Interdisciplinary Care Rounds

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Care Coordination Definition

“Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.” (AHRQ Dec 2010)
Care Coordination Bridges the Gap Between Care Providers

- Blue ring that connects the colored circles represents care coordination
- This ring bridges the gaps between participants and settings of care

Care Coordination Is Needed to Address the Gaps and Silos in the Current Expert-Driven System

- Each provider is an expert but even the most perfect nurse or physician cannot deliver optimal care while working in an uncoordinated system; we must integrate our expertise to provide a comprehensive patient centered plan of care inside or outside the hospital
- Goal of care coordination is to address any potential gaps in meeting patient’s interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences.¹

We Need a Different Approach to Cost Reduction That Improves Care Coordination

• Need a new approach to reduce waste and build systems of care

Collaboration and Communication

Be inclusive

- Recognize that it takes the efforts of all members of the team to achieve desired outcomes
- Promote cooperation and facilitate coordination of care
- Utilize the expertise and skills of all members of the team
- Form partnerships with key individuals and departments
- Come together around the common goal of providing excellent patient care
- Exhibit mutual respect and compassion for each other
Role for Interdisciplinary Rounds

- Clear communication among care team to reduce rework, delays in care decisions
- Set daily goals for patients and individualize the plan of care
- Assure patients and families understand the goals
- Identify barriers to discharge
- Ensure aftercare services are in place prior to discharge
- Improve patient/family satisfaction and staff satisfaction
- Reduce care variation when protocols and best practices exist
- Improve patient outcomes

Inpatient Interdisciplinary Rounds Are Highly Structured to Force Focus on Key Issues

- Interdisciplinary Rounds (IDCRs) are designed for efficient transfer of information and decision making
  
  6:00am   Lab draws
  7:00am   Physician begins rounds, nursing report/ begin patient care
  9:00am   Interdisciplinary Rounds on Med/ Surg Unit #1
  9:15am   Interdisciplinary Rounds on Med/ Surg Unit #2
  9:30am   Interdisciplinary Rounds on Med/ Surg Unit #3

- Initial meetings occur by the unit white board
- As teams develop this practice, the interdisciplinary rounds will evolve to include rounding at each patient’s bedside
- Begin on a pilot unit daily, Monday - Friday
Focus from the Start – Aim Statement

Sample Aim Statement:
Hospital, Multidisciplinary Rounds

What are Multidisciplinary Rounds?
Multidisciplinary rounds bring together all care providers daily to discuss each Hospitalist patient’s day of care, treatment plan, and preemptively planning the upcoming days leading to a safe discharge. Patients should be flagged 24 hours before a probable discharge so all clinical team members can jointly prepare for a morning discharge the next day. Patient discussions should be concise and positive, lasting 10 seconds to 1 minute per patient.

Who participates in Multidisciplinary Rounds?
Teams will be made up of a core group including unit based Hospitalists, Nurse Manager, Inbounder, Case Manager and Social Worker. Rounds will also include Pharmacy, Nutrition, Physical Therapy, when possible.

Where will Multidisciplinary rounds take place?
- ICU: 9:00-9:20 am
- Med/Surg 1: 9:20-9:30 am
- PCU: 9 AM
- ICU will engage in more in-depth Multidisciplinary rounds once a day with Intensivist.

Why are we implementing Multidisciplinary Rounds?
- To improve communication among care providers
- To set daily goals for patients & individualize the plan of care
- To assure patients and families understand the goals
- To identify barriers to discharge, such as insurers, insurance approvals, etc.
- To assure all needed services are in place prior to discharge
- To improve patient/family satisfaction
- To improve staff satisfaction
- To improve core measure outcomes

What will the format of these rounds be?
- The rounds will take place in available staff areas.
  - The nursing staff will have a checklist to discuss system issues: glucose, fluid balance, vital signs, patient care, etc.
  - Case Management will discuss prior services in place, current assessment, projected need, etc.
  - The rounds will be led by the Hospitalist on the floor.
- Each patient on the floor will be discussed in 30 seconds to 1 minute.
- Ground rules will be followed by all members of the team.

What will be monitored?
- Attendance
- Core Measures
- Readmissions
- Patient Satisfaction (Communication with Doctors and Nurses)

What Are the Benefits of IDCRs?

- Improve quality of care
  - Optimize quality and safety
  - Increase consistency of care
- Improve patient satisfaction
  - Keep patient and family informed and involved at all times
  - Reduce admission and discharge wait times
- Help build collaborative relationships
- Enhance the ability to plan proactively
- Move patients through the continuum more effectively
- Reduce reactive discharge planning
Daily Participation by Core Team and Specialists Are the Backbone of Timely Care Decisions

Core Interdisciplinary Rounds Team

- Hospitalist or attending provider
- Nurse manager
- Direct care nurse
- Case manager and/or social worker
- Pharmacist

Additional Participants

- Nutrition
- Physical therapy
- Respiratory therapy

Information Must Be Available for Interdisciplinary Rounds to Be Efficient and Effective

