

## QUALITY ASSURANCE

### **Introduction**

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

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

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

### **Assuring Structural Quality**

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

#### ***CMPA reports***

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

### **Assuring Procedural Quality**

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

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

The written minutes of this annual program evaluation meeting shall document the dates of the meeting(s), attendance, agenda and recommendations.

- (2) Quarterly service record review. At least Quarterly, the agency's board of directors, or a committee appointed by the board, shall, observing all confidentiality protocols, review a random sample of active and closed case records. Each record review shall be documented on a record review form and shall include, but not be limited to, verification that:
- (A) agency policies are followed in the provision of services to clients and families;
  - (B) clients and families actively participate in the care planning process, including the decision regarding how much coordination and monitoring is necessary and desirable;
  - (C) client, family and other community resources are integrated into the Care Plan;
  - (D) Care Management services are effective in maintaining an appropriate environment for the client;
  - (E) the provision of services is coordinated with those provided by other agencies to avoid duplication of services, and to integrate acute care with chronic care;
  - (F) action is initiated by the Care Management Provider Agency when unmet client service needs are identified. Pattern of unmet needs should be documented and reported to the Department of Health Services.
  - (G) the agency's sampling methodology shall be defined in its quality assurance program policies and procedures . . . .

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

Quality care management also needs to meet basic standards of good practice. Perhaps the most comprehensive effort to develop guidelines for practice was

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

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

### ***Annual Program Evaluation***

California Partnership for Long Term Care (CPLTC) regulations state that CMPAs are required to submit a written report annually to the California Partnership for Long Term Care that shall "summarize all findings and recommendations resulting from the quality assurance activities" (CPLTC 1999, § 58074). All three CMPAs provided annual reports to the CPLTC that included a summary of their quality assurance activities. CMPAs evaluated programs in a variety of ways. One CMPA utilized a "National Performance Management/Utilization Management Committee" to administer its quality assurance process. This interdisciplinary

committee reviews client audit and satisfaction reports “to expand the scope of the [CMPA] quality assurance program.” The components of the program include screening and credentialing, utilization management, employee competency, organizational customer sensitivity, and customer satisfaction. Another CMPA

utilizes quality specialists to monitor cases from the eligibility process through care plan development, implementation, and ongoing case management.

### ***Quarterly Service Record Review***

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

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

### ***CMPA reports***

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

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

### ***Our findings***

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

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

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

### ***Summary and recommendations***

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

truly be selected “at random,” it should be sufficient for CMPAs to report the methods they utilize to select the cases for review.

### ***Agency Policies and Procedures***

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

### ***CMPA reports***

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

### ***Our findings***

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

Table 47. Comparison of Deficits Identified in Record Reviews

Item Identified	CMPA Findings	Our Findings
Presence of timeframe on care plan	3 of 4 present	1 of 4 present
Presence of recommendations re problem/goal statements	2 of 4	3 of 4
Signed Claimant's Rights form	4 of 4	3 of 4

Note: n=4

### ***Summary and recommendations***

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

### ***Eligibility Determination***

#### ***Insurer/CMPA reports***

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

### ***Our findings***

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

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

### ***Summary and recommendations***

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

The benefit eligibility determination process could be improved through minor enhancements to the assessment information that is collected. In particular, assessments, when possible, should include the direct observation of ADLs, the type of assistance needed to perform them, and any safety issues related to physical limitations or cognitive

impairment. Translated versions of cognitive assessment tools (e.g., SPMSQ, MMSE) should be used with policyholders whose primary language is not English. A reliable and valid measure of behavioral disturbances that pose potential safety threats should be used, such as an aggregated version of the Behavioral Pathology in Alzheimer's Disease (BEHAVE-AD) scale (Reisberg, 1987). We also recommend that only trained professionals perform eligibility assessments to assure the accuracy and reliability of the assessment information.

### ***Care Plan Development***

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

### ***CMPA reports***

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

### ***Our findings***

Our examination of the case records of the four policyholders in our sample who were included in quarterly record audits found evidence of progress notes documenting participation in the care planning process in two of the case records; in one other case, we found a Claimant's Rights form confirming participation in care planning.

