Texas Association for Home Care & Hospice
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Winter Conference
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3:30pm-4:30pm

4b. A Practical Approach to Navigating IDG and Plan of Care Updates

Presented by:

Colleen Woods, MSNed, RN, Senior Consultant, JCC

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A PRACTICAL APPROACH TO NAVIGATING IDG AND PLAN OF CARE UPDATES

COLLEEN WOODS, MSNED, RN
JCC TEXAS

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Outcomes

At the conclusion of this educational activity, the participant will:

- Discuss the role of the IDG, and the importance and impact of documentation by the IDG on the patient plan of care
- Discuss the regulatory requirements for IDG and Plan of care, and the most common issues identified by surveyors and other reviewers related to these requirements
- Describe the expectation for plans of care in hospice, as well as the best practices to ensure documentation shows required updates, and impactful incorporation of the HOPE assessment data

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§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The hospice must designate an interdisciplinary group or groups as specified in paragraph

(a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.

(b) The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

Hospice COP – IDG/Care Planning & Coordination of Services

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Step 1:
Identify the needs of the patient and family as they relate to the terminal illness and any related conditions through assessment of the members of the IDG

Breaking down the steps

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There should be a direct link between the needs identified in the patient/family assessment and the plan of care developed by the hospice.

- Hospices may identify needs in the comprehensive assessment that are not related to the terminal illness and related conditions and should document that they are aware of these needs and note who is addressing them.
- Hospices are not required to provide direct services to meet needs unrelated to the terminal illness.
- Hospices are responsible for including services and treatments in the plan of care that address how they will meet the patient and family specific needs related to the terminal illness and related conditions.
- The medical director and/or other hospice physician is responsible for meeting the medical needs of the patient according to §418.64(a)(3) per the patient's attending physician's request or when the hospice is unable to contact the attending physician to address the patient's medical needs.

Expectations from the State Operations Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

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The care plan deficiency continues to be #1 for accrediting bodies and state surveyors. CHAP notes:

Individualized Plan of Care (66% noncompliance rate): Plans fail to reflect comprehensive assessments - lacking specific, measurable goals and tailored interventions

#1 Deficiency cited by CHAP (& others in 2025)

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Regulatory Requirement 418.56 1 (a)

Standard:

Approach to service delivery.

(1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients 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.

(2) 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 patient's and family's needs and implementation of the interdisciplinary plan of care.

(3) The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- (ii) A registered nurse.
- (iii) A social worker, marriage and family therapist, or a mental health counselor. *IN TEXAS A SOCIAL WORKER IS REQUIRED*
- (iv) A pastoral or other counselor.

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Each member of the IDG assesses the patient for the unique needs of the patient and family as they relate in particular to the patient's terminal illness & related illnesses.

When the IDG meets, the expectation is that the team reviews & discusses these findings and contributes from the perspective of the specialty that is impacted – eg – spiritual needs identified by any team member may be spoken to by any member, but in particular this falls under the SCC scope.

Step 2 – The IDG Meeting

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State Operations Manual Guidance

Members of the IDG must be appropriately trained in the hospice philosophy and competent to perform in their assigned area(s).

The hospice may involve other members of the care team in the IDG's activities.

"Supervision" of care by the IDG members may be accomplished by face-to- face or telephonic conferences, evaluations, discussions and general oversight, as well as by direct observations.

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Regulatory Requirement 418.56 1 (b)

b. Standard: Plan of care.

All hospice care and services furnished to patients 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 patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.

The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

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Core team members are expected to participate in the are planning process as members of the IDG, also though the reg requires input to be noted by:

the attending (if there is one) or, minimally coordination (such as sending the plan to the attending)

the family

the patient

the caregiver

Step 3 – Care Planning

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The reg also requires that the agency provide EDUCATION to the patient/family/caregiver regarding any care they are providing to the patient as appropriate to the patient's assessed needs

This could include:
Safety measures/falls prevention
Simple wound care
Diet
Hospice philosophy
End of life issues
Balancing activity & rest

Step 3 – Care Planning

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Regulatory Requirement 418.56 1(c)

c. Standard: Content of the plan of care.

