U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Assessment and Care Planning for the Frail Elderly:

A Problem Specific Approach

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ASSESSMENT AND CARE PLANNING FOR THE FRAIL ELDERLY: A Problem Specific Approach

Elizabeth Solan, B.S.N.
Marilyn Grannemann, M.S.N.
Elsie Carter, R.N.
Helen Wells-Hunter, A.C.S.W.
Patricia Decker, R.N.
Suzanne Bulvanoski, B.S.N.
Carol Coleman, R.N.
Maryellen Kluxen, R.N.
Tambria Johnson, M.S.W.

Temple University, Institute on Aging

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PREFACE

Although a good deal has been written about the process of care planning, the context of care planning in case management has not received much attention in the literature. It has frequently been assumed that a care plan flows naturally and unambiguously from a comprehensive assessment. This implies that once a condition or problem is identified, the solution is obvious.

Overlooked in such an assumption are the complexities of problem definition; the influence exerted by goal setting; the importance of knowledge of the wide range of potential solutions; and the uncertainties introduced by client preference.

It is our assertion that converting a comprehensive standardized assessment into a care plan is not a simple straightforward process. These authors have begun for all of us the task of systematically setting down and cataloging care planning content, including its complexities. They have used generic terms so that the material can be of assistance in the evolution of case management practice for the elderly in a variety of program settings.

The authors are experienced case management practitioners, including nurses and social workers, supervisors, and directors. Most were employed by the Middlesex County (NJ) Visiting Nurses Association, providing case management services under subcontract for the Middlesex County, New Jersey site of the National Long Term Care Channeling Demonstration. The VNA is to be commended for supportin the completion of this innovative work. Betsy Solan, Program Director of the Channeling sub-contract at the VNA, was responsible for the conceptualization of this work and provided the leadership to see it through.

Barbara Schneider
Project Director
National Long Term Care Channeling
Demonstration Technical Assistance Contract
Temple University Institute on Aging

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SECTION I

Introduction

In recent years the field of community-based long term care has grown. Knowledge in the area has become more sophisticated, and operational lessons have been learned in demonstration and waiver programs around the country. Case management and home care services have been actively promoted as an intervention in the care of elderly and disabled people and are seen as an alternative to some unnecessary nursing home placements. Both clinicians and policy makers have acknowledged the value of the case management function, clinicians for its wholistic and practical approach to meeting client needs, and policy makers for its potential to save on long term care expenditures by controlling service costs.

Case management can be considered to include the following components:

- **Outreach** to identify and attract the target population.
- **Screening** to determine whether an applicant is part of that target population.
- **Comprehensive needs assessment** to determine individual problems, resources, and service needs.
- **Care planning** to specify the types and amounts of care to be provided to meet the identified needs of individual.
- **Service arrangement** to implement the care plan through both formal and informal providers.
- **Monitoring** to assure that services are provided as planned and modified as necessary.
- **Reassessment** to adjust care plans to changing needs.

These functional areas are developed and implemented in a number of different ways to meet the objectives of various state and local case management programs. In addition, different program models utilize staff of varying backgrounds and levels of expertise. Case managers are most often nurses or social workers. Because of the variations among models, the clinical responsibilities and activities of case manager are not consistent. Major variables that may affect case manager functions are the structure of the setting, the philosophy and goals of the agency, the prescribed case management process, and the outcomes expected for staff and clients.

Case management is not taught as a separate function in most schools of nursing or social work. Therefore, it is particularly important that the role of the worker in a case management program be well-defined, and not based just on “they’ll know what to do because they are social workers (or nurses).”

Some successful “systems” of case management have been developed, but standards for practice are usually stated only generally, especially for the care planning function. Aspects of the case management process like the assessment form, the timing of monitoring visits, and guidelines for reassessment tend to be standardized to meet program requirements. Care planning, the “meat” of the case management process, is most often left to the clinical judgment of the worker. But what does this judgment consist of as it relates to the selection of formal and informal services?

As the picture of the client’s situation emerges during the assessment interview process, the case manager identifies and clarifies client problems, but how exactly does she identify them, and what concrete things does she do to begin to resolve them? Standards of practice can give substance to these intangibles of case management. However, there is no recipe book by which you take two parts home health aide, one part visiting nurse, a dab of legal aid, and a sprinkle of informal supports to solve clients’ problems. There are also no practical computer systems that can take a set of client problems and develop a care plan. It is a complex task to meet the multiple needs of frail elderly clients.

This paper presents some guidance to assist case managers in selecting appropriate services and interventions. There are two frameworks, **assessment guidelines** and **care planning options**. The guidelines deal with client problem definition and the options deal with problem resolution. These are intended to provide:

- guidance in establishing what the client’s problem is;
- insight into the range of problems a client can have;
- examples of the most common problems;
- direction as to goals for which the case manager and client should aim; and
- ideas about sources of available help to reach those goals.

Overview of the Care Planning Process

Care planning is the link between assessment and service delivery, whereby facts about the client gathered in the assessment process are analyzed and translated into problem areas. Identifying problem areas enables the case manager to describe desired outcomes and recommend a package of services that will help the client achieve those outcomes. Care planning leads to the development of a service package for each client. The client and the client’s significant others are involved through the process. Good care planning incorporates a careful consideration of all possible service alternatives before a decision is reached regarding which alternative is best for the client.

Care planning may be defined as:

> the process of developing an agreement between client and worker regarding problems identified, outcomes to be achieved, and services to be pursued in support of goal achievement.

