# My Connect/Connect + Medicare Support Plan

| Information About Me: | | | |
|---|---|---|---|
| **Name:**<br>Fred Flintstone | **My Health Plan ID Number:**<br>1234567890 | **My Health Plan Name:**<br>UCare Connect | **Today's Date:**<br>3/9/22<br><br>TOC update 5/2/22 SH<br><br>6 mo update 9/28/22 SH |
| **Phone #:**<br>123-456-7890 | **My DOB:**<br>12-34-56 | **Product Enrollment Date:** 2/1/22 | **My Waiver Type (if applicable):** |
| **My Address:**<br>1234 Rocky Road<br>Bedrock, MN 56789 | | | |
| **My Primary Health or Mental Health Diagnosis:** Diabetes type 2, Hypertension | | | |

**My primary language is:**

☒ **English** ☐ **Hmong** ☐ **Spanish** ☐ **Somali** ☐ **Vietnamese** ☐ **Russian** ☐ **Other (*Type in the "other" language*):**

**I need an interpreter:**

☐ **Yes** ☒ **No**

**Name:** na **Phone:** na

## My Care Team (Interdisciplinary Care Team-ICT):

| | | |
|---|---|---|
| **UCare Care Coordinator/Case Manager: Name:** Susie Helpsalot**, LSW**<br><br>**Phone #:** 345-678-9876 | **Primary Care Provider (PCP):** Stoney Curtis, PA-C<br>**Phone #:** 987-654-3210<br><br>**Fax #:** 987-654-3211 | **PCP Clinic:** U of M Becrock Cares Clinic<br>654 Mountain Path<br>Bedrock, MN 56789 |

**My Representative is (if applicable):**

**Name:** Wilma Flintstone

**Phone:** 123-456-7890

**They can be contacted for:** Emergency contact and health care agent

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**I have a Mental Health Targeted Case Manager:**

☐ **Yes** ☒ **No**

**Name:** NA **Phone Number:** NA

**Is My Mental Health Managed by a Health Professional (Psychiatrist, Psychologist, Primary Care Physician)?**

☐ **Yes** ☒ **No**

**Need Goal?** ☐ **Yes** ☒ **No** ☐ **Declined**

**Waiver Case Manager (if applicable):**

**Name:** NA - no waiver

**Phone Number:**

| Other Medical Care Team Members Name | Relationship to me | Give Copy of Support plan? | Date sent |
|---|---|---|---|
| Rock Hudson, U of M | Endocrinologist | declined/no | NA |
| | | | |
| | | | |

## What's Important to Me? *(e.g. living close to my family, visiting friends)*

**Initial/Annual:** Fred is a 56 year old former quarry rock digger who lives in his own home with his wife, Wilma, their daughter, Pebbles and their pet dinosaur, Dino. Fred is close with his neighbor friends, Barney and Betty Rubble. It's especially important to Fred that he is able to return to work, at least part time as this activity gave him great satisfaction and allowed him to socialize more with his cronys.

**Update:** 9/28/22 SH Fred recently began a new friendship with the Great Gazo. He continues to attend weekly Water Buffalo Lodge meetings with his friend Barney. He's been in contact with his former boss to discuss returning to work options.

## My Strengths: *(e.g. skills, talents, interests, information about me)*

**Initial/Annual:** Fred enjoys going bowling, taking attending the Water Buffalo Lodge meetings and using his BBQ to cook his favorite foods - especially Borontasaurus burgers. Fred is a devoted father an lover of all animals. He loves to drive his open air car.

**Update:** 9/28/22 SH Fred has struggled with driving over the last few months after his hospitalization in May. He's been checking his blood sugars more regularly to ensure he avoids low blood sugars as much as possible

## My Supports and Services: *(What do I want help with? Service and support I requested? From whom?)*

**Initial/Annual:** Fred is independent with most of his daily life needs. His is grateful for the support of his wife, Wilma, who assist him his medication regimen and check in this blood sugars regularly. Wilma also helps with showering periodically. Fred is normally able to drive and will depend on Wilma during times of weakness.

**Update:** 5/2/22 SH TOC update: CC recommends Fred switch to an continuous glucose monitor to help monitor sugar levels more closely CC to obtain order from PCP to obtain.

9/28/22 SH Fred reports the new BGSM is working well. He likes that it connect to his smart phone and is able to download info to his PCP easily. He states the monitoring helps him know when he can eat more during different times of the day.

