Organizing Patient Focused IDG Meetings

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What You Will Learn Today

- The purpose & regulatory requirements of the interdisciplinary group (IDG) meeting
- Ways to effectively manage & keep the IDG focused on patient needs
- Using patient and family goals as the focal point of the Plan of Care & IDG meeting

IDG 418.56
Key Concepts

- IDG works together to meet the needs of the patient and family
- Establishes/revises plan of care (POC)
- Coordinates care and services

IDG 418.56
Regulatory Requirements

- Interdisciplinary group composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement
  - Hospice physician
  - Registered nurse
  - Social worker
  - Pastoral or other counselor
IDG 418.56 Regulatory Requirements

- Establishes/revises plan of care
  - Hospice care and services must follow an individualized written plan of care established by the IDG in collaboration with the attending physician (if any), the patient or representative and primary caregiver
  - Ensure the patient and primary caregiver receive training appropriate to their care and service identified in the POC

- Establishes/revises plan of care
  - Must reflect patient and family goals and interventions based on problems identified in the assessments (initial, comprehensive and updated)
  - Interventions to manage pain and symptoms
  - Scope and frequency of services to meet the needs
  - Measureable outcomes anticipated from POC

A Word about the Comprehensive Assessment

- Comprehensive assessment means a thorough evaluation of the patient’s physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions
  - This includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient
  - Comprehensive assessment is about assessing WHAT the patient needs, not all about WHO completes the assessment or a particular form
Comprehensive Assessment

- All members of IDG must be involved with completing and updating the comprehensive assessment
- Evaluate and document the patient’s response to care
- Purpose is to make sure IDG has the most recent and accurate information to make care planning decisions

IDG 418.56

Regulatory Requirements

- Coordinates care and services
  - System of communication
  - Care and services provided in accordance with POC
  - Care and services based on all assessments
  - Ongoing sharing of information with other non-hospice healthcare providers

Cycle of Care

- IDG establishes plan of care to address needs.
- Patient/Family
- Plan of care implemented through results of analyses of comprehensive assessment and plan of care.
- Results of analysis used to implement performance improvement activities.
- Outcome data analyzed.
- Comprehensive assessment of patient needs and outcome data collected.

IDG Meetings

- Where do the regulations require the IDG “meeting”?
  - They don’t!
- They do require the IDG
  - Works together to meet the needs of the patient and family
  - Establishes/revises plan of care (POC)
  - Coordinates care and services
  - Communicates
IDG Meetings

- Significant component of the system of communication to review and revise the plan of care to meet the needs of the patient and family based on all comprehensive assessments

Value in an IDG Approach

- Improved communication regarding patients and families’ needs and care
- Provides for more effective decision making
- Supports a shared commitment to goals of care
- Improves patient care
- Leads to creative problem solving

IDG Team

- Not just what happens during team meetings
- How interdisciplinary is everyone outside of IDG meetings?
- Everyone aware of patient’s goals of care?

Purpose of an IDG meeting

- To utilize the discipline specific skills and knowledge of each member of the IDG
- To develop, evaluate and revise the plan of care to meet the patient’s and family’s unique needs
  - Based on the comprehensive assessment of the patient and family
- It’s ALL about the patient and family
An IDG Meeting Is a Process

- Includes an evaluation & review of the problems, goals and interventions to improve outcomes
- Addresses changes which might include new problems, goals and interventions, level of care, visit frequency, additional services, medications and DME
- Documents review of all current admissions, deaths, bereavement needs and recertifications

What’s at Stake?

- In hospice, the IDG is the basis for decisions involving patient’s care and services
- If the team is not functioning well?
  - It is the patients and their families who suffer

An IDG Meeting Is a Process

- Provides an opportunity to share expertise and to problem-solve the more challenging cases
- Provides an opportunity to anticipate possible crisis in the disease progression for proactive care planning
- Allows time to assess the eligibility of patients and their appropriate level of care

Common Problems – Anything Sound Familiar?

- Time runs on and on and on
- Staff are not prepared
- It’s a nursing report
- SW and Chaplains are marginalized
- It’s a report solely on eligibility
- It’s the story of the last visit
- Extraneous activities take away from the focus
Keys to an Effective IDG Meeting

- Plan
- Contribute
- Focus
- Assess

Plan

Plan Effective Team Leader

- Critical to assure the most patient centered, effective, and efficient meeting
- Utilizes effective communication skills including listening, observing, and questioning
- Sets expectations and commitment to an effective meeting and hold staff accountable

Plan

The Role of an Effective Team Leader

- Teach the RN case manager how to "case manage"
- Provide organizational leadership for the meeting
- Mediate among the various disciplines
- Assure that all disciplines are heard and participate appropriately