Of the 33 case records we reviewed as part of our overall study, only 8 contained any evidence of policyholder participation in developing the plan of care. Only four case records contained any evidence of policyholder participation in decisions about coordination and monitoring, and this was limited to policyholders' signatures on standard statements indicating their agreement with care plans, which included care monitoring.

### ***Summary and recommendations***

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

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

### ***Resource Integration***

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

### ***CMPA reports***

Both CMPAs include an item on their record review forms as to whether clients, family, and other community resources are integrated in the care plans, although neither

indicates specifically how this is to be determined. Nine out of 10 CMPA reviews noted adequate integration of client, family, and other community resources in the care plan.

### ***Our findings***

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

### ***Summary and recommendations***

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

### ***Service Coordination***

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

### ***CMPA reports***

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

### ***Our findings***

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

### ***Summary and recommendations***

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

### ***Comprehensiveness of the Care Plan***

#### ***CMPA reports***

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

### ***Our findings***

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

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

### ***Summary and recommendations***

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

### ***Care Monitoring***

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

#### ***CMPA reports***

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

#### ***Our findings***

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

Unmet needs were identified in 12 of 18 cases in which policyholders were interviewed; in another 4 cases, documentation was not sufficient to determine whether or not

all of the policyholders' needs were met. In a number of cases, progress notes indicated that care managers were aware of these needs; yet, there was no evidence that action was taken to resolve them.

### ***Summary and recommendations***

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

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

recording unmet needs, tracking changes in policyholders' condition, and documenting actions taken, it is difficult to assess the adequacy of CMPAs' ability to identify and respond to clients' unmet service needs.

### ***Unmet Needs***

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

#### ***CMPA reports***

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

#### ***Our findings***

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

#### ***Summary and recommendations***

Documenting patterns of unmet need is essential to improving care management systems and enabling state officials to allocate resources more effectively. However, care

monitoring activities and documentation procedures currently in place do not appear adequate for identifying unmet needs in a consistent manner. More reliable procedures for identifying policyholder needs and service inadequacies are required if CMPAs are expected to identify and document patterns of unmet need.

### ***Cultural Sensitivity***

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

- (2) a policy manual that includes the following:
- (J) documentation of efforts to provide culturally sensitive services.

### ***CMPA reports***

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

### ***Our findings***

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

### ***Summary and recommendations***

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

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

Culturally sensitive services may require that care managers commit greater than average amounts of time and resources in cases in which cultural factors are especially prominent. Resource materials are an important first step, especially if those materials are

sent to care managers at the time they are assigned particular cases. However, culturally sensitive services may require that care managers also have periodic training as well as the availability of consultants to respond to particularly difficult cultural issues. Although training to provide culturally sensitive services exists, outreach or marketing to more diverse cultures would allow all CMPAs to utilize this training in providing culturally sensitive services.

### **Assuring Service Effectiveness**

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

### ***Meeting Client Needs***

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

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

### *CMPA reports*

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

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

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

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

### ***Our findings***

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

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

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

As described in the Care Plan Development chapter of this report, our general analysis of case records and policyholder interviews revealed the presence of unmet needs in 12 of the 18 cases in which policyholders were interviewed; in another 4 cases, documentation was not sufficient to determine whether or not all of the policyholders' needs were met. Among the unmet needs identified were the following: a policyholder who apparently had been victimized by her independent provider and was not receiving

needed assistance with IADLs; a policyholder who was left alone despite the apparent need for continual supervision; family caregivers who were physically or emotionally exhausted; independent providers who did not show up, were tardy, or did not provide adequate care; and policyholders experiencing depression, anxiety, and other mental health problems.

### ***Summary and recommendations***

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

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

order to better assess and respond to their needs; however, the care managers believed that they did not have the time to make these home visits.

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

### *Maintaining an Appropriate Environment*

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

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

### *CMPA reports*

Record review forms for both CMPAs contained items addressing this issue. One CMPA used the exact phrasing of the regulation, while the other CMPA assessed whether

“care management services address changes in need or modify services to maintain an appropriate environment.”