## Managing and Improving My Health

| **Screening for my health** | | | | |
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| | **Check if educational conversation took place with me** | **Goal is needed** | **Check if N/A, contraindicated, declined** | **Notes** |
| **Annual Preventive Health Exam** | ☒ | ☐ | ☒ | 6/5/21 |
| **Mammogram** | ☐ | ☐ | ☒ | NA - male |
| **Colorectal Cancer Screening** | ☒ | ☐ | ☒ | Fred reports he completed in 2020. |
| **At Risk for Falls (Afraid of falling, has fallen in the past)** | ☒ | ☐ | ☒ | Fred had one fall in 2021 This was due to low blood sugar. Fall was single incident - no goal desired at this time. |

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| **Flu shot** | ☒ | ☐ | ☒ | 2021 |
| **Tetanus Booster** ***(Once every 10 years)*** | ☒ | ☐ | ☒ | 2015 - due in three years |
| **Hearing Exam** | ☒ | ☐ | ☒ | no concerns reported |
| **Vision Exam** | ☒ | ☒ | ☐ | overdue for diabetic vision exam |
| **Dental Exam** | ☒ | ☒ | ☐ | experiencing tooth pain - needs new dentist |
| **Aspirin**<br>**Rx for Aspirin?**<br>**(as directed by physician)** | ☒ | ☐ | ☒ | takes |
| **Blood Pressure** | ☒ | ☐ | ☒ | managed with medication<br>125/75 |
| **Cholesterol check** | ☒ | ☐ | ☒ | no concern noted |
| **Diabetic routine checks as recommended by physician:**<br>Hypertension →<br>Nephropathy →<br>Diabetic Eye exam →<br>Cholesterol →<br>A1C → | ☒<br>☒<br>☒<br>☒<br>☒ | ☐<br>☒<br>☒<br>☐<br>☐ | ☒<br>☐<br>☐<br>☒<br>☒ | Fred has been experiencing pain in his feet<br>Last A1c was 8<br>Wilma record daily blood sugar using log<br>Used to see Endocrinologist prior to losing insurance. Needs to re-establish care with specialist |
| **Other:** | ☒ | ☒ | ☐ | Sleep disturbance, returning to work |

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| **My Medications** | **I need help with my medications?**<br>☒ **Yes** ☐ **No** ☐ **N/A (no medications used)**<br><br>**If yes, create a goal.** Current supports meet Fred's need. No goal needed. |
| **Safe Disposal of Medication Discussion** | **I have discussed safe disposal of medications and was provided documents.**<br><br>☑ Yes ☐ N/A Comments |

**Health Improvement Referral** ☐ Yes ☐ Declined ☑ N/A

## 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**<br>☒ **Medium**<br>☐ **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.<br><br>Wilma to continue to assist with daily blood sugar monitoring and medication administration.<br><br>CC to provide a list of in network Endocrinologist to select a new provider. Fred and Wilma will schedule first visit within the | 3/2/23 | 5/2/22 TOC Update SH<br>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.<br>Continue goal<br><br>9/28/22 6 mo Update SH<br>Fred has been using his new blood glucose monitor and it's working well. He also established with his new Endocrinologist and had | |

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| | | next 6 weeks<br><br>Fred commits to decreasing his sweets/donuts to 1-2 times a week.<br><br>Fred plans to take advantage of the new fitness benefit offered by UCare. He wants to use the gym at least 3 x week. | | a medication change. continue goal | |
| ☐ **Low**<br>☐ **Medium**<br>☒ **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.<br><br>Fred and Wilma will schedule visit within the next 6 weeks.<br><br>Fred is encouraged to use a pain log to track his daily pain levels.<br><br>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<br>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<br>continue goal | |
| ☐ **Low**<br>☐ **Medium**<br>☒ **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.<br><br>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<br>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.<br><br>Fred received his electric toothbrush.<br>Goal met | 3/22 SH<br>Goal met |

| | | | | | |
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| | | CC provided education on dental benefits and ordered Fred a dental kit | | | |
| ☐ **Low**<br>☒ **Medium**<br>☐ **High**<br><br>**Test your knowledge:**<br><br>This support plan is missing two goals. Based on Fred's HRA, what are the missing SMART goals?<br><br>*Answers in Training HRA Notes section* | **Fred would like to return to part time work within the next six months** | **Fred is aware that in order to return to work, he will need to have a stable diabetic management plan in place.**<br><br>**Fred plans to work toward returning to work by reducing his A1c, exercising more and eating loss.**<br><br>**Fred plans to meet with his former boss in the next 3-4 months to provide and update on his progress and learn about opportunities that may be open to him.**<br><br>**CC to assist with resources, information and community programs for people with disabilities.** | ~~**9/15/22**~~<br><br>**New Target Date:**<br>**3/23** | 9/28/22 6 mo update SH<br>Fred has a little setback with his hospitalization, but has improved considerably since then. Fred is now using his continuous blood sugar monitor to track is sugar levels. Knowing his numbers has helped Fred be more aware of his fluctuations and has been able to adjust his eating habits.<br><br>Fred was able to meet with his former employer. He's not able to return to work just yet.<br><br>Continue goal and extend target date | |

## Barriers to meeting my goals: ☐ No barriers identified

**Initial/Annual:** Fred admits he lacks motivation at times to follow through on his medical care. Wilma provides support, reminders and encouragement to overcome this barrier.

**Update:** 9.28.22 6 month update SH - Fred has been more motivated since his last hospitalization and getting a new continuous glucose monitor.

## My follow up plan:

**Care Coordinator/Case Manager follow-up will occur:**

☒ **Every 6 months (High Needs POC)**

☐ **Every 12 months (Low Needs POC)**

☒ **Other (Please specify):** CC to follw up on immediate needs, during times of hospitalization and as needs arise.

