Integrating Your Interdisciplinary Team
For Resident Outcomes

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With lengths of stay shortening and acuity rising, it is imperative that organizations have strong interdisciplinary teams. Interdisciplinary team work is increasingly prevalent, supported by policies and practices that bring care closer to the patient and challenge traditional professional boundaries. To date, there has been a great deal of emphasis on the processes of team work, and in some cases, outcomes. The communication among the IDT can significantly improve resident outcomes and facility efficiencies. This session will explore strategies for effective IDT meetings, who should participate in these meetings and what should be discussed. We will examine how often these meetings should occur and what errors often happen during IDT meetings. This session will explore quantitative and qualitative strategies and measures to ensure the best practices.
Definition
What is IDT Care

- Coordinated, collaborative, independent delivery of care
- Focuses on issues best addressed by interdisciplinary teams
- Provided by a group of care givers with various backgrounds sharing common resident-care goals
- Relies on coordination, communication and shared responsibility
Roles
Who is on your IDT

- MDS
- NHA
- DON
- Social Services
- CNA
- Dietary
- Life Enrichment
- Therapy

Case Manager??
Physician??
Responsible party??
Teamwork Advantages

For organizations
- More efficient care delivery
- Maximize resources
- Increase preventative care
- Continuous quality improvement
- Develops cross-functionality for team members

For residents
- Improved care
- Integrated care
- Empowerment in decision-making
- Time efficiency
- Better outcomes
Key Aspects of Communication

- Care Planning
- Information Exchange
- Teaching
- Decision Making
- Negotiation
- Leadership
Why is your IDT important

• Health Care Reform brought about Integrated Health Care
• Collaboration and communication among the team caring for resident
• Manage the health and well-being of residents
• Team approach
• Cross-functional communication gives us the ability to validate RUG levels based on clinical outcomes
• Outcomes are also expected to be used to benchmark the performance of health care providers, potentially allowing payers to link reimbursement to evidence of the effectiveness of their treatment
Pressure for Enhanced Teamwork

• Healthcare System
  – Organizational Changes: mergers, acquisitions, closings
  – Financial Changes: incentives, reimbursement models
  – Priorities: shorter length of stay, out-patient services, home-based services
Enhanced Teamwork

- Cost effective care models
  - Hospice
  - Visiting Nurse
  - Day treatment
- Emphasis on health promotion
- Emphasis on disease prevention
- Community based services
Goals & Structure

VISION

SKILLS

GOALS
What to Track

What outcomes do you expect? What are you tracking?

• Length of stay
• Diagnosis
• Physician
• Referral Source
• Discharge location
• Planned or Unplanned discharges
Process

- Timely identification of patients in need of services, discharge planning starts at the time of admission to facility
- Referral to appropriate team member(s) who has a high level of expertise in the area(s) of health and social interventions needed
- Assessment by the IDT to determine the individual's strengths, challenges, prognosis, functional status, goals, and needs for specific services and resources
- Development of a plan that identifies short/long-term patient-centered goals, support systems, interdisciplinary collaboration and use of appropriate resources
Expectations

• Identification, procurement, and coordination of services and resources
• Provision for ongoing evaluation of the individual's progress; including revisions and updates, throughout the entire continuum of care
• Advocacy for the most appropriate, cost-effective, evidence-based services to assure quality of care and attainment of appropriate goals
• Promotion of the individual's self advocacy skills to achieve maximum self sufficiency: Individualized care
Expectations

• Have a basic understanding of the existing disease process
• Have routine times to contact patient and review progress / interview
• Assist the patient in meeting goals toward optimal function
• Facilitate communication during team meetings
• Patient advocate between all care providers
Outcomes Communication

- Patient
- Families/POA
- Physicians
- Referral Sources
- Managed Care/Insurance Companies
- ACO’s
Tools For Success
Tools To Help With The Process

• Follow your agenda
• Stick to day/time
• Tracking your progress
  – Bed board
  – Hand-outs
  – Projector
  – Computer
• COMMUNICATE
Bed Board

Rm 101
- Admit date
- Therapy end date
- Cardio Appt
- Flu Vac

Rm 102
- Wound
- Podiatry
- Home eval
- Payor change

Rm 103
- MCD app
- Dialysis transport
- Care plan meeting

Rm 104
- U/A
- Room change
- Fall Risk
- Restorative

Rm 105
- Empty
- Ready for move in
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Computer and Projector

