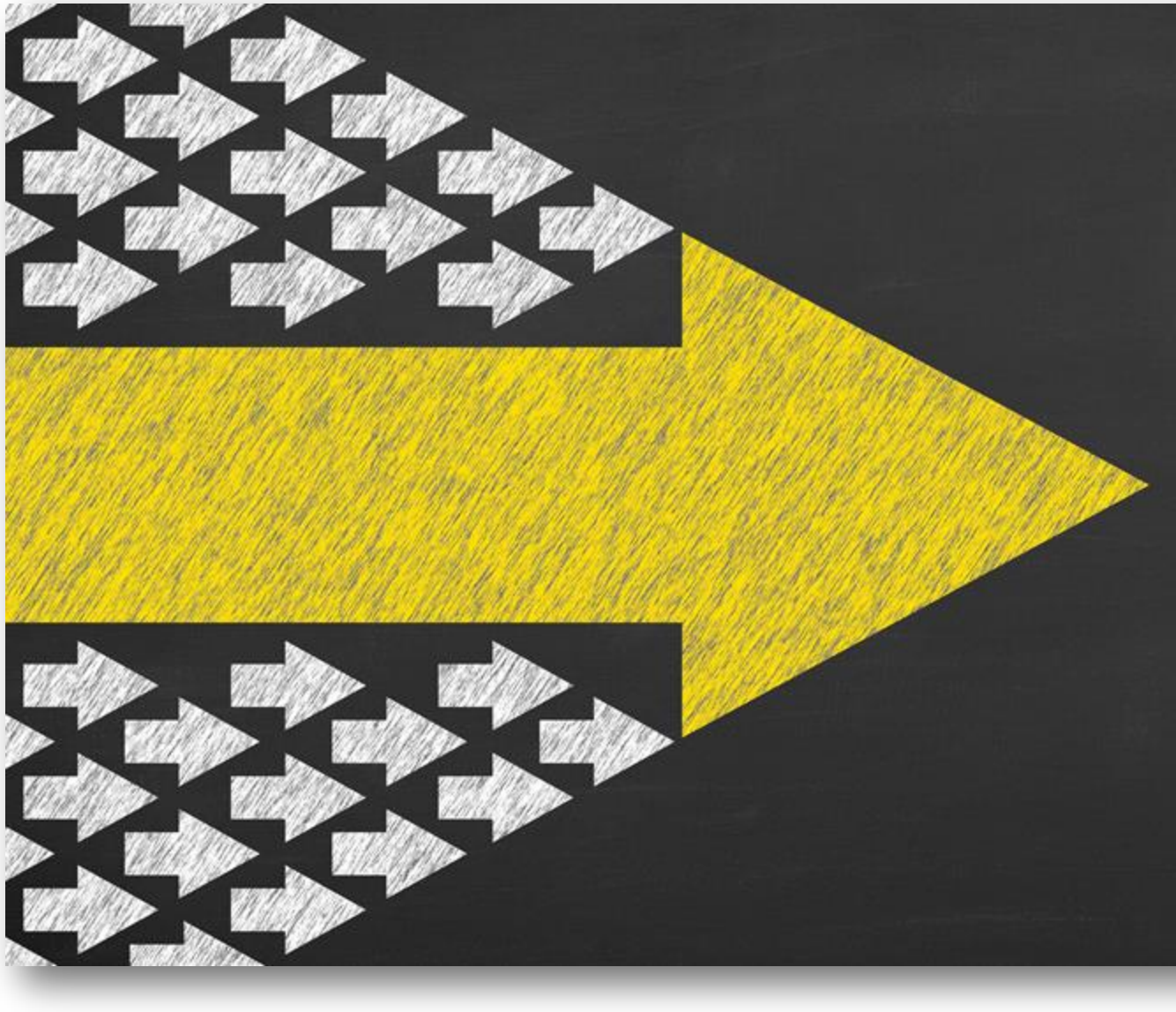
At new hire orientation, annual re-education, and as needed, have **all** team members sign a commitment outlining their role and responsibilities as a team member

My commitments to IDT (an exemplar)

IDT is the heart, soul and brains of hospice and palliative care. It is the time and place that we are all called upon to be prepared and committed to the welfare of each patient, their families, and each other.