The hospice must develop an individualized written plan of care for each patient.

The plan of care must reflect patient 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 patient 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 patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

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Step 3 – Care Planning

Content expectations are clear & comprehensive –
It must be individualized to the patient & family, which starts with a detailed comprehensive assessment – now required to include HOPE data(next)

It must be updated based on the findings of subsequent assessments

It must include all of the elements listed in the standard, and also:

The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

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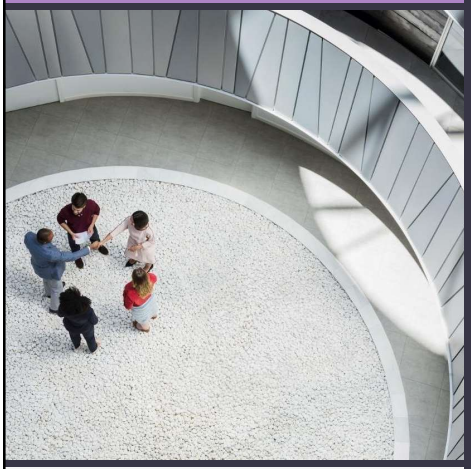

HOPE REQUIREMENTS & INTEGRATION

Using this requirement to create a better assessment & a better plan of care

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Key HOPE Elements that drive the POC:

- Pain, dyspnea, wounds, safety risks
- Psychosocial, spiritual, caregiver strain
- Functional status & decline indicators
- Medication risk and deprescribing opportunities

Transitioning HOPE assessment findings into action:

- Turning assessment findings into measurable goals
- Ensuring interventions match discipline scope
- Documenting patient/caregiver preferences and priorities

Integrating HOPE assessment data

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IMMINENCE OF DEATH IS NOT NEW - BASED ON THE ASSESSMENT OF THE RN HAS BEEN REQUIRED IN THE COP'S FOR SOME TIME, HOWEVER MANY FORMS, SOFTWARE, ETC. DID NOT SPECIFICALLY KEY THE USER TO ANSWER THIS,

ASIDE FROM PATIENT CARE ISSUES RELATED TO THIS, AGENCIES SHOULD CONTEMPLATE – WHY ARE THEY ASKING ME THIS QUESTION?

WHAT DOES IT SAY ABOUT THE AGENCY IF THE PATIENT IS NOT VISITED DAILY IF THIS IS A "YES"? WHAT DOES IT SAY ABOUT THE AGENCY IF THE PATIENT IS MARKED "YES" AND IS NOT IMMINENT/DOES NOT PASS?

J0050: Death is Imminent

J0050. Death is Imminent	
Enter Code ☐	At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less? 0. No 1. Yes

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

HOPE-SPECIFIC Questions

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PAIN ASSESSMENT

– **Mentioned in all forms/formats of expectation/citation & oversight**

J0900: Pain Screening

J0900. Pain Screening	
Enter Code ☐	A. Was the patient screened for pain? 0. No — Skip to J0905, Pain Active Problem 1. Yes B. Date of first screening for pain ☐☐ ☐☐ ☐☐☐☐ Month Day Year
Enter Code ☐	C. The patient's pain severity was: 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated
Enter Code ☐	D. Type of standardized pain tool used: 1. Numeric 2. Verbal descriptor 3. Patient visual 4. Staff observation

J0905: Pain Active Problem

J0905. Pain Active Problem	
Enter Code ☐	Is pain an active problem for the patient? 0. No — Skip to J2030, Screening for Shortness of Breath

J0910: Comprehensive Pain Assessment

J0910. Comprehensive Pain Assessment	
Enter Code ☐	A. Was a comprehensive pain assessment done? 0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes B. Date of Comprehensive pain assessment: ☐☐ ☐☐ ☐☐☐☐ Month Day Year C. Comprehensive pain assessment included:
↓ Check all that apply	
☐	1. Location
☐	2. Severity
☐	3. Character
☐	4. Duration
☐	5. Frequency
☐	6. What relieves/worsens pain
☐	7. Effect on function or quality of life
☐	9. None of the above