The written product of the process is the care plan, which lists problem areas, outcomes, services the client will need, providers who will deliver the needed services, timing of the services (when services will being and terminate), and the amount of services (how many times per week, how many hours per visit, etc.). The care planning process, however, does not end with the preparation of the care plan. A care plan is carefully tailored to the needs of the client, and as the client's needs change, so should the care plan. Thus, the case manager may have to repeat portions of the process in order to revise the plan to meet client needs over time.

Care planning calls for clinical judgment, creativity, and sensitivity. It requires the case manager to interpret subtle cues from family members and clients regarding their willingness to support clinical and functional goals. It requires translation of assessment information to useful problem statements and, ultimately, into service needs.

Problem areas in the system described here, (which was developed for use with frail elderly clients by the Temple University Institute on Aging,) will mainly relate to difficulties in the Activities of Daily Living (ADL) (eating, dressing, toileting, bathing, grooming, transferring), and Instrumental Activities of Daily Living (IADL) (telephone use, shopping, food preparation, housekeeping, laundry, using transportation, money management). Inability to provide these basic types of care for oneself is a frequent cause of institutionalization. The case manager should think in terms of the problems the client is having in maintaining independence and should attempt to define these problems as <u>functionally</u> as possible. That is, what is it that the client cannot do, which must be done in order for him/her to remain at home? A helpful format for writing problem statements is as follows:

CLIENT CANNOT_____

or

CLIENT HAS DIFFICULTY WITH_____

This format guides the case manager to define the problem in terms of the essential activities that must be accomplished if the client is to remain at home.

It is necessary to provide reasons for these functional difficulties. The reasons help in determining appropriate services to be delivered. For example, a functional problem with meal preparation may have several causes, requiring very different solutions.

EXAMPLE #1

CLIENT CANNOT PREAPRE MEALS, DUE TO PARALYSIS.

EXAMPLE #2

CLIENT CANNOT PREPARE MEALS, DUE TO WHEELCHAIR INACCESSIBILITY OF KITCHEN.

Stating the reason clarifies the problem further, making it possible for the case manager to address the cause as well as the problem in some cases.

Some problems are not readily defined in functional terms. For example, emotional problems and family tensions may require resolution in order for clients to remain at home. These, too, should be included in the problem list developed by the case manager. These types of problems, although not amenable in description in the format outlined above, should nevertheless be developed and described as clearly as possible, including stating the reason if possible. Problems in the environment that the case manager plans to address should be treated the same way. The format described above for writing problem statements is clear and simple to use. However, it should be deviated from whenever some other formulation results in a better statement of the problem.

Once the necessary information is collected, problem statements that include reasons can be formulated. The information obtained should also be sufficient to project realistic, time-specific goals in relation to each problem. The case manager can later turn her attention to determining the type of help best suited to meeting clients needs and identifying providers to render that help.

The remainder of the paper discusses the care planning process in more detail, one problem at a time. Section II describes the clinical information necessary to understand the reasons for problems. Section III follows each problem from the specification of outcome standards to the selection of providers.

II. ASSESSMENT GUIDELINES

The assessment guidelines address the end of the assessment function, where problems in performing activities of daily living are identified. The care planning process actually begins during the assessment, with the identification of functional problems and their causes. The assessment forms used by some programs are developed specifically for use by those programs. Other programs use statewide or standard assessment forms. All of the instruments contain standard data items, but frequently the process of conducting the interview is not standardized. Workers must often use their own conceptual frameworks and interviewing techniques to gather needed information from the client.

Whether an assessment form is four pages long or forty pages long, the information it contains gives the case manager only a beginning baseline of data. Once the standard assessment instrument is complete, it is up to the case manager to identify the areas of client functioning that seem problematic and investigate the details. The first general question may be, “why does the client have the problem?” That is, why can’t the client bathe himself, get meals or get to the doctor.

The reasons for functional problems may be divided into three major classifications. It may be a physical cause, an environmental cause, or a psychosocial cause. After clarification, the questions become:

- Can the cause and therefore all of the problems stemming from it be eliminated?
- Can the cause be modified to alleviate some of the attendant problems? or
- Is the cause unalterable, so that all problems resulting from it require specific intervention?

To make this determination, the case manager may require far more in the way of information than was available from the baseline assessment.

The assessment guidelines address the issue of “What do you ask after all of the standardized questions have been asked?” Just as every client’s situation is different, so are the information needs in each situation different. However, by looking at some of the common causes of client problems, it is possible to identify some basic information needs in relation to those causes.

Note that in this discussion, ‘cause of problem’ and ‘reasons for problems’ do not refer to disease diagnoses. Neither the diagnosis of disease nor the treatment of disease are within the purview of functionally-based long term care case management. The case manager will, of course, want to know whether an apparent condition had been diagnosed and if it is being treated; and the case manager can, if necessary, see

that the client gets to the appropriate professional for diagnosis and treatment. However, listing a diagnosis as a reason for a problem is not usually useful for the case manager's own problem solving role. It doesn't clarify what the case manager can do to solve a problem.

The first chart, on page 7, lists examples of common causes of client problems. They are divided into physical, psychosocial and environmental. In stating reasons for problems it becomes clear that not only are the causes themselves divisable into the categories of physical, psychosocial and environmental, but the information needs surrounding any one cause could also be divided in the same way. For example, in relation to the functional problem of incontinence, the case manager's inquiries about the incontinence can be broken down as follows:

What are the physical questions I need to ask? Like:
How often do you go?
Have you told the doctor? or

What are the psychosocial questions I need to ask? Like:
How does it make you feel?
How does the daughter feel?
Is the client anxious about it? or

What are the environmental questions I need to ask? For example,
Where is the bathroom?
Can you get to it?
Do you have a commode?

