(PC.I60.1) The Interdisciplinary Group Meeting Protocol

Basic Meeting Etiquette:

- Be on Time.
- Be prepared: all documentation should be completed prior to the meeting with the exception conversations and changes that occur during the meeting.
- Make introductions as necessary – always introduce any guests or newcomers to the meeting and describe their role/purpose.
- Follow the agenda.
- Speak clearly and professionally. Refer to patients and families by their proper names and do not speak about anyone in a derogatory manner.
- No cross talk – listen to others. No side conversations.
- Keep your report concise and remain focused on important and relevant information.
- Silence your phone and pay attention to the meeting.
- If you need to eat, as is often the case, be respectful of others and try to avoid strong smelling foods or loud wrappers/crunching.
- Clean up after yourself, and push your chair in.

Prior to the meeting, the Team Director or Designee should assign one or two people to scribe for the meeting. One person should be capturing a summary of the team discussion, the other can be entering any updates, or orders if given.

Throughout the meeting the patient's medical record should be projected and relevant sections shown during review (i.e. IDG summary, medication profile, etc.).

The Meeting Agenda

Team Building Exercise (5 minutes): Open the IDG meeting with a simple team building exercise. There are some suggestions available: http://www.ventureteambuilding.co.uk/category/5-minute-fillers/

Educational Presentation (10 minutes): Often presented by the team physician or the team manager, the education should be relevant to something that the team needs more information about. Look for interesting or unusual cases or situations.

Clinical Patient Review

Deaths (3 – 5 minutes per family):

Report as follows: Patient name, date and location of the death (home, facility, etc.). Quality of the death experience, were the patients wishes honored? Was the hospice team present and who pronounced?

Bereaved: Who is the primary bereaved for this patient? Who is the person who should receive the caregiver survey? Validate all the contact information for all bereaved and have the scribe update the EMR to ensure accurate delivery of mailings and calls.

Risk assessment: Low, moderate or high? Who will follow if high-risk? Who will follow if moderate or low-risk?

Live Discharges (2 – 3 minutes per patient):

Report as follows: Patient name, date of discharge, type of discharge, where patient was discharged to (hospital, home care, palliative care).

Note: These are the possible reasons for live discharge and the relevant details that should be reported for each:

Extended prognosis: Any follow up services required (DME, referrals, homecare), who from hospice will check in with patient/family for ongoing eligibility?

Revocation: Patient seeking aggressive care or care that is not congruent with the hospice philosophy. Patient can be seeking care that is other than hospice care.

Discharge:

Moved out of service area: Where did patient move to? Was a hospice referral made?

Seeking care in a non-contracted facility: Who will follow up with the facility to attempt to get a contract moving forward? Who will follow up with the patient if they will return to their home?

Discharge for Cause: Patient or family behavior is disruptive, abusive or poses a threat to the hospice staff or that precludes the delivery of care to the patient. Patient and/or family are unwilling to comply with the plan of care after all attempts to resolve the problem have failed.

Transfer: Which hospice was the patient transferred to? Was there a specific service failure that is appropriate for the team to discuss?

New Admissions (4 – 7 minutes per patient):

Discuss and review all patients admitted since the last IDG meeting

Review the admission information as follows:

Case Manager reports:

- **Demographic information**: Name, age, gender, location (ALF "name", primary caregiver and relationship, terminal diagnosis and supporting diagnoses, attending physician.
- **Eligibility Review**: LCD criteria with supporting information and contributing factors. Review of terminal diagnosis.
- **History of Illness:** Discuss the progression of the disease.
- **Medication Review** with IDG and Team Physician
- **Visit Frequency:** can be a range of one (ex. 1-2/week) but not less than once per week. No more than three (3) prn visits can be used.
- **Plan of Care**: active problems, interventions and goals for each problem.
- Any changes since admission and any new care needs or informational needs.

