ASSURING QUALITY CARE MANAGEMENT
UNDER LONG-TERM CARE INSURANCE

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December 30, 2000

This report was made possible through the generous support of the Retirement Research Foundation, the Kleiner Family Foundation, the California Department of Health Services, and the AARP Andrus Foundation.
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EXECUTIVE SUMMARY

This project examined the adequacy of current care management policies and procedures provided under long-term care insurance (LTCI or LTC insurance). In particular, this project: (1) investigated the experiences of long-term care insurance policyholders in light of existing regulations and standard practices in long-term care management; (2) developed recommended protocols and processes for assuring the quality of services provided under long-term care insurance; and (3) formulated policy recommendations for insurance carriers, case management organizations, regulatory agencies, and consumer groups in order to facilitate implementation of these quality assurance procedures. The project involved a collaboration of the University of California at Berkeley’s Center for the Advanced Study of Aging Services, the California Department of Health Services, and participating insurance carriers and care management provider agencies.

The research sample consisted of 35 California residents, ages 54 to 86, who had purchased long-term care insurance through the California Partnership for Long Term Care (CPLTC, the California Partnership, or the Partnership), a public-private partnership between long-term care insurance carriers and Medi-Cal (California’s Medicaid program), and who attempted to activate their benefits between August 1, 1998, and June 30, 1999. These 35 policyholders were followed for six months from the date of their initial eligibility assessment, including detailed reviews of individual eligibility assessments, care plans, progress notes, and insurance claims, in light of the CPLTC 1993 care management regulations that applied to their LTCI policies and using quality indicators based on established practice standards.

Nineteen of the 35 policyholders also received two in-person interviews and four telephone interviews over a six-month period. These interviews assessed their positive
and negative experiences with long-term care insurance, including their satisfaction with care management services, changes in their condition and corresponding changes to their care plans, and the adequacy of care plan implementation and monitoring. Information about the care management services offered under LTCI was also gathered from family members, care managers, care management provider agency (CMPA) personnel, and insurance company representatives.

**Claims Process**

Policyholders generally reported being satisfied with the process of filing a claim. In a number of cases, caregivers apparently provided care without assistance until they felt overwhelmed or became physically ill, or until policyholders fell and fractured a bone, leading to residential care. Earlier intervention might have relieved some of the burden on caregivers, perhaps reducing the likelihood that they would have become overwhelmed or ill, or that policyholders would have required placement in institutions.

**Eligibility Determination**

CPLTC regulations require policyholders to meet certain functional, cognitive, or medical requirements to qualify for benefits under their insurance policies. Assessment information and other available documentation supported insurer eligibility determinations in 32 out of the 35 cases reviewed. No one appeared to have been denied benefits inappropriately, although three policyholders considered eligible by insurers did not appear to meet exact CPLTC criteria. Eligibility assessment protocols had a number of inconsistencies that may reduce the accuracy of eligibility determinations.
Assessment of Client Needs

CPLTC regulations specify that care management should take “an all-inclusive look at a person’s total needs and resources.” A review of case records found that the assessment instruments used to make comprehensive assessments are not adequate to the task. Deficits were identified in the areas of emotional and psychological well-being, nutrition, tobacco and alcohol use, environmental safety, emergency response systems, social activity, culture and ethnicity, rehabilitation potential, and need for care management.

Care Plans

Care plans, which determine which services are reimbursable and eligible for asset protection, included all assessed home-care needs, but only 27 percent of day-care needs, 24 percent of transportation needs, 20 percent of caregiver education needs, 12 percent of mental health needs, and 11 percent of caregiver support needs. Most care plans included problem and goal statements, but lacked sufficient specificity. Services, providers, and sources of payment were indicated for most formal services, but cost, frequency, and potential informal supports were often omitted.

Policyholders and their families generally reported being involved in care plan development, although many policyholders expected or wanted services that were not included in the final care plan. Potential conflicts of interest were present in a number of cases that might have contributed to unmet policyholder needs.

Care Plan Implementation

Interviews with policyholders found that many care plans were not implemented fully. Possible reasons included lack of information about available services, confusion about
coverage, unaddressed familial or cultural factors affecting use of formal service providers, undocumented changes in policyholders’ needs or conditions, and confusion about what to expect from care managers. CPLTC regulations presume a discussion between policyholders and care managers concerning the need and desire for service coordination and monitoring; however, there was little evidence that such discussions occurred.

**Monitoring**

A review of case records and policyholder reports indicated that care managers had limited contact with policyholders, often consisting of one in-person visit to assess eligibility and develop a care plan, followed by periodic telephone calls (frequently from a care manager other than the one who developed the initial care plan). These contacts did not always appear sufficient to identify and respond to policyholder needs and service problems, as our review identified a number of unmet needs that were not documented in care manager progress notes. Moreover, progress notes seldom included evaluations of the effectiveness of recommended interventions or assessments of client progress toward meeting the goals identified in care plans.

**Quality Assurance Procedures**

Quality assurance policies and procedures established under Partnership regulations were generally found to be useful for consumer protection, although research identified a number of gaps in implementation. Policyholders were generally satisfied with the services they received, both from care managers and from direct service providers. Policyholders’ basic service needs appeared to be met in most cases, although two-thirds of policyholders had at least some unmet needs.
Our research revealed a number of factors that may constrain the ability of CMPAs to assure the quality of care management services, including the following:

- In some cases, insurers or third-party administrators (TPAs) apparently assume responsibility for approving care plans and monitoring care, raising the possibility of a conflict of interest.

- CMPAs apparently are unlikely to identify the existence of unmet policyholder needs in published reports, possibly reflecting inadequate systems for documenting and responding to unmet needs.

- While generally highly qualified, care managers apparently receive little training or supervision specifically regarding LTCI, and consultation with specialists from other disciplines is not always available.

This project resulted in a number of specific products that may be useful for enhancing the quality of care management under long-term care insurance: (1) a standardized eligibility assessment tool, reflecting CPLTC and Kassebaum-Kennedy tax-exempt criteria, (2) protocols and procedures for developing care plans, (3) protocols and procedures for implementing care plans and monitoring care, (4) recommended quality assurance processes for care management under long-term care insurance, and (5) recommended actions that could be taken by insurers, care management organizations, regulatory bodies, and consumer groups. In so doing, this project contributes to the development and implementation of policies and procedures that can improve the quality and consistency of care management services provided under long-term care insurance.
STATEMENT OF THE PROBLEM

Long-term care insurance (LTCI or LTC insurance) has emerged in recent years as a significant component of efforts to meet the needs of older adults with chronic health conditions. Policy improvements and tax-qualified status have made private long-term care insurance an increasingly attractive means for older persons to protect themselves from the risk of catastrophic long-term care expenses. Yet relatively little attention has been given to how long-term care insurance benefits are actually used. It has not been known, for example, how well the services provided under long-term care insurance actually meet policyholders’ long-term care needs, or the role of care management services in helping to assure that policyholders’ needs are met and their rights protected. Policymakers, insurance carriers, care management agencies, service providers, and consumers all share a common interest in the development and maintenance of high quality care management and quality assurance programs to assure that client needs are met in an equitable, effective, and efficient manner.

This research project examined provisions for protecting the rights and meeting the needs of elderly consumers who purchase long-term care insurance through the California Partnership for Long Term Care (CPLTC, the California Partnership, or the Partnership), a public-private partnership between long-term care insurance carriers and Medi-Cal (California’s Medicaid program). CPLTC is one of four such partnerships supported by the Robert Wood Johnson Foundation in an effort to make LTC insurance more available to middle-income persons, improve the quality of available LTC insurance products, and increase consumer protection.
These Partnerships for Long Term Care involve:

- model long-term care insurance policies designed to meet established standards of quality and coverage;
- mechanisms for consumer protection and quality assurance;
- asset protection coupled with eligibility for state Medi-Cal programs upon exhaustion of long-term care insurance benefits; and
- extensive consumer education about the risks of needing long-term care, ways to finance care, and the role of LTC insurance.

This project focused on

- investigating the experiences of long-term care insurance policyholders in light of existing regulations and standard practices in long-term care case management;
- developing protocols and processes for assessing consumer satisfaction with services provided under long-term care insurance; and
- formulating policy recommendations regarding the development of quality assurance procedures.

The project involved a collaboration of the California Department of Health Services, participating insurance carriers, care management provider agencies, and the University of California at Berkeley’s Center for the Advanced Study of Aging Services.
Eligibility for services under long-term care insurance policies and most other public and private long-term care programs is triggered by the determination that a policyholder has sustained sufficient physical or cognitive impairment to require long-term care services. Consistency in the determination of eligibility is essential, therefore, to assure equitable access to benefits. Moreover, eligibility determination directly affects the liability experienced by insurance companies, as well as the state’s eventual financial obligations under the asset protection feature of California Partnership for Long Term Care (CPLTC, the California Partnership, or the Partnership) policies. Benefit eligibility also determines whether long-term care insurance policies qualify for federal tax deduction status under the 1996 Health Insurance Portablility and Accountability Act (HIPAA), also known as the Kassebaum-Kennedy Act and HR 3103.

In this chapter we summarize the experiences of California Partnership policyholders with the process of eligibility assessment and determination, based on a careful review of 35 case records and interviews with 19 policyholders. Particular attention is given to how eligibility criteria are operationalized and their implications for implementation under (1) CPLTC and (2) insurance policies that meet the tax-qualified (TQ) requirements under HIPAA. We offer recommendations for actions that can be taken by insurers, care management organizations, and state regulators to help assure quality in the benefit eligibility assessment process. We also provide examples of standardized eligibility assessment instruments illustrating our recommendations. This chapter is organized around the three main components of the eligibility process: the claims procedure, eligibility determination, and reassessment.
Claims Procedure

Decision to File a Claim for Long-Term Care Insurance Benefits

Policyholders or their spokespersons were asked to describe how they decided to file a claim to activate their long-term care insurance (LTCI) benefits. Of the 19 policyholders interviewed, 7 filed a claim following an acute event that necessitated home care or upon discharge from a rehabilitation facility or acute care hospital. The other 12 had been receiving care at home for some time prior to filing a claim. In five of these 12 cases, a claim was filed when the policyholder entered a nursing home or residential care facility; in three cases, caregivers became so overwhelmed by increasing care responsibilities that they sought assistance; in two cases, caregivers were no longer available to provide care, either because of their own health problems or because they had exhausted their leave time from work; and in two cases, no clear reason for filing a claim was given. In one of these cases, a hospital discharge planner gave the policyholder the incorrect information that his LTCI policy would not cover home care, causing the policyholder’s spouse to provide care for 3 months before making a claim.

Time Between Initial Disability and LTCI Claim

Case records were examined to determine the approximate date on which policyholders first became disabled in relation to the time a long-term care insurance claim was filed. Sufficient data to estimate the approximate onset of the disabling condition were available for 32 out of 33 cases in which policyholders were approved for benefits. Time periods varied considerably for policyholders. Almost half of the policyholders (15 out of 32) filed a claim within 12 weeks (3 months) of their initial disability. Ten policyholders filed a claim between 13 and 52 weeks (3 months to 1 year) after they were
initially disabled, while 7 policyholders did not file a claim for benefits until after a year had passed since their initial apparent disability.

Six of the seven policyholders who filed a claim more than a year after the initial onset of a disabling condition had a progressive neurological disease, such as irreversible dementia or Parkinson’s disease. In four of these cases, the spouse who was caring for the policyholder decided to file a claim for benefits because s/he was feeling overwhelmed by the policyholder’s increasing care needs and wanted assistance. In the other two cases, policyholders with progressive neurological diseases fell and fractured a bone, leading to placement in a care facility because the caregiver did not feel able to provide the increased level of care required. The seventh case involved a policyholder with a spinal injury followed by a CVA, whose spouse was caring for him until her own health problems made it difficult for her to continue to provide care.

Satisfaction with the Application Process

Ten of the 19 policyholders interviewed initiated the claim process themselves by calling the insurance carrier directly, while one called his/her insurance broker. Calls were made to the insurance company by family members in five cases and by residential care facilities in two cases. The majority of policyholders indicated that they knew whom to contact from printed materials such as insurance paperwork or booklets, while a few relied on information from people they knew.

Policyholders or their spokespersons were asked to evaluate the process of filing a claim to activate their long-term care insurance benefits. Of the 19 policyholders interviewed, only 3 reported experiencing any problems with the application process. One policyholder indicated s/he had to wait a month from the first call until the start of
coverage; another policyholder had to wait while the company gathered information from the SNF; a third policyholder complained about receiving misinformation from a hospital discharge planner. The average amount of time from assessment until notification of the eligibility decision was 20.5 days, ranging from a minimum of 6 days to a maximum of 60 days.

Seven of the policyholders offered recommendations for improving the claims process. One was that the claims process be made clearer:

“I could have used someone from [the insurance carrier] to talk/walk [me] through the process, but this is a minor complaint.”

“I was unsure . . . if the claim had been approved. There is some ambiguity about actual approval.”

Another recommendation was to reduce or speed up the processing of paperwork:

“Seemed like a lot of red tape. I feel overwhelmed—eliminate paperwork to make the process easier.”

“Use a fax machine to speed up the process of getting paperwork submitted. The transition from filing claims to the time of coverage should be faster, so that help in the home can begin ASAP.”

“There should be simpler forms . . .”

“Send fewer papers . . . I had six shopping bags of papers when all of this was done.”

**Summary Regarding Claims Procedures**

In general, policyholders reported being satisfied with the process of filing a claim, although some policyholders would have benefited from additional assistance with the claims process or information about what to expect.

In a number of cases, caregivers apparently provided care without assistance until they felt overwhelmed or became physically ill, or until the policyholder fell and fractured a bone, leading to residential care. Earlier intervention might have relieved
some of the burden on the caregivers, perhaps reducing the likelihood that they would have become overwhelmed or ill, or that policyholders would have required placement.

**Recommendations Regarding Claims Procedures**

We recommend that policyholders be informed of the importance of contacting their insurance carrier or agent as soon as they become disabled, so that preventive services may be offered that might alleviate subsequent problems for policyholders and their caregivers. Examples of such preventive services include caregiver training, support groups, respite care, and a small amount of home care to reduce the burden and isolation caregivers often experience. Such services may be especially important when policyholders experience irreversible dementia or other progressive neurological diseases.

Some policyholders delayed making a claim to preserve their benefits. In doing so, they did not avail themselves of the assessment and care planning services available through their long-term care insurance policies, which would not have diminished their benefit amount. Moreover, given the unique feature of Partnership policies that allows policyholders to shelter assets and still qualify for Medi-Cal, there seems little reason for most policyholders to be concerned about exhausting their benefits prematurely.

**Eligibility Determination**

CPLTC regulations require enrollees to meet certain functional, cognitive, or medical requirements to qualify for benefits under their insurance policies.

The 1993 CPLTC eligibility criteria pertain to the policyholders in this study, while more recent policies are governed by 1999 CPLTC criteria. Face-to-face, in-person
eligibility assessments based on these criteria are administered by representatives of the three care management provider agencies (CMPAs) that contract with participating long-term care insurance carriers to perform eligibility assessments and care planning services. Assessment information is forwarded to the insurers, who make the final eligibility decisions.

**CPLTC 1993, § 58019.** “Insured Event” means that insured is eligible to receive insurance benefits and to have these benefits qualify for a Medi-Cal Property Exemption if any one (1) of the following criteria is met:

(a) The insured has at least two Deficiencies in Activities of Daily Living (ADLs) (to qualify for home and community-based services including but not limited to Home Health Care, Adult Day Health/Social Care, Personal Care Services, Homemaker Services Incidental to Personal Care Service, Respite Care and Residential Care Facility) or three Deficiencies in Activities of Daily Living (ADLs) (to qualify for nursing facility care); or

(b) The insured has a Cognitive Impairment; or

(c) The insured has a Complex, Yet Stable Medical Condition.

**CPLTC 1999, § 58003(b).** The insured will be considered a Chronically Ill Individual when one of the following criteria are met:

1. The insured is unable to perform, without Standby Assistance or Hands-On Assistance from another individual, [2 Activities of Daily Living] due to a loss of functional capacity and the loss of functional capacity is expected to last at least 90 days; OR

2. The insured has a Severe Cognitive Impairment requiring Substantial Supervision to protect the insured from threats to health and safety.

**Analysis of Case Records**

According to individual-level benefits eligibility information reported to CPLTC by insurance carriers, 33 of the 35 policyholders in our sample were reported as having experienced an “insured event,” while 2 policyholders were reported as not experiencing an insured event. We reviewed the benefit eligibility assessment completed by the care manager, as well as other available documentation about each policyholder’s level of functional and cognitive impairment and need for nursing care. Of the 33 policyholders reported as having experienced an insured event, our review of available documentation
found that 30 appeared to meet one or more of the CPLTC benefit eligibility criteria, while 3 did not appear to meet any of the CPLTC criteria (Table 1). Of the three policyholders who did not appear to meet CPLTC criteria, one (#03) was reported by the insurer to have met eligibility criteria for functional impairment, cognitive impairment, and a complex, yet stable medical condition; one (#29) was reported to have met eligibility criteria for functional impairment only; and one (#47) was reported to have met eligibility criteria for cognitive impairment only. Neither of the two policyholders reported by insurers as having failed to experience an insured event was found to have met any of the CPLTC eligibility criteria. No one found to meet CPLTC criteria was denied benefit eligibility.

Table 1. Insured Event Reporting

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<th>Insured Event</th>
<th>Reported as Having Insured Event</th>
<th>Reported as Not Having Insured Event</th>
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<tbody>
<tr>
<td>Met at least one criterion</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Did not meet at least one criterion</td>
<td>3</td>
<td>2</td>
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Policyholder Interviews

Policyholders were asked whether they knew the purpose of the assessment visit. Fourteen of the 19 policyholders interviewed understood that the assessment was needed to determine whether or not they were qualified for benefits, while 5 provided a different response. Interestingly, only 6 of the 19 understood that the assessment was also for the purpose of monitoring the level of their illness or care needs.

Policyholders were asked whether they knew what criteria their insurance company used to decide whether or not they were eligible to use their long-term care insurance benefits. Only 5 of the 19 persons interviewed knew that eligibility decisions
were based on the policyholder’s need for assistance with ADLs and on the level of cognitive impairment.

Policyholders or their representatives were asked whether there was anything that might have prevented the assessor from getting an accurate picture of the policyholder’s level of functioning. Six of the 19 respondents identified factors that might have led to an inaccurate assessment. Three respondents cited fluctuations in the policyholder’s capacity for self-care; two cited the failure of the assessor to observe directly the policyholder’s actual functioning; one cited the assessor’s apparent impatience.

Seven of the 19 policyholders interviewed offered recommendations about possible changes in the assessment process. Suggestions included providing the assessor with the policyholder’s medical information ahead of time, so that s/he would better understand the policyholder’s condition; having the assessor do a better job of introducing and explaining the assessment process; repeating the assessment at a different time or on a different day; and observing the policyholder doing ADLs rather than relying only on a self-report.

**HIPAA**

Under the 1996 Health Insurance Portability Assurance Act, long-term care insurance policies that qualify for tax deductibility must also meet certain requirements regarding the assessment for benefit eligibility. Under HIPAA, a “qualified long-term care insurance contract” must only cover “qualified long-term care services,” defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services. Qualified long-term care services must be required by a “chronically ill individual” and provided pursuant to a
plan of care prescribed by a licensed health care practitioner. A chronically ill individual is defined by functional and cognitive impairment criteria. These criteria are outlined in the law and are clarified in an interim IRS release (IRS, 1997).

Twenty-nine of the 30 policyholders in our sample who appeared to meet one or more of the CPLTC benefit eligibility criteria would also have qualified under HIPAA functional impairment criteria. One policyholder (#14) met CPLTC eligibility criteria for an insured event based solely on the presence of a complex, yet stable medical condition, which is not defined as an insured event under HIPAA criteria.

**Functional Impairment**

*CPLTC 1993, § 58013.* “Deficiency in Activity of Daily Living” means that the insured cannot perform one or more of the following six (6) Activities of Daily Living without substantial human physical assistance and/or constant supervision:

(a) Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.

(b) Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints;

(c) Toileting, meaning getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal;

(d) Transferring, meaning moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to promote circulation and prevent skin breakdown;

(e) Continence, meaning the ability to control bowel and bladder as well as use ostomy and/or catheter receptacles, and apply diapers and disposable barrier pads; and

(f) Eating, meaning reaching for, picking up, grasping a utensil and cup; getting food on a utensil, bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

*CPLTC 1999, § 58000.* “Activities of Daily Living” means the verbatim definitions of California Insurance Code Sections 10232.8(f) [tax qualified] and 10232.8(g) [not tax qualified] which must be used verbatim in Partnership Policies.
CIC § 10232.8(f). The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

1. Eating, which shall mean feeding oneself by getting food in the body from receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

2. Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

3. Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

4. Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

5. Toileting, which shall mean getting to and from the toilet, and performing associated personal hygiene.

6. Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

CIC § 10232.8(g). (g) The definitions of "activities of daily living" to be used in policies and certificates that are not intended to qualify for favorable tax treatment under Public law 104–191 shall be the following:

1. Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

2. Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

3. Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

4. Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

5. Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

6. Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

7. Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.
Analysis of Case Records

Reports to CPLTC by insurance carriers indicated that 29 of the 35 policyholders in our sample reportedly experienced deficiencies in activities of daily living (ADLs) sufficient to qualify as an insured event, while 6 policyholders did not experience such deficiencies in ADLs. Our review of benefit eligibility assessments (BEAs) found that 27 policyholders appeared to meet the CPLTC functional impairment criteria. Two policyholders, reported by insurers as having deficiencies in ADLs sufficient to qualify as an insured event, were not found to completely meet CPLTC functional impairment criteria. Of the six policyholders reported by insurers as not having deficiencies in ADLs sufficient to qualify as an insured event, none were found to meet CPLTC functional impairment criteria (Table 2).

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<tr>
<th>Functional Impairment</th>
<th>Reported as Having ADL Deficiency</th>
<th>Reported as Not Having ADL Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met criteria</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Did not meet criteria</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

The records of the two policyholders reported by insurers as having deficiencies in ADLs but not found to meet CPLTC functional impairment criteria were examined carefully to identify the source of the discrepancy. One of these policyholders (#03) was reported by the insurer as having deficiencies in the areas of dressing, bathing, toileting, and incontinence. BEA records indicated that this policyholder “can dress him/herself and is independent in mobility,” but “needs cuing” at times. With regard to incontinence, the policyholder was “unable to control bowel and/or bladder function but does not require supervision or assistance.” The other policyholder (#29) was reported to have deficiencies in the areas of dressing and bathing. BEA records indicated that this
policyholder was “able to complete the entire process of dressing and undressing without assistance but with difficulty,” taking her 30 to 45 minutes to complete the dressing process; s/he required hands-on assistance with bathing.

**Findings Regarding Benefit Eligibility Assessments**

The benefit eligibility assessment instruments found in the case records vary somewhat with regard to how each ADL is defined, and these definitions seldom match those specified in CPLTC regulations.

The BEAs appear to differ for some ADLs. For example, for dressing, one BEA states that the ability to dress and undress oneself “DOES NOT INCLUDE support hose, socks or tie/buckle shoes” (capitalization in the original), whereas the other two BEAs appear to include fastening shoes. With regard to bathing, one BEA states that “BATHING DOES NOT INCLUDE WASHING BACK OR HAIR” (capitalization in the original), whereas one BEA specifically includes “washing body/hair” and another BEA refers to “washing all parts of the body.”

There appears to be some question with regard to the conditions under which the following constitute an inability to perform an ADL “without substantial human physical assistance and/or constant supervision”:

- The inability to perform a task in a reasonable amount of time (e.g., requiring 30 minutes to get dressed because of arthritis)
- The occasional inability to perform an ADL (e.g., as a result of fluctuating health conditions or periodic treatments such as chemotherapy). In this regard, one BEA explicitly defines “substantial assistance” as “hands-on assistance at least 50 percent of the time”
The need for “standby assistance/oversight supervision” but not on a continual basis

The need for “occasional reminding or intermittent assistance with some parts of the activity (zippers, tying shoes, etc.)”

The need for periodic cuing or reminders

The inability to perform an ADL because of psychological rather than physical reasons (e.g., the need for assistance with transferring or bathing because of a fear of falling)

Major disabilities to which an individual has accommodated to reduce or eliminate the need for human physical assistance or supervision (e.g., a blind person who arranges her/his living environment to remove the need for human assistance; a paraplegic person who utilizes mechanical aids to transfer or bathe).

One BEA asked assessors to observe the direct performance of ADLs, while the other two BEAs provided room for noting “clinical observations.” Our review of case records found evidence of direct observation of one or more ADLs in 12 of the 35 cases; in 21 cases, there was no specific documentation indicating whether or not ADLs had been observed; and in 2 cases, documentation appeared to indicate the absence of any direct observation of ADL performance.

Information on ADL functioning was obtained from caregivers for each of the nine policyholders who were cognitively impaired. ADL assessment was also based on information from caregivers rather than policyholders for 7 of the remaining 26 cases, even though those policyholders were not cognitively impaired.
**HIPAA**

Under HIPAA, “qualified” long-term care services must be needed by a “chronically ill individual.” The functional impairment requirement of the definition of chronically ill requires an individual to be certified by a licensed health care practitioner as “being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity”; or having a similar level of disability (HIPAA, § 321c2A). Substantial assistance is defined as “hands-on assistance” or “standby assistance.” Standby assistance involves the presence of another person within arm’s reach that is necessary to prevent, by physical intervention, injury to the individual while performing the ADL (IRS, 1997).

All of the 27 policyholders in our sample who experienced deficiencies in activities of daily living sufficient to qualify as an insured event under the CPLTC functional impairment criteria would also have qualified under the HIPAA functional impairment criteria.

**Comparison of CPLTC and HIPAA Criteria**

The CPLTC and HIPAA functional impairment eligibility criteria are quite similar:

- The *level* of assistance with ADLs required by the two criteria are operationally the same; hands-on assistance or constant supervision or standby help is required under both programs.

- The HIPAA criteria are less stringent than the CPLTC criteria in the *number* of required ADL impairments, requiring only *two* ADL impairments for all types of long-term care.
The HIPAA criteria are somewhat less inclusive than the CPLTC criteria in the scope of activities required to perform each ADL. For example, whereas criteria for tax-qualifying policies (TQ) for eating allow use of a tube or IV to get food into one’s body, criteria for non-tax-qualifying policies (NTQ) require that an individual be able to eat independently, including cleaning one’s face and hands as necessary following a meal.

The HIPAA criteria require that the client have the ADL impairment for at least 90 days, while the CPLTC criteria do not specifically establish a time period. However, because CPLTC clients do not actually receive benefits until a 90-day elimination period has passed, the HIPAA 90-day rule is met under CPLTC policies. (Note that HIPAA tax-qualified policies are not required to have an elimination period, as under the CPLTC.)

HIPAA criteria require that a qualified long-term care insurance contract take into account at least five out of six of the ADLs, while CPLTC requires assessing impairment in six ADLs.

**Recommendations Regarding Functional Impairment**

Slight differences between NTQ and TQ functional impairment eligibility criteria suggest that different assessment instruments may be required for pre-1997 and post-1996 policies. We recommend using a revised version of the Katz index of dependency in ADLs, with some additions, to assess ADL impairment under both CPLTC and HIPAA criteria, as displayed in the Standardized Eligibility Assessment Tool in Appendix B.

Developed in 1963, the Katz scale is a widely used and validated instrument to measure basic functioning. The scale establishes three categories for each ADL—
independence, assistance, and dependence—by asking about the help received for specific tasks and components of an ADL. While the Katz scale does not specifically ask about “substantial assistance” or “constant supervision,” as worded in the CPLTC and HIPAA regulations, any ruling of “dependent” or “assistance” from the Katz scale usually meets these requirements. We recommend asking additional information about the need for “substantial human assistance and/or constant supervision” if a client reports needing assistance or dependence with an ADL. Also, to meet the HIPAA criteria, we recommend determining how long a client has had his/her current level of functional impairment, thus assessing whether the client has had the functional impairment for at least 90 days or if the impairment is expected to last at least 90 days.

The original Katz scale asks about “receiving” help in ADLs; however, the CPLTC and HIPAA regulations specify the inability to perform tasks without help. Both frames of reference have been widely used, with little evidence to suggest whether one is more useful than the other (Kovar & Lawton, 1994). Questions asking about the “need” for assistance attempt to account for contextual factors that might also contribute to a deficiency assessment. We recommend that whenever possible assessment instruments ask for comments/explanations and any contextual factors that might affect the need for “substantial” human help or constant supervision. For example, a patient in a nursing home may receive help in an activity, regardless of his/her ability to perform it independently (Kovar & Lawton, 1994).

When possible, assessments should include the direct observation of ADLs and the type of assistance needed to perform them. While specific performance tests of certain ADLs (e.g., toileting) may be unavailable, others can be easily observed (e.g., transferring or eating). Space should be provided in the assessment instrument for direct
The Eligibility Determination Process

observations. The literature suggests that the client’s self-report of functional limitations should be the primary data source for clients without cognitive impairment, as they have been found to be more accurate than family or physician reports (Elam, 1991; Kovar & Lawton, 1994). However, if the client shows signs of cognitive impairment or is unable to answer ADL questions, we recommend that the augmented Katz ADL questions be asked of caregivers to supplement self-report information and direct observations. For patients with moderate or severe dementia, patient self-reports provide important clinical data but should be supplemented with caregiver reports, as the capacity for self-observation of ADL dependence may only be partially preserved (Kiyak, Teri, & Borson, 1994).

Finally, we recommend that a “safe harbor” be established for insurers who wish to certify as eligible for benefits those individuals needing assistance equivalent to what is required by someone with two ADL impairments, but who do not explicitly meet existing CPLTC (or HIPAA) criteria. Examples are persons with multiple partial ADL deficits (requiring periodic hands-on assistance or supervision in a number of areas) or persons with one qualifying ADL deficit and multiple IADL deficits (e.g., taking medications, preparing meals, handling money).

Cognitive Impairment

**CPLTC 1993, § 58010.** “Cognitive Impairment” means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer’s disease, or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests or instruments prescribed or approved by the California Partnership for Long-Term Care.

**CPLTC 1993, § 58059.** The Mental Status Questionnaire (MSQ), and the Folstein Mini Mental State Examination will be used to assess Cognitive Impairment. Policy and Certificate holders will be deemed to have met the Cognitive Impairment criteria for the Insured Event by:
(1) Failing to answer correctly at least seven of the ten questions on the MSQ test; or,
(2) Exhibiting specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits, and failing to answer correctly at least four questions on the MSQ or achieving a score of 23 or lower on the Folstein Mini Mental State Examination.

**CPLTC 1999, § 58035.** “Severe Cognitive Impairment” means a loss or deterioration in intellectual capacity that:
(a) is comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia and;
(b) is measured by clinical evidence and standardized tests prescribed or approved by the California Partnership for Long-Term Care.

**Analysis of Case Records**

Reports to CPLTC by insurance carriers indicated that 12 of the 35 policyholders in our sample reportedly experienced cognitive impairment sufficient to qualify as an insured event, while 23 policyholders did not experience such cognitive impairment. Our review of benefit eligibility assessments found that nine policyholders appeared to meet the CPLTC cognitive impairment criteria. Three of the policyholders reported by insurers as having cognitive impairment sufficient to qualify as an insured event were not found to meet all of the CPLTC cognitive impairment criteria. Of the 23 policyholders reported by insurers as not having cognitive impairment sufficient to qualify as an insured event, none were found to meet CPLTC cognitive impairment criteria (Table 3).

**Table 3. Cognitive Impairment Reporting**

<table>
<thead>
<tr>
<th>Cognitive Impairment</th>
<th>Reported as Having Cognitive Impairment</th>
<th>Reported as Not Having Cognitive Impairment</th>
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<tr>
<td>Did not meet criteria</td>
<td>3</td>
<td>23</td>
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</table>
The records of the three policyholders reported by insurers as having cognitive impairment but not found to meet CPLTC cognitive impairment eligibility criteria were examined carefully to identify the source of the discrepancy. One of these policyholders (#03) was reported to have a score of 10 on the Short Portable Mental Status Questionnaire (SPMSQ) and a score of 28 on the Folstein Mini-Mental State Examination (MMSE), although copies of these tests could not be found in the case records provided to us. However, the policyholder apparently was sufficiently cognitively intact to sign a form indicating that s/he agreed to the service plan prepared by the care manager. The policyholder’s spouse indicated that the policyholder had a “tendency to wander,” although the interviewer indicated that “it was difficult to determine the extent of his/her deficit being related to cognitive impairment or difficulty [in] hearing.” A second policyholder (#33) had an SPMSQ score of 6 and an MMSE score of 19; however, there was no evidence of specific behavior problems requiring daily supervision. A third policyholder (#47) had an SPMSQ score of 7 and an MMSE score of 25. Although reported by the insurer as requiring daily supervision because of poor judgment, case records did not provide evidence of impaired judgment or other specific behavior problems. Problems in living independently were attributed to “drinking heavily and not eating well,” rather than to a deterioration or loss of intellectual capacity resulting from irreversible dementia.

**Findings Regarding Benefit Eligibility Assessment**

BEA instruments do not directly assess changes in cognitive functioning over time (e.g., “deterioration or loss of intellectual capacity”); nor can such changes be determined from scores on the SPMSQ or MMSE.
The MMSE and SPMSQ are administered to every policyholder. However, the MMSE does not appear to be required in cases in which scores on the SPMSQ are less than 4 or greater than 7. Nor does the MMSE appear to be required when policyholders do not exhibit specific behavior problems requiring daily supervision. Moreover, the initial 10 items on the MMSE are redundant with the SPMSQ. Copies of the SPMSQ and MMSE may be found in the Standardized Eligibility Assessment Tool in Appendix B.

All BEAs collect information about the presence of the specific behavioral problems indicated in the CPLTC regulations. But one of the BEAs does not appear to assess whether these behavior problems necessitate supervision.

Although two BEAs ask assessors to provide an explanation or description of any observations of behavior problems or the need for supervision, we could find no evidence of such observations. One BEA excludes observations from the list of desired information sources, instructing assessors to “obtain information . . . either from the patient’s professional caregiver, medical records/chart, or relative.”

Only one BEA instrument assesses whether “depression appear[s] to be the primary cause of any difficulty in functioning . . . exhibited by the client;” however, no guidelines are provided to assist the assessor in making this determination, which can be difficult even for experienced practitioners. One BEA instrument asks only whether the client “appears to be depressed, lonely, or isolated.” The other BEA instrument does not appear to gather any information that might be used to determine whether cognitive impairment is “related to, or a result of, mental illness.”

None of the BEA instruments addresses other possible reversible causes of dementia, such as polypharmacy, malnutrition, dehydration, thyroid dysfunction, or bacterial infection.
HIPAA

Under HIPAA, a person may be defined as “chronically ill” if s/he has been certified as “requiring substantial supervision to protect [the] individual from threats to health and safety due to severe cognitive impairment” (HIPAA, § 321c2Aiii). Severe cognitive impairment means “a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s (i) short-term or long-term memory, (ii) orientation as to people, places, or time, [or] (iii) deductive or abstract reasoning” (IRS, 1997). Substantial supervision means “continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her safety.” The regulations and interim guidance memo do not specify the clinical evidence or standardized tests that should be used to assess cognitive impairment. All of the nine policyholders in our sample who experienced cognitive impairment sufficient to qualify as an insured event under CPLTC criteria would also have qualified under HIPAA criteria.

Comparison of CPLTC and HIPAA Criteria

The HIPAA cognitive impairment criteria are more general than the CPLTC criteria. However, almost all of the HIPAA criteria can be met with the use of CPLTC instruments. Our review of current BEA instruments used to assess CPLTC eligibility found the following:

- One BEA assessed “threat to health or safety,” but not the need for continual supervision.
Two BEAs assessed the need for supervision, and whether there were “cognitive deficits that pose a threat to [the policyholder’s] ability to remain in the community.”

The HIPAA criteria do not require specific standardized instruments to measure cognitive impairment. The SPMSQ and the MMSE, required under CPLTC, could be used to meet the HIPAA requirement of the use of a reliable standardized test to measure short- and long-term memory and orientation, but only the longer MMSE somewhat meets the HIPAA requirement for assessment of deductive or abstract reasoning. In cases in which only the SPMSQ is used to determine severe cognitive impairment under CPLTC criteria, the HIPAA eligibility criteria will not explicitly be met.

While the CPLTC regulations specify the scores that qualify an individual as cognitively impaired, the HIPAA does not. However, the scores specified by the CPLTC are typically the cutoffs used to define “severe” impairment under these tests, and have been adopted as such for CPLTC TQ policies.

HIPAA criteria require “clinical evidence” of cognitive impairment, while CPLTC does not. However, if evidence from the standardized instruments is considered “clinical,” then the CPLTC assessment does meet this HIPAA criterion.

The HIPAA criteria do not specifically exclude cognitive impairment that may be a result of mental illness. However, they do require that impairment be an irreversible form of dementia. To the extent that cognitive impairment due to mental illness is reversible, then the CPLTC and HIPAA criteria are similar;
otherwise, the CPLTC criteria require a more detailed assessment of the *reasons* for the client’s cognitive impairment.