Plan

- Distribute agenda a day before the meeting
- Expect members to come prepared
- Maintain a consistent format
- Seating arrangements
- Be prepared to start on time
- Limited (if any) interruptions
Plan
Agenda
☐ Suggested items
  ☐ Opening greeting and remarks
  ☐ Deaths and bereavement
  ☐ Patient review (in order: admissions, recertifications, level of care changes, inpatient, continuous care, discharges, routine patient review) grouped by nurse case manager
  ☐ Completion of plans of care
  ☐ Education
  ☐ Announcements and any organizational updates
  ☐ Wrap up

Plan
The Role of Effective IDG Team Members
☐ Understand roles and responsibilities
☐ Come to each meeting prepared
☐ Contribute a diverse, yet appropriate mix of skills and experience
☐ Create a culture of trust, sharing, spontaneity and risk taking
☐ Set and commit to achieving specific, measurable, achievable, realistic and time bound goals
☐ Manage conflict

Plan
Organize the paperwork
☐ Orders and prescriptions to be signed before or after meeting
☐ Certification and recertification forms readily available when patients are presented
☐ Charts (paper or electronic) available with current plan of care and medication list

Contribute
IDG Members
☐ All members contribute
☐ Receptive to other points of view
☐ Are professional
☐ Are the expert and the resource in their area for the rest of the team
☐ Summarize problem list
☐ Review findings for others
Contribute

☐ Remember-
Each team member is there to present information and to be challenged in their thinking and action plan, **NOT** to get “rubber stamped” approval for what they have done or plan to do

Contribute

<table>
<thead>
<tr>
<th>Standardized Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do any of the IDG members have any plans for this patient and family that have not been addressed yet?</td>
</tr>
<tr>
<td>Discuss any new problems identified through the comprehensive assessment for the plan of care</td>
</tr>
<tr>
<td>Develop goals and interventions</td>
</tr>
</tbody>
</table>
  - New orders
  - New services
  - Change in interventions
  - Change to visit frequency

Focus

Communication at IDG

☐ Different than communicating with patients and physicians
☐ Focused
☐ "Executive summary"
☐ Needs to allow time for real interdisciplinary communication
☐ Challenging
☐ Proactive
☐ Educational
Focus

- Focus on present or anticipated problems
- Keep discussions on track
- Stick to the point
  - Case presentation not nursing report
  - Problem oriented
  - Patient confidentiality is protected
  - Not the place for interesting but unnecessary “gossip” about the patient or family
  - Avoid judgmental statements about the patient and/or caregivers

Focus on the Patient Through the Plan of Care

- Main source of documented communication both internally and externally

Flow of Communication

Focus Facilitator Questions to Ask the Team

- What does the patient want and what does the patient need in relationship to the want?
- Can you tell me more about that?
- Help me understand how that might relate to the issue we’re discussing?
- What do you find most difficult about this situation?
- Do we need to look at this from another perspective?
Focus on the Patient

Key Questions to Ask

- Are goals being met?
  - You only know through the comprehensive assessment
- If you are meeting the patient and family goals, keep doing it and document that it is working
- When goals are not being met, has the problem changed?
  - Are the goals in alignment with the patient and family?
- What interventions need changing?
  - Added?
  - What's not working?

More Key Questions to Ask

- Are the actions taken resulting in a favorable outcome for the patient and family, i.e. are they achieving the goals?
- What is the evidence from the comprehensive assessment that shows the interventions are working?
- How does the patient want to die?
- How prepared is the family for the patient’s death?
- Does the family know what to expect?

Focus on the Patient

Through the Plan of Care

- Patient centered goal
  - What does the patient want?
  - Don’t ask “what are your goals” since they may not know how to define goals
  - Instead ask
    - “What is important to you now?”
    - “What are your needs today?”
    - “What would you like to get accomplished over the next couple of weeks?”

What Do People Want?

1. Adequate pain/symptom control
2. Avoiding inappropriate prolongation of dying
3. Achieving sense of control
4. Relieving burden
5. Strengthening relationships with loved ones

Singer, et. al., Quality End-of-Life Care - Patients’ Perspectives, JAMA, 1999, 281:163-168 (Jan 14)
Plan of Care - The Road Map

- Is an on-going process
  - Not static
- Should be individualized to each patient / family based on individualized goals
  - Updated as patient gets "sicker" and goals change
- Includes
  - Physician orders
  - Medication profile
  - Hospice Aide assignment
  - Frequencies
  - Equipment ordered

A Word About Goals

- Goals-patient and family directed
- Measurable
- Must be flexible and able to change as the situation requires
- Should review any time there is a significant change in status

Focus on the Patient Through the Plan of Care

- Example: "Want my hair done every Wednesday."
  - Care planning then focused to support all that needs to happen to achieve the goal of getting her hair done
  - What is the role of each discipline?
    - Interventions to manage pain & symptoms
    - Transportation to the beauty shop
    - ADL support
    - Safety needs
    - What else?
- How does the POC change when she can no longer leave the house?

