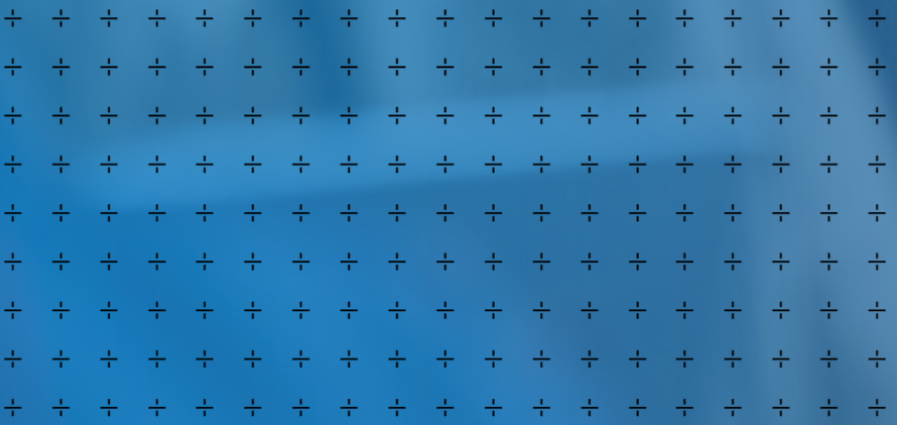




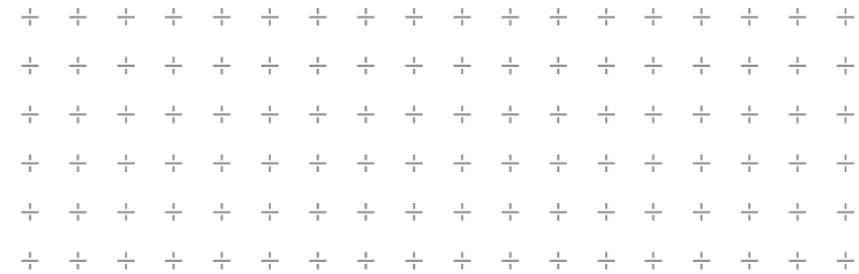
AHCC Talk: Crafting a Compliant POC

February 23, 2026



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Our Panel



Host

Jan Milliman, HCS-D,
Director, AHCC



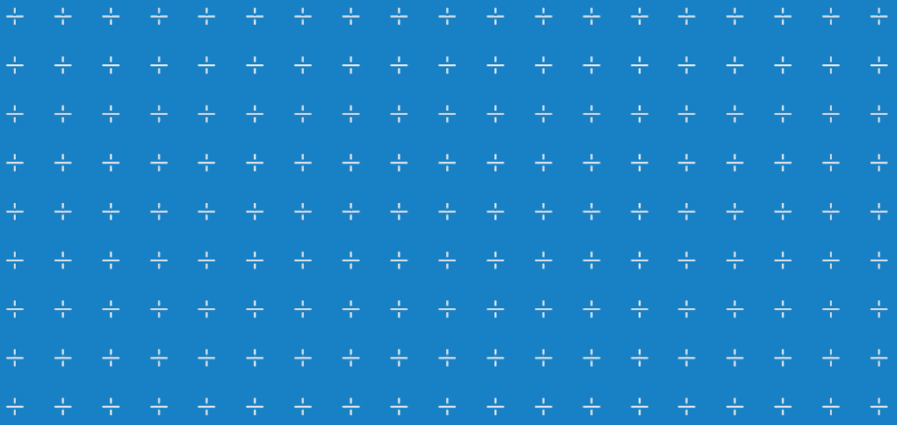
Panelist

Sherri Parson, RN, HCS-D,
HCS-O, HCS-H, COS-C,
CEO, Infusion Health



Panelist

J'non Griffin, RN, MHA, HCS-D,
HCS-H, HCS-C, COS-C,
Director, SimiTree Healthcare
Consulting



Crafting a Compliant Plan of Care



New Book developed by the AHCC Documentation Integrity Committee

- A guide to individualized plan of care (POC) for patients.
- Developing a POC can be challenging but is a vital step in optimizing patient outcomes.