- Under the HIPAA criteria, cognitive impairment requires substantial supervision to protect the individual from threats to health and safety, whereas CPLTC criteria can be met based on the SPMSQ score alone. If behavioral disturbances are assessed under CPLTC, then they may meet the HIPAA criteria, as long as one treats the CPLTC requirement for “daily supervision” the same as the HIPAA requirement of “continual supervision.”

- It is not clear whether certain deficits, such as an inability to take medications or perform IADLs because of memory impairment, constitute a “need for continual supervision to protect the severely cognitively impaired individual from threats to his or her safety.”

**Recommendations Regarding Cognitive Impairment**

*Assessing cognitive impairments through standardized instruments*

We recommend using the original 10-item SPMSQ from Duke University (1978) and Folstein’s 11-item version of the MMSE for English-speaking clients (1975). The literature on both the SPMSQ and the MMSE indicate that these scales are widely used and reliable and valid (Albert, 1994). The CPLTC eligibility criteria can in some cases be met with the SPMSQ alone, but in other cases require administering both the SPMSQ and the MMSE, whereas the HIPAA criteria can be met by administering the MMSE alone. Therefore, we recommend that the SPMSQ be utilized as a screening tool in all pre-1997 policies, accompanied by the MMSE for all policyholders scoring less than 7 out of 10
Assuring Quality Care Management Under LTC Insurance

However, there are issues in using these short assessment instruments among different populations, such as those with a low level of education and non-English-speaking populations. For example, when using these scales, it should be recognized that scores vary by education (Pfeiffer, 1975; Murden et al., 1991; Albert, 1994). In the original SPMSQ (Pfeiffer, 1975), the scoring should allow one more error if the subject has had only a grade school education (8 years or less), and allow one less error if the subject has any education beyond high school (more than 12 years). The literature on the MMSE also suggests adjusting scores for education. A score of 23 or less to identify cognitive dysfunction is appropriate for groups with 9 or more years (junior high or more) of education, while a score of 17 or less is appropriate for those with less than 9 years of education. These cutoffs maximize sensitivity and specificity at 93 percent and 100 percent for the high education group, and 81 percent and 100 percent for the low education group, respectively (Murden et al., 1991). Therefore, we recommend that all eligibility assessment instruments collect information on the client’s educational background in order to allow for the adjustment of cognitive impairment screening scores.

Another issue concerning the use of these established scales is their validity and reliability among ethnic and minority groups. In addition to differences in education and literacy, differences in language and cohort experiences may influence the assessment process and outcome. While both the SPMSQ and MMSE have been translated into different languages, items such as (repeating) “no ifs, ands, or buts” probably cannot be properly translated from English into other languages (Tang, 1996). Nevertheless,
Spanish-language versions, the S-MMSE and the S-MSQ, have been found to be reliable in discriminating between Alzheimer’s and non-demented Spanish-speaking elderly populations (Taussig, Mack, & Henderson, 1996). For the purposes of CPLTC criteria, which require the use of these specific instruments, we recommend using the S-MMSE and S-MSQ with clients who prefer to speak Spanish. Research suggests that the scores from the S-MMSE, like the English version, should be adjusted for educational level (Taussig, Mack, & Henderson, 1995; Mungas, 1996). Mungas (1996) found that differences in MMSE scores among English-speaking Hispanics, English-speaking non-Hispanics, and Spanish-speaking Hispanics were no longer statistically significant after controlling for the effects of education and age. Spanish versions of the MSQ and the MMSE from Taussig, Mack, & Henderson (1996) are included in the Standardized Eligibility Assessment Tool (Appendix B).

For the purposes of assessing eligibility under HIPAA criteria, instruments other than the MMSE and SPMSQ may be used. The Cognitive Abilities Screening Instrument (CASI), for example, is a short assessment instrument available in English, Spanish, Chinese, and Japanese that assesses the domains required under HIPAA eligibility criteria (Tang, 1996). Among these populations, different versions of the CASI can be used for literate versus illiterate populations. Also, since most of the CASI items were taken or modified from the MMSE, the MMSE score that can be calculated from the English version CASI has been found to be very close to scores from an independently administered MMSE (Tang, 1996).

We recommend that a “safe harbor” be established for insurers who wish to utilize the CASI or a comparable standardized instrument for assessing cognitive functioning other than the MMSE or SPMSQ. We also recommend that a safe harbor be
established for insurers who wish to certify as eligible for benefits those individuals who have levels of cognitive impairment requiring assistance equivalent to what is required by someone who “fail[s] to answer correctly at least four questions on the MSQ or achiev[es] a score of 23 or lower on the Folstein Mini Mental State Examination” (e.g., individuals with intermittent cognitive impairment, or individuals with mild cognitive impairment that poses a threat to health or safety).

**Behavioral disturbances**

Many instruments are available to measure behavioral disturbance that have been tested to be both reliable and valid, as reviewed by Teri & Logsdon (1994). Many of the instruments are designed to assess patients who have already been diagnosed with Alzheimer’s disease or cognitive dysfunction.

We recommend using an aggregated version of the Behavioral Pathology in Alzheimer’s Disease (BEHAVE-AD) scale (Reisberg, 1987) to assess behavioral disturbances and threats to individual safety. The BEHAVE-AD scale, reviewed by Teri & Logsdon (1994), is administered to the caregiver by an interviewer. It has been found useful with both outpatients and nursing home residents and with patients with moderate to severe dementia. The original BEHAVE-AD includes 26 assessment measures covering characteristic behavioral symptoms that commonly occur in an Alzheimer’s patient. The symptoms assessed reflect behaviors that are frequently disturbing to caregivers and that are presently thought to be potentially remediable, but which are largely independent of the primary, currently unremediable, cognitive symptomology (Reisberg, 1987).
Questions about behavioral disturbances should be asked of the individual identified as the primary caregiver, rather than the client. However, the interviewer should also be instructed to note any potential behavioral problems that may be observed. An aggregation of the BEHAVE-AD could include a question for each of the seven subgroups identified in the BEHAVE-AD: paranoid and delusional ideation, hallucinations, activity disturbances, aggressiveness, diurnal rhythm disturbances, affective disturbances, anxieties, and phobias. While the original BEHAVE-AD scale asks only if the behaviors in the scale are present or not, to meet CPLTC and HIPAA criteria we recommend asking if supervision is required because of the reported behavior problems. The BEHAVE-AD includes no cutoff points for “scoring” behavioral difficulties; however, CPLTC and HIPAA criteria are met if the client exhibits any behavioral problems that require daily supervision. An example of a revised, aggregated BEHAVE-AD scale, for the purposes of CPLTC and HIPAA criteria, is included in the Standardized Eligibility Assessment Tool in Appendix B.

**Exclusion of reversible cognitive impairment**

CPLTC and HIPAA regulations require that cognitive impairment be “irreversible,” and CPLTC criteria also require that impairment not be due to mental illness. The short assessment instruments used to determine cognitive impairment are not designed to distinguish irreversible organic deterioration from mental illness or other reversible causes of the impairment. Nor is any “standardized” assessment instrument designed for these purposes.

Among the major causes of reversible dementia are polypharmacy, malnutrition, dehydration, thyroid dysfunction, bacterial infection, and depression. Potential
physiological causes can and should be ruled out through laboratory tests (e.g., T4) and a careful history.

Accurate assessment of irreversible dementia versus depression is often difficult in elderly subjects. However, Ware & Carper (1982) identify a number of criteria that can help to distinguish dementia from depression. For example, in the case of depression, patients and families are often aware of psychiatric dysfunction and can date its onset; but in dementia, patients and families are often unaware of the slow, insidious onset of cognitive dysfunction (Ware & Carper, 1982). Also, patients with dementia are more apt to attempt to answer questions, even if they don’t know the answers, while depressed patients will often answer “don’t know.”

Common manifestations of depression in the elderly include psychomotor retardation and impairment of attention, concentration, memory, and initiative. These manifestations are easily mistaken for Alzheimer’s disease, but in depressed patients are more amenable to therapeutic intervention (Ware & Carper, 1982). Moreover, dementia and depression often co-exist together (Pancha, Gallagher-Thompson, & Thompson, 1994; Teri & Logsdon, 1994); an estimated 20 to 30 percent of patients with dementia are also depressed, and 20 percent of patients with depression exhibit cognitive impairment.

In cases where reversible cognitive impairment may be present, we recommend that eligibility assessment include laboratory tests and a medical review to rule out possible physiological causes of reversible dementia. We also recommend that the eligibility assessment instrument include probes to attempt to detect the possibility of depression or other forms of mental illness. Answers to these questions cannot definitively determine that cognitive impairment is due to mental illness or that cognitive
impairment is reversible, but they can indicate the need for a more detailed, clinical assessment (e.g., by a physician or neuropsychologist). For example, the caregiver might be asked if the client has had a history of mental illness or depression, and could then be asked a number of questions about the history and characteristics of the client’s cognitive dysfunction that might distinguish between cognitive impairment due to dementia and due to depression. The Standardized Eligibility Assessment Tool (Appendix B) includes a suggested list of questions based on clinical features differentiating depression from Alzheimer’s disease identified by Ware & Carper (1982).

If the answers to these questions indicate that the patient’s dysfunction may be due to depression, if the client had many answers of “don’t know” in the SPMSQ or MMSE tests, or if the caregiver reports a history of depression or other mental illness, then we recommend administering the 15-item Geriatric Depression Scale (GDS). The GDS is a sensitive and widely accepted self-report scale for screening in a geriatric population (Pancha, Gallagher-Thompson, & Thompson, 1994). A score of 5 to 9 on this scale indicates mild depression, while a score of 10 to 15 indicates severe depression. If the answers on this scale indicate either mild or severe depression, a more thorough clinical assessment with a physician or neuro-psychologist should be conducted to rule out the possibility that the cognitive impairment is “related to, or a result of” depression. The GDS is included in the Standardized Eligibility Assessment Tool (Appendix B). Translations of the GDS into more than 16 languages are available on the Internet at http://wings.buffalo.edu/~drstall/>. 
Complex, Stable Medical Condition

*CPLTC 1993, § 58011.* “Complex, Yet Stable Medical Condition” means that [a] twenty-four (24) hour a day nursing observation, or professional nursing intervention more than once a day, in a setting other than the acute care unit of a hospital is medically necessary, that is, the observation or intervention has been prescribed by a physician and it is not designed primarily for the convenience of the insured or the insured’s family.

Note: CPLTC 1999 and HIPAA regulations do not include “complex, stable medical conditions” as an eligibility criterion.

Analysis of Case Records

Reports to CPLTC by insurance carriers indicated that 5 of the 35 policyholders in our sample reportedly experienced a complex, yet stable medical condition, while 30 policyholders did not. Our review of benefit eligibility assessments found that four of these five policyholders appeared to meet all CPLTC criteria for a complex, yet stable medical condition (Table 4). The one policyholder (#03) that did not appear to meet CPLTC criteria for having a complex, stable medical condition apparently required a home health aide rather than professional nursing observation or intervention. None of the 30 policyholders reported by insurers as not having a complex, yet stable medical condition appeared to meet CPLTC criteria for this condition. One policyholder (#14) met CPLTC eligibility criteria for an insured event based solely on the presence of a complex, stable medical condition; i.e., this policyholder did not also meet CPLTC functional or cognitive impairment criteria.

<table>
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<th>Complex, Stable Medical Condition Reporting</th>
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<tbody>
<tr>
<td>Met criteria</td>
</tr>
<tr>
<td>Did not meet criteria</td>
</tr>
</tbody>
</table>
Summary of Findings Regarding Medical Condition

Information about the need for professional nursing observation or intervention was frequently found in a physician’s order for home health care or skilled nursing care, rather than as a part of the standard BEA. In most cases, it could not be determined whether or not professional nursing care was required on a daily basis. None of the care plans specifically included professional nursing care as a needed service.

Only one BEA specifically indicated whether a policyholder required continual nursing observation or daily professional nursing intervention. Another BEA asked the assessor to indicate the presence of a “complex unstable condition,” but apparently did not provide guidance on how this was to be determined. At least 10 of the 35 benefit eligibility assessments reviewed did not address whether professional nursing observation or intervention was needed.

The professional nursing care needed included administering medications (e.g., insulin injections for diabetes, analgesics for pain control, IVs for cellulitis) and observation (e.g., monitoring of cellulitis, coordination of terminal care). In one case, a BEA indicated that “professional nursing intervention at least once a day” was needed, but in fact the assessor was referring only to the policyholder’s need for assistance with ADLs. None of the BEAs apparently assessed either the client’s or the family’s ability to provide care.

Recommendations Regarding Medical Condition

There are no established geriatric assessment instruments that assess the presence of a complex, yet stable medical condition. In gathering information on this eligibility criterion, questions should attempt to assess the need for nursing observation or profes-
sional nursing care without having to rely on “physician certification.” However, if the complex, stable medical condition eligibility criterion cannot be definitively assessed using the information collected, a physician will need to verify eligibility. Therefore, we recommend that the eligibility assessment interview should include the name and number of the treating physician(s).

We recommend including in the eligibility assessment instrument a set of questions asking if the client has specific medical conditions that may require professional nursing care. The assessment should ask about the date of onset, the nature of the condition, and if the nursing care has been prescribed by a physician. A second set of questions could ask about the receipt of specific skilled nursing tasks, such as IV treatments, infusion therapy, inhalation therapy, injections, and medication management. For each treatment that the client reports needing, the assessment could ask about the frequency and the provider of the care (professional or informal caregiver), and whether the treatment could conveniently be provided by the policyholder’s family. Examples of these questions are included in the Standardized Eligibility Assessment Tool (Appendix B).

Qualifications of Assessors

*CPLTC 1993, § 58007.* “Care Manager” means a person who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

*CPLTC 1993, § 58070.* Care Managers shall meet or exceed both of the following qualifications:

1. be a registered nurse and/or graduate of an accredited four year college or university with a degree in nursing, health, social work, gerontology or other related area: and
2. have a minimum of two years of experience in the human service field, ideally in community-based care. A master’s degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.
Analysis of Case Records

BEAs were examined to identify the name and professional qualifications of the person performing the assessment. In 25 of the 35 cases reviewed, assessments were performed by an RN, PHN, or BSN. In two cases, assessments were performed by a licensed social worker. In the other eight cases, assessments were conducted by either an LVN (two cases) or an unlicensed, baccalaureate social worker with at least 2 years of experience (six cases).

HIPAA

The HIPAA criteria for assessor qualifications are more restrictive than CPLTC criteria. HIPAA requires that policyholders be certified as “chronically ill” by a licensed health care practitioner, which includes physicians, registered professional nurses, and licensed social workers.

In 27 of the 35 cases reviewed, assessors met HIPAA criteria as licensed health care practitioners. In the eight cases in which the assessor did not meet HIPAA criteria, documentation indicated that the benefit eligibility decision was made by an RN or licensed social worker based on the assessment report.

In 12 of the 35 cases, a physician’s assessment was also present in the case record. In six of these cases, the physician’s assessment concurred with the finding of the care manager, whereas in six cases it did not. Case records did not show any documentation indicating any attempts to resolve these discrepancies. However, it is notable that the discrepancies were always resolved in favor of the care manager rather than the physician, even when the care manager did not meet HIPAA criteria as a licensed health care practitioner.


**Recommendations Regarding Assessors**

It is not clear from the HIPAA regulations whether “certification” requires actual assessment and face-to-face contact with a policyholder, or whether a physician, professional nurse, or licensed social worker can certify an individual as chronically ill based on an assessment performed by an unlicensed assessor. However, given the expertise necessary to gather accurate information for making a complicated assessment of policyholders’ functional and cognitive impairment, we recommend that only trained professionals perform eligibility assessments to best assure the accuracy and reliability of the assessments. Moreover, given the finding that even some licensed health professionals (e.g., physicians) appear to disagree about policyholders’ level of impairment and eligibility for benefit, we recommend that assessors receive training in performing accurate assessments of functional and cognitive impairment. We also recommend that each BEA include the name and credentials of the person performing the assessment.

Practice Standard 10 in Table 1 of Appendix D calls for assessments to be performed by trained professionals.

**Reassessment**

*CPLTC 1993, § 58004c, and CPLTC 1999, § 58005c.* “Care Management . . .” includes, but is not limited to the following:

(c) the performance of a comprehensive, individualized reassessment at least every six months.

**Analysis of Case Records**

During the 6-month period of data collection, 17 of the 33 policyholders received a reassessment. Of the 17 reassessments completed, 16 were scheduled 6-month follow-up reassessments completed within or at 6 months, and one
was completed before 6 months due to a change in the policyholder’s condition. Of the remaining 16 cases, 14 were closed before the scheduled reassessment, either because the policyholder died (4) or because benefits were terminated (10). Two policyholders were reassessed after 6 months because of extenuating circumstances—one policyholder was hospitalized and unavailable, and the other one was in the midst of appealing the denial of benefits.

**Policyholder Interviews**

At the time of their initial interview by a member of the research team, policyholders were asked whether they knew how soon the next assessment of their situation would be done, and under what circumstances. Seven of the 19 policyholders interviewed knew that the assessment would be done, but only five knew why it was to be done. The remaining policyholders did not know or confused the reassessment with coordination and monitoring done by the care advisor.

When interviewed at the end of our study period, 8 out of the 19 policyholders stated that their care managers/care advisors had visited them recently. Seven of these eight policyholders accurately understood the purpose of the reassessment visit. Of the eight policyholders reassessed recently, seven of them indicated that the care manager/care advisor had an accurate picture of their abilities and disabilities as a result of the reassessment interview. Two of these seven policyholders stated that the care manager was “very thorough.” One policyholder stated that the care manager did not ask about all ADLs, specifically toileting. One policyholder stated that the care manager did not seem to have an accurate picture, “She did not really go into it . . . a quickie visit that skimmed the surface.”
When asked whether there was anything that might have prevented the care manager/care advisor from getting an accurate picture of their abilities and disabilities, three of the eight policyholders stated that there were obstacles. They mentioned the care manager’s lack of time, the policyholder’s difficulty in accurately communicating his/her functioning level, and fluctuations in the policyholder’s condition. One daughter indicated that her mother, the policyholder, has “such highs and lows . . . Mother can be clear one day and not at all the next day . . . time of day makes a difference.”

Two of the eight policyholders who were reassessed had suggestions for changing the reassessment process. Their suggestions included carefully choosing care managers according to particular clients’ needs, for example using someone with “sensitivity” to handle policyholders with dementia, and having the same person conduct all assessments and reassessments for the same policyholder.

**Summary of Findings Regarding the Eligibility Determination Process**

In this chapter we examined the experiences of California Partnership policyholders with the process of eligibility assessment and determination, based on a careful review of 35 case records and interviews with 19 policyholders. We examined these experiences in light of eligibility criteria for long-term care benefits under the California Partnership for Long-Term Care and for “tax-qualified” status under the Health Insurance Portability and Accountability Act of 1996.

Policyholders generally reported being satisfied with the process of filing a claim. In a number of cases, caregivers apparently provided care without assistance until they felt overwhelmed or became physically ill, or until the policyholder fell and fractured a bone, leading to residential care. In each of these cases, it seems possible that earlier
intervention might have relieved some of the burden on the caregiver, perhaps reducing the likelihood that caregivers would become overwhelmed or ill, or that policyholders would require placement.

Our review of assessment information and other available documentation found support for insurer eligibility determinations in 32 out of 35 cases reviewed. Three policyholders deemed eligible by insurers did not appear to meet a strict interpretation of CPLTC criteria, although each of them displayed sufficient impairment to warrant receiving assistance. No one was found to have been denied benefits inappropriately.

A review of eligibility assessment protocols found a number of inconsistencies that could reduce the accuracy of eligibility determinations. For example, the Benefit Eligibility Assessment instruments currently in use differ somewhat with regard to how each ADL is defined and what is considered indicative of an ADL deficiency; moreover, they seldom include direct observation of ADL performance or of behavior problems necessitating supervision. Potentially reversible causes of dementia, such as depression, polypharmacy, and malnutrition, were seldom assessed. Finally, the need for professional nursing care, a CPLTC eligibility criterion, was seldom assessed.

In general, the CPLTC benefit eligibility criteria were found to be more stringent than the HIPAA criteria; that is, a client found eligible under a CPLTC policy for a functional or cognitive impairment would also meet HIPAA criteria, although slight differences between Tax-Qualified (TQ) and Non-Tax-Qualified (NTQ) policies regarding functional impairment eligibility criteria suggest that different assessment instruments may be required for post-1996 and pre-1997 policies.

Since the HIPAA eligibility criteria consider only functional and cognitive impairment, while the CPLTC includes an additional criterion of a complex, yet stable
medical condition, clients who qualify for CPLTC benefits under this last criterion may not meet HIPAA eligibility criteria. Our study found one policyholder who met this last eligibility criterion alone, and who therefore would have qualified for eligibility under CPLTC criteria but not under HIPAA criteria. It should be noted that policyholders who qualify for eligibility under CPLTC policies are considered to have met the “tax-qualified long-term care services” requirement under HIPAA.

Recommendations Regarding the Eligibility Determination Process

Based on our analysis of current eligibility determination procedures and a review of the geriatric assessment literature, we have identified the following recommendations for enhancing the eligibility determination process in accordance with CPLTC and HIPAA regulations:

- When assessing ADL functional impairment, include information on the degree of help needed (e.g., hands-on versus stand-by), as well as the expected duration of each ADL deficit.
- Directly observe ability to perform ADL tasks whenever possible.
- Supplement client self-reports of functional impairment with information from caregivers in cases in which clients show signs of cognitive impairment or confusion.
- Assess cognitive impairment utilizing standardized instruments with proven reliability and validity, such as the Folstein Mini-Mental State Examination (MMSE).
- Adjust cognitive impairment scores on the SPMSQ and MMSE for number of years of formal education, so as to remove bias related to educational background.
- Use linguistically and culturally appropriate cognitive assessment instruments. When English is not a client’s primary language, use translated versions of the SPMSQ and the MMSE or a cognitive assessment instrument designed specifically for cross-cultural use (such as described in Tang, 1996).
- Collect information from family members or other caregivers regarding client behavioral disturbances and safety threats when these behaviors are not directly observed. Assess the degree of supervision needed, if any.
- Collect information needed to distinguish between cognitive impairment due to irreversible dementia and cognitive impairment due to depression or other potentially reversible causes.
- Assess for the presence of a “complex, yet stable” medical condition, especially in those cases in which clients do not otherwise qualify for eligibility under functional or cognitive impairment criteria.
- Use trained professionals to conduct eligibility assessments in order to assure the integrity of the assessment and to meet HIPAA requirements.

In Table 1 of Appendix D, we identify “quality indicators” for each of these recommendations. The quality indicators are objective, measurable items that can be found in the eligibility assessment instrument and the client’s eligibility assessment records, and that can serve as a checklist that a thorough and competent eligibility assessment has been performed.
In Appendix B, we give examples of augmented, well-established assessment tools that can be used to assess the specific eligibility criteria identified under CPLTC and HIPAA regulations. We also provide an example of a summary sheet for recording the results of the entire assessment, including: the number of ADLs requiring assistance; the score, adjusted and unadjusted, on the MMSE and SPMSQ or translated versions; results from the aggregated BEHAVE-AD scale, if administered, indicating the presence of behavioral problems requiring supervision; results from the questions to rule out depression as a cause of cognitive impairment, if administered, and any recommendation for further psychiatric screening; the score on the GDS, if administered; medical conditions; the need for constant nursing observation or daily nursing intervention, and whether this care has been prescribed by a physician; and the need for medication management.
CARE PLAN DEVELOPMENT

Of all the activities involved in the care management process, the development of the care plan is perhaps the most complex and dynamic, involving “the greatest amount of clinical judgment, creativity and sensitivity” (Schneider & Weiss, 1982). This complexity is related to the comprehensiveness of the assessment, the uniqueness of the individual client’s needs and preferences, the presence or absence of informal supports, the availability of appropriate formal services, and the experience and training of the care manager.

Perhaps this complexity explains why comparatively little has been published about evaluating the care planning process, even though much has been written about evaluation of care management in general. Most of the published work focuses on structural components of care plans such as the presence and content of problem statements, the identification of measurable goals, and the types of services needed to address specific needs. Only a few works address the more elusive issues of how care managers decipher assessment information and translate it into specific problem statements and goals.

To date, several sets of standards for care management have been developed that include specific guidelines for care plan development (Geron & Chassler, 1994; Schneider, 1989; National Association of Professional Geriatric Care Managers, 1992; National Council on Aging/National Institute on Community-based Long-Term Care, 1988; National Association of Social Workers, 1992; Rothman, 1992; St. Coeur, 1996). While the guidelines for care planning differ somewhat in their level of detail, several common principles emerge such as consumer involvement, timeliness, measurability, and the delineation of roles and responsibilities of all parties.
In this chapter, we review the care planning processes utilized by the CMPAs and assess the adequacy of those processes for developing care plans responsive to policyholder needs. Adequacy of the care planning process is examined in light of Partnership regulations and standards of quality care management practice, using the care plan itself and other case file documentation as proxy indicators that a thorough and competent care planning process was done. Areas examined include the following: (1) assessment of clients’ needs; (2) problem identification; (3) comprehensiveness of the care plan, including problem statements, goal statements, and service descriptors; (4) timeliness; (5) objectivity; (6) approval process; (7) consumer participation; and (8) consumer satisfaction.

Assessment of Client Needs

The first step in the development of care plans is a comprehensive assessment of clients’ needs. This is perhaps the most important step in the process, since it generates all of the raw data from which the care plan is constructed. Partnership regulations specify that the care management process take “an all inclusive look at a person’s total needs and resources” (1993, § 58004(d); 1999, § 58005(d)), which implies that a comprehensive assessment is required. While Partnership regulations outline specific domains to be covered in benefit eligibility assessments, there is no requirement for a separate assessment of clients’ needs aside from the benefit eligibility assessment.

A detailed analysis of assessment tools was conducted to evaluate whether the information collected was adequate in providing an “all inclusive look” at policyholders’ total needs. Deficits in these assessment tools were noted, including the omission of relevant information domains or inconsistent or insufficient information in existing
domains. The significance of these omissions is that they represent information gaps that are not identified as needs in the care plans. These deficits are discussed below with recommendations.

**Informal/Family Support**

Informal supports are crucial resources for persons during times of major illness or injury. While all assessment tools asked for some information about available informal supports, they did not adequately assess their willingness or capacity to assume care management responsibilities. This is an important omission, since the mere presence of family members or other informal caregivers does not guarantee active or adequate involvement. Additional information is needed in order to provide a more complete evaluation.

We recommend that all assessments include: full names, relationship to policy-holders, geographic proximity, and detailed contact information; availability, capacity, and willingness to provide specific types of support, such as emotional, financial, or personal care; estimated length of availability and specific schedule of support activities; an understanding of policyholders’ illness and need for information about diagnosis or prognosis; current and projected need for support and respite; and presence of family conflicts related to caregiving responsibilities, such as sibling disagreement about care options.

**Medications**

All current assessment tools provided space for listing medications; however, other information is needed in order to more completely assess clients’ needs in this important
area. We recommend that the following additional information be included: policyholders’ capacity to understand what each medication is used for, and its prescribed dosage and scheduling; any physical limitations in their capacity to correctly follow the medication regime (e.g., visual impairment, difficulty swallowing or opening bottles); cultural or cognitive factors that would limit compliance with the regime; and the date that a physician or pharmacist last reviewed the entire list of medications.

**Cognitive Status**

Cognitive status is perhaps the single most difficult realm to assess adequately, especially in a single home visit. All current tools included the required screening tests for cognition. However, these tools omitted important temporal information. In cases in which there is any indication of cognitive decline, it is imperative that information be obtained from caregivers who have observed the person over time, and that screening tools be administered periodically in order to provide a more accurate assessment.

Assessment should also collect other essential information, including the following: potential causes of the cognitive impairment, including the possibility of remediation or rehabilitation; decrements in self-care and other domains of functioning; adaptations by policyholders, caregivers, and others; uncompromised domains of functioning; and, unmet needs.

**Emotional/Psychological Status**

Although emotional status is another important factor in a comprehensive assessment, since it can affect health outcomes, it was often missing from assessments. Consequently, we recommend that assessments should routinely include a review of current
symptoms of depression, grief, isolation, anxiety, suicidal ideation, or psychosis. It is also suggested that these conditions and accompanying symptoms be clearly defined in order to avoid care managers’ differing interpretations due to differences in their background, training, and experience. For any symptoms noted, an assessment should also be made of date of onset, duration, frequency of symptoms, and impact on self-care and other domains of functioning. Depending on this information, a more extensive mental health examination or intervention may be indicated.

**Self-Care**

All of the assessment tools address ADLs and IADLs. However, there was considerable inconsistency in how they were reported and how dependency in a specific area impacted policyholders’ need for care. In addition, assessment of the impact of dependencies on policyholders’ emotional/mental status was also typically missing.

We recommend the following additions for specific ADLs and IADLs:

- **Ambulation.** In addition to noting level of functioning, a detailed history of falls is suggested.

- **Toileting and bathing.** Assessment should not only indicate dependency, but provide some assessment of whether this is temporary or on-going. It is also useful to assess policyholders’ capacity to manage particular aspects of the dependency, such as how much self-help they can provide.

- **Shopping and meal preparation.** Assessments of these items typically indicate all or no ability, even though individuals are often able to manage aspects of these activities. Consequently, assessment should reflect some details as to exactly what the individual is able to manage independently.
- **Transportation.** Unless they are institutionalized, policyholders typically need transportation to medical and therapy appointments. This area was not routinely explored on all assessments, and should be included for every community-living policyholder.

- **Managing finances.** Although many individuals are unable to manage their finances during periods of dependency, this area was also not routinely explored on all assessments. Specific questions related to bill paying should be included in assessment, and if dependency is noted, follow-up questions regarding the specific problem or deficit should be included.

**Nutrition**

Even though nutritional status is widely recognized as a significant factor in health outcomes, only one assessment included a brief item regarding whether the policyholder had experienced, or consulted a doctor about, or had been diagnosed or treated for “appetite, weight loss, or gain” in the past five years. We recommend that nutritional status be routinely assessed, including questions related to current intake of fluids and food, use of dentures, and any dental problems that affect the capacity to eat.

**Environmental/Safety Issues**

One assessment included a checklist of 20 safety/environmental hazards, including: condition of stairs, emergency exits and pathways; bathroom accessories such as handrails and height of toilet seat; adequacy of plumbing, lighting, heating, ventilation; and presence of smoke detectors and telephone. In addition to these, other safety areas that should be assessed include the presence of tripping hazards such as throw rugs, torn
carpet, uneven floors, raised thresholds, and electrical cords; presence of steps; ability to open security bars in case of fire; location of emergency exits; overuse of electrical outlets and frayed cords; and presence of combustible materials.

**Emergency Response System**

None of the assessments included information about the presence of an emergency response system or the need for one. This is particularly important if the individual is living alone or is alone for periods during the day or night. Because individuals are often unaware that these emergency response systems exist, we recommend its inclusion as an assessment item in order to prompt the care manager to explore this with policyholders, significantly increasing their sense of safety and security.

**Tobacco and Alcohol Use**

Because of the interaction of alcohol with medications, its impact on functional abilities, and increased incidence of falls and other injuries associated with excessive alcohol intake, assessment of alcohol use should be routinely included in assessments. At a minimum, this might include frequency, amount, and type of alcohol use, with a note to compare this with any history of falls or injury and adverse medication reactions. Smoking can also pose a potential safety hazard if there is a pattern of dropping lighted cigarettes or if oxygen equipment is nearby, and should be routinely assessed.

**Social Activities**

Changes in level or type of social activity are generally present during periods of illness or disability, and may affect emotional health and cognition. Therefore, we recommend
that assessment of changes in social activity be included, such as current level and type of activity as compared to premorbid activities. This can serve as an opportunity to explore alternate sources of social stimulation, if needed.

**Potential for Rehabilitation**

Unless there is permanent and progressive disability present, many individuals have some capacity for rehabilitation or improvement in their condition. Unfortunately, this is often not routinely included in assessments of older adults, reflecting the common stereotype among professionals and the elderly themselves that disability in later life is perhaps inevitable and not worth remediation. For this reason, we recommend that several questions should be routinely included in all assessments in order to identify any areas in which individuals might regain some functioning and independence, including: prior history of recovery/rehabilitation; current prescribed therapies; clients’ understanding of their illness and prognosis; clients’ ability and motivation to engage in rehabilitative therapies; and level of caregiver support in assisting with rehabilitation.

**Level of Care Management Needed**

Because individuals vary widely in their need and desire for case management, this should be routinely assessed also. Factors which might be considered include the cognitive status of the individual and the availability and capacity of informal supports to manage care independently. Care management activities should be delineated clearly, such as arranging specified services, bill paying, and hiring and supervising independent providers.
Summary of Assessment Findings

The assessment tools currently being used are not adequate for the purpose of taking “an all inclusive look” at policyholders’ needs. Several areas are typically omitted, such as emotional and psychological status, nutrition status, environmental safety, emergency response systems, changes in social activity, potential for rehabilitation, tobacco and alcohol use, and level of care management needed. In addition, other areas now included in assessments can be enhanced by adding more detail or additional questions. These areas include informal/family support, medications, cognitive status, and ADLs/IADLs. These additions and enhancements will provide more complete and comprehensive information needed to construct care plans that fully reflect policyholders’ “total needs and resources,” as called for in Partnership regulations. A Summary of Assessment Recommendations appears in Appendix C.

Problem Identification

Of all the care planning activities, translation of specific assessment information into a plan of action is perhaps the most critical, as it identifies individual deficits and strengths that form the heart of the resulting care plan. In spite of the importance of this function, however, remarkably little has been written regarding these analytic processes, either actual or ideal. Schneider’s analysis of 250 client records as part of the National Long-Term Care Channeling Demonstration provides rare insight into this translation process. Her study found that despite only minor differences in the number and type of problems identified at assessment, 20 to 30 percent of these identified problems did not form the basis for problem statements in the development of the care plan (Schneider, 1986). One conclusion that could be drawn is that the resulting care plans on their face did not fully
or adequately reflect the client’s needs, but it is unclear if this conclusion is valid in all cases.

Schneider (1989) suggests that one method for evaluating whether the case manager’s translation of assessment information was complete is the development of a comprehensive problem list that includes all the problems identified during the assessment. She also suggests that the list might be kept for the duration of the client’s tenure in the program and updated after each reassessment, or that a new list might be developed for each new care plan. This list serves several purposes: to document that the problems not addressed in the care plan were not overlooked, to permit reconsideration at a later date, and also to identify gaps in service as well as any unmet needs (Geron & Chassler, 1994). Schneider also recommends that the reasons for not addressing any problem be documented. Although the creation of a comprehensive problem list and documentation of reasons for not addressing all listed problems are extra steps not typically taken by case managers, it is a relatively simple way to document the case manager’s thoroughness in translating assessment information.

**Analysis of Case Records**

Two of the three CMPAs used problem lists that were summarized either from benefit eligibility assessments (BEA) or needs assessments. In all, 18 case records contained a problem list; 15 case records did not contain a problem list, even though 8 of these cases were managed by one of the CMPAs that included summary problem lists as part of its standard benefit eligibility assessment forms. Of the 18 case records with problem lists, 10 contained care plans that addressed all the problems listed, 7 care plans addressed some but not all listed problems, and one care plan was missing. Of the seven care plans
that did not address all of the problems on the summary list, no explanation was present in the case records.

Use of these problem lists did not appear to comprehensively capture all of the assessment data, however. A total of 114 issues identified in assessments did not appear in corresponding initial care plans, reflecting a considerable lack of congruity, as discussed below and summarized in Tables 5 and 6.

Table 5. Use of Problem List

<table>
<thead>
<tr>
<th>Problem List Created</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Part of BEA (12)</td>
<td>18</td>
</tr>
<tr>
<td>Part of needs assessment (6)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>15</td>
</tr>
</tbody>
</table>

Note: n=33

Table 6. All Problems on Lists Addressed in Care Plan

<table>
<thead>
<tr>
<th>Problems from List Are Addressed in Care Plan</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Care plan missing</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: n=18

**Issues related to ADLs and IADLs**

ADL deficits were identified for all 32 policyholders for whom care plans existed. Of those 23 policyholders who were living in community settings, all had at least one specific service recommendation addressing these deficits, typically in-home care. However, only three care plans indicated who would be responsible for making the referral; 12 included information about frequency of service; and 19 specified specific tasks to be performed, such as bathing or dressing. These omissions are significant because most family members do not know what tasks these in-home providers can
undertake, and few understand the training and skills they bring to the work. Other ADL issues identified in the assessment related to the need for occupational therapy, physical therapy, or durable medical equipment. Notations were present in 25 assessments regarding the need for these services; however, only 14 corresponding care plans included specific recommendations about these needs.

Table 7. Congruity Between Assessment and Initial Care Plan

<table>
<thead>
<tr>
<th>Issues</th>
<th>Noted in Assessments</th>
<th>Noted in Corresponding Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLs/IADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in-home care</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>OT/PT/DME</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>day treatment program</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>transportation</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>safety</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Caregivers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>caregivers support</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>health/capacity for care</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>respite</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>education</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Cognitive/Mental status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>depression</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>unclear mental status</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“at risk for SNF”</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>emergency response system</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>decubitus ulcer</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>172</td>
<td>58</td>
</tr>
</tbody>
</table>

Note: n=32

Although it is difficult to ascertain with absolute certainty what additional types of services might be appropriate for individuals from documents, clients with progressive dementing or physical illnesses are at risk for not maintaining their highest level of functioning without structured, stimulating activities, even with adequate in-home support. Such activities are rarely provided by in-home workers, nor are they always available in
board and care facilities. Although 15 assessments included diagnoses or notations related to social isolation, only 4 care corresponding care plans recommended socialization programs such as adult day care or Alzheimer’s day care.

