

Interdisciplinary Team (IDT) Meeting – Sample Agenda

Purpose

IDT meetings are an important tactic for house call programs to use to promote optimal care, quality outcomes, and team communication, often leading to improved clinical care and teamwork. This resource was developed to assist with the development and implementation of IDT team meetings for house call programs using the following recommended agenda items.

Key Metrics

- Discuss outcomes and/or clinical quality metrics the team is using to monitor success.

Hospitalizations

- Assign a team member to track admissions for your patients and investigate the root cause and diagnosis of each.
- Review recent hospitalizations and brainstorm care management or future treatment interventions to avoid future hospitalizations.

Case Management

- Social workers, pharmacists, clinical staff, and/or providers bring forward complex patient cases to discuss with the team – and to initiate appropriate planning and action for additional resources the patient requires.

Announcement and Updates

- A designated team member provides any “need to know” updates that affect the entire team.
- These updates may be logistical or operational in nature and may not be required at every meeting. Examples of updates include flu vaccine strategies, reviewing safety plans, or other team initiatives.

Waste Identification

- Identify any process breakdown or duplication in task(s) so a manager or practice improvement team can be assigned to strategize and develop a solution(s).
- Consider using a formal approach/methodology for process and quality improvement (e.g., Lean Six Sigma). This can help ensure a consistent, repeatable approach.

Recognition

- End the meeting with positive feedback.
- Encourage colleagues to recognize each other for acts of kindness, share an example of when a team member went above and beyond, and/or call out a team accomplishment.
- Consider having a place/box where team members can write and submit “Thank You” notes or “Caught in the Act” slips that can then be read at the next team meeting (these can be done anonymously, depending on preferences).

Example Outcome Metrics for Home-Based Primary Care

- Number of deaths at home vs. SNF, hospital and per zip code
- Incoming referrals per month per each source
- Number of visits per day and by month, per provider, and for the practice as a whole
- Total number of deaths on hospice
- Hospitalization rate/100 beneficiary months
- ICU stays 30 days before death
- Hospitalizations 90 days before death
- Yearly census
- Time to first visit (average and mean wait days)
- Time to Transitional Care Management (TCM) visit (average and mean wait days)

Example Clinical Quality Metrics for Home-Based Primary & Palliative Care

- National Home-Based Primary & Palliative Care Data Registry 2019 Measures¹
- Independence at Home Clinical Quality Metrics:²
 - Follow-up contact within 48 hours of hospital admission, hospital discharge, or emergency department visit
 - Medication reconciliation in the home within 48 hours of hospital discharge or emergency department visit
 - Annual documentation of patient preferences
 - All-cause hospital readmissions within 30 days
 - Hospital admissions for ambulatory care sensitive conditions
 - Emergency department visits for ambulatory care sensitive conditions

Primary Care First & SIP Quality Measures – Risk Score Groups 3-4 (pp. 31-33)³

- (Average HCC Score 1.5 > 2.0)
 - Advance Care Plan (Years 1-5)
 - Total Per Capita Cost Measure (Years 1-5)
 - Consumer Assessment of Healthcare Providers and Systems Satisfaction Surveys (CAHPS; Years 2-5)
 - 24/7 Access to a Practitioner (Years 3-5)
 - Days at Home (Years 3-5)

¹ https://www.medconcert.com/content/medconcert/NHBCPCR/BROCHURE_NHBPC_MeasureList.pdf

² <https://innovation.cms.gov/Files/fact-sheet/iah-yr5-fs.pdf>

³ <https://innovation.cms.gov/Files/x/pcf-rfa.pdf>

Appendix Resources

- [Ten Principles of Interdisciplinary Teamwork](#)
- [Interdisciplinary Team Care Facilitator Guide UCLA](#)
- [Effective Interdisciplinary Team Meetings: Resources for Integrated Care](#)
- [Lean Six Sigma](#)



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