Approaching the issue of "What information is needed or what questions should be asked" in an organized pattern of physical, psychosocial and environmental provides the case manager with a convenient and portable conceptual framework by which to proceed.

Subsequent charts focus on problem causes and outline information needs surrounding each one. The information needs are stated in the form of questions. Some questions are directed to the case manager him/herself, i.e., "What makes you think the client is addicted?" Other questions are most appropriately directed to the client or caregiver i.e., "How does the family feel about it?" Still other questions must be directed to an appropriate professional or provider, i.e., "Are medications given correctly?" should be asked of the physician, nurse or pharmacist. "Is the problem treatable?" should be asked of the physician, nurse or therapist. Remember that it is not up to the case manager to diagnosis, prescribe or treat. Her/his function is to gather information, seek recommendations, formulate plans which include the recommendations, and facilitate the execution of those plans in the interest of resolving client problems. If questions are unanswerable due to the lack of involvement of appropriate professions, it is then the case manager's responsibility to arrange for the appropriate specialized assessment so that answers can be obtained.

The Assessment Guidelines for the problem causes follow. They are arranged in the order in which they are listed on below.

COMMON CAUSES OF CLIENT PROBLEMS
Physical
Fatigue/weakness
Hearing impairment
Incontinence
Mobility impairment/paralysis
Pain
Poor nutrition
Speech impairment
Untreated health condition
Vision
Psychosocial
Alcohol abuse
Confusion or unsafe judgment
Difficult family relationships
Drug abuse
Emotional or behavioral problems
Physical abuse/neglect
Problem person in household
Environmental
Architectural barriers
Inadequate income
Inadequate level of care at home
Unsafe home/neighborhood

ASSESSMENT GUIDELINE #1
When **fatigue or weakness** is causing a client problem
Information Needs: Are there physical reasons for it? Medical diagnoses? Medication side effects? Infections? Untreated health condition? Poor nutrition/hydration? Are there psychosocial reason for it? Depression? Withdrawal/isolation? Are there environmental reasons for it? Client doing too much? Stair climbing?

ASSESSMENT GUIDELINE #2
When **hearing impairment** is causing a client problem
Information Needs: How do you know the client has a problem? How long has client had it? Has a physician/specialist examined the client? Is the loss treatable? Is treatment going on? How severe is the loss? If permanent, will an aide help? Has an audiologist evaluated? If the client has a hearing aide, who prescribed it, and when? Is it working? How often are batteries changed? How does the client feel about the hearing loss or wearing an aide? Does the client appear confused? Does he/she know how and when to use it? Is speech/communication a problem? Can client use telephone? Is safety a problem? Can the home be modified to be safer? If deaf, can the client read lips? Are there special groups/services in the area for people with hearing loss?

ASSESSMENT GUIDELINE #3
When **incontinence** is causing a client problem
Information Needs: What makes you think the client is incontinent? What is the pattern of "accidents"? How long has this been happening? Has there been a medical evaluation? What was the result? Was a specialist consulted? How does the client feel about the problem? Is there a confusion problem? How does the family feel about it? Is there a problem with personal care? Are toilet facilities adequate and accessible to the client? Is special equipment needed for toileting?

ASSESSMENT GUIDELINE #4
When **paralysis or impairment of mobility** is causing a client problem
Information Needs: How long has it been a problem? What are the functional areas affected by it? What is the cause of the impairment? How does the client feel about it? How does the caregiver feel about it? How does the paralysis affect the client's relationships? Has mobility been evaluated by a physical therapist? What special training for independence has client received? Can further treatment be helpful? What adaptive equipment or home modifications are in use or would be helpful? How is client safety assured?

ASSESSMENT GUIDELINE #5
When **pain** is causing a client problem
Information Needs: Where is the pain? How long has the client had it? What was the outcome of the medical evaluation? What is the plan for further treatment? How long is the pain expected to last? What medications is the client taking for the pain? Are they effective? Side effects? How does the client feel about the pain? How does the caregiver feel about it? Does the pain affect client's relationships? What adaptations have been made to the environment? How is client safety assured?

ASSESSMENT GUIDELINE #6
When **poor nutrition** is causing a client problem
Information Needs: How do you know the client has a nutrition problem? Is the physician aware of the problem? Has he/she recommended treatment? Is treatment being carried out? Who brings food to the home? How often? Who prepares meals? Daily and weekends? If client cannot prepare meals, why not? If client can prepare meals, does she? Why not? What medical conditions are involved? Are there dental or digestive problems? Constipation? Diarrhea? Does the client know when it is time to eat? How does the client feel about eating? Does client have proper facilities/equipment for cooking/storage of food? How is the clients appetite?

ASSESSMENT GUIDELINE #7
When **speech difficulty** is causing a client problem
Information Needs: Why does the client have difficulty with speech? How long has speech been a problem? When was the speech evaluation, by whom and what was the outcome? What activities of daily living are affected by the speech problem? How does the client feel about the problem? How does the caregiver feel? How are the client's relationships affected? What adaptations have been made to the environment? What are the implications for client safety?

ASSESSMENT GUIDELINE #8
When an **untreated health condition** is causing a client problem
Information Needs: Does the client have a physician? Has he had one in the past? How many physicians does the client see? Who is the primary care physician? Why is the client not receiving care? Is there a physical disability that prevents getting care? Are both the medical office and home accessible? Is transportation available? Does the client or family have medical insurance or money to pay medical bills? Has the client refused medical care? Why?