Our mutual work is to identify patient and family goals and concerns in order to ensure every day is the best it can be.

To maximize our potential in accomplishing this ideal, we work together as a team, taking advantage of our varied knowledge, training and experiences. IDT is a forum where we create a "brain trust" to benefit each patient under our care.



Therefore, I commit to:

____ Continuously work to identify patient and family goals as they evolve, and to assist in accomplishing them

____Continuously work to understand the patient and family sources of suffering, and to resolve them

To maximize the potential of hospice/palliative care, we must have effective and efficient means of collaborating as a team. My commitment to this process is to:

_____Be on time to IDT every time we meet

____ Be prepared in advance of the meeting

___ Give my cell phone to the receptionist during the meeting and notify him/her of any expected calls that are urgent

___ Ensure the patients' and families' evolving needs and care are the center of conversations during the meeting at all times; no side conversations

___ Use the provided checklist to be sure I cover all the necessary information efficiently and completely. The checklist is a prompt to expand on important patient and family goals and concerns, and should not be included in the medical record

___ Be efficient in my presentation, responses and questions to make best use of my colleagues' and my time

___ Publicly affirm and extol team members' extraordinary contributions

____ Listen attentively, so that each patient, family member and colleague can benefit from my and our collective knowledge and experience

____ Assure the plan of care is being followed, or modify it with the team based on new information to best meet the patients' and family caregivers' needs

____ Assure that psychosocial or spiritual concerns, physical symptoms and practical needs of each patient and family caregiver are appropriately assessed and addressed timely, in proportion to the degree of suffering they cause and their acuity or chronicity. These needs will be addressed and coordinated with my teammates NOT ONLY at IDT, but in between as needed and will be reflected in the written plan of care

____ Write notes in the patient record that reflect the POC or the need to modify it

____ Be respectful of all; be open to learning as well as teaching, enabling mutual growth

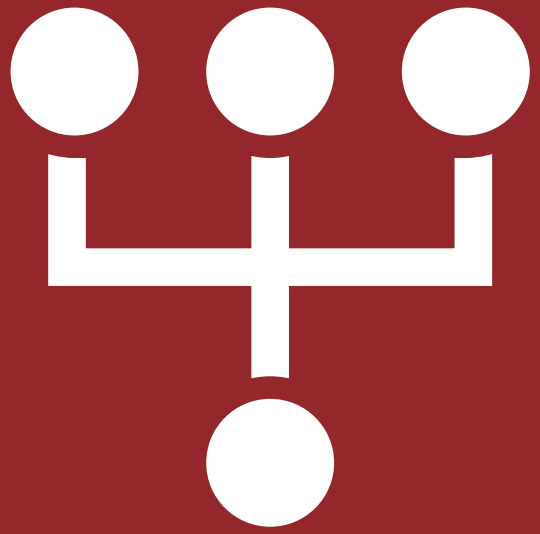
____ Attend to my and my colleagues' total well-being by participating in the opportunities outside of IDT that are offered to address our own grief, loss and personal concerns, such as debriefing opportunities, and mentoring/being mentored

____ Take advantage of offered opportunities to learn and grow to be my best self and team member

I commit to each of these to ensure that we deliver the best care possible, while being our best and most authentic selves and teammates

Signature Date

Policy and procedure reinforce the importance of commitment



Our commitment to your success & well-being

- We commit to ensuring you understand your role and the expectations for being a part of our team and to giving you the tools and education you need to succeed as a team member at our hospice
- We commit to providing opportunities in many formats to manage the grief and loss that inevitably comes with this job, such as:
  - Frequent opportunities outside of IDT for purposeful individual or small group debriefing after difficult visits or deaths
  - Opportunities for mentoring/being mentored
  - Funeral attendance
  - Mental health/grief days after particularly difficult deaths
  - Opportunities for individual counseling
  - Team bonding activities
  - Opportunities for off the clock group recreation

