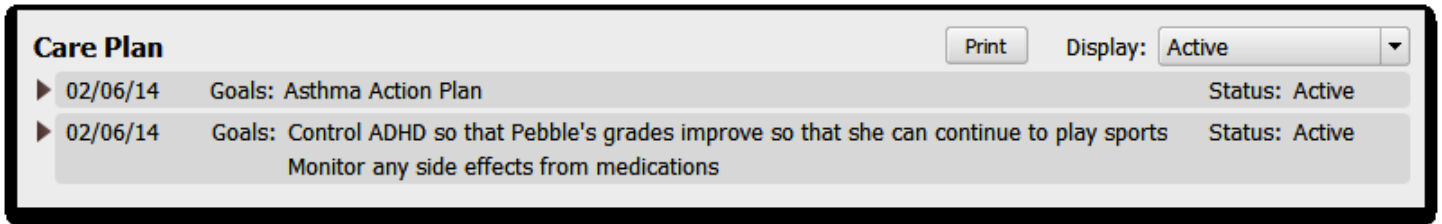


Factor 2: Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit

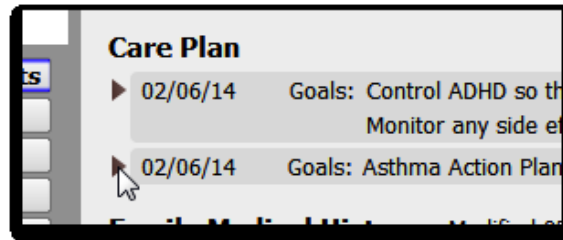
PCC EHR includes Care Plan functionality within every Medical Summary allowing the practice to store treatment goals and care coordination notes in a clear, structured format. PCC EHR's Care Plan functionality is most useful for tracking goals, progress, and next-steps for high-risk or complex patients 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:



The screenshot shows a 'Care Plan' window with a 'Print' button and a 'Display: Active' dropdown menu. Below the header, there are two rows of care plan items, each with a right-pointing arrow icon on the left and a 'Status: Active' label on the right. The first row is dated '02/06/14' and has the goal 'Goals: Asthma Action Plan'. The second row is also dated '02/06/14' and has the goal 'Goals: Control ADHD so that Pebble's grades improve so that she can continue to play sports'. Below the second row, there is a sub-goal: 'Monitor any side effects from medications'.

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.



This screenshot is a zoomed-in view of the 'Care Plan' window. It shows the same two rows of goals as the previous screenshot. A mouse cursor is positioned over the right-pointing arrow icon of the second row, which is 'Goals: Asthma Action Plan'. The first row, 'Goals: Control ADHD so that Pebble's grades improve so that she can continue to play sports', is partially visible above it. Below the second row, the sub-goal 'Monitor any side effects from medications' is also visible. The 'Status: Active' label is visible to the right of the second row.



▼ 02/06/14 Status: Active

Goals

- Asthma Action Plan

Actions

- Management of compliance with medication regimen
- Asthma management

Next Steps

Pebbles was shown at her last visit how to use her inhaler and she has been carrying it with her during basketball practice and games. She hasn't had an attack during a game in the last three weeks.

Scheduling asthma follow up appointments every three months for the next year. These follow up appointments will be to check on her medication and to discuss any new issues she may be having.

Care Coordination Notes (internal use)

Pebbles has done very well being compliant with her new inhaler and it has decreased the number of attacks she has had in the last few months. We will continue with regular follow up appointments for the next year and then if her asthma seems well controlled, the follow up appointments will happen every year.

Team Members

Fred Flintstone	Account: Guarantor
Work Phone: 802-555-0146	Address: 1400 Rock Road
Cell Phone: 802-555-0112	Winooski, VT 05404
Email: stoness@HannaBarbera.com	
Note:	

Veronica Clark	Specialty: Registered Nurse
Phone: 802-555-2345	Organization: Rock City High School
Fax: 802-555-2902	Address: 1501 Quarry Lane

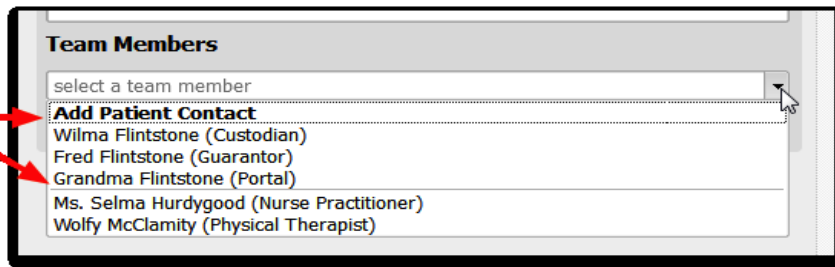
Each intervention can have Goals, Actions, Next Steps, Care Coordination Notes for internal use, and one or more Team Members. Each intervention can have a status of Active, Inactive, or Resolved. You can set the status and then filter which interventions appear, just as you can with problems on the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