Home Health Guide to Crafting a Compliant Plan of Care:

*A Hands-On Approach to Proving
Skilled Need, 2026*



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POC and the Conditions of Participation

Per the Conditions of Participation (CoP) §484.60(a)(2) The individualized plan of care must include the following:

- All pertinent diagnoses;
- The patient's mental, psychosocial, and cognitive status;
- The types of services, supplies, and equipment required;
- The frequency and duration of visits to be made;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
- Activities permitted;

- Nutritional requirements;
- All medications and treatments;
- Safety measures to protect against injury;
- A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.
- Patient and caregiver education and training to facilitate timely discharge;
- Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
- Information related to any advanced directives; and
- Any additional items the HHA or physician may choose to include.

Additional POC item guidance

- **Primary Diagnosis/Focus of Care:** The plan of care **MUST** include interventions and goals to address the primary diagnosis/focus of care.
- **Hospital Risks:** The plan of care must include a description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.
- **Patient Specified Goal:** The plan of care should include at least one patient-stated goal.
- **Short- and Long-term Goals:** The plan of care/treatment plan should include both short-term and long-term goals.
- **Interventions:** All goals should have at least one corresponding intervention.
- **PRN Visit Details:** Orders for PRN Visits must include number of visits needed and reason/indication for PRN visits. Reason/indication should be specific to each patient.
- **Verbal Order Details:** The plan of care should include details of the verbal order obtained to establish the plan of care.

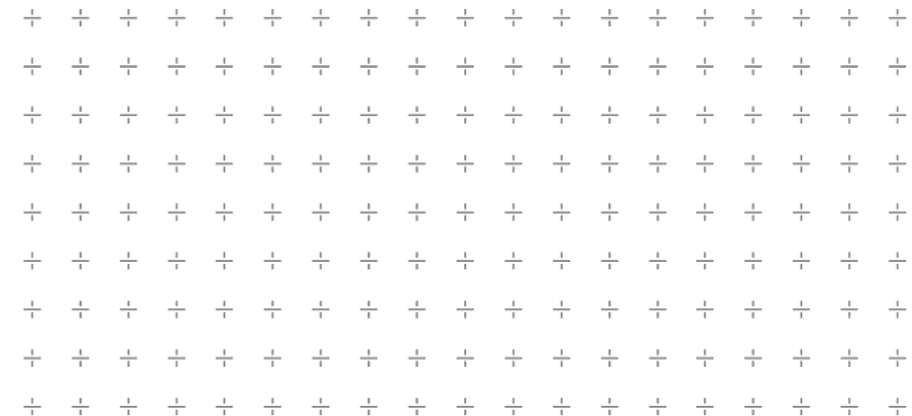
How to create a POC

Specific

When creating a POC, the specific needs of each patient **must** be considered.

Content

Interventions and goals should be individualized and updated according to patient's prior level of function, functional status, knowledge deficits, caregiver situation, living situation, strengths, goals and any barriers to success.



Intervention and Goal Considerations

Add appropriate interventions and goals (I/G) if the patient meets the following criteria:

Falls

Depression

Pain

Pressure
Ulcers



Falls Criteria

Diagnosis of fall/history of falls and/or Positive screen (MAHC 10 score of 4 or higher, TUG, etc.)



Depression Criteria

Diagnosis of depression and/or positive screening



Pain

Patient reports pain and/or patient has a diagnosis indicative of pain



Pressure Ulcers

Active pressure ulcer(s) and/or positive screening

When to add Interventions and Goals

Criteria: add I/G if patient.....

CHF

- has diagnosis of CHF

Diabetes

- has a diagnosis of diabetes

Anticoagulation Therapy

- on anticoagulation therapy requiring monitoring

Wounds

- wound present requiring care and monitoring

Catheter

- catheter requires changes or care

Infection

- has infection or is at risk of infection

Oxygen Therapy

- has a known cardiopulmonary disease/condition

Medications

- has knowledge deficits related to medication regimen

Telehealth

- would benefit from remote monitoring

POC tips to keep in mind

Keep the
POC
simple

Limit
Goals

Specific
to the
patient

Make
changes
to the
plan
through
out the
episode

Maintain
contact
with the
physician

QA staff
need to
watch visit
notes for
compliance
each visit
with POC

Identified Plan of Care Audit Risks

- Improper coding
- Improper sequencing of coding
- Frequencies inconsistent with patient condition
- Generalized PRN orders – PRNs must be specific to the patient
- Orders not followed
- Medications listed are inconsistent with meds in the home or other parts of the clinical record (i.e visit notes)
- Frequencies Goals are not individualized for patient/excessive in number
- Provider signature not signed in timely manner



Specific Examples of Developing Intervention and Goals

Aftercare of Surgery Education Examples:

What to expect after surgery

Provider orders, post-operative precautions, follow-up appointments.

