EXAMPLE FROM GUARDIAN ADHC – A PROGRAM OF CENTER FOR ELDERS INDEPENDENCE

THERAPEUTIC ACTIVITIES
Addresses participant needs/goals/desired outcomes identified in Box 12
#(s) 3, 5

1. Need / Problem: Sam is at risk for cognitive and functional decline related to Dx of Cerebral Palsy. Risk of isolation has increased during Public Health Emergency. Sam's sister stated that she wants him, " to keep busy and socialize" and "to keep moving, be active"

Treatment(s) / Intervention(s)	Frequency	Goal(s)
1 1. Staff will provide items of interest such as Word & Picture puzzles, coloring for adults, writing, painting and drawing supplies for cognitive engagement. 1.(b) staff will encourage Sam to participate in group activities such as community walk to music ensuring safety protocols are followed while engaging Sam in activities during center days.	1. 1-5x weekly	1. Sam will socially and cognitively engage in activities for enjoyment and satisfaction to maintain overall functional abilities during in-center attendance.

2. Need / Problem: Sam is at risk for cognitive and functional decline related to Dx of Cerebral Palsy. Risk of isolation has increased during Public Health Emergency.

Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. 1. Staff will provide items of interest in Activity Kit, such as Word & Picture puzzles, coloring for adults, writing, painting and drawing supplies for cognitive engagement at home. 1.(b) Staff will deliver Activity Kit to door-step.	1. 1x weekly	1. Sam will cognitively engage in Kit activities for enjoyment and satisfaction at home, to maintain overall functional abilities during Public Health Emergency.

SOCIAL SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12
#(s) 2

1. Need / Problem: Sam and his family need support in addressing his needs during the PHE.

Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. 1). SW will call weekly to provide support for the family. 2). SW will provide appropriate assistance and resources as needed	1. 1x/weekly	1. Sam and his family will receive the psychosocial support that they need during the PHE.

2. Need / Problem: Sam is at risk for social isolation and lack of stimulation. Sam's sister/ caregiver stated that she wants him to have social connections and a support system outside of the family.

Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. SW will assist Sam in transitioning to attending the center and will provide support as needed.	1. 1 - 5x weekly	1. Sam will be comfortable and feel supported at the center.

(13) CORE SERVICES

PROFESSIONAL NURSING SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12** **#(s) 1**		
1. Need / Problem: Risk for Covid-19		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Monitor for s/sx of Covid-19: Fever, chills, cough, shortness of breath, difficulty breathing, congestion, runny nose, fatigue, muscle aches, headache, sore throat, nausea, vomiting, diarrhea, loss of taste/smell	1. 1-5x/week while in the center	1. Minimized spread of Covid-19 infection for the next 6 months while at center.
2. Need / Problem: Risk for decreased cardiac output		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Monitor for s/sx of decreased cardiac output, such as ALOC, dizziness, SOB, weakness, cold clammy skin, poor cap refill, hypotension, tachycardia, weight gain, angina, edema, etc. Encourage to balance activity with rest. Encourage medication compliance and to drink adequate amount of fluids. Coordinate with MDT, PCP and/or CG as needed.	1. 1-5x/week while in the center	1. Sam will minimize complications from decreased cardiac output over the next 6 months.
3. Need / Problem: Risk for increased needs related to Covid-19 Pandemic		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Conduct wellness check at least once weekly. Coordinate with MDT, PCP and/or CG as needed. Provide remote services as needed.	1. 1x/week and PRN	1. Sam will remain stable while at home over the next 6 months.
4. Need / Problem: Risk for injury r/t Epilepsy, Cerebral Palsy, and agitation		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Monitor for ALOC, changes in behavior and mentation. Encourage medication compliance. Provide distraction as needed. Maintain safety, prevent falls, record duration and type of seizure report to PCP & CG Call 911 if needed for emergency treatment	1. 1-5x/week while in the center	1. Sam will remain safe and injury free for the next 6 months while at the center.
PERSONAL CARE SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12** **#(s) 1**		
1. Need / Problem: Risk for hygiene deficit r/t cerebral atrophy and cerebral palsy		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Monitor and assist with personal care and hygiene as needed. Provide cueing and assistance as needed Frequent reminders to use bathroom keeping skin to be clean and dry	1. 1-5x/week while in the center	1. Sam will remain clean and dry while maintaining independence

EXAMPLE FROM GUARDIAN ADHC – A PROGRAM OF CENTER FOR ELDERS INDEPENDENCE

REGISTERED DIETICIAN SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12** **#(s) 8**		
1. Need / Problem: Risk of variable intake related to cerebral palsy. Sam stated, "I don't want to eat too much. I just want to get full then stop".		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. monitor weight	1. monthly	1. No significant wt variance x 6 months.
2. Need / Problem: HTN		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Nutrition education for family via phone, mail, or in person.	1. as needed	1. Improved understanding of NAS diet.
3. Need / Problem: Risk of food insecurity related to the public health emergency.		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Home meal delivery as part of remote services.	1. weekly	1. Adequate access to food until congregate services resume or until meals are no longer wanted.

Additional RN goal for in-center services that is included on the flow sheet:

Need / Problem: Temperature Check		
Treatment(s) / Intervention(s)	Frequency	Goal(s)
1. Temperature check	1. Daily while in the center	1. <99F

BOX 15 Disclaimer:

CDA approval for Transition to Congregate Services was received on 4/13/21. Services in this review period will include a combination of in-center services and remote services. In-center services will increase based on person-centered care needs and spacing needed to maintain Covid-19 safety precautions. The goal is to safely transition to total approved days of in-center attendance within the next 6 months.

Anticipated Plan

In-center Services:

Start date at the center is scheduled for 5/6/21 for 1x weekly due to need for increased structure, cognitive stimulation and socialization, as well as providing respite to family. Covid assessment will be completed on day of attendance. Sam is fully vaccinated as of 4/1/21. In-center days to increase as spacing allows to 5x weekly.

TAS/Remote Services:

Door-step delivery of activity kits 1x weekly for cognitive stimulation.

Door-step delivery of 4 meals to be provided weekly to help maintain healthy weight.

RN wellness call 1x weekly for health management.

Social worker wellness call 1x weekly to provide support to the family and assist with transition to the center.

Needs will be assessed on an ongoing basis and remote services will decrease as in-center attendance increases.