INSTRUCTIONS FOR MY CONNECT/CONNECT + MEDICARE PLAN OF CARE

Information About Me: This will information will be incorporate the member's demographics, plan ID, plan name, the date of the assessment, product enrollment date, diagnosis, waiver type (if applicable) and primary language.	
1.	**Indicate if POC is High Need or Low Need (Connect + Medicare ONLY for a Low Need POC)**
2.	**Member Name**
3.	**Health Plan ID Number**
4.	**Health Plan Name**
5.	**Today's Date (date the POC is being completed)**
6.	**Member Phone Number**
7.	**DOB** (Date of Birth) – Enter member's date of birth
8.	**Member Product Enrollment Date:** Enter the member's date of enrollment of the current product.
9.	**Type of Waiver Member has:** Choose from the drop down box options of BI, CAC, CADI, or DD.
10.	**Member Address**
11.	**Diagnosis:** Enter the member's diagnosis (the member may have multiple diagnosis to enter)
12.	**Primary Language:** If the member's language is not on the list, check "Other" and document their language in this section. Is an interpreter needed? Check yes or no. Enter the name and number of the interpreter, if applicable.
Interdisciplinary Care Team (ICT): The composition of this team will vary based on an individual member's assessment. The care coordinator uses professional judgment and experience when establishing an interdisciplinary team's membership. The role of the ICT is to provide assistance in maintaining and maximizing the member's functional abilities and quality of life. Interdisciplinary teams consist, at a minimum, of the member and/or his/her representative; the Care Coordinator, and the Primary Care Provider (PCP).	
13.	**Name of Care Coordinator (CC)/Case Manager (CM) and Phone Number**
14.	**Primary Care Provider (PCP):** Enter the name, phone number, a fax number of member's PCP.
15.	**PCP Clinic:** Enter the name of the member's primary care clinic.
16.	**Member's Representative (if applicable):** A Representative is anyone the member delegates either formally (e.g. Authorized Representative for county paperwork, power of attorney, legal guardian, conservator) or informally (e.g. family member) to act on the member's behalf. Please indicate what the representative can be contacted for. Not all representatives would need to have access to all information. Best Practice Recommendations: Obtain a copy of the legal document(s) if the representative is formal.
17.	**Mental Health Targeted Care Manager:** Check yes or no. If yes, enter name and phone number.

18.	**Waiver Case Manager** (if applicable): Enter name and phone number of the waiver case manager.
19.	**Other Interdisciplinary Care Team Members:** Enter names of additional ICT members and their relationship to the member. Examples of other team members may include, but is not limited to, other physicians, specialists, psychiatrists, psychologist, etc. Document yes or no if the member would like the care plan shared with these ICT members. If yes, enter the date the care plan is sent.

What's Important to Me?	
20.	Enter information and preferences the member identifies as important to them (e.g. their culture, beliefs, dignity, living close to family, visiting friends, attending church). Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include 3-month check-ins or other updates throughout the year.

My Strengths	
21.	**Member's Strengths:** Include a list of the member's skills, talents, interest, and general information about themselves (e.g. is a strong advocate, enjoys being social, etc.) Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include 3-month check-ins or any other updates throughout the year.

My Supports and Services	
22.	Enter the member's preferences for services and supports. Includes person-centered choices for support and services that the member finds important to achieve or maintain independence. Also discuss if the support requested is formal or informal. These supports and services could be a part of the member's Self-Management Plans which are activities undertaken by member to help them manage their condition. Examples of these would be members asking for help maintaining a prescribed diet, taking medications as directed, charting daily readings, changing a wound dressing as directed, management of equipment, etc. Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include 3-month check-ins or any other updates throughout the year.

Managing and Improving My Health: CC/CM should have an educational conversation with the member or member's authorized representative about applicable health prevention/chronic conditions listed – If applicable, the member should be referred to a health care provider to discuss further action.	
23.	**Check the box if an educational conversation took place:** If the educational conversation did **NOT** take place, see #25 and/or add any applicable documentation in the Notes column.
24.	**Check box if goal is needed:** If the member needs assistance with a risk or identified need, create a goal in My Goals section.
25.	**Check applicable box if the Condition/Screening or goal is not applicable, contraindicated, or declined.**
26.	**Notes:** Free form area for any additional applicable information. Examples are date of screening, scores, reason for declining a goal, etc.
	Annual Preventative Health Exam
	Mammogram
	Colorectal Cancer Screenings
	At Risk of Falls (Afraid of falling, has fallen in the past)
	Flu shot
	Tetanus Booster (once every 10 years)
	Hearing Exam
	Vision Exam
	Dental Exam
	Rx for Aspirin: CC/CM should advise member to check with their doctor before taking medication and take as directed.
	Blood Pressure
	Cholesterol Check
	Diabetic routine checks as recommended by physician: CC/CM should inquire whether a member with diabetes has routine diabetic checks with their doctor. **<u>One box</u> for every routine diabetic check option should be marked**. If not completed or scheduled, the CC/CM should encourage the member to schedule a visit and attempt to create a goal to address this in the My Goals section. CC/CM should review and discuss with member patient education topics such as importance of an additional diagnosis of hypertension, nephropathy, diabetic eye exam, cholesterol (e.g diet), and knowing their A1C.
	Other: Enter other test or condition not addressed in this section.
	My Medications: CC/CM should discuss whether member needs help with their medication. Check yes, no, or not applicable. If, yes, attempt to create a goal with the member to address this.
	Health Improvement Referral: Check yes, declined, or N/A. If yes, include the diagnosis. *All health plans have different disease and process for their Disease Management Programs; please check with the member's health plan for direction.*

