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Examples of Shared Care Plans

- 1. Bare Bones Care Plan - Family Medical Group NE**
- 2. Your Personal Health Record – The Shared Care Plan**
- 3. My Shared Care Plan – Pursuing Perfection Project in Whatcom County**
- 4. Basic Person-Centered Care Plan - Providence Medical Group Southeast**

Access [Pediatric Care Plans](#) and a recording of the webinar [Care Plans - Best Practices for Development and Implementation](#) on our website.



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Bare Bones Care Plan - [Family Medical Group NE](#)

bare bones of care plan

Name:

DOB:

PATIENT CENTERED CARE PLAN

OPTIONS FOR ACCESSING CARE: May call the office at 503-364-2181 when help is needed or use the Internet portal for non-urgent issues.

INFORMATION ON CARE PLANNING AND CARE COORDINATION:

Call the office at 503-364-2181 and

Ask for REFERRALS - if you need information on insurance approval of referral or how appointment will be made.

Ask for CASE MANAGER – if you need information on education, resources, test results, equipment needs or special feeding needs.

PRIMARY CARE TEAM MEMBERS:

DOCTOR:

CASE MANAGER: Elizabeth Peasley or Jenn Brown

REFERRALS: Christi Trine or Heather Ball

RNs and MAs

DIAGNOSIS:

SELF MANAGEMENT GOALS: (Patient centered goals)

PREVENTATIVE OR CHRONIC ILLNESS CARE GOALS: (Medical centered goals)



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Your Personal Health Record – The Shared Care Plan

Welcome to Your Personal Health Record



What is the Shared Care Plan?

The Shared Care Plan is a free, easy-to-use, Personal Health Record that lets you keep track of vital health information in case of an emergency. You can also share this information with your family, physicians and other people you feel should have access to this information. For more information about the Shared Care Plan, please visit www.SharedCarePlan.org or call (360) 756-6840 or (888) 503-6843.

Electronic Shared Care Plan

If you would like to have an electronic Shared Care Plan housed on a secure Website please go to www.SharedCarePlan.org/signup. There, the information you enter online will be accessible to you and the people you specify from any Web ready computer around the world. The information can also be printed out as needed. There is also a pocket-sized summary that will easily fit in a wallet which is especially useful when traveling.

Critical Information Available in an Emergency

The SCP is a place to record key information that medical personnel need access to in an emergency. If you carry your SCP with you or let your emergency contact know where it is, the information is available to emergency personnel. This means that even if you are unable to communicate, your critical information is still available to health care professionals.

How can I make the most of my Shared Care Plan?

Fill out as much information as you can in your Shared Care Plan. If there are things you don't know, ask for that information from your clinic(s) at your next visit. Bring a copy of your Shared Care Plan with you to all of your health care appointments. Ask your Care Team members (anyone such as doctors, nurses, therapists, pharmacists, care-givers, family or friends who help you in your journey towards better health) to look at your Shared Care Plan for a current picture of your health and to help you keep the information accurate, up-to-date, and complete. You can also work together to define problems, set priorities, establish goals, create treatment plans, and solve problems. Also, keep a copy of your Advance Directives (if you have these) with your Shared Care Plan at all times. This way your wishes will be known and the legal documents immediately available in the case of an emergency.

How can I get another copy of this paper version of the Shared Care Plan?

You can find downloadable versions of the Shared Care Plan online in both Microsoft Word and Adobe PDF formats. There is also an English/Spanish version available. Go to www.SharedCarePlan.org for more information.

How do I put this booklet together?

The paper Shared Care Plan is designed to be printed double-sided and folded like a booklet although you can print it regularly as well. Refer to your printer's documentation for specific instructions. Generally, you select File and then Print. In the print dialog box, choose "odd pages" next to the word "Print:" After the pages have printed, flip them over and print the even pages this time. Fold the printed pages in half to form a booklet. You may have to select "Reverse pages" for one of these steps.



Care Team

Emergency Contacts

Your Emergency Contact is the person you would like called first should you have an emergency. Your Backup Emergency Contact is the person you would like called if your primary Emergency Contact is unavailable.

Contact	Name	Phone Number	Alternate Phone Number
Emergency Contact			
Backup Emergency Contact			

Care Team Members

Care Team Members are people and/or organizations who help you manage your health. Anyone who you feel has a role in your health care can be part of your Care Team.

