Monthly Monitoring

Member: _____ **Date:** _____

CM Agency: _____ **RID:** _____

OUTCOMES	**Service plan:_____ to _____**
CHRONIC HEALTH MANAGEMENT: Member is managing chronic health problems. Member has all needed medications and supplies. Taking all meds and keeping appointments. Member is informed of plan and understands pros and cons of not following. CM is providing oversight to service plan goals and is monitoring monthly. SN as authorized. **G0299/G0300: Correct code, frequency: *as authorized***	Met □ Unmet □ Partially met □ Changes/comments:
New Medication Orders:	Met □ Unmet □ Partially met □ Changes/comments:
Nutrition-Enteral Feedings:	Met □ Unmet □ Partially met □ Changes/comments:
DISEASE MANAGEMENT: **CM to add Disease Management outcomes from current goals to include wound care if members is receiving	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

PERSONAL CARE MANAGEMENT: Has assistance as needed. PCA is completing all tasks per service plan goals (if applicable). Bathroom safety equipment in place and used appropriately. Skin is intact. Neat, clean and well groomed. Has assistance when PCA is not in place. **PDN Nursing**_____ **PCA units for personal care**_____***as authorized*** **ASR units**_____ ***as authorized*** **Incontinence supplies**: *Type and Frequency (Monthly)*_____ _	Met □ Unmet □ Partially met □ Changes/comments:
HOUSEHOLD MANAGEMENT: Has assistance as needed. Member is managing household tasks. Home is as clean as member desires, pathways are clear, has clean clothes/linens, groceries and supplies. PCA is completing all tasks per service plan goals (if applicable). Bills are paid and utilities are on. Transportation needs are met. **PCA units**_____ ***as authorized*** **ASR units**_____ ***as authorized*** **HDM: List Provider and number of meals per week** _____	Met □ Unmet □ Partially met □ Changes/comments:
SAFETY/FALL MANAGEMENT: Member is safe at home. Able to verbalize emergency plans for weather, evacuation, location of telephone numbers for emergency contact and services. Verbalizes understanding of fall prevention plan. Uses assistive devices/equipment as instructed. Member verbalizes understanding of all prevention tips and is following recommendations to avoid falls. Able to exit home in an emergency and can call for help if needed. Verbalizes understanding of monthly education on abuse, neglect and exploitation. ****If member unable to call for help or evacuate the home without assistance, include how this need will be met.** **PERS: □ SYSTEM TESTED THIS MONTH: □**	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

PERSONAL GOAL: Meeting goal as evidenced by: ****Document personal goal.**	Met □ Unmet □ Partially met □ Changes/comments:
HIGH RISK MANAGEMENT: Member has supervision in place as needed. Following plan goals. Has medical oversight. No ER visits or hospitalization in last 30 days. Is able to call for help in case of emergency. ****If ER/Hospital include information below.** **ER Visit Location and date: _____** **Hospital Admission Location and date: _____** **Outpatient Visit: Location and date: _____**	Met □ Unmet □ Partially met □ Changes/comments:
MENTAL HEALTH: Member has counseling services available, if desired. Mood has improved. Appetite is adequate. Member is getting enough sleep. No thoughts of suicide. Less irritable. Less restless. Member knows when to seek emergency care for depression or other mental health issues. Taking mental health medications as prescribed.	Met □ Unmet □ Partially met □ Changes/comments:
SOCIALIZATION: Member reports feeling less alone. Member participates in _____ Member is making contact with _____ Involved in Activity:	Met □ Unmet □ Partially met □ Changes/comments:

CM Initials:

CAREGIVER BURDEN: More time to do things for self. Positive attitude and more energy. Less stress and a good appetite. Caregiver is seeing friends/family. Adequate supports in place. Continued desire and ability to continue in role.	Met □ Unmet □ Partially met □ Changes/comments:
SMOKING CESSATION: Member is giving accurate info about smoking history. Understands the health and safety risks of smoking, including disease and possible fire from displaced cigarettes. Will notify CM when ready to quit. Willing to accept responsibility for consequences of smoking. A cessation plan is available and encouraged.	Met □ Unmet □ Partially met □ Changes/comments:

***Include additional comments or updated goals in the section below.**

COMMENTS:

CASE MANAGER SIGNATURE: _____ Date: _____

Time In: _____ Time Out: _____