ASSESSMENT GUIDELINE #9
When **impaired vision** is causing a client problem
Information Needs: How do you know the client has a vision problem? How long has the client had it? How severe is the vision loss? Has the vision problem been evaluated medically? When? What was the result? Is the client wearing glasses, lenses, implants? Do they work? Has the client had special training in activities of daily living? Does the client use adaptive equipment? Special reading material? What activities of daily living are affected by the vision loss? How does the client feel about the vision problem? How does the family view the problem? Are there hazards in the client's environment?

ASSESSMENT GUIDELINE #10
When **alcohol abuse** is causing a client problem
Information Needs: What makes you think the client is addicted? Are any physical or medical conditions being affected by alcohol? Does the client/family believe addiction is a problem? Is the physician aware of the alcohol problem? Does the client want to change lifestyle? What are realistic expectations for the client to change lifestyle? Do the family/friends want the client to change? What are the area resources for treatment of alcohol problems for people with the disabilities that the client has? Is AA a possibility for the client? Is the meeting place accessible? Will someone from AA make a home visit? Is Al-anon available for the family? What is case managers response to client and family? To alcohol addiction in general?

ASSESSMENT GUIDELINE #11
When **confusion** is causing a client problem
Information Needs: How do you know the client is confused? How confused is the client? Is the confusion worse at sometimes than at others? How long has this been a problem? What behavior problems does the client have? Does the client show poor judgement? How often? Has the confusion been evaluated medically? What was the result? Are medications given correctly? Could medications be contributing to the confusion? What is the family's reaction? What orientation activities do the family and providers perform? What level of supervision does the client need? Is the client safe at home? Is the client legally competent? Is there a guardian/conservator/power of attorney?

ASSESSMENT GUIDELINE #12
When **difficult family relationships** are causing a client problem
Information Needs: Does the difficulty appear to be situational or the result of a long-standing pattern in family relationships? Are there medical factors affecting family relationships -- illness? fatigue, weakness? Does someone in the family have a mental health problem? Are they currently under treatment? By whom? What factors in the environment are affecting the problem: lack of space, scarce resources, lack of finances? legal issues/conflicts? Is the impending death or recent death of a family member increasing family tensions? Are family members motivated to improve relationships, if possible?

ASSESSMENT GUIDELINE #13
When **drug abuse** is causing a client problem
Information Needs: How do you know the client is abusing drugs? Which drugs? Is the client "addicted"? How do you know? Is the client confused? Accidently misusing drugs? Are the drugs prescribed by a physician? more than one physician? Are the drugs helping a condition that the client has? Is the client terminally ill? Does the client believe he/she is "addicted"? What is the family's attitude? Does the client or family want help? Whose wishes will prevail? Is the client obtaining drugs illegally? What are the resources for drug treatment in the area for people with disabilities that the client has?

ASSESSMENT GUIDELINE #14
When **emotional or behavioral problems** are causing a client problem
Information Needs: How do you know the client has an emotional or behavioral problem? Is the client aware of the problem? How long has the client had it? Does the problem appear to be situational or long-standing? Connected to substance abuse? Has the problem been evaluated medically? Psychiatrically? If the problem is amenable to treatment, is the client willing, motivated? Is treatment going on? What is the effect of the problem on the client's self care abilities? On the family relationships? On the informal caregiving? Is the safety of the client or others a problem? Are there barriers to treatment which can be removed? accessability of treatment? availability of transportation? financial resources to pay for treatment? If the treatment includes medication, can the client/family manage the medication? Is there a time of the day that is most difficult for the client/family? Why? Does the caregiver need relief on a regular basis? Has a recent death in the family contributed to the problem? Could the situation be improved by helping the family change its coping strategies. Is the behavior or emotional problem effecting people outside the home? Neighbors, police?

ASSESSMENT GUIDELINE #15
When **physical abuse or neglect of the client** is the reason for a client problem
Information Needs: How do you know the client is being abused? Who do you think is the abuser? Why do you think so? What are the physical signs that the client shows? What is the client's emotional reaction? Is she afraid? secretive? defensive? What is the family's reaction? Are they open? secretive? defensive? Do other family members need to become involved? What is their stress level? What is the environment like? Safe? Unsafe? How soon does client need help? Can family continue to care for client? Do they need respite? Other help?

ASSESSMENT GUIDELINE #16
When the client's household includes a person with a severe problem
Information Needs: What is the nature of the household member's problem. (e.g., mental retardation, severe physical disability, psychiatric disorder, suspected criminal activity, substance abuser). Is the client dependent on this household member? Is this household member dependent on the client? Is the household member dependent on the client's principal caregiver? What other service systems are involved with this household? Name of other worker(s)? Have any previously attempted interventions failed? Why? How does the client view this person's problem? How does the family view this person's problem? Is the client safe in the household?

ASSESSMENT GUIDELINE #17
When **architectural barriers** are causing a client problem
Information Needs: What is it that is keeping the client from traveling outside or maneuvering inside the home? Confined space? Narrow doorways? Stairs? Lack of a wheelchair? Lack of transportation? Lack of an escort? How does the client feel about this? How does the family feel? Is there a need for a specialized assessment by a PT, OT or carpenter? Is new housing appropriate if the home cannot be modified to meet the client's needs? Does the client of family have financial resources to modify the home? Would the client's self-care abilities be improved if architectural barriers were removed?