Infection control precautions

Surgical wound assessment and care

Signs and symptoms to report

Medication education

Pain management

Safety measures

Blood clot preventative measures and signs/symptoms to report

Ordered therapy/exercises/HEP

Pneumonia preventative measures such as deep breathing exercises, incentive spirometer

Nutrition

Skin care/pressure ulcer prevention

Contact your provider before starting any over-the-counter medications/vitamins/supplements/herbal remedies.

Aftercare Goal/Intervention Pairing Examples

Goal: Patient and caregiver will verbalize understanding of surgical aftercare precautions to follow and signs and symptoms to report within 1 week.

Intervention: SN to educate patient and caregiver on what to expect after surgery and ordered precautions.

Goal: Patient surgical wound to heal within weeks without infection or other complications.

Intervention: SN to educate patient and caregiver on infection control techniques and signs and symptoms to report.

Goal: Patient/caregiver will verbalize/demonstrate understanding of surgical wound care and signs and symptoms to report within 1 week.

Intervention: SN to educate patient and caregiver on surgical wound assessment. Maintain nonremovable dressing until follow-up appointment on _____ (*date*) per physician's orders. Teach patient/caregiver to report increased pain, drainage, and/or redness to home health immediately.

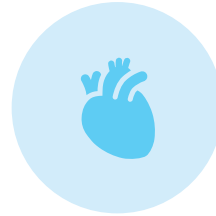
Goal: Patient perception of pain will decrease to _____ or acceptable patient level within 3 weeks.

Intervention: Clinician to assess pain each visit and educate on pain management methods including pharmacological and non-pharmacological modalities.

Cardiac Condition Example of Intervention Items



Document any education provided as well as verbalization of understanding and ongoing demonstration of compliance throughout the episode.



Include assessment of cardiac system for normal and abnormal findings in plan of care orders. *This assessment will vary depending on the diagnosis applicable to the patient.*



Include teaching on medications, whether new, changed, or those medications that patient may not understand. Assessment should include compliance with medications.



Include teaching on pathophysiology of the disease process, signs/symptoms to report and appropriate management techniques such as medication, diet, exercise, etc. in plan of care orders.



Include teaching on any disease-specific management techniques such as checking blood pressure and heart rate, daily weights, etc. and maintenance of a log with the results in the plan of care.

**Cardiac Disorders
Goal/Intervention
Pairing Examples**

Goal: Patient and/or caregiver will verbalize understanding of disease process (should be specific for diagnosis) within 3 weeks.

Intervention: SN to teach pathophysiology of disease process including disease management, signs/symptoms to report, long-term complications, and when to notify agency and/or provider. SN to notify MD of any uncontrolled or symptomatic signs/symptoms and any vital sign ranges outside patient expected ranges.

Goal: Patient and/or caregiver will demonstrate correct use of disease monitoring device within 4 visits (example: blood pressure monitoring device, scales for daily weight, etc.).

Intervention: SN to demonstrate use of _____ (disease monitoring device such as automatic blood pressure cuff, daily weights, etc.) and instruct on maintaining of a log of daily readings.

Goal: Patient and/or caregiver will demonstrate compliance with disease management measures including medications, diet, disease monitoring and maintenance of logs throughout the episode.

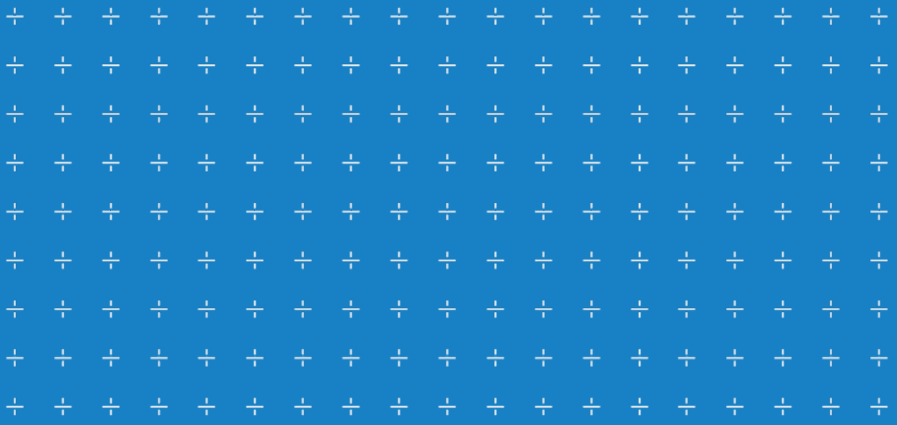
Intervention: SN to teach cardiac medications, assess medication compliance, and response to medications.

