Appendix A

Case Study Summaries of Apparent Unmet Needs
**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.
Appendix B

Standardized Eligibility Assessment Tool
Appendix B Table of Contents

A. Activities of Daily Living (ADL)
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
A. ACTIVITIES OF DAILY LIVING

Eating

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

I. FUNCTIONAL LEVEL

A. Independent, without mechanical aids:
   ___ Able to get food into the body from a receptacle (i.e., 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).
   ___ Able to clean face and hands as necessary following meal.

B. Independent, with mechanical aids:
   ___ Able to get food into the body by a feeding tube or intravenously.

   Type of equipment: ____________________________
   Reason for equipment: _________________________

C. Partial assist:
   ___ Able to get food into the body but requires some assistance from another person.

   1. What type of assistance is provided?
      ___ Cueing (prompting or direction)
      ___ Standby (not hands-on)
      ___ Physical (hands-on)

   2. For what aspects of eating is assistance required?

   3. When the 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%)

   4. Who assists? ________________________________

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

D. Total assist:
   ___ Not able to get food into the body without substantial human physical assistance or constant supervision.

   1. Who assists? ________________________________
2. Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, paralysis, cognitive impairment, etc.)

II. ONSET
Approximately when did the current level of disability begin? Month ___________ Year ______

III. OBSERVATION
If you observed insured attempting to eat, describe in detail:

Bathing
Currently, is the insured able to bathe himself/herself? This includes cleaning his or her body, either with a sponge bath or by using a tub or shower.

I. FUNCTIONAL LEVEL
A. Independent:
   ___ Able to clean the body using a tub or shower without human assistance, including getting into or out of tub or shower.
   ___ Able to clean the body without human assistance, using a sponge bath.
   ___ Able to reach head and body parts for soaping, rinsing, and drying.

    Insured’s usual form of bathing:
    ___ Tub
    ___ Shower
    ___ Sponge Bath

B. Partial assist:
   ___ Able to clean the body, but requires some assistance from another person.

   1. What type of assistance is provided?
      ___ Cueing (prompting or direction)
      ___ Standby (not hands-on)
      ___ Physical (hands-on)

   2. For what aspects of bathing is assistance required?

   2. When the 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%)

   4. Who assists? ________________________________
5. Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, paralysis, cognitive impairment, etc.)

D. **Total assist:**
   ___ Not able to clean the body without substantial human physical assistance or constant supervision.
   
   1. Who assists? ________________________________
   
   2. Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, paralysis, cognitive impairment, etc.)

II. **ONSET**
   Approximately when did the current level of disability begin? Month _________ Year ______

III. **OBSERVATION**
   If you observed insured attempting to bathe, describe in detail:

**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 special devices such as braces, fasteners, or artificial limbs.

I. **FUNCTIONAL LEVEL**

A. **Independent:**
   ___ Able to put on and take off all items of clothing without human assistance, including any necessary special devices such as braces, fasteners, or artificial limbs.
   ___ Able to put on and take off elastic stockings or garments.
   ___ Able to fasten all items of clothing without human assistance, including garments and undergarments and special devices such as such as braces, corsets, elastic stockings or garments, and artificial limbs or splints.

B. **Partial assist:**
   ___ Able to put on and take off all items of clothing and special devices, but requires some assistance from another person.
   ___ Able to fasten all items of clothing and special devices, but requires some assistance from another person.

   1. What type of assistance is provided?
      ___ Cueing (prompting or direction)
      ___ Standby (not hands-on)
      ___ Physical (hands-on)

   2. For what aspects of dressing is assistance required?
3. When the 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%)

4. Who assists? ________________________________

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

D. Total assist:
   ___ Not able to dress without substantial human physical assistance or constant supervision.

   1. Who assists? ________________________________

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

II. ONSET
   Approximately when did the current level of disability begin? Month ______ Year ______

III. OBSERVATION
   If you observed insured attempting to dress, describe in detail:

   Transferring

   Currently, is the insured able to get into or out of a bed or chair, and/or move from one sitting or lying position to another?

   I. FUNCTIONAL LEVEL

   A. Independent:
      ___ Able to get into or out of a bed or chair without human assistance.
      ___ Able to move from one sitting or lying position to another (for example, repositioning to promote circulation and prevent skin breakdown).

   B. Partial assist:
      ___ Able to get into or out of a bed or chair, but requires some assistance from another person.
      ___ Able to move from one sitting or lying position to another, but requires some assistance from another person.