- Designate a note taker
- Allows for team to see
Obstacles/Challenges
Challenges

- Too Many Meetings
- Logistics
- Staying on track
- Differences in communication styles
- Different disciplinary perspectives
- Excuses
- Absent team members
- Distractions
You Can Do It

• Stay calm
• Keep on track
• Know the expectations
• Train your team
• Be prepared to evolve
Communication

Across the Healthcare Continuum
Handoff is Essential

• Care transitions can be particularly difficult for elderly residents. During and after transitions, residents are more likely to experience complications and require acute care. It is important to monitor patients closely and put precautions in place to help prevent transition-related issues.
• More patient adverse events occur due to information not correctly passed on during the handoff.

• According to Joint Commission 62% of accidental deaths and 80% of serious medical errors are linked to communication failures.
Communication failures

- Resident taking anticoagulant
  - Increases risk for injury
- NPO
  - Increased potential for aspiration
  - May delay scheduled test/procedure
- Isolation status
  - Flu season, VRE, MRSA, Shingles
- Code Status
Breakdown of communication results in failure to achieve optimum patient outcomes
Safe Practices?

Healthcare entities tend to operate in SILOS resulting in Communication Failures
DEFINITION of 'Silo Mentality' An attitude found in some organizations that occurs when several departments or groups do not want to share information or knowledge with other individuals in the same company. A silo mentality reduces efficiency. In a Healthcare Environment: Compromises patient safety.
Good Communication

- Patient centered care
- Dissolution of silos
- Continuous flow of information that supports continuity of care
- Eliminates duplication of services.
Handoff continues to be the most critical time in a patient episode of care, and in many cases, the aspect that gets the least attention.
• More patient adverse events occur due to information not correctly passed on during the handoff.

• According to Joint Commission 62% of accidental deaths and 80% of serious medical errors are linked to communication failures.
Some Challenges

- **Patients**: Institutions foster dependence and complacency. Abrupt change with discharge home to self care

- **Practitioners**: Many physicians transfer patient to a setting in which they have never practiced. They do not orchestrate care across the continuum

- **Healthcare Institutions**: already established many operate in silos (aka synapse failure)
What IS Working?

- Hospital
- SNF
- Home Care
Healthdata Exchange vs Interoperability

- Healthdata exchange: Sending information, electronic health records (SBAR)
- Interoperability: being able to understand and use the data, the systems have to work together and exchange data in a manner that is understood by both parties.
Emerging Models

- Large Multispecialty Healthcare Providers: all inclusive care
- Professional Networks in geographical locations: Same data system
- Universal Health Record: participants have access anywhere, anytime.
Successful transitions are not only measured by the partnerships established reducing readmissions improvement in patient/family understanding

Both can be addressed by introducing a Caregiver who will provide oversight into the mix.
Care Coordinator Transition Coach

- Management of Disease Process
- Medication Management
- Compliance with follow up Practitioners

*Single Point of Contact*
Case Management Models

Disease Specific: Joint Coordinator

- Pre-surgical coordination of care
- Cultivate relationships with physician practices
- Pre-procedure education
- Prepares patient for transitions of care
- Attends follow up appointments and follows throughout duration of “episode of care”
Successful Organizations create a consistent, seamless experience and transition of care from pre-admission to discharge, connecting with PCP, SNF, and other healthcare provider as necessary.
Upstream and Downstream Partnerships
patient outcomes; proven track records
high quality care
satisfied patients
financial responsibility

Don’t forget communicating patient information across the continuum
...AND THAT IS WHY WE LIFT ON THREE...

COMMUNICATION
Resources:

- The Care Transitions Program: Eric A Colemen, MD, MPH. University of Colorado Health Sciences Center [www.caretransitions.org](http://www.caretransitions.org)

- Healthcare Management Technology: Living Case Study: Seamless Communication Across the Continuum of Care; Rhonda Collins, MSN,RN, CNO Vocera Communications

- IHI: Pursuing Perfection: the Synapse Between Silos: Patient-Centered Care in Whatcom County


- Healthcare IT News; ‘Silo’ one of healthcare’s biggest flaws.: Eric Wicklund