OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 6:	Patient Care	**POLICY: 6.011**
SUBJECT:	**Interdisciplinary Treatment Team Processes**	

POINT PERSON:	**RUPERT GOETZ** **CHIEF MEDICAL OFFICER**	
APPROVED:	**GREGORY P. ROBERTS** **SUPERINTENDENT**	**DATE: JUNE 11, 2012**

I. POLICY

It is the policy of Oregon State Hospital (OSH) to provide high quality patient care by utilizing an Interdisciplinary Treatment Team (IDT) model to develop individualized Treatment Care Plans for each patient. Patients are valuable members of their IDT. Interdisciplinary Treatment Team members complete indicated assessments, reassessments, and evaluations with each patient, and use information from those assessments to develop initial Treatment Care Plans, create Master Treatment Care Plans, and complete ongoing reviews and revisions to Master Treatment Care Plans. The purpose of IDTs and treatment care planning processes is to help patients reach their treatment and recovery goals and prepare them for transition out of the hospital.

II. DEFINITIONS

A. "Interdisciplinary Treatment Team (IDT)" means a group consisting of the patient, professional clinical staff, direct care staff, and others who have responsibility for collaborating in planning the care and treatment of an individual patient.

B. "Core Treatment Team" means the patient and/or the patient's guardian, family members or other members of the patient's support network (as allowed by the patient), a Psychiatrist or Psychiatric Mental Health Nurse Practitioner (PMHNP), Psychiatric Mental Health Registered Nurse, Psychologist, Treatment Care Plan Specialist, Social Worker, Rehabilitation Therapist/Occupational Therapist, the Case Monitor (a Licensed Practical Nurse or Mental Health Therapist), and Peer Support Specialist.

III. Procedures

General Provisions

A. Participation in IDT Meetings:

1. No treatment team meeting takes place without the Psychiatrist or Nurse Practitioner (or designee) and Registered Nurse (RN) except as noted in 5.c. below. The psychiatrist or PMHNP is the leader of the IDT.

2. Each IDT shall have an assigned Treatment Care Plan Specialist.

3. The patient shall be considered an integral part of his/her own IDT. If a patient is unable or unwilling to participate on his/her own IDT, or if participation is contraindicated, the psychiatrist/PMHNP shall document the reason(s) for non-participation on the Master Treatment Care Plan.

4. The IDT Core Members shall be at the initial 10-day IDT meeting. Attendance shall be monitored.

5. The IDT Core Members are expected to be at all other IDT meetings. If members of the treatment team are unable to attend a scheduled IDT meeting, they shall provide a substitute, or written input in advance of the meeting.

   a. The MD/PMHNP and RN must arrange for coverage by a member of the same discipline for planned absences from a scheduled IDT meeting.

   b. For unplanned absences, e.g., illness, the person's supervisor is responsible to arrange for coverage. (For this purpose, Rehabilitation Services Department staff shall be considered one discipline.)

   c. For the psychiatrist/PMHNP, any exceptions must be approved by the Chief Medical Officer or Chief of Psychiatry. In such events the supervising or covering psychiatrist shall review and sign the Treatment Care Plan as soon as practical.

6. Consultative IDT Members may include Mental Health Specialist group leaders, community service providers, Dietary, Vocational/Education Services, Internist, Spiritual Services, and others who may be needed periodically.

B. Roles of IDT Members:

1. Patient: The patient is the primary member of the treatment team and considered a core member. His or her experiences, goals, preferences, and strengths are integral parts of the treatment planning process. The patient's evolving perspective on his or her needs for care, treatment, and education are continuously considered as treatment progresses.

   People important to the patient, such as family and significant others, are incorporated into the treatment planning process with the patient's consent. If the patient has a guardian, both should be considered members of the IDT.

2. Psychiatrist/Psychiatric Mental Health Nurse Practitioner (PMHNP): Psychiatrist/PMHNP is the IDT leader, a core member and is ultimately responsible for patient care and treatment.