**I can contact my Care Coordinator to help me with my medical, social or everyday needs. I should contact my Care Coordinator when:**

- **Changes happen with my health**
- **I have a scheduled procedure or surgery or I am hospitalized**
- **I have experienced falls in my home or community**
- **I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying)**
- **If I need additional community services such as: equipment for bathroom safety or home safety; information about topics such as staying healthy, preventing falls, immunizations, etc.**
- **I need help finding a specialist**
- **I need help learning about my medications**
- **I would like information to help myself and my family make health care decisions**
- **I would like changes to my support plan or my services and supports**
- **I would like to talk about other service options that can meet my needs**
- **I am dissatisfied with one or more of my providers**

## My Safety Plan:

**My safety concerns were discussed with my Care Coordinator:** ☒ **Yes** ☐ **No**

**My plan for managing risks that I have discussed with my Care Coordinator is:**

Fred has had a fall in the past. He uses a grab bar in his bathroom for safety. Fred and CC talked about allowing his wife to drive when he is having increased foot pain to help prevent increased foot pain. Fred keeps a fire extinquisher by his BBQ grill for additional safety. Fred also keeps a glucose tab in his car to ensure if he has low blood sugar.

## Emergency Plan:

**In the event of an emergency, I will (check all that apply):**

- ☒ **Call 911**
- ☐ **Use Emergency Response Monitoring System**
- ☒ **Call Emergency Contact**
- ☒ **Call Other Person** **Name:** Barney Rubble **Phone:** 654-321-4567
- ☐ **Other (describe):**

## Self-Preservation/Evacuation Plan:

**If I am unable to evacuate on my own in an emergency, my plan is to:**

Fred is capable of identifying and responding to changing weather and safety concerns, such as fire. Fred and Wilma have a designated meeting space outside in case of fire evacuation. During severe weather, they huddle in their lower level of their home.

**If other concerns or plans, describe:**

## Essential Services Backup Plan: (*when providers of essential services are unavailable; essential services are services that if not received, health and safety would be at risk)*

**I am receiving essential services:** ☒ **Yes** ☐ **No**

**Essential services I am receiving:**

Wilma assists Fred with daily inuslin injections as Fred is not able to do this independently

**If Yes, describe provider's backup plan, as agreed to by me:**

If Wilma was not able to assist Fred with his insulin injection, Care Coordinator would assist Fred with arraning home care supports to provide medication management.

# HOME AND COMMUNITY BASED SERVICES

**My Current Services:** Mark "X" if service(s) are currently being used.

| | | |
|---|---|---|
| ☐ Adult Day Services | ☐ Help w/ MA, Finances, other paperwork | ☐ Personal Emergency Response System (PERS) |
| ☐ Customized Living | ☐ Homemaking | ☐ Respite |
| ☐ 24-hour Customized Living | ☐ Home Modifications | ☐ Therapies at home: PT, OT, ST |
| ☐ Care Coordination/Case Management | ☐ Home Delivered Meals | ☐ Transportation |
| ☐ Caregiver Support | ☐ Individual Community Living Support (ICLS) | ☐ Yard work/Chores |
| ☐ Companion Services | ☐ Nurse Visits | ☐ Foster Care |
| ☐ Personal Care Assistant (PCA) | ☐ Home Health Aide | ☐ Supplies and Equipment |
| ☐ PCA Supervision | ☐ ARMHS | ☐ ILS |
| ☐ Other: | ☐ Other: | ☒ Other: none |

**My HCBS (Not PCP, Specialty Providers, or others listed in ICT) Contact Information:**

| Provider Name & Phone # | Service Provided | Schedule/Frequency | Start Date/End Date |
|---|---|---|---|
| UCare - Susie Helpsalot 345.678.9876 | Care Coordination/Case Management | Every 6 months and as needed | Mar 2022 - Mar 2023 |
| | Select Service item | | |

| | | | |
|---|---|---|---|
| | Select Service item | | |
| | Select Service item | | |

| **Informal, non-paid community supports or resources (i.e., caregiver, family, neighbor, volunteer):** | | |
|---|---|---|
| **Informal Provider/Contact #** | **Service Provided** | **Schedule/Frequency** |
| Wilma Flintstone | Medication asssistance and blood sugar monitoring | daily |
| | | |
| | | |

**Additional comments, if applicable:**

# Signature Page: PLEASE ENTER CREDENTIALS WITH SIGNATURE

| | |
|---|---|
| **MY/MY REPRESENTATIVE SIGNATURE:** | **DATE:** |
| **CARE COORDINATOR/CASE MANAGER SIGNATURE AND CREDENTIALS:** | **DATE:** |
| **SUPPORT PLAN MAILED/GIVEN TO ME ON:** ☐ Yes ☐ No | **DATE:** |
| **SUPPORT PLAN MAILED/GIVEN TO MY DOCTOR (verbal, phone, fax, EMR):** | **DATE:** |

**Name:** **Health Plan I.D.Number:**