ASSESSMENT GUIDELINE #18
When **inadequate income** is causing a client problem
Information Needs: What are the client's income and expenses? Why is the income inadequate? What is the client's attitude towards money? Towards accepting help? Is the client able to manage money, pay bills? Are financial resources available from the family? From church or private resources? From public programs? Can client reduce expenditures?

ASSESSMENT GUIDELINE #19
When an **inadequate level of care at home** is causing a client problem
Information Needs: What makes you think the care at home is inadequate? Have available community services been tried? Is nursing home placement being sought? Why? What physical or medical conditions are involved? Is treatment needed? Are care needs likely to decrease in the future? Does the client wish nursing or boarding home placement? When? Does the family wish nursing or boarding home placement? When? Are there financial resources for short term or long term placement? What do other involved providers, VNA nurse, MD, etc. think? Does the case manager agree/disagree with placement decision? Do forms need to be filled out by client, family, Medicaid? Is a bed available? When?

ASSESSMENT GUIDELINE #20
When an **unsafe home or neighborhood** is causing a client problem
Information Needs: What are the hazards in the client's situation? danger from fails? fire? break-ins? other? Is the client aware of the hazards? Is the client capable of living in the current situation? Will she comply with safer practices? What options are available to modify the environment? disconnect stove? new bathroom equipment? locks? gates? bed rails? stair rails? Is the safety of the home preventing service providers from attending to the client? Must new housing be sought?

SECTION III. OPTIONS FOR CARE PLANNING

The second portion of this paper deals with the care planning process from the point of the completed problem statement through the selection of appropriate providers. Beginning on page 23 Options for Care Planning charts are presented. For each problem, these charts offer general outcome standards, common types of help needed, and service provider options that a case manager can select. The format of the option charts includes the following column headings:

			Service Provider Options	
Problem Type	Outcome Standards	Common Types of Help Needed	Informal	Agency

This format parallels that of the care plan form used in the National Long-Term Care Channeling Demonstration (see Appendix A for the care plan form.)

Stating the Problem

The statement of a client problem on a care planning option chart is different from a problem statement that would appear on the care plan since it does not include both a functional problem and a cause or reason. To include causes with each problem would produce a huge number of possible combinations of problems and causes, far too many to deal with on the option charts, which need to be clear in order to be useful to workers. It would also produce a considerable amount of repetition in this paper. The absence of reasons is important to keep in mind as the problems are worked across the chart. The functional problems identified in these columns are probably the most common ones identified by case managers, but the solution selected for an individual will vary according to many factors: the cause, the family situation, the client's preferences, funding, program requirements, etc.

Outcome Standards

Outcome standards illustrate what the goals of case management might be for each problem type shown in the charts. The more general term, outcome standard, is used here in place of the specific "desired outcomes" which would appear on a client care plan. Desired outcomes are individually tailored to the client and are time limited. Both the more general "outcome standards" included here and the specific "desired outcomes" written during care planning for a client should be expressed in terms of how the client will look, feel, function, or be, when the goal is achieved. Note that a problem may have more than one possible outcome. In that case, the options charts are completed for each possible outcome, and the case manager could include more than one desired outcome on a care plan.

Common Types of Help Needed

Identifying the causes of problems and the desired outcomes for clients assists the case manager to select the most appropriate types of help needed. Depending on the problem, the cause, and the desired outcome, a client may require only one or several types of help. The purpose of this column on the chart is to outline “types of help” case managers should find useful in resolving specific problems. There is a range of types of help listed, and they vary in intensity. Note that these are general types of help, not yet described in terms of a particular service or delivery system. The case manager would choose the most appropriate option or options rather than all of the listed options.

Service Provider Options

There are many variations in the services offered in different locations and service areas in a state. This contrast is even greater among states, so that generic service categories rather than specific program names are used on the charts. In the real world of practice, options would be modified to reflect the existing service environment in the area.

This column suggests appropriate providers of service for clients who have a particular problem and need a specified type of help. Generic terms for providers are used for the most part, but this was not always possible. It is true that many areas offer similar services under different names. For instance, what is called Medicaid in one state is called Medical in California, a Board of Social Service may be a Welfare Board elsewhere, or the Commission for the Blind may be the Division on the Blind in another state.

Eventually, all case managers come to suffer from an affliction know as abbreviationitis. We are no exception to this, so an Abbreviation Key is in order so that the options for care planning are clear. Although they could be written out in full in every case, efficiency required the use of such abbreviations.

V.A.	-	Veterans Administration
Dx	-	Diagnosis
C.I.	-	Contracted Individual - a person hired privately by the client to perform certain services
O.T.	-	Occupational Therapist
P.T.	-	Physical Therapist
S.T.	-	Speech Therapist
V.N.	-	Visiting Nurse or Home Health Agency Nurse
E.R.	-	Emergency Room
HHA or Homemaker	-	Home Health Aide/Homemaker (used interchangeably here)
M.D.	-	Medical Doctor
MOW	-	Home Delivered Meals or Meal on Wheels

Although most generic names for providers are self explanatory, there are a few that could bear some explanation.

Diagnosis Related Organizations	e.g., Cancer Society, American Heart Association, Multiple Sclerosis Society, etc.
Service Organization	e.g., Lions, Kiwanis, Elks, etc.
Retirement Groups	e.g., Retired Senior Volunteers, Retired Executives, etc.
Senior Transport	e.g., Local transportation programs for the elderly
Nutrition Project	On site meal programs
Volunteer	Usually refers to an unpaid individual who comes from an organization that provides volunteers
Insurance	Refers here to commercial insurance and Medicare, Medicaid

The “Options for Care Planning” charts are divided into two sections. In the first the problem causes or reasons are stated as separate problems. The second section contains the functional problems. If, in gathering further information about a functional problem and its cause, the case manager comes to a decision that the cause itself can be modified or alleviated, he/she may want to address the cause as a separate problem. The outcome of efforts to resolve the cause can impact heavily on approaches to other problems.