Appointments	Name	Phone #	Fax #	Role/Description	Comments

Insurance Providers

Record here any insurance policies you use for your health care.

Type of Insurer	Carrier Name	Policy Number	Group Number	Phone Number	Address
Primary Medical					
Secondary Medical					
Prescription Drug					

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About Me

I want the person working with me to know...

This section is for you to record important details about your health and life that will help health care professionals understand your needs.

This is the most important information you need to know about me: _____

I have challenges with: ☐ Vision ☐ Hearing ☐ Speech ☐ Mobility ☐ Transportation ☐ Other

My primary language is: ☐ English ☐ Español ☐ Other _____

I need a translator: ☐ Yes ☐ No

Comments _____

My blood type is: ☐ O+ ☐ O- ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB+ ☐ AB-

I have special dietary needs: ☐ Yes ☐ No

Comments _____

My religion/spirituality impacts my health care: ☐ Yes ☐ No

Comments _____

I have: ☐ Advance Directives ☐ POLST ☐ Power of Attorney

Comments _____

I live: ☐ Alone ☐ With a partner/spouse ☐ With family ☐ Other
☐ With others ☐ In assisted living ☐ In a nursing home

Comments _____

I learn best by: ☐ Reading ☐ Being spoken to ☐ Being shown
☐ Listening to tapes ☐ Seeing pictures/videos ☐ Other

Comments _____

I have access to the Internet: ☐ Yes ☐ No

Comments _____

Additional information

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Diagnoses

My Chronic and Long-Term Diagnoses
This is a list of all the conditions you have been diagnosed with and are managing.

Diagnosis	Description	Date Diagnosed	Diagnosed By	Comments



Next Steps

Where I am – My concerns

This section helps you identify the types of problems or concerns you are currently facing as you manage your health. Sharing your concerns helps your Care Team assist you with Next Steps.

- | | | |
|---|---|--|
| <input type="checkbox"/> My ability to manage my chronic condition(s) | <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Spiritual support |
| <input type="checkbox"/> Thinking/memory problems | <input type="checkbox"/> Financial issues | <input type="checkbox"/> Access to health care |
| <input type="checkbox"/> Family issues | <input type="checkbox"/> End of life issues | <input type="checkbox"/> Other |

Details _____

Where I want to be – Life goals

A Life Goal is a motivating reason you are working toward better health.

Completed	Goal Description
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

How I'm getting there – Next steps

Next Steps are small, short-term steps that you are ready and willing to take towards obtaining your life goals.

Completed	Date	Description
<input type="checkbox"/>		Step:
<input type="checkbox"/>		Action:
<input type="checkbox"/>		Action:
<input type="checkbox"/>		Step:
<input type="checkbox"/>		Action:
<input type="checkbox"/>		Action:
<input type="checkbox"/>		Step:
<input type="checkbox"/>		Action:
<input type="checkbox"/>		Action:

Be sure to reward yourself along the way!

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Health Log

Health Indicators

This is the place to record health indicators such as blood pressure, cholesterol and weight, the goal values that you want to reach or maintain and to monitor them over time.

Indicator:			Goal:		Comments:	
Date	Value	Comments	Date	Value	Comments	

Indicator:			Goal:		Comments:	
Date	Value	Comments	Date	Value	Comments	

Indicator:			Goal:		Comments:	
Date	Value	Comments	Date	Value	Comments	

Indicator:			Goal:		Comments:	
Date	Value	Comments	Date	Value	Comments	



Medications

Prescribed medications

These are medications that a health care professional has advised you to take, including medications, vitamins and supplements available over-the-counter.

Start Date	Prescribed By	Generic (Brand) Name and Strength	Directions	Use	OTC?	B	L	D	N
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									
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Comments:									
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									



Additional Medications

Add here any other medications that you are taking and that no health care professional has advised you to take, including herbal supplements, vitamins, etc.

Start Date	Prescribed By	Generic (Brand) Name and Strength	Directions	Use	OTC?	B	L	D	N
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									
					<input type="checkbox"/>				
Comments:									

Discontinued Medications

This is a list of all medications that you are no longer taking.

