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.

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Thank you to the many individuals and hospice programs that participated in this project.

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Thank you to the hospice and palliative care programs that volunteered to participate in this project.

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Hospice Outreach, Fall River
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Merrimack Valley Hospice, Lawrence
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Abstract:

This report is a Best Practice paper of the Hospice & Palliative Care Federation of MA. It presents the findings of field and survey research on the status of interdisciplinary team (IDT) meetings among Massachusetts hospices and offers recommendations on how to improve the effectiveness of the IDT meeting. It concludes that the purpose of the team meeting is to develop an interdisciplinary Plan of Care that meets the evolving needs and goals expressed by the patient and family. The report includes content from an educational conference held in April, 2004 that supports the implementation of a model of careplanning focused on patient and family goals rather than a disease-based model.
The Interdisciplinary Team Meeting

Promoting increased effectiveness of the IDT team meeting among Massachusetts Hospices

I. Background

The mission of the Hospice & Palliative Care Federation of MA is to advance and promote excellence in end of life care. Two of the strategies used to achieve this goal are: fostering innovation in hospice and palliative care practices and providing professional education to staff. To that end, the Federation's Education Committee supports the orientation and continued education of staff to advance their skills so they can provide quality hospice and palliative care to patients and families. This report on The Interdisciplinary Team (IDT) Meeting is a part of the Federation’s Best Practice series which offers guidance that can be used to support improvement in hospice and palliative care practices, policies and services.

The use of the interdisciplinary team in planning and sharing the care of the patient and family is a unique feature of the hospice philosophy as no one discipline is viewed as being solely responsible for caring for all the physical, psychosocial and spiritual needs of the patient and family. It takes a team. According to the Interdisciplinary Teams Training Project Resource Manual (University of Colorado Health Sciences,) ‘Interdisciplinary” implies the existence of a team. It is an integrated approach in which team members actively coordinate care and services across disciplines.”

In recognition of the IDT’s key role in the delivery of hospice, the Medicare Hospice Conditions of Participation require that an interdisciplinary group provide or supervise the care and services offered by the hospice program (42 CFR 418.68). In addition, Massachusetts licensure law (141.202) requires that an initial plan of care be developed within three days of admission by at least three members of the IDT and that the plan of care be reviewed and revised as necessary but at a minimum of two times per month, specifying the scope and frequency of services. The IDT meeting is the crucible in which that planning takes place. Although not required by regulation in palliative care, The National Consensus Project on Clinical Guidelines for Quality Palliative Care (2004) clearly lists the interdisciplinary team as a core element.

There are indications that an effective IDT meeting improves more than quality of care. One report by the National Hospice and Palliative Care Organization found that if team functioning is better, there are lower overall hospice costs, a lower cost per patient, and lower labor costs (NHPCO, National Hospice Social Work Survey, 2000).

However, some hospices report challenges to the effectiveness of their IDT meetings as their census grows and the length of stay continues to shorten. To support its members and their patients, the Federation undertook this project to focus on how the IDT meeting could be improved to further increase the effectiveness and quality of hospice care.

The project to date has had both research and educational components. An interdisciplinary Advisory Committee has reviewed this report and has provided recommendations based on the research findings and the content of the April 27 conference, “Increasing the Effectiveness of the Interdisciplinary Team.” This IDT report was approved by the Board of Directors on September 15, 2004.
II. Action Plan

The intention of Federation Best Practice reports is to support change in hospices and palliative care programs seeking to improve their practices, policies or services. While the culture of each program may be somewhat different, the IDT Advisory Committee provides this checklist for those who wish to get started in planning for improvements in their IDT meeting.

☐ Distribute IDT report to management and staff.

☐ Gain support from senior management and team members for improvement effort.

☐ Schedule team discussion on the report, team responsibilities and the team meeting.

☐ Clarify the purpose of the IDT meeting. The purpose is the one thing that is given to a team. It is not the result of consensus seeking.

