Caring for the Patient Using an Interdisciplinary Approach

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Objectives
- Be able to identify, define and develop an interdisciplinary patient care team to meet the patient’s needs and increase patient outcomes
- Be able to complete an accurate initial and comprehensive patient assessment throughout the entire interdisciplinary team
- Understand goal driven care verse task oriented care
- Know the importance of on-going communication

484.60 Condition of Participation: Care Planning, Coordination of Services and Quality of Care
- NEW CoPs – January 13, 2018
- Combined:
  - 484.18: Acceptance of Patients, Plan of Care, Medical Supervision
  - 484.14: Coordination of Care
- 5 standards:
  a) Plan of Care
  b) Conformance with physician orders
  c) Review and revision of the plan of care
  d) Coordination of care
  e) Written information to the patient
Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

The individualized plan of care must include the following:

- All prior items that were needed AND...
- A description of the patient's risk for emergency department visits and hospital re-admission
- Including all necessary interventions to address the underlying risk factors
- Not suggesting a specific tool or process at this time

All patient care orders, including verbal orders must be recorded in the plan of care.

The plan of care is an evolving document that outlines the patient's journey throughout HHA care and treatment.

It is essential that the plan of care be reflective of past orders and current orders that are actively ongoing.

As new orders are given to initiate or discontinue an intervention, the plan of care is updated to reflect those changes.

All verbal orders must be documented in the patient record, signed, dated and timed.

New versions of the plan of care are created as needed to assure that each clinician is working on the most recent plan of care, with older versions being filed away in the clinical record in any manner that meets the needs of the HHA.

Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and the physician who is responsible for the HHA plan of care.
Definition:
- Enhanced system of communication and integration to identify patient needs, factors that could affect patient safety and treatment effectiveness, coordinate care provided by all disciplines, and effectively communicate with physicians.

Final rule response:
- “Coordination of patient care entails assuring that patient needs are continually assessed, addressed in the plan of care, that care is delivered in a timely and effective manner, and that goals of care are achieved.
- HHAs may document these activities in a manner that suits their needs to demonstrate compliance”.

The Home Health MUST:
- Assure communication with all physicians involved in the plan of care.
- Integrate orders from all physicians involved in the plan of care and interventions provided to the patient.
- Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs & factors that could affect patient safety & treatment effectiveness & the coordination of care provided by all disciplines.

The Home Health MUST:
- Coordinate care delivery to meet the patient’s needs & involve the patient, representative (if any), & caregiver(s), as appropriate, in the coordination of care activities.
- Ensure that each patient, & his or her caregiver(s) where applicable, receive ongoing education & training provided by the HHA, as appropriate, regarding the care & services identified in the plan of care.
Coordination of Care –
Written Instructions to Patient

- The Home Health agency must provide the patient and caregiver with a copy of written instructions outlining:
  - Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA
  - Patient medication schedule/instructions
    - Including which medications will be administered by HHA personnel and personnel acting on behalf of the HHA
  - Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services
  - Any other pertinent instructions related to the patient’s care and treatments that the HHA will provide, specific to the patient’s care needs
  - Name and contact information of the HHA clinical manager

Interdisciplinary Patient Care

- Is dependent upon the interdisciplinary team working together towards collaborative goals and coordinating the patient care in a proactive manner
- The primary goal of the clinician is to enhance patient outcomes by planning a course of interventions and developing a plan to achieve the goal
- The case manager takes this a step further by coordinating the patient care with the other disciplines caring for the patient to ensure a collaborative team approach

Interdisciplinary Patient Care

- Begins with the referral:
  - Discharge orders from the hospital & physician must flow to the Plan of Care for a continuum of care to be effective
  - Ensure orders correlate with orders on the 48S
  - Begin planning the episode with assignment of disciplines already for the patient…….

THIS IS THE INTERDISCIPLINARY PATIENT CARE TEAM!
Initial Assessment Visit

- First clinician in the patient’s home who determines:
  - Eligibility for home care services
  - Homebound status if Medicare
  - Immediate care needs
- Clinician performing the initial assessment visit must have:
  - Excellent assessment skills
  - An understanding of payer’s coverage criteria

Timeframe:
- Must be completed within 48 hours from referral or return to home unless physician ordered SOC date

Who performs:
- If orders for nursing exist at all (1 visit or on-going visits) the RN must complete the initial assessment
- If orders are for therapy only, then therapist can complete
  - OT is NOT allowed to complete for Medicare

Explain the primary goal of services
- Discuss an anticipated discharge date
- This is NOT the 60 day episode

During assessment:
- Evaluate what other disciplines are required in order to meet the needs and goals of the patient
Comprehensive Assessment

- Looks at patients in 360 degrees
  - Clinical and functional
  - Caregivers and other services
  - Environment
- Perform a comprehensive assessment of the patient that includes:
  - Observation
  - Interview
  - Caregiver / representative, if applicable
  - Prior level of functioning
  - Patient history