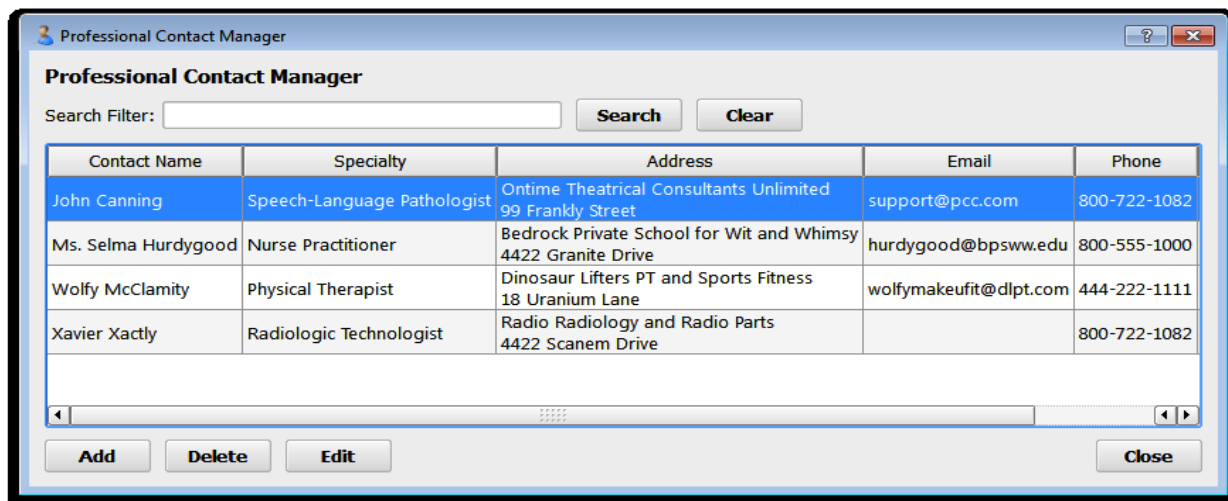
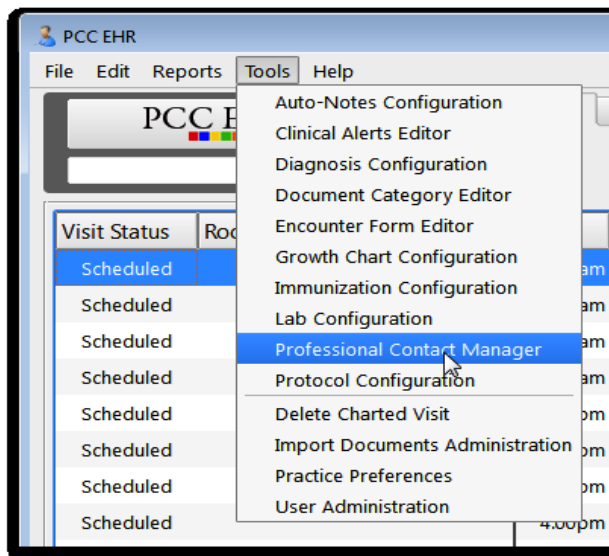
Care plan Intervention team members can be:

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

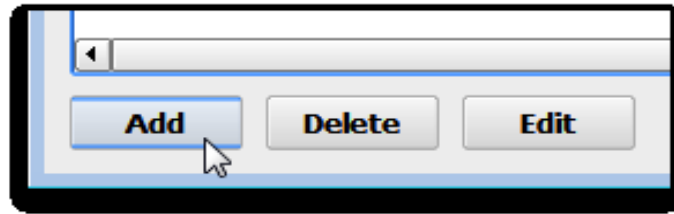


You can use PCC EHR's Professional Contact Manager tool to create a list of your practice's professional contacts, school medical personnel, and specialists who may be involved in care management for your patients.

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:

A screenshot of a dialog box titled "Add Professional Contact". The dialog box has a title bar with a question mark icon and a close button. The main content area contains several input fields: "Prefix", "First Name", "Middle Name", "Last Name", "Suffix", "Specialty" (a dropdown menu with "select a specialty" selected), "Organization", "Address" (with sub-fields for "address 1", "address 2", "city", "state", and "zip code"), "Phone", "Fax", and "Email". At the bottom right, there are "Cancel" and "Save" buttons.

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.

Pebbles Flintstone 10 yrs, 1 mo 3/08/04 F

Tags

Category
Correspondence

Attach Document
select a visit, phone note, etc...

04/09/14, Care Plan Intervention - Asthma action plan
 04/08/14, 9-10 Yr Well - Demo II
 04/07/14, 4-5 Years Well V2.0
 03/31/14, Care Plan Intervention - Lose weight to lower BMI
 02/28/14, Sick V2 CF
 11/04/13, Sick Demo
 03/16/13, 9-10 Yr Well - Brig...tures, Labs and Medical Tests
 01/18/13, Imms Only
 03/11/12, 9-10 Yr Well - Brig...tures, Labs and Medical Tests

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