☐ Gather data from the team. Consider surveying (or re-surveying) team members using the IDT survey tool included in the Appendix. Confidentiality should be guaranteed.

☐ Based on survey results, identify and agree upon action priorities.

☐ Consider options for improvement. Review the Federation’s IDT report for useful recommendations.

☐ Develop implementation plan and assign responsibility.

☐ Implement plan.

☐ Evaluate in 3-6 months and adjust plan as needed. Continue ongoing evaluation.

☐ Watch for emerging information, tools, trends that may support the improvement effort.

☐ Consider using an outside consultant to support the effort.

III. The Purpose of the IDT Meeting

The IDT Advisory Committee recommends that teams adopt the following statement as the purpose of the IDT meeting:

The purpose of the team meeting is to develop an interdisciplinary Plan of Care that meets the evolving needs and goals expressed by the patient and family.
IV. Summary of Recommendations

While field observers and team members reported many positive aspects of the team meeting, some problems were also noted:

- There was a lack of defined purpose or conflicting purposes for the meeting.
- The careplanning process was not focused upon patient and family goals.
- Careplans were not used as a resource.
- There was more reporting of medical information than interdisciplinary care planning.
- The nurse was overly relied upon for information and leadership of the group.
- Environments were characterized by distractions such as beepers, paper-passing, entrances and exits by staff.
- Staff energy seemed drained by lengthy meetings due to large numbers of patients.
- Not all disciplines participated equally in the discussion.
- Staff varied in the skill with which they presented patients.

The IDT Task Force and the IDT Advisory Committee met to review this report and make final recommendations based on the findings of the Federation’s IDT research project and the information provided at the April 27, 2004 educational conference, “Increasing the Effectiveness of the Interdisciplinary Team.” The report and its recommendations were approved by the Board of Directors on September 15, 2004.

For those IDTs who wish to improve the effectiveness of their team, the following recommendations are offered:

A. Agree on the purpose of the meeting.
- Clarify with team members that the purpose of the IDT meeting is to develop an interdisciplinary Plan of Care that meets the evolving needs and goals expressed by the patient and family. The Director should tell the team the primary goal of the meeting.
- Shift from a disease-based model that focuses on the treatment of disease and the alleviation of symptoms to a model where the focus is upon supporting the patient/caregiver in reaching their goals.
- Assess team needs for personal support and bonding and determine other ways to meet those needs such as through individual case conferences and team support groups. Recognize that bonding/support for the team is a valued by-product of good IDT process but not the primary purpose of the meeting.
- Review relevant regulations on careplanning and the IDT in the Medicare Hospice Conditions of Participation and MA Hospice Licensure regulations with all IDT members.
- Provide orientation to new staff in the interdisciplinary team meeting process.
- Provide ongoing training to staff to support interdisciplinary participation at team meeting. Consider an annual retreat where the team can reflect upon and evaluate their team process.

B. **Focus on problems and interventions that will support patient/family goals rather than reporting information.**
- Stay on track. Position careplanning for the patient and family as the focus of the meeting. Eliminate extraneous discussion not pertinent to meeting patient/family goals. (NOTE: one hospice keeps a "wand" on the table that can be waved by any team member should the conversation begin to wander).
- Provide ongoing training to staff to advance their case presentation skills.
- Have a core group of team members trained to act as mentors and help keep the meeting on track.
- After improvements have been made, have the team discuss the optimal number of patients per team to assure adequate time for case consideration.
- Evaluate patient/family outcomes of careplanning and adjust plan as needed.
- Periodically evaluate effectiveness of team performance by either holding a retreat, using evaluation tools, having monthly 15 minute post-meeting evaluation sessions, visiting other teams or having other teams visit them.

C. **Share leadership among all team members**
- Put the patient before the disease process. Have non-nursing disciplines present first and tell who the patient was before the illness and who he/she is now.
- Shift away from nurse-dominated meetings. Foster understanding that all disciplines and team members share equally in the responsibility for the development and implementation of the Plan of Care whether or not they have direct patient/family contact. They should do this through active participation at the meeting and by coaching other IDT members directly involved with the patient.