Comprehensive Assessment: NEW Requirements

- Must include:
  - The patient’s current health psychosocial, functional, and cognitive status
  - The patient’s strengths, goals, and care preferences, including the patient’s progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA
- Other changes:
  - Resumption of care assessments may be completed within 48 hours OR on physician-ordered resumption of care date

Comprehensive Assessment: OASIS

- Do not simply ask the questions, instead ask the patient to:
  - Walk you to the bathroom to show you how he/she gets in the shower/bath
  - Read you his/her medication bottles to you
  - Take his/her socks & shoes off for assessment and then put on again
  - Show you how he/she goes from a laying to sitting position
Comprehensive Assessment: OASIS
- By having the patient actually show you how he/she does things, the questions on the assessment will be answered in the most accurate fashion.
- Doesn’t take more time, as many questions can be answered when patient is performing one task.
- Observe for outcomes that the team can help the patient improve in.

Comprehensive Assessment: OASIS
- Assess:
  - Pain
    - Not just current but past 24 hours
    - Did the patient stop an activity because it was painful
    - Does pain prevent the patient from doing something
  - Shortness of breath
    - Include observed and any reported

Comprehensive Assessment: OASIS
- All disciplines on subsequent evaluations and visits need to perform the same type of assessment in order to be objective and assure accuracy of the patient outcomes.
- Often the variances in the assessments for OASIS timepoints are due to clinicians performing assessments differently.
- Especially on discharge OASIS.
Expansion of the One Clinician Convention

- Was effective as of January 1, 2018
- Comprehensive assessment will continue to be the responsibility of one clinician as required by the CoPs but......
  - Now allows the assessing clinician to get feedback from other agency staff to complete any or all OASIS items
- MOO90 – Date assessment completed may need changed
  - The last date the assessing clinician gathered or received any input to complete the comprehensive assessment documentation

References:
- Chapter 1 in the 2018 OASIS Guidance Manual

Involving the Patient and Caregiver/Family in the Plan of Care

- Establish preliminary goals for the episode of care
  - On the admission visit
  - Include the patient, representative (if any) and any other caregiver(s)

Goals:
- The goals must be realistic, objective and achievable
- Choose goals that will enhance patient outcomes
- The clinician and patient/caregiver must agree on goals or success cannot be achieved

Admission Conference

- Held by:
  - The admitting clinician
- Will involve:
  - All members of the patient care team and the clinical coordinator
- Topic of discussion:
  - Patient situation
  - Issues identified during the assessment
  - Keeps other clinicians from "going in blind"
- This interdisciplinary team will then develop a proposed plan based on:
  - Discussing diagnoses
  - Establishing projected frequency and duration of disciplines
The Plan of Care & Projecting the Episode

- Interdisciplinary communication should take place after each discipline assesses the patient.
- The goal:
  - Have input prior to printing of POC/485 in order to have discipline frequency, duration and orders.
  - If other disciplines see the patient within 48 – 72 hours, this can be possible.
  - This keeps the POC/485 from being just a nursing care plan.
  - For GOAL DRIVEN CARE this is essential.

The Plan of Care & Projecting the Episode

- The team projects number of visits per week and schedules as a team.
- Spread out visits
- Be each other’s eyes and ears - report issues to each other.
- Front load visits
- Increase frequency for all disciplines at beginning of care.
  - Then decrease plan as episode progresses and patient works towards the goals set by the team.

Schedule
Utilization of Disciplines

- Be sure that you are not under utilizing services thinking that you must do so to survive financially.
- If your patients are case managed, often utilizing more disciplines can:
  - Decrease SN visits
  - Decrease length of stay
  - Increase outcomes
  - May increase reimbursement

Most commonly used:
- Nursing
- PT

Underserved:
- Aide
- OT
- MSW

Big part of the interdisciplinary team
- New CoPs recognize this as well
- The aide is with the patient for a longer period of time and often in an intimate setting
- The patient talks more to the aide and the aide can see what the patient is able to do
- Ensure that the aide reports all changes to the team
Occupational Therapy

- Agency’s secret weapon if ADL and IADL scores are low to increase outcomes
- When aide services are ordered:
  - OT can assist the aide in progressing the patient’s independence leading to a decreasing of aide visits over the episode
  - For patients with compromised respiratory systems, OT’s can work on energy conservation techniques

MSW

- Specialty many agencies do not utilize
- An MSW visit can increase SN productivity and decrease visits and/or office time
- Be sure a skilled need is documented
- Be sure that the MSW follows up by making a second visit when necessary for resolution

