Comprehensive Care Planning

Comprehensive Care Plan
Children with Special Health Care Needs

This folder contains information about the essentials of comprehensive care planning for children with special health care needs (CSHCN). Three distinct types of documents present medical information plans, emergency plans, and working (action) care plans. When combined appropriately for CSHCN (based upon need), these tools make up a comprehensive care plan. A few of the care plan examples offer a combination of the three types of care plans (ie. an emergency plan and a medical information plan). These combined care plans are marked with an asterisk and will appear in both folders.

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Introduction to Essential Care Plan Components-

The Comprehensive Care Plan

NICHQ

National Initiative for Children's Healthcare Quality

The Comprehensive Care Plan:
Medical Summary, Emergency Treatment Plan and Working Care Plan
For Children with Special Health Care Needs

Children with special health care needs, their families, physicians, practice teams and community providers will benefit from having a clear, written medical summary, emergency treatment plan and plan of care. These components can be combined or developed separately. When combined the Medical Summary, Emergency Treatment Plan and Working Care Plan are the components of a Comprehensive Care Plan. The medical summaries, emergency treatment and care plans can be on paper, disk or if possible web-based. There are multiple purposes of the medical summary/care plans. These include:

- An available source of information for parents to provide to the medical, educational and other care teams,
- A quick reference with child-specific information in a medical emergency,
- An action plan that the entire care team, including the family and patient develop, use to prioritize, assign tasks, implement and assess care.

In the beginning remember that your practice team will decide who needs a medical summary or an emergency care plan depending on the complexity of the condition. The summary and/or emergency treatment plan will take some time to develop in the beginning, but the family, the clinicians and the community providers will find them very helpful. Your parent partners will be a great resource here with family friendly language.

The working care plan is a written framework combining the goals of the patient/family/team with the treatment plan. It is best to keep it simple at the start. Remember to start small with little steps. The Center for Medical Home Improvement Action Care Plan (working care plan) is a practical tool to get you started.

The major components of the comprehensive care plan include a medical summary with an emergency treatment plan and a working care plan:

1. **The Medical Summary:** The child's medical summary contains a short synopsis of the child's current diagnosis, problem list, treatment including medications and recurrent problems, past medical history and community based care. The specific components of the medical summary include:
   - Identifying and family contact (including emergency contact) information
   - Allergies and Medications
   - Diagnosis and Active Problem List (including critical equipment)
   - Consultants--Specialist and their contact information
   - Transport/Equipment Needs
   - Past History (Summary)
   - Review of Systems (Degree of current involvement)

- Coverage Concerns/Recurrent Problems
- Community Providers/Agencies
- Hospitalizations
- Assets and challenges unique to the individual child
- Other information the family wants caregivers to know about their child

Examples are available online at the AAP Medical Home website, the Center for Medical Home Improvement website, the PACC website (see links for these on the extranet), NICHQ Medical Home website, the EPIC-IC website and others.

2. **The Emergency Treatment Plan:** The medical summary can include information for emergency treatment and in many instances can serve as both the summary and the emergency plan. However, some parents and practices may want a separate Emergency Treatment Plan. The child with multiple, complex conditions and/or recurrent life threatening events may need an emergency treatment plan in addition to or in place of the medical summary. The AAP / ACEP emergency treatment plans are very similar to the medical summary and it would be duplicative to fill out both. The Emergency Treatment Plans do have more baseline physical/lab data. The AAP and the ACEP have approved them. The form is available on the AAP web site with links from the NICHQ website and others. (Some teams have found it helpful to use a medical summary and check of a box indicating an attached emergency plan).

3. **The Working Care Plan:** A care plan for a child with special health care needs can be as simple as a written, organized note developed during a visit, a more detailed plan of care developed during a meeting of the family, care coordinator and clinician or a comprehensive, integrated care plan developed by the child/family's multidisciplinary team. This plan helps direct the role/focus of the practice-based care coordinator. The critical components of the care plan include:
   - A prioritized list of main concerns/goals with
   - The current clinical/educational/social information pertinent to the concern/goal.
   - The current plan/intervention for that concern/goal
   - The person(s) responsible for that intervention
   - The due date for the intervention.