      1. What type of assistance is provided?
         ___ Cueing (prompting or direction)
         ___ Standby (not hands-on)
__ Physical (hands-on) __

2. For what aspects of transferring is assistance required?

3. When the insured moves into or out of a bed or chair, 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%)

4. Who assists? ________________________________

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

C. Total assist:
   ___ Not able to get into or out of a bed or chair without substantial human physical assistance or constant supervision.

   1. Who assists? ________________________________

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

II. ONSET
   Approximately when did the current level of disability begin? Month ___________ Year ______

III. OBSERVATION
   If you observed insured attempting to get into or out of a bed or chair, describe in detail:

   Using the Toilet

   Currently, is the insured able to use the toilet and perform associated personal hygiene? This includes getting to and from the toilet, getting on and off the toilet or commode, managing clothing, wiping and cleaning the body after toileting, and using and emptying a bedpan or urinal.

   I. FUNCTIONAL LEVEL

   A. Independent:
      ___ Able to get to and from the toilet without human assistance.
      ___ Able to get on and off the toilet or commode without human assistance.
      ___ Able to manage clothing without human assistance.
      ___ Able to wipe and clean the body without human assistance.
      ___ Able to use and empty a bedpan or urinal without human assistance.
B. **Partial assist:**
   ___ Able to use the toilet or commode, but requires some assistance from another person.
   ___ Able to manage clothing, but requires some assistance from another person.
   ___ Able to wipe and clean the body, but requires some assistance from another person.
   ___ Able to use and empty a bedpan or urinal, but requires some assistance from another person.

1. What type of assistance is provided?
   ___ Cueing (prompting or direction)
   ___ Standby (not hands-on)
   ___ Physical (hands-on)

2. For what aspects of toileting is assistance required?

3. When the insured uses the toilet or commode, 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%)

4. Who assists? ________________________________

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

C. **Total assist:**
   ___ Not able to use the toilet or commode without substantial human physical assistance or constant supervision.

1. Who assists? ________________________________

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

II. **ONSET**
   Approximately when did the current level of disability begin?   Month ___________   Year _____

III. **OBSERVATION**
   If you observed insured attempting to use the toilet or commode, describe in detail:
Continence

Currently, is the insured able to control bowel and bladder functioning? If not able to control bowel or bladder functioning, is the insured able to perform associated personal hygiene?

I. FUNCTIONAL LEVEL

A. Independent:
   ___ Able to control bladder functioning without human assistance.
   ___ Able to control bowel functioning without human assistance.
   ___ Not able to control bowel or bladder functioning, but able to perform associated personal hygiene (e.g., use ostomy or catheter receptacles, and apply diapers and disposable barrier pads) without human assistance.

B. Partial assist:
   ___ Able to control bladder functioning, but requires some assistance from another person.
   ___ Able to control bowel functioning, but requires some assistance from another person.
   ___ Able to perform associated personal hygiene, but requires some assistance from another person.

   1. What type of assistance is provided?
      ___ Cueing (prompting or direction)
      ___ Standby (not hands-on)
      ___ Physical (hands-on)

   2. For what aspects of bowel or bladder function is assistance required?

   3. When the insured empties his/her bowel or bladder, 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%)

   4. Who assists?  ________________________________

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

C. Total assist:
   ___ Not able to control bowel or bladder functioning without substantial human physical assistance or constant supervision.

   1. Who assists?  ________________________________

   2. Why does the insured require human assistance? (Note the underlying functional problem, including descriptive observations: e.g., unsteadiness, weakness, paralysis, cognitive impairment, etc.)
II. ONSET
Approximately when did the current level of disability begin? Month ___________ Year ______

III. OBSERVATION
If you observed insured attempting to manage bowel or bladder functioning, describe in detail:

Ambulation

Currently, is the insured able to walk or move around without support or help from another person?

I. FUNCTIONAL LEVEL

A. Independent, without mechanical aids:
   ___ Able to walk or move around outside the home without human or mechanical assistance.
   ___ Able to walk or move around inside the home without human or mechanical assistance.

B. Independent, with mechanical aids:
   ___ Able to walk or move around outside the home without human assistance, but requires mechanical aids (e.g., cane, crutches or braces).
   ___ Able to walk or move around inside the home without human assistance, but requires mechanical aids (e.g., cane, crutches or braces).

   Type of equipment: ________________________________
   Reason for equipment: ________________________________

C. Partial assist:
   ___ Able to walk or move around, but requires some assistance from another person.

   1. What type of assistance is provided?
      ___ Cueing (prompting or direction)
      ___ Standby (not hands-on)
      ___ Physical (hands-on)

   2. For what aspects of ambulation is assistance required?

   3. When the insured walks outside, 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%)

   4. When the 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%)

   5. Who assists? ________________________________
6. 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.)

D. **Total assist:**

___ Not able to walk or move around without substantial human physical assistance or constant supervision.

1. Who assists? ________________________________

2. 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.)

II. **ONSET**

Approximately when did the current level of disability begin? Month _________ Year ______

III. **OBSERVATION**

If you observed insured attempting to walk or move around inside or outside the home, describe in detail:
# B. SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE

Score 1 point for each correct answer; 0 points for incorrect or don’t know.

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<thead>
<tr>
<th></th>
<th>correct</th>
<th>incorrect</th>
<th>don’t know</th>
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<tbody>
<tr>
<td>1) What is the date today? (month/date/year)</td>
<td>___</td>
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<tr>
<td>2) What day of the week is it?</td>
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<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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<tr>
<td>5) How old are you?</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<td>6) When were you born? (month/date/year)</td>
<td>___</td>
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<tr>
<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>
<td>___</td>
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<td>___</td>
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<tr>
<td>9) What was your mother’s maiden name? (any name counted as correct)</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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**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

1. What is the....
   year?  ___ (1)  ___  ___  ___
   season?  ___ (1)  ___  ___  ___
   date?  ___ (1)  ___  ___  ___
   day?  ___ (1)  ___  ___  ___
   month?  ___ (1)  ___  ___  ___

2. Where are we....
   state?  ___ (1)  ___  ___  ___
   country?  ___ (1)  ___  ___  ___
   town/city?  ___ (1)  ___  ___  ___
   address (or place)?  ___ (1)  ___  ___  ___
   room (or floor)?  ___ (1)  ___  ___  ___

3. Name three objects, taking one second to say each. Then ask the R to
   repeat all three after you have said them once. Give one point for each
   correct answer. (Before preceding, repeat the answers until R learns all
   three)
   “Apple”  ___ (3)  ___  ___
   “Table”  ___  ___  ___
   “Penny”  ___  ___  ___

4. Begin with 100 and count backwards by 7. (Stop after 5 answers).
   (93, 86, 79, 72, 65)
   Alternate: Spell WORLD backwards.
   Give one point for each correct number or letter.
   ___ (5)  ___  ___

5. Ask for the name of the three objects learned in question 3. Give one
   point for each correct answer.
   ___ (3)  ___  ___

6. Show a pencil and a watch. Have the client name them as you point.
   pencil  ___ (1)  ___  ___
   watch  ___ (1)  ___  ___

7. Have the client repeat: “No ifs, ands, or buts.”
   ___ (1)  ___  ___

8. 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.”
   ___ (1)  ___  ___

9. Have the client read and obey the following words, “CLOSE YOUR
   EYES” (write in large letters).*
   ___ (1)  ___  ___

10. 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.)
    ___ (1)  ___  ___

11. 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.)

   |___|
   |   |
   |___|
   |___|
   |   |
   |___|
   |___|
   |___|

   Total  ___(30)  ___  ___
D. SPANISH LANGUAGE MINI-MENTAL STATE EXAMINATION
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

( ) client complains in detail about cognitive loss
( ) client complains little or only vaguely of cognitive loss

Interviewer Observation:

Which description best describes the client’s cognitive dysfunction....

( ) complains in detail about cognitive loss
( ) 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”
H. MEDICAL CONDITIONS

1. Please describe all medical conditions and illnesses you have currently:

<table>
<thead>
<tr>
<th># Medical Condition/Illness</th>
<th>Date of Onset</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
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>Health Professional (indicate who)</th>
<th>Caregiver/ Self (indicate who)</th>
<th>Is this care prescribed by a physician?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Meds/Injections</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Inhalation Treatment</td>
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<tr>
<td>Oxygen Therapy</td>
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<tr>
<td>Suctioning</td>
<td></td>
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<tr>
<td>Aseptic Dressing</td>
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<tr>
<td>Lesion Irrigation</td>
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<tr>
<td>Catheter/Tube Irrigation</td>
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<tr>
<td>Ostomy Care</td>
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<tr>
<td>Parenteral Fluids</td>
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<tr>
<td>Tube Feeding</td>
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<tr>
<td>Bowel/Bladder Rehab</td>
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<tr>
<td>Bedsore Treatment</td>
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<tr>
<td>Indwelling Catheter</td>
<td></td>
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<tr>
<td>Minor Skin Care</td>
<td></td>
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<tr>
<td>Chemotherapy</td>
<td></td>
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<tr>
<td>Tracheotomy</td>
<td></td>
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<tr>
<td>Intake/Output</td>
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<tr>
<td>Observation of Vital Signs</td>
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<tr>
<td>Other, describe</td>
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</tbody>
</table>

*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 _____ (/ 6)

II. COGNITIVE IMPAIRMENT ASSESSMENT:
   SPMSQ or S-MSQ Score (Adjusted for education) _____ (/ 10)
   MMSE or S-MMSE Adjusted Score (Adjusted for education) _____ (/ 23)
   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 _____ (/9)
   GDS Score: _____ (/15)
   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: ________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Appendix C

Standardized Care Planning Tools
Appendix C Table of Contents

Summary of Assessment Recommendations

Sample Problem List

Sample Care Plan

Sample Monitoring Protocol
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.
SAMPLE PROBLEM LIST

CLIENT NAME
CARE MANAGER
DATE OF ASSESSMENT

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.

<table>
<thead>
<tr>
<th>Describe each deficit identified:</th>
<th>Is deficit addressed in the care plan?</th>
<th>If NO, explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADLs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ ambulation</td>
<td></td>
<td></td>
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<tr>
<td>___ eating</td>
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<tr>
<td>___ dressing</td>
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<tr>
<td>___ bathing</td>
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<tr>
<td>___ transfer</td>
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<td></td>
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<tr>
<td>___ continence</td>
<td></td>
<td></td>
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<tr>
<td>___ using toilet</td>
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<td></td>
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<tr>
<td><strong>IADLs</strong></td>
<td></td>
<td></td>
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<tr>
<td>___ meal preparation</td>
<td></td>
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<tr>
<td>___ housework</td>
<td></td>
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<tr>
<td>___ laundry</td>
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<tr>
<td>___ shopping</td>
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<tr>
<td>___ transportation</td>
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<tr>
<td>___ financial mgt.</td>
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<tr>
<td>___ telephone use</td>
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<tr>
<td>___ mobility</td>
<td></td>
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<tr>
<td>___ history of falls</td>
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<tr>
<td><strong>Cognitive Status</strong></td>
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<td></td>
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<tr>
<td><strong>Emotional Status</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Informal Supports</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Medications</strong></td>
<td>Describe each deficit identified:</td>
<td><strong>Is deficit addressed in the care plan? (YES/NO)</strong></td>
</tr>
<tr>
<td>-----------------</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td><strong>Maintenance</strong> (nutrition, tobacco &amp; alcohol use, exercise, inoculations, emergency response system)</td>
<td>If NO, explain:</td>
</tr>
<tr>
<td><strong>Environmental/Safety Issues</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Psychosocial</strong></td>
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<tr>
<td><strong>Potential for Rehabilitation</strong></td>
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<td></td>
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<tr>
<td><strong>Level of Care Management Needed</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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?</th>
<th>Describe Changes in Status</th>
<th>Care Plan Changes Required? If yes, record changes on Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) ambulation</td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>(2) eating</td>
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<td>NO</td>
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<td>(3) dressing</td>
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<td>(4) bathing</td>
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<td>(5) transfer</td>
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<td>(6) continence</td>
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<tr>
<td>(7) using toilet</td>
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</tbody>
</table>

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>IADLs</th>
<th>Independ.</th>
<th>Needs Human Assist.</th>
<th>Needs Supervision or Prompt</th>
<th>Change in Status?</th>
<th>Describe Changes in Status</th>
<th>Care Plan Changes Required? If yes, record changes on Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) meal preparation</td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
<td></td>
<td>YES</td>
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<tr>
<td>(2) housework</td>
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<td></td>
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<td>NO</td>
<td></td>
<td>NO</td>
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<tr>
<td>(3) laundry</td>
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<td>YES</td>
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<td>YES</td>
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<tr>
<td>(4) shopping</td>
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<td></td>
<td>NO</td>
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<td>NO</td>
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<tr>
<td>(5) transportation</td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
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<td>YES</td>
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<tr>
<td>(6) financial management</td>
<td></td>
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<td>NO</td>
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<td>NO</td>
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<tr>
<td>(7) telephone use</td>
<td></td>
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<td></td>
<td>YES</td>
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<td>YES</td>
</tr>
<tr>
<td>(8) mobility</td>
<td></td>
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<td></td>
<td>NO</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>(9) falls</td>
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<td></td>
<td>YES</td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

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? Note: Check Yes or No for each item:</th>
<th>Describe Changes in Status</th>
<th>Change in Care Plan Required? Note: Check Yes or No for each item; If yes, record change on Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Cognitive Status**

**Emotional/Affective Status**

**Informal Supports**

**Medications**

**Health Maintenance**
(nutrition, tobacco & alcohol use, exercise, inoculation, emergency response system)

**Environmental/Safety Issues**

**Psychosocial**

**Potential for Rehabilitation**

**Level of Care Management Needed**
II. Review of the Current Care Plan

A. Goals Accomplished

(1) What care plan goals have been accomplished to date?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

B. Changes in Services

(1) List any changes in services (i.e., services added or deleted, or changes in providers) since the last monitoring contact and reason for change in services:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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:___________________________________________________________________
<table>
<thead>
<tr>
<th>#</th>
<th>PROBLEM STATEMENT</th>
<th>RECOMMENDED INTERVENTION</th>
<th>GOAL STATEMENT</th>
<th>GOAL ATTAINMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Client desires and needs service coordination due to (specify reason):</td>
<td>Specify help needed and type of service, and use an * to indicate which are authorized by LTCI (Example: Needs meals prepared; * home care worker)</td>
<td>Specify the desired outcome for client or family through this intervention (Example: Client will maintain adequate nutrition)</td>
<td>Specify timetable and how goal will be measured (Example: Hire home care aide by January 3, 2001)</td>
</tr>
</tbody>
</table>
**SAMPLE CARE PLAN** (page 2 of 2)

<table>
<thead>
<tr>
<th>#</th>
<th>SERVICE PROVIDER(S)</th>
<th>SERVICE FREQUENCY</th>
<th>COST</th>
<th>PAYOR SOURCE</th>
<th>PERSON RESPONSIBLE FOR IMPLEMENTING</th>
<th>CARE PLAN CHANGES</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>
<td>Specify person’s name and phone number</td>
<td>Document and date all changes</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 ___________
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 1. Benefit Eligibility Assessment 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). |
<p>| 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). |
| 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. Direct observation of behavioral disturbances can provide important information for eligibility decisions, and should be included whenever possible. | ▪ 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. |</p>
<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></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>
<tr>
<td></td>
<td>o Culture and ethnicity</td>
</tr>
<tr>
<td></td>
<td>o Informal/family support</td>
</tr>
<tr>
<td></td>
<td>o Medications</td>
</tr>
<tr>
<td></td>
<td>o Emotional/psychological status</td>
</tr>
<tr>
<td></td>
<td>o Nutrition</td>
</tr>
<tr>
<td></td>
<td>o Environmental/safety issues</td>
</tr>
<tr>
<td></td>
<td>o Emergency response system</td>
</tr>
<tr>
<td></td>
<td>o Tobacco and alcohol use</td>
</tr>
<tr>
<td></td>
<td>o Social activity</td>
</tr>
<tr>
<td></td>
<td>o Potential for rehabilitation</td>
</tr>
<tr>
<td></td>
<td>o Self-care ability and level of care management needed or desired</td>
</tr>
<tr>
<td><strong>3. Time Interval Between Assessment and Care Plan</strong></td>
<td>▪ Statement in CMPA’s policy and procedure manual that specifies the allowable turnaround time for developing care plans, including how this can be determined.</td>
</tr>
<tr>
<td></td>
<td>▪ Documentation that can be used to determine the time interval between completion of the assessment and development of the care plan.</td>
</tr>
<tr>
<td><strong>4. Problem List</strong></td>
<td>▪ A comprehensive list of all problems identified from assessment information.</td>
</tr>
<tr>
<td></td>
<td>▪ Documentation indicating the reasons that specific problems are not addressed in the care plan.</td>
</tr>
<tr>
<td><strong>5. Care Plan</strong></td>
<td>▪ The care plan should contain comprehensive information that describes the problems or unmet needs, desired outcomes, and recommended interventions:</td>
</tr>
<tr>
<td></td>
<td><strong>A. Problem Statements in the Care Plan</strong></td>
</tr>
<tr>
<td></td>
<td>The care plan should contain problem statements that specify the client’s needs or problems in functional terms.</td>
</tr>
</tbody>
</table>
### Practice Standards

<table>
<thead>
<tr>
<th>5. Care Plan (continued)</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. Goal Statements</strong></td>
<td>Care plan contains a goal statement(s) for each identified problem.</td>
</tr>
<tr>
<td>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.</td>
<td>Each goal statement contains a mechanism for determining whether a goal is met, including a time frame for attainment when applicable.</td>
</tr>
<tr>
<td><strong>C. Service Descriptors</strong></td>
<td>Care plan contains recommended intervention(s) for each problem and its corresponding goal statement.</td>
</tr>
<tr>
<td>The care plan should contain detailed descriptions of each recommended intervention.</td>
<td>Each recommended intervention will consist of at least the following descriptors:</td>
</tr>
<tr>
<td></td>
<td>o Type of service</td>
</tr>
<tr>
<td></td>
<td>o A list of potential service providers for each type of service</td>
</tr>
<tr>
<td></td>
<td>o The roles of the informal supports, the policyholder, and care manager in providing, coordinating and monitoring the service</td>
</tr>
<tr>
<td></td>
<td>o The cost of the service</td>
</tr>
<tr>
<td></td>
<td>o The source of payment of the service</td>
</tr>
<tr>
<td></td>
<td>o The frequency of the service</td>
</tr>
<tr>
<td><strong>6. Client Gets a Copy of Care Plan</strong></td>
<td>Documentation that the policyholder or officially designated representative received a copy of the care plan.</td>
</tr>
<tr>
<td>The client should receive a copy of the completed care plan.</td>
<td>CMPA policy and procedure manuals delineate allowable timetable for giving copy to policyholder.</td>
</tr>
<tr>
<td><strong>7. Objectivity and Impartiality</strong></td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3. Care Plan Implementation Practice Standards and Quality Indicators

<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Quality Indicator</th>
</tr>
</thead>
</table>
| **1. Consumer Participation and Information** | • Documentation indicating that the client and family were involved in determining how much service coordination is needed.  
• Documentation that a written description of the role of the care manager regarding service coordination was given to the client.  
• Separate item included in the care plan that specifies the frequency, cost, type of service coordination, and who is responsible. |
| The client and family should be actively involved in determining how much service coordination is needed, and should be fully informed about the role of the care manager in providing this service. |
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>▪ 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>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></td>
</tr>
<tr>
<td><strong>2. Consumer Participation and Information</strong></td>
<td>▪ Documentation indicating that the client and family were involved in determining how much monitoring is needed.</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 that a written description of the role of the care manager regarding monitoring 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 monitoring, and who is responsible.</td>
</tr>
<tr>
<td><strong>3. Reassessments</strong></td>
<td>▪ Care plan includes the projected date of reassessment.</td>
</tr>
<tr>
<td>Clients should be assessed periodically at established intervals or in response to changes in clients’ situation.</td>
<td>▪ CMPA policy and procedure manuals delineate guidelines for reassessments occurring at times other than the required 6-month intervals.</td>
</tr>
<tr>
<td></td>
<td>▪ Dated reassessment forms.</td>
</tr>
<tr>
<td></td>
<td>▪ Dated problems lists that correspond to dated reassessments.</td>
</tr>
<tr>
<td><strong>4. Changes to the Care Plan</strong></td>
<td>▪ Dated entries describing all changes to the care plan in detail with rationale for each change.</td>
</tr>
<tr>
<td>The care plan should be revised to reflect changes in the client’s status and needs.</td>
<td>▪ Documentation of care plan changes should be explicitly labeled as such.</td>
</tr>
<tr>
<td><strong>5. Discharge Plan</strong></td>
<td>▪ Documentation describing the reason(s) for discharge.</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>▪ Dated list of continuing care needs and recommended interventions, or documentation of lack of continuing needs, if applicable.</td>
</tr>
<tr>
<td></td>
<td>▪ Documentation that client received a copy of the discharge plan.</td>
</tr>
</tbody>
</table>