Start Date	Stop Date	RX By	Generic (Brand) Name and Strength	Directions	Use	Reason Discontinued
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						



Reactions

Allergies/Intolerances

These are substances (drug, food, or otherwise) that cause a bad reaction when you take, inhale or in some way come in contact with them.

Substance	Date Occurred	Type	Documented By	Reaction

Contraindications

These are substances (both drugs and food) that interact badly with your condition or medications that you are already taking.

Substance	Reason	Documented By



Procedures and Surgeries

Here you can keep track of any procedures and surgeries you have had. These can range from a biopsy to a cat scan to a mammogram.

[illegible]



Hospital Visits

Here you can keep track of any hospital visits you have had. Include visits to the emergency room and longer in-patient stays for observation and so forth, but you do not need to duplicate stays listed under surgeries.

Description	Date Admitted	Comment

Immunizations

Immunizations are vaccines taken to prevent illness. It is important to keep a record of these in case you are ever exposed to a serious contagious disease.

Vaccine	Dose # in Series	Date	Vaccine	Dose # in Series	Date

YOUR PERSONAL HEALTH RECORD



The Shared Care Plan

*It's your health-
you can take charge!*

This Print Version belongs to:

*Additional copies available at
www.SharedCarePlan.org*



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transforming primary care
www.pcpici.org

My Shared Care Plan – Pursuing Perfection Project in Whatcom County

My Shared Care Plan

A Health Management Tool



Additional copies located on
www.patientpowered.org

What is “My Shared Care Plan”?

“My Shared Care Plan” is a self-management tool that can help you keep track of what is going on with your health. Having this information with you when you visit your doctor may help you become more of a partner in your care.

“My Shared Care Plan” has been tested with more than 40 patients across Whatcom County, WA who are living with diabetes and/or heart failure. We would like to hear what you think. Visit www.PatientPowered.org to share your thoughts and to see what others are saying.

How can I make the most of “My Shared Care Plan”?

Fill out all of the information that you know in “My Shared Care Plan”. If there are things you don’t know, ask for that information from your clinic at your next visit. Bring “My Shared Care Plan” with you to all of your health care appointments. Ask your care team members (doctors, nurses, therapists, pharmacists, etc.) to look at “My Shared Care Plan” for a current picture of your health and to help you keep the information accurate, up-to-date, and complete. You can also work together to define problems, set priorities, establish goals, create treatment plans, and solve problems.

What is “Self-Management”?

Self-management means that you play a key role in managing your care. You are part of a team, along with your doctors, nurses, pharmacists and others, working together to manage your health. For more information on self-management, visit www.PatientPowered.org.

What are “Advanced Directives”?

Advanced Directives state your preferences for end of life decisions. These include:

- **Healthcare Advance Directives (Living Will):** This is a legal form that does not require a lawyer. Your Living Will communicates your wishes about artificially prolonging your life if you are unable to make your wishes known.
- **Physician Order for Life Sustaining Treatment (POLST):** This is a bright green form you and your physician must complete and sign together. These Physician’s orders state your preferences for end of life medical care.
- **Durable Power of Attorney for Health Care:** This is a legal form that does not require a lawyer. This form allows you to name a person as your health care agent – someone who can make decisions about your medical care if you are unable to make the decisions for yourself.

For more information on Advanced Directives, talk to your Doctor. You can also obtain forms and information from the Washington State Medical Association 1-800-552-0612.

What are “Next Steps”?

“Next Steps” are small, short-term goals that move you in the direction of a positive lifestyle change. Share your next steps with your care team members so they can support you in reaching your goals.

How can I get another copy of “My Shared Care Plan”?

You can find this file at www.PatientPowered.org.

You can also pick up a copy of “My Shared Care Plan” at

- LifeQuest - (360)738-6720
3333 Squalicum Parkway Bellingham, WA 98225
- St. Joseph Hospital – Information Desk
2901 Squalicum Parkway Bellingham, WA 98225.