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PAIN ASSESSMENT New HOPE related questions

J0915. Neuropathic Pain

J0915. Neuropathic Pain	
Enter Code ☐	Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)? 0. No 1. Yes

J2050. Symptom Impact Screening

J2050. Symptom Impact Screening	
Enter Code ☐	A. Was a symptom impact screening completed? 0. No — Skip to M1190, Skin Conditions 1. Yes B. Date of symptom impact screening: ☐☐ ☐☐ ☐☐☐☐ Month Day Year

J2051. Symptom Impact

J2051. Symptom Impact

Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. Pain	☐
B. Shortness of breath	☐
C. Anxiety	☐
D. Nausea	☐
E. Vomiting	☐
F. Diarrhea	☐
G. Constipation	☐
H. Agitation	☐

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SYMPTOM IMPACT SCREENING & RESPONSE

J2052. Symptom Follow-up Visit (SFV)

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)	
Enter Code ☐	An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV). A. **Was an in-person SFV completed?** 0. **No** — Skip to J2052C, Reason SFV Not Completed. 1. **Yes** B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact. ☐☐ ☐☐ ☐☐☐☐ Month Day Year
Enter Code ☐	C. **Reason SFV Not Completed** — Skip to M1190, Skin Conditions. 1. Patient and/or caregiver declined an in-person visit. 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired). 3. Attempts to contact patient and/or caregiver were unsuccessful. 9. None of the above

If the patient reported any of the S/S on the symptom impact screening as having an IMPACT ON THEIR LIFE moderate or above (as opposed to having “moderate pain” for example) the agency is expected to revisit the patient within 2 days to re-evaluate that symptom impact.
Why?
If the agency is not providing an intervention when an issue is identified on a HOPE timepoint – the SFV will reflect this in that there won’t be improvement on that SFV
If the agency is not providing timely follow-up for an issue identified on HOPE assessment, then what does that say about that agency?

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SYMPTOM IMPACT SCREENING & RESPONSE

This particular issue is one of great importance to CMS – we know this because the first 2 HOPE related outcomes that are objectively measurable will be related to the timeliness of follow-up based on assessment findings

1 for pain, and 1 for non-pain symptoms.

How will that data be used to judge your agency?

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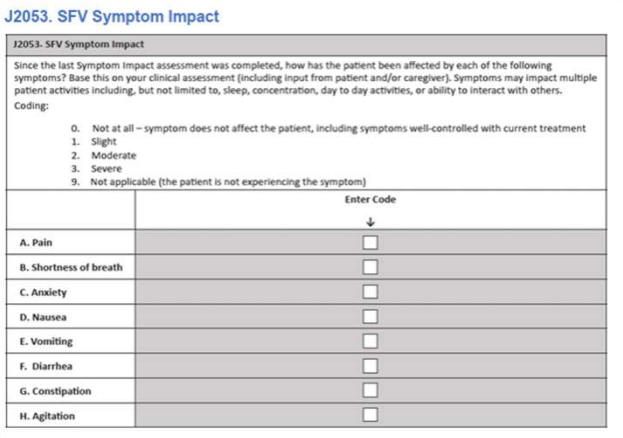
J2053 – reviewing symptom impact on follow-up visits



J2053. SFV Symptom Impact

J2053. SFV Symptom Impact	
Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others. Coding: 0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment 1. Slight 2. Moderate 3. Severe 9. Not applicable (the patient is not experiencing the symptom)	
	Enter Code ↓
A. Pain	☐
B. Shortness of breath	☐
C. Anxiety	☐
D. Nausea	☐
E. Vomiting	☐
F. Diarrhea	☐
G. Constipation	☐
H. Agitation	☐

Because of concerns that patients/families are not receiving what they need from all hospices (related to care planning deficiencies on assessed needs) The HUV 1 and HUV 2 were also implemented, and also required those problematic S/S to be re-assessed

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Integrating assessment findings of HOPE into the plan of care

What processes does the agency use to extrapolate what the RN finds on Admission, HUV1 or HUV2 to build the patient-specific Plan of Care?