D. **Create an environment conducive to team participation.**
- Encourage debate and healthy conflict of ideas in an atmosphere of openness and trust.
- Ask team members to identify behaviors or conditions that detract from the meeting.
Agree upon ground rules that eliminate or decrease the distractions e.g., late arrivals, beepers, paper passing.
- Begin the meeting with a reading, reflection or moment of silence to ground the staff and to affirm and acknowledge the mission, values of hospice and the team members responsibility to their patients and to each others.
- Experiment with ways to manage the list of patients to keep everyone involved.
Some hospices divide their teams into geographic regions or by nursing home/home setting. Others alternate moving through the list A-Z, then Z-A. One hospice integrates bereavement patients into the patient list alphabetically rather than at the beginning or end of the meeting.
E. **Focus on making meetings more efficient to reduce the length of the meeting and assure adequate time for interdisciplinary discussion.**
- Grant the facilitator of the meeting the responsibility for managing time.
- Focus on careplanning to meet the goals of the patient and family. Eliminate stories and anecdotes not relevant to this purpose or relegate them to another setting. Find other ways to provide staff support outside the team meeting. Team support inside the meeting should come from help with complex cases and learning from more experienced staff.
- Provide both on-going training and the tools to improve case presentation skills.
- If there is no change in the patient/family’s goals or services, the team member can say, “The Plan of Care is effective as implemented” and move to the next patient.
- Consider daily mini-sessions for “hot issues” that need to be resolved that day using 15 minute meetings or conference calls at the start of the day.
- Implement a telephone Conference Line or shared e-mail file where staff can check messages regarding changes in the Plan of Care.

F. **Develop documentation and forms that support effective and efficient interdisciplinary planning.**
- Revise forms to reflect careplanning focused on patient/family goals. Review tools/forms used for care planning: the initial plan of care, the plan of care, certification/recertification discussions.
- Eliminate duplicative requests for information. Integrate paper files and computer records where possible.
- Redesign forms to allow adequate space for input from all disciplines.
- Use a scribe (QA staff, clinical team assistant, volunteer with clinical background) to record discussion, future plans, and changes in the Plan of Care and input the data into the computer.
- Provide education regarding team roles and responsibilities on how to establish, review and update a plan of care and then use it as the primary tool to drive patient care.
- Investigate the use of computer software for careplanning forms and consider use of LCD projection of the plans during team meeting.
V. Careplanning as the Focus of the IDT Meeting...
Shifting from a Disease-based Model to a Patient/Caregiver Experience Model

A. Background
Over the course of the research project, the Federation’s IDT Task Force did an extensive literature review and attended a number of educational conferences on the IDT. The IDT Education Task Force concluded that the purpose and function of the IDT meeting needed to focus on a model that placed the goals of the patient and family at the core of the careplanning process. Two faculty were recruited to offer this approach at the Federation’s conference, “Increasing the Effectiveness of the Hospice Interdisciplinary Team: Putting the puzzle pieces together” on April 27, 2004 at the Four Points Sheraton in Norwood. They were Kathleen Egan, MA, BSN, CHPN, Vice President, Hospice Institute of the Florida Suncoast and Gary Gardia, MSW, M.Ed, Vice President, Nathan Adelson Hospice in Las Vegas. This report provides a summary of the model and ways in which it can be implemented.

B. Changing the Approach

From Disease Focus Model

<table>
<thead>
<tr>
<th>Diagnosis of disease &amp; symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curing of disease focused goals</td>
</tr>
<tr>
<td>Treatment of disease and alleviation of symptoms</td>
</tr>
</tbody>
</table>

To Patient/Caregiver Experience Model

| Patient/caregiver identify their end-of-life goals |
| Assess how symptoms, issues are helping or hindering them in reaching goals |
| Interventions to reach end-of-life goals |
| Quality of life closure |

Focus on THE PATIENT/CAREGIVER Experience

Alleviation of patient/caregiver suffering
Life and relationship self-determined completion and closure
Bereavement support for caregivers.
C. Principles of the Patient/Caregiver Experience Model

Principle 1: Dying and caregiving are unique personal experiences based on the patient’s and caregiver’s personal values and goals.