   His/her duties include the following: The psychiatrist/PMHNP has primary authority for patient care, performs and documents diagnostic evaluations, supervises treatment, and acts as a clinical resource person to staff. The psychiatrist/PMHNP participates in appropriate interventions defined in the Treatment Care Plan, including medication, and is responsible, with the patient, for the overall patient's progress. Psychiatrists/PMHNPs are required to document services and orders in the medical record, review all treatment and maintain the dynamic formulation of the case, and approve all treatment plans. The Treatment Care Plan is an extension of the psychiatrist/PMHNP's orders at a hospital level of care.

3. Mental Health Registered Nurse (MHRN): The Mental Health Registered Nurse (MHRN) is a core member of the IDT.

   The MHRN presents his/her assessment findings to other members of the IDT, participates and collaborates in the development of the TCP, assists the patient in identifying problems and developing measurable goals/objectives and suggests psychiatric and medical nursing interventions related to the patient's specific short-term goals.

   The MHRN is responsible for all nursing interventions on the Master Treatment Care Plan. A RN may directly provide the intervention, or may delegate any intervention permitted by state statute and/or regulation to be done by a staff member who is not a

RN. The individual to whom an intervention is delegated may also be listed on the Treatment Care Plan.

4. Licensed Practical Nurse (LPN)/Mental Health Therapist (MHT) Roles: Under the direction of the MHRN, LPNs conduct and document initial and ongoing focused nursing assessments of the patient's health status through observations, examinations, interviews, and written records. When the LPN or MHT is the patient's case monitor, they are a core IDT member.

   The LPNs and MHTs contribute and participate in the development of the interdisciplinary care plan and assist the patient in developing his/her problems, goals, and objectives.

   The LPNs and MHTs participate in carrying out psychiatric and medical nursing interventions as directed by the MHRN and are responsible for sharing their observations of the patient and the patient's responses to interventions with the MHRN and IDT team.

5. Medical Physician: The Medical Physician serves as a consultant member of the IDT and is not a core IDT member. The role of the Medical Physician is to address non-psychiatric medical issues. The IDT may request the treating Medical Physician to attend IDT and Treatment Care Plan meetings. It is the expectation that the Medical Physician attend these meetings when requested.

6. Psychologist: Psychologists are core members of the IDT. They are responsible for psychological services, including psychological assessments, testing and referrals, psychotherapy, individual behavioral programming and interventions, milieu behavioral programming, staff and patient education, and consultation to IDTs on integration of behavioral support plans into Master Treatment Care Plans. Psychologists document all services they provide as well as complete billing forms for billable services.

7. Mental Health Specialist: Mental Health Specialists function as consultants to the IDT, and are not core members. They provide psychotherapeutic and psychoeducational groups in the treatment malls, individual behavioral programming and interventions, milieu behavioral programming, and staff and patient education. They may complete abuse/dependency assessments. Mental Health Specialists are required to document all services they provide.

8. Social Worker: Licensed Clinical Social Workers are core members of the IDT, and provide rehabilitative services which target transitional and community integration barriers and supports as the

individual progresses through hospital-based treatment and back into their community. Social Workers shall coordinate communication with families and other members of the patient's community support network.

The primary role and responsibility of the Social Worker in the IDT is the clinical evaluation of a person's strengths and needs. The Social Workers bring clinical expertise within the IDT regarding barriers to discharge, transitional services, and community integration – both internal to the hospital environment and external to the broader community. From admission through the individual's transition back into community living, Social Workers guide clinical assessment, planning, coordination, and advocacy to the IDT regarding the individual's successful return to community living at the greatest level of independence and success.

9. Recovery Specialist: The Recovery Specialists are core IDT members and participate in the meetings as much as possible. They provide multiple supports to the IDT. Primary among them are:

   a. Keeping the team focus on person-centered interventions and supports;

   b. Ensuring that planning is trauma-informed and recovery-oriented;

   c. Providing advocacy for patients' active participation in treatment planning; and

   d. Assisting IDT staff in understanding unique perspectives, concerns, and issues as they are experienced by patients.

10. Rehabilitation Services Staff: Rehabilitation Services Staff include a broad array of disciplines, including Rehabilitative, Occupational, Vocational, Educational, and Recreational Therapy staff.

    Rehabilitative and Occupational Therapy staff are core members of the IDT, the other staff are consultative members. Spiritual Care staff are also part of this Department, serving primarily patients' spiritual needs and consulting with the IDT when needed and possible.