My Goals – Goals for everyday life (taking care of myself or my home), my relationships and community connections, my safety, my health, and my future plans.	
27.	**Rank by Priority:** Care Plan goals should be prioritized. When ranking the goals, the CC/CM should consider the member's specific situation or condition as well as their and their caregiver's needs and preferences. Member's preferences may include, for example, care or services that are in accordance with the member's desire to remain in their own home and to maintain their independence and current daily activities. Member's social needs and personal preferences can drive activities, supports and care coordination service. An understanding of these areas is useful for creating an individualized and person-centered care management plan. Goals can be documented in any order, as long as the order of priority is clear. A Care Plan must contain at least one high priority goal. Prioritizing goals is a member-centered activity. **There is no right or wrong way as long as the member/responsible party is involved.**
28.	**My Goals:** List appropriate member-centered goals to meet the risks identified by the member of found during the HRA, or other related member documentation. Goals should be SMART (Specific, Measurable, Attainable, Relevant, and Time-bound).
29.	**Support Needed:** Document any intervention(s) related to achieving this goal – What will the member need to accomplish the goal and how will the CC/CM help the member achieve the goal?
30.	**Target Date:** List the target date (month/year) for completion of the goal. "On-going", "yes", or "no" are **NOT** acceptable target dates. Members should have at least on "active" or "open" goal on their care plan and the target date should extend to the next annual assessment.
31.	**Monitoring Progress/Goal Revision Date:** This column should be used to document progress during the 3-month contract and/or as needed throughout the year. The CC/CM should have a discussion with the member about each goal and the member's progress toward meeting a goal. This discussion should include determining if the goal was met or not met, and an evaluation of whether the goal will be discontinued, modified, or carried forward. The CC/CM should document the date (month/year) of the review and a brief progress note. Reminder: The plan of care is a "living document" that should be updated at minimum four times per year for high need members, and once per year for low needs members. Best Practice Recommendation: The CC/CM should document their monitoring of the care plan and/or updates directly on the care plan. If the CC/CM uses case notes to document progress on goals, the progress regarding **EACH** goal should be clearly addressed in the case notes.
32.	**Date Goal Achieved/Not Achieved:** This column is used to document the goal outcome. Document the date (month/year) the goal was achieved or if not achieved or if not achieved, and the date (month/year) it was reviewed. This coumn may also be used to document progress notes, and must, at a minimum include the final outcome of each goal at annual reassessments (e.g. goal discontinued, modified, or carried forward to next year's care plan).

Barriers to Meeting My Goals	
33.	**Initial/Annual:** Care Coordinators/Case Managers Document member identified barriers that may prevent them from meeting their goals. If the member does not identify any barriers the CC/CM should document that a discussion took place. This is also an area where the CC/CM can document if the member is unable to participate in the care plan due to cognitive/mental health reasons. **Barriers could include**: language or literacy, lack of or limited access to reliable transportation, a member's understanding of their condition, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairments, etc. If there are no barriers mark the box to indicate NO barriers identified. Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include 3-month check-ins or any other updates throughout the year.
34.	**CC/CM Follow-Up Plan:** Check the box that describes the frequency of the follow-up contracts or visits (e.g. every 3 months, 12 months, or other). If "other" is selected, describe the frequency.
35.	**My Safety Plan:** CC/CM should review the member's identified safety concerns and the services/supports documented in the members care plan and "yes". Though additional notes are not required, there is additional room in this section for any notes the CC/CM wants to add. If there are identified health and safety risks document how these will be addressed with services or the member's plan for managing risk. If the member doesn't have a plan because the member doesn't have risks identified or doesn't believe they have any risks, then the CC/CM should note that in this section of the care plan. If the CC/CM offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted in this section as well.
36.	**Emergency Plan:** Discuss and document with them ember/representative what the member would do in the case of an emergency.
37.	**Self-Preservation/Evacuation:** Describe the evacuation plan for a member who cannot evacuate independently (e.g. customized living evacuation procedure). Describe other self-preservation concerns or plans (e.g. member at risk for financial or physical abuse – what is the plan to address the risk?).
38.	**Essential Services Backup Plan:** Essential services are services that if the member did not receive them, the member's health or ability to maintain safety in their home would be compromised. If the member has essential services document what the provider's back up plan is, as agreed to by the member. Example, the member's only source of nutrition is Meals-on-Wheels, then it is an essential service.