Social Worker reports:

- **Visit Frequency**: Can be a range of one (1-2x/month) with no more than one (1) prn visit.
- **DNR/DNI** status and next steps
- **Advanced Directives** and next steps
- **Primary bereavement** person, risk and validated contact information
- **Psychosocial assessment** data that is relevant for the team
- **Plan of care** for any supportive care needs

Spiritual Care Coordinator reports:

- **Visit Frequency**: Can be a range of one (1-2x/month) with no more than one (1) prn visit.
- **Funeral home** and end-of-life plan/status (i.e. organ donor, cremation, etc.)
- **Spiritual Assessment** data that is relevant for the team
- **Plan of care** for any spiritual needs
- Anticipated spiritual care needs.

Recertifications: (3 – 5 minutes per patient)

Case Manager Reports:

- **Demographic information**: Name, age, gender, location (ALF "name", primary caregiver and relationship, terminal diagnosis and supporting diagnoses, attending physician.
- **Eligibility Review**: LCD criteria with supporting information and contributing factors. Report on any decline in the past benefit period and since admission. Review of terminal diagnosis.
- **Medication Review** with IDG and Team Physician
- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Plan of Care**: active problems, interventions and goals for each problem.
- **Any changes since last certification** and any new care needs or informational needs

Social Worker Reports:

- **DNR/DNI/Advanced Directive** status and next steps**.**
- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Eligibility Review**: report on any psychosocial changes or declines that have occurred since previous certification and since admission.
- **Assessment/POC update**: Review of existing POC problems and progress towards goals, new problems identified and plan of care to address new problems. Anticipated social work needs for the upcoming two weeks.

Spiritual Care Coordinator Reports:

- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Eligibility Review**: report on any spiritual changes or declines that have occurred since the previous certification and since admission.
- **Funeral home** and end-of-life plan/status (i.e. organ donor, cremation, etc.).
- **Assessment/POC update**: Review of existing POC problems and progress towards goals, new problems identified and plan of care to address new problems. Anticipated spiritual needs for the upcoming two weeks.

Review of Active Patients (1 - 5 minutes per patient – acuity based):

Best Demonstrated Practice (BDP): Existing patients should be reviewed using the Red/Yellow/Green method. High risk (red) patient should be reviewed first to allow ample time for care planning. Moderate risk factors are reviewed next and then routine care patients without

active/intense issues. Note: If a patient remains “green” for more than six (6) weeks, then the registered nurse case manager should review patient for ongoing eligibility.

Red patients: Active or challenging symptom management needs, higher level of care (GIP/CC), concurrent care, psychosocial high-risk patients, spiritual high-risk patients, families likely to call 911, frequent after-hours calls, no DNR/Full code, patient who might be moving towards live discharge and their plan.

Review the patient’s plan of care in the following order:

Social Worker reports:

- **Demographic information**: Name, Age, Gender, Location, terminal diagnosis.
- **DNR/DNI/Advanced Directive status.**
- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Assessment/POC update**: Review of existing POC problems and progress towards goals, new problems identified and plan of care to address new problems. Anticipated social work needs for the upcoming two weeks.

Spiritual Care Coordinator reports:

- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Funeral home** and end-of-life plan/status (i.e. organ donor, cremation, etc.)
- **Assessment/POC update**: Review of existing POC problems and progress towards goals, new problems identified and plan of care to address new problems. Anticipated spiritual needs for the upcoming two weeks.

Case Manager reports:

- **Visit Frequency**: state frequency, *date of last visit* and *next anticipated visit date*.
- **Eligibility review**: state how the patient meets LCD criteria and any new decline to support ongoing eligibility.
- **Assessment/POC Update**: Review of previously identified active problems and intervention response for the past two weeks. Report of new problems identified during the past two weeks and new interventions for plan of care. Anticipated nursing needs/changes for the upcoming two weeks. This review should include review of any new medications, treatments.
- **Hospice Aide** can contribute any additional relevant information at this point if they are present, although the case manager should have already been informed of any changes.