Transportation needs were noted in 21 assessments, but transportation services appeared in only 5 of the corresponding care plans. Safety issues were noted in eight assessments, including the need for a raised toilet seat, smoke detector, grab bars, and strategies to minimize risk from wandering; however, safety-related interventions appeared in only three of the eight care plans.

**Issues related to caregivers**

In 28 of the 32 assessments reviewed, caregivers were noted who provided some level of care or support to policyholders. In 11 of these cases, a spouse was the primary caregiver. However, only three of the corresponding care plans specifically addressed the issue of caregiver support, e.g., recommending a caregiver support group. A related issue is the health and capacity of the caregivers to provide care. Twelve assessments included some notation related to caregivers’ health or capacity, such as “spouse gives medications but forgets usually,” “spousal condition declining,” and “conflict between spouse and daughter”; however, only one of these corresponding care plans addressed the identified status of the caregiver. Respite care information was another area noted in eight assessments for policyholders for whom in-home care was either recommended or already in place; however, only one of the corresponding care plans included respite information. Need for education about policyholders’ illness and prognosis was another area identified in 10 assessments; however, only 2 of the corresponding care plans addressed this issue.
**Issues related to cognitive and psychological status**

Fourteen assessments included medical diagnoses that are known to carry a high risk for depression, and all had specific notations that indicated the need for further psychological evaluation. Examples of such notations included “great depression;” “lack of appetite, some depression, previous history of psychiatric care;” “not eating well, not taking meds, loneliness;” and “states he feels out of control, lonely, has lost a lot of interest, appears depressed.” However, only two of the corresponding care plans addressed the need for further assessment or mental health interventions. Three assessments noted unclear mental status with changing cognitive capacities, but none addressed this in the corresponding care plans.

**Other issues**

Three other areas identified in assessments were not included on corresponding care plans. Three assessments noted that policyholders were at risk for SNF, but their care plans did not appear to address this issue specifically. Another assessment noted the need for an emergency response system, but this was not included in the care plan. Decubitus ulcer was noted in another assessment, but not addressed in the care plan.

**Policyholder Experience**

In the first in-person interviews with 19 policyholders, two questions were asked regarding their satisfaction with the care planning process, particularly the care plan. In response to a question about whether there were services they expected or wanted which were not included in the care plan, 11 stated that their care plans did not include services they expected or wanted, 7 stated that their plans did, and data were missing in two cases.
In response to whether their care plans accurately reflected their needs, 14 stated that they did reflect their needs, and 5 stated that they did not. The five policyholders who stated that they did not accurately reflect their needs also stated that their care plans did not include services they wanted or expected, reflecting significant disparities between their perceived needs and the care planning process (Table 8).

Table 8. Policyholder Satisfaction with Care Plans

<table>
<thead>
<tr>
<th>Does the care plan accurately reflect your needs?</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were there services you expected or wanted that were not included in the care plan?</td>
<td>11</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=19

**Summary of Problem List Findings**

In spite of using problem lists, a significant number of issues identified in assessments were not addressed in corresponding care plans. Many of these issues correspond to the gaps in assessment tools discussed in the previous section, such as psychological and emotional status. There are several possible explanations for this. It is possible that policyholders themselves may not have wanted some of the issues identified to be addressed at that time, or that the issues were no longer problems by the time care plans were developed, or that policyholders may not have perceived the identified issues as problems that needed to be addressed. Another possible explanation is that while all of the CMPAs state that their policies and procedures are intended to look at the person’s total needs, the actual practice is to focus on covered services or those over which they have control. Another explanation might be that care managers lack adequate training or guidance in assessing particularly challenging areas such as depression, caregiver burden, and environmental and cognitive assessment. Whatever the reason, however, it is clear
that some policyholders were not satisfied with their care plans because they did not include all of the relevant issues that they perceived to be important.

**Recommendations Regarding Problem List**

In addition to incorporating the additional assessment questions already discussed above in the section on Assessment of Client Needs, we recommend that a comprehensive list of all problems identified from assessment information be developed for each case, and that this list include the additional assessment questions recommended. We also recommend that documentation indicating the reasons that specific problems are not addressed in the care plan appear in the case record. A sample Problem List is included in Appendix C.

**Comprehensiveness of the Care Plan**

The ultimate product of thorough care planning activities is comprehensive care plans that address all of the individual’s needs in a clear, explicit fashion. The care management literature identifies several care plan components that provide the detail necessary for implementing the plan. These include: problem statements; corresponding goal or outcome statements; recommended interventions for each problem, including service type, name, and frequency; cost of each service; payor; and the role of informal supports and other parties.

Partnership regulations do not specify any particular care plan format or that care plans contain problem or goal statements. However, a variety of service descriptors are specified, including type, frequency, providers, and cost. All of these required and nonrequired care plan components are discussed in detail below.
**Problem Statements**

One of the most commonly recognized hallmarks of care planning is its problem orientation, i.e., client needs or problems are identified, and the care plan outlines how these needs will be met. It follows that the development of problem statements is the linchpin of care plans. Quinn (1993) states: “The importance of accurate problem identification cannot be emphasized enough, because the best designed care plan is worthless if it is addressing the wrong problems.”

Problem statements are generated from assessment information, requiring considerable clinical judgment and skill in translating this assessment information into accurate statements that adequately reflect the highly individual nature of the client’s situation. Even though there is no consensus about what information should be included in problem statements, it seems reasonable that problem statements should include at least the client’s specific functional problems or deficits that necessitate intervention. For example, “COPD” would not be an adequate problem statement, but “unable to change bed linens, clean floors or vacuum due to shortness of breath caused by COPD” would be adequate, since it identifies the client’s specific functional disability that requires intervention. Similarly, “dementia” does not specify the resulting disability, whereas “wanders off if unsupervised due to disorientation” provides the specific functional impairment for which a specific intervention can be proposed. This specification of functional deficits distinguishes problem statements in the care plan from the less detailed problem list discussed in an earlier section.
Analysis of case records

Of the 32 case records containing care plans, 20 care plans included one or more problem statements. Of these, seven plans consistently used functional terms to describe all problems, another six plans used functional terms for most or some of the problems, and seven plans did not use functional terms at all. All 20 of these cases were administered by one CMPA. Twelve plans did not include any problem statements, since the plan formats did not include any space for problem statements; these 12 cases were administered by the two other CMPAs (Tables 9 and 10).

Table 9. Presence of Problem Statements

<table>
<thead>
<tr>
<th>Care Plan Includes Problem Statements</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: n=32

Table 10. Content of Problem Statements

<table>
<thead>
<tr>
<th>Problem Statements Are in Functional Terms</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7</td>
</tr>
<tr>
<td>Most</td>
<td>4</td>
</tr>
<tr>
<td>Some</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>7</td>
</tr>
<tr>
<td>No problem statements</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: n=32

Summary of problem statement findings

In view of the important function that problem statements serve, it is interesting that two of the three CMPAs do not require these in their care plans. In these cases, it was difficult if not impossible to ascertain what the recommended interventions were intended to address. Also, considerable variation was noted in how problem statements were constructed in terms of detail and reference to particular functional impairments. If plans
are to be used as educational tools or references for subsequent care managers, policy-holders, or family members, explicit descriptions of specific needs are vital.

**Recommendations for implementation regarding problem statements**

We recommend that all care plans contain a space for problem statements, and that these statements specify clients’ needs or problems in functional terms.

**Goal Statements**

The area of goal setting has received considerable attention in case management literature. Although “goal,” “outcome,” and “objective” are often used interchangeably in the literature and in practice, we use “goal” to refer to desired, client-oriented outcomes, and “goal statements” as the statements in the care plan that specify these desired client outcomes. In spite of the use of different words in care management literature, there is some consensus about the purpose of goal setting and what goal statements should contain. Lowy (1979) describes the purpose of goal setting as developing clear expectations about what is to be achieved through case management. St. Coeur (1996) also states that “without explicit goals and expected outcomes, the case management process will have no direction.” She also provides a “SMART” mnemonic that neatly summarizes the most commonly discussed features of well-written goals: Specific, Measurable, Achievable, Realistic, and Timely. Schneider (1989) also provides a useful discussion about the development of goal statements, pointing out the common error of confusing an intervention (the specific action) with a goal (the desired outcome).

Of St. Coeur’s five SMART characteristics of goal statements, measurability is perhaps the most important, since it provides a basis for determining to what extent the
desired outcome has been attained, i.e., how the client has benefited from the intervention. Geron & Chassler (1994) suggest that goal statements should be written in terms of behavioral objectives that are measurable or observable whenever possible. They also suggest that all goal statements include a time frame for goal attainment that provides clear, measurable expectations for both the client and case manager.

**Analysis of case records**

Of the 32 care plans reviewed, all 20 administered by one CMPA contained a column labeled “goal”; goal statements were present in all of these care plans, and were matched to specific problem statements in an adjacent column. Five other care plans administered by another CMPA contained a column labeled “purpose”; these statements were matched to specific interventions, since the care plan format did not include a space for problem statements. Four other care plans administered by a third CMPA contained a separate space labeled “Specify goals and reasons for each type of service.” Three care plans did not include any space for goal statements.

The content of goal statements varied considerably. In those care plans which did not contain problem statements, the spaces labeled “purpose” or “specify goals . . .” elaborated on the services being recommended, and did not reflect client-oriented outcomes. For example, one notation cited “personal care, light housekeeping, dressing, bathing, transfer” as the goals for “home health aide”; another notation indicated that “bereavement counsel” was the goal for hospice. In those plans which contained problem statements, the corresponding goal statements generally did reflect client-oriented outcomes. For example, “meds and diet will be changed so that client’s diabetes will be in better control to promote wound healing” was one of the more detailed goals; “ADLs
will be met” was a more common entry. Only two care plans specified what measurements would be used to determine goal attainment or specified a timetable for goal implementation (Table 11).

Table 11. Presence of Goal Statements

<table>
<thead>
<tr>
<th>Goal Statements Included in Care Plan</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: n=32

**Summary of goal statement findings**

Although all CMPAs included items labeled “goal” or “purpose” in their care plans, they varied widely in their apparent interpretations of the purpose and content of this device. Two CMPAs appeared to use it as a mechanism for elaborating on service interventions rather than on client-oriented outcomes. It is perhaps not a coincidence that these care plans also lacked problem statements. The care plans administered by the third CMPA did include client-oriented goals, although these varied considerably in terms of their specificity. The overall lack of time frames or other specific ways to measure goal attainment, a common deficit in care plans, was also noted. The absence of such measures makes it difficult, if not impossible, for care managers, clients, and families to determine the efficacy of interventions.

**Recommendations for implementation regarding goal statements**

We recommend that a care plan contain at least one client-oriented goal statement for each identified problem statement, and that each goal statement contain an explicit mechanism for measuring when the goal will be attained, including a time frame for attainment when applicable.
Service Descriptors

Descriptions of recommended services should flow directly from the problem and goal statements outlined in the care plan, and contain enough detail so that the client understands in concrete terms what is being proposed. These service descriptors serve several functions, including enabling the client to make informed selections about the recommendations, and providing specific information for how to implement the plan. This is especially important for clients who do not have case managers to provide coordination and monitoring, and need such detailed information to implement the plan themselves.

There is much consensus in the case management literature about the type of information needed to fully describe service recommendations. Discussions consistently include the type of service needed, who can provide these services, the cost of services, the frequency of services, and the roles of the various parties. Payment source for services is another important service descriptor that serves to educate clients regarding financing options and makes it clear what they will expected to pay themselves. Geron & Chassler (1994) also provide another rationale by stating that “sheltering consumers from the knowledge of costs prevents them from learning the actual costs of services and also hinders their ability to consider the monetary or nonmonetary value they place on the various options open to them.”

Partnership regulations require the following service descriptors:

CPLTC 1993, § 58026. “Plan of Care” means a written individualized plan of services approved by a Care Management Provider Agency which specifies the type, frequency, and providers of all Formal and Informal Long-Term Care Services required for the individual, and the cost, if any, of any Formal Long-Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client’s medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.
**CPLTC 1999, § 58027.** “Plan of Care” means a written individualized plan of services prescribed by a Licensed Health Care Practitioner which specifies the type, frequency, and providers of all Formal and Informal Long-Term Care Services required for the individual, and the cost, if any, of any Formal Long-Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client’s medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

**Analysis of case records**

Spaces were noted on all 32 care plans for type of service, provider name and phone number, and cost, as required by regulations. Frequency of service was noted on care plan formats administered by two CMPAs. Both of these formats also included “duration” or “estimated duration” on the formats. There was no space for frequency provided on the third care plan format; however, care managers often put this information in other spaces, including a column labeled “interventions” and another column labeled “implementation plan, by whom & when.” All care plans also included a column for “payor source.”

Care plans were reviewed to determine whether the required descriptors were present for all services recommended in the care plan, as specified in Partnership regulations or for “most” services (i.e., only one item missing), for “some” services (i.e., more than one item missing), or for “none” of the services.

For all recommended interventions stated in these 32 care plans, type of service was noted for all interventions in 30 cases; a list of potential service providers for each service listed was noted in 24 cases; the cost of each service was noted in 13 cases; the frequency of each service was noted for all services in 12 cases; the source of payment for each service listed was noted in 21 cases; and the role of informal supports was noted in 18 cases (Table 12).
Table 12. Presence of Service Descriptors in Care Plans

<table>
<thead>
<tr>
<th>Service Descriptor</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of service listed and described</td>
<td>All 30</td>
</tr>
<tr>
<td></td>
<td>Most 1</td>
</tr>
<tr>
<td></td>
<td>Some 0</td>
</tr>
<tr>
<td></td>
<td>None 1</td>
</tr>
<tr>
<td>List of providers offered for each listed service</td>
<td>All 24</td>
</tr>
<tr>
<td></td>
<td>Most 4</td>
</tr>
<tr>
<td></td>
<td>Some 2</td>
</tr>
<tr>
<td></td>
<td>None 3</td>
</tr>
<tr>
<td>Cost of each listed service noted</td>
<td>All 13</td>
</tr>
<tr>
<td></td>
<td>Most 4</td>
</tr>
<tr>
<td></td>
<td>Some 3</td>
</tr>
<tr>
<td></td>
<td>None 12</td>
</tr>
<tr>
<td></td>
<td>Not applicable (spouse provided all care) 1</td>
</tr>
<tr>
<td>Frequency of each listed service</td>
<td>All 12</td>
</tr>
<tr>
<td></td>
<td>Most 2</td>
</tr>
<tr>
<td></td>
<td>Some 1</td>
</tr>
<tr>
<td></td>
<td>None 8</td>
</tr>
<tr>
<td></td>
<td>Not applicable (policyholder in SNF/ALF) 9</td>
</tr>
<tr>
<td>Source of payment for each listed service</td>
<td>All 21</td>
</tr>
<tr>
<td></td>
<td>Most 1</td>
</tr>
<tr>
<td></td>
<td>Some 2</td>
</tr>
<tr>
<td></td>
<td>None 7</td>
</tr>
<tr>
<td></td>
<td>Not applicable (spouse provided all care) 1</td>
</tr>
<tr>
<td>Informal supports noted</td>
<td>Yes 18</td>
</tr>
<tr>
<td></td>
<td>No 14</td>
</tr>
</tbody>
</table>

**Summary of service descriptor findings**

Of the six types of service descriptors noted in the care plans, type of service and provider information were almost always indicated. Source of payment, although listed all or most of the time in two-thirds of the care plans, was missing in approximately one-third of the plans. Information about cost of services was missing in over two-thirds of
the plans. These findings are somewhat surprising, since knowledge of payor sources and costs are essential for proper development and implementation of care plans, if consumers are to make informed choices. Although frequency of services was missing in over one-third of plans for noninstitutionalized policyholders, this is perhaps more understandable than the absence of other descriptors, since this variable is typically somewhat harder to establish at this stage and approximately half of these care plans did not have a designated space for indicating frequency. Informal supports were also missing from almost half of the care plans, which represents a significant omission since most policyholders had at least one family member involved with their care.

**Recommendations for implementation regarding service descriptors**

We recommend adding source of payment to the list of required service descriptors, since it is essential information for educating consumers about long-term care services, and since it is already included by all CMPAs. We also recommend that all required service descriptors be consistently identified for all services included in care plans.

**Timeliness**

Consideration of the time interval between assessment and development of the care plan is perhaps the most straightforward of all the practice standards. Prompt development of the care plan after the assessment has been completed decreases the chances that the client’s condition will change, thereby resulting in the need to redo the assessment (Geron & Chassler, 1994). However, the case management literature is generally silent on the optimum interval between completion of the assessment and development of the
care plan. This may be due to the complexities of defining benchmarks, such as when an assessment or a care plan is actually “completed” so that turnaround times can be calculated. Only one discussion could be found in which actual standards were cited for six states’ case management programs, although no rationale was presented (GAO, 1993).

Partnership regulations do not specify an optimum time interval, although the regulations do require CMPAs to indicate turnaround times for conducting assessments and developing care plans in their policy and procedure manuals:

*CPLTC 1993 and 1999, § 58076(a).* Prior to the Care Management Provider Agency being approved by the State, and with an Annual update thereafter, the Care Management Provider Agency must file the following with the Department of Health Services and with each Issuer with whom they contract:

(2) a policy manual that includes the following:

(C) Care Manager availability and turn-around time for conducting assessments and developing Plans of Care.

**Analysis of Case Records**

Each CMPA specified turnaround time in its policy manual. Although no revisions to turnaround times were noted in the annual reports from the CMPAs, updated information was requested during the data analysis phase of the study because policy manual descriptions did not appear to reflect current procedures in some cases. Because these policies varied considerably in terms of benchmarks to be used in calculating turnaround intervals, and proved difficult to calculate in many cases, our calculations are based on the interval between the date that the insurer made a referral to a CMPA to conduct assessments or develop care plans and the date on the completed documents.

In 19 of the 33 cases reviewed, turnaround times were met. In seven cases, turnaround times could not be calculated because dates were missing for some or all of the needed benchmarks. In seven other cases, turnaround times were not met; all CMPAs had
cases in this category. Extenuating circumstances were noted in five of these cases (Table 13).

Table 13. Compliance with Specified Turnaround Times

<table>
<thead>
<tr>
<th>Turnaround Time Met</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Unable to determine</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: n=33

**Summary of Findings Regarding Timeliness**

Although calculation of turnaround times should have been a relatively easy task, it proved to be quite difficult due to outdated information in policy manuals, unclear benchmark definitions, and the lack of needed data in case records for making calculations.

**Recommendations Regarding Timeliness**

We recommend that allowable turnaround times for completing assessments and developing care plans continue to be established by CMPAs, and that specific descriptions of these allowable time intervals be included in their policy and procedure manuals. Furthermore, we recommend that case records contain clear documentation of information needed to calculate whether turnaround times are met.

Due to the variability of their current benchmarks and the desirability of using benchmarks that reflect client outcomes and not solely administrative convenience, we recommend that the following benchmarks be used, and that the indicated dates be
documented clearly in the case record:

- Time interval from the initial claim to the completion of the benefit eligibility assessment;
- Time interval from the review and approval of the benefit eligibility assessment to the completion of the care plan;
- Time interval from the initial claim to notification of policyholders’ approval or denial of the claims.

In cases where benchmarks are not met, we further recommend that documentation be required that details any extenuating circumstances which accounted for the delay in meeting the allowable turnaround time.

**Objectivity and Impartiality**

Although “conflict of interest” is the phrase more commonly used, “objectivity and impartiality” as used in Partnership regulations is more descriptive of its essential features, specifying the desired attitudes and actions of the care manager. In spite of the recognized primacy of the client’s welfare throughout case management literature, this standard is rarely discussed in the care management literature. Perhaps this is due to the differing notions regarding what constitutes conflict of interest, or that case management generally has not been subject to such confounding influences. Geron & Chassler (1994) provide one of the few discussions about impartiality, and recommend that protocols should be established that describe when and under what circumstances a case management service should also provide direct services.

In the new world of managed care and long-term care insurance, objectivity and impartiality have become increasingly important considerations due to the introduction of
unique ethical dilemmas for case managers. For example, case managers may work for agencies that also provide services, and may be expected to include these services in their care plan recommendations, even if these services are not necessarily the only choice or the best choice for policyholders. For this reason, Partnership regulations provide explicit and comprehensive mandates in this regard:

**CPLTC 1993 and 1999, § 58075.**
(a) To insure objectivity, the Care Management Provider Agencies which also provide other services included in an insured’s Plan of Care will be required to document that clients were made aware of a full array of services, and the costs and availability of other providers of these services.
(b) Individuals who provide direct care as described in Section 58059(e) (i.e., home health, adult day health/social care, personal care services, homemaker services incidental to personal care services, respite care, and residential care facility) cannot also act as Care Managers for assessment and care planning.
(c) Direct service providers and Care Managers should not report to the same clinical supervisor.
(d) Employees of the Issuer cannot also act as Care Managers for assessment and care planning.

**Analysis of Case Records**

The policy manuals for all CMPAs include the language of this regulation. From examination of case records, it did not appear that any individuals who provided direct care as described in item (b) also acted as care managers for assessment and care planning. Of the 32 case records containing care plans, none listed the CMPA as a service provider as specified in item (a). However, the intent of this regulation appears to apply also to assessors and care managers who are employed by agencies that provide other services included in the care plan, not just to the CMPAs. Consequently, case records were also examined to determine this. In three cases, the assessors or care managers who conducted the initial assessments or developed initial care plans were employed by agencies that provided personal care services to the policyholder. There was no evidence in any of these three case records that policyholders were provided with lists of other providers to
choose from. In these three cases, we have no information about whether the case managers and direct service providers reported to the same supervisor. In three additional cases, we were unable to determine the name of the agency that employed the care manager and could not determine whether the assessors or care managers were employed by the policyholder’s service provider, because these records were not available due to the sale of the CMPA to another company. None of the case managers were employed by issuing insurance companies. However, in 20 cases, care monitoring was provided by employees of a TPA (Tables 14 and 15).

Table 14. Objectivity and Impartiality

<table>
<thead>
<tr>
<th>CPLTC 1993 and 1999, § 58075</th>
<th>No</th>
<th>Yes</th>
<th>Unable to Determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) CMPAs that also provide other services in care plan</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(b) Direct care providers who are also assessors/care managers</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(c) Direct service providers who report to same supervisor</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>(d) Care managers who are also employees of issuer</td>
<td>12</td>
<td>0</td>
<td>20</td>
</tr>
</tbody>
</table>

Note: n=32

Table 15. Potential Conflicts of Interest

<table>
<thead>
<tr>
<th>Services in care plan provided by same agency that employed assessor/care manager</th>
<th>No</th>
<th>Yes</th>
<th>Unable to Determine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: n=32

Summaries of the three cases in which services were provided by the same agency that employed the care advisor/care manager suggest a number of potential problems.

**ID #25**

Two different care managers, both of whom worked for the home health agency that appears in the care plan and was utilized by the policyholder, were apparently involved in the development of the care plan. There is no evidence that the policyholder was “...made aware of a full array of services, and the costs and availability of other providers of these services,” as specified in the regulations. Although the policyholder’s caregiver reported that all care needs were adequately met by this home health agency, s/he
displayed considerable confusion about the role of the care manager, which may have resulted from the dual role played by the agency. In addition, the policyholder’s caregiver reported that a supply of Vicodin was found to be missing early in the claim period, although this was not recorded in the progress notes.

**ID #28**

The initial care plan indicated that the policyholder was receiving care in a skilled nursing facility. However, when the policyholder was subsequently discharged to the home with home health care, no changes were made to the care plan, and the spouse reported that all arrangements were made by the same care manager, who apparently also owned the home health agency that provided these services. There is no evidence that the policyholder was “. . . made aware of a full array of services, and the costs and availability of other providers of these services,” as specified in regulations.

**ID #29**

The care manager was employed by the same agency that provided home health services, but there is no evidence that the policyholder was “. . . made aware of a full array of services, and the costs and availability of other providers of these services.” The policyholder reported several serious problems with these services, including no-shows by the aide and forgery of the policyholder’s signature on timesheets. She subsequently terminated services, stating that she was “leery” about home health services, even though she had continuing care needs.

**Summary of Findings Regarding Objectivity and Impartiality**

Although it is not possible to conclude with certainty that any particular incident in these cases was directly related to using care managers who were employed by the same agencies that also provided direct services, these cases reinforce the intention of Partnership regulations in minimizing the environment for intentional and unintentional conflict of interest. The fact that three cases involved potential conflicts of interest indicates a lack of procedures that could have identified such problems.

**Recommendations Regarding Objectivity and Impartiality**

We recommend retaining all of the items in the regulations, but deleting “Care Management Provider Agency” from item (a) and substituting “assessors and care
managers who work for organizations which also provide other services included in an insured’s Plan of Care.” We also recommend that CMPAs’ policy and procedure manuals contain a clear discussion of each item in § 58075, including what documentation will be completed to certify that individuals who provide direct care and employees of the issuer do no act as care managers for assessment and care planning, that direct service providers and care managers do not report to the same clinical supervisor, and that clients are made aware of a full array services and costs of other providers of the services.

Approval of the Care Plan

Unlike private care management practice in which “approval” of care plans is typically informal and may consist of the verbal acquiescence of the client, long-term care insurance procedures are generally more formal and involve written documentation. Partnership regulations call for an external body, a CMPA, as the official approver of care plans, as follows:

_CPLTC 1993 and 1999, § 58059(f)._ Care Management services by a Care Management Provider Agency. Changes for the initial assessment and individualized Plan of Care provided by a Care Management Provider Agency shall not be considered as a claim cost. Charges for coordinating the provision of care and monitoring services can be considered as a claim cost. Insurance benefit payments can count toward the Medi-Cal Property Exemption to the extent they are for Long-Term Care Services Countable Toward Medi-Cal Property Exemption delivered to insured individuals and are part of an individualized Plan of Care approved by the State-approved Care Management Provider Agency as the result of a face-to-face assessment conducted by the Care Management Provider Agency (or its Qualified Official Designee).

For all 33 case records reviewed, we were unable to determine from available documentation whether or not the CMPAs approved the care plans (Table 16).
Table 16. Care Plans Approved by CMPAs

<table>
<thead>
<tr>
<th>Evidence in Case File that Care Plan Was Approved by CMPA</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
</tr>
</tbody>
</table>

Summary of Findings Regarding Care Plan Approval

While policy manuals for all three CMPAs indicate that they will approve care plans, none specify how or when this will be done or who within the organization is responsible. Because of this lack of specificity and the lack of evidence in the case records of formal approval, research staff requested specific information from CMPAs to clarify this procedure. Typically, internal case managers in the CMPAs review care plans submitted by local field case managers for appropriateness and completeness. However, it is still unclear whether this in fact constitutes “approval,” and whether any official written documentation is completed. Moreover, some CMPAs apparently send care plans to insurers for review and approval, raising serious questions regarding whether these CMPAs are fulfilling the role intended by regulations.

Recommendations Regarding Care Plan Approval

We recommend that the process of approving care plans by the CMPAs be clearly described in their policy and procedure manuals, and that documentation of the approval of the care plan by the CMPA appear in the case file.

Consumer Participation

Consumer participation in care management is a universally acknowledged practice standard regarding the importance of safeguarding the client’s right of self-determination.
through direct participation. Quinn (1993) emphasizes this point by stating that “Care plan decisions ultimately rest with the clients,” and that “. . . the case manager must defer to the client’s right to autonomous decision making.” A more recent elaboration of this concept appears in the 1996 statement by the National Institute on Consumer-Directed Long-Term Services (NICDLTS), which highlights choice and control as the key elements of consumer participation:

Consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumer direction may exist in differing degrees and may span many types of services. It ranges from the individual making all decisions and managing services directly, to an individual using a representative to manage needed services. The unifying force in the range of consumer-directed and consumer choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature of their disability or the source of payment for services. (NICDLTS, 1996)

In addition to its status as a right, self-determination through direct participation is also commonly seen as a necessary practicality. Brubaker (1987) sums up what many practitioners know through experience: “If elderly clients believe that they have little or no impact on the plans being made concerning them, they are less likely to become involved in this process than if they feel they play an integral role in decision making.” She goes on to point out that the significance of this involvement is in the subsequent success or failure of the plan, and that “change only occurs when clients are willing to become involved and to work at the change process.” Quinn (1993) also recognizes the efficacy of client participation, stating that “a successful care plan is built on consensus between the client, caregivers (formal and informal), and the case manager.” A logical extension of autonomy often cited in the literature pertains to complying with the client’s wishes regarding the inclusion or exclusion of family or others in the care planning process. Geron & Chassler (1994) also suggest that the wishes of family members and
recommendations of case managers should not override those of competent consumers, even when these involve issues of health care and safety.

While the exact nature of “active client participation” is not typically specified in written practice standards, it is presumed that clients or their officially designated representatives are directly involved in discussions with the care manager regarding their needs and preferences regarding care. The National Institute on Consumer-Directed Long-Term Care Services (1996) outlines some specific topics that might be discussed, including who provides services, what services a worker performs, why particular services are made available to the consumer, when services are provided, and how services are delivered (NICDLTS, 1996).

In spite of “active client participation” (the process), the resulting care plan (the product) may not necessarily reflect the client’s wishes and values in their fullest sense, however. In order to ensure that the plan has translated the client’s preferences accurately, a further step of obtaining the client’s agreement with the care plan is recommended (NCOA, 1994). Schneider (1989) further suggests that such agreement should be documented in the form of the client’s signature to that effect. Simmons et al. (1985) also applied this to family members by having them sign the care plan as an indication of willingness and commitment to their role in the plan.

Finally, the issue of competence is central to the idea of consumer participation and direction, and is discussed by several authors (Rothman, 1992; Brubaker, 1987; NASW, 1992; Geron & Chassler, 1994; NICDLTS, 1996; Schneider, 1989). There is some consensus that case managers should involve clients to the extent possible, regardless of their competence, and that a proxy or surrogate decision maker should only make care decisions when clients are severely cognitively impaired and consequently unable to
participate in the care planning process. Although Partnership regulations use the term “officially designated representative,” neither these regulations nor the cited authors provide guidance about how competency should be defined or determined, who should officially designate the representative, or under what circumstances a representative should be designated. Because of these ambiguities and the need to protect the client’s right to self-determination, Geron & Chassler (1994) recommend that the case manager should document the identity of the representative as well as the reasons why the client was unable to participate.

Reflecting the importance of consumer participation, Partnership regulations specify that policyholders have a right to actively participate in the development and implementation of the plan of care:

**CPLTC 1993 and 1999, § 58072(a).** A Care Management Provider Agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. The list shall include:

(5) a right for active client participation in the development and implementation of the Plan of Care. The client or officially designated representative shall, prior to implementation, receive a copy of the Plan of Care and a written list of all potential service providers to be involved in implementation of the plan of care.

**Analysis of Case Records**

Of the 33 case records reviewed, 8 cases contained documented evidence that the policyholder participated in developing the plan of care, including signed Claimant’s Rights forms which affirmed that the plan was developed with policyholders’ input and that they agreed with it, entries in the progress notes written by the care manager, and a care plan signed by the policyholder that included a statement that the policyholder “discussed” the care plan with the care manager. In 25 of 33 cases, no documentation was present to indicate that the policyholder participated in the development of the care plan. In 4 of
these 25 cases, the policyholder was incapacitated and was not able to participate in
development of the care plan. “Incapacitated” was defined as meeting the criteria for
cognitive impairment in the benefit eligibility assessment. (Claimant’s Rights forms used
by one CMPA were sent to each policyholder or representative with a request to sign and
return them; these were then appended to the care plan in the case records.)

Regarding the participation of representatives/family members, 11 out of 33 case
records showed evidence of active participation. Evidence also included signed
Claimant’s Rights forms which affirmed that the plan was developed with their input and
that they agreed with it, entries in the progress notes written by the care manager, and
care plans signed by the representatives that included a statement that they “discussed”
the care plan with the care manager. In 22 of 33 cases, no documentation was present to
indicate that representatives/family members participated in the development of the
care plan.

Policyholder and Family Interviews

In the initial in-person interviews, policyholders were asked three questions to determine
the extent of their involvement in the development of the care plan, including whether
they were asked about their situation and needs, the kind of help they preferred, and
whether they actively participated in the overall process. Fifteen out of 19 policyholders
interviewed responded affirmatively to all three questions, indicating that they had been
actively involved in the care planning process. Six policyholders responded negatively to
one or more of the three questions; of these six, three consistently indicated for all
questions that they did not participate. Only one of these policyholders gave acute illness
as a reason for lack of involvement; the other five policyholders who did not participate in care planning did not provide explanations for this (Table 17).

Table 17. Policyholder Participation in the Development of the Care Plan

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records (N=33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress notes (3)</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Signed Claimant’s Rights (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care plan (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policyholder interviews (N=19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did care manager ask you about:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your situation and needs?</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>• The kinds of help you prefer?</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Did you actively participate in making decisions about the care you would receive?</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>

Representatives/family members were also asked questions to determine the extent of their involvement in the development of the care plan. Of the 18 family interviews completed, 14 respondents stated that the care manager discussed the policyholders’ care needs with them, and 16 stated that they were involved in decision making about the actual services the policyholder would receive. When asked about specific types of involvement in the process, 13 said that they were asked about their own situation and needs, and 15 stated that they were asked about the kinds of help the policyholders needed participated in the overall process.

A total of eight individuals responded negatively to one or more of these four questions. Two of these individuals responded negatively to all four questions; one of these was also the representative/family member for one of the policyholders mentioned
above who responded negatively to all the questions related to policyholders’ involvement (Table 18).

Table 18. Participation by Family Members/Representatives in the Development of the Care Plan

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records (N=33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress notes (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed Claimant’s Rights (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care plan (2)</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Family Interviews (N=18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the care manager discuss policyholders’ care with you?</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Did the care manager ask your opinion about:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your own situation and needs?</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>• The kinds of help policyholder needed?</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Did the care manager involve you in decisions about the actual services the policyholder would receive?</td>
<td>16</td>
<td>2</td>
</tr>
</tbody>
</table>

Summary of Findings Regarding Consumer Participation

Interviews revealed that policyholders and their representatives were much more involved in developing care plans than case documentation indicated. This shows that the lack of such documentation does not necessarily reflect noncompliance with the regulations. An example of this is the case of one CMPA that routinely sent out their Claimant’s Rights forms to policyholders for signature, but often did not get them back, illustrating a lack of documentation, not necessarily a lack of process or participation. We also note that this CMPA has subsequently modified its procedure in this area and now requires progress notes that document participation in addition to the signed Claimant’s Rights forms.
Nevertheless, a number of policyholders and representatives indicated that they were not actively involved in spite of these processes. Furthermore, it is altogether unclear to what extent, if any, other policyholders and representatives who were not interviewed actually participated in the development of their care plans.

**Recommendations Regarding Consumer Participation**

In view of the central importance of consumer participation and the lack of clear evidence that it is being implemented, we recommend that written documentation be included in case records that clearly indicates that policyholders participated in the development of the care plan. We suggest that this could be in the form of a signed statement which affirms that they discussed the care plan with the care manager and concurred with its recommendations. If policyholders are severely cognitively impaired, the statement should be signed by the officially designated representatives indicating that they participated in the development of the care plan and agree to the plan as written. Additional documentation specifying the identity of the representatives and why policyholders were unable to participate in the care planning process is also suggested.

**Client Receives a Copy of Care Plan**

This standard reflects the right of clients to be fully informed in writing about the details of their care plan, specifying service options or other interventions that are designed to meet their needs. This can serve as a useful educational tool by helping the client and family see how problems, goals, and interventions are identified and linked. The written plan also provides the client with a blueprint for its coordination, whether by the client or by a care manager. If the client elects to implement the care plan on his/her own, it serves
as a reference for how to do this. On the other hand, if someone else provides coordination and monitoring, the plan provides a set of expectations about what will be done, and can be used in evaluating the performance of the care manager and other providers.

Partnership regulations require that policyholders or their representatives receive a copy of their care plan prior to its implementation:

*CPLTC 1993 and 1999, § 58072(a).* (a) A Care Management Provider agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. The list shall include:
(5) a right for active client participation in the development and implementation of the Plan of Care. The client or officially designated representative shall, prior to implementation, receive a copy of the Plan of Care and a written list of all potential service providers to be involved in implementation of the Plan of Care.

*Analysis of Case Records*

In all 33 cases reviewed, there was no evidence in case records to indicate that policyholders received a copy of their care plan. Because there were no data available, we were not able to determine compliance with the regulation requiring that this copy was received by the policyholder “prior to implementation.”

*Policyholder/Family Interviews*

Although analysis of case records showed no evidence that policyholders received a copy of the care plan, policyholder and family interviews revealed that a copy of the care plan was received by 12 out of the 19 policyholders who were interviewed. Of the caregivers who stated that they received a copy of the care plan, seven policyholders or representatives remembered when they received their copies: two policyholders received copies at the time of assessment, two of them received them one week after their
assessments, and three policyholders received copies 2 to 4 weeks after their assessments (Table 19).