The working or action care plans are available on the NICHQ Medical Home web site, the AAP Medical Home web site and others.

<u>Note:</u> Some care planning examples combine two or more of the three components in the document. When this is the case an * indicates so in the table of contents for that documents.

Section One: Medical Information Care Plans

MEDICAL SUMMARY - EPIC-IC

Date updated____________________

Patient Name ________________________________ DOB ________________________________

Parent's Name_____________________________Phone(H)_____________(W)_______________

Address___________________________________ E-mail_________________________________

Other Emergency Contact ________________ Phone_________Relationship_______________

Insurance ____

Principal Diagnosis______________________ PCP ___________________________________

Secondary Diagnosis ______________________ PCP Phone_____________________________

____ PCP Fax/E-mail_______________________

Emergency Plan Yes____No____ Immunizations up-to-date Yes____No___Date______

Allergies/Rxns (meds/foods/procedures)____

Problem List (with critical equipment)

Medications / Dose	Medications / Dose

Specialists	Phone Number/Fax/E-mail

Equipment/Transport Information

History

Review of Systems & general/baseline physical/lab data	
HEENT (vision/hearing)	**Musculoskeletal**
CV	**Skin**
Respiratory	**Neuro**
GI	**Psych**
Hem	**Endo**
GU	**Immune**

Coverage Concerns/Recurrent Presenting Problems

Problem	**Diagnostic Studies**	**Treatment**

Support Services

Service	**Frequency**	**Contact Information**
Home Care		
PT/OT		
DME		
School/Child Care/EI		
Other		

Hospitalizations/Surgery	**Date**	**Procedures**

MEDICAL CARE PLAN

GIFFORD MEDICAL CENTER
RANDOLPH, VERMONT 05060

Name:	**Nick Name:**	**DOB:**
Allergies:	**Complexity:**	
Parent/Guardian:	**Phone #:**	
PCP:	**Insurance:**	
PCP Phone #:	**Parent Emergency #:**	

Special Instructions:

Unique Family Needs/Assets:

Antibiotic Prophylaxis:	***Indications:***	***Medication & Dose:***

PROBLEM LIST	**MED Y / N**	**SPECIALIST INVOLVED**	**OUTCOME**	**HOW OFTEN**	**LAST VISIT**
Health Maintenance					

(*) – See Med Sheet in Chart

MEDICAL CARE PLAN

Patient Name:

PROCEDURES	TESTS	LABS	LAST DONE	VALUE

Other Services:

TYPE OF SERVICE	SERVICE GIVEN BY	FREQUENCY

DEVICES	DATE STARTED

*****Unique Immunization Needs:***

Influenza									
Pneumococcal									
RSV									
Other									

(**) For full record see chart.

List of Health Care and Other Service Providers

Child's Name: ______________________________DOB: ___________________________
Dx: 1__________________Dx: 2______________________Dx:3 ______________________

Health Care:	Name/Location	Phone #	Fax #	Referral Date
Specialists:				
Special Clinics: (coordinators)				
Other:				

School Services:	Name/Location	Phone #	Fax #	Effective Dates
Early Intervention:				
School attending:				
School Principal(s):				
Classroom teachers:				
School nurse(s):				
Spec. ed. Coordinator:				
Other personnel:				

Community services:	Name/Location	Phone #	Fax #
Family Support coordinator:			
Visiting nurse:			
Mental Health Provider:			
HMO/Insurance contact:			
DCYF case worker:			
Other service providers:			
Informal supports: minister, friend, etc.			

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE

Care Planning

Parent's Names ______________________________ / ________________________________
Child's Name ______________________________ Diagnosis (s) ________________________
Phones (H) ________________ / ______________ (W) ______________ / ______________
Best Time / Place To Call _______________________ FAX # if available ______________________

CCM Monitoring: Questioning & Inverventions in the following areas:

Date:				
Family's #1 Issue				
Health Provider's #1 Issue				
Chronic Condition Update (meds, acute episodes, etc.)				
Child's Life/Recent Accomplishments:				
Family Life				
Comm/Family Support Issues				
Financial Issues (insurance, SSI, etc.)				
School Needs				
Specialist Contacts				
Patient Education/Self Care				
Other				

