Ideal
Home Health
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Understanding Your Plan of Care

How your physician-ordered plan of care works and what to expect at each visit

What Is a Plan of Care?

Your plan of care (POC) is the roadmap for your home health services. It's developed with your physician (or another authorized practitioner) before your first visit and describes exactly what care you'll receive, why, and how often. Every visit our clinicians make is guided by this plan, and every visit is documented against it.

Federal Medicare rules (42 CFR §484.60) require every home health plan of care to be individualized to you — not a generic template — and to include the following:

- All pertinent diagnoses and your current health conditions
- Your mental, psychosocial, and cognitive status
- The types of services, supplies, and equipment you need
- How often and how long each type of visit will occur
- Your prognosis and rehabilitation potential
- Functional limitations and what activities you're permitted to do
- Nutritional requirements
- All medications and treatments ordered by your physician
- Safety measures to protect you from injury
- Your risk for hospital readmission or emergency visits, and the steps your care team will take to reduce that risk
- Specific goals and measurable outcomes your care team is working toward with you
- Information about advance directives, if you have them
- Instructions for a timely and safe discharge or referral when your care ends

Who's Involved

- Your physician or authorized practitioner orders home health care and certifies that you need it. They review and re-sign your plan of care at least every 60 days, or sooner if your condition changes.
- Your registered nurse or therapist carries out the plan, documents your progress at each visit, and reports any changes in your condition back to your physician.
- Care Coordination manages the behind-the-scenes work — scheduling, physician orders, insurance verification — so your plan stays current and nothing falls through the cracks.
- You and your family participate in the plan. You have the right to ask questions, understand your goals, and be told in advance about any changes.

What to Expect at Each Visit

1. Your clinician reviews your current status against the goals in your plan of care.
2. They provide the ordered service — skilled nursing, therapy, aide care, or another discipline — and document what was done.

3. Any change in your condition, medications, or home environment is noted and communicated to your physician if it affects your care.
4. Your clinician updates you and your family on your progress and what to expect at the next visit.

When Your Plan of Care Changes

Your plan of care isn't fixed — it's updated whenever your condition, goals, or physician's orders change. You'll always be told in advance of any change to frequency, services, or goals, and you have the right to ask for those changes to be explained in terms you understand.

As your care progresses toward discharge, your care team will begin discharge planning with you — covering what support you'll need going forward and how to access it.

Questions About Your Plan of Care

Ideal Home Health — Care Coordination	413-322-8614	24/7 for clinical concerns
Medicare (CMS) — general coverage questions	1-800-MEDICARE (1-800-633-4227)
SHINE Program — free MA Medicare counseling	1-800-243-4636	SHINE@mass.gov

Per Medicare Conditions of Participation 42 CFR §484.60 (Care Planning, Coordination of Services, and Quality of Care).