# Plan of Care, Easy as 1, 2, 3

# Purpose

- To consider different approaches to the development of the Plan of Care
- To discuss Needs Based versus Benefits Based Plan of Care

# Session Objectives

- To present several cases for discussion about the Plan of Care
- To provoke some thought about the approaches an Insurance Carrier can take toward the Plan of Care development

# Needs Based vs Benefits Based POC

- Needs based plan of care is based solely on ADL/IADL deficits
  - Accurate picture of care needs
  - Can lead to unexpected out of pocket expense for insured
- Benefits based plan of care is a combination of ADL/IADL deficits and daily benefit (to reduce out of pocket)
  - Can reflect lower care needs than actually required
  - Must provide rate in order to establish (to ensure it is within daily benefit)
  - Limits out of pocket expense for insured

# Insurance Carrier Responsibilities

- Case Manager's responsibilities
  - Review reported care needs and diagnosis and recommend appropriate plan of care
  - Identify any community resources/DME that may be beneficial
- Adjudicator's responsibilities
  - Determine if approved provider is appropriate to render care and is covered by the policy
  - Review ongoing bills/care notes to verify services billed fall within plan of care

# Example 1

- 51 year old female
- Dx: Schizoaffective disorder, Anxiety, Depression, HTN
- Suffers from overwhelming fear and anxiety which is almost paralyzing, has suicidal ideations
- MMSE score 30/30
- Bathing – verbal cues
- Dressing – verbal cues
- Toileting – independent
- Transfers – independent
- Continence – independent
- Eating – independent
- Mobility – supervision outdoors, independent indoors
- Home filthy, cluttered, unkempt

# Example 2

- 64 year old female
- DX: Stage 4 Pancreatic cancer with bone mets
- Lives at home with spouse, hospice services in place for end of life care
- Bathing – Hands on assist
- Dressing – Hands on assist
- Toileting – Stand by assist
- Transfers – Stand by assist
- Continence – Independent
- Mobility – Stand by assist
- Eating – Independent
- Dependent for all IADLs

# Example 3

- 86 year old female with Tax Qualified policy
- DX: S/p fall with hip fx 8/10/15, partial replacement 8/13/15-it is noted that insured was somewhat deconditioned due to prior TKR 4/2015
- Fell while in rehab resulting in hematoma but discharged home 9/6/15 with the following care needs:
  – Bathing- hands on assistance
  – Dressing- hands on assistance
  – Transfers- standy by assistance
  – Continence- independent
  – Toileting- independent
  – Ambulation- independent
  – Eating- Independent

# Example 3-cont

- Based on acute diagnosis insured was not expected to meet Chronically Ill Criteria, however, she was re-admitted to the hospital 9/20/15 due to infection. Insured was discharged home 10/8/15 with the need for long term antibiotics and below care needs:
  - Bathing- hands on assistance
  - Dressing- hands on assistance
  - Transfers- hands on assistance
  - Continence- independent
  - Toileting- hands on assistance
  - Ambulation- stand by assistance
  - Eating- Independent

# Example 3-cont

- Insured determined to be Chronically Ill due to multiple acute conditions complicated by deconditioning and comorbidities of DM and CAD
- POC of 24/7 effective 10/8/15 recommended
- CM contacted insured on 10/20/15 and verified following care needs:
  - Bathing- hands on assistance
  - Dressing- hands on assistance
  - Transfers- stand by assistance
  - Continence- independent
  - Toileting- independent
  - Ambulation- independent
  - Eating- Independent
- POC of 12/7 recommended

# Example 3-cont

- CM contacted insured on 11/5/15 and verified following care needs:
  - Bathing- hands on assistance
  - Dressing- hands on assistance
  - Transfers- independetnt
  - Continence- independent
  - Toileting- independent
  - Ambulation- independent
  - Eating- Independent
- POC of 8/7 recommended

# Example 3-cont

- CM contacted insured on 12/5/15 and verified the following:
  - discharged from PT after plateauing. Continued to require assistance with multiple ADLs, therapist documents that it is unlikely for insured to return to baseline due to limited progress and comorbidities
  - Bathing- hands on assistance
  - Dressing- hands on assistance
  - Transfers- independent
  - Continence- independent
  - Toileting- independent
  - Ambulation- independent
  - Eating- Independent

# Example 3-cont

- POC of 6/7 recommended, CM will follow up in 3 months to verify ongoing care needs and if no changes at that time, active CM may be discontinued as conditions appear to be chronic

# Example 4

- 91 year old male
- DX: Lewy Body Dementia, GERD, BPH, Anxiety, Insomnia
- Resides in locked memory care unit
- MMSE score 1/30
- Behaviors:
  - reportedly physically aggressive in the morning
  - urinates in public areas (ie: in the trash can, behind couch) instead of the restroom
  - wanders around memory care unit
  - becomes combative when staff or family try to assist with bathing or dressing
  - appears agitated, restless, was cursing during assessment
  - insured stated his wife was “a man” and did not know her name

# Example 4 - cont

- Bathing – verbal cues
- Dressing – verbal cues (would wear the same clothes for several days if not cued to change)
- Toileting – verbal cues
- Transfers – verbal cues
- Continence – verbal cues
- Eating – verbal cues
- Mobility – stand by for safety
- Assist needed for all IADLs

# Example 5

- 90 year old female
- Dx:  OA, DM, HTN, Hyperlipidemia, Anemia,  GERD, Peripheral Neuropathy, CAD
- MMSE score 26/30
- Resides in ALF
- Bathing – hands on assist
- Dressing – hands on assist
- Toileting – independent with equipment
- Transfers –  stand by assist
- Continence – independent
- Eating – independent
- Mobility – stand by outdoors, independent indoors
- Assist needed for all IADLs except phone use