Audience Survey

Which of these does your hospice offer? (Choose all that apply)

- Frequent opportunities for purposeful individual or small group debriefing after difficult visits or deaths outside of IDT
- Opportunities for mentoring/being mentored
- Funeral attendance
- Mental health/grief days after particularly difficult deaths
- Opportunities for individual counseling
- Team bonding activities
- Opportunities for off the clock group recreation

Policy: Our commitment to your commitment

- Commitment to the welfare of our patients and to mutuality in team communication is so critical to our function as a hospice, that a violation of your signed commitment constitutes a reason for disciplinary action.

- Such violations of care and mutual respect, such as not being on time, not being prepared, and not listening or contributing to patients other than your own during IDT, will be treated as any other serious breach of duty and can ultimately result in termination.

IDT Procedures; Structure begets results

- Manned sign in sheet with typed names, signature column, time in and time out.
- Receptionist trained to accept phones and identify emergency texts and calls and to ask if it can wait 2 hours
- IDT is never more than 2 hours and has a 10’ break at the 55’ mark; meeting ends promptly at 2 hours.
- If there are too many patients to be covered in this time frame, the meeting needs to be broken into 2 days, i.e., a weekly meeting of 2 hours.
- Deaths are covered in 2’, New admissions are allotted 6-8’, follow up patients 3-4’
- Timekeeper is respectful and respected. Timekeeper duty changes meeting to meeting
- Scribe, preferably knowledgeable about medical terminology and EMR superuser

IDT members

- Patient and family caregiver, their contractors (sitters, nurses)
- Outside attendings
- Volunteer coordinator and volunteers
- Hospice aides
- QAPI coordinator
- RT/PT/OT/Child life/recreational/music/massage therapists
- Pharmacist
- SW/Grief and bereavement coordinator, consulting psychologists, counselors
- Chaplains, patients' personal clergy if relevant
- Admitting nurses, nurse case managers
- Team physician

IDT procedures

Presenter of each NEW patient is the admitting nurse

All new patient presentations should focus on assuring the patient qualifies for hospice services, then developing a coherent POC

- **POC prioritizes patient and family goals, concerns and sources of suffering, as well as the outside attending physician's input**

A standardized process to solicit outside attending input and ensure ongoing involvement in developing and implementing the POC is in place

IDT Procedures

The first presenter for FOLLOW UPS (F/U) is the person managing the most pressing issues, which may be the chaplain, social worker, RT or other discipline

All F/U patient presentations focus on whether the patient continues to qualify for hospice care; is the patient's condition deteriorating/more difficult to manage?

F/U patient presentation also focuses on the existing POC and any new issues that need to be part of the POC. **"NO CHANGE" is never a correct assessment.**

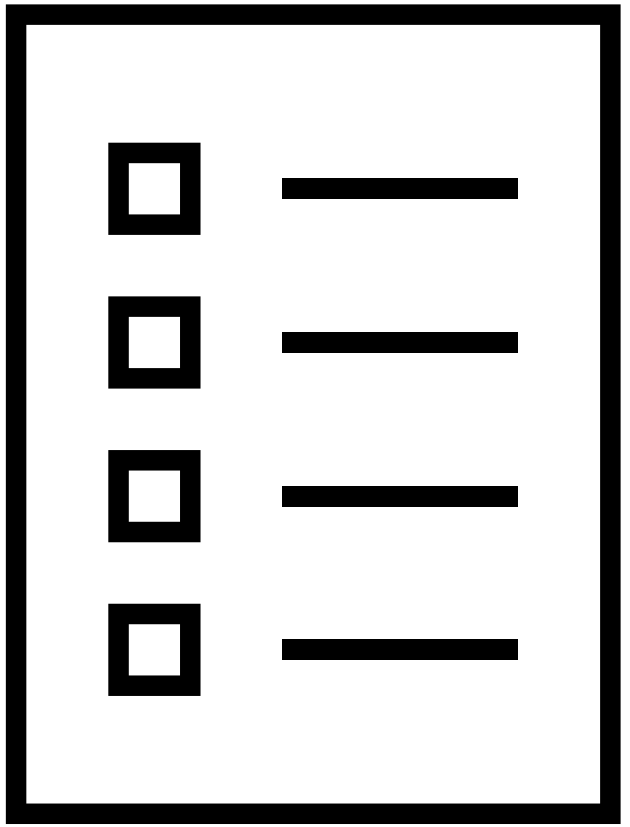
Revocations and live discharges should be presented in 1-2 minutes, and focus on the possible root cause, such as failure to secure OOH DNR; QAPI manager should be present to identify possible patterns

