APPENDIX B. GEORGIA SOURCE CAREPATH

Service Options Using Resources
In
Community Environments

SOURCE
LEVEL ONE CAREPATH

Member_____

Medicaid No. _____

SOURCE Case Manager _____

Signature _____ **Date** _____

SOURCE Case Management Supervisor_____**Date**_____

SOURCE Physician _____

Signature _____ **Date** _____

SOURCE Medical Director _____

Signature _____**Date** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member resides in community, maintaining maximum control possible over daily schedule and decisions. **GOALS:** **A. Member/caregiver contributes to the design and implementation of community-based services plan.** *Key member responsibilities:* • Accept services as planned with case manager; • Provide accurate information on health status and service delivery; and • Maintain scheduled contact with case manager. B. Member keeps scheduled medical appointments. C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and case managers. *Key provider performance areas:* • *Reliability of service* • *Competency and compatibility of staffing;* • *Responsiveness to member concerns and issues; and* • *Coordination with case manager.*	**Stabilize chronic conditions** and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/case manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness. PCP: _____Case Mgr._____ *SOURCE PCP role:* Evaluate and treat episodic /acute illness Manage chronic disease, including: Risk factor modification/monitoring of key clinical indicators Coordination of ancillary services Education for members/informal caregivers Medication review and management Conference/communicate regularly with case manager Review support service plans Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services Promote wellness, including immunizations, health screenings, etc. *SOURCE Case Manager role:* Maintain contact with member, for ongoing evaluation: Monthly by phone or visit (minimum) Quarterly by visit (minimum) PRN as needed Educate members on patient responsibilities Encourage/assist member in keeping all medical appointments Conference/communicate regularly with PCP Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work Coordinate with informal caregivers and paid providers of support services Educate or facilitate education on chronic conditions Assist members in ALL issues jeopardizing health status or community residence NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met 2nd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met 3rd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met 4th review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions **GOALS:** **A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (PCP, ADH or other report).** **B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by case manager or provider, self- or caregiver report).**	**MEMBER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___Candler Dietary Department ___other _____ MEAL PREPARATION: ___self-care (total) ___assistance by informal caregiver(s)_____ _____ _____ ___home delivered meals ___ALS (alternative living service) ___ PSS aide (includes G-tube) **MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HDM, PSS or ALS):** Mon _____B _____L _____S Thurs ____B_____L_____S Tues _____B_____L_____S Fri _____B_____L_____S Wed _____B_____L_____S Sat _____B_____L_____S Sun _____B_____L_____S NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): A. __met __not met B. __met __not met 2nd review period (__/__/__): A. __met __not met B. __met __not met 3rd review period (__/__/__): A. __met __not met B. __met __not met 4th review period (__/__/__): A. __met __not met B. __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti. **GOALS:** **Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.**	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other _____ **MONITOR SKIN** for integrity: ___SOURCE PCP ___self care ___informal caregiver _____ ___ADH ___specialist _____ ___PSS aide/PSS RN every 62 days ___ALS ___skilled nursing provider:_____ Dates of Service: Assistance required: ___turning/repositioning (see page_____) ___continence (see page _____) ___nutrition (see page____) NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist. ___blood pressure ___blood glucose ___weight (as indicator of illness) ___lab values ___other_____	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other_____ MONITOR CLINICAL INDICATORS: ___SOURCE PCP (OV) ___self care ___ASSISTANCE REQUIRED ___informal caregiver_____ ___ADH ___ADH mini-clinic ___PSS aide ___ALS ___RN provider: _____ Dates of Service: ___other _____ NOTES:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member/caregiver understands and complies with medication regimen (self- or caregiver report, physician/RN report or observation by case manager).	MEMBER/CAREGIVER EDUCATION: ___SOURCE PCP/PCP staff ___SOURCE educational material ___other_____ **MEDICATION ADMINISTRATION/MANAGEMENT:** ___self care ___informal caregiver _____ ___ADH/DHC ___ALS ___PSS aides (cueing) ___RN provider_____ Dates of Service: OBTAINING MEDICATIONS: **___self care** ___informal caregiver ___pharmacy delivery _____ ___other_____ PHARMACY:_____ NOTES:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments. **GOALS:** **No observations by case managers or reports from mbr./caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.**	**___ASSISTANCE REQUIRED:** (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service): _____bathing _____dressing _____eating _____transferring _____toileting/continence _____turning/repositioning _____errands _____chores _____financial mgt. _____meal prep. **__informal caregiver(s)** providing assistance: _____ _____ **___home delivered meals** **___ADH** **___ALS** **___ERS** **___incontinence carepath** **___PSS aide** Total hours/week: _____ Indicate no. of hours: Monday _____AM _____PM Thursday _____AM _____PM Tuesday _____AM _____PM Friday _____AM _____PM Wednesday _____AM _____PM Saturday _____AM _____PM Sunday _____AM _____PM NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY PARTICIPANT OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Problem behavior will not place the member at risk of social isolation, neglect or physical injury to themselves or others. Diagnosis: ___depression ___substance abuse ___bi-polar disorder ___schizophrenia ___Alzheimer's ___other dementia ___other _____ **GOALS:** A. Residential arrangements remain stable. **B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:** • hospitalization for condition • discussion of potential institutionalization • increased level of caregiver stress • physical danger to self or others posed by behavior • discharge from a program or service due to behavior Examples of problem or symptomatic behavior: wandering profoundly impaired memory substance abuse profoundly impaired judgment physical aggression suicide attempts or threats	**ROUTINE AND PRN MONITORING AND EVALUATION** by SOURCE PCP for signs of changes in mental status **MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP ___other_____ **__ongoing management of condition** by mental health professional provider:_____schedule_____ ___**supervision** by informal caregiver(s): _____ ___**ALS** for supervision and monitoring ___**PSS** aides for supervision and monitoring ___**day program** for supervision and monitoring of mental status when or if informal support is unavailable provider: _____ schedule: M T W Th F NOTES: _____ _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (___/___/___): A. _ met _ not met B. _ met _ not met 2nd review period (___/___/___): A. _ met _ not met B. _ met _ not met 3rd review period (___/___/___): A. _ met _ not met B. _ met _ not met 4th review period (___/___/___): A. _ met _ not met B. _ met _ not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Transfers and mobility will occur safely. **GOALS:** **Member has no falls due to unsuccessful attempts at transferring or mobility.**	**MEMBER/CAREGIVER EDUCATION:** __SOURCE PCP/PCP staff __SOURCE educational material __other_____ **ASSISTANCE REQUIRED:** ___i**nformal caregiver(s)** to provide assistance with transfers and mobility: _____ _____ ___**PSS aide** for assistance if/when informal support is unavailable ___**ALS** ___**ADH program** for assistance if/when informal support is unavailable ___**Adaptive equipment** as indicated, with training as required (specify): _____ _____ _____ ___**Home modifications** as indicated (specify): _____ _____ NOTES:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE member. **GOALS:** **No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).**	___**Ongoing SOURCE case management/support service plan** ___**Referral to support group** _____ ___**In-home respite** Extended Personal Support (EPS) schedule: _____ ___**Out-of-home respite** provider: _____ schedule/dates: _____ _____ ___**ADH** for respite purposes for informal caregiver NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
		MEASURES: 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met 4th review period (___/___/____): _ met _ not met ----------
GOALS: **GOALS:** **GOALS:**		1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met 4th review period (___/___/___): _ met _ not met