

Factor 4: Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.

PCC EHR includes Care Plan functionality within every Medical Summary for organizing materials and information in preparation for transitioning a patient from pediatric care to adult care. The following example shows how Care Plan functionality within PCC EHR can be used to transition a patient to adult care.

Patient Beau O'Leary is 18 years old and transferring to an adult primary care setting. He has a history of migraines and has seen a neurology specialist in the past to help manage the migraines.

For patients like Beau with complex medical histories, the Care Plan is a good place to document the goals for and progress made with the patient's care. It can also contain the patient's care team information, including family members and professionals involved in the patient's care. Here, a Care Plan intervention was initially created to track the progress with the treatment of Beau's migraines but it is now marked as resolved since the migraines are under control and he is no longer seeing a specialist.

The screenshot displays the PCC EHR interface. On the left, a sidebar menu lists various patient details and navigation options. The main area is titled "Medical Summary" and shows a "Care Plan" section. The "Care Plan" header includes the patient's name, age, gender, and birth date. Below the header, there are sections for "Goals" and "Actions". The "Goals" section lists "Manage migraines". The "Actions" section lists "Follow-up neurological assessment". There is also a "Next Steps" section with a note about avoiding caffeine and managing diet. A "Care Coordination Notes (internal use)" section is present. The "Team Members" section lists "Brent O'Leary (Custodian)" with contact information and "Dr. James Andrews, M.D." with their organization and address. A "Note" field is available for each team member.

Because Beau is transferring to a new practice, a new Care Plan intervention is created to help

organize the tasks related to transitioning him out of the practice. In Beau's medical summary a new "Transition to adult care" intervention is added:

PCC EHR

Medical Summary

Beau O'Leary 18 yrs, 2 mos 1/24/96 M

Care Plan

04/08/14

Goals

- Transition to adult care setting

Actions

- Transfer practice

Next Steps

1. Identify adult primary care
2. Identify adult emergency care
3. Identify specialty care needs
4. Obtain release for transfer of records to adult care
5. Provide health information summary to adult care practice

Care Coordination Notes (internal use)

Beau will be transitioning to Westwood Family Practice in Portland. His emergency and hospital care will be provided by Bay Area Medical Center. Beau has seen a neurologist in the past to help manage severe migraines he was having, but this issue seems to be resolved based on recent visits I've had with him. See attached intervention re: migraine care plan. Release for transfer of records is attached and a health info summary is being sent to Westwood Family Practice.

Team Members

General (1 Page)

Note: Release form for transfer of records [pcc]

Attached to: 04/08/14 - Care Plan Goal "Transition to adult care setting"

Date: 04/08/14

Print **Display: All Statuses** **Status: Active**

EDIT TAGS **VIEW DOCUMENT**

Print care plan intervention(s)

The practice collaborates with the patient to get a signed records release transfer form to be scanned and attached directly to the Care Plan as shown in the above screen shot.

The above care plan intervention, in addition to the now-resolved migraine care plan intervention, and all attached documents can be printed together or saved as a .pdf to be sent to the adult care practice. Note that this would also include all documents such as specialist reports that would have been attached to the now-resolved migraine treatment intervention.

Medical Summary

Beau O'Leary 18 yrs, 2 mos 1/24/96 M

Care Plan

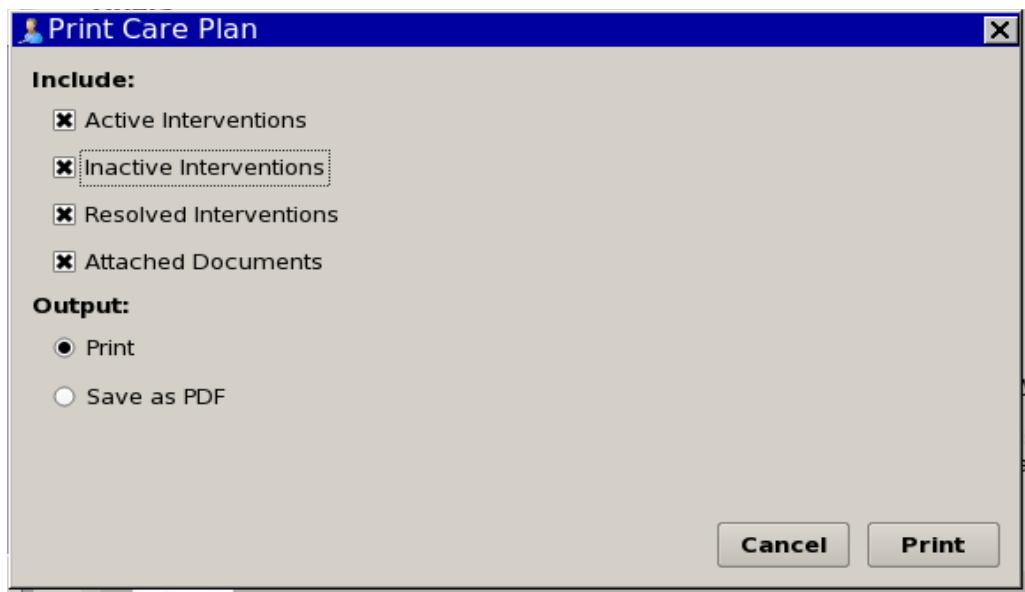
04/08/14

Goals

- Transition to adult care setting

Print **Display: All Statuses** **Status: Active**

Print care plan intervention(s)



Note that the printed care plan also includes any documented care team members. Because the neurologist is a care team member for the migraine treatment intervention, he is included in the report with any other documented care team member:

Care Plan Beau O'Leary (18 yrs, 2 mos; M; 01/24/96)

Team Members

Brent O'Leary (Custodian)

Home Phone:	802-555-0191	Address:	5658 Hillview Lane
Work Phone:	802-555-0120	Essex Junction, VT 05453	
Cell Phone:	802-555-0166		
Emg Phone:	802-555-0144		

Dr. James Andrews, M.D. (Clinical Neuropsychologist)

Organization:	Harborview Neurology
Address:	25 Broadway St
	South Portland, ME 04106

Additionally, the patient's health information summary can and should be sent to the adult care practice. This would include Beau's problem list, medication allergies, medication history, immunization history, and diagnostic test results. Details on how to generate a Health Information Summary within PCC EHR are shown below.