Creating a Compliant and Person-Centered IDT

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Decision-making for "Unrepresented" Residents is Changing

This presentation is a follow up to the April 2021 webinar entitled "The Unrepresented Resident: A Guide to the Epple IDT Process for Decision-Making." https://www.cahf.org/Education-Events/Event-Info/sessionaltcd/WEBINAR051821

We encourage you to view that program as well if you have not done so already.

Not All IDTs Are The Same!

Some examples:

F657 (42 CFR 483.21) requires an interdisciplinary team to develop a comprehensive person-centered care plan. The term "interdisciplinary" appears 97 times in the latest CMS State Operations Manual for SNFs.

F868 lists required members of the QAA committee and encourages participation of direct care staff and other departments.

F689 requires an "interdisciplinary and systemic approach" to accident prevention which includes root cause analysis

An IDT frequently convenes by policy in other situations.

The Unrepresented Resident IDT
(sometimes called the Epple IDT)

The IDT is convened for the following reasons:

1. "A medical intervention or treatment that requires informed consent" is proposed for a resident

2. The resident lacks the capacity to understand the risks and benefits of the proposed intervention or treatment

3. The resident does not have a legal representative to act on his or her behalf in making the treatment decision

4. The facility is unable, after reasonable effort, to locate a family member or other healthcare decisionmaker.

When Informed Consent is Required

Psychotheraputic Medications

Prolonged use of a device that may lead to the inability to regain use of a normal bodily function

POLST, DNR, comfort care, and hospice election

Other medical procedures above and beyond routine nursing care

Note: In an *emergency* the intervention may be implemented prior to the IDT meeting

Convening the IDT

The IDT must include the attending MD, an RN with responsibility for care of the patient, and other disciplines as appropriate.

For now, the IDT must have a "patient representative where practicable"

The patient representative requirement will change next year, some time between January 1 and July 1, 2022, when the Long-Term Care Patient Representative Program has been established in Sacramento.

A Patient Representative may be an individual whose interests are aligned with the resident, perhaps a family member or friend who is unable to take full responsibility as a decision maker but is willing to serve on the IDT. If no such person is available, the facility must request someone from the new Long-Term Care Patient Representative Program. The Ombudsman's office has declined to serve in this capacity.

Stay informed by subscribing to the CAHF online forum!

So . . . What's New?

Increased oversight as the Long-Term Care Patient Representative Program becomes operational.

Historic misunderstandings about the purpose of the IDT

Public fear of "death panels"

Broadened scope to include end of life care (POLST, Hospice election, etc.)

Participation by individuals outside our local SNF facility world

Outline of IDT Discussion

- Review of the physician's assessment of the resident's condition
- The reason for the proposed medical intervention
- Discussion of the resident's desires, if known (research this before the meeting by asking resident if possible, reviewing records, and contacting family and friends if any)*.
- The type of medical intervention proposed including frequency and duration
- The probable impact on the resident's condition with and without treatment
- Reasonable alternative interventions considered or utilized and why they are not appropriate
- * NOTE: There can be exceptions if the resident's wishes are are inconsistent with the resident's best interests, require medically ineffective health care, or are contrary to generally accepted health care standards.

Best Practices: The IDT and Bioethics

In the mid 1970s, hospitals began to develop bioethics committees following the end-of-life court case regarding Karen Quinlan

In 1992 the Joint Commission required certified hospitals to have an "ethics mechanism"

1997, the Society for Post-Acute and Long Term Care Medicine, formerly the American Medical Directors' Association, began to recommend that nursing facilities have bioethics committees in order to provide a forum for discussion of end of life issues. In 2008 they reaffirmed this as official policy.

By incorporating bioethics considerations into our IDT we are elevating our decision-making for unrepresented residents to encompass both legal and ethical standards.

Basic Bioethics Principles

- Autonomy: Protecting individual rights, self-determination and choice
- Beneficence: The course of action that will give the greatest benefit
- Non-Maleficence: The course of action that will cause the least harm
- Justice: Fairness to the patient with consideration of the needs and rights of others

Incorporating Bioethics Principles into the IDT

1. Review of the physician's assessment of the resident's condition
2. The reason for the proposed medical intervention BENEFICENCE
3. Discussion of the resident's desires, if known (research this before the meeting by asking resident if possible, reviewing records, and contacting family and friends if any). AUTONOMY
4. The type of medical intervention proposed including frequency and duration
5. The probable impact on the resident's condition with and without treatment BENEFICENCE/NON-MALEFICENCE
6. Reasonable alternative interventions considered or utilized and why they are now inappropriate BENEFICENCE/NON-MALEFICENCE

Unrepresented Resident IDT Members

"The IDT must include the attending MD, an RN with responsibility for care of the patient and other disciplines as appropriate." ---- Health & Safety Code §1418.8

Which other disciplines?