The caregiver should offer, provide and support the patient with:
- Choice
- Advocacy
- Compassion
- Dignity

Principle 2: People experience the last phase of life-relationships through many related dimensions that impact the quality of that experience and time in their lives.

An Interdimensional Model of Care - FIVE DIMENSIONS

Transcendent - The experienced degree of connection with an enduring construct, degree of experienced meaning and purpose in life.

Functional - the perceived ability to perform accustomed functions and activities of daily living; experienced in relation to expectations.

Interpersonal - the degree of investment in personal relationships and the perceived quality of one’s relationships with family and friends.

Well-being (intrapersonal) - the self-assessment of a person’s internal condition; subjective sense of wellness or “disease”, contentment, or lack of contentment.

Physical - the experience of the physical discomfort associated with progressive illness; perceived level of physical distress.

No dimension exists or functions alone... when one dimension changes it effects other dimensions... And the quality of life or relationship closure.
Care planning from an interdimensional approach - Ask these questions...

- What is happening in all of these dimensions and how is it affecting other dimensions?
- What is helping the patient/family reach their goals?
- What is hindering the patient/family from reaching their goals?
- What can we offer as choices to strengthen what is helping and minimize what is hindering?

Principle 3: *The last phase of life and relationship provides continued opportunity for positive closure experiences in the face of suffering.*

**Life Completion and Life Closure Tasks**

1. Sense of completion with worldly affairs
2. Sense of completion in relationships with the community
3. Sense of meaning about one’s own life
4. Experience of love of self
5. Experience of love of others
6. Sense of completion in relationships from family and friends
7. Acceptance of the finality of life - one’s existence as an individual
8. Sense of a new self (Personhood) beyond personal loss
9. Sense of meaning about life in general
10. Surrender to the transcendent, to the unknown, “letting go”

*Adapted from Ira Byock, “The nature of suffering and the nature of opportunity at the end-of-life.” Clinics in Geriatric Medicine.*


**D. Examples of Questions to Elicit End-of-life Goals**

- What do you think is most important to your family?
- What are your needs at this time?
- What are your concerns now and for the future?
- What do you wish you could still do?
- What is important to you to have control over?
- What are things that bring you joy and comfort?
- What are the most important relationships in your life?
- Is there any one you would like to see, talk to or visit with?
- What are you hopeful about?
- How and where do you want to live for the rest of your life?
- If you have pain, what would be an acceptable level of pain for you on a 0-10 scale?
VI. Interdisciplinary Team Meeting

A. Interdisciplinary Team Collaboration Model
1. Have the primary team member (which is any discipline - the one most involved) begin by telling the story of who this patient/family are and were before the disease.
2. Then ask all of the disciplines who have been involved to share “What are the patient’s and family’s goals, wishes, needs at this time -- as they define them.
3. Ask all disciplines who are involved with their care: ‘What is happening in this situation that is helping or hindering this patient and family from reaching their goals, wishes, needs?
   - Each discipline should then have the opportunity to share what they feel is happening with the team focusing on the patient/family strengths and challenges. All disciplines involved should have an opportunity to participate. No issue, problem or opportunity is owned by any discipline because they belong to the patient/family. All disciplines can address and work on all dimensions (physical, functional, interpersonal, well-being and spiritual).
   - Collaborate on how the team can help support their strengths and provide options for them to choose to deal with their challenges.
4. Evaluate the effectiveness of the careplan based on whether or not the patient and family have been able to accomplish, meet, or finish their end-of-life goals, wishes and needs.

