Title: **Hospice Policy 411**
Section: **ELIGIBILITY FOR SERVICES**
Subject: **Interdisciplinary Group, Plan of Care and Coordination of Services**
Reference: **37.40.805, 42 CFR 418.56**
Supersedes: **Policy 411, October 2016**

INTERDISCIPLINARY GROUP, CARE PLANNING AND COORDINATION OF SERVICES

The hospice must designate an interdisciplinary group which in consultation with the member's attending physician, must prepare a written plan of care for each member. The plan of care must specify the hospice care and services necessary to meet the member and family-specific needs identified in the comprehensive assessment as they relate to the terminal illness and related conditions.

APPROACH TO SERVICE DELIVERY

The hospice must designate an interdisciplinary group or groups composed of members who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice members and families facing terminal illness and bereavement.

Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each member's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, members who are qualified and competent to practice in the following professional roles:

1. A doctor of medicine or osteopathy (who is an employee or under contract with the hospice);
2. A registered nurse;
3. A social worker; and
4. A pastoral or other counselor.

If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

PLAN OF CARE

All hospice care and services furnished to members and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the member or representative, and the primary caregiver in accordance with the member's needs. The hospice must ensure that each member and the primary care giver(s) receive education and training provided by the hospice as appropriate to their plan of care.

CONTENT OF THE PLAN OF CARE

The hospice must develop an individualized written plan of care for each member. The plan of care must reflect member and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

1. Interventions to manage pain and symptoms;
2. A detailed statement of the scope and frequency of services necessary to meet the specific member and family needs;
3. Measurable outcomes anticipated from implementing and coordinating the plan of care;
4. Drugs and treatment necessary to meet the needs of the member;
5. Medical supplies and appliances necessary to meet the needs of the member;
6. The interdisciplinary group's documentation of the member's or representative's level understanding, involvement, and agreement with the plan of care, in accordance with the

hospice's own policies, in the clinical record; and

7. Services must be consistent with the plan of care.

REVIEW OF THE PLAN OF CARE

The hospice interdisciplinary group (in collaboration with the member's attending physician, if any) must review, revise and document the individualized plan as frequently as the member's condition requires, but no less frequently than every fifteen calendar days. A revised plan of care must include information from the member's updated comprehensive assessment and must note the member's progress toward outcomes and goals specified in the plan of care.

COORDINATION OF SERVICES

The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures to:

1. Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided;
2. Ensure that the care and services are provided in accordance with the plan of care;
3. Ensure that the care and services provided are based on all assessments of the member and family needs;
4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement; and
5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.