IDT Agenda, D.A.R.E.
(thanks to Catherine Dehlin, RN, MSN, CHPN, COQS, CHCM)

- Moment of reflection- 2 minutes
- Announcements
- Educational Pearl- any discipline, preferably relevant to cases on service, 5 minutes

- **DARE** Mnemonic for patient reviews and suggested content prompts:
  - **D**eaths, **A**dmissions, **R**ecerts, **E**valuations

- **Deaths** - Individuals to be contacted, bereavement risks, plans, assignments



IDT Agenda, DARE Continued

Admissions (continued) SBARG: Situation, Background, Assessment, Recommendations, Goals

- Admission nurse:
  - Patient name, age, location, caregiver situation and name
  - WHO the patient is- the REAL DEAL, (man not male, woman not female), prior occupation, how they spent time and treasure when healthier
  - HOW the patient meets criteria: admitting diagnosis, comorbidities,
  - Symptoms that are of concern (concerns not complaints)

IDT agenda, new admissions, continued

- Current rx/OTC/herbal meds, identified medications that may be deprescribed, need lab monitoring, infusion services
- Code status
- Psychosocial or spiritual concerns, need for ancillary services (e.g., RT, PT, OT, massage)
- Patient and family goals, hopes and fears
- Recommendations for realistic, timebound, measurable goals

IDT, DARE, continued

- SW admission discussion, if visit has occurred:
  - Hospice appropriateness
  - Patient and family goals, concerns, hopes
  - Anxiety or depression
  - Veteran status
  - Preferences for place of death
  - Family dynamics
  - Patient capacity for DM, MPA
  - Need for ancillary services, e.g., housekeeping, sitter, volunteers
  - Recommendations for realistic, timebound, measurable goals

IDT, DARE, continued

- Chaplain
  - Hospice appropriateness
  - Pt/family goals, concerns, hopes
  - Patient's religious preferences
  - Existential concerns
  - Rites to plan for
  - Veteran status
  - Preferences for place of death
  - Recommendations for realistic, timebound, measurable goals

IDT Agenda, DARE Continued

- Physician
  - Confirm hospice eligibility and appropriateness
  - Patient and family goals, hopes, concerns if direct contact
  - Medication review, deprescribing plan, management of symptoms, affirm bowel regimen
  - Collaboration with outside attending, if relevant
  - Recommendations for realistic, timebound, measurable goals
- ***Team agreement regarding patient meeting hospice criteria and appropriateness, immediate needs, priorities, goals, POC for next 2 weeks, including level of care and visit frequency, individual assignments.***

Medication Review- ALL participate!