Goal: Vital signs will remain within patient-specific parameters throughout the episode.

Intervention: SN to assess cardiac system every visit with emphasis on _____ (HTN, Heart failure, chronic kidney disease, coronary artery disease, myocardial infarction, atrial fibrillation/flutter).

Goal: Patient will remain free of complications such as MI, CVA, or DVT throughout the episode.

Intervention: SN to instruct on possible complications/signs/symptoms of atrial fibrillation/flutter including deep vein thrombus, pulmonary thrombus, stroke.



Scenario Spotlight



January Scenario

OASIS Scenario: PT is working with a newly admitted patient with a diagnosis of dementia. Patient is using their walker for ambulation and PT is having patient stand briefly on one leg and then the other to work on increasing their balance due to an unsteady gait. While standing on the left leg, with right foot off the floor, the patient fell against the kitchen counter and immediately complained of right upper arm pain. MD was notified and patient sent to ER where they were found to have a right mid-shaft humerus fracture. The patient was admitted to the hospital for an ORIF of the fracture.

How should the clinician completing the transfer respond to J1800: Any Falls Since SOC/ROC and J1900: Number of Falls since SOC/ROC?

January Scenario Answer

OASIS Scenario Answer: Score this patient as follows:

J1800: Any Falls Since SOC/ROC: 1. Yes

J1900: Number of Falls since SOC/ROC: C. Major injury: 1. One (assuming no other falls with major injury are documented.)

Updated falls definitions were released in early January with an effective date retroactive to Jan. 1. Although these definitions were mentioned in the 4th quarter OASIS Q&A, the errata was released several months after the Q&A.

The updated fall definition continues to state an intercepted fall that occurs while therapy is intentionally challenging a patient's balance, assuming no injury, is not considered a fall. However, the guidance has been updated to reflect if a patient has a major injury, such as a fracture, from an intercepted fall while therapy is intentionally challenging a patient's balance, it would be considered a fall with major injury.

Resources:

Home Health J1800/J1900 Errata: <https://www.cms.gov/files/document/oasis-e1-guidance-manual-errata-fmi-items.pdf>

October 2025 CMS Quarterly OASIS Q&As:

https://qtso.cms.gov/system/files/qtso/CMS_OAI_Qtr_4_2025_QAs_October_2025_508c.pdf

February Scenario

POC Scenario: An 84-year-old male was hospitalized for COPD exacerbation. Patient is O2-dependent and has nebulizer treatments every 4-6 hours. The patient's other comorbidities include hypertension that is well managed with medication, Type 2 diabetes with a sliding scale of Humalog, and Lantus 20 U daily. Patient also has hypothyroidism, hyperlipidemia, and anxiety. The RN case manager has admitted the patient to home health and is now preparing the plan of care for this patient.

What conditions should be considered when establishing goals and interventions on the POC based on industry best practices?

Product Spotlight

Home Care Leadership Summit

May 19th through 21st in Orlando, Florida

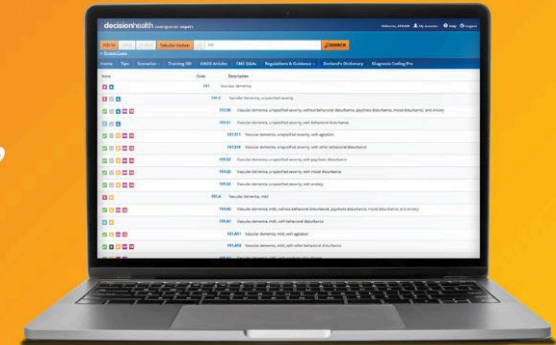
Don't miss your chance to join industry leaders, gain actionable insights, and connect with peers at this year's summit. Save up to \$100 when you register before March 11, 2026.

To learn more or reserve your spot at the Home Care Leadership Summit, visit decisionhealth.com/hcls2026.



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What's new with AHCC

AHCC Networking call March 31

- Join us to meet fellow members and work through scenarios.

Home Health Guide to Crafting a Compliant Plan of Care

- Order your guide here:
<https://store.decisionhealth.com/2026-plan-of-care-guide>.





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Next episode: March 16