Interdisciplinary Team Meetings (IDT)

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Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to discuss the purpose of IDT
- The participant will be able to describe the IDT process

418.56 Interdisciplinary group, care planning, and coordination of services

- The Interdisciplinary team (IDT) works together to meet the physical, medical, psychosocial, emotional, spiritual and bereavement needs
- A designated RN provides coordination of care, and ensures continuous assessment of needs, and implementation of the plan of care
- The IDT includes a doctor, an RN, a social worker and a pastoral counselor

IDT – What it is

- Patient goal centered
- Problem centered
- Future centered
- Planning centered
- Whole team centered
- Team mate helping centered
- Care PLANNING centered

IDT – What it is Not

- A report of the last visit
- A time to catch up with other team members
- A time to tell the other disciplines what you are doing with a shared patient

418.56 (d) Review of the Plan of Care

Review of the plan of care includes:

- Information from the updated comprehensive assessment including the progress toward achieving specified outcomes and goals.

- Plan of care must be reviewed, revised as necessary and documented as frequently as the patient's condition requires, but no less frequently than every 15 days.

418.56 (d) Review of the Plan of Care

Review of the plan of care includes:

- A revised plan of care notes the progress toward outcomes and goals.

- Focus on patient care planning . What is plan for next 15 days?

  (Typically accomplished at IDT meeting with updates to attending)

Care Planning

- Patient is assessed by each discipline. Problems, goals& interventions are identified based on patient/family needs & goals and this becomes the POC

- Each discipline provides care and services to patient; each visit and visit note should be focused on a problem identified in the POC and reflect professional interventions to achieve the identified goal

Care Planning

- The team summarizes the effectiveness of interventions& plans for the next 2 weeks at the IDT meeting
- Every visit note & IDT note should reflect the problems, intervention and goals

Care Planning

- If focus is on a new problem – add to POC
- If goal met, resolve the problem
- Adjust visit frequencies based on patient/family needs and goals

Goals of IDT

- Review new admissions
- Review re-certification and eligibility
- Update to comprehensive assessment & response to interventions
- 2-week care planning
- Evaluation of Hospice care/death – begin bereavement care planning

IDT Policy

- Each patient's plan of care is reviewed every 15 days and more often if necessary, by the patient's status and level of care
- The meeting is facilitated by the Clinical Manager/designee
- Volunteers are invited to attend if available

IDT Procedure

- **IDT meeting is held weekly**
  - Care planning
  - Updates to Plan of Care
  - Recertification discussions
  - Review of new admissions and their initial Plan of Treatment
  - Review of patient discharges, transfers and deaths

- **IDT members sign into the meeting electronically via the clinical record**

IDT Procedure

- **An IDT Care Plan Review is completed for each patient every 14 days**

- **Prior to the meeting, each team member develops an IDT update in the clinical record, which includes but not limited to**
  - Medication and their effectiveness; medication changes
  - An increase or decrease in symptoms or acuity, including nutritional status, pain management, and condition of skin including the presence/status of pressure ulcers

IDT Procedure

- Increases or decreases in frequency of visits by team members, and reason for the change
- Changes in the location of care
- Psychosocial and other consultations/conferences with patient/family/caregiver
- Ongoing spiritual needs
- Plan for future interventions
- Progress/lack of progress toward treatment goals for each problem addressed

IDT Procedure

- Problem solving for optimal care of the patient/family/caregiver occurs and changes are documented on the IDT Care Plan Review
- For patients residing in a SNF, any changes in the POC will be communicated to the nursing staff of the SNF
- Verbal orders are obtained from the Attending Physician as required for any changes to the POC

IDT Procedure

- **IDT members present information at the meeting related to the patient/family/caregiver that may include but is not limited to:**
  - Patient's name, diagnosis and date of admission
  - Patient's location, and availability of family and caregiver(s)
  - Identified problems and goals
  - Outcome of interventions and status of problems (i.e. unchanged, resolved)

IDT Procedure

- Pertinent information related to the patient's current status and changes since the previous team discussion
- Scope and frequency of services provided
- Continued eligibility for Hospice services