



The Interdisciplinary Team Meeting
Promoting increased effectiveness of the IDT team meeting
among Massachusetts Hospices

A report of
the IDT Task Force of the Education Committee
Hospice & Palliative Care Federation of MA

This best practice paper is offered as guidance and not as legal authority.

© Copyright, 2004. Hospice & Palliative Care Federation of MA
September 15, 2004

APPENDIX

- IDT Project: Survey Instrument 2003
- Medicare Hospice Conditions of Participation
 - Sec. 418.58 Conditions of participation - Plan of Care
 - Sec. 418.68 Conditions of participation - Interdisciplinary group
- MA Hospice Licensure Regulations
 - 141.207 Plan of Care/ Assessment
 - 141.203 Interdisciplinary team
- National Consensus Project: Clinical Practice Guidelines for Quality Palliative Care Executive Summary (2004)

Your Interdisciplinary Team
A Self-Assessment Survey

Developed for a Research Project on the Effectiveness of the IDT
Hospice & Palliative Care Federation of MA

The Education Committee of the Hospice & Palliative Care Federation is planning an educational conference to provide practical ways for a hospice or palliative care service to improve the effectiveness of its interdisciplinary team. We are seeking input from team members to assure that we have a program consistent with your needs.

Please take a few minutes to complete this survey and return it in the envelope that is provided. Individual team results will be returned to your hospice in summary form so you can compare your performance against others in the state. Any identifying information will be removed so that all answers will remain confidential.

We thank you for participating in this project. With your help, we will offer a sound program that builds practical skills and produces better outcomes for the team, the program and the family.

Please check your response in the appropriate column.

	Mostly	Sometimes	Rarely
<u>Team participation</u>			
• Team members attend IDT mtg regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• IDT mtg. atmosphere is characterized by openness and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• There is mutual agreement about the purpose of the meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Members of each discipline contribute their professional input equally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• The contribution of all disciplines is valued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Members ask for clarification on vague comments or positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Team Participation (continued)

Mostly Sometimes Rarely

- Teams members feel comfortable expressing differing view
- Members know how to reach agreement when there are differences of opinion
- The leadership role is shared among team members

Care Planning at the team meeting

- IDT focuses on problems, interventions and goals rather than reporting
- Care plans are used as a resource at the meeting to resolve problems, and identify changes and new problems
- Data and assessment information is used in making a care plan
- The team develops cost-effective care plans
- IDT documentation clearly reflects input from all disciplines
- Documentation by the team clearly outlines the goals and services of the plan of care

<u>Training</u>	Yes	No
• My organization provides orientation on IDT functioning to new staff	<input type="checkbox"/>	<input type="checkbox"/>
• My organization provides training to improve the effectiveness of the team	<input type="checkbox"/>	<input type="checkbox"/>
• Training in IDT process and outcomes would be useful for my team	<input type="checkbox"/>	<input type="checkbox"/>
• I would attend a program to improve IDT effectiveness	<input type="checkbox"/>	<input type="checkbox"/>
• Of particular interest to me would be:		
-Understanding team roles and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>
-Improving team process and behavior	<input type="checkbox"/>	<input type="checkbox"/>
-Reaching consensus	<input type="checkbox"/>	<input type="checkbox"/>
-Improving team outcomes such as care planning	<input type="checkbox"/>	<input type="checkbox"/>
-Improving documentation	<input type="checkbox"/>	<input type="checkbox"/>
-How to provide support to the team	<input type="checkbox"/>	<input type="checkbox"/>

In your opinion, what is the value of IDT for you in your work with patient?

Any other comments about your IDT?

ALL RESPONSES WILL REMAIN CONFIDENTIAL:

Program name (optional) _____

Your position on the team: (circle one)

Executive Director

Bereavement Coordinator

Medical Director

Hospice Volunteer

Clinical Leaders

Home Health Aide

Staff Nurse

Social Worker

Other: _____

Chaplain

Volunteer Coordinator

Please seal all confidential surveys in envelope provided and give to field visit staff or collect and mail to: Rigney Cunningham, Hospice & Palliative Care Federation of MA, 1420 Providence Highway, Suite 277, Norwood, MA 02062.

Medicare Hospice Conditions of Participation

Sec. 418.58 Condition of participation--Plan of care.

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

- (a) **Standard: Establishment of plan.** The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.
- (b) **Standard: Review of plan.** The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.
- (c) **Standard: Content of plan.** The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

Sec. 418.68 Condition of participation--Interdisciplinary group.

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.

- (a) **Standard: Composition of group.** The hospice must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice:
 - (1) A doctor of medicine or osteopathy.
 - (2) A registered nurse.
 - (3) A social worker.
 - (4) A pastoral or other counselor.
- (b) **Standard: Role of group.** The interdisciplinary group is responsible for--
 - (1) Participation in the establishment of the plan of care;
 - (2) Provision or supervision of hospice care and services;
 - (3) Periodic review and updating of the plan of care for each individual receiving hospice care; and
 - (4) Establishment of policies governing the day-to-day provision of hospice care and services.
- (c) If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described in paragraph (b)(4) of this section.
- (d) **Standard: Coordinator.** The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

MA Hospice Licensure Regulations

141.202 Plan of Care/ Assessment

(A) A comprehensive plan of care shall be developed by an interdisciplinary hospice care team and if applicable, the patient's attending physician, prior to provision of services. The initial plan of care shall be developed within three days of admission by at least three members of the interdisciplinary team as defined by 105 CMR 141.203, including a registered nurse and the medical director. The initial plan of care shall be reviewed and ratified by the full interdisciplinary team at their next scheduled meeting.

(B) The patient/family shall be permitted and encouraged to actively participate in the care planning process and the provision of care. Such participation shall be documented in the patient/family record.