Home and Community Based Services	
39.	**My Current Services:** Mark "X" for each service that is currently in place. The "Other" options can be used if a service is being received and not already listed.
40.	**My HCBS (No PCP, Specialty Providers, or other listed in ICT) Contact Information:**
	Provider Name & Phone #: Enter the individual(s) name and phone number.
	Service Provided: Select the appropriate option from the drop down box that describes the services the provider is responsible for. If "Other – See Notes section below" is selected, describe services in the Notes section.
	Schedule/Frequency: Enter the day(s) and/or the frequency of the services being provided.

	Start Date/End Date: If available, enter the date the service(s) began, and if applicable, enter the date the service(s) will end.
41.	**Informal, non-paid community supports or resources (i.e. caregiver, family, neighbor, volunteer:**
	Informal Provider/Phone #: Enter the individual(s) name and phone number.
	Services Provided: Free form text field for CC/CM to document anything not covered in another area.
	Schedule/Frequency: Enter the day(s) and/or the frequency of the services being provided.
	Additional comments, if applicable: Free form text field for CC/CM to document anything not covered in another area.

Signature Page	
42.	**My/My Representative Signature:** Member or member's representative's signature and date of signature **MUST** be placed in this section.
43.	**Care Coordinator/Case Manager Signature:** The CC/CM's signature and date **MUST** be placed in this section.
44.	**Plan of Care Mailed/Given to Me on:** Check box "Yes" or "No". If "No" option is chosen provided detail in the Additional comments section outlining the reason it was not provided. Provide the date the POC was mailed or given to the member.
45.	**Plan of Care Summary Mailed/Given to My PCP (verbal, phone, fax, EMR):** Provide the date the POC Summary was provided and how it was provided to the PCP.

ADDENDUMS

GOAL EXAMPLES: Goals should be SMART (Specific, Measurable, Attainable, Relevant, and Time-bound.

My Goals	Rank by Priority	Support Needed	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
I want to be smoke free	☐**Low** ☐**Medium** ☒**High**	-I will schedule appointment with PCP to discuss smoking cessation aides -CC will provide information regarding Health Plan's quit line -I will take OTC products or medication as prescribed by PCP	3/2016	9/20/2015 – Has talked with PCP about smoking cessation. No OTC products or prescriptions used at this point. Member developed plan with quit plan representative. Has cut down to 5 cigarettes/day.	3/15/2016-Goal Met. Member has been smoke free since 1/1/2016. Goal modified on next care plan to "member will remain smoke free".

				Priority changed to Medium	
My PTSD signs/symptoms will be under control as evidenced by my sleeping at least 4-6 hours per night	☐**Low** ☒**Medium** ☐**High**	-I will take sleep aide medication as prescribed -CC will provide information on MH supports and refer as needed -I will contact MD if signs/symptoms worsen for possible medication adjustment	3/2016	9/20/2015-Reviewed with member at 6 month check-in. Member reports she has been sleeping at least 4 hours most nights.	Reviewed 3/15/16-Member stated she has been sleeping well at night (at least 4 hours each night). Goal met, member would like to continue. See goal on new Care Plan.
I want my Congestive Heart Failure to remain stable	☐**Low** ☐**Medium** ☒**High**	-I will follow cardiac diet -I will do regular w-Weight checks -I will take cardiac meds daily -I will utilize health coach referrals	9/2016	3/2015 Member states she follows cardiac diet, no calls needed to MD for weight gain	

Example Case Notes:

7/10/17 Change in XYZ Homemaking Service *- CC talked with member on the phone about her approved request for an increase in homemaking hours from 2 hours/week to 3 hours/week due to her decreased mobility after breaking her foot. Member is in agreement with the plan and wants a copy of the updated budget worksheet sent to her for signature. Informed member that CC will send her a summary letter along with updated budget worksheet instructing her to sign and return. Discussed sharing her pertinent care plan information and support instructions with XYZ provider. Member decided to share a care plan summary with XYZ provider*.

7/11/17 CC mailed cover letter and updated budget worksheet to member for signature with instructions for returning signature page to CC for member file.

7/12/17 CC faxed Care Plan Summary Letter with service change to Homemaking provider for signature with instructions for returning signature page to CC for member file.

8/1/17 CC received signed member signature page for change in Homemaking Service hours. CC attached document to member's Care Plan.

8/1/17 CC received signed provider signature page from Homemaking provider for change in homemaking service hours. CC attached document to member's Care Plan.

8/15/17 ***Change in Homemaking Service – 2nd attempt*** *CC made follow-up phone call to homemaking provider; and left a detailed message reminding provider to sign and return the signature page that was faxed to them by CC on 7/12/17. Advised provider to contact CC if they have any questions about this.*