The charts on the following pages first address these **causes** as separate problems.

1. Abuse and neglect
2. Alcohol abuse
3. Confusion
4. Drug abuse
5. Emotional or behavioral problems
6. Fatigue/weakness
7. Hearing problem
8. Inadequate level of care
9. Mobility impairment/paralysis

10. Problem person in the household
11. Speech problem
12. Vision problem

Then the following **functional problems** are covered.

13. Client is unable to shop
14. Client is unable to do laundry
15. Client is unable to do housework
16. Client is unable to prepare meals
17. Client is unable to manage money
18. Client is unable to self administer medication
19. Client is unable to bathe self
20. Client is unable to dress self
21. Client is unable to perform self toileting
22. Client is unable to feed self
23. Client has difficulty with ambulation/mobility
24. Client has difficulty with transfers
25. Client is unable to maintain informal support system
26. Client is unable to maintain social contacts
27. Client has inadequate financial resources
28. Client has difficulty obtaining medical care
29. Client is unable to maintain a safe environment
30. Client is unable to secure adequate heat
31. Client is unable to secure adequate housing

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OPTIONS FOR CARE PLANNING #1: ABUSE AND NEGLECT				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Abuse and Neglect	Client is safe **or** Client will not be abused	Respite Care	Family Friends	Homemaker Home Health Aide Nursing Home Overnight Companion
		Counseling		Clergyman Social Worker
		Family conference		Case Manager
		Legal Services		Lawyer/Legal Aid
		Reporting		Case Manager
		Protective Services		Welfare Board

OPTIONS FOR CARE PLANNING #2: ALCOHOL ABUSE				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Alcohol Abuse	Client controls alcohol intake **or** Client does not drink alcohol	Medical evaluation		MD Clinic Rehab
		Psychological evaluation		MH Center
		Support group		AA Al-anon
		Monitoring	Family	

OPTIONS FOR CARE PLANNING #3: CONFUSION				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Confusion	Client is no longer confused	Medical evaluation		Agency MD Clinic
		Psychological evaluation		Mental Health Center
	and/or	Family counseling		Clergymen Social Agency Mental Health Center
	Client is in a safe situation		SEE PROBLEM "Client unable to maintain safe environment (#29)	

OPTIONS FOR CARE PLANNING #4: DRUG ABUSE				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Drug Abuse	Client as not addicted to drugs **and/or** Client obtains drugs legally **and/or** Client takes drugs as prescribed by MD	Medical evaluation		MD Clinic
		Psychological/Mental Health evaluation		Psychologist Psychiatrist MH Center
		Counseling		Clergyman MH Center Social Worker
		Monitoring/ Supervision	Family Friends	Home Health
		Support groups		AA or other
		Drug Rehab		Drug Rehab Center

OPTIONS FOR CARE PLANNING #5: EMOTIONAL OR BEHAVIORAL PROBLEMS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Emotional or Behavior Problems	Client is no longer disturbed	Medical evaluation		MD Clinic
		Psychiatric evaluation		Mental Health Center
	and/or	Psychiatric treatment		Mental Health Center Psychiatric Day Hospital Psychiatric In-patient Facility
		Behavioral Therapy		Mental Health Center
		Situational Counseling		Social Agency Mental Health Center Clergyman
	Client is in a safe situation		SEE PROBLEM "Client unable to maintain safe environment" (#29)	

OPTIONS FOR CARE PLANNING #6: FATIGUE/WEAKNESS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Fatigue/Weakness	Client has energy for daily activities	Medical evaluation		MD
		Pharmacologic evaluation		Pharmacist
		P.T. evaluation		P.T.
		Mental Health evaluation		Mental Health Center
		Evaluation of rest/ activity patterns		Home Health Agency

OPTIONS FOR CARE PLANNING #7: HEARING PROBLEM				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Hearing Problem	Client has maximum hearing	Medical evaluation		MD Specialist
	and/or	Audiologic evaluation		Audiologist
		Hearing aid repair		Hearing Aid Company
	Client is safe	Special equipment	Family Friends	Telephone Company Deaf Association
		Monitoring	Family Friends	
		Modify environment	Family	

OPTIONS FOR CARE PLANNING #8: INADEQUATE LEVEL OF CARE				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Inadequate Level of Care	Client receives needed care **or** Client is in safe situation	Medical evaluation		MD Clinic
		Instruction in home care		Home Health
		Increase level of service		Case Manager
		Caregiver counseling		Social Worker
		Respite	Family Friends	Nursing Home Home Health Homemaker
		Modify environment	Family	Home Health Case Manager
		Family conference		Case Manager
		Nursing home placement	Family	
		Temporary		Case Manager
		Permanent		

OPTIONS FOR CARE PLANNING #9: MOBILITY IMPAIRMENT/PARALYSIS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Mobility Impairment/ Paralysis	Client has optimal mobility and use of arms and legs	Medical evaluation		MD Clinic
		P.T. evaluation		Home Health Rehab Clinic
		O.T. evaluation		Home Health Rehab Clinic
		Modify environment	Family Friends	Volunteers Contractors
		Obtain equipment		Medical Supply House Clubs Churches