Table 19. Policyholders Receiving Copy of Care Plan

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records (n=33)</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Policyholder interviews (n=19)</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

Eight out of 12 policyholders who received a copy of their care plan stated that the written copy of the care plan was helpful. For example, one stated that it was “a good summary” of the services that were being provided; another stated that it was helpful for referencing details such as dates; and another stated that it reduced confusion and helped communicate needs to family members. Ten out of 18 family members interviewed also felt that a copy of the care plan was helpful.

Four policyholders who received a copy of their care plan stated that it was not helpful to have a copy of the care plan. One policyholder felt that a copy of the care plan was not helpful because he was “already doing” what was indicated on the care plan; one policyholder felt a written copy was not necessary because he and the care advisor “had already talked about it all”; and one policyholder indicated that she had not looked at her care plan since receiving it in the mail. Two family members out of 18 interviewed indicated that they did not find the care plan helpful, but neither family member indicated why they felt that having a copy of the care plan was not helpful.

Of the seven policyholders and representatives who stated that they did not receive or could not remember receiving a copy of the care plan, four stated that it would have been helpful to receive a copy of the care plan. Several reasons offered for why it would have been helpful included “it would have improved the communication process,”
the policyholder “would not have had to ask so many questions,” and it would have helped the policyholder “to set goals.”

**Summary of Findings Regarding Care Plan Receipt**

Although no case record contained evidence that policyholders were given copies of their care plans, a majority of those interviewed indicated that they in fact had received copies. As in the case of consumer participation, this again shows that the lack of documentation does not necessarily reflect noncompliance with regulations. Of particular interest was that a majority of those who reported receiving copies indicated that they were very helpful, and that many remembered when they had received copies. This appears to affirm the usefulness of giving policyholders copies of their care plan as a practice standard and the retention of the regulation requiring it.

**Recommendations Regarding Care Plan Receipt**

We recommend retaining the requirement that policyholders receive written copies of their care plans, and also suggest that the time frame for giving policyholders copies be more clearly specified; “prior to its implementation” is not uniformly understood and cannot be measured with available case file documentation. We recommend that CMPAs’ policy and procedure manuals define clearly an allowable timetable for giving a copy of care plan to each policyholder. Furthermore, we suggest that documentation appear in the case file that confirms when copies were given to policyholders.
Satisfaction with the Care Planning Process

Policyholder/Family Interviews

In the first in-person interview, policyholders were asked how satisfied they were with the care planning process. Of the 19 policyholders interviewed, 9 indicated that they were very satisfied, 7 indicated they were somewhat satisfied, 1 was very dissatisfied, and no response was entered for 2 others. When asked what would make the process better, three stated that earlier and more involvement would have been helpful, and three others stated that better follow-up would have improved the process.

These themes were also echoed by family members. Five stated that earlier and more in-depth involvement by the care manager would have been helpful. One family member stated: “Care manager should be on the case immediately instead of leaving the coordination and care to the family during the deductible period.” Five others indicated that more guidance about services and policy requirements would have been helpful. The following two examples illustrate this theme: “A little more guidance would have been helpful about getting into the process,” and “It would have been more helpful if it had been clear upon discharge [from the hospital] that homecare was a covered benefit” (Tables 20 and 21).

Table 20. Policyholder Satisfaction with the Care Planning Process

<table>
<thead>
<tr>
<th>Satisfaction Level</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>9</td>
</tr>
<tr>
<td>Somewhat satisfied</td>
<td>7</td>
</tr>
<tr>
<td>Not satisfied</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=19
Table 21. Recommendations for Improving the Care Planning Process

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policyholder interviews (n=19)</td>
<td></td>
</tr>
<tr>
<td>▪ More/earlier involvement</td>
<td>3</td>
</tr>
<tr>
<td>▪ Better follow-up</td>
<td>3</td>
</tr>
<tr>
<td>▪ No recommendations</td>
<td>7</td>
</tr>
<tr>
<td>▪ Not applicable</td>
<td>2</td>
</tr>
<tr>
<td>Family interviews (n=18)</td>
<td></td>
</tr>
<tr>
<td>▪ Earlier/more in-depth involvement</td>
<td>5</td>
</tr>
<tr>
<td>▪ More guidance re services/LTCI policy</td>
<td>4</td>
</tr>
<tr>
<td>▪ No recommendations</td>
<td>7</td>
</tr>
<tr>
<td>▪ Response not applicable to care planning process</td>
<td>2</td>
</tr>
</tbody>
</table>

**Summary of Findings Regarding Satisfaction**

Overall, almost half of all policyholders interviewed were very satisfied with the care planning process. These data along with policyholders’ and family members’ recommendations, particularly the themes of earlier and greater involvement, provide useful information for improving the policies and procedures involved in this critical care management activity.

**Summary of Findings Regarding Care Plan Development**

The assessment tools currently being used as the bases for developing care plans are not adequate for the purpose of taking “an all inclusive look” at policyholders’ needs. Several areas are typically omitted, such as emotional and psychological status, nutrition status, environmental safety, emergency response systems, changes in social activity, potential for rehabilitation, tobacco and alcohol use, and level of care management needed.

Moreover, a significant number of issues identified in current assessments were not addressed in corresponding care plans in spite of using summary problem lists. A related finding was that some policyholders were not satisfied with their care plans because they did not include all of the relevant issues that they perceived to be important.
Regarding specific structural elements of care plans, two of the three CMPAs did not require problem statements on their care plans. In these cases, it was difficult if not impossible to ascertain what the recommended interventions were intended to address. Also, considerable variation was noted in how problem statements were constructed, in terms of detail and reference to particular functional impairments. Although all CMPAs included items labeled “goal” or “purpose” on their care plans, interpretations varied widely. Two CMPAs appeared to use goal statements as mechanisms for elaborating on service interventions rather than on client-oriented outcomes. The care plans administered by the third CMPA did include client-oriented goals, although these varied considerably in terms of their specificity. The overall lack of time frames or other specific ways to measure goal attainment was also noted. Of the six types of service descriptors noted in the care plans, type of service and provider information were almost always indicated. However, source of payment was missing in approximately one-third of the plans, information about cost of services was missing in over two-thirds of the plans, frequency of services was missing in over one-third of the plans for noninstitutionalized policyholders, and the role of informal supports was missing from almost half of the care plans.

Several other aspects of care plan development were also reviewed. Calculation of turnaround times proved to be quite difficult due to outdated information in policy manuals, unclear benchmark definitions, and the lack of needed data in case records for making calculations. Three cases of potential conflict of interest were identified in which assessors/care advisors were employed by agencies that also provided other services. Case records also lacked explicit evidence of approval of care plans by the CMPAs, as required by regulation. Although verbal information solicited from CMPAs revealed that internal case managers in the CMPAs typically reviewed care plans submitted by local
field case managers for appropriateness and completeness, it is still unclear whether this in fact constitutes “approval,” and whether any official written documentation was completed.

Regarding consumer participation, interviews revealed that policyholders and their representatives were much more involved in developing care plans than case documentation indicated, indicating that the lack of such documentation does not necessarily reflect the lack of a process or noncompliance with the regulations. Nevertheless, a number of policyholders and representatives indicated that they were not actively involved in spite of these processes. Furthermore, it is altogether unclear to what extent, if any, other policyholders and representatives who were not interviewed actually participated in the development of their care plans. Similarly, a majority of policyholders interviewed indicated that they in fact had received copies of their care plans as required by regulations, although no case record contained evidence that they were given copies. Finally, almost half of all policyholders interviewed were very satisfied with the care planning process.

**Recommendations Regarding Care Plan Development**

A summary of all of our recommendations related to the care planning process follows:

- Use a comprehensive list of all problems identified from assessment information; include documentation in case records indicating reasons for omitting problems identified in the assessment.
- Include documentation in case records of active participation by policyholders and representatives/family members; include documentation in case records
specifying any reasons that policyholders could not participate, if applicable, and the identity of their designated representative.

- Specify allowable turnaround times in CMPA policy manuals, using time intervals between initial claim and completion of assessment, between approval of assessment and completion of care plan, and between initial claim and policyholder notification of claim status; include documentation in case records of benchmark dates to allow determination of compliance, and any reasons for delay in meeting specified time intervals.

- Delete from regulations the time frame for giving copies of care plans to policyholders; require CMPAs to specify in manuals the time frame for giving copies of care plans to policyholders; include documentation in case records confirming that policyholders receive a copy of the care plan.

- Specify process for approving care plans in CMPA manuals; include documentation in case records of care plan approval.

- Delete “CMPAs” from regulation § 58075(a) and substitute “assessors and care managers; specify procedures in CMPA manuals regarding how regulations will be met.

A Sample Care Plan illustrating a format for implementing these recommendations is provided in Appendix C.
CARE PLAN IMPLEMENTATION

Care plan implementation involves an array of care management activities through which the care plan is put into effect. These activities may include providing information about available services, as well as educating clients and family members about how to access services or perform specific care activities themselves. It may also entail “service coordination,” which we define as the active involvement of a person or persons, such as clients, family members, or case managers, in arranging for or maintaining specific services.

Geron & Chassler (1994) state that care plan implementation should be timely and cost-effective, with the goal of maximizing “client independence and choice while using the least intensive, least intrusive, most cost effective, and highest quality interventions.” Information and education are also seen as important components of the process, since many consumers are not knowledgeable about the long-term care system and require specific instruction about how to maximize their access to and utilization of needed health and social services (Seltzer et al., 1987; Quinn, 1993; Geron & Chassler, 1994).

There is also recognition that implementation involves a variety of considerations, such as the services and goals identified in the care plan, funding limits and authority to purchase services, availability of local providers, and size of caseload (Quinn, 1993; GAO, 1993; Geron & Chassler, 1994).

It is widely recognized that not all clients need or want help with implementing their care plans. For example, they may not need information about services when the care plan is simply a replication of services already in place, or they may wish to coordinate services themselves or have family members who are capable and willing to do this. On the other hand, some clients do not have the capacity or desire to implement their own
care plans due to factors such as lack of family support or cognitive or physical impairment. Under these circumstances, assistance with implementation of care plans for these clients, including service coordination, may be desired by them or required to ensure safety.

In this chapter, we review care management activities related to the implementation of the care plans. Case records and policyholder reports of implementation activities are examined in light of Partnership regulations and established practice standards. Areas examined include: documentation of implementation activities, information and education, service coordination, system coordination, client participation, and, consumer satisfaction.

**Documentation of Implementation Activities**

The three CMPAs vary considerably in the details provided in their manuals regarding their definitions of care plan implementation. One includes it in a description of the role of the care manager: “Contact client and direct service providers and arrange for . . . service delivery.” Another CMPA refers to “coordination and implementation” following the development of the care plan, stating that it will be “. . . scheduled on a case by case basis, mostly by telephone.” The third CMPA’s description originally included two distinct levels of implementation, one which was primarily involved in assisting the client or family to implement the care plan themselves by providing information or education, and another in which the care manager assumed full responsibility for all service arrangements. This policy was subsequently replaced with a new care management schema, which includes a uniform “care planning and implementation” phase that is specifically authorized and ordered in writing by the insurer’s agent for all clients.
According to this new policy, implementation entails identifying, arranging, and coordinating needed services by the care manager, as agreed upon by the policyholder or official designee, and begins immediately after the care plan is finalized with the policyholder.

**Analysis of Case Records**

Of the 33 case records reviewed, 19 contained documentation that at least one care plan implementation activity was performed by the case manager. Fourteen case records had no evidence of any implementation activities; 11 of these had no progress notes, and the 3 case records that contained progress notes lacked any specific documentation related to implementation activities (Table 22).

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records</td>
<td></td>
</tr>
<tr>
<td>Evidence of implementation</td>
<td>19</td>
</tr>
<tr>
<td>No evidence of implementation</td>
<td>14</td>
</tr>
</tbody>
</table>

Note: n=33

Of the 19 cases reviewed, 7 included explicit orders to institute the “care planning and implementation” phase. Another 10 cases contained progress notes reflecting various implementation activities immediately after the care plan was finalized, but lacked any official orders for care plan implementation. The remaining two cases were administered by another CMPA, which labeled these activities as implementation, although they occurred during the first few weeks after development of the care plan (Table 23).
Table 23. Care Plan Implementation Delineated

<table>
<thead>
<tr>
<th>Implementation phase delineated</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase ordered (7)</td>
<td>17</td>
</tr>
<tr>
<td>Phase not ordered but apparent in notes (10)</td>
<td></td>
</tr>
<tr>
<td>Implementation phase not delineated</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=19

Two of the CMPAs do not appear to have placed a specific timeframe on implementation activities. In the case of the third CMPA, the “care planning and implementation” phase appears to be a start-up activity rather than an ongoing activity. This is reinforced by the CMPA’s description of its next case management phase, the “ongoing case management” phase, which was ordered after care plan implementation when services were in place and “stable.” Case records for this ongoing care management phase were distinct, and characterized by structured monthly monitoring progress notes, typically extending for several months. For 16 of the 17 cases administered by this CMPA, the average time span for care plan implementation was 35 days, with a low of 14 days and a high of 97 days, even in those cases in which orders indicated that the implementation phase was to extend for only 7 days (Table 24).

Table 24. Time Span for Care Plan Implementation Phase

<table>
<thead>
<tr>
<th>Length of Implementation Phase</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14 days</td>
<td>1</td>
</tr>
<tr>
<td>15–28 days</td>
<td>9</td>
</tr>
<tr>
<td>29–42 days</td>
<td>2</td>
</tr>
<tr>
<td>43–56 days</td>
<td>1</td>
</tr>
<tr>
<td>57+ days</td>
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</tr>
<tr>
<td>Data missing</td>
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</tr>
<tr>
<td>Average length of implementation phase</td>
<td>35</td>
</tr>
<tr>
<td>Range of days</td>
<td>14–97</td>
</tr>
</tbody>
</table>

Note: n=17. “Care Plan Implementation” is delineated by the CMPA as beginning immediately after the care plan is developed, and continuing until the services are implemented and “stable.”
Case records revealed that a variety of implementation activities were performed. A total of 79 separate implementation activities were noted in the 19 cases in which implementation activities were documented. These activities fell into five general categories: general education/information about available services, information about policy coverage, arrangement of services, assistance with paperwork for independent providers (IP), and assistance with billing/payment. The first two items regarding information and education will be discussed separately from the three latter items, which fall under our definition of “service coordination” (Table 25).

Table 25. Types/Instances of Implementation Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information re LTCI policy</td>
<td>23</td>
</tr>
<tr>
<td>Information re services</td>
<td>7</td>
</tr>
<tr>
<td>Arrange services</td>
<td>9</td>
</tr>
<tr>
<td>Assist with IP paperwork</td>
<td>9</td>
</tr>
<tr>
<td>Assist with billing Request</td>
<td>31</td>
</tr>
<tr>
<td>Coordinate with providers</td>
<td></td>
</tr>
<tr>
<td>Total activities</td>
<td>79</td>
</tr>
</tbody>
</table>

Note: n=19

**Information and Education**

Providing information about available services, and educating clients and their families about how to access these services, is a basic component of implementing care plans. Most consumers are unaware of the full array of available services or how to contact services they may have heard about. Provision of prepared lists and brochures describing specific services that might meet their needs and instruction about how to obtain such information for themselves is an essential role of care managers. Once appropriate services have been identified, many clients need further assistance in understanding the complexities of eligibility requirements and application procedures in order to success-
fully negotiate service systems. This information is particularly important when clients
implement their own plans. In addition, some clients may need tips on hiring and supervis-
ing in-home workers, and may also benefit from education about specific health
conditions and self-management.

Analysis of Case Records

Of the 79 separate implementation activities documented, 7 involved providing informa-
tion about available services. The most common type of information provided related to
home-care agencies; assisted living and skilled nursing facilities were the second most
common type of information provided. In several instances, the type of material provided
was noted (i.e., list or directory), although no mention was made in any of the case notes
about whether these materials were prepared by the care managers or obtained from other
sources, or whether they were comprehensive listings of all available services or selective
listings.

An additional type of information that is typically needed by policyholders of
long-term care insurance policies relates to their policy coverage. Twelve of the 19 case
records that documented implementation activities noted 23 separate conversations
related to policy information between policyholders or family members and care advisors
or insurer’s agents. The most common questions related specifically to the deductible or
“elimination” period, including what services would meet it, how was it calculated, what
paperwork was required to verify expenditures made, and how would they know when it
was met. These questions were generally asked during the first several weeks following
the initial claim, and then tapered off.
Service Coordination

Service coordination differs from information and education in that it entails the active involvement of individuals, such as clients themselves, their family members, or care managers, in arranging for or maintaining specific services.

Although CPLTC regulations do not define service coordination, the following statute reflects this variability in need for service coordination by specifying a decision-making process that involves two distinct, but linked processes:

*CPLTC 1993, § 58004; 1999, § 58005.* “Care Management/Care Coordination” includes, but is not limited to the following:
(d) when desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services.

Regulations also specify that these services, when elected, can be considered a “claim cost.”

*CPLTC 1993 and 1999, § 58059(f).* Care management services by a Care Management Provider Agency. Charges for the initial assessment and individual Plan of Care provided by a Care Management Provider Agency shall not be considered as a claim cost. Charges for coordinating the provision of care and monitoring services can be considered as a claim cost.

Most Partnership insurers administer service coordination as an optional claim cost that is billed under policyholders’ policies. One insurer includes service coordination as an administrative expense during its care plan implementation phase, and makes these services available to all of their policyholders for at least seven days.

According to Weil (1985), the heart of service coordination is getting all the pieces of the care plan into place so that they are carried out in a logical sequence. Specific service coordination activities may include working with providers to assure service availability; locating other providers, and developing substitute services when necessary (Capitman, Haskins, & Bernstein, 1986); sending written service requests to
appropriate service providers; establishing a minimum response time between ordering services and the first monitoring contact to determine whether the service has been provided in a timely manner (NCOA, 1994); contacting service providers; assisting with paperwork related to services; coordinating payment sources; and handling bills. Other activities include identifying, negotiating with, and coordinating service providers (Quinn, 1993), and informing the consumer’s family, service providers, and health and social service providers of relevant information from the assessment and care plan (Applebaum & Austin, 1990; Brubaker, 1987). These activities may involve distributing written requests for services, and possibly copies of the care plan, to the involved formal service providers.

Coordination of services for persons who have disabilities and chronic conditions poses special challenges. These services are likely to be provided by a number of different formal and informal providers in acute and long-term care service systems having different payors with diverse policies and procedural requirements. Therefore, coordination requires that the care manager be knowledgeable about these funding sources in order to ensure the “continuity and complementarity” of the range of necessary interventions (NASW, 1992). Coordination of payment sources is particularly important under private long-term care insurance policies such as Partnership policies. CPLTC regulations require that the care manager link the person to a full range of services using all available funding sources, and integrates acute care with chronic care to avoid service duplication. Moreover, Partnership policies will only reimburse for long-term care services after all other funding sources, such as Medicare, have paid. Therefore, an important part of the service coordination process under the Partnership involves
coordinating with other payors such as Medicare, acute care health plans, and supplemental insurance plans.

Analysis of Case Records

Of the 33 case records reviewed, care manager progress notes indicated that service coordination was provided in 19 cases; in 4 of these cases, service coordination was provided directly by the insurer rather than by a local care manager. UDS data indicated that “coordination” was reported for only 8 of the 33 cases. Moreover, it is unclear whether this category was interpreted as meaning “service coordination” only, or if it was used for all implementation activity including service coordination. Of these eight cases reported in the UDS, only three cases also showed evidence in progress notes of service coordination (Table 26).

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>UDS</td>
<td>8</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: n=33

Of the 19 case records documenting service coordination, only 1 contained documentation that the policyholder expressed a desire for it and that there was a determination of its necessity. This determination was done by an insurance agent, not a care manager or CMPA as specified in regulations, who also stated incorrectly in a file note that coordination was “required” since it was a Partnership case. Also of interest is that the insurance agent contacted an agency directly rather than referring the case to the CMPA. An entry for service coordination did not appear on the UDS for this case.

Detailed analysis of the 19 cases documenting service coordination revealed 47 separate instances of service coordination. These activities fell into three general types:
assistance with billing/payment, arranging services, and assistance with paperwork related to independent home-care providers. Assistance with billing and payment for services, especially during the deductible period, was the most common coordination activity, accounting for over two-thirds of all instances. This included requests for medical records to verify service provision used to count against the deductible, and coordinating bill payment with service providers. All of these activities were provided by the insurer’s in-house care managers, not local field care managers contracted by the CMPA. The second most common coordination activity was assisting with paperwork related to hiring independent providers and documenting work provided. This included sending out release of liability forms and timesheets, and explaining how to complete timesheets. These activities were also generally performed by the insurer’s in-house care managers rather than local field care managers. Nine instances of arranging for services were noted. These included seven specific instances in progress notes (e.g., ordering medical supplies, arranging for examinations, and making referrals for specific services such as home care and friendly visitation), and two additional instances that were identified in policyholder interviews, including obtaining medications and arranging for services. Seven of these activities were performed by local field care managers, and two were performed directly by insurers.

An analysis of services actually utilized, as reported to the UDS, revealed gaps in care plan implementation, perhaps reflecting inadequate or incomplete service coordination. Of the 32 policyholders whose care plans were reviewed, only 10 reportedly utilized all of the services authorized in their care plan (Table 27).
Table 27. Types of Service Coordination Provided

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Instances</th>
<th># of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrange services</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Independent provider paperwork</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Assist with billing/payment</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Request for records (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill coordination (4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The number of cases in which specific activities were noted exceeds n=19 since many cases noted multiple service coordination activities.

System Coordination

Two Partnership regulations contain guidelines for coordinating services across systems:

**CPLTC 1993, § 58004; 1999, § 58005.** . . . Care Management/Care Coordination takes an all-inclusive look at a person’s total needs and resources, and links the person to a full range of appropriate services using all available funding sources.

**CPLTC 1993 and 1999, § 58073(a)(2).** . . . Each record review shall be documented on a record review form and shall include, but not be limited to, verification that:

(E) the provision of services is coordinated with those provided by other agencies to avoid duplication of services, and to integrate acute care with chronic care.

Analysis of Case Records

These stipulations require knowledge of available services and alternate payor sources, as well as direct coordination of these sources by the care manager. Awareness of other payor sources was evident in 27 of the 32 care plans, all of which included at least one payor source. In all, 40 separate notations of payor sources were listed, including private pay, long-term care insurance, Medicare, and Kaiser. Most of these notations consisted of a single payor for each recommended service; private pay was the most common notation (16), and Kaiser was the least common (3). Of the seven Medicare notations, only one specified Part A or Part B. Long-term care insurance was noted in only six instances.
Multiple payors for recommended services were noted in eight instances. A unique example of multiple payor sources for home health care listed “private pay until 30 day deductible met, then [long-term care insurance].” Only five plans did not include payor information; this information was missing in four plans, and was not relevant in one case or because the family provided all of the care.

Progress notes were also reviewed for evidence of active coordination and integration of acute and long-term care services. Of the 20 case records that included progress notes, 9 specifically identified other insurance coverage, such as Kaiser, Medicare, and Blue Shield. Of these, four case records explicitly mentioned active coordination of benefits, including “consultation and follow-up with Kaiser”; one indicated coordination of payment for services with other insurance carriers; one indicated coordination with workers’ compensation; and one indicated that a Medicare provider had been asked to verify care. Progress notes in five other cases documented the status of billing by other payors, but did not indicate active coordination with them (Table 28).

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single payor Sources</td>
<td></td>
</tr>
<tr>
<td>Private pay/client only (16)</td>
<td></td>
</tr>
<tr>
<td>Medicare only (7)</td>
<td></td>
</tr>
<tr>
<td>Long-term care insurance only (6)</td>
<td></td>
</tr>
<tr>
<td>Kaiser only (3)</td>
<td></td>
</tr>
<tr>
<td>Multiple Payor Sources</td>
<td>8</td>
</tr>
<tr>
<td>Private pay and LTCI (6)</td>
<td></td>
</tr>
<tr>
<td>Kaiser, LTCI, and private pay (1)</td>
<td></td>
</tr>
<tr>
<td>Medicare or private pay (1)</td>
<td></td>
</tr>
<tr>
<td>Total notations of payor sources</td>
<td>40</td>
</tr>
</tbody>
</table>

Note: n=27. Total number of payor sources exceeds the number of care plans reviewed, since some care plans included several service recommendations.
These data suggest that while most case records included information about services and payor sources, little active coordination or integration of acute and chronic care was actually done. This may be due to the ambiguity of the regulatory phrase “integration of acute and chronic care” and the resulting confusion about what this should entail. It may also be due to the difficulty in coordinating with care systems that are outside of local field care managers’ jurisdictions, and consequently are not viewed as legitimate or practical aspects of the care manager’s role.

**Policyholder Experience**

Interviews with 19 policyholders provided other perspectives on service coordination activities. In the initial in-person interviews, conducted 30 to 180 days after the date of the care plan, 7 policyholders reported some involvement of their care manager in coordinating services. Policyholders’ reports of specific coordination activities generally reflected care managers’ progress notes in the areas of arranging services, assistance with IP paperwork, and billing. Monthly telephone interviews indicated that much of the assistance they required related to understanding their long-term care insurance policies and negotiating insurers’ paperwork requirements. Of the 12 policyholders who reported in the in-person interview that their care managers were not involved in coordinating services, 3 policyholders reported that they coordinated services themselves, and family or friends performed this role in the other nine cases.

A particularly interesting finding from these interviews was the apparent lack of understanding of the care manager’s role by seven of the policyholders. Two reported specifically that they were confused about service coordination, stating, “. . . I did not know I could use the care manager for [service coordination] and didn’t know what her
job is and what she can do,” and “I did all the arrangement myself. If I had known about this care manager, I would have called.” Five other policyholders also indicated that they were not clear about the role of the care manager in general, perhaps resulting in an underutilization of service coordination. A representative comment was, “I really don’t know what to expect of her.”

**Client Participation**

Partnership regulations give policyholders the right to actively participate in the implementation of their care plans; this right is implied for their representatives:

*CPLTC 1993 and 1999, § 58072(a).* A Care Management Provider Agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. This list shall include:

(5) a right for active client participation in the development and implementation of the Plan of Care.

**Analysis of Case Records**

Nine case records contained documentation in progress notes that these policyholders participated in the implementation of their plans. In 24 cases, no documentation was present to indicate this. In four of these cases, progress notes indicate that policyholders were incapacitated and not able to participate. Twenty-one case records contained evidence that policyholders’ designated representatives or family members were involved in implementing their care plans; 12 case records contained no such documentation (Table 29).

| Table 29. Policyholder/Family Participation in Care Plan Implementation |
|--------------------------|----------------|------|
|                         | Yes | No  |
| Policyholders           | 9   | 24  |
| Representatives/family members | 21  | 12  |

Note: n=33
Consumer Satisfaction

As part of in-person exit interviews, policyholders were asked to respond to four questions relating to whether or not they were satisfied with service coordination. While most policyholders were satisfied with services, three respondents stated that they needed more help than they received from their care manager, six indicated that their care manager had failed to get services they needed, five wished that their care manager could have done more, and four did not think that their care manager had done a good job in setting up care for them. When these responses were analyzed for patterns, the same two policyholders consistently expressed dissatisfaction in all four domains, indicating a comparatively negative experience with service coordination (Table 30).

Table 30. Policyholder Satisfaction with Service Coordination

<table>
<thead>
<tr>
<th>Question Asked</th>
<th>Yes, Definitely</th>
<th>Yes, I think so</th>
<th>Maybe yes/maybe no</th>
<th>No, I don’t think so</th>
<th>No, definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need more help from my care manager than I get (#9d)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>My care manager has failed to get me the services I need (#9h)</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>I wish my care manager/advisor could do more things for me that I need to have done (#9i)</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>On the whole, my care manager/advisor does a good job setting up care for me (#9i)</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: n=17 for questions #9d, 9h, and 9i, and n=16 for question #9i.

Policyholders made a number of recommendations regarding how care managers could better help them. Five policyholders stated that they would have liked their care managers to provide more liaison with the insurance company or agencies, three wanted specific recommendations of services, and two would have liked more help finding or hiring providers (Table 31).
Table 11. Policyholder Recommendations Regarding Service Coordination

<table>
<thead>
<tr>
<th>Type of Recommendation</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>More liaison with insurance company or agencies</td>
<td>5</td>
</tr>
<tr>
<td>More specific service recommendations</td>
<td>3</td>
</tr>
<tr>
<td>More helpful finding/hiring independent providers</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=10

The following are sample responses:

“Could have helped him more in obtaining an aide originally by recom- mending someone. Provided him with a list and he had to interview. Could have provided him with assistance with the interview process . . . at least the first few.”

“The initial care manager could have helped to get workers who were a good match; we went through several who did not work out. The second care manager did assist with hiring appropriate workers.”

“If the care manager has been involved sooner, she would have saved us a lot of time. Perhaps the care manager could spend time to investigate [providers] locally so that she could recommend agencies. All we ever got was a list of providers.”

“The case manager could have helped collect the necessary paperwork from Kaiser and the convalescent home to process [the policyholder’s] file quicker. [The policyholder] could have lost her aide because she couldn’t pay for her entire amount.”

“Care manager is not knowledgeable about services in this area, what insurance will cover, or how to get services covered. Perhaps insurer can provide training in this area.”

“It is difficult to get itemization from the SNF and submit it to the insurer. Perhaps the care manager could help and perhaps check into SNF quality of care.”

**Summary of Findings Regarding Care Plan Implementation**

“Care plan implementation” and “service coordination” are not clearly defined in regulations or in the care management literature. This is reflected in the variability evidenced by CMPAs in their own definitions, in the inconsistent UDS reporting of these activities, and in the considerable differences in how these activities are organized and administered by the CMPAs. It is especially striking that these services appeared to be underutilized, since 20 of the 33 cases reviewed provided them as an administrative expense for all policyholders. While the low utilization level may be partially due to policyholders’ own
preferences or the lack of need for this service, we were not able to determine any definitive explanation for this. This was due to the lack of evidence that policyholders and care managers engaged in a mutual decision-making process about the desire or need for it, as required by regulation. What we did identify was that a number of policyholders were not entirely satisfied with the process, and many were confused about the role of care managers. This may have been related to the finding that much of the documented implementation/service coordination was provided by insurer agents or their in-house care managers rather than by local field care managers.

Information collected through questionnaires and interviews with local field care managers and CMPA staff also revealed several other factors that may impact care implementation activities. Local field care managers appear to have limited responsibility and decision-making ability regarding what services are provided. Rather, their role is to collect information and make recommendations to the CMPAs, which then decide how much service will be provided and for how long. Level of reimbursement for local field care managers’ time also appeared to be a factor. Local field care managers for one CMPA are paid a capitated monthly fee, regardless of how much assistance their clients required. This may have had a limiting effect on the amount of implementation and service coordination actually provided. One care manager’s comment in this regard is illustrative: “There have been some cases where I thought it was important to see the client more than once, and if I happened to be in their area, I might drop by to talk to them. But I do this on my own time since I don’t really get paid for it.”

**Recommendations Regarding Care Plan Implementation**

Based on these findings, we recommend that care managers assess whether policyholders need information and education about services, and whether there is a need for service
coordination. Documentation should appear in case records reflecting the discussion between care manager and policyholder about the availability of service coordination, whether or not the policyholder desires it, and whether or not the Care Management Provider Agency determines that it is necessary, along with the rationale for this determination. If service coordination if not elected, documentation should be included identifying who will be responsible for coordinating services. If service coordination is elected, it should appear as a separate item in the care plan, and should be described fully in terms of frequency, cost, specific types of coordination activities, and who is responsible for providing these activities.

We also recommend that a written description of the care manager’s role be given to the policyholder, specifically outlining what service coordination is, and how it can be obtained. This is intended to address the confusion among policyholders about what to expect from care managers, and may also improve consumer satisfaction ratings.

Finally, we recommend that the wording of regulation § 58072(a)(5) be changed, deleting the italicized words: “. . . a right for active client participation in the development and implementation of the Plan of Care.” Our rationale is that whereas the right of clients to actively participate in care planning is an established standard of good care management, “implementation” of the care plan is not well defined. Consequently, it is subject to varied interpretation, is not consistently administered, and is difficult to measure. In addition, it is an unnecessary mandate, since many policyholders do not receive implementation or service coordination under Partnership policies, and may prefer to implement their own care plans without the assistance of care managers.
CARE MONITORING

Care monitoring is the process of checking on the status of clients, their needs, and the services currently in place to address those needs. It can serve a number of purposes, such as measuring and evaluating progress toward goals identified in the plan of care (SF Commission, 1996; Weil, 1985), assessing whether provider services are being implemented in accordance with the care plan, and determining whether problems in the service delivery may require changes to the care plan (Geron & Chassler, 1994; Weil, 1985). Care monitoring may also fulfill agency and governmental requirements, such as verifying that clients still qualify for benefits under health care and long-term care insurance policies. Care monitoring also is one of the primary methods through which quality assurance requirements in CPLTC regulations can be implemented, including determining whether client needs are met as identified in the plans of care, assessing client satisfaction, and eliciting client suggestions (CPLTC 1993 and 1999, § 58073a1F).

Monitoring services play an important role in assuring the quality of direct services (Weil, 1985; Geron & Chassler, 1994) and improving the overall quality of care (Kane, 1988; Applebaum, 1992). In both the Channeling demonstration and the Ohio Quality Assurance Project, PASSPORT, individual care manager functions were important in efforts to monitor the quality of service providers. Monitoring functions included scheduling visits at the same time as provider visits, keeping logs of provider problems, and using written checklists of services to be performed to inform and encourage clients and their families to be better consumers of care (Applebaum & McGinnis, 1988, 1992; Kemper 1990).

Monitoring includes many responsibilities for the care manager, and is a “core function that is often difficult to carry out” because case managers must stay involved
with clients (Weil, 1985). It requires regular contact with clients, family members, and providers in order to evaluate both the client’s condition and the quality of provided services. Monitoring of services must also recognize unscheduled demands, crisis points, and service reentry requirements. Monitoring should involve establishing a minimum required frequency of contact with the individual and establishing whether contacts should be made by telephone or in person (NCOA, 1994). The time frames for monitoring, as well as specific services, should be established in the care plan.

Care monitoring can be accomplished in a number of different ways, including any or all of the following methods: phone or face-to-face contact with clients, verbal or written reports from service providers, and client or family-initiated contacts with the care manager to report changes in client status or quality of service delivery. Monitoring may involve both scheduled and nonscheduled contacts. The frequency of monitoring varies depending on the intensity of client needs and the types of services being provided (Applebaum & Austin, 1990). Although the type of monitoring done will depend on its intended purpose to some extent, several dimensions can be used to analyze it. These include process characteristics such as the mode of contact used, frequency of contact, and content of the contact, as well as outcome characteristics such as what information was collected and documented, and what response was made by the care manager.

Published case management standards and guidelines agree that all monitoring contacts with the client should include the following: a review of consumer goals, needs, and desired outcomes; an assessment of consumer satisfaction with the care plan and with services provided; and an evaluation of effectiveness of the type and frequency of monitoring being provided. It is important to review any identified problems with clients
and all of the parties involved with their care (Quinn, 1993), and document all monitoring
contacts including date, information obtained, actions taken, and follow-up needed.

Unlike assessments and the development of care plans, which are required com-
ponents of Partnership policies, ongoing monitoring of services is not required, but rather
may be elected through a decision-making process that involves two distinct but linked
processes: client choice and professional determination of need.

*CPLTC 1993 and 1999, § 58004.* “Care management” includes, but is not limited
to the following: (d) when desired by the individual and determined necessary by
the Care Management Provider Agency, coordination of appropriate services and
ongoing monitoring of the delivery of such services.

Regulations also specify that these services, when elected, can be considered a
“claim cost”:

*CPLTC 1993 and 1999, § 58059(f).* Care management services by a Care Man-
agement Provider Agency. Charges for the initial assessment and individual Plan
of Care provided by a Care Management Provider Agency shall not be considered
a claim cost. Charges for coordinating the provision of care and monitoring
services can be considered a claim cost.

In this chapter, we examine reports of monitoring activities in light of Partnership
regulations and practice standards. Aspects of care monitoring examined include: (a)
documentation of care monitoring, (b) election of care monitoring, (c) types of contact,
(d) care plan changes, (e) identification of clients’ needs, (f) consumer satisfaction, and,
(g) discharge planning.

**Documentation of Care Monitoring**

Most Partnership insurers administer monitoring services as optional claim costs that can
be billed under policyholders’ policies. One insurer includes monitoring as an adminis-
trative expense, and typically makes it available to all of its policyholders for 6 months
after the care plan is finalized, unless otherwise ordered by the insurer’s benefits administrators.

The CMPAs vary somewhat regarding how case monitoring is implemented. One CMPA instructs its local field care managers to conduct at least one telephone contact for each enrollee per month in the early stages of the claim. Care managers are supposed to use a set of standardized monitoring questions, including prompts for determining continued eligibility, need for changes in the care plan, appropriateness of services being provided, and presence of newly identified needs. Care managers are advised to use their professional discretion when asking these questions, and to document all monitoring contacts. Home visits may also be ordered, if needed. When the case becomes “stable,” care managers in the third-party administrator’s offices then assume responsibility for case monitoring; frequency of monitoring depends on policyholders’ needs, but contacts are made no less often than every 6 months.

