Care Plan EHR Template Example

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

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.

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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, SR 1 CAPSULE BY MOUTH ACTIVE EVERY DAY
- Non IHS Medications OUTSIDE MED MICELLANEOUS TAB ACTIVE
- Non IHS Medications OXYCODONE SMG TABLET SMG 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
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.