

## 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 policyholders, 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

Problem List Created	Frequency
Yes Part of BEA (12) Part of needs assessment (6)	18
No	15

Note: n=33

Table 6. All Problems on Lists Addressed in Care Plan

Problems from List Are Addressed in Care Plan	Frequency
Yes	10
No	7
Care plan missing	1

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

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

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

	Yes	No	Missing
Does the care plan accurately reflect your needs?	14	5	0
Were there services you expected or wanted that were not included in the care plan?	11	7	2

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

Care Plan Includes Problem Statements	Frequency
Yes	20
No	12

Note: n=32

Table 10. Content of Problem Statements

Problem Statements Are in Functional Terms	Frequency
All	7
Most	4
Some	2
None	7
No problem statements	12

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

Goal Statements Included in Care Plan	Frequency
Yes	29
No	3

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 be 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

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

### *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

Turnaround Time Met	Frequency
Yes	19
No	7
Unable to determine	7

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

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

Note: n=32

Table 15. Potential Conflicts of Interest

	No	Yes	Unable to Determine
Services in care plan provided by same agency that employed assessor/care manager	26	3	3

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 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 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

Evidence in Case File that Care Plan Was Approved by CMPA	Frequency
Yes	0
No	33

### ***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

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

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

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

### ***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

Data Source	Yes	No
Case records (n=33)	0	33
Policyholder interviews (n=19)	12	7

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

Very satisfied	9
Somewhat satisfied	7
Not satisfied	1
No response	2

Note: n=19

Table 21. Recommendations for Improving the Care Planning Process

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

### ***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.