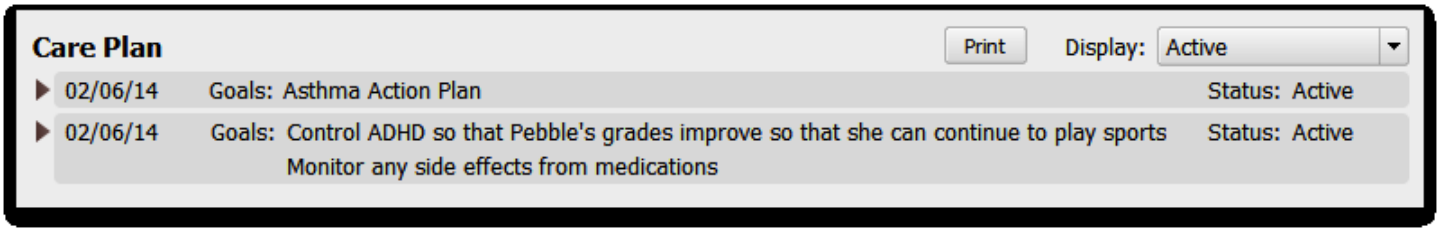
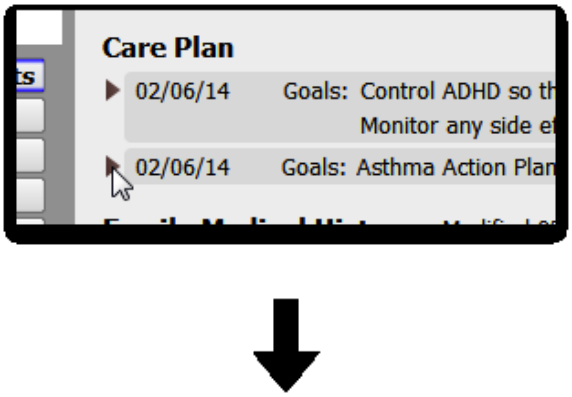
Factor 2: Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit

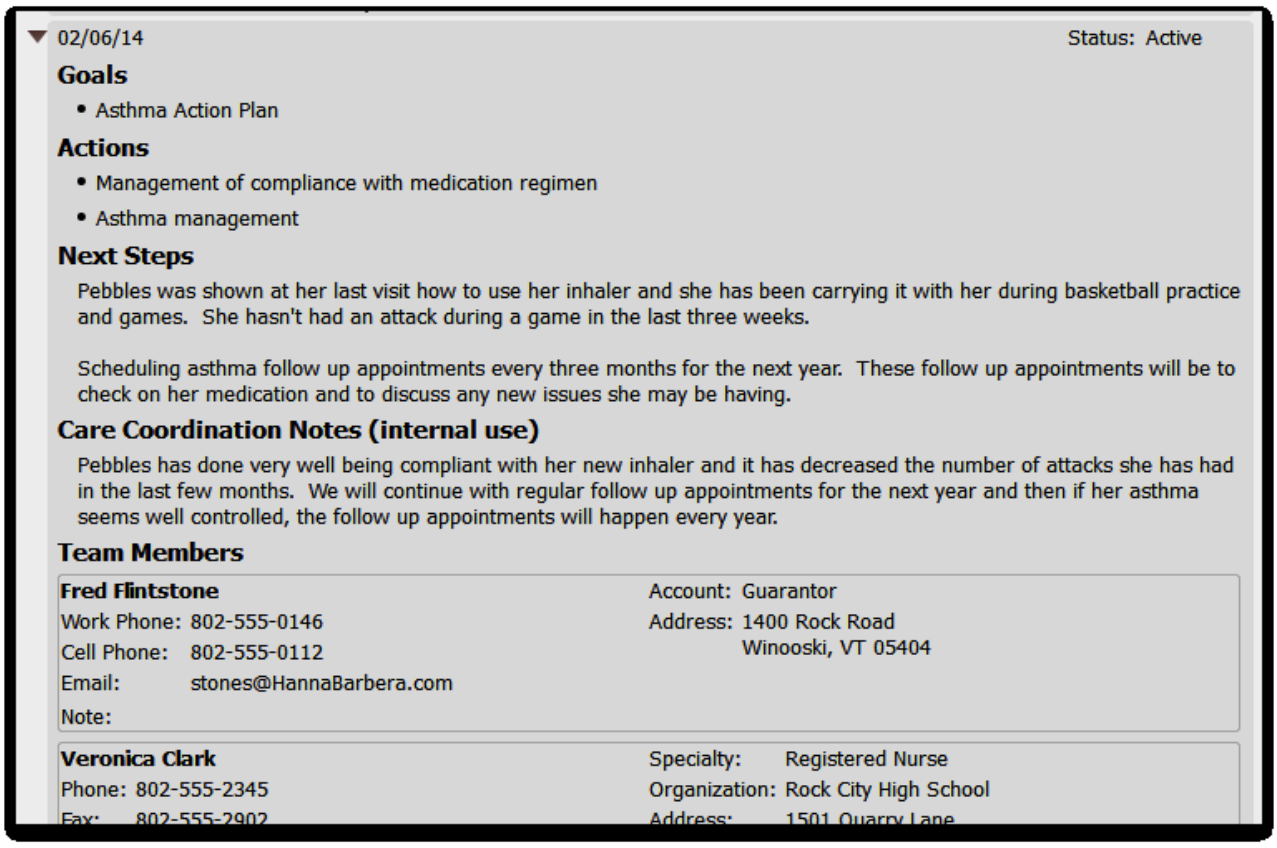
PCC EHR includes Care Plan functionality within every Medical Summary allowing the practice to store treatment goals and care coordination notes in a clear, structured format. PCC EHR's Care Plan functionality is most useful for tracking goals, progress, and next-steps for high-risk or complex patients as well as identifying the Care Team of family members and other professionals involved in the patient's care.

When reviewing a patient's chart, the Care Plan can be found within the patient's Medical Summary or it can be inserted within a chart note template. Here is an example of a Care Plan for Pebbles Flintstone who has a history of both asthma and ADHD:



In this Care Plan example, two "interventions" have been added for Pebbles, one addressing her asthma and the other addressing her ADHD. While reviewing the care plan summary, click the arrow to see more details. For example, you can review and edit a Pebble's Asthma Action Plan.





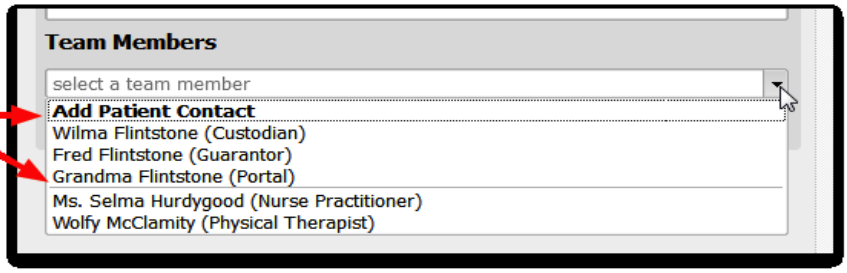
Each intervention can have Goals, Actions, Next Steps, Care Coordination Notes for internal use, and one or more Team Members. Each intervention can have a status of Active, Inactive, or Resolved. You can set the status and then filter which interventions appear, just as you can with problems on the Problem List.

An intervention can have multiple goals, which are free text boxes where the clinician can document the treatment goals. During relevant visits, the treatment goal would be reviewed and updated if necessary. Progress made toward these goals would be documented in the general Care Coordination Notes section. Based on collaboration with the patient, their family, and any other care team members, negotiated actions or "Next Steps" would be documented and are meant to include instructions for the patient and areas to discuss during the next relevant visit.

One or more care "Team Members" can be documented with the Care Plan intervention. Click on the down arrow to see a list of available members. You can add a new patient contact, or select from the patient's custodian, guarantor, or linked My Kid's Chart portal users. You can also choose from a list of your practice's professional contacts.

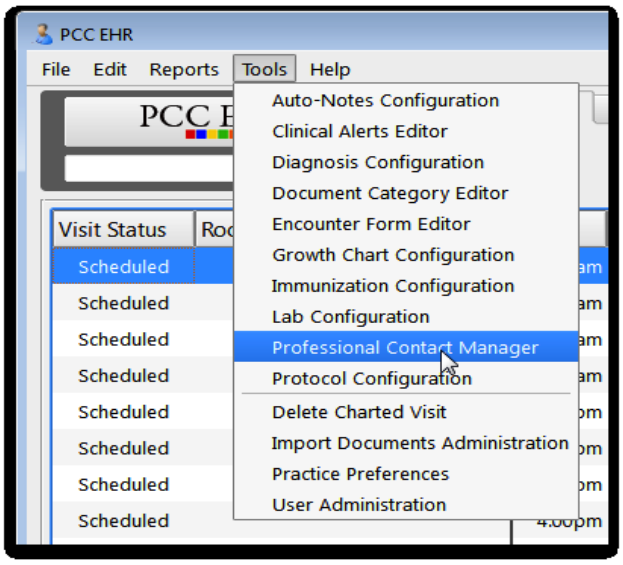
Care plan intervention team members can be:

