Vermont Integrated Communities Care Management Learning Collaborative

Shared Care Plan Fact Sheet

What is it?

A Shared Care Plan is a document created by the person receiving services and/or her family and the care team. It “tells the person’s story,” by describing strengths and interests, short and long-term needs, and personal and clinical goals and priorities. The care plan identifies strategies and a timeline for achieving goals, and specifies who is responsible for each part of the plan, e.g. the physician, Lead Care Coordinator, person receiving care, etc. Finally, the Shared Care Plan is a tool to facilitate communication between all parties involved. It is:

- Designed to organize information about a person receiving care or services from multiple organizations. (Based on the principle of Integrated Care Management)
- Focused on person-centered care and person’s identified priorities
- Updated as needed by only the Lead Care Coordinator
- Standardized document that multiple organizations are familiar with
- Contains only information needed to coordinate care, not a treatment record or clinical record
- Contains high-level patient and medical goals and lists strategies and care team members responsible for achieving goals within a specific time frame.
- Is an agreement that specifies ways in which people will direct and participate in their own care; designed to be written and shared with the person receiving services.
- Ideally in electronic form to allow for communication between organizations and future interoperability with EHRs.
- Designed to provide easy access to critical information about complex people receiving services from multiple organizations.

What it’s not:

- Does not replace any organization’s clinical record, but serves as a tool of integrated care management across organizations
- Does not need to be maintained by multiple people – Lead Care Coordinator updates and disseminates as needed.
- Confusing or overwhelming – it condenses needed information for the goal of care coordination and facilitates better communication between organizations with the goal of improved outcomes
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Create and Implement Shared Care Plan

List personal and clinical goals.

Describe strategy for achieving each goal.

Identify needed partners and link them into the Shared Care Plan. Identify person responsible for each goal, clarify their role, and determine time line to achieve goal.

Determine communication process among team members & frequency of communication.

Set the date for the next meeting or describe circumstances which will trigger another meeting.

Ensure the Plan is accessible, retrievable and available to all.

Person agrees with plan and signs the plan. Give everyone a copy of plan.