EXAMPLE 2

CARE PLAN

Printed/stamped: 12 Feb 2015
Demographics (last update 12/15/2014, General Hospital)
Mary Smith
Birthdate: 8/15/1947
Address: 123 Anywhere Lane, Our Town, MD 222XX
Phone(s): 312.555.5555, 708.444.4444
SSN: XXX_XXX_XXXX
Payer 1: Medicare (#YYYYYY)
Payer 2: GoodPlan Medigap (#ZZZZZ)
Care Coordination Intensity: HIGHEST

PCP (by CCM): Chris Smith, MD

Care Coordinator: Pat Jones, RN

Hospitalizations/ED: 11/29/14 (3 day), 10/01/2014 (0 days)

Medical Problem List:
COPD
Venous stasis dermatitis
Tobacco use

Medication List:
Albuterol 2.5mg/3cc via neb every 4 hours as needed
Tiotropium 1 capsule via handihaler once a day
Beclamethasone 2 puffs inhaled BID
Prednisone 20mg as instructed

Care Coordination Problems/Goals/Intervention:
Problem: Frequent ED visits
Goal: Patient institutes action plan when symptoms worsen
Intervention: Care coordinator perform action plan teach back at each encounter

Problem: Recommended intervention not agreed to
Goal: Reconcile care team and patient's understanding of risks, benefits and costs
Intervention: Discuss OXYGEN THERAPY when symptoms present

Action Plan:
When patient has worsening of COPD as evidenced by (1) use of Albuterol more than every four hours or (2) greater than 50% increase in mucous production or (3) increased shortness of breath consistent with past exacerbations then the patient will (1) take Prednisone 60 mg, (2) start antibiotic last prescribed and (3) increase Albuterol to every two hours as needed to improve dyspnea.

Self-management goal: perform treadmill at 2 mph with no incline for 3 minutes daily

Physician Orders for Life Sustaining Treatment: No intubation/ventilator, No CPR

Free text communication for next encounter: Daughter-in-law to discuss increased assistance for housekeeping and discuss serious of illness with family