PARENT NOTEBOOK GIVEN (DATE) ________________ OFFICE CONTACT PERSON______________________

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE
NEXT STEPS NEEDED

Child's Name ______________________________ **Phone Number** ______________________
Diagnosis (s) ____

Date	**Task**	**Who**	**Notes**	**Date Done**

Next appointment needed/Next CCM monitoring visit:

Date Care Plan Last Revised: / / / / / / / / /

CHRONIC CONDIDTION MANAGEMENT (CCM) IN PRIMARY CARE

CARE PLANNING

NOTES:

Hitchcock Clinic—Concord
Pediatric Care Plan Part I

Child's Name__________________________Nickname________________DOB____________________

Parent (Caregiver)____________________________(Relationship)______________________________

____

Address____

Phone #(home)_____________(Blocked? Y__N__) Best time to reach________E-mail___________________

Mom Alternate Phone_________________________Dad Alternate Phone__________________________

____

Emergency Contact___________________________Phone _____________Relationship______________

Emergency Contact___________________________Phone_____________Relationship______________

Health Insurance/Plan_________________________Identification #_______________________________

____

Diagnose(s): ↓ ➔ **Emergency Plan** ❒ **Yes** ❒ **No** **Complexity Level**_______________

Primary ________________________ICD9__________ Primary __________________________ICD9________

Secondary_______________________ICD9__________ Secondary_________________________ICD9________

Secondary_______________________ICD9__________ Secondary_________________________ICD9________

Allergies/reaction:______________________________ ______________________________________

____ ______________________________________

Medications/dose:______________________________ ______________________________________

____ ______________________________________

____ ______________________________________

PCP___________________________**Phone**____________**Fax**_________**E-Mail**____________

#1 Specialist/Specialty Clinic/Hospital Phone	Other (fax, e-mail, etc.):
#2	Other (fax, e-mail, etc.):
#3	Other (fax, e-mail, etc.):
#4	Other (fax, e-mail, etc.):

Nursing Service/Respite_______________________________________**Phone** ______________________

Child's Name: Nickname: Date:

Common Presenting Problems/Findings with Specific Suggested Managements

( ) See specialist letter(s) attached

Problem #1 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #2 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #3 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Comments on child, family, or other specific medical issues:

X

Physician/Provider Signature **Print Name above**

X

Family/guardian *signature* giving consent for release of this information to the emergency room **Print Name above**

Care Plan Part II: Child Description

Name_________________________**Nickname**_____________________**DOB**________

Child's Assets & Strengths____

____

____

____

Vital Sign (baselines)

Ht_______________Wt________________Temp____________________Other_______________

Challenges (check all that apply, please explain on lines below)

❐ Behavioral	❐ Learning	❐ Stamina/Fatigue
❐ Communication	❐ Orthopedic/Musculoskeletal	❐ Respiratory
❐ Feed & Swallowing	❐ Physical Anomalies	❐

Other_________________________

❐ Hearing/Vision	❐ Sensory	❐

Other_________________________

____

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____

Procedures/foods/activities to be avoided:

____

____

____

Prior surgeries/procedures:

______________________ Date ______	______________________ Date ______
______________________ Date ______	______________________ Date ______
______________________ Date ______	______________________ Date ______

Most recent labs/diagnostic studies:

Labs ______________________	EEG ______________________
______________________	EKG ______________________
______________________	X-rays ______________________
Drug levels ______________________	C-Spine ______________________
______________________	Other ______________________
______________________	Other ______________________
MRI/CT ______________________	______________________

Care Plan Part II: Child Description

Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

❒ Gastrostomy	❒ Adaptive Seating	❒ Wheelchair
❒ Tracheostomy	❒ Communication Device	❒ Orthotics
❒ Suction	❒ Monitors: (✓) __Apnea __O2	❒ Crutches
❒ Nebulizer	__Cardiac__Glucose	❒ Walker
		❒ Other_______________

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School System/Child Care: **Contact Person/Role:** **Phone:**

____

____

____

____

Family Information:

Caregivers______________________________________

Siblings____

Other important facts ____________________________

____

____

Special Circumstances/Comment/What you would like us to know

____

____

____

____

______________________ ______________________

Parent /Caregiver Signature & Date **Primary Care Provider Signature & Date**

Section Two: Specialized Emergency Information

(Medical Information / Emergency Care Plan)

CMHI

Emergency Information Form for Children With Special Needs

Last name:

Date form completed By Whom	Revised	Initials
	Revised	Initials

Name:	Birth date:	Nickname:
Home Address:	Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:	
Signature/Consent*:		
Primary Language:	Phone Number(s):	

Physicians:

Primary care physician:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	

Diagnoses/Past Procedures/Physical Exam:

1 .	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.
2.
3.
4.
5.
6.