    Unless otherwise specified below, Rehabilitation Services Staff shall provide documentation of assessments and progress notes for treatment services. Assessments and treatment services shall

focus on skills needed for being functional in their day-to-day lives. This may be in the areas of physical, sensory, cognitive, affective, social and interpersonal abilities, and areas in need of treatment. These are then related to how persons function in taking care of themselves, use of their leisure time, creative expression, regulating their behavior and emotions to interact successfully in different environments, to be able to interact and get along with others in many different settings and developing skills to be able to live successfully outside of the hospital. RSD staff conduct reassessments of functional skills over time. They also identify discharge needs to assist patients with living in the community.

11. Vocational Services Staff: Vocational Services Staff are members of the Rehabilitative Services Department and are consultants to the IDT, not core members. They are provided campus-wide in Salem on a referral basis. These services include sheltered employment in a bench assembly center and/or in small work enclaves with a focus on horticulture, woodworking, janitorial, and recycling teams. Patient-pay positions are provided on an individual basis for patients that have demonstrated the ability to work with minimal direction and oversight and supervision is provided by nonclinical departments of the hospital with Supported Employment staff as liaison between the patient and the work area. Supported Employment staff are also available to support patients that have the appropriate privileges to work in the local community on an independent basis.

12. Educational Services Staff: Educational Services staff are members of the Rehabilitative Services Department and are consultants to the IDT, not core members. They are provided campus-wide to patients under the age of 21 by the Willamette Educational Service District (ESD) through the Quest School Program in Salem, or through the local ESD in Portland.

    Patients over the age of 21 are provided services on a referral basis. Services include basic education, pre-GED (General Educational Development), GED, and English as a Second Language. These services are provided in the Harbors, Trails, Springs, and Portland treatment malls. In addition, some patients may be involved in outings to educational settings to practice in vivo all aspects of educational participation (with appropriate privileges).

13. Treatment Care Plan Specialists: Treatment Care Plan Specialists function as core members of each patient's IDT. They have primary responsibility to organize, schedule, and facilitate each patient's

treatment care plan review meetings. They are also responsible to ensure each Treatment Care Plan Review meeting results in a finalized, electronic care plan which meets all required elements per Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) standards and integrates all aspects of patient care into the TCP including the START, Behavioral Support Plans, and other key assessments. The position is also required to manage patient grievances and ensure they are resolved appropriately and in a timely manner.

C. Treatment Care Plan Changes:

1. The Treatment Care Plan does not get changed outside of IDT meetings except in urgent situations (i.e., serious self-harm attempt; increase in privileges; or return from outside medical hospital care.)

2. Changes to a Treatment Care Plan in an urgent situation can be made with only the Psychiatrist and RN. Other IDT members shall review the changes to the Treatment Care Plan within two (2) working days. Urgent changes to treatment care plans can be accomplished either by making revisions to the existing Master Treatment Care Plan in Avatar, or by completion of an Emergent Care Plan Addendum form in hard copy.

Specific Provisions

A. Initial Treatment Care Plan:

1. Following completion of the four-hour (4-hour) Nursing Assessment and the psychiatrist/PMHNP's Admitting Note, an Initial Treatment Care Plan shall be developed with each patient by 72 clock hours, excluding weekends and holidays.

2. This shall be done using the paper Nursing Initial Care Plan, the Physician's Admission Note in Avatar, or the Master Treatment Care Plan option in Avatar.

B. Assessments:

1. Person-centered care begins with the assessment process. This process shall include identification of the patient's hopes, dreams, and expectations.

2. Preliminary discipline-specific assessments shall be completed with all patients during the first 10 days of admission, and in all cases

shall be done before the meeting to develop the Master Treatment Care Plan. These include assessments by psychiatry, nursing, social work, psychology, and rehabilitation services staff members.

3. Interdisciplinary Treatment Team members shall come to the scheduled 10-day IDT meeting prepared to share the results of their assessments, and to provide input into the Master Treatment Care Plan.

4. Additional assessments and/or evaluations may be requested from other disciplines as needed, by a psychiatrist/PMHNP's order.

5. A START assessment and an Interdisciplinary Substance Use Review Form (ISURF) shall be completed within the first 30 days of admission on all clinically appropriate patients.