### ***Our findings***

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

### ***Summary and recommendations***

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

Efforts to assure that policyholders reside in an appropriate environment would seem to require a systematic method of determining what living situation(s) would be appropriate for each policyholder, as well as whether care management services would be effective in maintaining them. Assessment instruments should collect information regarding such factors as the following: (1) policyholder’s desired living situation; (2) policyholder’s ability to maintain her/himself in a healthful and safe manner in that living situation; (3) physical and functional characteristics of that living situation; (4) availability, adequacy and stability of adequate supports and resources; and (5) likely physical,

economic, and emotional impact on family members and other involved persons. Care plan documents should explicitly identify desired and appropriate environments as goals, and indicate activities and services required to maintain or achieve those environments. Finally, care monitoring activities should document whether or not those activities are successful in enabling policyholders to live in those environments.

### ***Financial Protection***

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

#### ***Insurer/CMPA reports***

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

#### ***Our findings***

A review of UDS records for the 33 policyholders in our sample revealed that the median amount of benefits claimed and of assets protected was about \$4,000. Interviews with 19 of these policyholders revealed a number of services that policyholders reported receiving, but for which claims were not reported on the UDS. Services potentially covered by insurance for which claims were not reported included home health care,

personal care, transportation, meals on wheels, medical equipment, and support groups. At the same time, there were at least two examples of services for which claims were reported, but which had not been authorized by the policyholder's plan of care.

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

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

### ***Summary and recommendations***

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

Assuring that assets are protected and benefits used properly requires consistent care monitoring by care managers to be sure that policyholders receive the services they need. Also needed is direct contact between care managers and insurance company

claims managers, so that reported service use can be compared with submitted claims.

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

### **Assuring Client Satisfaction**

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

(F) assessing client satisfaction and incorporating client suggestions.

Perhaps the best source of data regarding the quality of case management is clients themselves. However, consumer reports may be distorted due to unrealistic expectations. To the extent that clients expect that their care manager will provide the same level of care as a loving daughter or spouse, they are apt to be disappointed with the service they receive. More often, we find that clients report being quite satisfied with almost *any* care they receive, largely because of their own feeling of being undeserving. Consumer satisfaction reports may also be inflated because of clients' reluctance to complain or their fear of reprisals if they do so, because of their dependence on or sense of obligation to their care providers. For example, more than 93 percent of clients who received care management as part of the National Channeling Demonstration reported being satisfied or partly satisfied with the service arrangements; however, almost 92 percent of those in the control group also reported being satisfied or partly satisfied.

Dr. Robert Applebaum and his colleagues have demonstrated that more valid measures of consumer satisfaction can be obtained by asking about specific service characteristics, such as timeliness, reliability, and the adequacy of specific services, rather than just seeking global satisfaction ratings. Moreover, for most elderly consumers, quality is most closely related to a sense of autonomy and personal control, whatever the specifics of the service under consideration (Woodruff & Applebaum, 1996).

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

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

### ***Assessing Client Satisfaction***

#### ***CMPA reports***

All of the CMPAs reported assessing client satisfaction, and indicated it as a "primary goal" and "key component" of their organization. All of the CMPAs indicated that they evaluated client satisfaction based on care manager observation in the field or

suggestions solicited through regular communication with care managers and other CMPA staff. In addition to personal and telephone contact, the CMPAs also reported conducting satisfaction surveys. All the CMPAs reported high levels of satisfaction among their clients.

### ***Our findings***

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

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

As part of our exit interview at the end of the policyholders' use of benefits or at 6 months after initial eligibility, we asked policyholders how well their care managers met their expectations. Six policyholders reported that the care manager exceeded their

expectations, six reported that the care manager just met their expectations, while three policyholders reported that the care manager failed to meet their expectations.

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

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

### *Summary and recommendations*

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

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

All three CMPAs also stated that telephone contacts with policyholders were used to monitor satisfaction. However, care monitoring contacts were inconsistent and apparently failed to identify numerous instances of policyholder dissatisfaction with services.

In general, CMPAs would achieve more client input if they developed an integrated method of assessing satisfaction on a regular basis, incorporating both open-ended questions and in-depth interviews with standardized measures. This would help to improve the accuracy of findings and more constructively contribute to improvements in the planning and delivery of services by better reflecting the priorities of policyholders.

### ***Incorporating Client Feedback***

#### ***CMPA reports***

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

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

### ***Our findings***

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

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

### ***Summary and recommendations***

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

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