A second CMPA also conducts case monitoring primarily by telephone. During the first month, monitoring is supposed to be conducted as needed by “field care managers”; afterward, contacts might be made every 60 days depending upon the policyholder’s status. When cases are “longstanding and stable,” monitoring contacts may be made by the “internal case managers, perhaps every 90 days.” No external case monitoring is considered necessary when policyholders are in skilled nursing or assisted living facilities.

Care monitoring procedures are less detailed for the remaining CMPAs. A statement in a recent annual report states: “Once the plan of care is implemented, there is a monthly monitoring contact. The monthly contact includes contact with the client, their
caregivers, and/or the service providers. During the monthly contact, the client status, service needs and service delivery are reviewed.”

**Analysis of Case Records**

A review of case records revealed that monitoring was documented in progress notes for 20 of the 33 cases reviewed. All 20 of these cases had policies with the insurer that included monitoring as an administrative expense. UDS data include reports of monitoring for 14 of the 33 cases reviewed. Six other cases had progress notes that reported monitoring contacts, but monitoring was not reported on the UDS (Table 32).

<table>
<thead>
<tr>
<th>UDS Reports</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case records</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: n=33

**Election of Care Monitoring**

Only 6 case records out of the 33 reviewed included any evidence of the two-step process outlined in CPLTC regulations for determining whether monitoring would be implemented. In all six cases, the evidence consisted of a notation, signed by policyholders, stating that the policyholder had discussed the plan with the care manager and agreed with it, as well as a specific item on the care plan calling for monitoring by the care manager. Four of these case files, whose care plans were written by the same care manager, included progress notes documenting monitoring contacts; no monitoring notes were present in the other two case files, however.
Of the 33 case records reviewed, 11 of the records included specific notations indicating that “ongoing care management,” including regular monitoring contact, was ordered by the insurer’s administrator. These orders actually represented a change in administrative procedure, rather than some special determination that monitoring was needed by these particular policyholders. That is, while all policyholders insured by this carrier were supposed to receive ongoing care management as an automatic benefit, a specific order for it was instituted by the insurer during the study period (Table 33).

Table 33. Evidence of Policyholder Desire for Monitoring and CMPA Determination

<table>
<thead>
<tr>
<th></th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>27</td>
</tr>
</tbody>
</table>

Note: n=33

**Types of Care Monitoring Contacts**

The mode of contact for almost all monitoring contacts was by telephone; only two instances of in-person visits were noted. The frequency of these telephone contacts was typically twice a month for 2 months after the care plan was finalized, and then once a month for an additional 4 months until the 6-month reassessment.

Monitoring contacts appeared to serve several purposes, including determining whether new needs had arisen, whether current services were adequate or new services were needed, whether changes in the care plan were needed, and whether policyholders continued to meet eligibility requirements for policy coverage. Monitoring notes of one CMPA were designed to systematically collect information about policyholders’ functional status and needs through the use of a standardized progress note format. This included a checklist of questions about ADL/IADL status, mental status/cognition, and
changes in provider or care plan, with a comments section for elaboration on particular items such as a change in services or policyholder status. Check boxes were also included regarding whether or not services matched clients’ needs and whether or not a change to the care plan was needed, although these last two questions were subsequently replaced with one question regarding whether services matched the plan of care, also with instructions to elaborate in the comments section. The format also included space for the date and name of the care manager.

Overall, care managers generally completed all questions, although some information was occasionally omitted entirely or in part. This may have been due to the discretion of care managers in deciding which questions to ask during monitoring contacts. In addition to these standardized progress notes, case records also included summaries of conversations with policyholders, family members or providers. (Note: Three case records included progress notes from providers of services, such as visiting nurses, home health aides and skilled nursing facilities. However, there was no evidence that these reports were used by care managers to monitor care.)

**Care Plan Changes**

Care plans should be modified when warranted by new information collected during care monitoring, such as changes in physical or cognitive status. Partnership regulations include two statutes related to how changes must be documented, and when and how such changes impact the Medi-Cal property exemption:

**CPLTC 1993 and 1999, § 58027.** “Changes in the Plan of Care must be documented to show that such alterations are required by the clients’ medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.”
**CPLTC 1993 and 1999, § 58078.** Each insurer shall maintain information as stipulated in subsection (f).

(f) The information to be maintained includes the following:

(3) In order for services to qualify for a Medi-Cal Property Exemption, these services must be in accord with a Plan of Care developed by a Care Management Provider Agency. If the Policy or certificate holder has received any benefits delivered as part of a Plan of Care, the Issuer must retain the following:

(B) a copy of any changes made to the Plan of Care. Such services shall count towards the Medi-Cal Property Exemption after the Care Management Provider Agency adds the documented need for and description of the new services to the Plan of Care. In cases when the service must begin before the revisions to the Plan of Care are made, the new services will only count towards a Medi-Cal Property Exemption if the revisions to the Plan of Care are made within ten (10) business days of the commencement of new services. Care Management Provider Agencies must act upon requests for changes in the Plan of Care in an expeditious manner.”

**Analysis of Case Records**

Of the 32 case records that included care plans, 17 contained evidence of changes in care plans. All changes were noted within the progress notes, rather than on the initial care plans. Fifteen case records did not contain any evidence of changes to care plans. Twelve of these did not contain any progress notes or any other documentation that might have contained changes; three contained case notes, but no changes were apparently warranted, either because the policyholder’s situation remained stable or because the case was closed within a few weeks after the care plan was developed. From the available information in case records, compliance with the CPLTC regulation regarding the time interval between documented revisions and implementation of new services could not be determined (Table 34).

<table>
<thead>
<tr>
<th>Table 14. Evidence of Care Plan Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes documented</td>
</tr>
<tr>
<td>No changes documented</td>
</tr>
<tr>
<td>No progress notes (12)</td>
</tr>
<tr>
<td>No changes warranted (3)</td>
</tr>
</tbody>
</table>

Note: n=32
Of the 17 cases in which care plan changes were noted, a total of 46 separate changes were found. The most frequent care plan changes were in new services added (16 entries), changes in frequency or amount of service (12 entries), and services discontinued (11 entries). Only four entries noted changes in provider, primarily independent providers. Three entries were unclear regarding the type of change (Table 35).

Table 35. Types of Care Plan Changes

<table>
<thead>
<tr>
<th></th>
<th>Entries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service added</td>
<td>16</td>
</tr>
<tr>
<td>Frequency/amount of service change</td>
<td>12</td>
</tr>
<tr>
<td>Service discontinued</td>
<td>11</td>
</tr>
<tr>
<td>Provider changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency changes</td>
<td>4</td>
</tr>
<tr>
<td>Independent provider changes</td>
<td>3</td>
</tr>
<tr>
<td>Unclear</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: n=17

Of 46 care plan changes identified, 26 entries were clearly labeled as such, although accompanying documentation in the comments section was sometimes difficult to interpret. For example, even though “change in the care plan” was checked off, the change was either not described clearly or could not be identified at all. In another 20 instances, “Change in the care plan” was not checked off, but changes in these care plans were clearly noted in care managers’ written comments.

In spite of the use of standardized monitoring questions and instructions to include comments where needed, it was often difficult to identify the specific rationale for changes. For example, one note indicated that there had been several ADL status changes, but the accompanying comments did not specify if one or all of the changes had necessitated the care plan change. Of the 46 changes noted, 30 provided some type of rationale for the changes, 13 entries did not appear to include a rationale for the changes,
and notes for three other entries were unclear regarding the specific reason for the changes. Of the rationales that were provided, all instances appeared to be related to clients’ medical situation, functional or cognitive abilities, behavioral abilities, or the availability of social supports, as specified in CPLTC regulations (Table 36)

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
</tr>
<tr>
<td>Unclear</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: n=17

A review of UDS records regarding service utilization found that three policyholders had claims reported on the UDS for services not listed on their care plans or in changes to the care plans. Moreover, this was undoubtedly a conservative estimate, since it only represented claims reported on the UDS, and policyholder interviews indicated that more than half of policyholders utilized services that never appeared on the UDS (Table 37).

Service use without accompanying care plan changes or documentation of changes in condition is particularly problematic, since CPLTC regulations state that only services listed on the care plan may be reimbursed and only those services count toward Medi-Cal asset protection. Failure to update care plans to reflect changes in service needs could mean that some services would not qualify for asset protection under CPLTC regulations, nor for tax-qualified status under the provisions of HIPAA.
Table 37. UDS Services Included in Care Plan or Care Plan Revisions (Excluding Care Management Services)

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>All UDS services included in care plan</td>
<td>18</td>
</tr>
<tr>
<td>Some UDS services not included in care plan</td>
<td>3</td>
</tr>
<tr>
<td>No services on UDS</td>
<td>11</td>
</tr>
<tr>
<td>No care plan</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: n=33

**Identification of Clients’ Needs**

In addition to examining the types of monitoring questions used by care managers, our analysis also looked at whether policyholders’ service or care needs were identified and addressed, as well as the needs of their caregivers. Using care managers’ progress notes and policyholders’ comments from monthly telephone interviews, our analysis tracked whether care managers identified and addressed emerging needs over time. Monthly interviews with policyholders included specific questions regarding changes in their health and ability to care for themselves, as well as whether they had discussed these changes with their care manager; changes or problems with services received; what assistance they received from their care manager; whether they were getting their needs met; and their recommendations for improving monitoring. These data were then compared to care managers’ progress notes during the same time period to determine whether the same needs and concerns were identified and how care managers responded.

**Policyholder Interviews**

In general, policyholders reported in initial interviews and throughout monthly follow-up interviews that their needs were met. However, an interesting finding was that this pattern changed significantly over time. Almost half of all policyholders indicated that they were
not receiving as much help as they needed at the time of our exit interviews, 6 months after initial benefit eligibility (Table 38).

Table 38. Policyholders’ Reports of Getting Their Needs Met

<table>
<thead>
<tr>
<th>Data Source/Question Asked</th>
<th>No</th>
<th>Yes</th>
<th>Mostly</th>
</tr>
</thead>
<tbody>
<tr>
<td>First interview: Are your current needs adequately being met by services being received? (n=19)</td>
<td>3</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Monthly interviews: Are you getting the services you need? (n=48)</td>
<td>1</td>
<td>47</td>
<td>N/A</td>
</tr>
<tr>
<td>Exit interview: Are you currently receiving as much help as you need? (n=18)</td>
<td>8</td>
<td>10</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: Because multiple monthly interviews were conducted with each policyholder, the n=48 for the second question exceeds the number of policyholders interviewed.

Eighteen policyholders whose case records contained progress notes indicating that monitoring was performed were interviewed. Analysis of case records and policyholder interviews revealed that no unmet needs were apparent in 2 of these 18 cases. In 12 cases, at least one unmet need was identified. In 4 cases, it was unclear whether all of policyholders’ needs were met due to gaps in monitoring notes or uncertainty about whether services provided were appropriate because care managers worked for provider agencies (Table 39).

Table 39. Unmet Needs Identified

<table>
<thead>
<tr>
<th>Unmet Needs Identified</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No unmet needs identified</td>
<td>2</td>
</tr>
<tr>
<td>Unmet needs identified</td>
<td>12</td>
</tr>
<tr>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>Gaps in monitoring notes (3)</td>
<td>4</td>
</tr>
<tr>
<td>Uncertain if services appropriate (1)</td>
<td></td>
</tr>
</tbody>
</table>

Note: n=18

In the 12 case records with unmet needs, specific unmet needs were identified using information in case file notes and policyholders’ specific responses to interview questions. Annual CMPA reports covering the same time period as the study reported no unmet needs for clients.
A total of 32 individual instances of unmet needs were identified. Unmet needs fell into two broad categories: problems with services and not addressing policyholders’ functional needs. By far the most frequent problem related to in-home care, including no-show and tardiness, and other more serious incidents involving stolen property, forged timesheets, and a medication error reported by policyholders. Other service problems included lack of transportation, social activities, and durable medical equipment; lack of caregiver respite services; and, lack of sufficient service coordination. Monitoring notes in four cases also stated that “services do not match client’s needs/care plan,” but notes were not always clear about what this entailed (Table 40).

<table>
<thead>
<tr>
<th>Unmet Needs Re Services</th>
<th>Instances</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-home care</td>
<td>8</td>
</tr>
<tr>
<td>No-shows, absences (3)</td>
<td></td>
</tr>
<tr>
<td>Forged timesheet (2)</td>
<td></td>
</tr>
<tr>
<td>Tardy (1)</td>
<td></td>
</tr>
<tr>
<td>Medication error (1)</td>
<td></td>
</tr>
<tr>
<td>Stolen property (1)</td>
<td></td>
</tr>
<tr>
<td>Lack of services</td>
<td>14</td>
</tr>
<tr>
<td>Service coordination (5)</td>
<td></td>
</tr>
<tr>
<td>Transportation (3)</td>
<td></td>
</tr>
<tr>
<td>Caregiver respite (3)</td>
<td></td>
</tr>
<tr>
<td>Social activities (2)</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment (1)</td>
<td></td>
</tr>
<tr>
<td>“Services do not meet client’s needs”</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unmet Needs Re Policyholder Functioning</th>
<th>Instances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>2</td>
</tr>
<tr>
<td>Falls/falls evaluation</td>
<td>2</td>
</tr>
<tr>
<td>Increased incontinence/urination</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=12

In addition to problems with services, several instances were also noted in which policyholders’ functional needs were apparently not addressed, including mental health issues, fall prevention and evaluation, and increased incontinence and urination. Brief
case summaries describing unmet policyholder needs are provided at the end of this chapter.

**Policyholders’ Satisfaction with Monitoring**

Policyholders reported many positive experiences with their care managers. For example, seven reported that their care managers were supportive, and seven reported that they were available when needed. A sampling of policyholders’ comments is provided below for illustration:

“The care manager calls regularly, shows concern and interest in [the policyholder’s] progress. I feel I can turn to her if needed. Her continued interest is appreciated.”

“She sincerely cares, and is helpful on the phone and good with suggestions.”

“Her attitude is good and she gives moral and psychological support . . . she listens.”

“It is reassuring that she remembers about [the policyholder’s] condition and asks pertinent questions.”

“You can talk to her about things, she understands, and that makes [the policyholder] feel confident in her abilities.”

When asked to make recommendations about improving the monitoring process, three policyholders commented that they would have liked more frequent contact, and two stated that in-person visits would have been helpful, “to visually see my needs,” as one policyholder stated. Seven policyholders indicated that they needed more assistance (Table 41).

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>More frequent contact</td>
<td>3</td>
</tr>
<tr>
<td>More in-person contact</td>
<td>2</td>
</tr>
<tr>
<td>More direct assistance</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: n=19
Several other questions were asked in exit interviews to measure policyholders’ attitudes about their care managers, including whether they felt that they could contact their care managers and whether their care managers were responsive. Policyholders’ responses were generally quite positive. However, two policyholders felt they could not contact their care managers if they needed to; another policyholder felt that “it would be a waste of time to call my care manager if I had a problem.” All three of these policyholders when interviewed also reported that they had unmet needs (Table 42).

Table 42. Policyholder Attitudes About Care Manager

<table>
<thead>
<tr>
<th>Question Asked</th>
<th>Yes, definitely</th>
<th>Yes, I think so</th>
<th>Maybe yes/ Maybe no</th>
<th>No, I don’t think so</th>
<th>No, definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know I can contact my care manager if I need to.</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>My care manager ignores what I tell him/her about the things I need.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>It would be a waste of time to call my care manager/advisor if I had a problem.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

Note: n=17

Discharge Plan/Transition Plan

Benefits under long-term care insurance may be terminated for a number of reasons. These include nonpayment of premiums, death, exhaustion of policy coverage, or improvement in policyholders’ functioning that makes them ineligible for continued benefits. CPLTC regulations specify that a discharge plan be developed for policyholders who are no longer eligible for benefits due to improvement in their functioning, and a transition plan be made for those who exhaust their benefits:

CPLTC 1993, § 58072: Client Bill of Rights and Responsibilities
(a) A Care Management Provider Agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. The list shall include:
(1) a right to a discharge plan when the Care Management Provider Agency services are about to be terminated. If the Policy or Certificate holder is immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan. . . .

_CPTLC 1999, § 58072._ Client Bill of Rights and Responsibilities

(b) A Care Management Provider Agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. The list shall include:

(11) a right to a discharge plan when the Care Management Provider Agency services are about to be terminated. If the Policy or Certificate holder is immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan. The transition plan and/or discharge plan must be provided to the Policy or Certificate holder within 30 days after receipt of notification from the Insurer that coverage will be exhausted.

_CPTLC 1999, § 58005(e):_ Case Management/Care Coordination includes but is not limited to the following:

(e) the development of a discharge plan when the care management provider agency services or the policy benefits are about to be terminated and if further care is needed. If the insured is immediately eligible for MediCal, the Care Management Provider Agency shall prepare a transition plan.

**Analysis of Case Records**

During the study period, benefits were terminated in 14 out of 33 cases. In four cases, benefits were terminated because the policyholders died; the rationale for terminating benefits was unclear in 2 cases; improved functioning was the reason documented in the other 8 cases. In the 10 cases of surviving policyholders, only 2 case records showed evidence of a discharge plan. Documentation in both cases was contained in the progress notes. Even though benefits for both of these policyholders were terminated due to improvement in their functioning, the plans were referred to differently. In one case, two separate notes were present, one labeled “case closed/transition plan” and another, 2 days later, as “care planning for discharge.” In the other case record, the notation was labeled “transitional plan of care.” Four of the 10 surviving policyholders had continuing care
needs at the time that benefits were terminated, 2 did not have continuing needs, and the presence of needs was unclear in 4 other cases (Tables 43 and 44).

In one case, documentation of policyholder notification regarding benefit termination was present, and the time interval between this and the discharge plan notation was well within the required time period. While a case note indicated that this plan was discussed with the policyholder’s power of attorney, there was no indication that the plan was provided to the policyholder as required by regulation. In the other case, there was no documentation indicating when the policyholder was notified, so compliance with the time interval could not be calculated. There was no indication that the plan was discussed directly with or provided to the policyholder as required by regulation (Tables 45 and 46).

Table 43. Benefit Coverage of Policyholders During Research Study Period

<table>
<thead>
<tr>
<th>Benefits terminated</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits continuing</td>
<td>19</td>
</tr>
</tbody>
</table>

Note: n=33

Table 44. Discharge or Transition Plans Developed

<table>
<thead>
<tr>
<th>Plans developed</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No plans documented</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: n=14

Table 45. Reasons Documented for Termination of Benefits

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in functioning</td>
<td>8</td>
</tr>
<tr>
<td>Policyholder died</td>
<td>4</td>
</tr>
<tr>
<td>Reason unclear</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=14
Table 46. Surviving Policyholders with Continuing Care Needs at Time of Benefit Termination

<table>
<thead>
<tr>
<th>Continuing needs identified</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No continuing needs identified</td>
<td>2</td>
</tr>
<tr>
<td>Unclear re: continuing needs</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: n=10

Summary of Findings Regarding Discharge Plans

From the data, it appears that the development of discharge and transition plans has been overlooked or not documented in most cases. The inconsistent use of terms, even in the same case record, also indicates that there is some confusion about the intended difference between these types of plans. Neither plan was apparently provided to policyholders.

Recommendations Regarding Discharge Plans

We recommend that the wording of CPLTC § 58005e be changed from “... and if further care is needed” to “... and if any further care is needed.” This change is intended to more clearly articulate the intention of the statute in addressing all continuing care needs, not just those that are covered by LTCI.

We also recommend that CMPAs include definitions of “discharge plan” and “transition plan” in their policy and procedure manuals, with an allowable timetable for developing these plans, and how and when policyholders are to be provided with these plans.

We recommend that the specific reason for termination of benefits appear in the case record, and that discharge and transitional plans be clearly labeled in case notes, accompanied by a list of continuing care needs, along with how and when policyholders
are to be provided with these plans. If there are no continuing care needs, this should be clearly documented.

**Summary of Findings Regarding Care Monitoring**

Evidence of care monitoring was found in 20 of the 33 case records reviewed. Evidence of a mutual decision-making process for electing monitoring, as required in Partnership regulations, was apparent in only 6 case records. All of the policyholders who received monitoring were living in the community; monitoring was not apparently performed for policyholders in skilled nursing or assisted living facilities. While none of the CMPAs reported unmet needs in their annual reports coinciding with the period of this study, analysis of case records found unmet needs in 12 case records; the documentation in 4 other records did not contain enough information to make a clear determination. In all, 32 instances of unmet needs were identified. Most of these instances related to unmet needs in the provision of in-home care and lack of particular types of services such as transportation, service coordination, respite, social activities, and durable medical equipment. Another category of unmet needs related to failure to identify or address policyholders’ physical or mental health needs. Early policyholder interviews indicated that most were getting their needs met; however, a significant number reported unmet needs in exit interviews.

Monitoring was typically performed on a monthly basis by local field care managers by telephone. Internal case managers in the administrative offices also contacted policyholders directly after cases were “stable”; however, it was unclear whether these calls supplemented or replaced local field care manager contacts. All of the monitoring contacts by local field care managers utilized a standardized format that was designed to systematically collect a variety of information about policyholders’ condition.
and services being received. These appeared to be effective for identifying some, but not all, needs.

Changes to care plans were noted in just over half of the case records reviewed, including changes in the amount or provider of services or the addition or discontinuance of services. A total of 46 changes were noted, although it was often difficult to identify the specific change or rationale for the change in the documentation provided.

A question that arises from these findings is why our analysis revealed so many unmet needs. The fact that research staff were able to elicit information about unmet needs when care advisors apparently did not, even with a standardized format, raises some interesting questions about the process of gathering information. For example, did care advisors limit their questions to areas that pertain just to policy benefits, thereby missing other areas of need? What other questions might they have asked to elicit this information? Did policyholders tend to answer just the specific questions they were asked, or were they encouraged to provide other information not specifically asked for? Did the manner in which these questions were asked make a difference? Does the finding that many policyholders were confused about the care managers’ role have a bearing on what information policyholders think is appropriate to share? This last question is particularly significant because most policyholders are unfamiliar with care management in general, and may not identify or articulate pertinent information without some instruction and prompting.

Another possible explanation for our findings pertains to documentation. The use of a standardized monitoring format is very useful if instructions are clear and care managers are trained to follow it consistently and uniformly. On occasion, however, checkboxes relating to whether services matched a client’s needs/care plan or whether
there was a care plan change were not completed, and comments did not always provide clarification. Another documentation issue is how much information care managers were allowed or encouraged to provide. The monitoring format typically had only eight or nine lines allocated for “comments,” which might imply that this was all the information that was desired.

Our findings related to the difficulty in identifying changes to care plans also raise questions about definitions and instructions given to care managers. A possible explanation for the inconsistencies noted is that “changes to the care plan” might have been interpreted in different ways by individual care managers. For example, changes in community services or services not paid for by LTCI were not consistently labeled as care plan changes by all care managers. Similarly, changes in service frequency and independent providers were labeled as care plan changes by some, but not all, care managers. Our interviews with care managers revealed a belief among some care managers that they were not supposed to document services other than home care and nursing care, especially if services were not covered under LTCI.

Recommendations Regarding Care Monitoring

A primary recommendation is that all community-living and institutionalized policy-holders should receive some level of basic monitoring in order to verify that the services being received are appropriate and that needed changes are identified, implemented, and documented in the care plan. This is not only good practice, but also is required by Partnership regulations to ensure that these services are counted toward the Medi-Cal exemption. This recommendation represents a significant change from current regulations which specify that monitoring can be a claim cost, and eliminates the need for the current
two-step decision making of electing monitoring “... when desired by the individual and determined necessary by the CMPA.” We also recommend that the frequency of monitoring contacts should be at least monthly for policyholders experiencing significant changes in their health, functioning, or the availability of social supports, and at least every 90 days for those whose situations are or are likely to be unchanging. These circumstances (i.e., “significant changes” and “situations that are or are likely to be unchanging”) should be explicitly defined by the CMPAs in their policy and procedure manuals, and documented in case records.

Such basic monitoring should include at least a review of policyholders’ current status and a review of the current care plan. It is essential that clear documentation of these reviews be included in the case records, including the date of all contacts and names of personnel conducting contacts. A sample monitoring protocol is included in Appendix C. A discussion of each type of recommended review follows.

**Review of Policyholder’s Current Status**

Physical and health functioning should be reviewed to assess any changes in policyholders’ need for assistance with ADLs and IADLs. Three other domains should also be reviewed, including cognitive status, mental health/illness, and caregivers’ needs and capacity to provide appropriate care, as well as changes in these.

**Review of Current Plan of Care**

Although a review of care plan goals is essential to determine whether recommended interventions have been effective, this was almost never evidenced in the case records. Suggested domains for review include the extent to which each listed goal has been
attained and whether each goal is still appropriate. Current service utilization should also be reviewed for all LTCI-covered and noncovered services, such as informal and community services, with particular attention to any changes since the last monitoring contact and the reason for the changes. Policyholders should also be asked specifically whether or not they are satisfied with each service and what concerns or problems with services they are experiencing, if any. Policyholders also should be asked whether or not their needs are being met and whether or not they desire more assistance than they are currently receiving, including care management services.

All care plan changes and the rationale for these changes should be clearly documented in order to comply with the regulatory requirement for identifying specific changes as they relate to the Medi-Cal property exemption. Such documentation will also facilitate file audits by new case managers, quality assurance reviewers, and claims personnel keeping track of “Long-term Care Services Countable Toward Medi-Cal Property Exemption.” Automated care management information systems may be useful in facilitating care plan reviews and updates.

**Case Study Summaries of Apparent Unmet Needs**

**ID #12**

This policyholder had multiple medical problems and dementia, lived at home with a spouse and adult child, was dependent in all ADLs and IADLs, and required constant supervision. Although the care manager documented the policyholder’s increased urination, there was no evidence of any follow-up discussion or referral for evaluation or treatment. Also, two consecutive progress notes stated that “services do not match client’s needs,” but there was no explanation or change in the care plan. The policyholder reported an unmet need for weekend respite that was discussed with the care manager, and also indicated not having adequate help at our exit interview.
**ID #7**

This policyholder had been hospitalized with multiple medical conditions, and was discharged to the home with five ADL dependencies. Because she lived alone and had few social supports, she received in-home help from a live-in attendant. The policyholder reported that she had been victimized by her independent provider, who had stolen her car and some credit cards, and had forged signatures on timesheets and on checks. In addition, the same aide was often tardy or did not show up at all, and had incorrectly administered medications to the policyholder. None of these incidents appeared in the case record; it is unclear if the policyholder informed the care manager about these incidents. A progress note indicated that the policyholder had fallen, but there was no indication of any follow-up. Several other progress notes indicated the need for help with laundry and grocery shopping, and transportation to medical appointments, but no follow-up was noted. These are troubling reports, especially because this policyholder lived alone, had limited social support, and was reported by the care manager and a friend of the policyholder to have memory lapses that might affect “whether client will remember to eat.”

**ID #8**

This policyholder had Alzheimer’s disease, was dependent in three ADLs and six IADLs, and lived with his wife who was his primary caretaker. A previous claim had been closed because she decided not to use services at that time, since they planned to move for financial reasons. When the second claim was approved 5 months later, a new care plan was apparently not developed, and no changes were noted to the plan, even though several formal services were added during the deductible period. In regard to the policyholder’s needs, the care manager noted in a progress note that the policyholder’s caregiver would check about group activities for the policyholder’s stimulation, but no further action was noted either by the care manager or the caregiver. Another unmet need involved the policyholder’s safety related to increasing disorientation and wandering. A progress note stated that the policyholder “can no longer be left alone,” yet acknowledged that this did happen when the caregiver went out; a similar note was also recorded the following month. There was no follow-up documentation of any action on the part of the care manager to assist the spouse in addressing this need.
ID #9

This policyholder had an unstable medical condition, lived at home with an elderly spouse, and was dependent in five ADLs and five IADLs. Unmet needs were identified for both the policyholder and caregiver. The caregiver reported increased incontinence and incidence of falls for the policyholder, but neither of these were documented or addressed in the progress notes. The caregiver also reported physical and emotional exhaustion from caregiving, particularly due to getting up at night with the policyholder. On one occasion, the caregiver experienced chest pains and was taken to the ER; subsequently, a family member moved in for a time to assist with caregiving. The policyholder reported that he needed evening and weekend respite in addition to more daytime help, but indicated that the care manager was unsuccessful in finding such services; progress notes do not reflect this effort. A modest increase of 4 additional hours per week for home care was eventually requested and received, but no change was made in the plan of care. The policyholder reported not having adequate help at our exit interview.

ID #23

All of the case manager’s monitoring notes indicated that “services do not match clients needs.” Case notes indicated that all of the policyholder’s care was provided by a daughter-in-law and an elderly spouse. Both the policyholder and care manager indicated that the spouse was not fully capable of providing all needed care. Monitoring notes were missing from 12/16/98 to 4/7/99, which coincided with the period immediately after the care plan was finalized. Apparently, this was also the period of the policyholder’s appeals related to the insurer’s disallowance of the daughter-in-law as an eligible provider. The policyholder stated that the care manager did not seem knowledgeable about some local services or whether the LTCI would cover them. He also stated in the fourth monthly interview that the policyholder’s needs were not being met, and that he was not satisfied with care management services; progress notes from this time period did not reflect this dissatisfaction. At the exit interview, the policyholder reported not having as much help as needed due to difficulty finding affordable in-home care aides.

ID #24

The policyholder’s affective status was not addressed. Although the policyholder mentioned in one interview that he was depressed, and in three out of four monthly interviews stated that that he was “frustrated,” only one monitoring note reported that the policyholder was “a little discouraged about [his condition].” All other notes reported medical progress exclusively. This is significant since the policyholder was very disabled and relied on attendants, had several complex medical conditions, lived alone, and had no family in the immediate area. The policyholder also stated in an early interview that more service coordination would have been helpful, especially assistance with interviewing aides, and furthermore that “the system has imposed a duty upon a sick person to hire qualified caregivers or pay extra for a professional caregiving agency to do it, and there is nothing the insurance company does to alleviate the possibility of danger . . . if the caregiver is not qualified, it could endanger the beneficiary’s health and life.”
**ID #25**

The policyholder’s caregiver appeared to be confused about the role of the care manager. Consequently, care management services may not have been utilized appropriately, particularly in relation to reporting and monitoring of service needs. This confusion was evidenced in several ways: (1) the caregiver’s response to an interview question about what services the care manager had provided that month: “She does not do any arranging or getting services—she is just a claims adjuster acting with [home care agency name]. She is with [insurer name]. Does not discuss [policyholder’s] care at all;” (2) a note in the case file by the internal care manager indicated that the caregiver inappropriately called the home care agency asking for an onsite visit from the care manager; no follow-up note was present in the file regarding whether or not the onsite visit was conducted; (3) the policyholder’s report to interviewers regarding missing pain medications and changes in ADLs, which were not noted in progress notes and may not have been reported to the care manager, perhaps due to misunderstanding the care manager’s role; (4) a reduction in the in-home aide’s hours, which was not noted in progress notes or as a care plan change, and may have been initiated by the policyholder without the care manager’s knowledge; and (5) the policyholder’s statement that it would have been helpful to have “a piece of paper that said these are the types of services [the care manager] provides and questions that she can answer.” This policyholder had three different local field care managers over time, and another “internal case manager” from the administrative office who apparently replaced the third local field care manager. Two of the local care managers were also employed by the same agency that provided in-home care.

**ID #26**

Prior to being discharged to the home, where he lived alone, this policyholder was in skilled nursing and rehab facilities following an accident that left him dependent in five ADLs and six IADLs. Case records indicated that the care manager made several monitoring contacts with the policyholder during this time, and provided a list of home care providers. When the policyholder was discharged to home with an IP he hired, he identified several problems with the IP within the first month, including long absences, misunderstanding orders, and not taking initiative in cleaning the house. During this period, the policyholder stated that his needs were not being met, that he did not know what to expect of the care manager, did not feel that she was helpful but “just checking in once a month,” and that in-person contact would have been helpful. None of these problems were recorded in case notes. In view of the policyholder’s incapacitating disability, his lack of informal supports in the immediate area, and his apparent lack of experience with hiring and supervising attendants, these problems reflect that perhaps more monitoring might have identified his need for intensive service coordination. Upon termination of benefits, the policyholder requested information about Lifeline. This request was conveyed to the local care management agency, but no follow-up note was present in the case file. At the exit interview, this policyholder indicated that he was not receiving as much help as he needed, particularly transportation.
**ID #29**

The policyholder reported that the home health aide was not reliable and did not show up twice in one month, presumably resulting in a lack of adequate care during the aide’s absences. The policyholder also reported that the aide was excessively expensive, and forged her name on the timesheets for these missed days. Although the policyholder reported the forgery to the home health agency, it was apparently not reported to the care manager, and no case notes reflected these incidents. Shortly afterward, the policyholder terminated the agency services, stating that she decided to just do things herself and that she was “leery” about hiring another aide because of this experience. It is significant because this policyholder lived alone, was very frail, did not have informal supports in the immediate area, and was one of the cases in which there was an apparent conflict of interest. She appeared to still have difficulty with some ADLs and IADLs when benefits were terminated, indicating at the exit interview that she was not receiving as much help as needed.

**ID #30**

It is unclear whether the policyholder had any unmet needs for 2 months after the care plan was finalized, since no monitoring was done during this time. A file note indicated that the care manager did not receive the order for monitoring. This period was especially crucial since the plan of care indicates that the amount of help the policyholder received at that time from the IP was not meeting her needs, along with a recommendation for a substantial increase in hours. However, it was not clear whether this increase was implemented and, consequently, whether the policyholder’s needs were met. Benefits were terminated during the study period, although the policyholder indicated at the exit interview that she still had needs that required more help than she was receiving.

**ID #45**

The policyholder’s daughter reported that the policyholder’s needs were not being met for all 4 months of telephone interviews. During this period, the policyholder was at home with limited formal services and assistance from the daughter and the policyholder’s spouse. The couple subsequently moved into an assisted-living facility. Progress notes consistently indicated that “services do not match client’s needs/the plan of care” during the period when the policyholder was living at home. One progress note specifically noted the daughter’s concern that the spouse was not capable of providing adequate care, but there was no further elaboration or evidence of follow-up. The daughter also reported several problems with care being provided in the assisted-living facility, and expressed a desire for more active service coordination (i.e., “speaking to ALF staff about the policyholder’s care needs and following up about them,”) and indicated that the policyholder was not receiving as much help as needed at the exit interview. Progress notes did not indicate that the daughter was dissatisfied or desired more service coordination.
**ID #47**
The policyholder’s family member reported in two of the four monthly interviews that the policyholder’s needs were not being met, stating that there were not enough activities in the assisted-living facility and that transportation to community activities was difficult to arrange. Although the family member reported that she had spoken to a care manager during the interview period, there were no monitoring notes in the case file.

**ID #49**
The policyholder reported several unmet needs including depression, isolation, occurrence of anxiety attacks, transportation to physical therapy, need for durable medical equipment, and more active service coordination, stating that “even if [the case manager] makes suggestions, [the policyholder] can’t do the follow-up to get what she needs.” Two separate progress notes in the case file indicated that “services do not match the plan of care,” but it was unclear what this mismatch involved or that any follow-up was initiated. When the policyholder requested coverage for some durable medical equipment, she was informed that she did not have a DME benefit, and that the care manager would “assist her in accessing resources” for these. Her subsequent appeal was denied, stating that she was already “reaching her monthly max with current services,” and that her request would be reconsidered “in the event you decrease your current amount of services.” There was no documentation of any efforts to assist her in accessing other resources for obtaining the DME, and the policyholder indicated at the exit interview that this was still an unmet need. This policyholder also stated that the role of the care manager was unclear, that “there is a lot of information that they don’t give you. Their job is to give you what they have, not what you need,” and that a 2-month delay in processing “the paperwork” caused financial difficulties.
QUALITY ASSURANCE

Introduction

Quality assurance in long-term care case management remains a relatively new and largely undeveloped area. Even among exemplary case management agencies, only 39 percent collect any information at all that might be used to demonstrate the quality of their services (Kane & Degenholtz, 1997).

We examined quality in LTC case management in four domains: structure, process, and the client outcomes of service effectiveness and consumer satisfaction. Structural characteristics have traditionally been the dominant mechanism for assuring quality. Indeed, Kane & Degenholtz’s (1977) recent survey of 95 exemplary case management agencies found that 73 percent had explicit structural standards for quality services, whereas only 9 percent had explicit process standards and only 2 percent had quality standards related to client outcomes. Interestingly, explicit quality standards were observed in 85 percent of those case management agencies that were part of the “official” aging network, but in only 18 percent of fee-for-service agencies.

This chapter presents current CPLTC policies that address each of the four quality assurance domains, describes each CMPA’s intended quality assurance program, reports CMPA activities actually performed (based on evidence from annual reports, case records, interviews with policyholders, and interviews with CMPAs and CM providers), discusses the adequacy of current CMPA quality assurance methods, and considers recommendations for possible modifications in current quality assurance practices.
Assuring Structural Quality

Structure refers to the organizational context within which services are provided. From this perspective, it is assumed that certain minimal organizational characteristics are necessary, if not sufficient, for quality care management. These might include agency certification, level of professionalization and licensure, staff-client ratios, and other measures assumed to represent the organization’s capacity for providing quality care management. Under CPLTC regulations, CMPAs are charged with assessing the structural capacity of the individuals and organizations with which they subcontract.

