Care Plan Webinar

Review of Care Plan Examples and the Care Plan Attestation Process
Agenda

- Welcome & Introductions
- Care Plan Guidance
- Care Plan Examples
- Submitting Care Plan Attestations
Care Plan Guidance
Care Plan Metric (A)

- 70% of high-priority beneficiaries (identified in Section 241.000) whose care plans as contained in the medical record includes:
  - Documentation of a beneficiary’s current problems;
  - Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary;
  - Instructions for follow-up and
  - Assessment of progress to date.
  - The care plan must be updated at least twice a year.
Documentation of a beneficiary’s current problems

- Each visit-related encounter document should include a list of current problems.
- Example:

Subjective: This is a 6-year old male who comes in rechecking his ADHD medicines, accompanied by both parents. We placed him on Adderall...

Problem List:
- Urinary incontinence, ICD-9: 788.30, SNOMED: 165232002, status: Active, diagnosed 7/16/2014
- Gastroesophageal reflux disease, ICD-9: 530.81, status: Chronic, diagnosed 7/10/2013
- Mixed hyperlipidemia, ICD-9: 272.2, status: Chronic, diagnosed 07/06/2012
- Osteopenia, ICD-9: 733.90, status: Chronic, diagnosed 07/06/2012
Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary.

**Example 1:**
- Type II Diabetes Mellitus: Improved after recent increase in insulin dosing.
  Continue current insulin and metformin doses. Refer to patient educator for help with diet. Follow-up in the clinic in 6 months with Hgb A1C and microalbumin.

**Example 2:**
- **PLAN:** Discussed with mother two options. Switch him to the Ritalin LA, which I think has better release of the medicine early in the morning or to increase his Adderall dose. As far as the afternoon, if she really wanted him to be on the medication, we will do a small dose of the Adderall, which she would prefer. So I have decided at this point to increase him to the Adderall XR 15 mg in the morning and then Adderall 5 mg in the afternoon. Will ask for educator feedback on child progress through clinic feedback form. Mother is to watch his diet. We would like to recheck his weight if he is doing very well, in two months. But if there are any problems, especially in the morning then we would do the Ritalin LA. Mother understands and will call if there are problems. Approximately 25 minutes spent with patient, all in discussion.
Instructions for Follow-up

• Encounter/office visit should contain documentation that mentions future visit that is linked to a problem(s) that is under management.

P:
- Advise patient to monitor his blood sugar twice a day. Refer for additional diabetic education, appointment on 7/7/14
- Lab Results – will notify patient of results within 5 days and will address any medication changes.
- Advise patient to begin an exercise regimen. Discussed what patient was capable of completing and since he generally rides his golf cart to the end of his drive to pick up his mail, he agreed to walk this short distance daily. Discussed how this will help improve his BP, decrease his weight (over time) and improve his blood sugar. We will recheck his weight, BP and review home blood sugar logs in 1 month and address how he is progressing with this activity.
- Counsel patient about diet during visit in 1 month for weight follow up.
Assessment of Progress to Date

• The encounter document should contain a problem-based assessment for all problems that were addressed during the visit.

Progress to Date:
Patient could not tell a difference in attention when on 10mg Adderall XR; dose increased to 15mg in October, 2013 with improvement in attention. Referred to Families Inc in fall, however, patient did not keep appointment.
Review of Care Plan Examples
PROGRESS NOTE

CC: ADHD Recheck, lower back pain

Hx of Present Illness: He is here for another refill on Focalin. He takes 5mg tablet in the morning, at noon and after school. He is doing well on the current dose. He eats well and sleeps well according to Mom. He has had back pain for about a week now. He doesn’t remember injuring his back but is very active. No f/v/d.

Past Medical Hx: ADHD

Drug Allergies: NKDA

Current Medications: Focalin 5mg tablet in the morning, at noon and after school

Physical Exam: Ht: 62.75" Wt: 132 BP: 110/68 T: 98.0

Mental Status: Alert no acute distress

Abd: No hepatosplenomegaly, no masses, non-tender

HEENT: Peri, eomi, lids normal and conjunctiva clear, tms normal bilaterally, oropharynx clear

Neck: Supple, no lymphadenopathy, no masses, no goiter

CV: Regular rate and rhythm without murmur

Ortho: Muscle strain in back

Lungs: Clear to auscultation bilaterally, no distress or retractions

Skin: No rashes, no sores

Assessment / Plan:

A: ADHD, Muscle Strain

1. Refill Focalin 5mg – take 1 tab po in the morning, at noon and after school, #90 NRF – Discussed stable status of ADHD with Mom and instructed patient and Mom to make f/u appointment in 6 mo. Mom to call office each month to request written refill of medication. Advised that if any new signs or symptoms arise to call the office.