- Social Services: Input regarding resident's pre-admission social history
- Second MD/ Medical Director: Highly recommended particularly in end-of-life cases; including a non-treating physician is consistent with bioethics committee guidelines
- Individual with background/training in bioethics if available
- Other staff members who may be knowledgeable about the resident's needs, personal background and/or expressed wishes; the CNA often has a wealth of information. In some cases, a representative from therapy or dietary may be appropriate.

NOTE: The IDT meeting does not require that all participants be physically in the same room at the same time. If there is anything we have learned during COVID-19 is the value of conference lines and Zoom.

IDT Documentation Outline

1. Meeting Attendees (name and title)
2. Reason for meeting: Resident [name]'s attending physician, proposes [intervention that requires informed consent]. Dr. [name] has determined that [resident] lacks decision making capacity and has no legal representative.
3. Attending physician: Dr. [name]'s assessment of the resident's condition, type of medical intervention proposed (including frequency and duration), reasons for the recommendation, probable impact on the resident's condition with and without treatment and reasonable alternatives considered or utilized. Dr. [name] also provides information about resident's expressed wishes if known.
4. Facility Staff Member: Efforts made to locate a family member, other legal representative, or an appropriate individual to serve as a patient representative. Also any available information as to the resident's expressed desires regarding health care.
5. Discussion, opportunity to ask questions, IDT consensus

Special considerations for End-of-Life care and Hospice Election

Terminology is important. Certain buzzwords and phrases such as "withdrawing care" are inaccurate and can be misunderstood. Care is never withdrawn. If certain interventions would not provide a benefit and/or could cause harm then a decision may be made to transition to comfort care, palliative care and/or hospice care.

Even if this change in care seems obvious, the attending physician must still present the medical rationale including risks and benefits (if any) and answer questions from other IDT members.

Although not required by statute, best practice is to have a second physician participate in the meeting.

A hospice election and/or POLST should be signed by one member of the IDT *on behalf of the IDT*. This individual should *not* be one of the physicians.

The IDT representative signs a POLST as the "legally recognized decisionmaker" and indicates their relationship as "IDT representative."

IMPORTANT
What This Presentation Does NOT Cover

This presentation addresses only the conduct and documentation of the IDT meeting itself. It does not cover the following:

Statutory notice requirements and time deadlines
Components of the medical determination that a resident lacks capacity
Definition of "legal decisionmaker" and "patient representative"
Definition of an "emergency"
How the "Long-Term Care Patient Representative Program" will operate
Steps the facility must take to seek evidence of previously expressed wishes
Frequency of IDT meetings for continuing treatment
When a court order might be needed
Data that must be kept
Other details of the new law

STAY TUNED: CAHF will be presenting more information on the above! A webinar with CAHF attorney Mark Reagan is presently scheduled for December 8, 2021.

Bioethics Resources

Publications:

Beauchamp, T. L. & Childress, J. F. (2019). Principles of Biomedical Ethics (8th ed.) Oxford University Press

Post, L. F. & Blustein, J. (2015). Handbook for Health Care Ethics Committees (2nd ed.) Johns Hopkins University Press

The Society for Post-Acute and Long Term Care Medicine. (2008, March 1) The Role of a Facility Ethics Committee in Decision-Making at the End of Life. https://paltc.org/amda-white-papers-and-resolution-position-statements/role-facility-ethics-committee-decision-making

Steinberg, K, (2019, February) Bioethics in Post-Acute and Long Term Care. Provider. https://www.providermagazine.com/Topics/Special-Features/Pages/Bioethics-in-Post-Acute-and-Long-Term-Care.aspx

ALSO: See if your local hospital has a bioethics committee and/or bioethicist who might be able to provide education and/or guidance. Also, some universities have non-degree basic bioethics courses (as well as graduate degree programs).

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Thank you for your time and attention

Any questions?

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