TEAM CONFERENCE TIP SHEET

Purpose

The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize and achieve treatment goals. The periodic interdisciplinary team conferences must focus on:

- Assessing the patient's progress toward rehabilitation goals
- Considering possible resolutions to any problems that could impede the patient's progress toward the goals
- Reassessing the validity of the rehabilitation goals previously established
- Monitoring and revising the treatment plan, as needed

Regulatory Requirements

- Team conferences must be held once a week, seven consecutive calendar days that begin the day of admission.
- Participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the IRF medical record) must be present:
    - A rehabilitation physician with specialized training and experience in rehabilitation services
    - A registered nurse with specialized training or experience in rehabilitation
    - A social worker or a case manager (or both)
    - A licensed or certified therapist from each discipline involved in treating the patient.

Roles

Team conferences are typically between 5-10 minutes. A team conference typically follows the following agenda:

Responsible Party	Information/Activity
Nursing	Complete weekly summary and update Care Plan.
Therapy	Complete weekly summary, update short term goals (i.e., met, not met), document barriers to progress, update STG's/interventions to be addressed for the next 7 days.
Case Manager and/or IRF-PAI Coordinator	Run UDS report showing CMS Expected LOS
Case Manager	Update Discharge Calendar with Target LOS (-2 days)
Case Manager	Distribute team conference schedules to all interdisciplinary team members- who is to be teamed and what time
Case Manager	Introduces the patient's case with the following information: ▪ Discharge Plan (i.e., home with family, assisted living, etc.) ▪ Home situation ▪ Support System ▪ Funding/Insurance issues and parameters for length of treatment ▪ Patient/Family Goals
Nursing	Highlights patient's status with the following if part of care plan and being addressed: ▪ Bowel and Bladder Issues ▪ Skin Integrity- Wound Care ▪ Sleep Pattern Concerns ▪ Intake/Hydration Concerns ▪ Medication Concerns/Needs ▪ Safety Issues ▪ Any functional barriers noted on the unit (transfers, toileting, activities of days of living, locomotion, cognition, expression/comprehension) that have improved or worsened. Any observations of noted exceptions- For example, "the patient requires significantly more verbal cues for safe transfers in the evening". ▪ Patient/Family Education Needs
Therapies	▪ Discuss and review patient's progress toward goals ▪ Discuss barriers to progress and recommendations for alterations in the plan of care to facilitate timely discharge ▪ Patient safety issues ▪ Equipment needs

	▪ Patient/Family Education needs ▪ Discharge follow-up care and treatment needs.
Respiratory, Dietary, SW if part of Team	▪ Discuss and review patient's progress ▪ Discuss barriers to progress and recommendations for alterations to the plan of care ▪ Patient/Family education needs
Rehabilitation Physician	1. Synthesizes team's discussion and makes recommendations for: ▪ Any additional labs/diagnostic tests that may be needed ▪ Any medication changes that may be needed (discuss with Hospitalists) ▪ Any additional consults that may be needed (Neuropsych, Dietary, Cardiology, Neurology, etc.) ▪ Any changes to therapy frequency/duration that may be needed ▪ Any additional rehabilitation nursing needs. 2. Reviews CM's target LOS with team makes any modifications (shorter, longer) as appropriate 3. Confirms or modifies discharge goal (i.e., home, SNF, etc.) 4. Confirms or modifies discharge follow-up care that is thought to be needed (i.e., home health, outpatient therapy, etc.).
Case Manager	Closes the discussion by reviewing any remaining issues that could have impact upon the treatment and or discharge plan, based on the teams presentation.
Following Team Conference	
Case Manager	1. Communicates to the patient/family any recommended changes to the plan of care recommended to the team 2. Communicates to the patient/family the targeted discharge date and thoughts on discharge destination and needed follow-up care 3. Sign team conference note so it sends to the rehabilitation physician for their signature
Rehabilitation Physician	1. Writes any new orders that may have come out of the team conference discussion. 2. Add the team conference attestation and your signature to the team conference note. 3. *Note- if the first team conference was within the first 4 days also add the Plan of Care attestation when signing the note.