6. Clinicians shall ensure assessments are complete, and shall actively seek missing information. When missing information is available, the clinician shall append the information to the assessment as soon as possible.

C. Reassessments:

1. The need for any reassessments shall be considered at each IDT meeting. Reassessments may be needed because previous assessments are about to expire, there has been a change in the patient's condition, the patient has returned from an outside medical facility, a better assessment instrument is now available, the Psychiatric Security Review Board (PSRB) has requested an assessment, the patient has been readmitted within 30 days, or for any other reason as determined by the Psychiatrist/PMHNP.

2. For disciplines listed on the patient's Treatment Care Plan, comprehensive discipline-specific reassessments shall be considered no less than annually. If it is determined that no reassessment is indicated, the rationale shall be documented by the responsible discipline member.

3. Whenever a reassessment is completed, the clinician shall review information from any prior, similar assessment and assure that a complete assessment is entered into the medical record.

D. Master Treatment Care Plan:

1. The IDT shall develop a Master Treatment Care Plan for each patient by the 10th day following the patient's admission to the hospital.

2. Master Treatment Care Plan Content:

a. The Master Treatment Care Plan shall include diagnoses; patient strengths; patient aspirations, hopes, and desires; identified problem areas; a case formulation; long-term goals; a stage of change for each long-term goal; short-term goals, interventions; names of staff members responsible for specific interventions; and discharge planning. Specific instructions for completing sections of the form shall be found in the OSH Treatment Manual and the Avatar Training Manuals.

b. Problem statements shall identify and precisely describe behaviors, rather than generalized statements or generic terminology. Identified Problem areas shall be written in the patient's own words whenever possible.

c. For every Axis III diagnosis that is listed in Avatar, the following shall be included at the beginning of the 'remarks' field, the letter "A," "M," or "H":

i. "A" is for active medical problems. This includes medical problems that are requiring frequent monitoring, appointments, and adjustments to medications (i.e., Uncontrolled Diabetes Mellitus type 2). This also includes medical problems that are impacting the functional capabilities of the patient, which also requires ongoing services such as physical therapy or occupational therapy. This also includes problems which are impacting the patient's psychiatric condition (i.e., opiates for chronic pain).

ii. "M" is for medical problems that are in maintenance. This includes problems that are stable with or without treatment, and do not require more than routine monitoring, appointments, and adjustments to medications (i.e., Hypothyroidism on stable dose of levothyroxine or hyperlipidemia controlled with diet).

iii. "H" is for historical medical problems. This includes problems in the patient's past medical history that no longer require follow-up.

iv. Initial Codes (A, M, or H) are listed next to the Axis III diagnoses in Avatar by the nurse practitioners who complete histories and physicals with newly admitted patients. Those initial codes shall be reviewed by the psychiatrist/PMHNP at the patient's next treatment team meeting and shall be revised as needed. All Medical Problems listed as A, for Active, shall be addressed in the patient's Treatment Care Plan. Those medical problems listed as M, for maintenance, shall be documented in the MD or nursing progress note sections of the EHR.

d. Long-term goals must be written as observable, measurable patient behaviors to be achieved. Discharge criteria may be included as long-term goals.

e. Short-term goals shall be measurable, and written so that they can be reached by the next scheduled IDT Master Treatment Care Plan Review. "Continuous and ongoing" shall not be used when entering target dates for short-term goals.

f. All interventions shall include a description of the intervention, the focus of the intervention, and the frequency and duration of the intervention. If relationship of the intervention to the short-term goal is obvious, the short-term goal shall serve as the focus. If the relationship of the intervention to the short-term goal is not obvious, the intervention statement shall include a focus. A responsible person must be listed for all interventions, by name and discipline. Use of "all staff," "all nursing staff," "all treatment mall staff," or other non-specific terms shall not be used for responsible party.