B. Thoughts for Effective Careplanning
• Begin with critical needs of the patient and family
• Remember your purpose
• Consider time
• Troubleshoot
• Give thought to what you include or report
• Consider the roles of patient and family in achieving goals
• Consider team roles in achieving goals

C. Looking at Outcomes of Effective Careplanning
• Is it working? Quickly?
• Quickly change course if it is not working
• Are there new goals? New treatments?
• Did it work? If not, remove from careplan
D. Watch Your Language
Professional jargon may obscure the behavior or condition that is affecting the patient or family. Use non-judgmental language to describe what the patient/family are experiencing in order to focus on the intervention that will meet the need. Avoid the use of words such as:
“Difficult patient or family”
“Dysfunctional”
“Unrealistic”
“Non-compliant”
“Crazy”
“Very religious”
“Nice”

E. Team Performance
Consider:
- What proportion of time does each of the disciplines talk during your team meetings?
- What is hindering full team participation?
- What can be done to foster full team participation?

F. The Team and the Short Stay Patient
With the length of stay for patients very short (2002 Median LOS in MA was 15.8 days. One-third died in one week), the effectiveness of the team and the skill of each team member is even more critical. Team teaching is essential. If a team member, such as the chaplain or social worker, can not get in to visit the patient, the team member who is in direct contact with patient/family should be coached by others to provide the support needed for the patient and family to reach their goals.
VII. Research Plan and Process

In 2003, the IDT Task Force developed its research plan which included:

-Field visits to observe the IDT meeting at hospice programs
  All 40 hospices and one palliative care program were invited to participate.
  Seventeen volunteered as an observation site. Eleven site visits were completed.
  One program declined the field visit but participated in the survey.

-Survey of IDT members at participating hospices and palliative care programs
  The staff survey included questions on their perceptions of the team meeting
  process, its value, and the incidence of training in IDT method at the agency. (See
  Appendix for Survey Instrument). 140 surveys were returned. Responses to the
  survey were confidential and were summarized using quantitative and qualitative
  methods. In March 2004, custom reports of survey findings were sent to each of
  the 12 hospice programs participating in the field visits in March, 2004.

In order to develop a helpful curriculum, research findings were made available to the
faculty of a one-day conference on April 27, 2004 sponsored by the Federation, "Increasing the
Effectiveness of the IDT...Putting the puzzle pieces together."

VIII. Research Findings

A. Field Visits

The purpose of the field visits was to observe teams in action to understand their
challenges so that a helpful curriculum could be developed for the one-day conference in Spring,
2004 and to formulate recommendations on how to increase the effectiveness of the IDT
meeting. Eleven field sites were conducted between Spring and Fall, 2003.

While field observers reported respect among members, team bonding and general
openness during the meetings, they also found some opportunities for improvement. These
included:

- Lack of purpose or conflicting purposes for the meeting.
- Careplanning lacked a focus on patient and family goals.
- Careplans were not used as a resource.
- There was more reporting of information than on interdisciplinary care planning.
- Nurses were overly relied upon for information and leadership. Discussion by nurses
dominated the meeting.
- Environments were characterized by distractions such as beepers, paper-passing,
  entrances and exits by staff.
- Lengthy meetings drained staff energy.
- Not all disciplines participated equally in the discussion.
- Staff varied in case presentation skills.
Because of the relatively low number of responses, the differences among scores may not be statistically significant. However, they are provided to trigger discussion by team members. The answers were grouped by high, middle and low average scores of the participating hospice programs. The columns show:

- Overall averages scores for programs
- The range of averages reported from lowest average to highest average (A broad range would indicate that there is considerable variability among hospices as to how well they are performing on that factor. A narrow range means that the performance among programs is fairly similar).

Field observers ranked their observations on a 1-3 scale.

3 = Mostly
2 = Sometimes
1 = Rarely

Overall, field observers’ average score of 2.2 was consistently lower than that of IDT members’ whose average score was 2.6. This discrepancy in perception is frequently observed as individual respondents often rank themselves higher, tending to be more optimistic or positive than an external observer.

