

## Shared Care Plan

### for Children and Youth with Special Health Needs

|                                                                                                                            |                              |                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------|--|
| Child/youth name:                                                                                                          |                              | Necessary releases obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Child/youth likes to be called:                                                                                            |                              | Team meeting date:                                                                    |  |
| Date of birth:                                                                                                             |                              | Meeting location:                                                                     |  |
| Parent(s):                                                                                                                 |                              | Referred by:                                                                          |  |
| Parent phone #:                                                                                                            |                              |    |  |
| Primary care provider:                                                                                                     | Interpreter (if applicable): |                                                                                       |  |
| Gender identity: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other, please specify:     |                              |                                                                                       |  |
| Pronouns: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> Other, please specify: |                              |                                                                                       |  |



### Child/Family Strengths and Assets

|  |
|--|
|  |
|--|

## Child/Family Language and Culture

|  |
|--|
|  |
|--|

## Child/Family Concerns and Goals

|            |
|------------|
| For today: |
|            |

|                      |
|----------------------|
| For the longer term: |
|                      |

| Brief Medical Summary                                   |                      |
|---------------------------------------------------------|----------------------|
| Diagnosis:                                              |                      |
| Medications:                                            |                      |
| Current Interventions:                                  | Tried Interventions: |
| Health Care Providers:                                  |                      |
| Other Important Medical Information (Allergies/Alerts): |                      |
| Preferred Hospital:                                     | Preferred Pharmacy:  |

| Brief Summary of Involvement with Education/Community-Based Services |
|----------------------------------------------------------------------|
|                                                                      |

| Team Members Contact List                                                            |                          |                     |
|--------------------------------------------------------------------------------------|--------------------------|---------------------|
| <i>Note: Initial next to name to note attendance at meeting. Add rows as needed.</i> |                          |                     |
| Name                                                                                 | Role/Responsibility      | Best way to contact |
|                                                                                      | Family member            |                     |
|                                                                                      | Primary care provider    |                     |
|                                                                                      | Education                |                     |
|                                                                                      | Mental/behavioral health |                     |
|                                                                                      | Public health            |                     |
|                                                                                      | Health plan/insurance    |                     |
|                                                                                      | Interpreter              |                     |
|                                                                                      |                          |                     |
|                                                                                      |                          |                     |
|                                                                                      |                          |                     |

**Action Plan***Note: Add rows as needed.*

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

| Shared goal:                                                                        | Who?          | Is doing what?        | By when?                                   |
|-------------------------------------------------------------------------------------|---------------|-----------------------|--------------------------------------------|
|  | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
| <b>Date identified:</b>                                                             | <b>Notes:</b> |                       |                                            |
| <b>Date resolved:</b>                                                               |               |                       |                                            |

**Action Plan***Note: Add rows as needed.*

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

| Shared goal:                                                                        | Who?          | Is doing what?        | By when?                                   |
|-------------------------------------------------------------------------------------|---------------|-----------------------|--------------------------------------------|
|  | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
| <b>Date identified:</b>                                                             | <b>Notes:</b> |                       |                                            |
| <b>Date resolved:</b>                                                               |               |                       |                                            |

**Action Plan***Note: Add rows as needed.*

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

| Shared goal:                                                                        | Who?          | Is doing what?        | By when?                                   |
|-------------------------------------------------------------------------------------|---------------|-----------------------|--------------------------------------------|
|  | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
|                                                                                     | This person   | Will take this action | By this date<br><br><b>Date completed:</b> |
| <b>Date identified:</b>                                                             | <b>Notes:</b> |                       |                                            |
| <b>Date resolved:</b>                                                               |               |                       |                                            |

Developed by: Oregon Center for Children and Youth with Special Health Needs (OCCSYHN), August 2016, rev. May 2020

**Use with permission – contact OCCYSHN**Phone: 503-494-8303, email: [occyshn@ohsu.edu](mailto:occyshn@ohsu.edu)

Includes original content as well as adapted content from:

- Jeanne W. McAllister. May, 2014. *Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs: An Implementation Guide*. Lucile Packard Foundation for Children's Health.
- Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: Critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA29020090000191TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. Jun 2011.
- Community Connections Network –Shared Care Plan (Community Connections Network is a program of The Oregon Center for Children and Youth with Special Health Needs)

*This project is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Oregon's Title V Maternal and Child Health Block Grant (#B04MC28122, in the amount of \$1,859,482) and the "Enhancing the System of Services for Oregon's CYSHCN" grant (#D70MC27548, in the amount of \$300,000). The project receives no nongovernmental funding. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.*