**CMPA reports**

Reports from the CMPAs indicated that they had reviewed the organizational capability of each of the agencies in their network and had found them to have the capability to provide good quality care management services.

Assuring Procedural Quality

*CPLTC 1993 and 1999, § 58073(a).* A Care Management Provider Agency shall have a written quality assurance program which shall include but not be limited to:

1. Annual program evaluation. The agency’s board of directors (or their appointed designees) shall, at least Annually, review policies and make recommendations on:
   1. admission and discharge criteria;
   2. Plans of Care and records;
   3. personnel qualifications;
   4. quality assurance program;
   5. delivery of Care Management services; and
   6. methods for assuring the quality of direct services provided including whether client needs as identified in the Plans of Care were met, assessing client satisfaction and incorporating client suggestions.

   The written minutes of this annual program evaluation meeting shall document the dates of the meeting(s), attendance, agenda and recommendations.
(2) Quarterly service record review. At least Quarterly, the agency’s board of directors, or a committee appointed by the board, shall, observing all confidentiality protocols, review a random sample of active and closed case records. Each record review shall be documented on a record review form and shall include, but not be limited to, verification that:

(A) agency policies are followed in the provision of services to clients and families;
(B) clients and families actively participate in the care planning process, including the decision regarding how much coordination and monitoring is necessary and desirable;
(C) client, family and other community resources are integrated into the Care Plan;
(D) Care Management services are effective in maintaining an appropriate environment for the client;
(E) the provision of services is coordinated with those provided by other agencies to avoid duplication of services, and to integrate acute care with chronic care;
(F) action is initiated by the Care Management Provider Agency when unmet client service needs are identified. Pattern of unmet needs should be documented and reported to the Department of Health Services.
(G) the agency’s sampling methodology shall be defined in its quality assurance program policies and procedures . . . .

Procedural quality refers to how care management services are provided, and is typically assessed by comparing what is done to some set of external standards, based on pragmatics or ethics. Drs. Rosalie and Robert Kane have suggested, for example, that there are certain basic “enabling” characteristics of good practice, which represent the minimum necessary for quality care management. We expect that case managers will be honest and decent in their interactions with clients and their families, that they will be reliable, and that they will have at least some minimal level of interpersonal and technical competence. We also assume that quality care management includes at least some minimal level of client involvement and consumer direction, as well as mechanisms for feedback among clients, family members, and service providers.

Quality care management also needs to meet basic standards of good practice. Perhaps the most comprehensive effort to develop guidelines for practice was
Connecticut Community Care’s Robert Wood Johnson-funded effort, drawing upon the extensive wisdom of a national advisory committee composed of established national leaders in the field of LTC case management (Geron & Chassler, 1994). This initiative resulted in specific guidelines for quality practice in nine areas, including: consumer rights, preferences, and values; comprehensive assessment; care plan; implementation; monitoring; reassessment; discharge and termination; quality improvement; and efficient use of resources. Consensus indicates that quality care management should include features such as the following:

- an accurate assessment of a client’s physical and psychosocial needs and problems;
- a care plan that reflects those needs;
- oversight to assure that services are provided as specified in the care plan; and
- some type of monitoring or feedback mechanism to assure that services change as clients’ needs change.

**Annual Program Evaluation**

California Partnership for Long Term Care (CPLTC) regulations state that CMPAs are required to submit a written report annually to the California Partnership for Long Term Care that shall “summarize all findings and recommendations resulting from the quality assurance activities” (CPLTC 1999, § 58074). All three CMPAs provided annual reports to the CPLTC that included a summary of their quality assurance activities. CMPAs evaluated programs in a variety of ways. One CMPA utilized a “National Performance Management/Utilization Management Committee” to administer its quality assurance process. This interdisciplinary
committee reviews client audit and satisfaction reports “to expand the scope of the
[CMPA] quality assurance program.” The components of the program include
screening and credentialing, utilization management, employee competency,
organizational customer sensitivity, and customer satisfaction. Another CMPA
utilizes quality specialists to monitor cases from the eligibility process through care plan development, implementation, and ongoing case management.

**Quarterly Service Record Review**

*CPLTC 1993 and 1999, § 58073(a)(2).* . . . At least Quarterly, the agency’s board of directors, or a committee appointed by the board, shall, observing all confidentiality protocols, review a random sample of active and closed case records. . . .

*CPLTC 1993 and 1999, § 58073(a)(2)(G).* The agency’s sampling methodology shall be defined in its quality assurance program policies and procedures. . . .

**CMPA reports**

Although one CMPA reported having seven CPLTC cases between 1996 and 1999, it did not conduct quarterly service record reviews, stating in each of its annual reports: “[CMPA] did not provide Case Management services to any California Partnership clients during this period. As a result, no cases were reviewed.” Because of this apparent misunderstanding of CPLTC regulations by this CMPA, little is known about its quality assurance activities.

The other two CMPAs described their general case record review procedures and sampling methodologies in their annual reports, and included summaries of quarterly record review audit information. Each of these CMPAs reviewed a sample of individual case records using a standardized record review audit checklist. Several of the completed checklists were also included in the reports.
Our findings

Our review of the annual reports and record reviews showed that CMPAs consistently followed their stated sampling methodologies. One CMPA reviewed 100 percent of all CPLTC cases every year, while the other reviewed a percentage of cases (11 percent in 1999). However, the latter CMPA did not indicate clearly how those cases were selected for review.

The checklists included all of the record review requirements stated in CPLTC regulations (§ 58073(a)(1)(F)), often using the exact language of the regulation. Reviewers were asked to check off “yes/no/not applicable” or “adequate/inadequate” as to whether each item was met; in addition, a space for “comments/action” was also included for elaborating on identified deficits. However, no criteria were specified for determining how each item was to be operationalized.

Of the record reviews submitted by the CMPAs, we were able definitively to identify four reviews that corresponded to policyholders participating in our sample. This enabled us to compare CMPA record reviews for these four policyholders with our independent reviews.

Summary and recommendations

Quarterly reviews of at least a 10 percent sample of case records would seem to be a reasonable standard. CPLTC regulations call for “a random sample of open and closed case records.” Given that there seems to be little reason to review cases closed a long time previously, this regulation might be revised to refer only to “cases open during the previous quarter.” Although it is unrealistic to assume that the sample of cases would
truly be selected “at random,” it should be sufficient for CMPAs to report the methods they utilize to select the cases for review.

**Agency Policies and Procedures**

*CPLTC 1993 and 1999, § 58073(a)(2)(A).* Agency policies are followed in the provision of services to clients and families.

**CMPA reports**

The record review audit form utilized by one CMPA addressed a variety of care management policies and procedures, sorted by type (i.e., benefit eligibility assessment, care plan implementation, and ongoing care management). Most of the care management activities required under CPLTC regulations were reflected in this list, with the exception of three: policyholder involvement in deciding if/how much coordination and monitoring is desirable or necessary; reassessment procedures; and development of discharge/transition plans. The record review form used by the other CMPA assessed compliance with agency policies with a single item, which asked whether “Agency policies were followed in the provision of services to clients and families.”

**Our findings**

Our examination of the four record review audits that represented policyholders participating in our sample found general agreement between our findings and those of the reviewers. Minor discrepancies were found in three areas, which are summarized in Table 47.
Table 47. Comparison of Deficits Identified in Record Reviews

<table>
<thead>
<tr>
<th>Item Identified</th>
<th>CMPA Findings</th>
<th>Our Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of timeframe on care plan</td>
<td>3 of 4 present</td>
<td>1 of 4 present</td>
</tr>
<tr>
<td>Presence of recommendations re problem/goal statements</td>
<td>2 of 4</td>
<td>3 of 4</td>
</tr>
<tr>
<td>Signed Claimant’s Rights form</td>
<td>4 of 4</td>
<td>3 of 4</td>
</tr>
</tbody>
</table>

Note: n=4

**Summary and recommendations**

The inclusion of specific items in record review audit forms can enable reviewers to identify particular deficits in care management policies and procedures. Indeed, in the case of one CMPA, information from the record review audits apparently was used to modify several policies and procedures over the course of the study, including the introduction of new forms and documentation procedures. Because of the lack of specificity in the other CMPA’s record review audit forms, it is unclear what the ratings mean, how they were determined, or to what practical use the information could have been put.

**Eligibility Determination**

**Insurer/CMPA reports**

Insurance carriers determine benefit eligibility, based on eligibility assessment information collected by care managers under the auspices of the CMPAs. CPLTC regulations clearly specify benefit eligibility criteria and the assessment information upon which eligibility decisions are to be based. However, CPLTC regulations are silent regarding mechanisms for assuring the accuracy of eligibility determinations or the adequacy of the assessment information that is collected.
**Our findings**

As described in the chapter on The Eligibility Determination Process, our review of assessment information and other available documentation found support for insurer eligibility determinations in 32 out of 35 cases reviewed. Three policyholders deemed eligible by insurers did not appear to meet CPLTC criteria; no one was found to have been denied benefits inappropriately.

Our review of assessment instruments utilized by the CMPAs found inconsistencies or inadequacies in a number of areas, including the following: (1) variations in how ADLs are defined; (2) failure to consistently include direct observations, where feasible, of ADL performance or behavior problems necessitating supervision; (3) failure to consistently assess depression and other potentially reversible causes of dementia; (4) variations in the assessment of “complex, stable medical conditions.”

**Summary and recommendations**

Mechanisms should be established for assuring the accuracy of eligibility determinations and the adequacy of the assessment information upon which they are based. One possibility would be for an independent third party to review a sample of eligibility determinations on a quarterly or semiannual basis. Discrepancies or instances of insufficient information could be noted and resolved through discussions with the relevant insurer.

The benefit eligibility determination process could be improved through minor enhancements to the assessment information that is collected. In particular, assessments, when possible, should include the direct observation of ADLs, the type of assistance needed to perform them, and any safety issues related to physical limitations or cognitive
impairment. Translated versions of cognitive assessment tools (e.g., SPMSQ, MMSE) should be used with policyholders whose primary language is not English. A reliable and valid measure of behavioral disturbances that pose potential safety threats should be used, such as an aggregated version of the Behavioral Pathology in Alzheimer’s Disease (BEHAVE-AD) scale (Reisberg, 1987). We also recommend that only trained professionals perform eligibility assessments to assure the accuracy and reliability of the assessment information.

**Care Plan Development**

*CPLTC 1993 and 1999, § 58073(a)(2)(B).* Clients and families actively participate in the care planning process, including the decision regarding how much coordination and monitoring is necessary and desirable.

**CMPA reports**

Record review forms for both CMPAs contained items regarding whether the client or family participated in the care planning process. The CMPAs reported that all of the 10 cases reviewed during the study period contained progress notes documenting participation in the care planning process. Neither of the CMPAs’ review forms included items regarding whether clients and families were involved in deciding how much coordination and monitoring was necessary and desirable.

**Our findings**

Our examination of the case records of the four policyholders in our sample who were included in quarterly record audits found evidence of progress notes documenting participation in the care planning process in two of the case records; in one other case, we found a Claimant’s Rights form confirming participation in care planning.
Of the 33 case records we reviewed as part of our overall study, only 8 contained any evidence of policyholder participation in developing the plan of care. Only four case records contained any evidence of policyholder participation in decisions about coordination and monitoring, and this was limited to policyholders’ signatures on standard statements indicating their agreement with care plans, which included care monitoring.

**Summary and recommendations**

In addition to progress notes regarding client participation in the care planning process, policyholders’ signatures on Claimant’s Rights forms, which assert that they understand and agree with care plans, appear to be another reasonable way of documenting client participation, in that they present information directly from clients or family members.

Record review forms should also include a mechanism for determining whether clients and families actively participate in the decision-making process regarding the need for coordination and monitoring. In light of policyholders’ apparent confusion regarding coordination and monitoring, and apparent arbitrariness in their provision, it may be particularly important to assess client participation in this area.

**Resource Integration**

*CPLTC 1993, § 58073(a)(2)(C).* Client, family and other community resources are integrated into the Plan of Care.

**CMPA reports**

Both CMPAs include an item on their record review forms as to whether clients, family, and other community resources are integrated in the care plans, although neither
indicates specifically how this is to be determined. Nine out of 10 CMPA reviews noted adequate integration of client, family, and other community resources in the care plan.

**Our findings**

Among the four reviews corresponding to policyholders in our sample, integration of these resources in the care plan was found for three cases; however, our independent review found that only two of the four care plans adequately included client, family, or other community resources.

**Summary and recommendations**

Failure to include client, family, or community resources was a common deficit in care plan development, as noted in the chapter on Care Plan Development. Although an examination of reviews of our four sample cases revealed only minor discrepancies, this is an area to which reviewers should give particular attention.

**Service Coordination**

*CPLTC 1993 and 1999, § 58073(a)(2)(E).* The provision of services is coordinated with those provided by other agencies to avoid duplication of services, and to integrate acute care with chronic care.

**CMPA reports**

The review form utilized by one CMPA contained essentially the same wording as in the regulation, whereas the other CMPA operationalized this issue by stating simply: “Care management services collaborated with other agencies or services.” CMPAs reported that 9 out of the 10 cases reviewed were adequate in coordinating services with other agencies, although neither specified how this was determined.
Our findings

Among the four reviews corresponding to policyholders in our sample, adequate coordination was found for three cases; however, our independent review found adequate coordination for only one of the four cases.

Summary and recommendations

The process of coordination or collaboration with other agencies seems to be a reasonable requirement, which should be explicitly noted in care plans or progress notes. However, our observations suggest a discrepancy in the review process used to assess coordination, and the need for better documentation. Furthermore, neither CMPA apparently addressed the very specific outcomes that coordination is intended to produce: avoidance of service duplication and integration of chronic and acute care. It should be noted, however, that integration of chronic with acute care is fairly vague, making it difficult to measure.

Comprehensiveness of the Care Plan

CMPA reports

CPLTC regulations stipulate that each plan of care should specify “the type, frequency, and providers of all Formal and Informal Long-Term Care Services required for the individual, and the cost, if any, of any Formal Long-Term Care Services prescribed.” (CPLTC 1993, § 58026; 1999, § 58027). However, there is no requirement that care plans be reviewed for adequacy, either with regard to their comprehensiveness or their accuracy.
**Our findings**

As noted in the chapter on Care Plan Development, our review of 32 care plans found substantial variation in their inclusion of formal and informal service needs identified in the assessment process. While the need for in-home care was consistently noted in care plans, some other identified service needs seldom appeared, including the following: day treatment programs; transportation; safety; caregiver education, respite, and support; and depression and other mental health issues. In its annual reports, one CMPA noted that some of its care managers did not document all client needs in the care plan, particularly with regard to rehabilitation consultation, OT safety evaluations in the home, adaptive clothing, and support groups.

Our review of the presence of specific service descriptors in these 32 care plans found the following: type of service, a list of potential service providers, and a source of payment for each service were present in at least two-thirds of the care plans; informal supports were listed in just over half of the care plans; and the cost and frequency of each service was indicated in about 40 percent of the care plans.

**Summary and recommendations**

Given the central role that care plans play in identifying formal and informal service needs, determining which services are covered under long-term care insurance, and deciding the extent of asset protection, it is essential that care plans be accurate and comprehensive. CMPAs should adopt methodologies for assuring the quality of care plans, including a periodic review of a sample of care plans in terms of their accuracy and comprehensiveness, based on a set of clearly specified criteria.
**Care Monitoring**

*CPLTC 1993 and 1999, § 58073(a)(2)(F).* Action is initiated by the Care Management Provider Agency when unmet client service needs are identified. . . .

**CMPA reports**

Neither of the two CMPAs appeared to address this issue directly. One CMPA simply asked, “Were there any unmet client service needs identified requiring action by the care management provider agency?” The other CMPA apparently operationalized this issue with the following two items: “Care management services identify care plan changes as they occurred” and “Care management services address changes in need or modify services to maintain an appropriate environment.” Record reviews by this CMPA indicated that documentation of changes to the care plan were not adequate in 4 of the 10 cases reviewed. As a result, the CMPA developed a new care plan form to ask for more specific documentation. The CMPA also reported enhancing its case monitoring format “to provide greater clarity in the improvement or deterioration of the client.”

**Our findings**

Among the four reviews corresponding to policyholders in our sample, the CMPA found care plan changes in response to unmet client needs in only one case; however, our independent review found care plan changes in all four cases. As noted in the Care Plan Development chapter of this report, care plan changes were identified in 17 of the 32 overall cases we reviewed, although in many cases it was impossible to determine the reason for these changes.

Unmet needs were identified in 12 of 18 cases in which policyholders were interviewed; in another 4 cases, documentation was not sufficient to determine whether or not
all of the policyholders’ needs were met. In a number of cases, progress notes indicated that care managers were aware of these needs; yet, there was no evidence that action was taken to resolve them.

**Summary and recommendations**

Failure to consistently identify unmet client needs may have been due in part to inconsistencies in the availability of ongoing monitoring by care managers. CMPAs apparently lacked specific criteria for identifying policyholders who required ongoing care monitoring. Consequently, for some policyholders, there was no mechanism in place for tracking whether their needs were being met. Moreover, even when care monitoring was being provided, progress notes were often not sufficient to identify clearly the presence of specific unmet needs or actions taken to resolve them. Indeed, in our interviews with care managers, some indicated that they saw little reason to document unmet needs, since it seemed unlikely that any action would be taken to resolve them.

Once unmet needs are identified, at least two possible types of actions might be taken: (1) care management interventions might be required to assist clients to obtain needed services already identified in existing care plans or (2) care plans might need to be changed to reflect changes in clients’ needs. One CMPA utilizes record review items that appear to address these two possible approaches, although neither is clearly labeled as such. Comparison of analyses indicated that the standards used by the CMPA for identifying care plan changes apparently were more stringent than those used in our own analysis. However, it should be noted that we had some difficulty in clearly identifying changes to care plans and other actions, because changes were often embedded in progress notes and not always specifically labeled as such. Lacking standardized methods for
recording unmet needs, tracking changes in policyholders’ condition, and documenting actions taken, it is difficult to assess the adequacy of CMPAs’ ability to identify and respond to clients’ unmet service needs.

### Unmet Needs

*CPLTC 1993 and 1999, § 58073(a)(2)(F).* . . . Pattern of unmet needs should be documented and reported to the Department of Health Services.

**CMPA reports**

Each of the three CMPAs indicated that it would report patterns of unmet needs in its annual reports to CPLTC. However, a review of annual reports revealed that no unmet needs were identified by any of the three CMPAs in their annual reports coinciding with our study period, although previous annual reports from one CMPA had identified an unmet need for respite care.

**Our findings**

Our analysis of case records and policyholder interviews revealed that certain policyholder needs were unmet in a number of cases. These included problems with home-care providers, service coordination, transportation, mental health, and falls. However, none of these problems occurred in more than 25 percent of the cases we reviewed, making it difficult to conclude that they represent a “pattern.”

**Summary and recommendations**

Documenting patterns of unmet need is essential to improving care management systems and enabling state officials to allocate resources more effectively. However, care
monitoring activities and documentation procedures currently in place do not appear adequate for identifying unmet needs in a consistent manner. More reliable procedures for identifying policyholder needs and service inadequacies are required if CMPAs are expected to identify and document patterns of unmet need.

**Cultural Sensitivity**

*CPLTC 1993 and 1999, § 58076(a).* Prior to the Care Management Provider Agency being approved by the State, and with an Annual update thereafter, the Care Management Provider Agency must file the following with the Department of Health Services and with each Issuer with whom they contract:

2. a policy manual that includes the following:

J. documentation of efforts to provide culturally sensitive services.

**CMPA reports**

All three CMPAs report utilizing multicultural, multilingual staff or translation services. One of the CMPAs also makes available books, videos, and other resource materials, while another CMPA provides care managers with a booklet on cultural sensitivity and dedicates a page of its policy and procedure manual to this subject.

**Our findings**

None of the case records we reviewed contained information regarding policyholder ethnicity, immigrant status, or language. Consequently, it was not possible to determine the presence of possible language barriers or other culturally based attitudes or practices that might impact service needs or utilization. Nor did any of the case records we reviewed include evidence of any efforts by the care manager to respond differentially based on a policyholder’s unique cultural characteristics.
Summary and recommendations

Efforts by the CMPAs to provide “culturally sensitive services” focused primarily on two areas: (1) provision of interpreters or bilingual, bicultural staff for non-English-speaking clients and (2) availability of books, videos, and other resource materials, primarily upon request from care managers. However, accepted definitions of cultural sensitivity are typically much broader, combining “extensive knowledge about various cultural groups” with “the worker’s attitude of acceptance, respect, and appreciation for each client’s cultural uniqueness” (Miley, O’Melia, & DuBois, 2001, p. 66). Culturally competent case management providers “develop programs and procedures that focus on client strengths, employ culturally sensitive assessment instruments, consider culture a resource, and make use of ethnically-oriented, indigenous helping networks” (Miley, O’Melia, & DuBois, 2001, p. 72). In our review of cases, we found no documented evidence that care managers’ activities were tailored to respond to policyholders’ unique cultural backgrounds.

Among the cases we reviewed, assessments did not include sufficient information to determine whether or not there were culturally based attitudes and practices that might impact care plans. Such information is essential for culturally sensitive services. Even among English-speakers, numerous cultural factors can substantially affect service utilization. For example, the care managers we interviewed gave a number of examples of policyholders who failed to utilize needed services because of culturally based attitudes regarding the use of nonfamily care providers.

Culturally sensitive services may require that care managers commit greater than average amounts of time and resources in cases in which cultural factors are especially prominent. Resource materials are an important first step, especially if those materials are
sent to care managers at the time they are assigned particular cases. However, culturally sensitive services may require that care managers also have periodic training as well as the availability of consultants to respond to particularly difficult cultural issues. Although training to provide culturally sensitive services exists, outreach or marketing to more diverse cultures would allow all CMPAs to utilize this training in providing culturally sensitive services.

Assuring Service Effectiveness

Ultimately, the best test of the quality of care management is whether it results in positive outcomes. Among the outcome domains that have typically been considered are the following: whether client needs are met, safety, independence, quality of life, consumer choice, family well-being, and cost of care. However, very few care management providers actually assess these or other client outcomes (Kane & Degenholtz, 1997), primarily because of the expense and methodological complexities of outcomes research. Moreover, the benefits of care management may not emerge fully until a number of months or even years after the intervention has occurred, making it difficult to link specific outcomes to care management interventions.

Meeting Client Needs

CPLTC 1999, § 58073(a)(1). A Care Management Provider Agency shall have a written quality assurance program which shall include but not be limited to:

(F) methods for assuring the quality of direct services provided including whether client needs as identified in the Plan of Care were met . . . .
**CMPA reports**

All CMPA policy manuals and annual reports indicated mechanisms for assessing client needs, including case monitoring and quarterly record review audits. Additional information was also obtained through questionnaires completed by two of three CMPAs.

Two CMPAs utilize staff referred to as “quality specialists,” “quality assurance care managers,” or “home office case managers” to review progress notes by field care managers. In the case of one CMPA, field care managers conduct monthly monitoring contacts with policyholders, typically by telephone, utilizing a standardized set of monitoring questions as a framework for their contacts. After a case becomes “stable,” “case managers” from the third-party administrator also contact policyholders “no less than every six months” to monitor the care plan, make and receive calls from the claimant and family, and review invoices from claims examiners. If the TPA case manager identifies changes in policyholder needs, referral is made to the field care manager for follow-up.

Another CMPA stated that it provides one month of monitoring for new cases; this frequency is reduced thereafter to approximately every 60 days. “Long-standing, stable” cases may receive monitoring contacts from “internal case managers” every 90 days. Documentation of these contacts occurs “if the case warrants it.” In addition, internal case managers are supposed to evaluate cases informally on an ongoing basis, through their contacts with field care managers, to review all aspects of the case and to assure quality in this area.

The third CMPA’s policy and procedure manual indicated that care managers make monthly contacts with “clients and/or family and the service providers to ensure the services are appropriate for client needs” and that these contacts are documented.
Our findings

A review of case records revealed evidence of monitoring contacts for policyholders of only one of the three CMPAs. These case records contained progress notes submitted by care managers, as well as summaries of contacts with policyholders, family members, and providers made by the CMPA documenting efforts to monitor and address clients’ needs. No monitoring notes were present in case records administered by either of the other two CMPAs. One of the two CMPAs stated in its annual reports that it did not provide “care management services” for any of its CPLTC cases, although no reason was given for this.

No unmet needs were identified by any of the three CMPAs in their annual reports coinciding with our study period. (Note: Previous annual reports from one CMPA had identified respite care as an unmet need in several instances.)

Our examination of the four case records of policyholders in our sample who were also reviewed by CMPAs in their quarterly record reviews revealed evidence of unmet needs in all four cases. These unmet needs fell into two general categories: needs that were not identified by case managers, and consequently, not addressed; and needs that were identified through the assessment process, but not addressed in care plans or subsequent care management contacts.

As described in the Care Plan Development chapter of this report, our general analysis of case records and policyholder interviews revealed the presence of unmet needs in 12 of the 18 cases in which policyholders were interviewed; in another 4 cases, documentation was not sufficient to determine whether or not all of the policyholders’ needs were met. Among the unmet needs identified were the following: a policyholder who apparently had been victimized by her independent provider and was not receiving
needed assistance with IADLs; a policyholder who was left alone despite the apparent need for continual supervision; family caregivers who were physically or emotionally exhausted; independent providers who did not show up, were tardy, or did not provide adequate care; and policyholders experiencing depression, anxiety, and other mental health problems.

**Summary and recommendations**

A fundamental criterion for evaluating the effectiveness of care management services in long-term care insurance is the ability to assure that client needs are met. Yet, our findings suggest substantial gaps in the ability of CMPAs even to identify unmet client needs, let alone take action to resolve them.

The CMPAs’ stated methods of assessing clients’ ongoing needs, including monitoring contacts and quarterly record review audits, seem quite adequate. Modifications in the amount and types of monitoring, such as reducing the number of contacts or transferring responsibility to a central office, seem reasonable. However, our case reviews suggest that, at least for two of the CMPAs, the intended monitoring contacts do not occur (or at least are not documented). Moreover, those contacts which do occur are conducted almost exclusively by telephone and primarily by a case manager whom the policyholder has never met. In many cases, the case manager works for a third-party administrator rather than the CMPA, so it is not surprising that many policyholders apparently see the case manager’s role as assisting with benefit administration rather than helping them to meet their care needs. The care managers we interviewed provided a number of examples of policyholders who would have benefited from home visits in
order to better assess and respond to their needs; however, the care managers believed that they did not have the time to make these home visits.

The provision of care monitoring apparently is based on policies imposed by insurers, rather than on the specific care needs of individual policyholders. As discussed in the Care Plan Development chapter, our review found few instances in which the need for care monitoring was assessed by care managers or discussed with policyholders. Moreover, even when the need for care monitoring was assessed, CMPAs apparently lacked consistent criteria for determining the amount and type of ongoing care management needed. CMPAs would benefit from the use of a standardized protocol for levels of care management, such as the Differentiated Approach to Care Management developed by Paul Searle and his colleagues at Devon County Social Services in England. The Differentiated Approach relies on three levels of care management—personal care management, care coordination, and self-care management—based on careful assessment and detailed protocols, and has been found to result in better and more cost-effective services to elderly clients and their families (Searle, 1998).

Maintaining an Appropriate Environment

*CPLTC 1993 and 1999, § 58073(a)(2)*. . . Each record review shall be documented on a record review form and shall include, but not be limited to, verification that:

(D) Care Management services are effective in maintaining an appropriate environment for the client.

**CMPA reports**

Record review forms for both CMPAs contained items addressing this issue. One CMPA used the exact phrasing of the regulation, while the other CMPA assessed whether
“care management services address changes in need or modify services to maintain an appropriate environment.”

**Our findings**

CMPA record reviews indicated that in 9 of the 10 cases reviewed care management services were effective in maintaining an appropriate environment for the client. It was not clear what criteria were used to make this determination. Our review of the case records of policyholders in our sample did not yield sufficient assessment information to identify what would be considered an “appropriate environment” for each policyholder.

**Summary and recommendations**

Of all the Partnership regulations, maintaining an appropriate environment is one of the most important and complex concepts, and articulates a central goal of the care management process. At the same time, it is also one of the most vague concepts in the regulations, lacking a specific definition about what “an appropriate environment” is intended to mean.

Efforts to assure that policyholders reside in an appropriate environment would seem to require a systematic method of determining what living situation(s) would be appropriate for each policyholder, as well as whether care management services would be effective in maintaining them. Assessment instruments should collect information regarding such factors as the following: (1) policyholder’s desired living situation; (2) policyholder’s ability to maintain her/himself in a healthful and safe manner in that living situation; (3) physical and functional characteristics of that living situation; (4) availability, adequacy and stability of adequate supports and resources; and (5) likely physical,
economic, and emotional impact on family members and other involved persons. Care plan documents should explicitly identify desired and appropriate environments as goals, and indicate activities and services required to maintain or achieve those environments. Finally, care monitoring activities should document whether or not those activities are successful in enabling policyholders to live in those environments.

**Financial Protection**

*CPLTC 1993, § 58077(e)*. Report on service/benefit utilization. Each Issuer shall submit on a semiannual basis and in a format specified by the State of California, a report to the Department of Health Services that will include . . . the services or benefits paid during the reporting period.

**Insurer/CMPA reports**

Claims data for all covered policyholders were reported to CPLTC by insurance carriers on a quarterly basis, and maintained as part of the Uniform Data Set (UDS). In addition, reports were sent to policyholders apprising them of the cost of benefits expended on their behalf, which of their assets could count toward the Medi-Cal property exemption, as well as the remaining amount of coverage under their long-term care insurance policy. CMPAs were not involved in this process.

**Our findings**

A review of UDS records for the 33 policyholders in our sample revealed that the median amount of benefits claimed and of assets protected was about $4,000. Interviews with 19 of these policyholders revealed a number of services that policyholders reported receiving, but for which claims were not reported on the UDS. Services potentially covered by insurance for which claims were not reported included home health care,
personal care, transportation, meals on wheels, medical equipment, and support groups. At the same time, there were at least two examples of services for which claims were reported, but which had not been authorized by the policyholder’s plan of care.

Interviews with family members revealed that they continued to spend an average of $280 per month of their own money to assist with the policyholder’s care. For the majority of caregivers, these expenditures were at least as much as they had been before insurance coverage began.

Policyholders indicated that care managers were not knowledgeable about benefits issues, and therefore could not always help them in making decisions about the most effective use of their benefits. Policyholders reported a great deal of confusion regarding the exclusion/deductible period, which often required substantial out-of-pocket expenditures before coverage began. Care plans and care manager progress notes were noticeably silent on this issue.

**Summary and recommendations**

Asset protection is a primary reason for purchasing long-term care insurance. However, current insurer and CMPA practices do not seem to include mechanisms for assuring that the correct dollar amount of assets is protected, that policyholders receive the services for which claims are submitted, or that claims are submitted for all covered services. It is not known whether or not insurers contact service providers on a regular basis to assure that claims match service provision.

Assuring that assets are protected and benefits used properly requires consistent care monitoring by care managers to be sure that policyholders receive the services they need. Also needed is direct contact between care managers and insurance company
claims managers, so that reported service use can be compared with submitted claims.

The failure to inform care managers regarding policyholders’ coverage and insurance benefits seriously undermines their ability to develop care plans that help policyholders to make the best use of their benefits. In order to be most helpful to their clients, care managers need to be informed regarding policyholders’ financial situation and insurance coverage.

**Assuring Client Satisfaction**

*CPLTC 1993, § 58073(a)(1).* A Care Management Provider Agency shall have a written quality assurance program which shall include but not be limited to:

(F) assessing client satisfaction and incorporating client suggestions.

Perhaps the best source of data regarding the quality of case management is clients themselves. However, consumer reports may be distorted due to unrealistic expectations. To the extent that clients expect that their care manager will provide the same level of care as a loving daughter or spouse, they are apt to be disappointed with the service they receive. More often, we find that clients report being quite satisfied with almost any care they receive, largely because of their own feeling of being undeserving. Consumer satisfaction reports may also be inflated because of clients’ reluctance to complain or their fear of reprisals if they do so, because of their dependence on or sense of obligation to their care providers. For example, more than 93 percent of clients who received care management as part of the National Channeling Demonstration reported being satisfied or partly satisfied with the service arrangements; however, almost 92 percent of those in the control group also reported being satisfied or partly satisfied.
Dr. Robert Applebaum and his colleagues have demonstrated that more valid measures of consumer satisfaction can be obtained by asking about specific service characteristics, such as timeliness, reliability, and the adequacy of specific services, rather than just seeking global satisfaction ratings. Moreover, for most elderly consumers, quality is most closely related to a sense of autonomy and personal control, whatever the specifics of the service under consideration (Woodruff & Applebaum, 1996).

Interviews with 244 users of Rhode Island’s home-care program, for example, found that 89 percent reported that their home-care worker arrived on time, 93 percent felt they were treated with respect and dignity by their home-care worker, and 88 percent reported that the home-care worker stayed the full amount of time; but only 76 percent reported that the worker performed the tasks they were supposed to, and fewer than 50 percent of clients reported that they were involved in helping to decide what tasks were to be performed (Consumer Satisfaction Survey, 1994).

Client satisfaction may lead to improved service utilization (Geron, 1996). Moreover, consumer satisfaction is an important indicator of service quality (Davies & Ware, 1988), and therefore has become an important component of total quality management and continuous quality improvement efforts as they have been applied to the provision of health care services (Gold & Wooldridge, 1995).

**Assessing Client Satisfaction**

**CMPA reports**

All of the CMPAs reported assessing client satisfaction, and indicated it as a “primary goal” and “key component” of their organization. All of the CMPAs indicated that they evaluated client satisfaction based on care manager observation in the field or
suggestions solicited through regular communication with care managers and other CMPA staff. In addition to personal and telephone contact, the CMPAs also reported conducting satisfaction surveys. All the CMPAs reported high levels of satisfaction among their clients.

**Our findings**

Although annual reports for all the CMPAs state that client satisfaction was evaluated, a review of the reports showed that only one CMPA provided some documentation regarding its client satisfaction activities. The CMPA provided a copy of its client satisfaction survey assessing policyholders’ opinions of the care management services.

The CMPA’s survey was mailed to policyholders with a return envelope provided. The survey asked policyholders to rate four areas of care management: (1) contact with the care manager (very good, somewhat good, not very good); (2) whether referrals met their needs (yes, no [explain], don’t know); (3) feedback on specific care manager traits such as courtesy, caring, and knowledge (always, sometimes, never); and (4) general comments. The survey results included responses for 52 policyholders or their representatives. The results show that 90 percent felt that contact with the care managers was very good and 75 percent indicated that care managers’ referrals met their needs. Care managers were rated as always knowledgeable, caring, responsive, etc. by 88 to 94 percent of policyholders. There was no summary reported of the results of the general comments.

As part of our exit interview at the end of the policyholders’ use of benefits or at 6 months after initial eligibility, we asked policyholders how well their care managers met their expectations. Six policyholders reported that the care manager exceeded their
expectations, six reported that the care manager just met their expectations, while three policyholders reported that the care manager failed to meet their expectations.

Examples of care manager activities that exceeded policyholder expectations included helping arrange and monitor care, contacting family members, and advocating with insurance companies regarding coverage and paperwork. Examples of areas in which the care manager failed to meet policyholder expectations included difficulty getting care, being unclear about what to expect or what was available from care management, or expecting more contact or communication. On a 10-point scale, policyholders rated care managers’ helpfulness with a mean score of 7.12 (SD=2.93). Family members were also asked to rate their satisfaction with the assistance they or their family member received from the care manager; all respondents were very (11) or somewhat (5) satisfied.

Policyholders also completed the Case Management portion of the Home Care Satisfaction Measures (HCSM) (Geron, 1995). Examination of HCSM responses indicated that policyholders generally endorsed high “positive interpersonal” relations with their care managers, low “negative interpersonal” relations, and relatively high levels of care manager “competency.” Lower ratings were endorsed on the “service choice dimension,” with policyholders less likely to report that care managers got them needed services, did a good job of setting up care, gave them enough choice of services, or generally did enough for them. Policyholders also indicated that care managers were not very knowledgeable about LTCI benefits and coverage, and that they did not necessarily teach them about or help them to obtain community services.
Summary and recommendations

Accurate information regarding client satisfaction of elderly service users is difficult to obtain. It is well documented that older persons are especially susceptible to response bias, i.e., giving responses that they believe others would like to hear. This is especially true when their role as service recipients makes them vulnerable to the perceived possibility of deleterious consequences should their care providers learn of their concerns. Obtaining accurate information regarding the perspectives of elderly consumers is facilitated by direct contact between the consumer and an impartial interviewer. Global satisfaction items and closed-end questions should be avoided, so as to reduce the likelihood of response bias. Instead, open-ended questions regarding specific aspects of care provision should be used, to the extent possible.

