

CASE MANAGEMENT MONTHLY REPORT

LCP MFW

MEMBER: _____ ID# _____ HV Phone

Spoke with: Member Caregiver Other: _____

PCA: _____ Present Not Present

30 Day Follow-up 90 Day Follow-up Routine Monthly Visit ASR in the Home PCA Family Member

Member evaluated for High Risk per agency high risk criteria: Yes No Is Member High Risk? Yes No

(If high risk, HR Monitor Checklist completed monthly for updates in change in member's status.)

<p>MEMBER'S/FAMILY'S RESPONSE TO CARE GIVEN AND TO CAREGIVER</p> <p><input type="checkbox"/> Case management only, no PCA hours in plan Name of person assisting with ADLs and IADLs: _____</p> <p><input type="checkbox"/> Unstaffed (weekly telephone calls to member must be completed)</p>	<p><input type="checkbox"/> Pleased with caregiver</p> <p><input type="checkbox"/> Member and caregiver have good rapport</p> <p><input type="checkbox"/> Member pleased with all services</p> <p><input type="checkbox"/> Request change in caregiver</p> <p><input type="checkbox"/> Member and caregiver have an uncomfortable relationship</p> <p>Date of problem reported to office: _____</p> <p>Name of person receiving report: _____</p>
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<p>MONITORING OF OBJECTIVES AND EXPECTED OUTCOMES</p> <p>PERSONAL CARE: Member is clean, odor free and groomed. Reports no falls while bathing.</p> <p>PCA units for personal care: _____</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Staffing not available for all units</p> <p><input type="checkbox"/> Member frequently not available for PCA</p> <p><input type="checkbox"/> Needs increased / decreased services.</p>
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<p>HOMEMAKING: Member is managing household tasks. Home is as clean as member desires, pathways are clear, has clean clothes, groceries and supplies. PCA is completing all tasks per service plan goals. Review each task from Service Plan.</p> <p>PCA units for homemaking: _____</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Staffing not available for all units</p> <p><input type="checkbox"/> Member frequently not available for PCA</p> <p><input type="checkbox"/> Needs increased / decreased services</p>
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<p>ASR: Ambulation, AROM, PROM, Hoyer Lift, Foley Cath, Ostomy</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Staffing not available for units</p>
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<p>Respite:</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Staffing not available for units</p>
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<p>NUTRITION: Member has three meals per day. No weight loss reported.</p> <p><input type="checkbox"/> Home delivered meals, delivered per service plan</p> <p>Number per week: _____</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not met</p> <p><input type="checkbox"/> Needs increased / decreased services</p> <p>PCA units for preparation of meals: _____</p>
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<p>CASE MANAGEMENT: Member has all services coordinated. There is no duplication or harmful gaps in services. Appropriate payer will be responsible for services.</p> <p><input type="checkbox"/> Home Health / Hospice in Home</p> <p>Name of Home Health Agency: _____</p> <p>Home Health Services (include frequency): _____</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not met</p> <p><input type="checkbox"/> Home charts in the home</p> <p><input type="checkbox"/> Current service plan/goals in home chart</p> <p>Date of contact with office if not in the home : _____</p> <p>Dates of Community Service Plan Certification: _____</p>
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Page 1 of 2 - Continued on Next Page. Initials of Case Manager: _____

CASE MANAGEMENT MONTHLY REPORT – Page 2

Member ID: _____

<p>CHRONIC HEALTH: Member is managing chronic health problems. Member has no disease complications that have not been reported to the physician. Member has all needed medications and supplies. Medications are current and member takes medications as prescribed.</p> <p><input type="checkbox"/> Adjustments needed in Living Choice or Waiver services</p> <p>Specify: _____</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Met <input type="checkbox"/> Vendor awaiting Rx from physician <input type="checkbox"/> Vendor awaiting prior authorization <input type="checkbox"/> Vendor awaiting equipment / supplies <input type="checkbox"/> Member not pleased with:
<p>SAFETY: Member is safe at home. No emergencies have been reports without immediate assistance. Member is able to verbalize emergency plans for weather, evacuation, location of telephone numbers for emergency contact and services.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> Case management intervention needed <p>Specify: _____</p>
<p>OTHER OBJECTIVES:</p> 	
<p>OBSERVATION OF SERVICE DELIVERY</p> <p>Case management intervention to correct:</p> <p><input type="checkbox"/> Adjustment needed in service plan</p> <p>Specify: _____</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Duties carried out adequately <input type="checkbox"/> Plan followed as written <input type="checkbox"/> Changes in plan is communicated and member/legal agent agree with changes in plan <input type="checkbox"/> PCA is competent to complete to carry out plan <input type="checkbox"/> PCA does not know duties <input type="checkbox"/> PCA not following plan <input type="checkbox"/> PCA needs further training
<p>HEALTH ASSESSMENT OF MEMBER</p> <p>Date of 6 month RN evaluation: _____ Copy received and reviewed by case manager: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of scheduled physician visit: _____</p> <p>Name of physician: _____</p> <p>Reason for physician visit: _____</p> <p>Hospitalization: _____</p>	
<p>PHYSICAL, EMOTIONAL, SOCIAL, FUNCTIONAL ENVIRONMENTAL ASSESSMENT OF MEMBER SINCE LAST VISIT IS:</p> <p><input type="checkbox"/> Case management intervention needed</p> <p>Specify: _____</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Changed <input type="checkbox"/> Specify <input type="checkbox"/> Unchanged <input type="checkbox"/> Services are being delivered as authorized <input type="checkbox"/> Service plan adequate as written <input type="checkbox"/> Member pleased with caregiver
<p>Date of last hospital/rehab/nursing home stay?</p>	

Member satisfied with all services? Yes No If no, list service not satisfied with: _____

**** OTHER COMMENTS - SEE ATTACHED PROGRESS NOTE**

Member Signature: _____

SIGNATURE/TITLE: _____

CASE MANAGEMENT MONTHLY REPORT Date: _____ Time in: _____ Time out: _____

January February March April May June July August September October November December