OPTIONS FOR CARE PLANNING #10: PROBLEM PERSON IN HOUSEHOLD				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Problem Person in Household	Person receives care	Medical evaluation of family member		MD
		Mental health care of family member		Mental Health Center
		Counseling client and family member		Social Worker
	and/or			
	Client is comfortable in home situation	Move client to other setting	Family Friends	Case Manager
		Provide Respite	Family Friends	Homemaker/ Home-Health Aide
		Legal/Advocacy for client to maintain rights		Lawyer Legal Services
		Financial management	Family Friends	Conservator Power of Attorney Bank

OPTIONS FOR CARE PLANNING #11: SPEECH PROBLEM				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Speech Problem	Client communicates needs **and/or** Client has social contact	Speech evaluation/ therapy		Home Health ST
		Modify environment	Family	
		Monitoring	Family Friends	
		Escort	Family Friends	Volunteer

OPTIONS FOR CARE PLANNING #12: VISION PROBLEM				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Vision Problem	Client has maximum possible vision	Medical evaluation		MD
		Optometric evaluation and prescription		Optometrist
		Modify environment for safety and to promote independence	Family	OT
		Obtain adaptive equipment		Commission for the Blind Home Health Nurse Case Manager
		Arrange for reading material (large type, talking books, etc.)		Case Manager Commission for the Blind
		Monitoring and supervision	Family Friends Neighbors	

OPTIONS FOR CARE PLANNING #13: CLIENT UNABLE TO SHOP				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Shop	Client will have sufficient supplies of food and household goods to maintain adequate nutritional intake, hygiene, and safe, sanitary environment	Someone to shop	Family Friend Neighbor	Volunteer Homemaker CI Chore Service Senior Apartment Shopping Service
		Someone to write shopping list	Family Friend Neighbor	Volunteer Homemaker CI
		Transportation to grocery store	Family Friend Neighbor	Volunteer CI Homemaker Senior Transport Taxi
		Escort and assistance with carrying packages	Family Friend Neighbor	Volunteers CI Homemaker Taxi Driver
		Delivery Service		Local stores Senior Housing Convenience Concessions
		Financial Assistance for purchases	Family	Food Stamps Senior Discounts Coupons Emergency Food Bank Surplus Food Distribution SSI Service Organizations

OPTIONS FOR CARE PLANNING #14: CLIENT UNABLE TO DO LAUNDRY				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to do Laundry	Client will have available supplies of clean clothing and linens	Someone to do laundry	Family Friends Neighbors	Homemaker CI Chore Service Volunteer Laundry Service
		Someone to assist with laundry	Family Friends Neighbors	Homemaker CI Chore Service Volunteer
		Someone to move washer and dryer to accessible location	Family Friends Neighbors	Handyman Service CI Volunteer
		Finances for purchase of washer and dryer	Client Family	Service Organization Donation
		Increased supply of clothing and linens to reduce frequency of need for laundering	Client Family	Service Organization Donation
		Instruction in independent laundering		OT

OPTIONS FOR CARE PLANNING #15: CLIENT UNABLE TO DO HOUSEWORK				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Do Housework	Client will have a clean environment	Someone to do light and heavy housework	Family Friends Neighbors	Volunteer CI Chore Service Cleaning Company Senior Apartment Cleaning Service
		Someone to do light housework	Family Friends Neighbors	Homemaker Chore Service Volunteer
		Instruction in independent housekeeping		OT
		Equipment for cleaning	Client Family	Donations

OPTIONS FOR CARE PLANNING #16: CLIENT UNABLE TO PREPARE MEALS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Prepare Meals	Client will have meals prepared that meet nutritional requirements and are acceptable to client	Meals pared in the home	Family	Homemaker CI Volunteer
		Hot meals delivered	Family Neighbor	MOW Restaurant Delivery Volunteer
		Frozen meal a delivered	Family Neighbor Friend	Volunteer
		Site for congregate meals		Nutrition Project Day Care
		Shared meals	Family Neighbor Friend	
		Instruction in independent meal preparation		OT Commission for the Blind
		Specialized equipment		OT & Medical Supplier
		Instruction in special diet		Nutritionist VN
		Financing of adequate cooking facilities	Client Family	Service Organizations Housing Rehab Program
		Relocation to handicapped equipped apartment 1) Information on available housing		Case Manager Housing Authority Local Housing Information Agency
		2) Application	Client Family Friend	Senior Housing Personnel Volunteer
		3) Moving	Family Friend	Volunteer Professional Movers
		4) Financing	Client Family	Service Organization
		Transportation to meal site	Family Friends Neighbors	Senior Transport Taxi CI Volunteer Nutrition Program Transport
		Escort for Transportation	Family Friend Neighbor	CI Volunteer Homemaker

OPTIONS FOR CARE PLANNING #17: CLIENT UNABLE TO MANAGE MONEY				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Manage Money	Clients finances will be managed effectively	Total budgeting and financial responsibility	Family Protective Payee Power of Attorney Legal Guardian Conservator Friend	
		Legal assistance in naming power of attorney, legal guardian, conservator		Lawyer Legal Aid Protective Services
		Assistance with financial management	Family Friend	Social Worker Protective Services Commission for the Blind
		Instruction in effective budgeting		Home Economist Social Worker

OPTIONS FOR CARE PLANNING #18: CLIENT UNABLE TO SELF ADMINISTER MEDICATIONS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Self Administer Medications	Clients will take medications as prescribed by the physician	Administration of medications	Family Friend Neighbor	Private Duty Nurse VN
		Pouring medications	Family Friend Neighbor	
		Supervision and instruction regarding medications		VN MD
		Setting up a medication system	Family	VN
		Revision of medication dosage schedule		MD
		Reminder to take medications	Family Friend Neighbor	CI Homemaker HHA
		Easy open medication containers		Pharmacist
		Instruction in identifying medications (if vision problem exists)		Commission for the Blind
		Assistive devices for medication administration		Pharmacist Surgical Supplier
		Payment for assistive device	Client Family	Disease Specific Organization Insurance

