MY CONNECT/CONNECT + MEDICARE PLAN SUPPORT PLAN

Instructions

Information About Me: This information will include 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.	**Member Name**
2.	**Health Plan ID Number**
3.	**Health Plan Name**
4.	**Today's Date (date the POC is being completed)**
5.	**Member Phone Number**
6.	**DOB** (Date of Birth) – Enter member's date of birth
7.	**Member Product Enrollment Date:** Enter the member's date of enrollment of the current product.
8.	**Type of Waiver Member has:** Choose from BI, CAC, CADI, or DD.
9.	**Member Address**
10.	**Diagnosis:** Enter the member's Primary and Secondary diagnosis (may also include mental health dx or other significant dx)
11.	**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).	
12.	**Name of Care Coordinator (CC) and Phone Number**
13.	**Primary Care Provider (PCP):** Enter the name, phone number, a fax number of member's PCP.
14.	**PCP Clinic:** Enter the name of the member's primary care clinic.
15.	**Member's Representative (if applicable):** A Representative is anyone the member delegates either formally (e.g., Authorized Representative for county paperwork, financial power of attorney, health care agent, 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.
16.	**Mental Health Targeted Care Manager:** Check yes or no. If yes, enter name and phone number.
17.	**Is My Mental Health Managed by a Health Professional:** Check yes or no. Indicate yes or no if a goal is needed or declined.

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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. that are actively involved in the members' care. Document yes or no if the member would like the Support Plan shared with these ICT members. If yes, enter the date the Support 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 are entered in the second row. Updates include a minimum 6-month check-ins or other updates throughout the year. Best practice is to add the CC initials and date to any additions/updates.

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, supportive family, interested in art/music/TV/exercising etc.) Complete the first row at the initial/annual assessment. Updates are entered in the second row. Updates include a minimum 6-month check-ins or other updates throughout the year. Best practice is to add the CC initials and date to any additions/updates.
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 (paid) or informal (provided by unpaid caregivers/family/friends etc.). 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 are entered in the second row. Updates include a minimum 6-month check-ins or other updates throughout the year. Best practice is to add the CC initials and date to any additions/updates.

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Managing and Improving My Health: Care Coordinator should have an educational conversation with the member or member's 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. Review of medications would not ASA prescribed.
	Blood Pressure
	Cholesterol Check
	Diabetic routine checks as recommended by physician: CC 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 should encourage the member to schedule a visit and attempt to create a goal to address this in the My Goals section. CC 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 should discuss whether member needs help with medication management. Check yes, no, or not applicable. If, yes, attempt to create a goal with the member to address.
	Safe storage of medications Discussion: Mark Yes, when discussed with member or NA if the member does not take medications
	Health Improvement Referral: Check yes, declined, or N/A. If yes, include the diagnosis. *Review disease management programs available based on member's dx*

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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:** Support Plan goals should be prioritized. When ranking the goals, the CC considers 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 Support 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 identified risks, concerns, priorities, and the member's personal choice goals identified during the HRA. Goals are to be written as SMART (Specific, Measurable, Attainable, Relevant, and Time-bound).
29.	**Support Needed:** Document the intervention(s) related to achieving this goal – What will the member need to accomplish the goal. Identify health plan benefits the member could use to achieve goals (i.e., transportation, supplemental benefits, PT/OT, DME needs, health coaching programs etc.) and/or community resources that would aid in goal achievement (i.e.: AA, grants, ARMHS etc.). Include steps the member, caregivers, CC or others will take to 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 must have at least on "active" or "open" goal on their Support Plan and the target date may extend to the next annual Assessment or less if the expected target completion date is sooner (i.e., acute dental need).
31.	**Monitoring Progress/Goal Revision Date:** This column is used to document progress during the 6-month contract and/or as needed throughout the year. The CC should have a discussion with the member about each goal and the member's progress toward meeting a goal. This discussion includes 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 documents 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 of every 6-months, during transitions of care and more if the follow up plan is greater than every 6 months (i.e., complex members with complicated health care issues, unmet needs, frequent hospitalizations etc.). Best Practice Recommendation: The CC should document their monitoring of the Support Plan and/or updates directly on the Support Plan. If the CC uses case notes to document progress on goals, the progress regarding **EACH** goal should be clearly addressed in the case notes.

