

Interdisciplinary Group (IDG) PC.155

Regulatory Citation(s):**L-Tag(s):**

42 CFR 418.56; 418.56(a); 418.56(a)(1); 418.56(a)(1)(i)-(iv)
536, 537, 539, 540, 541

POLICY: Lifesong Hospice and Palliative Care designates an IDG composed of qualified individuals who assess, plan, provide and evaluate the care and services provided to hospice patients/caregivers.

PROCEDURE:

1. The IDG at Lifesong Hospice and Palliative Care includes, at a minimum, the following individuals:
 - a. a Doctor of Medicine or osteopathy;
 - b. a registered nurse;
 - c. a social worker; and
 - d. a pastoral or other counselor.
2. In addition, the IDG may include:
 - a. the patient's attending physician (if any);
 - b. trained volunteers under the supervision of the Volunteer Coordinator;
 - c. hospice aides;
 - d. bereavement counselors; and
 - e. others with appropriate clinical and educational experience who meet specific needs of the hospice's patients as identified in the plan of care.
3. The IDG is responsible for:
 - a. establishing, implementing, reviewing and revising the patient's plan of care;
 - b. providing or coordinating care and services in accordance with the patient's plan of care;
 - c. documenting all care and services provided in a timely manner in accordance with the hospice's documentation requirements;
 - d. promoting the patient's acceptance of his/her own strengths and unique qualities;
 - e. communicating with the patient's attending physician (if any) on a regular basis;
 - f. recognizing and addressing the patients emotions (for example, loss, despair, loneliness, unresolved guilt, fear and anger; and
 - g. promoting opportunities for the patient's personal growth including identifying areas for reconciliation, facilitating expressions of love, concern, regret and forgiveness.
4. A registered nurse member of the IDG is designated as the RN Case Manager for each patient/family. The RN Case Manager is responsible for coordinating the care and services provided by the IDG, ensuring continuous assessment of patient/family needs, and implementing the interdisciplinary plan of care.

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