These items are expected to inform the care that the patient/family receive – for example – if the patient reports pain has a moderate impact on their life at SOC, the RN evaluates and implements an opioid for relief. On the scheduled follow-up visit, the LVN finds that the impact of pain has improved to slight – the plan of care created by the RN at the SOC includes this opioid, & appropriate, related goals. Based on the findings at SFV, this does not need to be changed AT THIS TIME.

If the RN finds again at the HUV1 visit that the pain (or whatever symptom) is again at a moderate impact level, then the expectation would be that the plan of care would be reviewed & updated because the initial intervention is no longer working.

In this example, the change to a stronger opioid is decided, and the RN/LVN re-evaluate the effectiveness/progress to goals at the SFV. If the goal is not met, then the expectation is that the IDG will determine an updated intervention to implement to achieve the patient's pain goal.

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Integrating assessment findings of HOPE into the plan of care

The previous example is just one way that the care planning process works WITH the HOPE to make the care provided by the agency organic and patient/family centric – finding out what works and what doesn't, then documenting the pivot is crucial to demonstrating compliance with this key Condition of Participation.

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Once the IDG team have assessed and evaluated the needs of the patient/family, it would seem logical to implement interventions based on assessment findings – however – it's important not to jump straight to interventions.
Start by determining what the goals will be for this issue – "you can't hit a target that you can't see"

Back to the Process – STEP 3

Goal Setting

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Make sure that the IDG's goals are aligned with all disciplines, and that they meet all the SMART elements, most importantly – how will you know when you get there?

Pain: "Patient will report pain ≤3/10 within 48 hours using scheduled and PRN opioid regimen."
• Dyspnea: "Patient will demonstrate reduced respiratory distress during ADLs with positioning and pacing strategies."
• Psychosocial: "Caregiver will verbalize reduced anxiety through weekly SW support and crisis planning."

Back to the Process – STEP 3

Goal Setting

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§418.56(c)(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.
Interpretive Guidelines §418.56(c)(3)

The outcomes should be a measurable result of the implementation of the plan of care. (DOES THE AGENCY/CARE PROVIDED ADD VALUE TO THE PATIENT/FAMILY'S LIFE FOR THE $$ INVESTED BY CMS??)
The hospice should be using data elements as a part of the plan of care to see if they are meeting the goals of care.
Are the outcomes documented and measurable? Look for movement towards the expected outcome(s) and revisions to the plan of care that have been made to achieve the outcomes.

Goal setting expectations from the State Operations Manual

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REGULATORY REQUIREMENT 418.56 1(d)

(d) Standard: Review of the plan of care. The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

***It's important that IDG meeting documentation demonstrates that the POC is updated according to updated findings – this issue is #3 on CHAP's list of citations for 2025:**

Comprehensive Assessment Updates:

Failure to update assessments to reflect changing patient conditions.

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REGULATORY REQUIREMENT 418.56 1 (e)

Standard: 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 patient 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.

(5)Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

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RESOURCES

CONDITIONS OF PARTICIPATION FOR HOSPICE CARE CFR TITLE 42., PART 418. Electronic conditions of federal registry. ECFR.GOV: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.56
Accessed 2/6/2026
HOPE GUIDANCE MANUAL. CMS.GOV: www.cms.gov/files/document/hope-guidance-manualv100.pdf
Accessed 2/6/2026
STATE OPERATIONS MANUAL. CMS.GOV: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
Accessed 2/6/2026.

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QUESTIONS?
CONTACT US AT:
INQUIRY@JCCTEXAS.COM
(940) 427-2488

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