Reports for Interdisciplinary Rounds

- Physician
  - Latest lab results available on a computer in the room where rounds are held
- Nursing
  - Census
  - Vaccination report
  - Lasix report
- Case manager
  - LOS
  - 30-day readmissions
  - Observation vs. inpatient status
- Pharmacist
  - Current medications
  - Medications discontinued in the last 24 hours
  - Lab result trends over the last 48 hours
**Meeting Participants**

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Primary Nurse</th>
<th>Case Management Representative</th>
<th>Physician/Representative</th>
<th>Other Disciplines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURING ROUNDS</strong></td>
<td>• Facilitate rounds (ensure appropriate attendance, timed start/stop time)</td>
<td>• Provide brief introduction to the patient, including facility or care measures updates</td>
<td>• Discuss current plan of care and vision for patient’s stable disposition</td>
<td>• Share patient’s status and progress towards medical milestones (e.g., specific weakness or strength)</td>
</tr>
<tr>
<td></td>
<td>• Ensure tools such as pathways are available in the meeting and activity references</td>
<td>• Discuss pre-morning efforts to address any necessary variation from standard of care (e.g., order sets)</td>
<td>• Report recent changes in patient condition</td>
<td>• Identify clinical follow-up sections to ensure progress towards medical milestones (e.g., Respiratory Therapy protocol)</td>
</tr>
<tr>
<td></td>
<td>• Hold the case team accountable for creating a plan of care for every patient</td>
<td>• Discuss medical milestones that will demonstrate readiness for discharge and where to address them (e.g., patient only needs an MRI before discharge and it should be expedited)</td>
<td>• Discuss medical milestones that will demonstrate readiness for discharge; focus on those that have not been achieved and why; use pathway-specific milestones if available</td>
<td>• Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations)</td>
</tr>
<tr>
<td></td>
<td>• Address follow-up items from previous rounds</td>
<td>• Identify clinical follow-up actions to ensure progress toward medical milestones</td>
<td>• Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge</td>
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</tr>
<tr>
<td></td>
<td>• Identify and assign new follow-up activities</td>
<td>• Complete follow-up actions</td>
<td>• Complete follow-up actions</td>
<td>• Complete follow-up actions</td>
</tr>
</tbody>
</table>

| **AFTER ROUNDS** | • Check to ensure follow-up assignments have been identified | • Talk with physician about discharge readiness | • Facilitate rounds (ensure sets) | • Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations) |
| | • Proactively work with Case Manager to investigate and address any unnecessary variation from the standard of care (e.g., pathways, protocols) | • Complete follow-up actions | • Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations) | • Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge |
| | • Work with Case Manager to facilitate rounds (ensure sets) or address any unnecessary variation from the standard of care (e.g., pathways, order sets) | • Discuss specific barriers to discharge and ways to address them (e.g., patient only needs an MRI before discharge, and it should be expedited) | • Identify clinical follow-up sections to ensure progress toward medical milestones (e.g., Respiratory Therapy protocol) | • Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge |
| | • Prepare for rounds in shift reports | • Identify anyone with potential level of care (LOC) changes | • Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations) | • Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge |
| | • Document updates to Expected Discharge/Transfer Dates | • Discuss specific barriers to discharge and ways to address them (e.g., patient only needs an MRI before discharge, and it should be expedited) | • Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations) | • Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge |
| | • Discuss and ensure update of Discharge/Transfer Dates (for disposition clarification) | • Discuss discharge planning needs and options (e.g., nursing challenges; level of care needed; patient, family needs) | • Discuss barriers to discharge (e.g., funding, placement, patient suitability considerations) | • Identify any needs (e.g., equipment, placement, medication, therapy, and/or decision) before transition and post-discharge |
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| **Scripts Can Be Helpful**

**Scripting for Multidisciplinary Rounds**

- **Nutrition Services**
  - **Ground Rules**
    - Arrive for rounds at your scheduled time
    - No phone calls or side discussions during rounds
    - Limit paging during rounds
    - Ask questions, clarify when needed
    - Focus on the patient
    - Be respectful of each discipline—allow them to present without interruption
    - More in-depth discussions will need to take place immediately after all multidisciplinary rounds are completed

  **Important information for discussion at rounds**
  1. **Vaccine (flu and pneumococcal)**
  2. **Blood pressure/heart rate**
  3. **Nutrition support indications/limitations of TPN infusion**
  4. **Skin breakdown/decubitis**
  5. **Significant weight changes**
  6. **Allergies**
  7. **Discharge disposition indication for nutrition referral**

  **Pharmacy Guidelines**
  - **Ground Rules**
    - Arrive for rounds at your scheduled time
    - No phone calls or side discussions during rounds
    - Limit paging during rounds
    - Ask questions, clarify when needed
    - Focus on the patient
    - Be respectful of each discipline—allow them to present without interruption
    - More in-depth discussions will need to take place immediately after all multidisciplinary rounds are completed

  **Important information for discussion at rounds**
  1. **Critical lab values**
  2. **Vaccine (flu and pneumococcal)**
  3. **Therapeutic lab values (e.g., vanco level)**
  4. **Medication compliance issues**
  5. **Fall risk potential**
  6. **Medication renewals (i.e., antibiotic repeat doses)**
## Expected Length of Stay Tool