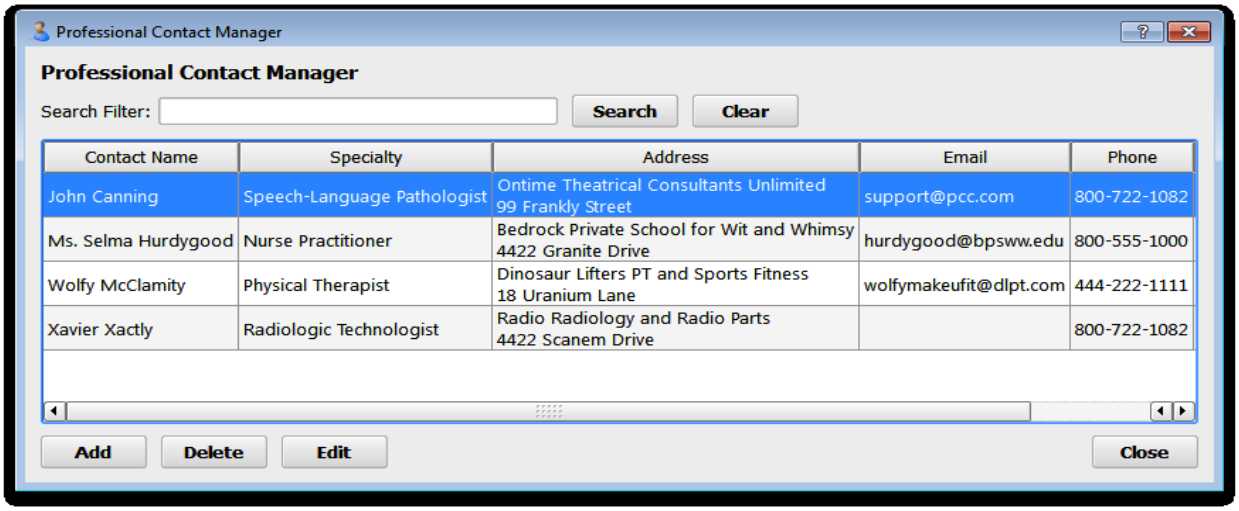
- **a custom patient contact**
- **the custodian or guarantor**
- **a user with MyKidsChart portal access**
- **one of your practice's professional contacts**



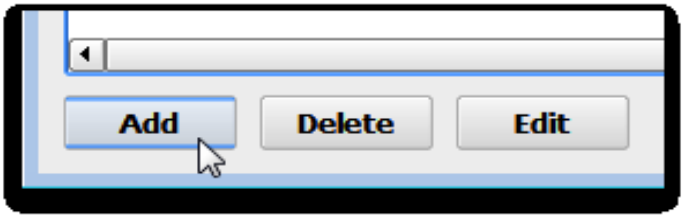
You can use PCC EHR's Professional Contact Manager tool to create a list of your practice's professional contacts, school medical personnel, and specialists who may be involved in care management for your patients.

