

Journey Pathway™ - Care Plan

DEMO PATIENT #2 | Client ID 002 | Age 72 | WILSON/66736 | MEDICARE

Original Intake Narrative

72-year-old male with Parkinson's disease living alone. Recently stopped driving due to increasing mobility and safety concerns and currently uses a cane. Daughter lives approximately 45 minutes away and checks on him twice weekly but cannot provide daily assistance. Patient reports increasing difficulty with transportation, shopping, heavier household tasks, and managing appointments. He has increasing unsteadiness and a recent near-fall in the home. Bathroom does not have grab bars. Patient recently had an eye examination and needs new glasses but cannot afford his out-of-pocket cost. Patient wants to remain safely and independently in his home as long as possible.

Identified Needs	Open	Follow-Up Needed	Session Minutes
8	8	1	90

Current Care Plan

Transportation / General transportation barrier

Priority	Priority (w/in 72 hrs)	Status	IN PROGRESS
Initial need	he stopped driving and now has trouble getting to appointments/shopping	Current step	Step 2 of 4: Explore standard transportation options
Goal	Identify the transportation barrier and connect the client with the best available ride resource.	Follow-up	No

Housing / Home Repair/Accessibility

Priority	Priority (w/in 72 hrs)	Status	FOLLOW-UP NEEDED
Initial need	unsteady with cane, near-fall/fall concern, no grab bars, possible trip hazards	Current step	Step 2 of 7: Provide and assist with financial housing resources
Goal	Assess repair or accessibility needs and connect the client with appropriate housing modification resources.	Follow-up	Yes

Food / Needs meal delivery

Priority	Priority (w/in 72 hrs)	Status	IN PROGRESS
Initial need	he is skipping meals because shopping/preparation is getting hard	Current step	Step 1 of 6: Assess severity of food insecurity and immediate food need
Goal	Assess eligibility and connect the client with home-delivered or community meal services.	Follow-up	No

In-Home Support / Vision / Eyeglass Access Needed

Priority	Routine	Status	OPEN
Initial need	needs new glasses after an eye exam but cannot afford them	Current step	Step 1 of 4: Clarify the vision problem and how it affects daily function and safety. Determine whether the person needs routine glasses or replacement glasses, has a current prescription, is overdue for an eye exam, or has new or worsening symptoms that require clinical evaluation.
Goal	Resolve barriers to eye care, a current prescription, affordable glasses, and usable vision support.	Follow-up	No

In-Home Support / Needs help with ADL's

Priority	Routine	Status	OPEN
Initial need	needs help with things like shopping, heavier housekeeping, transportation, and keeping up with appointments	Current step	Step 1 of 5: Assess which ADLs or IADLs require help. Include bathing, dressing, toileting, transfers, eating and mobility, as well as meals, shopping, housekeeping, laundry, transportation, medication routines, finances, telephone use, and appointments. Determine the level, frequency, timing, and urgency of assistance and whether the person can remain safely alone.
Goal	Assess the person's ADL assistance needs, immediate safety, caregiver capacity, preferences, coverage and funding, then route to the appropriate caregiver, community, private-pay, home-health, existing-service, or ADRC/waiver pathway.	Follow-up	No

Long-Term Care Planning / Wants to remain at home

Priority	Routine	Status	OPEN
Initial need	his stated goal is to stay independent at home	Current step	Step 1 of 11: Assess client's goals for remaining at home
Goal	Assess safety and supports and develop an individualized plan for remaining safely at home.	Follow-up	No

In-Home Support / Frail elderly waiver needs

Priority	Routine	Status	OPEN
Initial need	because he is over 65 with Parkinson's and emerging functional needs; screen, don't assume eligibility.	Current step	Step 1 of 6: Explain the FE waiver path and current waitlist: ADRC intake → Maximus level-of-care assessment → Medicaid financial eligibility → waitlist/waiver enrollment → KanCare/AAA service planning → provider start. Clarify that these are separate decisions and the CHW tracks each stage, required documents, contacts, and follow-up dates.
Goal	Use the Frail Elderly waiver pathway, including ADRC intake, assessment, Medicaid review, and provider follow-up.	Follow-up	No

In-Home Support / Caregiver unable to meet needs

Priority	Routine	Status	OPEN
Initial need	daughter helps twice weekly but cannot provide daily care	Current step	Step 1 of 10: Assess caregiver capacity by reviewing the care tasks required, the caregiver's physical ability, time, knowledge, stress level, and backup support. Ask the caregiver to explain or demonstrate key tasks when appropriate, identify any missed or unsafe care, and determine whether the current arrangement can continue safely.
Goal	Assess caregiver limitations and safety, connect additional supports, and escalate when care cannot safely continue.	Follow-up	No