Care Plan EHR Template Example

The note template imports the patients problem list, medications and allergies

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Template: CARE PLAN
☑  ████████████████████  -- Care Plan

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   DEMO,PATIENT GRAMMA     Chart #09-99-93
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   Chronic Problems:
    1)*Diabetes Ii/unspec Uncontrolled
    2)*Dyslipidemia
    3)Benign hypertension |
    4)*problem list update
    5)*Abscess
    6)*Bartholin gland abscess
    7)*Tietze's Syndrome
    8)*Diarrhea
    9)*Headache
   10)*Major Depressive Disorder, Single Episode, Moderate Degree
   11)*breast cancer
   12)*Osteoarthritis
   13)Disturbance in mood |
   14)Asthma |
   15)Long term methotrexate user |
   16)*ABNORMAL PAP SMEAR
   17)Drug therapy finding |
   18)*GLAUCOMA, PRIMARY OPEN-ANGLE
   19)Moderate major depression, single episode | long hx of depression


   Active Outpatient Medications (including Supplies):

   Non IHS Medications CINNAMON CAPSULE 1 CAPSULE              ACTIVE
   Non IHS Medications ECHINACEA CAP/TAB 2 TABLETS  TWICE A    ACTIVE
     DAY
   Non IHS Medications ESOMEPRAZOLE CAP,SA 1 CAPSULE BY MOUTH  ACTIVE
     EVERY DAY
   Non IHS Medications OUTSIDE MED MICELLANEOUS TAB            ACTIVE
   Non IHS Medications OUTSIDE MED MICELLANEOUS TAB  BY MOUTH  ACTIVE
   Non IHS Medications OXYCODONE 5MG TABLET 5MG BY MOUTH AS    ACTIVE
     DIRECTED
   Non IHS Medications QUETIAPINE FUMARATE 25MG TAB 25MG BY    ACTIVE
     MOUTH DAILY


   Allergies/ADR's:
   WORK, HYDROCODONE, PENICILLIN, CODEINE, AMOXICILLIN, IODINE, ERYTHROMYCIN
   IBUPROFEN, NAPROXEN, MEPERIDINE, NUTS
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The Care Plan in itself will meet
CM 04 (Core) Establishes a person centered care plan for patients identified for care management. **The care plan includes: problem list, expected outcome/prognosis, treatment goals, medication management, and may address community or social services.**

☑ Patient preferences and lifestyle goals

☑ Treatment goals:

☑ Barriers to meeting goals:
  ☐ Making time to exercise
  ☐ Making time to do self-care
  ☐ Food insecurities
  ☐ Lack of transportation
  ☐ Remembering to take medications regularly
  ☐ Lack of understanding about conditions
  ☐ Lack of understanding about medications
  ☐ Can't get an appointment when needed
  ☐ Substance abuse/dependency
  ☐ Mental health
  ☐ Disabilities
  ☐ Homelessness
  ☐ Age factors

☑ Care team members: (examples: PCP, nurse, CHN, 4D, Outside Specialty Providers)

  ☐ Provider:
  ☐ Nurse:
  ☐ Pharmacy:
  ☐ CFS:
  ☐ Diabetes Team:
  ☐ Other ▮▮▮:
  ☐ Outside Specialist:
☑ Self Care Plan:

☑ This was provided in writing to the patient/fa▮

| All | None | * Indicates a Required Field | Preview | OK | Cancel |

Meets CM06 (Credit) Documents patient preference and functional/lifestyle goals in individual care plans. These are the goals that patient creates not the provider.

Meets CM01 (Core) Care plans include treatment goals. These are the goals the provider makes.

Meets CM07 (Credit) Identifies and discusses potential barriers to meeting goals in individual care plans.

Patients may experience some of the same barriers to meeting their goals so this practice made a checklist for their providers to simplify the process. And included a text box if there were other barriers not included in the checklist. This helps the providers still address the barriers, but saves times on documentation.

Meets CM09 (Credit) Care Plan is integrated and accessible across settings of care.

This practice included who the Care Team members are and who they were going to share the plan with. They had internal people they could share it with and included a place for the outside specialist. If they referred out to the specialist, the care plan is included in all of the other information (referral, demographics, office note, etc) that is sent to the referring provider.

Meets CM08 (Credit) Includes a self-management plan in individual care plan. This section follows barriers so it can include tools/resources that patients can use to manage their own conditions.

Meets CM05 (Core) Provides a written care plan to the patient/family/caregiver.

In order to meet this criteria you must have a place in the care plan or some type of report that can be generated, or a text box where your providers can type that they gave the patient a written copy. The check box was easy for them to add so they can print a report.