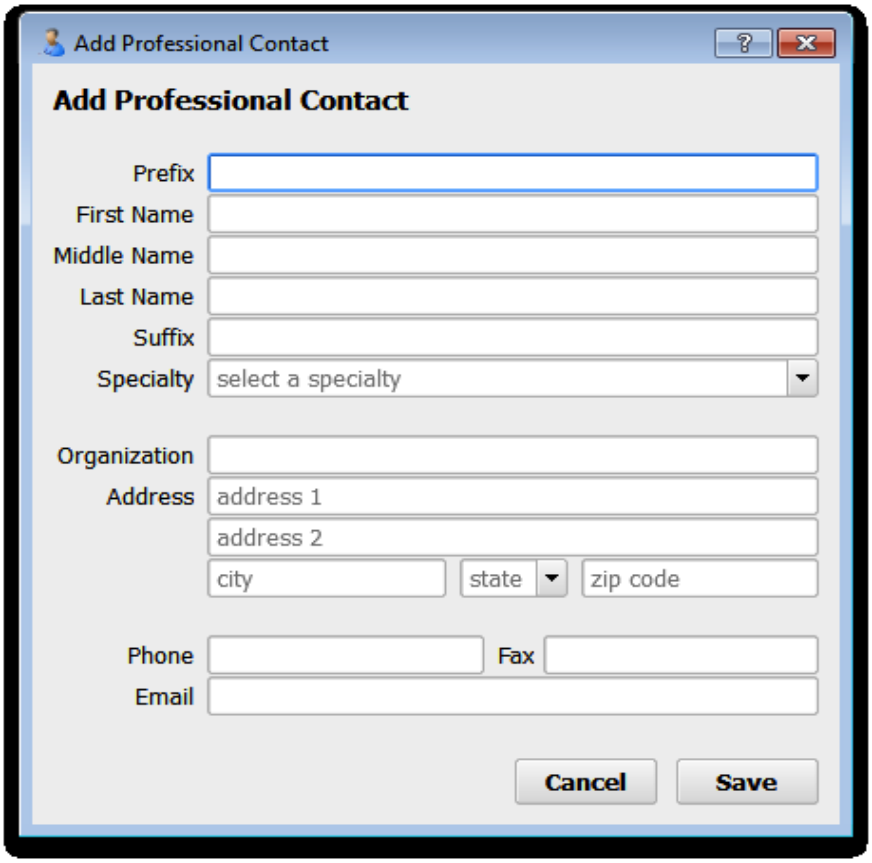
When you add team members to an intervention in a patient's care plan, you can select from your practice's list of Professional Contacts.





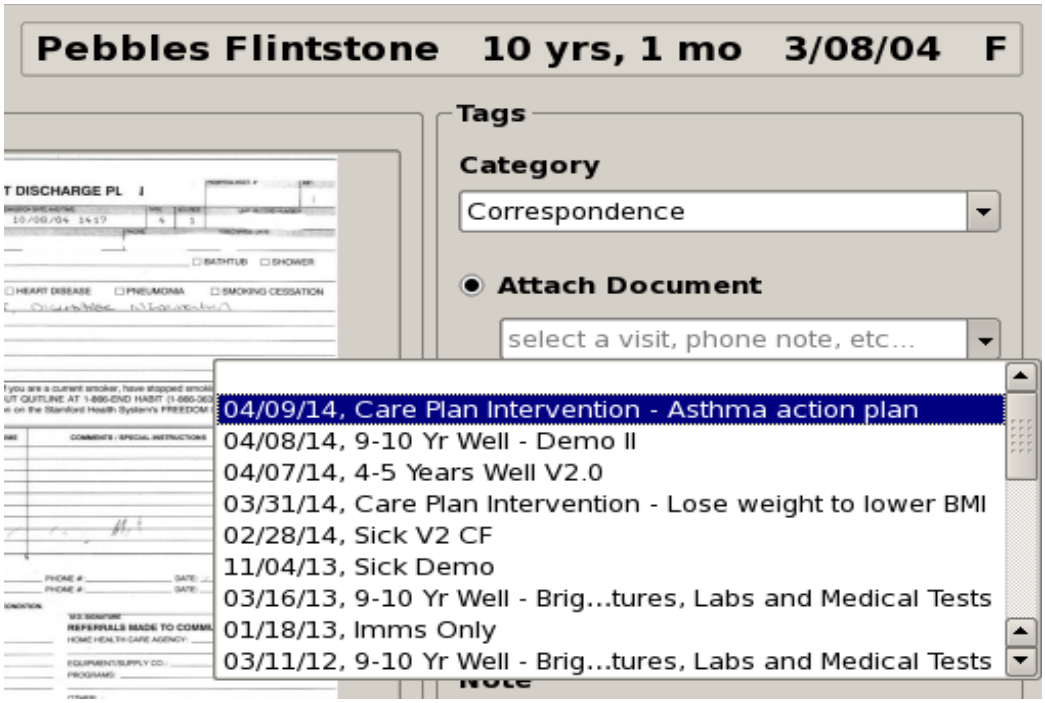
Click “Add” to create a new contact:





After adding a professional contact, you can select them as a team member for an intervention in a patient's care plan. For complex patients who see multiple specialists, it is useful to have all Care Team members displayed in one place. When reviewing the Care Plan during visits, you can easily tell who else is involved in the care management for the patient. It is also very useful for the patient and family to have a full list of specialists they may be working with.

You can attach specialist reports or other documents to a patient's care plan intervention. When importing scanned documents in PCC EHR, each of the patient's interventions will appear in the Import Documents window as well as in the Edit Tags window in the Documents section of a patient's chart.



After adding a document to an intervention, it will appear attached to that intervention.