It was encouraging to see one CMPA attempt to implement and report the results of a satisfaction survey. A few limitations should be noted, however. First, the survey focused only on care management and did not address satisfaction with direct services, such as home health aid or homemaker services. Second, the limited range of the response categories did not provide for a sufficient distribution of response and was slanted toward more positive response choices. Third, there was no assurance that answering the survey would not impact policyholder services, especially since it was unclear whether or not the survey was anonymous. Finally, there was insufficient documentation to determine how representative the sample results were to CMPA populations, making it impossible to determine the adequacy of the process.

All three CMPAs also stated that telephone contacts with policyholders were used to monitor satisfaction. However, care monitoring contacts were inconsistent and apparently failed to identify numerous instances of policyholder dissatisfaction with services.
In general, CMPAs would achieve more client input if they developed an integrated method of assessing satisfaction on a regular basis, incorporating both open-ended questions and in-depth interviews with standardized measures. This would help to improve the accuracy of findings and more constructively contribute to improvements in the planning and delivery of services by better reflecting the priorities of policyholders.

**Incorporating Client Feedback**

**CMPA reports**

One of the three CMPAs reported a detailed protocol of how feedback was to be received, reviewed, and incorporated into the program. This CMPA reported specific steps for reviewing client suggestions, including review by the director of Long-Term Care Clinical Operations and, if deemed appropriate, review by a program evaluation committee. This CMPA also pointed out that, upon assessment, policyholders receive copies of the bill of rights and the appeal/grievance process to advise them on what to do if they have concerns or complaints.

The two other CMPAs reported that suggestions are incorporated into programs, but neither provided details on how feedback is reviewed. One of the CMPAs indicated that modifications are made to care plans when feedback indicates a problem with one of the procedures. This CMPA also reported that specific concerns are investigated and resolved immediately. The other CMPA stated that suggestions for improvement are evaluated and incorporated when possible.
Our findings

Only one CMPA demonstrated an instance of program modification as a result of client feedback. After receiving information that both clients and care advisors were unclear of procedures related to receiving respite benefits, the information explaining respite benefits to both clients and care advisors was modified and a specific form was developed specifically for respite benefit requests.

As noted previously, our interviews with policyholders and case record reviews revealed numerous instances of client concerns, which apparently were not documented by CMPAs or incorporated into their quality assurance programs.

Summary and recommendations

While it is encouraging that CMPAs report that feedback is acted upon immediately on a case-by-case basis, the adequacy of this process for improving the quality of services for all clients appears questionable. First, the documentation of the process is so limited that it is impossible determine its adequacy. Second, CMPA solicitation of policyholder feedback depends upon the adequacy of periodic care monitoring contacts and satisfaction surveys; the limitations of both have been discussed previously. None of the CMPAs included an explicit procedure for incorporating this information into their review processes.

In our interviews with policyholders, we found numerous examples of suggestions that might contribute to service and process improvements. By making a more concerted effort to obtain and utilize policyholder input, CMPAs might improve their systems, while enhancing consumer education and involvement.
SUMMARY AND CONCLUSIONS

This research project examined provisions for protecting the rights and meeting the needs of elderly consumers who purchase long-term care insurance through the California Partnership for Long Term Care (CPLTC), a public-private partnership between long-term care insurance carriers and Medi-Cal (California’s Medicaid program). In particular, this project: (1) investigated the experiences of policyholders in light of existing regulations and standard practices in long-term-care case management, (2) examined the adequacy of existing quality assurance procedures, and (3) developed recommendations for assessing consumer satisfaction and enhancing consumer protection with services provided under long-term care insurance.

The research methodology involved in-depth process analysis of the experiences of 33 long-term care insurance policyholders. The analysis included longitudinal case studies involving detailed case record reviews, multiple interviews with 19 policyholders, as well as information gathered from family members, care managers, care management provider agency personnel, and insurance company representatives.

We found that policyholders were generally satisfied with the services they received, both from care managers and from direct service providers. Policyholders’ basic service needs appeared to be met in most cases, although there were a few cases in which inadequate services or insufficient care management may have contributed to deleterious policyholder outcomes.

Following is a summary of specific findings and recommendations regarding existing policies and procedures, quality assurance, and consumer satisfaction.
Adequacy of Existing Policies and Procedures

Claims Process

Policyholders generally reported being satisfied with the process of filing a claim. In a number of cases, caregivers apparently provided care without assistance until they felt overwhelmed or became physically ill, or until policyholders fell and fractured a bone, leading to residential care. In each of these cases, it seems possible that earlier intervention might have relieved some of the burden on caregivers, perhaps reducing the likelihood that they would have become overwhelmed or ill or that policyholders would have required placement.

Recommendations regarding claims process

1. Policyholders should be informed of the importance of contacting their insurance carrier or agent as soon as they become disabled, so that preventive services may be offered that might alleviate subsequent problems for policyholders and their caregivers.

2. Policyholders may benefit from some additional assistance with the claims process and information about what to expect.

Eligibility Determination

CPLTC regulations require policyholders to meet certain functional, cognitive, or medical requirements to qualify for benefits under their insurance policies. Eligibility decisions based on these criteria are made by insurers, based on information gathered by CMPA assessors in face-to-face, in-person eligibility assessments.
As described in the chapter on Eligibility Determination, our review of assessment information and other available documentation found support for insurer eligibility determinations in 32 out of the 35 cases reviewed. Three policyholders deemed eligible by insurers did not appear to exactly meet CPLTC criteria; no one was found to have been denied benefits inappropriately.

A review of eligibility assessment protocols found a number of inconsistencies that could reduce the accuracy of eligibility determinations:

- The benefit eligibility assessment instruments differed somewhat with regard to how each ADL is defined and what is considered indicative of an ADL deficiency.
- Assessments usually lacked any evidence of direct observation of ADL performance or of behavior problems necessitating supervision.
- Potentially reversible causes of dementia were not assessed consistently, including depression, polypharmacy, malnutrition, dehydration, thyroid dysfunction, and bacterial infection.
- Information about the need for continual nursing observation or daily professional nursing intervention was not collected consistently. None of the assessment instruments apparently assessed the client or family’s ability to provide care in order to determine whether nursing care was absolutely necessary, in accordance with CPLTC criteria.

**Recommendations regarding eligibility determination**

3. Slight differences between Tax-Qualified policies (TQ) and Non-Tax-Qualified policies (NTQ) regarding functional impairment eligibility criteria suggest that
different assessment instruments may be required for post-1996 and pre-1997 policies.

4. When possible, assessments should include the direct observation of ADLs, the type of assistance needed to perform them, and any safety issues related to physical limitations or cognitive impairment. While specific performance tests of certain ADLs (e.g., toileting) may be unavailable, others are easily observed (e.g., transferring or eating). Space should be provided in the assessment instrument for direct observations.

5. Translated versions of cognitive assessment tools (e.g., SPMSQ, MMSE) should be used with policyholders whose primary language is not English. In addition, consideration should be given to adjusting scores on cognitive impairment screening instruments for policyholders with low levels of education and literacy.

6. A reliable and valid measure of behavioral disturbances that pose potential safety threats should be used, such as an aggregated version of the Behavioral Pathology in Alzheimer’s Disease (BEHAVE-AD) scale.

7. Eligibility assessments should be conducted by trained professionals to assure the accuracy and reliability of the assessment information. Clarification is needed regarding whether “certification” that an individual is “chronically ill,” as required under HIPAA, requires actual assessment and face-to-face contact with the policyholder, or whether a physician, professional nurse, or licensed social worker can certify an individual as chronically ill based on an assessment performed by an unlicensed assessor.
Assessment of Client Needs

CPLTC regulations specify that care management should take “an all-inclusive look at a person’s total needs and resources,” indicating the importance of a comprehensive assessment upon which to base an appropriate care plan. However, our review of case records found that assessment instruments currently being utilized do not appear adequate for collecting data about a policyholder’s “total needs and resources.” Deficits were identified with regard to such areas as emotional and psychological well-being, nutrition, tobacco and alcohol use, environmental safety, emergency response systems, social activity, culture and ethnicity, rehabilitation potential, and need for care management.

Recommendations regarding assessment of client needs

8. Assessments should collect detailed information regarding the specific types and amounts of assistance policyholders require to accommodate for physical and cognitive limitations.

9. Assessments should collect information regarding policyholders’ psychosocial well-being and the adequacy of psychosocial supports. Assessments should also consider the availability and capacity of informal caregivers, including their short-term and long-term ability to provide specific types of support, such as emotional, financial, or personal care.

10. Assessments should collect information about policyholder ethnicity, immigrant status, and language, as well as other culturally based attitudes or practices that might impact service needs or utilization.
11. Assessments should consider policyholders’ rehabilitation potential, including personal or situational factors that might affect their ability to achieve higher levels of functioning and independence.

12. Policyholders’ ability to manage their own care should also be assessed, including their need and desire for case management.

**Care Plans**

Care plan development incorporates the complex process of translating assessment data into meaningful problem statements and appropriate goals, with the active involvement of clients and their families. CPLTC regulations specify that care plans should be developed in a timely manner and should include the following: client, family, and community resources; type, frequency, providers, and cost of all formal and informal services; and coordination of service providers to avoid duplication and integrate acute with chronic care. Clients and family members should actively be involved in care plan development.

A review of case records identified a number of policyholder needs identified in assessments that were not addressed in the corresponding care plans, especially with regard to needs other than home care. Most care plans included problem and goal statements, although they tended to lack sufficient specificity. Services, providers, and source of payment were indicated for most formal services, but cost and frequency were often omitted, as were potential informal supports.

Policyholders and their families generally reported being involved in care plan development, although many policyholders also indicated that there were services they expected or wanted that were not included in the final care plan. Documentation of client participation, including receipt of a final care plan, was quite inconsistent.
To protect against potential conflicts of interest, care managers should not also be direct care providers; moreover, those who work for agencies named in the care plan should assure that clients are given other options. A review of case records identified a number of cases in which potential conflicts of interest may have occurred and which may have contributed to policyholders’ unmet needs.

**Recommendations regarding care plans**

13. Policyholders or their representatives should participate in the development of the care plan, and their participation and concurrence with care plan recommendations should be documented in the case record.

14. Care plans should reflect “an all inclusive look at a person’s total needs and resources,” including physical, cognitive, psychosocial, financial, familial, cultural, environmental, and other factors that might impact service needs or utilization.

15. A comprehensive list of all problems identified from assessment information should be developed for each case, and explanations should be provided for any problems not addressed in the care plan.

16. Care plans should contain a space for problem statements, and these statements should specify clients’ needs or problems in functional terms.

17. Care plans should include goal statements reflecting each identified problem, as well as a time frame and explicit mechanisms for measuring goal attainment.

18. Care plans should include at least the following descriptors: the type, frequency, and providers of all formal and informal long-term care services required for
clients; the cost, if any, of any formal long-term care services; and the source of payment.

19. Care plans should include information about responsibility for necessary care coordination and monitoring activities, including the frequency of contact and the manner in which this will occur.

20. To assure objectivity and impartiality, individuals who provide direct care and employees of the issuer should not act as care managers for assessment and care planning. In cases in which care managers work for organizations that also provide other services included in an insured’s plan of care, clients should be made aware of a full array of services and costs of other providers of these services, which should be documented in the case record. This may require a minor change in CPLTC regulations (§ 58072).

**Care Plan Implementation**

Care plan implementation involves providing information about available services and how to access them, and educating clients and family members about possible care activities they can perform. It may also include service coordination, which involves arranging or maintaining specific services.

Proper implementation of care plans is not only good practice, but is also important since CPLTC regulations specify that “Insurance benefit payments can count toward the Medi-Cal Property Exemption to the extent they are for Long-Term Care Services Countable Toward Medi-Cal Property Exemption delivered to insured individuals and are part of an individualized Plan of Care approved by the State-approved Care Management Provider Agency . . .” (1993, § 58059(f)).
Our interviews with policyholders and reviews of UDS data found that most care plans were not implemented fully, as evidenced by services identified in the care plan that apparently were never utilized. Possible reasons include lack of information regarding services available, confusion about LTCI coverage, unaddressed familial or cultural factors that affect use of formal service providers, and undocumented changes in policyholders’ needs or condition.

Interviews with policyholders also revealed confusion about what to expect from care managers. CPLTC regulations presume a discussion between policyholders and care managers regarding the need and desire for service coordination and monitoring; however, there was little evidence that such discussions occurred.

**Recommendations regarding care plan implementation**

21. Assessments should specifically assess potential personal, familial, or cultural barriers to service utilization, and whether there is a need for assistance with care plan implementation.

22. Care managers should inform policyholders regarding the availability of service coordination. A written description of the care manager’s role should be given to the policyholder, specifically outlining what service coordination is and how it can be obtained.

23. Case records should include documentation regarding discussions between care managers and policyholders about the availability of service coordination, whether or not the policyholder desires it, and whether or not the care management provider agency determines that it is necessary, along with the rationale for this determination.
**Care Monitoring**

Care monitoring can assess whether services are being provided in accordance with the care plan, are of good quality, and are meeting policyholders’ needs, while also evaluating progress towards intended goals. CPLTC regulations specify that monitoring should be provided “when desired by the individual and determined necessary by the Care Management Provider Agency . . .” (1993, § 58005(d)).

A review of case records and policyholder reports indicated that care managers typically have limited contact with policyholders, often consisting of one in-person visit to assess eligibility and develop a care plan, followed by periodic telephone calls (frequently from a care manager other than the one who developed the initial care plan). These contacts did not always appear sufficient to identify and respond to policyholder needs and service problems, as our review identified a number of unmet needs that were not documented in care manager progress notes. Moreover, progress notes almost never included evaluations of the effectiveness of recommended interventions or assessments of client progress toward meeting the goals identified in care plans.

**Recommendations regarding monitoring**

24. All policyholders should receive some level of basic monitoring to verify that the services being received are appropriate or that needed changes are identified, implemented, and documented in the care plan. This recommendation represents a change from current CPLTC regulations, which specify that monitoring can be a claim cost “when desired by the individual and determined necessary by the Care Management Provider Agency . . .” (1993, § 58005(d)).
25. The level of monitoring required should be guided by predetermined protocols such as the “Differentiated Approach to Care Management” (Searle, 1998), based on an assessment of policyholder vulnerability, the availability of informal resources for monitoring care, and the desires of policyholders and their representatives.

26. Monitoring should include at least a review of policyholders’ current status, service utilization, and care plan goals. Changes in current status should include all ADLs and IADLs, as well as changes in cognitive status, mental health/illness, and caregivers’ needs and capacity to provide appropriate care. Current service utilization should be reviewed for all LTCI covered and noncovered services, such as informal and community services, with particular attention to any service changes since the last monitoring contact and the reason for the changes. Each listed goal should be reviewed as to whether it has been attained and is still appropriate.

27. Policyholders should be asked whether or not their needs are being met, whether they are satisfied with services, and whether or not they desire more assistance than they are currently receiving, including care management services.

**Care Plan Changes**

Care plan modifications are necessitated by changes in clients’ abilities and needs, or by changes in the availability of formal and informal services. CPLTC regulations require that care plan changes be documented, along with the rationale for those changes. This is necessary to ensure that services based on the modified care plan count toward the Medi-Cal property exemption.
Specific changes to care plans were often difficult to discern in the case records we analyzed. Care plan changes were typically mentioned in care manager progress notes, rather than on an identifiable care plan document. Moreover, substantial inconsistencies were found in how care plan changes were identified and documented, making it extremely difficult to track long-term care services countable toward Medi-Cal property exemption.

Recommendations regarding care plan changes

28. A definition of “changes to the care plan” should be included in CMPA policy and procedure manuals, and communicated to local care managers.

29. All care plan changes and the rationale for these changes should be explicitly labeled to more easily identify the most recent plan of care.

30. The wording of CPLTC § 58005e should be changed from “. . . and if further care is needed” to “. . . and if any further care is needed.”

31. Definitions of “discharge plan” and “transition plan” should be included in CMPA policy and procedure manuals, with an allowable timetable for developing these plans, and how and when policyholders are to be provided with these plans.

32. The specific reason for termination of benefits should appear in the case record, and discharge and transitional plans should be clearly labeled in case notes, accompanied by a list of continuing care needs, along with how and when policyholders are to be provided with these plans. If there are no continuing care needs, this should be clearly documented.
Quality Assurance Recommendations

Care Management

CPLTC regulations invest the primary responsibility for quality assurance with the CMPAs, who are charged with approving care plans, assessing client satisfaction, and identifying unmet needs. Quality care management services are assured through quarterly service record reviews, as well as hiring qualified care managers who receive adequate training and supervision and have access to consultation for specific issues.

Our research revealed a number of factors that may constrain the ability of CMPAs to assure the quality of care management services, including the following:

- CPLTC regulations are silent about mechanisms for assuring the accuracy of eligibility determinations, the adequacy of assessment information that is collected, or the comprehensiveness of resulting care plans.

- Perhaps because of the limited nature of their contacts, policyholders do not generally see their assigned care managers as sources of assistance with the full array of care-related issues.

- In some cases, insurers or third-party administrators (TPAs) apparently assume responsibility for monitoring care, raising the possibility of a conflict of interest. Moreover, policyholders often see the insurer’s or TPA’s role only in terms of administering benefits or helping with paperwork, rather than as a source of assistance with care management.

- Final approval of care plans often rests with insurers or TPAs rather than CMPAs.

- CMPAs apparently are unlikely to identify the existence of unmet policyholder needs in published reports, possibly reflecting inadequate systems for documenting and responding to unmet needs.
While generally highly qualified, care managers apparently receive little training or supervision specifically regarding LTCI, and consultation with specialists from other disciplines is not always available.

**Recommendations regarding assuring the quality of care management**

33. Mechanisms should be established for assuring the accuracy of eligibility determinations and the adequacy of the assessment information upon which they are based. One possibility would be for an independent third party to review a sample of eligibility determinations on a quarterly or semiannual basis. Discrepancies or instances of insufficient information could be noted and resolved through discussions with the relevant insurers.

34. Policyholders need to be educated regarding what to expect from care management, including the types of care management available and the charges for each.

35. The roles of CMPAs, insurers, and TPAs should be clarified, especially with regard to care plan approval and ongoing care monitoring. Under current CPLTC regulations, CMPAs should be responsible for final approval of care plans, based on explicit criteria; documentation of approval by the CMPA should appear in the case record.

36. CMPAs should adopt methodologies for assuring the quality of care plans, including a periodic review of a sample of care plans in terms of their accuracy and comprehensiveness.

37. Protocols for targeting more intensive care management to more complex cases (e.g., unstable, comorbid physical and social conditions, cultural barriers, and unavailable family support) should be developed.
Summary and Conclusions

38. More reliable processes for identifying, documenting, and responding to unmet needs are needed, and incentives for employing them should be considered.

Service Delivery

Long-term care insurance covers a variety of services designed to meet the needs of individuals who have significant physical or cognitive disabilities. However, our research identified a number of areas in which there may be unmet policyholder needs:

- Care plans and resulting service provisions focused primarily on ADLs, often neglecting psychological, social, and rehabilitation needs.
- Policyholders frequently sought services that were not included in the care plan, many of which were not claimed for LTCI benefits.
- Care plans and resulting service provisions seldom addressed the needs of caregivers, which is perhaps one reason why caregivers continued to experience strain and out-of-pocket expenses months after policyholders became eligible for LTCI benefits.
- Cultural issues were not typically assessed, and there was little documented evidence of culturally sensitive services.

Recommendations regarding assuring the quality of service delivery

36. Clarification is needed as to whether LTCI benefits are intended to meet all of policyholders’ care needs or are just intended to cover physical care (e.g., nursing homes, assisted living facilities, home care).

37. Greater attention should be given to services designed to improve functioning and promote wellness, rather than being limited to meeting basic ADL needs.
38. Greater attention should also be given to the needs of caregivers, cultural attitudes and practices, and other factors that can impact service use and policyholder well-being.

39. Policyholders need better education regarding the benefits to which they are entitled under their LTCI policy.

40. Service use should be monitored on a regular basis to identify and overcome barriers that contribute to unmet needs.

41. Studies should be conducted regarding the health and economic impacts of LTCI benefit eligibility.

Consumer Satisfaction

Assessing client satisfaction and incorporating consumer feedback are important components of any quality assurance effort. Client satisfaction might be assessed through satisfaction surveys, as well as suggestions solicited through regular in-person or telephone communication with care managers and other CMPA staff. One CMPA conducted a client satisfaction survey assessing policyholders’ opinions of care manager services. However, care monitoring contacts were inconsistent and apparently failed to identify numerous instances of policyholder dissatisfaction with services.

Recommendations regarding assessing consumer satisfaction

42. Client satisfaction should be assessed on a regular and ongoing basis, rather than relying on one-time, cross-sectional surveys. For example, client satisfaction questions should be incorporated into monitoring calls and included in six-month reassessment interviews.
43. Standardized instruments should be used to collect information about consumer satisfaction, whenever possible. For example, the Home Care Satisfaction Measures have been designed for community-based long-term care populations and have demonstrated high internal consistency and reliability.

44. Global measures of satisfaction should be combined with specific questions about particular services or aspects of care. For example, policyholders should be asked about their experiences with specific services, including any concerns or problems they may be experiencing.

45. When using global satisfaction measures, multivariate techniques should be employed to circumvent some sources of response bias (e.g., age, level of disability, living arrangement, level of familial support, and life satisfaction).

46. Policyholders need better information about what to expect from care managers and service providers, so that they can be better consumers and provide more accurate feedback.

47. Assessments of client satisfaction might involve impartial third parties, such as state officials, who are not perceived as having a vested interest in clients’ satisfaction or dissatisfaction. Whether assessments of policyholder satisfaction are conducted by CMPAs, insurers, or state officials, care should be taken to reassure policyholders about their fears of dependency or reprisal, and assure that they are provided real alternatives in the delivery of their long-term care benefits.
IMPLICATIONS

The findings of this project have important implications for changes in the policies and procedures utilized by insurance carriers, care management organizations, regulatory bodies, and consumer groups in order to best protect the rights and meet the needs of elderly consumers who purchase long-term care insurance.

Implications for Insurers

1. Insurers should provide policyholders with better information at the time of their benefit eligibility determination regarding the specific details of their coverage, criteria for eligibility, the nature of care plans, the role of care management, and the appeals process. Policyholders also need to be more fully informed about the asset protection feature of their policies and the process of making the transition into Medi-Cal.

2. Insurers should review benefit eligibility assessment instruments to assure that they are consistent with CPLTC and HIPAA criteria. Slight differences between tax-qualified policies (TQ) and non-tax-qualified policies (NTQ), for example, may necessitate different assessment instruments for post-1996 and pre-1997 policies.

3. Insurers should develop a better system for tracking claims, so that discrepancies with care plans can be more easily identified.

4. Insurers should consider providing care management organizations with incentives for identifying, documenting, and responding to their clients’ unmet needs.

5. Insurers may wish periodically to assess client satisfaction directly, rather than relying solely on care management organizations to do so.
Implications for Care Management Organizations

1. Eligibility assessments should be conducted by trained professionals to assure the accuracy and reliability of the assessment information. Assessments should take “an all-inclusive look at a person’s total needs and resources,” including psychosocial well-being, culturally based attitudes and practices, rehabilitation potential, and need for assistance in managing care. Assessments, when possible, should include the direct observation of ADLs, the type of assistance needed to perform them, and any safety issues related to physical limitations or cognitive impairment.

2. In assessing cognitive impairment, a reliable and valid measure of behavioral disturbances that pose potential safety threats should be used, such as an aggregated version of the Behavioral Pathology in Alzheimer’s Disease (BEHAVE-AD) scale (Appendix B). Also, translated versions of cognitive assessment tools, such as SPMSQ and MMSE (Appendix B), should be used with policyholders whose primary language is not English.

3. Care plans should reflect “an all-inclusive look at a person’s total needs and resources,” including physical, cognitive, psychosocial, financial, familial, cultural, environmental, and other factors that might impact service needs or utilization. Care plans should include a comprehensive list of problems and corresponding goal statements, and should clearly delineate responsibility for arranging and coordinating care, including the care manager’s role, if any. Goals should include improving functioning and promoting wellness, not just meeting basic ADL needs.

4. Care management organizations should adopt methodologies for assuring the accuracy and comprehensiveness of care plans.
5. Care management organizations should educate policyholders about what to expect from care management, including the types of care management available and the charges for each.

6. Care management organizations should consider developing protocols for targeting more intensive care management to more complex cases, such as those involving unstable, comorbid physical and social conditions, cultural barriers, or unavailable family support.

7. Care management organizations should develop more reliable processes for identifying, documenting, and responding to unmet needs, including monitoring service use on a regularly scheduled basis.

8. Care management organizations should assess client satisfaction on a regular and ongoing basis, rather than relying on one-time, cross-sectional surveys. For example, client satisfaction questions should be incorporated into monitoring calls and be included in 6-month reassessment interviews. Assessment of client satisfaction should include standardized instruments, such as the Home Care Satisfaction Measures, as well as specific questions about experiences with particular services or aspects of care.

9. Implications for Regulatory Bodies

   1. Oversight mechanisms should be established for assuring the accuracy of eligibility determinations and the adequacy of the assessment information upon which they are based. One possibility would be for an independent third party to review a sample of eligibility determinations on a quarterly or semiannual basis. Discrepancies or
instances of insufficient information could be noted and resolved through discussions with the relevant insurers.

2. Consideration should be given to allowing insurers to adjust eligibility determination scores on cognitive impairment screening instruments for policyholders with low levels of education and literacy.

3. Clarification is needed regarding whether “certification” that an individual is “chronically ill,” as required under HIPAA, requires actual assessment and face-to-face contact with the policyholder, or whether a physician, professional nurse, or licensed social worker can certify an individual as chronically ill based on an assessment performed by an unlicensed assessor.

4. The roles of CMPAs, insurers, and TPAs need to be clarified, especially with regard to care plan approval and ongoing care monitoring.

5. Care management organizations should be required to review periodically a sample of care plans in terms of their accuracy and comprehensiveness.

6. Clarification is needed as to whether LTCI benefits are intended to meet all of a policyholder’s care needs or are just intended to cover physical aspects of care as provided by nursing homes, assisted living facilities, and home care.

7. Regulations may need revision to assure objectivity and impartiality in cases in which care managers work for organizations that also provide other services included in an insured’s plan of care.

8. Regulations should be revised to ensure that all policyholders receive some level of periodic monitoring to verify that the services being received are appropriate or that needed changes are identified, implemented, and documented in the care plan.
9. Regulatory bodies may wish periodically to conduct an independent assessment of a client’s experiences under LTCI.

Implications for Consumer Groups

1. Consumers, including but not limited to policyholders currently receiving benefits, need better education about the coverage afforded by LTCI and its limitations.

2. Consumers who have purchased LTCI policies should be informed of the importance of contacting their insurance carrier or agent as soon as they become disabled, so that preventive services may be offered that might alleviate subsequent problems for policyholders and their caregivers.

3. Consumers, including but not limited to policyholders currently receiving benefits, need better education about what care management is and its potential role in identifying, obtaining, and monitoring needed services.

4. Research is needed regarding the impact of LTCI on policyholders’ out-of-pocket expenditures, policyholders’ physical and psychosocial well-being, and caregivers’ responsibilities and well-being.
DISSEMINATION AND FOLLOW-UP

A copy of this report has been distributed to CMPAs, insurers, Department of Health Services staff, and leading experts in the areas of long-term care insurance, community-based long-term care, case management, research methodology, and public policy. These CMPAs, insurers, and experts have been asked to assess the potential usefulness of the proposed quality assurance policies and consumer satisfaction protocols, as well as whether or not they actually plan to implement these procedures once the project period is over. In addition, these constituencies have provided important input on our research methodology and findings regarding the experiences of long-term care insurance policyholders and existing long-term care insurance policies and procedures.

Final recommendations will be disseminated to a wide range of interested parties, including the Administration on Aging, HCFA, ASPE, the California Department of Health Services, the California Commission on Aging, other state and federal regulatory agencies, HIAA, individual insurance carriers, case management organizations, the Public Interest Center for Long-Term Care, and other consumer advocacy groups. Project staff members also plan to present project findings at appropriate national and local meetings, including HIAA’s annual Long-Term Care Insurance Conference, the International Long-Term Care Case Management Conference, and the annual meeting of the American Society on Aging.
REFERENCES


Consumer Reports. (1997, October). Long-Term Care Insurance.


References


Appendix A

California Partnership for Long-Term Care Regulations, 1999
Appendix B

Standardized Eligibility Assessment Tool
Appendix B Table of Contents

A1. Functional Impairment (Not Tax Qualified)
A2. Functional Impairment (Tax Qualified)
B. Short Portable Mental Status Questionnaire (SPMSQ)
C. Folstein Mini-Mental State Examination (MMSE)
D. Spanish Mini-Mental State Examination (S-MMSE)
E. Aggregated BEHAVE-AD Scale
F. Exclusion of Depression
G. Geriatric Depression Scale
H. Complex, Stable Medical Conditions
I. Standardized Eligibility Assessment Tool Summary Sheet
Appendix C

Standardized Care Planning Tools
Appendix C Table of Contents

Summary of Assessment Recommendations

Sample Problem List

Sample Care Plan

Sample Monitoring Questions
SUMMARY OF ASSESSMENT RECOMMENDATIONS

Informal/Family Support

- full names, relationship to policyholders, geographic proximity, and detailed contact information;
- availability, capacity, or willingness to provide specific types of support, such as emotional, financial, or personal care;
- estimated length of availability and specific schedule of support activities; their understanding of the policyholders’ illness and need for information about diagnosis or prognosis;
- current and projected need for support and respite;
- presence of intra-family conflicts related to caregiving responsibilities.

Medications

- policyholders’ capacity to understand what each medication is used for, and its prescribed dosage and scheduling;
- physical limitations in their capacity to correctly follow the medication regime;
- cultural or cognitive factors that would limit compliance with the regime;
- date that a physician or pharmacist last reviewed the entire list of medications.

Cognitive Status

- recent changes in mental status, as reported by the policyholder or caregiver;
- prior tests done to assess cognitive changes;
- when changes in mental status occur and any patterns to these changes;
- behavioral problems associated with the cognitive impairment.
Emotional/Psychological Status

- review of current symptoms of depression, grief, isolation, anxiety, suicidal ideation, and/or psychosis; for symptoms noted, an assessment of date of onset, duration, and frequency of symptoms;
- definitions of these conditions and accompanying symptoms.

ADLs/IADLs

- Ambulation: history of falls;
- Toileting and bathing: policyholders’ capacity to manage particular aspects of the dependency;
- Shopping and meal preparation: policyholders’ capacity to manage particular aspects of the dependency;
- Transportation: what transportation is needed for community-living policyholders;
- Managing finances: questions related to bill paying, and if dependency is noted, follow-up questions regarding the specific problem or deficit.

Nutrition

- nutritional status, including questions related to current intake of fluids and food, and use of dentures and any dental problems that affect the capacity to eat.

Environmental/Safety Issues

- environmental hazards, including presence and condition of stairs, emergency exits and pathways; overuse of electrical outlets and frayed cords; presence of combustible materials and equipment such as oxygen tanks;
- bathroom accessories such as handrails and height of toilet seat;
- adequacy of plumbing, lighting, heating, and ventilation;
- presence of smoke detectors and telephone;
- the presence of tripping hazards such as throw rugs, torn carpet, uneven floors, raised thresholds, and electrical cords;
- ability to open security bars in case of fire;
- location of emergency exits.

**Emergency Response System**

- Need for emergency response.

**Tobacco and Alcohol Use**

- frequency, amount, and type of alcohol use, with a note to compare this with any history of falls or injury and adverse medication reactions;
- pattern of dropping lighted cigarettes.

**Social Activity**

- changes in social activity, such as current level and type of activity as compared to premorbid activities.

**Potential for Rehabilitation**

- areas in which individuals might regain some functioning and independence, including prior history of recovery/rehabilitation;
- current prescribed therapies;
- clients’ understanding of the illness and prognosis, and their ability and motivation to engage in rehabilitative therapies;
- level of caregiver support in assisting with rehabilitation.
Level of Care Management Needed

- cognitive status of the individual, and the availability and capacity of informal supports or the client to provide care management independently or partially.
This list is a summary of all of the problems identified through the assessment process. In the far right column, indicate whether problems have been addressed in the care plan, and/or the reason for not addressing any problem.

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<th>Is deficit addressed in the care plan? (YES/NO)</th>
<th>If NO, explain:</th>
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<td>Cognitive Status</td>
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<td>___recent change in mental status</td>
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<td><strong>Psychosocial</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>___ change in social activities</td>
<td></td>
<td></td>
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<tr>
<td>___ lack of resources</td>
<td></td>
<td></td>
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<tr>
<td>___ recent loss or stress</td>
<td></td>
<td></td>
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<tr>
<td>___ other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potential for Rehabilitation</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>___ unaddressed need for rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ understanding of prognosis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>___ motivation for rehab</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>___ other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level of Care Management Needed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ needs assistance implementing care plan</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>___ needs routine monitoring</td>
<td></td>
<td></td>
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<tr>
<td>___ other _________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SAMPLE CARE PLAN (page 1 of 2)

CLIENT
NAME

CARE MANAGER ______________________________________________________________________
#________________________
CARE MANAGER AGENCY________________________________________________________________

DATE COMPLETED_______________________________
DATE OF REASSESSMENT________________________

<table>
<thead>
<tr>
<th>#</th>
<th>PROBLEM STATEMENT</th>
<th>RECOMMENDED INTERVENTION</th>
<th>GOAL STATEMENT</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specify areas/issues in which client or family experience difficulty</td>
<td>Specify type of service</td>
<td>Specify the desired outcome for client or family through this intervention</td>
<td>S</td>
</tr>
</tbody>
</table>
SAMPLE CARE PLAN (page 2 of 2)

CLIENT
NAME___________________________________________________

CARE MANAGER
NAME___________________________________________________Phone#___________________________________________________

<table>
<thead>
<tr>
<th>#</th>
<th>SERVICE PROVIDER(S)</th>
<th>SERVICE FREQUENCY</th>
<th>COST</th>
<th>PAYOR SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specify provider name and phone number</td>
<td>Specify how often or amount</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have discussed a variety of care options and service providers with my care manager. This care plan was developed with my input, and I agree with it.

Client’s Signature___________________________________________________________
Date________________

Client’s Representative_______________________________________________________
Relationship________________________Date________________


**SAMPLE MONITORING QUESTIONS**

CLIENT NAME________________________________________________________________________
CARE MANAGER________________________________________________________________________
DATE OF CONTACT_______________________ MODE OF CONTACT_________________________
INFORMATION PROVIDED BY____ CLIENT _____FAMILY _____OTHER (Specify)____________________

I. Review of Client’s Current Status

<table>
<thead>
<tr>
<th>ADLs</th>
<th>Independ.</th>
<th>Needs Human Assist.</th>
<th>Needs Supervision or Prompt</th>
<th>Change in Status? (Yes/No)</th>
<th>Specify Status Change</th>
<th>Does Change Require Change in Care Plan? (Yes/No)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) bathing</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>(4) transfer</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(5) continence</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*If yes, complete Section II-D

Who is currently providing assistance with these activities?