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32.	**Date Goal Achieved/Not Achieved:** This column is used to document the goal outcome any time during the year (i.e., achieved early, or member wished to d/c goal) and at the time of reassessment. Document the date (month/year) the goal was achieved or if not achieved, and the date (month/year) it was reviewed. Include a brief summary of the outcome for each goal at annual reassessments and indicate if the goal was discontinued, modified, or carried forward to next year's Support Plan.

Barriers to Meeting My Goals	
33.	**Initial/Annual:** Care Coordinators document member identified barriers that may prevent them from meeting their goals. If the member does not identify any barriers the CC should document that a discussion took place. This is also an area where the CC can document if the member is unable to participate in the Support 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 are to be entered in the second row. Updates include 6-month check-ins or any other updates throughout the year.
34.	**CC Follow-Up Plan:** Check the box that describes the frequency of the follow-up contracts or visits (e.g., every 3 months, 6 months, or other). If "other" is selected, describe the frequency.
35.	**My Safety Plan:** CC should review the member's identified safety concerns and the services/supports documented in the members Support Plan and "yes". 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 is to note that in this section of the Support Plan. If the CC offers a service that is critical to the member's health and safety that is not accepted by the member, note in this section. Though additional notes are not required, there is additional room in this section for any notes the CC wants to add.
36.	**Emergency Plan:** Discuss and document with them member/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. Example, the member's only source of nutrition is Meals-on-Wheels, then it is an essential service. Describe the essential services the member receives and what the agreed upon back up plan is if the essential service/support in not able to be provided.

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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 Contact Information:** Do not add PCP, Specialty Providers, or others already listed in ICT.
	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 Signature and Credentials:** The CC signature with credentials and date must be placed in this section.
44.	**Support Plan 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 Support Plan was mailed or given to the member.
45.	**Support Plan Summary Mailed/Given to My PCP (verbal, phone, fax, EMR):** Provide the date the Support Plan was provided and how it was provided to the PCP.

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ADDENDUM

GOAL EXAMPLES: Goals are written as SMART (Specific, Measurable, Attainable, Relevant, and Time-bound)

My Goals: ***Discuss with Care Coordinator, goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.***

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	I would like to reduce my A1c to 7 within the next year.	Care Coordinator (CC) provided information about Health Improvement coaching with UCare. Fred would like to participate. CC to make referral. Wilma to continue to assist with daily blood sugar monitoring and medication administration. CC to provide a list of in network Endocrinologist to select a new provider. Fred and Wilma will schedule first visit within the next 6 weeks Fred commits to decreasing his sweets/donuts to 1-2 times a week. Fred plans to take advantage of the new fitness benefit offered by UCare. He wants to use the gym at least 3 x week.	3/2/23	5/2/22 TOC Update SH Fred was hospitalized for low blood sugar. He was exercising and eating less, but didn't realize he was getting low and fainted while at the gym. CC recommended a continuous blood glucose monitor and will assist Fred with obtaining. Continue goal 9/28/22 6 mo Update SH Fred has been using his new blood glucose monitor and it's working well. He also established with his new Endocrinologist and had a medication change. continue goal	
☐ Low ☐ Medium ☒ High	Fred would like to decrease his foot pain from 8 to 4 in the next year	CC to assist with locating in network Endocrinolgy providers. Fred and Wilma will schedule visit within the next 6 weeks. Fred is encouraged to use a pain log to track his daily pain levels. CC to assist with diabetic foot wear if needed and other medical equipment as needed.	3/2/23	9/8/22 6 mo update SH Fred reports since his change in blood sugar monitoring, exercising more and eating less sweets he has experience fewer days with feet pain. He's been able to drive more which he's been very happy about continue goal	
☐ Low ☐ Medium ☒ High	Fred will self report seeing a dentist within the next 3 months	Fred is having tooth pain in his upper molar. CC assisted Fred with locating new dentist during visit and scheduled an acute dental appointment for 3.28.22. Fred will follow through on attending his dental visit and additional preventative dental care thereafter.	6/15/22	9/28/22 6 mo update SH Fred completed his acute dental visit in March 2022. He had a cavity which was causing his pain. He also scheduled a 6 month follow up exam. Fred received his electric toothbrush. Goal met	3/22 SH Goal met