(C) The plan of care shall include but not be limited to:

- (1) pertinent diagnosis and prognosis;
- (2) identification of the physical, psychological, social, economic and spiritual status of the patient/family;
- (3) need for inpatient care (respite or general), nutritional needs, medication needs, need for management of discomfort and symptom control, and need for management of grief;
- (4) plan to address identified needs including scope of services required;
- (5) identification of anticipated frequency of services needed;
- (6) designation of the primary care giver or alternate plan to provide 24 hour care and support in the patient's home;
- (7) identification of the person responsible for coordinating care;
- (8) plans instructing the patient/family or designated caregiver in patient care;
- (9) plans for support and care at the time of death
- (10) plans for providing bereavement care to family

(D) The comprehensive plan of care shall reflect the changing care needs of the patient/family, and be reviewed and revised as necessary but at least twice a month by the interdisciplinary care team. These reviews shall be documented in the patient/family record.

141.203: Interdisciplinary Team

(A) The hospice shall establish an interdisciplinary care team(s) ~~which~~ that includes but is not limited to:

- (1) medical director
- (2) registered nurse
- (3) coordinator of volunteers
- (4) social worker
- (5) spiritual or other counselor
- (6) bereavement coordinator

A team member may serve more than one role on the team.

(B) The interdisciplinary team's responsibilities shall include but not be limited to:

(1) establishing a plan of care for each patient/family

(2) conducting regularly scheduled meetings to review the plan of care as needed but at least twice monthly for each patient/family receiving hospice services

(3) encouraging active involvement of the patient/family in development and implementation of plan of care

(4) providing or supervising the provision of hospice care and services

(5) implementing written policies governing the day-to-day provision and evaluation of hospice care and services

(6) monitoring continuity of care across all settings

(C) One member of the interdisciplinary team shall be designated as coordinator of a patient's care and shall be responsible for coordinating the implementation of the plan of care for that particular patient and assuring that all services required for the particular patient's care are in place.

National Consensus Project for Quality Palliative Care

Core Elements of Palliative Care

The National Consensus Project includes the following key elements of palliative care:

- **Patient population:** The population served includes patients of all ages experiencing a debilitating chronic or life-threatening illness, condition or injury.
- **Patient- and family-centered care:** The uniqueness of each patient and family is respected, and the patient and family constitute the unit of care. The family is defined by the patient or, in the case of minors or those without decision-making capacity, by their surrogates. In this context, family members may be related or unrelated to the patient; they are individuals who provide support and with whom the patient has a significant relationship. The care plan is determined by the goals and preferences of the patient and family, with support and guidance in decision-making from the health care team.
- **Timing of palliative care:** Palliative care ideally begins at the time of diagnosis of a life-threatening or debilitating condition and continues through cure, or until death, and into the family's bereavement period.
- **Comprehensive care:** Palliative care employs multidimensional assessment to identify and relieve suffering through the prevention or alleviation of physical, psychological, social, and spiritual distress. Care providers should regularly assist patients and their families to understand changes in condition, and the implications of these changes as they relate to ongoing and future care and goals of treatment. Palliative care requires the regular and formal clinical process of patient-appropriate assessment, diagnosis, planning, interventions, monitoring and follow-up.
- **Interdisciplinary team:** Palliative care presupposes indications for, and provision of, interdisciplinary team evaluation and treatment in selected cases. The palliative care team must be skilled in care of the patient population to be served. Palliative care teams may be expanded to include a range of professionals, based on the services needed. They include a core group of professionals from medicine, nursing and social work, and may include some combination of volunteer coordinators, bereavement coordinators, chaplains, psychologists, pharmacists, nursing assistants and home attendants, dietitians, physical-, occupational-, art-, play-, child-life- and music therapists, case managers and trained volunteers.
- **Attention to relief of suffering:** The primary goal of palliative care is to prevent and relieve the many and various burdens imposed by diseases and their treatments, and consequent suffering, including pain and other symptom distress.
- **Communication skills:** Effective communication skills are requisite in palliative care. These include developmentally appropriate and effective sharing of information, active listening, determination of goals and preferences, assistance with medical decision-making, and effective communication with all individuals involved in the care of patients and their families.
- **Skill in care of the dying and the bereaved:** Palliative care specialist teams must be knowledgeable about prognostication, signs and symptoms of imminent death, and the associated care and support needs of patients and their families before and after the death, including age-specific physical and psychological syndromes, opportunities for growth, normal and aberrant grief, and bereavement processes.

- **Continuity of care across settings:** Palliative care is integral to all health care delivery system settings (hospital, emergency department, nursing home, home care, assisted living facilities, outpatient and non-traditional environments such as schools). The palliative care team collaborates with professional and informal caregivers in each of these settings, in order to ensure coordination, communication, and continuity of palliative care across institutional and home care settings. Prevention of crises and unnecessary transfers are important outcomes of palliative care.
- **Equitable access:** Palliative care teams should work toward equitable access to palliative care across all ages and patient populations, all diagnostic categories, all health care settings including rural communities, and regardless of race, ethnicity, sexual preference or ability to pay.
- **Addressing regulatory barriers:** Concerns about drug abuse have led to increased concerns about medically appropriate use of opioid analgesics. While efforts to address abuse are necessary, they should not interfere with medical practice and the care of patients in pain. Palliative care professionals should collaborate with policy-makers, law enforcement and regulators to achieve a balanced and positive regulatory environment for pain management and palliative care.
- **Quality improvement:** Palliative care services should be committed to the pursuit of excellence and high quality of care. Determination of quality requires regular and systematic evaluation of the processes of care and measurement of outcomes data using validated instruments.