However, field observers did agree with team members about several problems in team functioning.

- “Care plans were used as a resource to identify problems” received the lowest average score from both groups.
- “The leadership role is shared among team members” was the second lowest score in both groups.
- Three factors: “Members feel comfortable expressing different views”, “The focus is on problems, interventions, goals and not on just reporting,” and “Members reach agreement when differing opinions are voiced” all scored below average by both team members and surveyors.

B. Findings of the Team Member Surveys
140 team members responded to the survey, also ranking statements 1-3.

Respondents included:

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>3</td>
</tr>
<tr>
<td>Chaplain</td>
<td>13</td>
</tr>
<tr>
<td>Fellow</td>
<td>3</td>
</tr>
<tr>
<td>Medical Director</td>
<td>8</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Bereavement Coordinator</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Leader</td>
<td>7</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>3</td>
</tr>
<tr>
<td>Social Worker</td>
<td>18</td>
</tr>
<tr>
<td>Volunteer Coordinator</td>
<td>7</td>
</tr>
<tr>
<td>Declared</td>
<td>25</td>
</tr>
</tbody>
</table>
1. **Team Meeting Process**

*Highest Average Scores*
Overall, hospices had the highest average scores on these factors meaning that most respondents agreed with these statements.

<table>
<thead>
<tr>
<th>Hospice Average</th>
<th>Range of Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team members attend IDT meeting regularly</td>
<td>2.9</td>
</tr>
<tr>
<td>IDT meeting is characterized by openness and trust</td>
<td>2.8</td>
</tr>
<tr>
<td>There is mutual agreement as to the purpose of the meeting</td>
<td>2.8</td>
</tr>
<tr>
<td>Contributions from all disciplines are valued</td>
<td>2.8</td>
</tr>
<tr>
<td>Members clarify vague comments, positions</td>
<td>2.7</td>
</tr>
</tbody>
</table>

*Middle Range Average Scores*
These factors were in the mid-range meaning that there was moderate agreement with these statements.

<table>
<thead>
<tr>
<th>Hospice Average</th>
<th>Range of Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of each discipline contribute equally</td>
<td>2.6</td>
</tr>
<tr>
<td>Members reach agreement after differing</td>
<td>2.6</td>
</tr>
<tr>
<td>Data/assessments are used to develop the careplan</td>
<td>2.6</td>
</tr>
<tr>
<td>The team develops cost-effective plans</td>
<td>2.6</td>
</tr>
<tr>
<td>Documentation reflects input from all disciplines</td>
<td>2.6</td>
</tr>
<tr>
<td>Documentation outlines goals and services of the careplan</td>
<td>2.6</td>
</tr>
</tbody>
</table>

*Lowest Average Scores*
Hospices received the lowest averages overall on these factors making these factors priorities for change.

<table>
<thead>
<tr>
<th>Hospice Average</th>
<th>Range of Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team members are comfortable expressing differing views</td>
<td>2.4</td>
</tr>
<tr>
<td>Focus in on problems/interventions/goals--not reporting</td>
<td>2.4</td>
</tr>
<tr>
<td>The leadership role is shared among members</td>
<td>2.2</td>
</tr>
<tr>
<td>Careplans used as a resource to identify problems/changes</td>
<td>2.2</td>
</tr>
</tbody>
</table>

*Most Agreement By Hospices That These are Problems*
These two factors were perceived as problems by most programs:
- The leadership role is shared among members
- Focus is on problems/interventions/goals -- not reporting
Most Variability Among Hospice Programs
Some hospices are doing well on these two factors but others are having difficulty:
- Careplans are used as a resource to identify problems/changes
- Team members are comfortable expressing differing views

2. Training in Interdisciplinary Process
About four-fifths of IDT members reported that they had received training in team participation during orientation but only half reported receiving on-going training. Almost 90 percent expressed an interest in training that would improve the effectiveness of their team.