3. Master Treatment Care Plan Documentation:

a. The most current version of the Master Treatment Care Plan form shall be used. All applicable sections of the Master Treatment Care Plan form shall be completed.

b. After each Master Treatment Care Plan meeting, the psychiatrist, psychiatric mental health nurse practitioner

(PMHNP), or designee shall sign the plan. It is preferred, but not required, that the patient shall also sign the plan. The Treatment Care Plan Specialist (TCPS) shall document the names and credentials of other individuals present at the Master Treatment Care Plan meeting. Those individuals do not need to sign the plan. A copy of the Master Treatment Care Plan shall be printed out and given to the patient. In rare cases, if contraindicated, certain sections of the Master Treatment Care Plan may be withheld from the patient. If a section is withheld, the psychiatrist/PMHNP shall document the reasons in a progress note written the same day as the Master Treatment Care Plan meeting. Individuals listed as providing interventions on a treatment care plan are not required to sign the plan, but they are responsible for knowing the goals and interventions listed for the services that they provide.

E. Master Treatment Care Plan Reviews:

1. The IDT shall minimally complete reviews of all Master Treatment Care Plans in the frequency described in Section V.A.1., below. All areas of the Master Treatment Care Plan form shall be reviewed for any needed revisions/updates. The need for any special assessments or reassessments shall be considered at each Master Treatment Care Plan Review.

2. Master Treatment Care Plan Review Documentation:

   a. Required Documentation: After each Master Treatment Care Plan Review, a new Master Treatment Care Plan document shall be printed, dated, timed, and signed. A copy of the revised Master Treatment Care Plan shall be given to the patient, unless contraindicated, as above. The two most recent versions of the Master Treatment Care Plan form shall be retained in the patient's active medical record. Prior versions shall be thinned and placed in the patient's brown chart, or stored as prior versions in Avatar.

   b. At the end of each IDT meeting, a designated IDT member may write an IDT Note in the Treatment Care Plan section of the patient's Medical Record, or in the progress note section of Avatar. The note shall summarize the basis for any revisions to the Master Treatment Care Plan. An IDT Team note is not a requirement.

3. Master Treatment Care Plan Review for Thresholds:

   a. An IDT meeting to review and modify, as necessary, the Master Treatment Care Plan shall occur in response to the following thresholds: a serious incident, two or more episodes of seclusion/restraint in a calendar day, any seclusion or restraint event that lasts more than 12 hours, two or more patient falls in a calendar month.

   b. The IDT meeting shall occur the next business day following the threshold having been met. An exception can be made for a patient when an alternative method of working with an individual who repeatedly meets a threshold has been presented to the Chief Medical Officer (CMO), the CMO has evaluated the patient, and the CMO has signed the Master Treatment Care Plan.

F. Documenting Progress Related to the Master Treatment Care Plan:

1. Master Treatment Care Plans shall specify staff members who are responsible for the provision of specific interventions. Those staff members are responsible for reporting progress related to those interventions. Unless using an approved discipline-specific progress note form (either electronic or paper), except for the psychiatrist/PMHNP, progress notes shall utilize the BIO-R (Behavior, Intervention, Outcome, Recommendation) format. A description of what to include in each section of BIO-R is found in the OSH Treatment Manual.

2. All clinical disciplines shall write progress notes in BIO-R format (Behavior, Intervention, Outcome, Recommendation) at the frequency specified in the attached table (see Attachment 2). Progress notes for groups shall be entered in the Group Notes section of the Medical Record. Progress notes for individual sessions and services by non-nursing services staff shall be entered in the Treatment Plan IDT/MD Notes section of the Medical Record. Psychiatrist/PMHNPs and Registered Dietitians shall utilize the SOAP format for their monthly progress notes (Subjective, Objective, Assessment, Plan).

3. Registered Nurses shall conduct and document all nursing assessments regardless of who provides the intervention. Mental Health Therapists may only document observations (i.e., what they see, what they hear).

G. Monitoring/Quality Improvement: The Standards & Compliance Department shall conduct chart audits utilizing the Admission Documentation Review Worksheet and the Comprehensive Post-10-Day Chart Audit Tool.

IDT Meeting Timeframes

A. Timeframes/frequency of regularly scheduled IDT Meetings:

1. Interdisciplinary Treatment Team meetings shall be held with all newly admitted patients by 72 clock hours, excluding weekends and holidays; by 10 days; and by 30 days from the date of admission. For subsequent IDT meetings, they shall be scheduled every 30 days for the first six months. After six months, IDT meetings shall be held for each patient every 60 days. After one year, IDT meetings shall be held for each patient every 90 days.