- Project on screen for best outcomes
- *Drug profile.* A review of all of the **patient's** prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
  - **(i)** Effectiveness of drug therapy
  - **(ii)** Drug side effects
  - **(iii)** Actual or potential drug interactions
  - **(iv)** Duplicate drug therapy
  - **(v)** Drug therapy currently associated with laboratory monitoring

IDG Agenda, DARE, continued

- **Recerts –** Team discussion of whether the patient continues to qualify for hospice care, referencing the fiscal intermediary's criteria. For 3rd and subsequent periods, timely F2F by NP/MD/DO is required in specified time frame and discussed at IDT.
- **"Evaluations"** (current patients on service, ongoing evaluation)
  - Patients who have had a change in condition, level of care
  - Patients who are on CC or inpatient care and whether that is still required
  - Discuss patient and family caregiver response to "what is most important to you now"? AND their level of understanding about and agreement with the POC
  - Changes in symptoms, psychosocial, emotional, spiritual, existential concerns and progress toward identified goals, new goals, need for referrals
  - Medication review (deprescribing and new medication response)
  - Problem focus, goals, level of care, referrals, visit frequency for next 2 weeks per IDT
- **Live discharges**

Keep your referrers happy

PLEASE, PLEASE, PLEASE Communicate with attending and referring physicians after each meeting and with significant changes in the patient's condition

Ensure immediate notification of death, consider condolence cards for physician, staff

WHEW! That’s A LOT to manage!

Using tools wisely: Stand up, checklists, and your EHR

Stand up

- Daily, first thing in the morning call, updating the team regarding:
  - Overnight call
  - Concerns that arose the previous day, such as need for a symptom visit
  - POC changes, such as visit frequency
  - Patients needing CC or GIP care initiation or discontinuation
  - Deaths
  - New family concerns

Checklists for each discipline: reminders, prompts, not the whole shebang

- Please see handouts

Use the EHR wisely

- Writing notes during or immediately after the visit allows your team to be continuously updated on the patient and family well-being, need for change in POC
- Expand on any item that is new or urgent, document actions taken and modification of POC
- **Any discipline** should document changes that may indicate the last week of life- newly bedbound, not eating more than a few mouthfuls per day, not drinking, not urinating or defecating, **even if it is not a field that pops up** - put it in your narrative and let the nurse case manager know your concerns immediately. It may be time for daily visits and the service intensity add-on.

EHR may enable comprehensive documentation

- Don’t get lulled by check boxes
- Use the EHR to its highest ability to assist in your goals, document during/after each visit
- Ask the vendor for modification, if needed, to better meet your needs (e.g., “Team” vs “Group”, organize IDT note by GOAL/Problem vs Discipline)
- If done well, the IDG note can be communicated to the attending and referring physicians, increasing their allegiance to your hospice or PC program. In the WellSky solution, this is called the “IDG snapshot” and can be printed and faxed as needed for a point in time report
- Be sure anything sent to outside docs is short and pithy, not repetitive and unhelpful

IDG Comprehensive Assessment Details

Effective Date
02/04/2019
This field is required.

Next Idg Date

Bereavement Assessment discussed (if deceased)?
Yes No N/A

Recertification discussed (if recertification)?
Yes No N/A

IDG Meeting Notes

Volunteer Services Offered

Volunteer Services Offered (Other):

Comprehensive Medication Review
Yes No N/A

Medication Review Follow-Up

Patient/Caregiver is in continued agreement with POC
Yes No N/A

Primary Physician notified of updated POC
Yes No N/A

Disaster Acuity
CLASS4 - More than 72 hour Res

Disaster Priority Tree

Patient and/or family/caregivers have been determined to be safely administering medications/biologicals
Yes No N/A

Medication/Biologicals Administration Plan

Patient/Caregiver able and willing to provide care
Yes No N/A

Patient/Caregiver plan for providing care

Other

Patient/Caregiver POC change requests

Additional Comprehensive Assessment Comments

Issues For Next IDG Meeting

Create Return to top

In summary

- IDT is the opportunity to integrate the observations and concerns of the last 2 weeks and turn them into an action plan for resolution
- Orientation and other educational materials, policies, procedures and your documentation must support the integrated function of your team
- A new tool, the “My Commitment” document, and discipline specific checklists were provided to assist your hospice in being the best it can be
- We are privileged to be in the meaningful and worthwhile business of ensuring patients and their family have the best possible day every day!

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Thank you for all you do every day!

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