*My hospice provides training on teams:*
- During orientation 79%
- Ongoing training 51%

*Team members expressed the MOST interest in these training topics*
- Improving team effectiveness 89%
- IDT process and outcomes 81
- Providing support to team 78
- Improving team process/behavior 74

*Team members expressed the LEAST interest in these training topics*
- Understanding team roles and responsibilities 47%
- Reaching consensus 46

3. Perceived Value of Team Meeting
Team members were asked to comment in their own words, “In your opinion, what is the value of IDT for you in your work with patients?” Responses were coded for content. While not statistically significant, the responses provide an indication of team member’s perceptions. Their comments indicate considerable variation in how team members view the value of IDT.

Team members’ perception of IDT’s value was often not related to planning for the care of the patient. Less than half (44%) of team members valued the IDT for purposes of careplanning: Thirty percent said they valued it for devising the interdisciplinary care plan and 14% said they valued it for problem-solving. Thirty-nine percent viewed the meeting as a vehicle for reporting information. Nine percent valued it for mutual support, 5% for providing education to team members and 3% for team bonding.
Samples of team member responses to this question are listed below:

*Reporting what is happening with patients* 39%
“Sharing of information and input from other team members”
“IDT is a valuable time to hear from other disciplines, however, it tends to be more reporting than collaboration.”
“Sharing information about patients and families between team members. This is necessary, helpful.”
“Being informed for all patients, especially for on-call.”
“Staff generally spend most of the time reporting, not dealing with problems.”

*Interdisciplinary care planning* 30%
“To clarify goals and improve the Plan of Care”
“The rich diversity of approaches of various disciplines. Excellent care plans as a result.”
“Helps with forming the best care plan using everyone’s expertise and experience.”
“Reaching consensus on the patient’s family’s care plan effectiveness.”
“Collaboration of different ideas to improve the Plan of Care.”

*Problem Solving* 14%
“Getting input from all members of the team in dealing with difficult issues with patients.”
“Trouble-shooting about symptoms and issues.”
“Getting opinions and suggestions for problems encountered.”
“Our IDT meetings help to offer suggestions for problem-solving when we encounter clinical problems with patients.”

*Support to Individuals* 9%
“To support one another.”
“To help support other team members who may be having a difficult time with a specific patient.”
“As a new employee, it helps me feel I am not alone in the care of my patients.”

*Education* 5%
“It gives me an opportunity to get input and awareness of treatments and concepts that may be new to me.”
“It helps to learn about a variety of home and disease-process situations that we may have been unaware of.”
Bonding and Team Building
“Opportunity for group cohesiveness and team building.”
“Collegial contact for team members.”
“It brings the team closer together.”
“For camaraderie with team members.”

4. Perceived problems with team meetings
The final question of the IDT survey was also an open-ended comment section.
Many respondents took the opportunity to report on problems they say get in the way of an effective team meeting. These comments were coded and then summarized. The results can be used to suggest general trends and areas for further evaluation.

Problems included: Long meetings that left members feeling pressed for time (24%); meetings that were primarily led by nurses that left other disciplines feeling less valued (19%); a deficit in skills for effectively and efficiently presenting cases (16%); meeting environments characterized by a host of distractions (9%).

Meetings too long, pressed for time
“It is a very long meeting and getting longer as our census grows.”
“Something has got to change. We leave the long, tedious meetings exhausted and irritable.”
“Too long (3+ hours).”
“Team members in a hurry to leave.”
“Too many patients to discuss within the time frame.”

Meetings are nurse-dominated. Other disciplines, less active.
“The primary thrust of the meetings is focused on nursing/medical issues. Would like to see more room for input other than RNs.”
“Would like to see more comments from other IDT members seeing the patient. Reports very medically based, but I feel it is improving and there is more input from other disciplines.”
“The IDT continues to be mostly a nursing team meeting. Other team members do not interject as much as they could on all patients.”
“Overly weighted on nursing/medical focus. Continue to work on all team members being active.”