My name:	Birthdate:	Updated date:
Phone: (days) (eves/wknds)	Email address:	
Insurance Company:		
Emergency contact and phone:		

I want the person working with me to know...		
I have challenges with: <input type="checkbox"/> Transportation <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> English as a second language (ESL) <input type="checkbox"/> Other Comments:		
I have issues with Diet:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
My Religion/Spirituality impacts my health care:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
Advanced Directives		
Healthcare Advance Directives	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
Physician Orders for Life Sustaining Treatment (POLST)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
Power of Attorney (Financial / Healthcare)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
I live: <input type="checkbox"/> alone <input type="checkbox"/> partner/spouse <input type="checkbox"/> Extended family <input type="checkbox"/> Other:		
I learn best by: <input type="checkbox"/> Reading <input type="checkbox"/> Being talked to <input type="checkbox"/> Being shown how <input type="checkbox"/> Listening to tapes <input type="checkbox"/> Seeing pictures or video		
I have access to the Internet: <input type="checkbox"/> YES <input type="checkbox"/> NO		

Next appointment	Name	Office Phone	On-Call Number	Role
				Primary Care Doctor

I authorize that my personal health record to be shared with my care team listed above: <input type="checkbox"/> YES <input type="checkbox"/> NO Others with whom I agree to view my plan include:

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Medical Condition/Diagnosis		

Drug Allergies/Intolerances	Reaction	Date Occurred	Comments
Other Allergies:			

Over-the-counter Medications I take				
Name	Directions	Times Taken	Why I take this	Comments

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Prescription Medications									
Date	Prescribed by	Drug Name	Directions	Why I take this	B 8-9	L 12-1	D 6-8	Bed 9-11	Comments
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Medications I have stopped taking									
Date I stopped taking it	Prescribed by	Drug Name	Directions	Why I took this	B 8-9	L 12-1	D 6-8	Bed 9-11	Why I stopped taking this
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I am concerned about:

- ☐ My ability to manage my chronic condition ☐ My decreased energy level / Fatigue
☐ Financial issues
☐ Having access to healthcare
☐ Emotional issues ☐ Family issues ☐ Spiritual support ☐ Thinking or memory problems ☐ End of life issues
☐ Other:

My Next Steps:

This section to be completed by you in partnership with your care team. Steps may include concerns about medical condition, problems, barriers or goals and are followed by action, solutions, observations, the current status of the step, etc.

[illegible]



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Basic Person-Centered Care Plan - Providence Medical Group Southeast

Person-Centered Care Plan

Risk Level: (High, Moderate, Low)

Last updated by: (dot s)

Original Author: (dot s)

Medical Summary:

Patient Care Team: (dot)patientcareteam to pull in all team members

Personal Support Team:

(Include community contacts, caseworkers, therapists, etc here, primary caregiver/contact information goes here.)

Patient's care goals (chronic and preventive) (Patient's personal goals for care goes here)

Patient's self management tools: (patient education, groups, referrals go here)

Patient's barriers to care/goals: (psychosocial and other risk factors go here)

Team Goals: (chronic and preventive)

Sample Plan:

Risk Level: High

Last updated by: XXX XXX, RN 1/16/2013

Original Author: XXX XXXX, MD 11/11/2012

Medical Summary: Cindy is a 48 y/o single mother of two children, Johnny 13 and Amelia 9. Cindy has diabetes , high blood pressure, and knee pain. She is 85 lbs over her desired weight . She has a past history of alcohol and methamphetamine use but clean and sober for 13 years. Her diabetes and hypertension are under poor control and it is difficult to persuade her to get needed lab work and show up for office visits.

Care Team:

Personal Support Team: Boyfriend Joe 503-222-2222, Mother Carol 971-333-3333, AA sponsor Kim, 503-111-1111

Patient's Care Goals (chronic and preventive)

1. "I would like to eat better so I can lose some weight"
2. "I need some help in managing all the stress I'm under with money and the kids"

Patient's Self Management Tools:

1. Call TOPS (Take Off Pounds Sensibly) 503-444-4444 for a support group near your home
2. Meet with Diabetes Education for refresher on nutrition and diet 503-214-9999
3. Meet with our clinic behavioral coach, Dr Jones, about your high blood pressure and stress

Patient's barriers to care:

1. Has to take 2 buses to get to clinic for lab and office visits
2. Boyfriend is overweight and resists making changes in family food choices

Team Goals

1. Cindy will come in for office visit and lab work at least twice a year
2. Cindy will sign up for MyChart and use the diabetes self care to keep team posted on her blood sugar and blood pressure.