Are the client’s needs being met in these activities? _____YES _____ NO. If NO, explain in detail below:
### IADLs

<table>
<thead>
<tr>
<th>IADLs</th>
<th>Independ.</th>
<th>Needs Human Assist.</th>
<th>Needs Supervision or Prompt</th>
<th>Change in Status? (Yes/No)</th>
<th>Specify Status Change</th>
<th>Does Change Require Change in Care Plan? (Yes/No)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) meal preparation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(2) housework</td>
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<tr>
<td>(3) laundry</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>(4) shopping</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>(5) transportation</td>
<td></td>
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<td></td>
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<tr>
<td>(6) financial management</td>
<td></td>
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<td></td>
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<tr>
<td>(7) telephone use</td>
<td></td>
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<tr>
<td>(8) mobility</td>
<td></td>
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<tr>
<td>(9) falls</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*If yes, complete Section II-D

**Who is currently providing assistance with these activities?**

**Are the client’s needs being met in these activities?**

___YES___ NO. If NO, explain in detail below:
<table>
<thead>
<tr>
<th>Change in Status?</th>
<th>Specify Status Change</th>
<th>Does Change Require Change in Care Plan? (Yes/No)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Cognitive Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Affective Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal Supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
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<tr>
<td>Environmental/Safety Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco &amp; Alcohol Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Care Management Needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If yes, complete Section II-D
II. Review of the Current Care Plan

A. Goals Accomplished

What care plan goals have been accomplished to date?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

B. Changes in Services

List any changes in services (i.e., services added or deleted, or changes in providers) since the last monitoring contact:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

C. Client Satisfaction

(1) Is the client satisfied with current services? ____YES ____NO

(2) If NO, describe in detail what problem the client is experiencing with services:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

(3) What is your plan of action to address this problem?_________________________________
________________________________________________________________________________________

(4) Are the client’s needs being met? ____YES ____ NO

(5) If NO, specify what needs are not being met, and indicate your plan of action to address each unmet need:

UNMET NEED:______________________________________________________________________
PLAN OF ACTION:____________________________________________________________________

UNMET NEED:______________________________________________________________________
PLAN OF ACTION:____________________________________________________________________
D. Changes to the Care Plan

(1) Are all current problem statements in the care plan still valid? ____YES ____ NO

(2) If NO, indicate which current problem statement is no longer valid and why:

Current invalid problem statement #1:______________________________________________________
Indicate reason: ___change in medical situation
___change in functional ability
___change in cognitive ability
___change in behavioral ability
___change in availability of social supports

Current invalid problem statement #2:______________________________________________________
Indicate reason: ___change in medical situation
___change in functional ability
___change in cognitive ability
___change in behavioral ability
___change in availability of social supports

(3) If problem statements need to be REVISED, indicate the revised problem statements below, along with revised intervention, goal statement, and provider information, if appropriate:

Revised problem statement #1:_________________________________________________________
__________________________________________________________________________________
Revised intervention:______________________________________________________________
Revised goal statement:______________________________________________________________
Revised goal attainment:______________________________________________________________
Service provider:______________________________________________________________
Service frequency:______________________________________________________________
Service cost and payor source:______________________________________________________
Who is responsible for implementation?________________________________________________

Revised problem statement #2:________________________________________________________
__________________________________________________________________________________
Revised intervention:______________________________________________________________
Revised goal statement:______________________________________________________________
Revised goal attainment:______________________________________________________________
Service provider:______________________________________________________________
Service frequency:______________________________________________________________
Service cost and payor source:______________________________________________________
Who is responsible for implementation?________________________________________________
(4) If **NEW** problem statements need to be added, indicate the new problem statements below, along with recommended intervention, goal statement, and provider information, if appropriate:

**New problem statement #1:**

___________________________________________________________

__________________________________________________________________________________

Intervention:________________________________________________________________________

Goal statement:______________________________________________________________________

Goal attainment:_____________________________________________________________________

Service provider:________________________________________________________

Service frequency:___________________________________________________________________

Service cost and payor source:________________________________________________________

Who is responsible for implementation?_____________________________________________

**New problem statement #2:**

___________________________________________________________

___________________________________________________________________________________

Intervention:________________________________________________________________________

Goal statement:______________________________________________________________________

Goal attainment:_____________________________________________________________________

Service provider:________________________________________________________

Service frequency:___________________________________________________________________

Service cost and payor source:________________________________________________________

Who is responsible for implementation?_____________________________________________
Appendix D

Summary of Care Management Practice Standards

and Quality Indicators
Appendix D Table of Contents

Table 1. Benefit Eligibility Assessment Practice Standards and Quality Indicators
Table 2. Care Plan Development Practice Standards and Quality Indicators
Table 3. Care Plan Implementation Practice Standards and Quality Indicators
Table 4. Care Monitoring Practice Standards and Quality Indicators
<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicators</th>
</tr>
</thead>
</table>
| 1. The assessment of functional impairment in ADLs should collect information on the degree of help needed and on the duration of the impairment. | ▪ The ADL questionnaire contains, or is augmented to contain, questions about the degree of help needed.  
▪ The ADL questionnaire asks about the *duration* of the functional impairment. |
| 2. Direct observation of functional tasks is an important, objective source of assessment information, and should be performed whenever possible. | ▪ The eligibility assessment instrument contains spaces for the collection of direct observations of ADL functioning. |
| 3. Patient self-report of functional impairment should be supplemented with information from caregivers when the patient shows signs of cognitive impairment or confusion. | ▪ The eligibility assessment instrument contains a section for caregiver reports of functional impairments.  
▪ If a client is unable to answer ADL questions or shows signs of cognitive impairment, the section on caregiver reports of ADLs is completed. |
| 4. Cognitive impairment should be assessed utilizing standardized instruments with proven reliability and validity. | ▪ The eligibility assessment includes administration of at least the Folstein Mini-Mental State Examination (MMSE). |
| 5. Cognitive impairment scores on the SPMSQ and MMSE should be adjusted for educational background. | ▪ The eligibility assessment collects information on education attainment (years of education).  
▪ The scores of the SPMSQ and MMSE are adjusted using educational information (according to guidelines in Pfeiffer, 1975 and Murden, 1991). |
| 6. Linguistically and culturally appropriate cognitive assessment instruments should be utilized. | ▪ When English is not a client’s primary language, the eligibility assessment should include translated versions of the SPMSQ and the MMSE or a cognitive assessment instrument designed specifically for cross-cultural use (such as described in Tang, 1996). |
### Table 1 (continued)

| 7. | Information on behavioral disturbances and threats to safety should be collected from the family/caregiver and should include information on the degree of supervision needed, if any. | ▪ The eligibility assessment should include questions about behavior problems that pose a threat to safety; where such behavior problems are present, the need for daily supervision also should be assessed.  
▪ The eligibility assessment includes space for the direct observation of behavioral disturbances. |
| 8. | Since symptoms and behaviors often overlap, an attempt should be made to distinguish between cognitive impairment due to depression and cognitive impairment due to irreversible dementia. | ▪ The eligibility assessment instrument includes questions about the history of the client’s cognitive impairment and psychiatric symptoms (e.g., questions from Ware and Cooper, 1982).  
▪ If indicated, a reliable and valid instrument to assess depression is administered.  
▪ If the client shows signs of depression based on the questions above, a more thorough clinical assessment with a physician or neuropsychologist is performed before an eligibility decision is made. |
| 9. | Clients who do not qualify for eligibility through functional or cognitive impairment should also be assessed for medical conditions and other medical needs. Eligibility qualification is also possible through the presence of a “complex, yet stable” medical condition. | ▪ The eligibility assessment instrument collects the name and phone number of the treating physician(s).  
▪ The eligibility assessment instrument collects information on medical conditions, the medical treatments required for these conditions, and the frequency and providers of the treatments.  
▪ The eligibility assessment instrument collects information on the necessity of formal provision of these treatments, i.e., whether or not the family/caregiver could easily provide the treatments.  
▪ The eligibility assessment instrument collects information on other daily medical needs such as medication management. |
| 10. | Eligibility assessments should be performed by trained professionals. | ▪ The eligibility assessment instrument includes the name and professional degree of the person performing the assessment. |
Table 2. Care Plan Development Practice Standards and Quality Indicators

<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Consumer Participation</strong></td>
<td>A statement signed by policyholders indicating that they participated in the development of the care plan and agree to the plan as written.</td>
</tr>
<tr>
<td>The client has a right to participate in the development of the care plan, and to have his/her wishes and preferences respected.</td>
<td>If policyholders are severely cognitively impaired, a statement signed by the officially designated representatives indicating that they participated in the development of the care plan and agree to the plan as written; documentation identifying the officially designated representatives and why the policyholders were unable to participate in the care planning process.</td>
</tr>
<tr>
<td><strong>2. Assessment of Needs</strong></td>
<td>In addition to assessment of ADL/IADLs, cognitive status, and health status, the following areas should also be included:</td>
</tr>
</tbody>
</table>
| The assessment should include a comprehensive look at a person’s total needs and resources. | o Culture and ethnicity  
o Informal/family support  
o Medications  
o Emotional/psychological status  
o Nutrition  
o Environmental/safety issues  
o Emergency response system  
o Tobacco and alcohol use  
o Social activity  
o Potential for rehabilitation  
o Self-care ability and level of care management needed or desired |
| **3. Time Interval Between Assessment and Care Plan** | Statement in CMPA’s policy and procedure manual that specifies the allowable turnaround time for developing care plans, including how this can be determined. |
| The care plan should be completed as soon as possible after the comprehensive assessment is completed; a minimum time frame to complete the care plan should be established. | Documentation that can be used to determine the time interval between completion of the assessment and development of the care plan. |
| **4. Problem List** | A comprehensive list of all problems identified from assessment information. |
| A comprehensive list of all problems or needs should be generated from the client’s assessment information; care managers should document the reason that any problem on the list is not addressed in the care plan. | Documentation indicating the reasons that specific problems are not addressed in the care plan. |
| **5. Care Plan** | A.. Problem Statements in the Care Plan |
| The care plan should contain comprehensive information that describes the problems or unmet needs, desired outcomes, and recommended interventions: | The care plan should contain problem statements that specify the client’s needs or problems in functional terms. |

A.. Problem Statements in the Care Plan

The care plan should contain problem statements that specify the client’s needs or problems in functional terms.
<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Care Plan (continued)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **B. Goal Statements** | ▪ Care plan contains a goal statement(s) for each identified problem.  
▪ Each goal statement contains a mechanism for determining whether a goal is met, including a time frame for attainment when applicable. |
| The care plan should contain a goal statement for each problem statement that specifies the desired outcome for the client; goal statements should be measurable and include a time frame for the attainment of the desired outcome. | |
| **C. Service Descriptors** | ▪ Care plan contains recommended intervention(s) for each problem and its corresponding goal statement.  
▪ Each recommended intervention will consist of at least the following descriptors:  
  o Type of service  
  o A list of potential service providers for each type of service  
  o The roles of the informal supports, the policyholder, and care manager in providing, coordinating and monitoring the service  
  o The cost of the service  
  o The source of payment of the service  
  o The frequency of the service |
| The care plan should contain detailed descriptions of each recommended intervention. | |
| **6. Client Gets a Copy of Care Plan** | ▪ Documentation that the policyholder or officially designated representative received a copy of the care plan.  
▪ CMPA policy and procedure manuals delineate allowable timetable for giving copy to policyholder. |
| The client should receive a copy of the completed care plan. | |
| **7. Objectivity and Impartiality** | ▪ CMPA’s policy and procedure manuals contain discussion of each item in Section 58027, including what documentation will be completed to certify that individuals who provide direct care and employees of the issuer do not act as care managers for assessment and care planning; that direct service providers and care managers do not report to the same clinical supervisor; and that clients are made aware of a full array of services and costs of other providers of the services.  
▪ Documentation which verifies that individuals who provide direct care and employees of the issuer do not act as care managers for assessment and care planning; that direct service providers and care managers do not report to the same clinical supervisor; and that clients are made aware of a full array of services and costs of other providers.  
Note: If a CMPA does NOT provide services included in the insured’s care plan, a notation referencing Section 58075 to this effect should appear in its manuals, thereby eliminating the need to elaborate on the above items. |
| All aspects of the care planning process should serve the client’s welfare as the primary objective, and should avoid influences that could comprise the objectivity and impartiality required to attain this objective. | |
### Table 3. Care Plan Implementation Practice Standards and Quality Indicators

<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Consumer Participation and Information</strong></td>
<td>▪ Documentation indicating that the client and family were involved in determining how much service coordination is needed.</td>
</tr>
<tr>
<td></td>
<td>▪ Documentation that a written description of the role of the care manager regarding service coordination was given to the client.</td>
</tr>
<tr>
<td></td>
<td>▪ Separate item included in the care plan that specifies the frequency, cost, type of service coordination, and who is responsible.</td>
</tr>
</tbody>
</table>
Table 4. Care Monitoring Practice Standards and Quality Indicators

<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Minimum Monitoring</strong></td>
<td></td>
</tr>
<tr>
<td>All clients should receive at least a minimum amount of monitoring in order to verify that services being received are appropriate or that needed changes are identified.</td>
<td>• Documentation of all monitoring contacts, including at least a review of client’s current status, service utilization, care plan goals, needs, and satisfaction with services.</td>
</tr>
<tr>
<td><strong>2. Consumer Participation and Information</strong></td>
<td></td>
</tr>
<tr>
<td>The client and family should be actively involved in determining how much monitoring is needed, and should be fully informed about the role of the care manager in providing this service.</td>
<td>• Documentation indicating that the client and family were involved in determining how much monitoring is needed. • Documentation that a written description of the role of the care manager regarding monitoring was given to the client. • Separate item included in the care plan that specifies the frequency, cost, type of monitoring, and who is responsible.</td>
</tr>
<tr>
<td><strong>3. Reassessments</strong></td>
<td></td>
</tr>
<tr>
<td>Clients should be assessed periodically at established intervals or in response to changes in clients’ situation.</td>
<td>• Care plan includes the projected date of reassessment. • CMPA policy and procedure manuals delineate guidelines for reassessments occurring at times other than the required 6-month intervals. • Dated reassessment forms. • Dated problems lists that correspond to dated reassessments.</td>
</tr>
<tr>
<td><strong>4. Changes to the Care Plan</strong></td>
<td></td>
</tr>
<tr>
<td>The care plan should be revised to reflect changes in the client’s status and needs.</td>
<td>• Dated entries describing all changes to the care plan in detail with rationale for each change. • Documentation of care plan changes should be explicitly labeled as such.</td>
</tr>
<tr>
<td><strong>5. Discharge Plan</strong></td>
<td></td>
</tr>
<tr>
<td>A written discharge plan should be developed with client input that addresses all continuing care needs, and a copy given to the client.</td>
<td>• Documentation describing the reason(s) for discharge. • Dated list of continuing care needs and recommended interventions, or documentation of lack of continuing needs, if applicable. • Documentation that client received a copy of the discharge plan.</td>
</tr>
</tbody>
</table>
STANDARDIZED ELIGIBILITY ASSESSMENT TOOL
A1. FUNCTIONAL IMPAIRMENT (NOT TAX QUALIFIED)

Ambulation

Currently, is the insured able to move around without support or help from another person? This includes the ability to walk or move around inside or outside the home regardless of the use of a cane, crutches or braces.

I.

A. 1. Able to and does independently
   2. Able to use equipment/device independently
      Type of equipment: Reason for equipment:

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
C. What type of assistance is provided and for what portion(s) of this activity?
   a) Cueing (prompting or direction); OR
   b) Standby (not hands-on, but for safety) Equipment used:
   c) Physical (hands-on) Equipment used:

D. Describe:

E. Who assists?

F. Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

G. When this insured walks inside, how often is human assistance provided?
   Every time (100%)
   Most of the time (75%-99%)
   Half of the time (50%-74%)
   Some of the time (25%-49%)
   Infrequently (5%-24%)

H. 1. Total assist: not able to do any portion of the activity
   Why?
   Bedbound
   W/C Dependent
   Other
   Describe
   Who assists?

II.

A. 1. What month and year did the insured begin functioning at the present level?
   Month Year

III.

A. 1. If you observed insured ambulating, describe in detail:
Eating

Currently, is the insured able to feed himself/herself once a meal is prepared, set-up, and placed in front of himself/herself? This includes reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

Feeding Tube TPN

I.
A. 1. Able to and does independently
    2. Able to use equipment/device independently
    Type of equipment
    Reason for equipment
B 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
   A. What type of assistance is provided and for what portion(s) of this activity?
      Cueing (prompting or direction); OR
      Standby (not hands-on, but for safety) Equipment used; OR
      Physical (hands-on) Equipment used:

Describe

Who assists?

Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

When this insured eats, how often is human assistance provided?

   Every time (100%)
   Most of the time (75%-99%)
   Half of the time (50%-74%)
   Some of the time (25%-49%)
   Infrequently (5%-24%)

C 1. Total assist: not able to do any portion of the activity

   Why?

   Who assists?

II.
A. 1. What month and year did the insured begin functioning at the present level?

   Month
   Year

III. If you observed insured eating, describe in detail:
Bathing

Currently, is the insured able to bathe himself/herself? This includes cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying. Insured’s usual form of bathing.

- Tub
- Shower
- Sponge Bath
- Bed Bath
- Whirlpool Bath

I.
A. 1. Able to and does independently
   2. Able to use equipment/device independently
      - Type of equipment
      - Reason for equipment

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
B. What type of assistance is provided and for what portion(s) of this activity?
   - Cueing (prompting or direction): OR
   - Standby (not hands-on, but for safety) Equipment used: OR
   - Physical (hands-on) Equipment used:

Describe what part(s) of the Bathing ADL require(s) human assistance (check all that apply):
- Get to and from the tub, shower, or sink
- Assistance to wash parts of the body
- Get in and out of the tub or shower
- Obtain and dispose of water, control temperature
- Towel dry

Who assists?

Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

When this insured bathes, how often is human assistance provided?
- Every time (100%)
- Most of the time (75%-99%)
- Half of the time (50%-74%)
- Some of the time (25%-49%)
- Infrequently (5%-24%)

C. 1. Total assist: not able to do any portion of the activity
   - Why?
   - Who assists?

II.
A. 1. What month and year did the insured begin functioning at the present level?
   - Month
   - Year

III.
A. If you observed the insured bathing, please describe:
Dressing

Currently, is the insured able to dress and undress himself/herself? This includes putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

I.
A. 1. Able to and does independently
   2. Able to use equipment/device independently
      Type of equipment
      Reason for equipment

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
   
C. What type of assistance is provided and for what portion(s) of this activity?
   - Cueing (prompting or direction): OR
   - Standby (not hands-on, but for safety) Equipment used: OR
   - Physical (hands-on) Equipment used:

D. Describe what part(s) of the Dressing ADL require(s) human assistance (check all that apply):
   - Assistance to get clothing from the closets or drawers
   - Put on and take off all items of clothing (excluding tie/buckle shoes and socks)
   - Fastening all clothing

Who assists?

Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

When this insured dresses, how often is human assistance provided?

   - Every time (100%)
   - Most of the time (75%-99%)
   - Half of the time (50%-74%)
   - Some of the time (25%-49%)
   - Infrequently (5%-24%)

C. 1. Total assist: not able to do any portion of the activity
   - Why?
      - Bedbound
      - Other
   - Describe
   - Who assists?

II.
A. 1. What month and year did the insured begin functioning at the present level?
   - Month
   - Year

III.
A. 1. If you observed the insured dressing please describe:
Transferring

Currently, is the insured able to get in or out of a bed or chair by him/herself? This includes moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

I.

A. 1. Able to and does independently
    2. Able to use equipment/device independently

    Type of equipment
    Reason for equipment

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.

E. What type of assistance is provided and for what portion(s) of this activity?
   Cueing (prompting or direction): OR
   Standby (not hands-on, but for safety) Equipment used:
   Physical (hands-on) Equipment used:

Describe

Who assists?

Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

When this insured transfers, how often is human assistance provided?

   Every time (100%)
   Most of the time (75%-99%)
   Half of the time (50%-74%)
   Some of the time (25%-49%)
   Infrequently (5%-24%)

C. 1. Total assist: not able to do any portion of the activity

   Why?
   Bedbound
   Other

   Describe

   Who assists?

II.

A. 1. What month and year did the insured begin functioning at the present level?

   Month
   Year

III.

A. 1. If you observed insured transferring, describe in detail:
Continence

Currently, is the insured able to get to the bathroom on time to empty his/her bladder? This includes the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

I  Has no incontinence

II  Requires catheter, urostomy, or nephrostomy device
   Is the insured able to manage this device by himself/herself? (Record answer, either A, B, or C below)

III  If the insured is incontinent:
   How often? _____(#) Times per: day week month year
   Is the insured able to care for himself and any soiled items? (Record answer, either A, B, or C below.)

A.  1. Able to and does independently
    2. Able to use equipment/device independently
       Type of equipment
       Reason for equipment

B.  1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.

   F.  What type of assistance is provided and for what portion(s) of this activity?
      Cueing (prompting or direction): OR
      Standby (not hands-on, but for safety) Equipment used: OR
      Physical (hands-on) Equipment used:

      Describe when incontinent, what human assistance does the insured require in order to maintain a reasonable level of personal hygiene? (Check all that apply):
      Wash self (insured)
      Dispose of soiled items
      Change clothing
      Care for medical devices

   Who assists?

   Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

   When this insured is incontinent of urine, how often is human assistance provided?
      Every time (100%)
      Most of the time (75% - 99%)
      Half of the time (50% - 74%)
      Some of the time (25% - 49%)
      Infrequently (5% - 24%)

C.  1. Total assist: not able to do any portion of the activity
   Why?
   Who assists?

IV.A.  1. What month and year did the insured begin functioning at the present level?
**A2. FUNCTIONAL IMPAIRMENT (TAX QUALIFIED)**

**Eating**

Currently, is the insured able to feed himself/herself once a meal is prepared, set-up, and placed in front of himself/herself? This includes feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

- Feeding Tube
- TPN

I.

A. 1. Able to and does independently
   2. Able to use equipment/device independently
      - Type of equipment
      - Reason for equipment

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
   - What type of assistance is provided and for what portion(s) of this activity?
     - Cueing (prompting or direction); OR
     - Standby (not hands-on, but for safety) Equipment used: OR
     - Physical (hands-on) Equipment used:

   - Describe
   - Who assists?

   - Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

   - When this insured eats, how often is human assistance provided?
     - Every time (100%)
     - Most of the time (75%-99%)
     - Half of the time (50%-74%)
     - Some of the time (25%-49%)
     - Infrequently (5%-24%)

C. 1. Total assist: not able to do any portion of the activity
   - Why?
   - Who assists?

II.

D. 1. What month and year did the insured begin functioning at the present level?
   - Month
   - Year

III. If you observed insured eating, describe in detail:
Bathing

Currently, is the insured able to bathe himself/herself? This includes cleaning the body washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

Insured’s usual form of bathing:
- Tub
- Shower
- Sponge Bath
- Bed Bath
- Whirlpool Bath

I.
A. 1. Able to and does independently
   2. Able to use equipment/device independently
      Type of equipment
      Reason for equipment

B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
   · What type of assistance is provided and for what portion(s) of this activity?
     - Cueing (prompting or direction): OR
     - Standby (not hands-on, but for safety) Equipment used: OR
     - Physical (hands-on) Equipment used:

   Describe what part(s) of the Bathing ADL require(s) human assistance (check all that apply):
   - Get to and from the tub, shower, or sink
   - Assistance to wash parts of the body
   - Get in and out of the tub or shower
   - Obtain and dispose of water, control temperature
   - Towel dry

   Who assists?

   Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

   When this insured bathes, how often is human assistance provided?

   - Every time (100%)
   - Most of the time (75%-99%)
   - Half of the time (50%-74%)
   - Some of the time (25%-49%)
   - Infrequently (5%-24%)

C. 1. Total assist: not able to do any portion of the activity
   Why?
   Who assists?

II.
A. 1. What month and year did the insured begin functioning at the present level?
   Month
   Year

III.
A. 1. If you observed the insured bathing, please describe:
Dressing

Currently, is the insured able to dress and undress himself/herself? This includes putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

I.
   A. 1. Able to and does independently
       2. Able to use equipment/device independently
       - Type of equipment
       - Reason for equipment
   B 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.
   E. What type of assistance is provided and for what portion(s) of this activity?
      - Cueing (prompting or direction): OR
      - Standby (not hands-on, but for safety) Equipment used: OR
      - Physical (hands-on) Equipment used:

      Describe what part(s) of the Dressing ADL require(s) human assistance (check all that apply): Assistance to get clothing from the closets or drawers
      - Put on and take off all items of clothing (excluding tie/buckle shoes and socks)
      - Fastening all clothing

      Who assists?

      Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment. etc.)

      When this insured dresses, how often is human assistance provided?
      - Every time (100%)
      - Most of the time (75%-99%)
      - Half of the time (50%-74%)
      - Some of the time (25%-49%)
      - Infrequently (5%-24%)

   C. 1. Total assist: not able to do any portion of the activity
      - Why?
      - Bedbound
      - Other
      - Describe

      Who assists?

II.
   A. 1. What month and year did the insured begin functioning at the present level?
      - Month
      - Year

III.
   A. 1. If you observed the insured dressing please describe:
Transferring

Currently, is the insured able to get in or out of a bed or chair by him/herself? This includes the ability to move into or out of bed, a chair or wheelchair.

I.
   A. 1. Able to and does independently
   2. Able to use equipment/device independently
      Type of equipment
      Reason for equipment

   B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.

   F. What type of assistance is provided and for what portion(s) of this activity?
      Cueing (prompting or direction): OR
      Standby (not hands-on, but for safety) Equipment used:
      Physical (hands-on) Equipment used:

      Describe

      Who assists?

      Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

      When this insured transfers, how often is human assistance provided?

         Every time (100%)
         Most of the time (75%-99%)
         Half of the time (50%-74%)
         Some of the time (25%-49%)
         Infrequently (5%-24%)

   C. 1. Total assist: not able to do any portion of the activity
      Why?
         Bedbound
         Other

      Describe

      Who assists?

II.
   A. 1. What month and year did the insured begin functioning at the present level?
      Month
      Year

III.
   A. 1. If you observed insured transferring, describe in detail:
Using the Toilet

Currently, is the insured able to get to the bathroom and use the toilet? This includes getting to and from on or off the toilet, and performing associated personal hygiene.

I.  
   A.  1. Able to and does independently
       2. Able to use equipment/device independently
          Type of equipment
          Reason for equipment

   B.  1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.

   G.  What type of assistance is provided and for what portion(s) of this activity?
       - Cueing (prompting or direction): OR b) 
       - Standby (not hands-on, but for safety) Equipment used: OR 
       - Physical (hands-on) Equipment used:

       Describe what part(s) of the Toileting ADL require(s) human assistance (check all that apply):
       - Get to and from the toilet
       - Transferring on and off the toilet
       - Cleanse self after elimination
       - Adjust clothing

       Who assists?

       Why does the insured require human assistance? (-Note the underlying functional problem, including descriptive observations., e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

       When this insured toilets, how often is human assistance provided?

       - Every time (100%)
       - Most of the time (75%-99%)
       - Half of the time (50%-74%)
       - Some of the time (25%-49%)
       - Infrequently (5%-24%)

   A.  1. Total assist: not able to do any portion of the activity
       Why?

       Who assists?

II.  
   A.  1. What month and year did the insured begin functioning at the present level?
       Month
       Year
Continence

Currently, is the insured able to get to the bathroom on time to empty his/her bladder? This includes the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

I. Has no incontinence

II. Requires catheter, urostomy, or nephrostomy device; Is the insured able to manage this device by himself/herself? (Record answer, either A, B, or C below)

III. If the insured is incontinent:
   - How often? _____ (#) Times per: day  week  month  year
   - Is the insured able to care for yourself and any soiled items? (Record answer, either A, B, or C below.)

   A. 1. Able to and does independently
       2. Able to use equipment/device independently
          Type of equipment
          Reason for equipment

   B. 1. Partial assist: the insured is able to participate in this activity, but requires one of the following types of assistance from another person.

   H. What type of assistance is provided and for what portion(s) of this activity?
      - Cueing (prompting or direction): OR
      - Standby (not hands-on, but for safety) Equipment used: OR
      - Physical (hands-on) Equipment used:

      Describe when bladder incontinent, what human assistance does the insured require in order to maintain a reasonable level of personal hygiene? (Check all that apply):
      - Wash self (insured)
      - Dispose of soiled items
      - Change clothing
      - Care for medical devices

   Who assists?

   Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, tendency to wander, paralysis, cognitive impairment, etc.)

   When this insured is incontinent of urine, how often is human assistance provided?
   - Every time (100%)
   - Most of the time (75%-99%)
   - Half of the time (50%-74%)
   - Some of the time (25%-49%)
   - Infrequently (5%-24%)

   C. 1. Total assist: not able to do any portion of the activity
      - Why?
      - Who assists?

IV.A. 1. What month and year did the insured begin functioning at the present level?
B. SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

*Score 1 point for each correct answer; 0 points for incorrect or don’t know.*

<table>
<thead>
<tr>
<th>Question</th>
<th>correct</th>
<th>incorrect</th>
<th>don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What is the date today? (month/date/year)</td>
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<tr>
<td>2) What day of the week is it?</td>
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<tr>
<td>3) What is the name of this place?</td>
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<td>4) What is your telephone number? (if no telephone number, what is your street address?)</td>
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<td>5) How old are you?</td>
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<td>6) When were you born? (month/date/year)</td>
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<td>7) Who is the current president of the United States?</td>
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<td>8) Who was the president before him?</td>
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<tr>
<td>9) What was your mother’s maiden name?</td>
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<td><em>(any name counted as correct)</em></td>
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<tr>
<td>10) Subtract 3 from 20 and keep subtracting each new number you get, all the way down. (Answer: 17,14,11,8,5,2)</td>
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</tbody>
</table>

**Total:** __ (10) __ __ __

**Adjusted Total*: __

* Adjusted Total: if education is less than 9 years: add one (1) point to Total
if education is 9-12 years: add zero (0) points to Total
if education is more than 12 years: subtract one (1) point from Total
C. FOLSTEIN MINI-MENTAL STATE EXAMINATION (MMSE)

**Score 0 if incorrect, point value if correct**

<table>
<thead>
<tr>
<th></th>
<th>Correct</th>
<th>Incorrect</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>year?</td>
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<td>season?</td>
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<td>month?</td>
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<td>2.</td>
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<td>country?</td>
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<td>town/city?</td>
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<td>address (or place)?</td>
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<td>room (or floor)?</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<td>3.</td>
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<tr>
<td></td>
<td>“Apple”</td>
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<td>“Table”</td>
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<tr>
<td></td>
<td>“Penny”</td>
<td>___ (3)</td>
<td>___ ___ ___</td>
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<td>4.</td>
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<td>Begin with 100 and count backwards by 7. (Stop after 5 answers). (93, 86, 79, 72, 65) Alternate: Spell WORLD backwards.</td>
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<td>Give one point for each correct number or letter.</td>
<td>___ (5)</td>
<td>___ ___ ___</td>
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<td>5.</td>
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<td>Ask for the name of the three objects learned in question 3. Give one point for each correct answer.</td>
<td>___ (3)</td>
<td>___ ___ ___</td>
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<td>6.</td>
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<td>Show a pencil and a watch. Have the client name them as you point. pencil</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<tr>
<td></td>
<td>watch</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<td>7.</td>
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<td>Have the client repeat: “No ifs, ands, or buts.”</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<td>8.</td>
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<td></td>
<td>Have the client follow a three-stage command: “Take a paper in your right hand. Fold the paper in half. Put the paper on the floor.”</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<td>9.</td>
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<td></td>
<td>Have the client read and obey the following words, “CLOSE YOUR EYES” (write in large letters).*</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<tr>
<td>10.</td>
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<tr>
<td></td>
<td>Have the client write a sentence of his or her choice. (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.)</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
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<td>11.</td>
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<tr>
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<td>Have the client copy the design below. (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.)</td>
<td>___ (1)</td>
<td>___ ___ ___</td>
</tr>
</tbody>
</table>

**Total** ___(30) | ___ ___ ___
D. SPANISH LANGUAGE MINI-MENTAL STATE EXAMINATION (S-MMSE)
E. Aggregated BEHAVE-AD Scale

Section should be asked of the caregiver if the client shows signs of cognitive impairment:

(A) Does the client exhibit or is the client reported to have any of the following behavioral disturbances.....

1. Wandering? Observed? ___ yes ___ no
   Reported? ___ yes ___ no By Whom?________________________
   If yes, please describe: _______________________________________________________________
   ___________________________________________________________________________________

2. Abusive or assaultive behavior? Observed? ___ yes ___ no
   Reported? ___ yes ___ no By Whom?________________________
   If yes, please describe: _______________________________________________________________
   ___________________________________________________________________________________

3. Poor judgment or uncooperativeness that poses a threat to self or others? Observed? ___ yes ___ no
   Reported? ___ yes ___ no By Whom?________________________
   If yes, please describe: _______________________________________________________________
   ___________________________________________________________________________________

4. Extreme or bizarre personal hygiene habits? Observed? ___ yes ___ no
   Reported? ___ yes ___ no By Whom?________________________
   If yes, please describe: _______________________________________________________________
   ___________________________________________________________________________________

5. Other behavioral problems that pose a potential threat to the client’s health or safety?
   Observed? ___ yes ___ no
   Reported? ___ yes ___ no By Whom?________________________
   If yes, please describe: _______________________________________________________________
   ___________________________________________________________________________________

(B) Caregiver Rating: Does this client appear to require supervision (e.g. verbal prompting, gestures, etc.) by another person in order to protect his or her safety?

___ yes ___ no    Describe:
_____________________________________________________________________________________
If yes, how often is this supervision needed?
___ every day
___ less frequently than every day
Describe:

______________________________________________________________

(C) Assessor Rating: Does this client appear to require supervision (e.g. verbal prompting, gestures, etc.) by another person in order to protect his or her safety?
___ yes  ___ no        Describe:

______________________________________________________________

If yes, how often is this supervision needed?
___ every day
___ less frequently than every day
Describe:

______________________________________________________________
F. Exclusion of Depression

Section should be completed if the client displays cognitive impairment.

Questions for Caregiver:

Which description best describes the client’s cognitive dysfunction....

( ) you are able to date the onset with some precision
( ) you cannot precisely date the onset
( ) rapid progression of symptoms
( ) slow progression of symptoms
( ) history of psychiatric dysfunction
  give details:
  __________________________
  __________________________
  __________________________
( ) no history of previous psychiatric dysfunction

Interviewer Observation:

Which description best describes the client’s cognitive dysfunction....

( ) complains in detail about cognitive loss
( ) client complains little or only vaguely of cognitive loss
( ) highlights failures and communicates a strong sense of distress
( ) appears unconcerned
( ) has attention and concentration that are well preserved
( ) has attention and concentration that is usually faulty
( ) “don’t know” answers are typical
( ) near-miss answers frequent
( ) has memory loss for recent and remote events that is equally severe
( ) has memory loss for recent events usually more severe than for remote events

Answers in left-hand column indicate possible depression.

G. GERIATRIC DEPRESSION SCALE

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? __ yes __ no
2. Have you dropped many of your activities and interests? __ yes __ no
3. Do you feel that your life is empty? __ yes __ no
4. Do you often get bored? __ yes __ no
5. Are you in good spirits most of the time? __ yes __ no
6. Are you afraid that something bad is going to happen to you? __ yes __ no
7. Do you feel happy most of the time? __ yes __ no
8. Do you often feel helpless? __ yes __ no
9. Do you prefer to stay at home, rather than going out and doing things? __ yes __ no
10. Do you feel you have more problems with memory than most? __ yes __ no
11. Do you think it is wonderful to be alive now? __ yes __ no
12. Do you feel pretty worthless the way you are now? __ yes __ no
13. Do you feel full of energy? __ yes __ no
14. Do you feel that your situation is hopeless? __ yes __ no
15. Do you think that most people are better off than you are? __ yes __ no

Total number of bolded answers: _____

Answers in bold receive one point. A score of
0-4 = “normal”
5-9 = “mild depression”
10-15 = “severe depression”
1. Please describe all medical conditions and illnesses you have currently:

<table>
<thead>
<tr>
<th>#</th>
<th>Medical Condition/Illness</th>
<th>Date of Onset</th>
<th>Comments</th>
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2. Please describe the type and frequency of all medical treatments or nursing care you require for this condition(s) on a daily basis, and who provides them:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency</th>
<th>Provided By:</th>
<th>Is this care prescribed by a physician?</th>
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<td>Health Professional (indicate who)</td>
<td>Caregiver/ Self (indicate who)</td>
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</tbody>
</table>

- Parental Meds/Injections
- Inhalation Treatment
- Oxygen Therapy
- Suctioning
- Aseptic Dressing
- Lesion Irrigation
- Catheter/Tube Irrigation
- Ostomy Care
- Parenteral Fluids
- Tube Feeding
- Bowel/Bladder Rehab
- Bedsore Treatment
- Indwelling Catheter
- Minor Skin Care
- Chemotherapy
- Tracheotomy
- Intake/Output
- Observation of Vital Signs
- Other, describe

Ask caregiver: Could the family or client easily provide the services above without the help of the health professional? ___ yes ___ no

Medical Condition Checklist:
Client has medical condition which:

- (1) requires twenty-four (24) hour a day nursing observation or professional nursing intervention more than once a day?
- (2) is prescribed by a physician
- (3) is not primarily for the convenience of the family
3. Medications

Please describe ALL medications you are currently taking, including over-the-counter drugs: (list name of drug, reasons for taking, frequency/dosage, and how long client has been taking)

1. ______________________________________________________________________________
2. ______________________________________________________________________________
3. ______________________________________________________________________________
4. ______________________________________________________________________________
5. ______________________________________________________________________________
6. ______________________________________________________________________________
7. ______________________________________________________________________________
8. ______________________________________________________________________________

Do you need help managing these medications?  ___ yes  ___ no
Describe: __________________________________________________________________________
__________________________________________________________________________________

Ask caregiver: Does the client currently need help managing medications?
 ___Yes  ___ No
If yes, please describe: __________________________________________________________________
__________________________________________________________________________________
I. STANDARDIZED ELIGIBILITY ASSESSMENT TOOL SUMMARY SHEET

I. FUNCTIONAL IMPAIRMENT ASSESSMENT:
Number of ADL impairments requiring hands on assistance
or constant supervision

II. COGNITIVE IMPAIRMENT ASSESSMENT:
SPMSQ or S-MSQ Score (Adjusted for education)

MMSE or S-MMSE Adjusted Score (Adjusted for education)

BEHAVE-AD: Behavioral problems requiring constant supervision: yes no

Optional screening for cognitive impairment due to depression:
Depression Rule Out Questions: number of on left-hand side of instrument

GDS Score:

Recommendation for further psychiatric screening yes no

III. COMPLEX YET STABLE MEDICAL CONDITION IMPAIRMENT:
Number of Medical Conditions
Number of Medical Conditions requiring constant nursing supervision or daily nursing intervention
Care prescribed by a physician yes no
Need for Medication Management yes no

IV. RECOMMENDATION FOR CPLTC ELIGIBILITY:

NO

YES based on (check all that apply):

functional impairment

cognitive impairment

SPMSQ Score

MMSE Score alone

MMSE score and behavioral problems

medical condition

RECOMMEND FURTHER SCREENING

explanation: ________________________________

_________________________________________________________________________

_________________________________________________________________________

___________________________________ _______________________________________