Staff need more case presentation skills
“Some staff go into TOO much depth.”
“People need to stay focused on information which is PERTINENT and make SHORT presentations about patients and families.”
“Sometimes get too involved in little details and spend too much time on them.”
“It is a struggle to keep people from reporting rather than what is new/different/problematic.”
“The meetings are allowed to ramble, often unfocused. People speculate endlessly and often comment inappropriately.”

Too many distractions. 9%
“Disorganized, sidetracked very easily, interrupted often with people coming late, starting late, pagers, cell phones, etc. Need larger room for meeting. Very tight.”
“It would be great if everyone could be FREE AND ATTENTIVE for the entire meeting rather than shuffling papers and signing reports.”
“I have yet to listen completely to what my colleagues are saying about their patients because I’m so busy with all this documentation.”

5. Suggestions on how to improve the IDT meeting
Also in the final comment section, IDT respondents sometimes cited opportunities for improvement in a variety of areas as shown below:

Environment
“Meetings should start on time with all present.”
“Distractions should be kept to a minimum: no cell phones, no passing paperwork.”
“I have a space adequate for the size of the team.”
“Leadership should address any attitudinal/behavioral problems that arise.”

Team process and participation
“Share the facilitator role among all disciplines.”
“Have all IDT member contribute to the leadership role.”
“Reimburse part-time, off-shift and per diem staff to attend team meeting.”
“Increase the involvement of the Hospice Medical Director.”

Orientation and training
“Provide more orientation to new team members about how the team works and the expectations of involvement/participation of all members.”
“Consider having an outside consultant who facilitates the team occasionally.”

Presentation skills
“Organize patient/family information more effectively.
- Begin with basics about the patient and family.
- Present the patient/family using a problem-oriented style versus a narrative style.
- Have a well-defined process for patient/family discussion.”
**Documentation**

"Restructure documentation to allow more input from all disciplines."

"Eliminate duplication of documentation requirements."

23
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.

<table>
<thead>
<tr>
<th>Team participation</th>
<th>Mostly</th>
<th>Sometimes</th>
<th>Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team members attend IDT mtg regularly</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>IDT mtg. atmosphere is characterized by openness and trust</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is mutual agreement about the purpose of the meeting</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Members of each discipline contribute their professional input equally</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The contribution of all disciplines is valued</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Members ask for clarification on vague comments or positions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Team Participation (continued)</td>
<td>Mostly</td>
<td>Sometimes</td>
<td>Rarely</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>Teams members feel comfortable expressing differing view</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Members know how to reach agreement when there are differences of opinion</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The leadership role is shared among team members</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

**Care Planning at the team meeting**

<table>
<thead>
<tr>
<th>Care Planning at the team meeting</th>
<th>Mostly</th>
<th>Sometimes</th>
<th>Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDT focuses on problems, interventions and goals rather than reporting</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Care plans are used as a resource at the meeting to resolve problems, and identify changes and new problems</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Data and assessment information is used in making a care plan</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The team develops cost-effective care plans</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>IDT documentation clearly reflects input from all disciplines</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Documentation by the team clearly outlines the goals and services of the plan of care</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Training

- My organization provides orientation on IDT functioning to new staff
  - Yes □ No □

- My organization provides training to improve the effectiveness of the team
  - Yes □ No □

- Training in IDT process and outcomes would be useful for my team
  - Yes □ No □

- I would attend a program to improve IDT effectiveness
  - Yes □ No □

- Of particular interest to me would be:
  - Understanding team roles and responsibilities
    - Yes □ No □
  - Improving team process and behavior
    - Yes □ No □
  - Reaching consensus
    - Yes □ No □
  - Improving team outcomes such as care planning
    - Yes □ No □
  - Improving documentation
    - Yes □ No □
  - How to provide support to the team
    - Yes □ No □

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
- Medical Director
- Clinical Leaders
- Staff Nurse
- Social Worker
- Chaplain
- Volunteer Coordinator

Other: _______________________

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.

(E) 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 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.
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.