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| Subject: Interdisciplinary Team (IDT) Process | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
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POLICY:

The program will have an identified Interdisciplinary Team (IDT) to ensure a comprehensive approach to the patient’s medical and/or rehabilitation needs hence increasing the opportunity to achieve the highest level of function the patient may be expected to attain in a given length of time.

There will be a pre-determined scheduled interdisciplinary team meeting on set days and time based on the date of admission to allow for a first IDT conference within 3 days of admission and weekly thereafter. [Make sure you change this to what you do if you do not agree with this process].

Team Members for the actual IDT meetings may include: [remove the ones you do not have and add others if pertinent]:

* Care Management
* Therapists (PT/OT/SLP)
* Nurse Manager or designee
* Respiratory Therapists
* Pharmacist
* Dietician or representative
* Physician caring for the patient or designee.
* Chaplain.

PROCEDURE:

# Each discipline will complete a discipline specific admission assessment to include therapy discipline as ordered by the physician within the same day if at all feasible but no less than within 48 hrs. of admission due to weekend/holiday and based on the discipline.

# Care Management will complete a discharge planning assessment involving the patient and family to ensure a comprehensive approach to identifying the patient’s specific needs and discharge goals.

# The patient and family will be informed about the interdisciplinary team process including the availability of the IDT to meet with the patient/family as needed based on theirs or the team’s request.

# At the initial IDT meeting, the Care Manager will represent the patient/family and start by introducing the patient using the information gathered during the discharge planning assessment.

# Also, at the initial IDT meeting, each discipline included will share the outcome of their discipline specific assessment and treatment plan with the team.

# The IDT members will then discuss skilled needs and agree on key functional and measurable discharge goals [including specific self-care & mobility goals compared to admission score – delete if you are not following option 2 of the QAPI project], discharge disposition and the estimated length of stay.

# If measuring Self Care and Mobility within 3-day of admission and comparing with scores within 3-days pre discharge as part of the PI/QI process, it will be imperative for nursing, therapists, and care manager to huddle and score chosen ADLs as close to admission as possible and again as close to discharge as possible.

* This may be part of IDT meetings if the timing is correct or separately as needed.

# Care Management will meet with the patient/family following the initial IDT meeting to discuss the outcome and discharge goals which he/she will also write on the patient’s whiteboard [note here if you will be using anything else but whiteboard] to be used as a reminder for patient/family and staff.

# There will be a weekly IDT meeting 7 days from the date of the initial IDT meeting to discuss progress, make changes in the treatment or discharge plan as needed and to ensure a clinically strong and cost-effective program. This is over and above daily huddles to discuss clinical issues that may interfere with the plan of the day and/or the discharge plan.

# Each team member will complete documentation of a weekly progress note the day prior or morning of the subsequent ITD meetings to ensure that the meeting is used to discuss and share information vs writing a progress note.

# Care Management will meet with the patient/family at a minimum on a weekly basis within a few days prior to and within 24 to 48 hrs. post each IDT meetings to be able to represent them at the meeting and update them on the progress and on-going plan.

# At the subsequent IDT meetings, Care Management starts the review of each patient care by giving a quick overview of the patient i.e., the admission date, diagnosis, ELOS, and planned days left.

# Care Management will then lead the team in reporting their findings based on discharge goals to determine readiness. This meeting will also serve to discuss DME or other services the patient may need during the program or post discharge.

# Any patient/family issues, which may impact the discharge, and revision for the discharge plan if applicable will be documented on the ITD meeting form.

# If the physician involved in the care of the patient is not able to attend the IDT meetings, he/she will discuss the status of the patient with the care manager prior to the IDT meeting and will be informed of the outcome of the IDT meetings and on-going needs and/or anticipated discharge date the day of or day after each IDT meetings.

# The care plan will be revised weekly as part of the Interdisciplinary Team process. This can be incorporated into the team meeting. This revision to the care plan must occur at a minimum weekly and must be based on the Interdisciplinary Team review.

# The [hospital name] conducts “huddles” [daily or other timeframe] to discuss acute patient’s status, medical issues, change in condition, or issues that may interfere with the treatment plan for the day. Swing bed patients will be included in this discussion if there is anything pertinent – otherwise they will be discussed separately at the initial and weekly IDT meetings only. The therapy staff will be notified of potential needs if the day’s treatment plan needs to change.

* Note: if the patient is part of a case managed payor or bundled payment, the team may want to discuss and review the progress and discharge plan on a more frequent basis than weekly.

# Separate from the IDT meetings, huddle with nursing, therapists, and care management will be required if scoring admitting self-care & mobility scores and discharge ADL scores.

# Care Management will inform the patient in writing using the Medicare’s Notice of Non-Coverage within 2 days of discharge, as agreed to by the IDT team if the patient is discharge to any other place than hospital inpatient acute care, acute rehab, long-term care hospital or SNF level of care.