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Diagnosis Description</th>
<th>Expected Length of Stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>143.9</td>
<td>product specifications</td>
<td>5.3</td>
</tr>
<tr>
<td>415.1</td>
<td>expected description</td>
<td>5.3</td>
</tr>
<tr>
<td>143.9</td>
<td>expected description</td>
<td>5.3</td>
</tr>
<tr>
<td>194.1</td>
<td>expected description</td>
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<td>expected description</td>
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## Ensure Perfect Core Measure Process by Addressing Process Measures Daily

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>AMI/Chest Pain</th>
<th>Heart Failure</th>
<th>Stroke</th>
<th>Pneumonia</th>
<th>SCIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin at Arrival</td>
<td>Evaluate LV Function (EF &lt;40%)</td>
<td>Early Anti-thrombotics</td>
<td>Blood culture within 24 hours of Adm.</td>
<td>Antibiotic D/C 24 hours post-op</td>
<td></td>
</tr>
<tr>
<td>ACE/ARB for LVSD (EF &lt;40%)</td>
<td>ACE/ARB for LVSD (EF &lt;40%)</td>
<td>LDL</td>
<td>Blood culture prior to 1st dose of antibiotic</td>
<td>Foley removed by PO day #1 or 2</td>
<td></td>
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<tr>
<td>Aspirin at Disch</td>
<td>Beta Blocker</td>
<td>VTE Prophylaxis</td>
<td>Antibiotic within 6 hours after arrival</td>
<td>VTE prophylaxis</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Smoking Cessation</td>
<td>Rehab Note/Consult</td>
<td>Influenza Vaccine</td>
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<td></td>
</tr>
<tr>
<td>Beta Blocker at Discharge</td>
<td>Disch Instructions</td>
<td>Smoking Cessation</td>
<td>Smoking Cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statin at Disch</td>
<td>Education Packet</td>
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<td></td>
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</tbody>
</table>

Proprietary & Confidential
Care Progression Questions:

• What needs to happen for this patient to be extubated today?
• What clinical indications must be met for this patient to be trached?
• Now that the patient is 24 hrs post op, is there any reason we cannot remove the urinary catheter?
• What needs to happen so the patient can be discharged?

Daily Goals Should be Set by Care Team and Patient Together

• Care team identifies clinical goals for the day
• Discussion with patient about clinical goals
  ▪ Discussion with patient about personal goals for the day
  ▪ Feedback/ reflection on yesterday’s goals
• Examples of patient goals:
  ▪ Wean off opioid pain medication by 3pm
  ▪ Walk from bed to bathroom today
  ▪ Initiate hospice planning today
Goals Summary Should Be Placed on Patient’s White Board

- “Goals for the day, goals for the stay”
- Plan for discharge
- Communicating the plan

Benefits of Timely Discharge Planning

- Improved patient outcomes
- Increased satisfaction for all involved
- Securing appropriate reimbursement
- Reduction in avoidable days
- Increased bed utilization and timely discharges
Measure Process and Outcomes to Know Change Is an Improvement

**Process Measures**
- Staff attendance at interdisciplinary rounds, duration of discussion per patient, duration of each interdisciplinary rounds
- White board audit for daily goals
- Percentage of all patients or family caregivers who were able to “teach back” content taught
- Percentage of all patients discharged who had a follow-up visit scheduled prior to being discharged
- Percent of patients with a discharge call completed

**Outcome Measures**
- Percent of patients discharged by 11am
- Length of Stay
- HCAHPS – Communication with doctors
- HCAHPS – Communication with nurses
- Other patient experience measures – Discharge readiness, understanding medications
- Staff satisfaction
- Readmission rate

Satisfaction, Decreased Rework, Appropriate Care, and Decreased Cost Result from Multi-disciplinary Rounds

- Appropriate use of admission, discharge and transfer criteria to provide the right care in the right setting
- Pharmacy representation reduces medication errors and reduces prescription costs
- Fewer delays in care as a result of proactive coordination
- Adherence to clinical pathways and protocols
- Improved compliance with core measure processes of care
- Earlier detection of lab and symptoms
- Earlier detection of barriers to discharge can be mitigated and length of stay is reduced
- Improved appropriateness of referral patterns
- Fewer disruptions to care team work
- Increased accountability among care givers
- Routine communication promotes further collaboration and team building
- Improved staff satisfaction
- Lower turnover rates
- Inter-professional learning
Resources

Texas Hospitals

Care Coordination Concepts

Rural Care Coordination – Outpatient Settings
• Safety Net Medical Home Initiative. Website: http://www.safetynetmedicalhome.org/change-concepts/care-coordination
• Derrett S, Gunter K. Care Coordination in Rural Communities: Preliminary Findings on Strategies used at 3 Safety Net Medical Home Initiative Sites. 24 July 2012.

Interdisciplinary Rounds

Readmission Prevention
The Quorum Difference

The Quorum Difference is the extraordinary combination of consulting guidance and operations experience that enables client healthcare organizations to achieve a sustainable future.

Thank you

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.