Dear Dr. Jeff:

I keep reading about the “interdisciplinary team,” but at my facility the feeling is more that of a free-for-all. Getting different departments and different disciplines to work together seems almost impossible. Do you have any suggestions about how to make this work?

Dr. Jeff responds: In many long-term care facilities, there are individuals of good will who recognize the interdisciplinary team’s potential to improve the quality of resident care and the work atmosphere, as well. Here are some suggestions as to how to move in the right direction.

Several tools, although designed for other purposes, have the happy effect of fostering interdisciplinary communication. For example, the Interventions to Reduce Acute Care Transfers (INTERACT) tools were initially designed for their named purpose. Because this project’s support from the Centers for Medicare & Medicaid Service and its obvious potential for care and financial benefits in nursing homes, INTERACT can garner support from a wide variety of facility professionals and staff, including administrators. Furthermore, a systematic attempt to introduce and use INTERACT’s tools might qualify as the facility’s Quality Assurance/Performance Improvement (QAPI) requirement under the Affordable Care Act.

The key here to reducing unnecessary hospitalizations is improved communication. For example, INTERACT encourages certified nurse assistants (CNAs) to point out to nurses any change in the status of a resident. That input builds the information that the floor nurses provide to attending physicians and non-physician practitioners.

Obviously, this communication can improve the decisions to be made by practitioners. It also signals that floor nurses have a significant role in these decisions and invites all staff to use their assessment skills in a collaborative way. The program creates a format for a genuine interdisciplinary discussion of the care plan for an acutely ill patient, whether or not the ultimate outcome is hospitalization.

Many of AMDAs clinical practice guidelines can also function as a framework for interdisciplinary care. Because pressure ulcers, diabetes, falls, dementia, and other problems inherently call on multiple disciplines, working together around one or more of the guidelines and their implementation toolkits can demonstrate the technique and the value of interdisciplinary care. The process reminds each member of the team that other disciplines have key information and skills to bring to the table.

Ultimately, good interdisciplinary teamwork occurs at the nursing unit and bedside (or at least chartside) level. Getting directors of nursing, administrators, and medical directors to talk to each other may be a good first step, but it is the care team, not the leadership team, that occupies the center of interdisciplinary care. INTERACT and AMDAs clinical practice guidelines will work only when they are brought to the bedside. There are some simple steps to make that happen.

The Very Good Book

One possible practice is using communication books. These should be individualized to the attending physician or nonphysician practitioner who is regularly seeing the resident. Team members need to write, off the chart, what they are observing and thinking. Since medical visits often occur when other team members are unavailable, this is an opportunity to address care issues together in at least a virtual conversation. A book should have some mechanism for marking when questions or suggestions have been read and there must be space for an appropriate response.

In my experience, communication books are more effective than telephone messages or faxes, because input occurs near the chart, the order book, and the patient. Obviously, comments should be more thoughtful than “yes” and “no.”

Although some professionals naïvely believe that everyone else is reading their chart notes, the immense volume of information on most nursing home charts, the location of key information in multiple locations on and off the chart, which often vary from facility to facility or even unit to unit, along with inscrutable hieroglyphic handwriting and idiosyncratic abbreviations, makes charts documents for state surveyors and lawyers rather than effective communication tools.

Few physicians can honestly say that when they make a monthly visit, they plow through all the intervening notes. Even those who do so must then proceed to the Medication Administration Record to see: the results of finger stick blood sugars or vital sign monitoring, track down weight sheets or weight books to identify gains or losses, and check CNAs’ accountability records to determine bowel habits.

In many facilities, recreation therapists and social workers write notes only quarterly. Physical therapy progress notes may be maintained in the rehab department and are only occasionally digested to the chart. In some buildings, Minimum Data Set forms, which include depression and cognitive scores, are kept separately from the main chart. Designed primarily to meet the scrutiny of insurance auditors, the official bundles of paper or electronic entries are generally ineffective in conveying concerns about problems such as existential pain or dyspnea.

Even when legible, physician progress notes rarely reflect the thinking involved. The inclusion of elements important for billing doesn’t necessarily imply an effective communication. Frequently, practitioners assume that other staff will draw appropriate conclusions from what has been ordered without ever actually providing a diagnosis, much less a differential diagnosis. No one seems to expect CNAs to read resident charts at all.

Information vs. Communication

As useful as the Minimum Data Set process can be to care planning, its length, obscure coding rules, use of measurement scales unfamiliar to many clinicians (such as the “BIMS”), and its irregular timing requirements do not lead to its utility as a communication tool among clinicians. The Minimum Data Set primarily drives reimbursement and identifies problems requiring assessment.

Actual problem solving and monitoring of a patient’s response require the work of an interdisciplinary team. Although the information in a communication book need not be an extended essay, more information and explanation is clearly better. For example, imagine a note that reads “Mrs. S has lost 4 pounds in the last month.”

Although this statement reflects data that the rest of the team needs to know, it is a piece of information hanging in space. A more helpful note might be “Mrs. S has lost 4 pounds since her daughter’s death last month. SW thinks she is depressed.” Alternatively, “Mrs. S has lost 4 pounds in the last month since her diuretic was increased. CNA says she no longer wheezes during floor ambulation.” And so on.

The first note was informational, but only the alternatives reflect genuine communication, even if the theories expressed prove to be ultimately incorrect. The resident might have been losing weight to fit into a dress for a family event or from increased activity and muscle tone. She might have a thyroid condition or uncontrolled diabetes, or she could be getting medication that suppresses her appetite. Or someone has taken away her breakfast bacon.

Interdisciplinary care planning around weight loss can come up with the answer. It is quite different from reflexively ordering a supplement.

Federal regulations require an interdisciplinary care planning process without specifying exactly how this might occur. The only two disciplines formally required to communicate face to face are nursing and medicine – the latter specifically being the attending physician – and then only at the time of care plan formulation and renewal. Ideally, the head nurse or nursing care coordinator should take the lead in communication because only nurses can provide full information about a resident to the rest of the team.

Communication by the book is certainly inferior to direct speech, but it is dramatically better than nothing. It allows staff at every level to participate in the discussion without ridicule or blame.

Nursing, with its 24/7 knowledge about the resident, should take responsibility for making the communication book work.

Once, a practitioner who was following a subacute resident came to my office to complain that when she came to the facility after her office hours, her patient and all the staff were in the dining room and the therapy staff were gone! Regularly scheduled rounds, coordinated with key players on the team are more efficient and effective for the practitioner and dramatically increase the prospects for interdisciplinary care. Many unit head nurses readily reorganize their work schedules to ensure their presence for rounds, particularly when they can go to the bedside with the physician or nurse practitioner to review the progress of a skin ulcer, evaluate a rash, or assess a swollen leg.

Still, the therapy staff can’t necessarily break away from the gym, and the dietician and social worker can’t necessarily adjust their schedules to meet the needs of every practitioner. So, without any suggestion of proselytization, let me urge us all to become people of the book.

By Jeffrey Nichols, MD

Team-Building Is a Skill That Can Go by the Book

This is the second “Dear Dr. Jeff” column in response to the following inquiry. The first appeared in the October issue of Caring for the Ages.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island.