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

Management Data:

Allergies: Medications/Foods to be avoided **and why:**

1.
2.
3.

Procedures to be avoided **and why:**

1.
2.
3.

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

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Hitchcock Clinic—Concord
Pediatric Care Plan Part I

Child's Name________________________Nickname_______________DOB__________________

Parent (Caregiver)__________________________(Relationship)___________________________

____

Address____

Phone #(home)____________(Blocked? Y__N__) Best time to reach_______E-mail_______________

Mom Alternate Phone________________________Dad Alternate Phone________________________

____

Emergency Contact__________________________Phone ____________Relationship______________

Emergency Contact__________________________Phone____________Relationship______________

Health Insurance/Plan________________________Identification #_____________________________

____

Diagnose(s): ↓ ➔ **Emergency Plan ❐ Yes ❐ No** **Complexity Level**______________

Primary________________________ICD9________ Primary________________________ICD9________

Secondary______________________ICD9________ Secondary______________________ICD9________

Secondary______________________ICD9________ Secondary______________________ICD9________

Allergies/reaction:______________________________ ______________________________

______________________________ ______________________________

Medications/dose:______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PCP________________________**Phone**____________**Fax**_________**E-Mail**____________

#1 Specialist/Specialty Clinic/Hospital Phone	Other (fax, e-mail, etc.):
#2	Other (fax, e-mail, etc.):
#3	Other (fax, e-mail, etc.):
#4	Other (fax, e-mail, etc.):

Nursing Service/Respite_____________________________________**Phone** ____________________

Child's Name: Nickname: Date:

Common Presenting Problems/Findings with Specific Suggested Managements

( ) See specialist letter(s) attached

Problem #1 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #2 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #3 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Comments on child, family, or other specific medical issues:

X

Physician/Provider Signature **Print Name above**

X

Family/guardian *signature* giving consent for release of this information to the emergency room **Print Name above**

Care Plan Part II: Child Description

Name_________________________**Nickname**_____________________**DOB**________

Child's Assets & Strengths____

____

____

____

Vital Sign (baselines)

Ht_______________Wt________________Temp_______________________Other_______________

Challenges (check all that apply, please explain on lines below)

❐ Behavioral	❐ Learning	❐ Stamina/Fatigue
❐ Communication	❐ Orthopedic/Musculoskeletal	❐ Respiratory
❐ Feed & Swallowing	❐ Physical Anomalies	❐

Other_________________________

❐ Hearing/Vision	❐ Sensory	❐

Other_________________________

____

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Procedures/foods/activities to be avoided:

____

____

____

Prior surgeries/procedures:

______________ Date ______	______________ Date ______
______________ Date ______	______________ Date ______
______________ Date ______	______________ Date ______

Most recent labs/diagnostic studies:

Labs ______________	EEG ______________
______________	EKG ______________
______________	X-rays ______________
Drug levels ______________	C-Spine ______________
______________	Other ______________
______________	Other ______________
MRI/CT ______________	______________

Care Plan Part II: Child Description

Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

- ❒ Gastrostomy
- ❒ Tracheostomy
- ❒ Suction
- ❒ Nebulizer
- ❒ Adaptive Seating
- ❒ Communication Device
- ❒ Monitors: (✓) __Apnea __O2 __Cardiac__Glucose
- ❒ Wheelchair
- ❒ Orthotics
- ❒ Crutches
- ❒ Walker
- ❒ Other_______________

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____

School System/Child Care: **Contact Person/Role:** **Phone:**

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____

Family Information:

Caregivers____

Siblings____

Other important facts ____

____

____

Special Circumstances/Comment/What you would like us to know

____

____

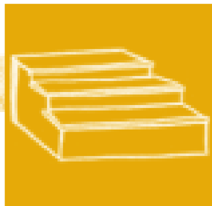
____

____

______________________________ ______________________________

Parent /Caregiver Signature & Date **Primary Care Provider Signature & Date**

Section Three: Working (Action) Care Plans



List of Health Care and Other Service Providers

Child's Name:______________________________DOB:____________________

Dx:1____________________Dx2____________________Dx3____________________

Health Care:	Name/Location	Phone #	Fax #	Referral Date
Specialists:				
Special clinics: (coordinators)				
Other:				

School Services:	Name/Location	Phone #	Fax #	Effective Dates
Early intervention:				
School attending:				
School principal(s):				
Classroom teacher(s):				
School nurse(s):				
Spec. ed. coordinator:				
Other personnel:				

Community services:	Name/Location	Phone #	Fax #
Family support coordinator:			
Visiting nurse:			
Mental health provider:			
HMO/Insurance contact:			
DCYF case worker:			
Other service providers:			
Informal supports: minister, friend, etc.)			

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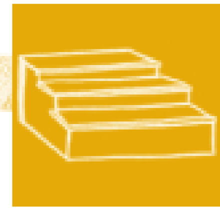

CHRONIC CONDITION MANAGEMENT (CCM)
IN PRIMARY CARE

Care Planning

Parent's Names________________________ / ________________________

Child's Name ________________________ Diagnosis(s) ________________________

Phones(H) ____________ /____________ (W)____________ / ____________

Best Time / Place To Call ________________ FAX # if available ________________

CCM Monitoring: Questioning & Interventions in the following areas:

Date:				
Family's #1 Issue				
Health Provider's #1 Issue				
Chronic Condition Update (meds, acute episodes, etc.)				
Child's Life/ Recent Accomplishments:				
Family Life				
Comm/Family Support Issues				
Financial Issues (insurance, SSI, etc.)				
School Needs				
Specialist Contacts				
Patient Education/ Self Care				
Other				

PARENT NOTEBOOK GIVEN (DATE)____________ OFFICE CONTACT PERSON____________________

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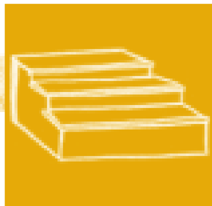


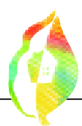
CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE
NEXT STEPS NEEDED

Child's Name ____________________ Phone Number____________________
Diagnosis(s)____

Date	Task	Who	Notes	Date Done

Next appointment needed/Next CCM monitoring visit:

Date Care Plan Last Revised: / / / / / / / /



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CARE PLANNING

NOTES:

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Medical Home Learning Collaborative
Action Care Plan

Child's name: DOB: Parents/Guardians:
Primary diagnosis: Secondary Diagnosis: Secondary diagnosis(s)

Original Date of plan: Updated Plan: / / / / /

Main Concerns	Related Current Clinical Information (sx, labs, etc)	Current Plans/Interventions	Person(s) Responsible	Due Date & Date Completed

Parent/Caregiver Signature:

Clinician Signature: Name Care Coordinator:

Medical Home Learning Collaborative
Action Care Plan

Child's name: Matthew Stone DOB: 8-13-98 Parents/Guardians:
Primary diagnosis: Down Syndrome Secondary Diagnosis: Congenital Heart Disease Secondary diagnosis(s) Hypothryoidism

Original Date of plan: 6/3/03 Updated Plan / / / /

Main Concerns	Related Current Clinical Information (sx, labs, etc)	Current Plans/Interventions	Person(s) Responsible	Due Date & Date Completed
Falling asleep at school	L-thyroxine 50 mcg T4=6.5 TSH=1.0 Waking at night Snores Sleeps sitting up	Log & observe sleep for apnea Arrange for nap study Check with cardiologist	Mrs. S. Care Coordinator Dr. C.	6/10/03 6/10/03 6/08/03
Attention span Short, distractible ? ADHD		Conner scale Home & school Review last triennel evaluation and testing See #1 above	Mrs. S. Care coordinator for school Dr. C	6/14/03 6/14/03 6/21/03 see above

Parent/Caregiver Signature:

Clinician Signature: Name Care Coordinator: