From Paper to Purpose:

Igniting Patient-Centered Care Plans

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Tidal Healthcare Consulting, LLC
Navigating Excellence

Course Overview

- Why care planning must go beyond compliance
- Capturing the patient's voice & lived experience
- Building individualized, specific care plans
- Igniting interdisciplinary teams
- Documentation that tells the full story
- Avoiding citations and common POC pitfalls
- Real-world Case Application
- Takeaways, Tools & QA

Code Red: When Following the Rules Isn't Enough

Care Planning Beyond Compliance

The Compliance Trap: When 'Good Enough' Isn't Good

When Plans Are Built for the Surveyor, Not the Patient:

- Generic goals that no patient ever actually said
- Identical interventions across unlike diagnoses
- Missing hospital risk assessment interventions
- Discharge planning that starts at Week 8
- Documentation written for the payor, not the person
- Copy-paste visit notes with no clinical narrative

What Patient-Centered Care Planning Looks Like:

- Goals in the patient's own words "in quotes"
- Interventions tied to the specific focus of care
- Plans the patient helped build and understands
- Discharge planning present from day one
- Documentation that tells the patient's story
- Collaboration that reflects the whole person

The Regulatory & Financial Stakes of Care Planning

G574
Most cited CoP in home health surveys nationally

G572
Failure to fulfill POC orders or notify the physician

5%
HHVBP payment swing tied directly to care plan quality

RCD
Pre-claim review denials linked to POC inconsistencies

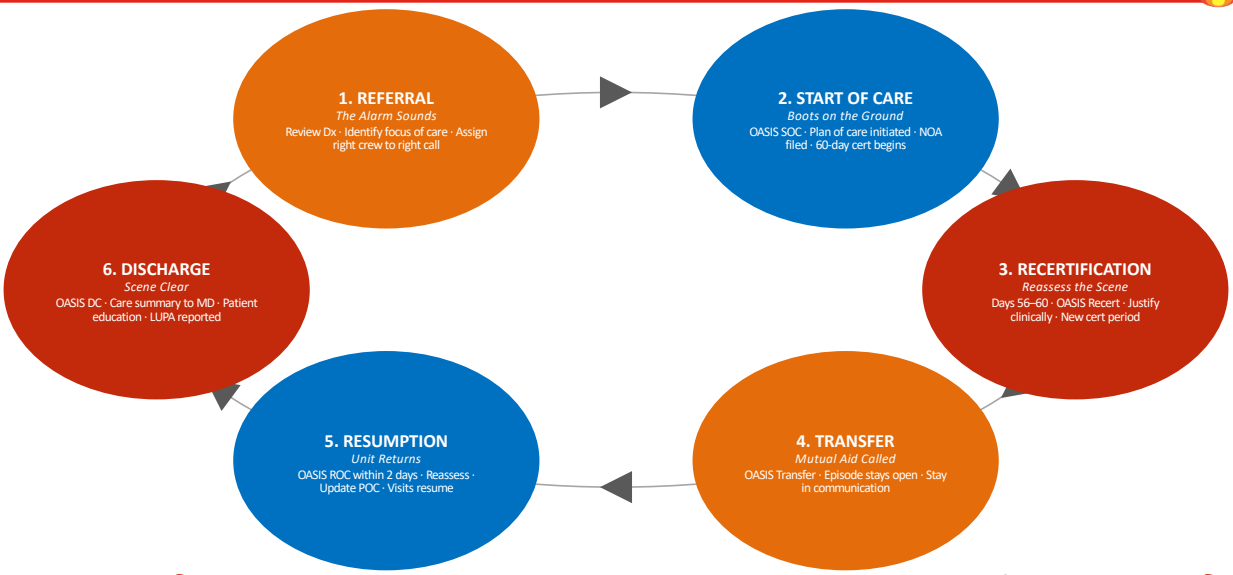
The stakes are not just surveyors and citations.
They are your patients' outcomes, your agency's star rating, and your Medicare reimbursement.

Medicare CoP 484.60(a)(2) requires the POC include: patient-identified goals, measurable outcomes with achievement dates, hospital risk assessment WITH specific prevention interventions, and ALL pertinent diagnoses including psychosocial and cognitive status.

On the Scene Intel

The Patient's Voice

Life Cycle of an Episode



The Patient-Stated Goal: More Than a Compliance Checkbox

"I want to walk to my mailbox by myself again."

— This is a patient-centered goal. Document it in quotes. Build the entire POC around it.

HOW to Elicit Goals

- Ask open-ended questions: 'What does getting better look like for you?'
- Ask about what the patient can no longer do that they miss
- Ask about a typical day BEFORE the illness or injury
- Listen for functional language, not medical language
- Involve caregivers — they often articulate what patients won't say
- Document the patient's exact words in quotation marks

COMMON MISTAKES to Avoid

- Writing 'Patient will improve', or 'Return to PLOF': these are NOT goals in the patient's language
- Identical goals across all patients with same diagnosis
- Goals with no timeline or achievement target
- Goals that reflect what the CLINICIAN wants, not the patient
- Skipping the goal conversation entirely at SOC
- Using clinical jargon instead of patient language

Beyond the Diagnosis: Social Determinants & the Whole Person

- **Housing Stability**
  - Unsafe stairs, overcrowded home, no climate control
- **Caregiver Support**
  - Isolation, caregiver burnout, language barriers
- **Health Literacy**
  - Medication confusion, inability to read instructions
- **Mental and Emotional**
  - Depression, grief, fear, all directly impact compliance
- **Cultural and Religions**
  - Beliefs that shape treatment acceptance and care preferences

Do you review these questions when completing the POC?

No Two Alarms are the Same

Individualized Care Plans

G574 Required POC Elements: The Non-Negotiables

1. All pertinent diagnoses INCLUDING mental, psychosocial, and cognitive status
2. All services, supplies, and equipment WITH specific frequency and duration
3. Prognosis AND rehabilitation potential
4. Functional limitations and activities permitted; nutritional requirements
5. All medications and treatments
6. Safety measures to protect against injury
7. RISK for ED and hospital readmission WITH specific prevention interventions
8. Patient-specific interventions and education WITH measurable goals and dates

All elements must be individualized. No two patients should have identical plans.

Intervention Specificity: Vague Orders = Citations & Denials

Every intervention in the POC must answer: WHO, WHAT, WHEN, HOW, and WHY.

Wound Care	✗ Wound care as ordered	✓ SN to perform wound care to left lower leg twice weekly: cleanse with Wound Wash, apply Mepilex border dressing, secure with Kerlix roll
Infusion Therapy	✗ Flush per SASH / PICC dressing weekly	✓ SN to flush PICC with 10mL NS pre and post medication, change PICC dressing every 6-8 days using sterile technique. May cleanse site with alcohol, chloraprep or betadine, air dry, cover with transparent dressing. May use skin prep for security, may us stabilization device.
Medication Education	✗ Educate patient on medications	✓ SN to educate patient and caregiver on purpose, dose, and side effects of Warfarin; review INR log at each visit; reinforce fall precautions

Goal Architecture: Measurable, Achievable, Patient-Specific

A well-written goal has four components. All four must be present.

W	A	M	D
WHO	**ACTION**	**MEASURE**	**DATE**
The patient (or caregiver, be specific)	What they will do or demonstrate	How we will know it was achieved	By when, a specific achievement date

✗ *Generic: 'Patient will improve wound healing.'*

✓ *Patient-specific: 'Patient will demonstrate correct wound dressing change technique, applying Mepilex to left lower leg independently without caregiver assistance, by 11/30/2026.'*

Regulatory note: Patient MUST agree to the goal — and that agreement must be documented in the visit note.

Sound the Horn

Interdisciplinary Collaboration

The IDT Fire Brigade: Every Role, Every Visit, One Direction

Every discipline must be directed at the SAME focus of care — and documentation must show it.

Skilled Nursing
Clinical lead: assessment, medications, wound care, education, care coordination

Physical Therapy
Mobility, fall risk, GG function items, strengthening, equipment needs

Occupational Therapy
ADL assessment, aide supervision, adaptive equipment, discharge planning

Speech Therapy
Dysphagia, cognition, communication, nutrition support

Medical Social Work
SDOH barriers, caregiver support, community resources, crisis intervention

The Collaboration Engine: SOC Conference to Case Conference

- Reason for admission matches F2F documentation
- Ensure all Medicare criteria are addressed: homebound, medical necessity, skilled need
- Verify certifying physician and all other MDs involved
- Need for referrals for other disciplines/services
- Review requested visit frequency
- Review ordered interventions (wound care, medication administration, infusions)
- Order requested DME and supplies
- Review OASIS functional scores: sets expectations for DC Function scoring
- Document this communication: counts toward care coordination requirements
- Use SOC report to cross-reference SOC visit note

The Collaboration Engine: SOC Conference to Case Conference

SOC CONFERENCE

- Occurs same day as SOC before clinician leaves the area
- Confirms consistency between F2F, orders, and OASIS
- Clinical Manager reviews: homebound status, skilled need, medical necessity
- Assign disciplines based on acuity, not habit
- Flag high-risk patients immediately for front-loaded visits

ONGOING CASE CONFERENCE

- Weekly review of high-risk patients and LUPA risk
- Review of functional status and GG progression
- Interdisciplinary alignment: all notes reflecting same focus of care
- Medication reconciliation updates shared across team
- Discharge planning discussed at every conference

WHAT GOOD COLLABORATION SOUNDS LIKE

- 'PT noted patient can now transfer without max assist, nursing updated the POC'
- 'OT assessed aide need, HHA frequency reduced, patient more independent'
- 'MSW identified transportation barrier, care plan updated with community resource'

CLINICAL MANAGER ROLE IN COLLABORATION

- Review SOC documentation before approving for billing
- Catch inconsistencies between disciplines EARLY
- Require documentation that proves interdisciplinary communication
- Own the 30-day care conference and ensure POC updates

From the Scene to the Station

Documentation

Every Word Has an Audience — Document for All of Them

What Every Visit Note Must Include to Stand Alone

Each note must stand on its own — if pulled in an audit, it must prove homebound, skilled need, and goal progression.

1	**Homebound Status:**	Documented at every visit; not assumed, not copied from prior note
2	**Skilled Necessity:**	WHY this visit required a skilled clinician; specific to today
3	**Physical Assessment:**	Pertinent to the focus of care; vitals alone are not sufficient
4	**Skilled Services Rendered:**	WHAT was done; specific, not 'nursing care as ordered'
5	**Education Provided:**	TOPIC, METHOD, and patient/caregiver RESPONSE; not just 'education given'
6	**Goal Progression:**	Tie every visit back to at least one POC goal; progress noted or barrier identified
7	**Plan for Next Visit:**	What will happen, when, and why; connects to the episode trajectory

Documentation Support

- EMR templates
  - Interventions and goals
  - Risk assessment and interventions
- Disease state management programs
  - Allows for consistency in care
  - Assists with visit utilization
  - Support for newer clinicians
  - Allow flexibility for patient differences
- AI transcription
  - Assists with translation
- QA Review
  - Justify changes for education

RCD Tips

- Separate Medicare Certification Statement
  - F2F information
  - Medical necessity & skilled need
  - Attestation statement
  - Homebound confirmation
- Patient identified goals
- Clinical summary, especially on recert
  - If goals are extended, document reason for delay
  - Reiterate any acute issues, changes in meds, ER or hospital visits to justify the recert
- Hand off documentation when certifying MD changes
- Wound description

Watch for Backdraft

Common POC Citations

Citation Patterns and Prevention

G574: POC CONTENTS

- Missing patient-identified goal (must be in quotes)
- Goals without a measurable method or end date
- All patients with same diagnosis have identical goals
- Therapy orders missing specific modalities, frequency, location
- Patient on anticoagulant: no safety measures documented
- Missing hospital risk assessment AND prevention interventions
- Missing rehab potential or discharge planning

G572: POC FULFILLMENT

- Lack of MD notification when patient status changes
- Missed visits or ordered treatments without physician notification
- Patient refuses wound care multiple times — no MD contact
- Visit frequency reduced for staffing without physician notification
- Patient reports fall or new skin breakdown — no MD contact made
- Verbal order documented but signed order never received
- Notes document services without corresponding orders on POC

Live Fire Training

Case Application

Case Study

Mrs. Rivera is a 74-year-old woman with CHF, Type 2 DM, and depression. She was hospitalized for 5 days after acute fluid overload. She lives alone; her daughter visits weekly. She told the SOC nurse: 'I just want to be able to cook my own meals again without getting so winded.'

Original POC

- Goal: Patient will improve CHF management
- SN to monitor vitals and assess for SOB x 3w
- Educate patient on CHF diet and medications
- Hospital risk: High: monitor closely
- No discharge planning noted
- No caregiver or SDOH assessment documented

Corrected POC

- Goal: 'I want to cook my own meals without getting so winded'. Patient will demonstrate 2-minute activity tolerance with <2/10 dyspnea by 10/15/2026
- SN to weigh daily, assess bilateral edema, lung sounds; notify MD for >2lb gain in 24h or >5lb in 5 days
- Educate on low-sodium diet, fluid restriction, symptom escalation; document patient response
- Hospital risk: High Interventions: SN to front-load visits Wk 1, teach when to call agency vs. MD vs. 911
- MSW referral for SDOH screen, depression, isolation, food access
- DC planning: assess community meal support; OT eval for kitchen safety

Post-Incident Debrief

Bringing it all Together

Your 8 Sparks: What to Carry Out of This Room

01	Patient goals belong in the patient's own words: In quotes, agreed to, and measured
02	Every intervention must answer WHO, WHAT, WHEN, HOW, and WHY vague
03	The whole person arrives at the door, screen for SDOH and document what you find
04	SOC conference is non-negotiable, catch inconsistencies before they become citations
05	All disciplines must document toward the same focus of care
06	Hospital risk requires SPECIFIC prevention interventions, 'monitor closely' is not enough
07	Discharge planning starts at SOC, the NOMNC is not a last-minute task
08	Your documentation is your license, your reimbursement, and your patient's story, make it count

Thank you!

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