Patient Outcomes

- Many are related to ALL disciplines:
  - Pain
  - Ambulation
  - Dyspnea
- Team meeting:
  - Hold after all disciplines have performed initial assessments
  - Choose outcomes that will be focus of episode
  - Formulate a plan to increase the outcomes by working together
Communication
- Team needs frequent and ongoing communication
- Communication should be kept:
  - Brief
  - Concise
  - To the point
- Formal case conferences may not be frequent enough
- Recommend at least weekly communication
  - As needed with any pertinent changes

Communication
- Identify what should be communicated
  - Important to avoid lengthy and/or detailed communication
- Coordination of care communication needs to be pertinent information between the entire team
- Identify methods and how often:
  - Electronic,
  - Voice mail, and/or
  - Face to face
- All coordination of care must be documented in the medical record

Communication
- Sub-contracted disciplines
  - Agency "owns" the patient and is responsible for coordination of care
  - Hold sub-contractors accountable
  - Set up processes and meet
  - Sub-contractors must interact with the team as if they were your employee
Evaluate How the Plan is Working

- The patient’s progress needs to be regularly assessed and discussed as a team
- Helps to ensure that the team is on the same page
- Helps to decide if another discipline is needed in order for the patient to meet the goals
- Helps to decide if the goals/outcomes or the plan of care needs revisions
- Ensure physician is included and that orders are received

Root of the Problem

- Clinicians in home care are typically very good at identifying patient problems
  - However, often the problem is not fully addressed in an appropriate manner
- Much easier to get to the root of the problem when working together as a team
- By communicating regularly as a team, solutions to problems often occur
- Increases patient outcomes
- Documentation of any follow-up and resolution is important

Discharge or Recertification

- A formal case conference is advised at least monthly to plan for the upcoming month
- Patients with ending episodes approaching in 2 – 3 weeks should be discussed as a team
  - A team decision should be made to:
    - Discharge from care,
    - Discharge from a discipline, or
    - Recertify
- A case conference should always be held before a discipline discharges
  - Formally or informally
Discharge

- When discharging the patient, ensure the assessment is done in a thorough and objective manner
- Use the same approach at admission and throughout care
- Results of your patient outcomes, your agency's outcome measurements, and 5 star rating depend on this consistency

Recertification

- When recertifying a patient
  - Assure that continuing communication occurs between team members still seeing the patient
  - Review goals and revise as needed
  - Key element that is necessary but often overlooked
  - Ensure that the plan of care for the next episode doesn’t mirror previous episode

Scheduling an Effective Interdisciplinary Patient Care Team System

- Set up clinical teams by geography and/or skill
- All disciplines on a team
- Assign patients to clinician teams
  - Team then carries a patient caseload
- Set up a process where clinicians submit their schedules to the agency
  - Weekly, bi-weekly, monthly
  - Includes agency employees and sub-contractors
  - Clinical manager provides oversight of schedules
  - Verify patients are seen and visits are done per physician orders
Scheduling an Effective Interdisciplinary Patient Care Team System

- Identify qualified RN’s to be case managers
- Goal / outcome-oriented
- Great organizational and communication skills
- Knowledgeable with OASIS comprehensive assessment
- Looks at the big picture
- Form teams consisting of case manager and visit nurses
  - RN
  - LPN's / LVN's
  - Assign all disciplines on an interdisciplinary patient care team
  - PT / PTA
  - OT / COTA
  - SLP
  - MSW
  - Aides

Steps to Case Management

- Look at the big picture
  - You are caring for the patient, not the wound
  - Coordinating care and collaborating with multi-disciplines, not acting alone
  - Working with patient in his/her home environment with his/her family or caregivers interacting in a dynamic fashion
  - Be active, not passive
  - You and other clinicians are identifying issues and concerns relating to your patient’s well-being
  - Be sure to address every one of these issues
  - Your team must be responsible to follow through with problem-solving for your patient
  - Patients depend on you

Case-Management & Care Coordination

- Effective case management and care coordination leads to:
  - Increased patient and agency outcomes
  - Increased financial viability
  - Increased customer satisfaction
  - Increased employee satisfaction
QAPI Indicator –
Coordination of Care

Criteria

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<thead>
<tr>
<th>Patient A</th>
<th>Patient B</th>
<th>Patient C</th>
<th>Compliance</th>
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<tr>
<td>Team Coordination (RN / Therapy / Aide / MSW etc.)</td>
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<td>• After initial visit (each discipline)</td>
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<td>• Adequate to RN and OT with follow-up</td>
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<td>• Adequate every time a revised care plan needed</td>
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<td>• RN documents follow-up to date</td>
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<td>Coordination of Care with Clinical Manager and/or designee</td>
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<td>• Prior to agency discharge</td>
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Team Works to Improve with Patient

• Within 30 days of initial care plan documents communication that identifies areas to improve
• Documentation of areas to improve documented at minimum every 30 days

Physician Notified as Necessary

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Thank you!