2. If a patient transfers to a new unit, the receiving unit's IDT shall meet with the patient within 72 clock hours of transfer, excluding weekends and holidays, and conduct a full review of the patient's Master Treatment Care Plan for any needed changes. The schedule for future IDT meetings shall then continue at the frequency described above, and set from the date of the transfer meeting.

B. Exceptions:

1. Urgent reviews with the Psychiatrist and RN do not affect the time of regularly scheduled IDT reviews.

2. Interdisciplinary Treatment Teams shall plan ahead for vacations or other absences of core treatment team members, and shall schedule IDT meetings in advance so that the 72-hour, 10-day, 30-day, 60-day, and 90-day review standards are met.

3. Patients preparing for discharge should have at least one IDT meeting that addresses discharge needs and expectations within 30 days of discharge.

IV. ATTACHMENTS

Attachment A – Oregon State Hospital Treatment Manual Documentation Standards

Attachment B – Required Psychological Assessments by Commit Type

V. REFERENCES

CMS Standards, 42 CFR 482, Subchapter E, Conditions of Participation for Hospitals
The Joint Commission's Comprehensive Accreditation Manual for Hospitals (CAMH)
OAR 309-031-0200 through 309-031-0220
Oregon State Hospital Plan for Professional Services and Staff Composition
ORS 179.360(1), 426.010, 426.130(3), 426.175 through 426.220, 426.300 through 426.309
OSH Policy and Procedure 6.025, Advance Directives – Medical
OSH Policy and Procedure 6.042, Short-Term Assessment of Risk and Treatability (START)
OSH Policy and Procedure 6.045, Clinical Documentation

Replaces Oregon State Hospital Policy and Procedure 6.011, *Interdisciplinary Treatment Teams*, dated 3/16/2012.

OREGON STATE HOSPITAL TREATMENT MANUAL DOCUMENTATION STANDARDS

ASSESSMENT TIMELINE

	1st day	72 hours	10th day	1st 30 days	1st 60 days	1st 90 days	Q 90 days	1st 6 months
Interdisciplinary Team		Initial Treatment Care Plan	Update TCP	Update TCP. START & ISURF	Update TCP	Update TCP	START Reassess	Update Treatment Care Plan monthly
Physician	Admit note							AIMS Q 6 months
Rehabilitation Services			Initial					
Vocational/Education Services				As referred				
Psychologist			PAN		IPA	VRA		
Registered Nurse	Within 4 hours							
Social Worker			Psychosocial					
Language & Diversity Services		Assessment		As referred				
Others (Dietitians, Spiritual Svs, etc.)				As referred				

PROGRESS NOTE TIMELINE

	Per Shift	Per Week	Per Month	Other- Discipline Specific	Annual
IDT Review Note		First 60 days, all disciplines listed on TCP write notes (Group notes count-RSD only). MDs utilize SOAP or approved format. All other disciplines use BIOR or approved format. PRS MHTs need not chart if RN charts.	After 60 days, all disciplines listed on TCP write progress notes, at minimum, on a monthly basis. All disciplines document more frequently if significant event or change has occurred. (Weekly group notes meet and exceed this standard.)		Annual reassessment required of all disciplines listed on TCP, unless reassessment completed more frequently.
Physician					
RSD/Vocational Education Services					
RSD-Individual treatment & patients in GTS seen in on-unit treatment				PRN- at time of service	
RSD-IDT note if unable to attend or verbal summary for IDT note					
Psychologist/ Mental Health Specialist				Time of service -BIOR format,	
Registered Nurse	For 72°			PRN	
Mental Health Therapist				PRN	
Social Work				PRN & D/C Progress Summary Note	
Treatment Mall- all disciplines				PRN – at time of Service	

OREGON STATE HOSPITAL

Required Psychological Assessments by Commit Type

	PSRB	.370	Civil	Gero
ISURF	Y	N	N	PSRB Only
VRA	Y	N	As Rx	PSRB Only
IPA	Y	As Rx	As Rx	PSRB Only
START	Y	N	Y	PSRB, .370
PAN	Y	Y	Y	Y