Actual Documentation

- N: Patient was experiencing "Cabin fever" and dpt asks "do the rules allow for him to go on outings and appointments to his podiatrist and dermatologist?"
  - No problem or need related to this identified on plan of care and nothing was measurable but there were lots "issues" and none of them had a corresponding goal to address "cabin fever" or "outings"
  - Caregiver issues
  - Elimination issues
  - Grief
  - Depression
  - Tasks of dying
  - Respiratory issues
  - Wound issues
  - Medication management issues
  - Coping
  - Pain
  - Cardiovascular issues
  - Mobility issues
  - Neurological issues
IDG Should **NOT** Be

- Form-speak (recital of the plan of care)
  - Just how many times do we need to hear that the constipation is managed?
- A whine session
- A support group for staff
- A gossip session about patients and families
- An opportunity to criticize the medical care of others

IDG **Should**

- Use the comprehensive assessment and plan of care to
  - Manage the patient's symptoms (in all areas)
  - Prepare the patient and family for the death
  - Support them through this process
  - Help the patient and family make the transition from curative to palliative
  - Discuss if the patient remains eligible

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**Comprehensive Assessments & Associated POC**

- Daughter “worn out”
  - Goal – Daughter will report less fatigue
    - Interventions
      - SW to arrange respite for 3 days so daughter can have uninterrupted sleep
      - SW to assist daughter in finding help/support through community resources
      - Volunteer to visit once a week to allow daughter time to get nails done

- Patient isolated and lonely
  - Goal – Patient will report feeling less isolated
  - Interventions
    - Volunteer once a week to read to patient
    - Chaplain weekly visits for scripture readings and prayer
**A Key Question to Ask at Every Team Meeting**

“How does this patient want to die?”

then

“How will this patient die?”

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**Audience at IDG**

- Not everyone is directly on the case
- Not everyone cares about the minute details
- Everyone should
  - Trust professionals to be doing their jobs
  - Learn the difference between case study and back fence gossip
  - Learn not to be *voyeurs of tragedy* or to *gossip*

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**Voyeurs of Tragedy**

- People who enjoy hearing about others’ misfortunes
- Gain satisfaction from feeling “above it all”
- Allows us to “fix” others
- Paternalistic
- Us-Centered *NOT* Patient-Centered

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**Gossip**

- Ignores solving problems
- Loves nit-picky details
- Hates it when there are “no problems”
- Presumes people don’t know details and forces them to share them to show they know them
- Offers “help” when it is neither needed nor desired
  - Gossip help is *meddling*
Case Discussion

- Case discussion presumes professionals know the details and are acting upon them
- Case discussion presumes professionals will ask for help
- Case discussion is interdisciplinary
- It’s the patient’s plan of care, not “my plan of care”

Assess Your IDG Meetings

- Does the plan of care provide the interventions to achieve the outcomes identified?
- Can you measure the success of the plan of care in the comprehensive assessment?
- Are visit frequencies adequate to meet the needs of the patient and family?
- Do they change as needs change?
- Are they individualized to patient needs?
- Does the scope of services meet the needs of the patient and family?

Assess Your IDG Meetings

- Does the patient’s plan of care get changed based on IDG discussion?
- Have high risk patient needs been thoroughly evaluated?
- Did each IDG member contribute to the discussion on assigned patients and got help caring for their patients?
- Was each patient’s medication profile reviewed?

Assess Your IDG Meetings

- If stories are of last visit – not addressing any problems at the visit – why go?
  - Becomes a professional visit not case managing
- During death review did you include
  - Is there anything we could have done differently/better?
IDG Ratings

1. Nurse reads the forms or attempts to provide a report to the doctor.
   Everyone else sits there or makes less than meaningful comments like "once this month."

2. Everyone comments on "their" plan of care and frequencies based on the form.
   Essentially a care plan recital. "This is the status" but little planning or care coordination is done.

3. Interdisciplinary discussion of patient/family issues (what are the patient and family needs/goals) and planning for future issues.
   What might happen based on the comprehensive assessment, how do we anticipate and prepare for potential problems.

In Summary …

- A successful IDG is...
  - Interdisciplinary discussion of patient/family issues (what are the patient and family needs/goals) and planning for future issues.
  - What might happen based on the comprehensive assessment, how do we anticipate and prepare for potential problems.

- It is all about the patient!
- What 1 thing will you change at your next IDG Meeting?
- How will you know if it was effective?

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