2. Ibuprofen – 600 mg po q 6 hours atc x 48 then prn. If symptoms are not improved within 3-5 days RTC for additional f/u
**Care Plan Example 2**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Age: 14 yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRESS NOTE</td>
<td></td>
</tr>
</tbody>
</table>

**Chief Complaint:** RECHECK ON ADHD, WANTS TO WAIT FOR PHYSICAL

**Hx of Present Illness:** On Focalin 5mg po qAM, qnoon, qafternoon. Grades were “not so good” this year. Medication helps, is happy with the medication and thinks it helps. Homework time is going well.

**REVIEW OF SYSTEMS:** no appetite problems, sleep

**PAST MEDICALHX:** ADHD

**SOCIAL/FAMILY HX:** Going to the 9th grade

**SURGICAL/HOSP HX:** No / no

**DRUG ALLERGIES:** NKDA

**CURRENT MEDICATIONS:** FOCALIN as above

**PHYSICAL EXAM:** Ht(in): 66.75 Wt(lbs): 150.5# HC(cm): BP: 122/72 Temp: 97.0

<table>
<thead>
<tr>
<th>Mental Status: Alert, active, cooperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT: NC, AT, eyes clear, TM's clear, nares clear, OP clear</td>
</tr>
<tr>
<td>Abd: Soft, no HSM, no mass</td>
</tr>
<tr>
<td>GU:</td>
</tr>
<tr>
<td>Neuro: 2+ DTRs</td>
</tr>
<tr>
<td>Ortho: Well perf</td>
</tr>
<tr>
<td>Resp/Oth:</td>
</tr>
</tbody>
</table>

**Orders:**

**ASSESSMENT/PLAN:**

ADHD: Focalin 5mg qAM, qNOON, qAfternoon #80 NRF

Call with problems, new or worse exc...

Documentation of current problem

No instructions for follow-up or Assessment of progress to date
Problem / Assessment: ADHD
12 year old with longstanding history of ADHD
Progress to Date: Patient on ADHD meds at least since age 9 years for hyperactivity, impulsiveness. Patient has undergone medication changes and dose changes. She has seen Families, Inc. Psych reports noncompliance as a problem. Patient's family recently moved back to Smalltown after living in TX. Patient is currently on Adderall XR 20mg q AM.
Treatment / Self Management:
Continue Adderall XR 20mg q AM
Patient will be compliant with meds and with keeping follow up appointment.

Problem / Assessment 2: Sleep Disorder
12 year old with longstanding problem with sleep disorder
Progress to Date: Patient requires sleep medication in order to sleep well. Her recent dose is Clonidine 0.2 mg at hs. She underwent a recent medication increase.
Treatment / Self Management:
Clonidine 0.2mg at hs. Sleep Hygiene. Patient to be compliant with medication. Patient to keep appointment in 1 month. Patient to increase responsibility and independence for own health. Avoid smoke exposure. Patient will maintain health, safety, well being. Patient will stay current on vaccines including influenza vaccine. Patient will have regular dental check ups. Follow up appointment in 1 month.
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Treatment / Self Management:
Continue Adderall XR 20 Take 2 q AM
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Continue Adderall XR 20 Take 2 q AM
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Care Plan Example 4

**Past Medical History**
Asthma, Unspecified; Esophageal Reflux; Tracheomalacia

**Assessment**
- Well Child Check-Up (All Ages) V20.2
- Developmental Delay 315.2
- Asthma, Unspecified 493.90
- DTaP V06.1
- HEP A Vaccination V03.89
- HIB Vaccination V03.81
- MMR Vaccine V06.4
- Prevnar V03.89
- Varicella (Chicken Pox) Vaccine V05.4

**Instructions**
- Call or seek medical attention if the patient develops fever, respiratory symptoms, feeding problems, decreased urination, increased sleepiness, fussiness, or other signs of illness
- Appropriate anticipatory guidance given
- Handout given with age-specific care instructions and safety precautions
- Use car seats at all times
- Consent obtained for immunizations
- Return for check-up in 1 year unless new concerns arise
- Reviewed asthma care and stressed compliance with medications

**Disposition**
- Call or Return if symptoms worsen or persist.

- No problem focused instructions for follow-up
- No Assessment of progress to date for problems
Questions?
Submitting Care Plan Attestations
Questions?
Thanks for Attending!

Contact us at PCMHQQA@afmc.org.