OPTIONS FOR CARE PLANNING #19: CLIENT UNABLE TO BATHE SELF				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Bathe Self	Clients will bathe/be bathed at intervals sufficient to maintain hygiene and skin integrity	Someone to bathe client	Family Friend	Homemaker CI
		Someone to assist with bathing	Family Friend	Homemaker CI
		Someone to supervise bathing	Family Friend	Homemaker CI
		Instruction in bathing (independent)		VN OT
		Equipment for bathing 1) Assessment of need, instruction in use		VN OT
		2) Source	Equipment donations	Medical Supplier
		3) Financing	Client Family	Service Organization Diagnosis Specific Organization Insurance
		Correction of Plumbing problems/ architectural barriers		
		1) Evaluation/ estimates		Plumber Contractor
		2) Doing Corrections	Family Friend	Volunteers Plumber Contractor
		3) Financing	Client Family	Housing Rehab Program Home Improvement Loans Reverse Mortgage Home Equity Loan Service Organization Insurance
		Relocation to handicapped equipped apartment 1) Information on available housing		Case Manager Local Housing Authority Local Housing Information Agency
		2) Assistance with application	Client Family Friend	Senior/Handicapped Housing Personnel Volunteer
		3) Moving	Family Friend	Volunteer Professional Movers
		4) Financing of relocation	Client Family	Service Organization
		5) Assistance with rental payments	Client Family	Rental Assistance Program

OPTIONS FOR CARE PLANNING #20: CLIENT UNABLE TO DRESS SELF				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Dress Self	Client will change clothing/have clothing changed upon rising and retiring	Someone to dress client	Family Friend	Homemaker CI
		Assistance with dressing	Family Friend	Homemaker CI Volunteer
		Someone to supervise dressing	Family Friend	Homemaker CI Volunteer
		Instruction in independent dressing		VN OT
		Specialized equipment for dressing 1) Assessment of need, instruction in use		VN OT
		2) Source	Donations	Medical Supplier
		3) Financing	Client Family	Service Organizations Diagnosis Specific Group Insurance

OPTIONS FOR CARE PLANNING #21: CLIENT UNABLE TO PERFORM SELF TOILETING				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Perform Self Toileting	Client will toilet/be toileted at intervals sufficient to meet body requirements and to maintain hygiene **or** Client will be clean and dry	Reminder to toilet	Family Friends Neighbors	Homemaker CI Volunteers Day Care
		Assistance with toileting	Family Friend	Homemaker CI Day Care
		Instruction in independent toileting		OT PT VN
		Equipment/supplies related to toileting/ incontinence care 1) Assessment of need, instruction in use		VN PT OT
		2) Source		Equipment Donations Medical Supplier
		3) Financing	Client Family	Insurance Diagnosis Specific Organization Service Organization
		Medical Evaluation		MD
		Bladder and/or bowel training Instruction Follow-up	Family	VN CI Homemaker
		Medical procedure/ interventions		MD VN
		Provision/assistance with incontinence care	Family	Homemaker CI VN
		Correction of plumbing problems/ architectural barrier 1) Evaluation		Plumber Contractor
		2) Doing corrections	Family Friend	Volunteers Plumber Contractor
		3) Financing	Family Friend	Housing Rehab Program Home Improvement Loans Reverse Mortgage Home Equity Loan Service Organization Insurance

OPTIONS FOR CARE PLANNING #22: CLIENT UNABLE TO FEED SELF/EAT				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Feed Self/Eat	Client will be fed/feed self meals sufficient to meet nutritional requirements	Someone to feed clients	Family Friend Neighbors	Homemaker CI Volunteers Companion
		Assistance with eating	Family Friend Neighbors	Volunteer Homemaker CI Companion
		Supervision of eating and set up of food	Family Friend Neighbors	Volunteer Homemaker CI Companion Day Care
		Instruction in independent eating		VN OT Commission for the Blind
		Medical assessment of feeding problems		MD VN OT ST
		Instruction in specialized feeding procedures		VN
		Specialized equipment for eating/feeding 1) Assessment of need and instruction in use		VN OT Commission for the Blind
		2) Source		Medical Supplier Commission for the Blind
		3) Financing	Client Family	Service Organization Diagnosis Specific Organization Insurance
		Instruction in diet modifications		VN Nutritionist
		Dental exam and follow-up		Dentist Dental Clinic
		Financing of dental work	Client Family	Insurance Low Income Dental Clinic Dental Discounts for Seniors
		Transportation to MD/Dentist	Family Friend Neighbors	Senior Transport Taxi CI Volunteer Diagnosis Specific Organization Ambulance Service
		Escort for transportation	Family Friend Neighbors	CI Volunteer Homemaker

OPTIONS FOR CARE PLANNING #23: CLIENT HAS DIFFICULTY WITH AMBULATION/MOBILITY				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Has Difficulty With Ambulation/ Mobility	Client will ambulate independently/be mobile	Assistance with ambulation/mobility	Family Friend	Homemaker CI
		Instruction in independent ambulation		PT VN
		Specialized equipment for ambulation/mobility (ambulation devices, wheelchairs, ramps, rails) 1) Assessment of need, instruction in use		VN PT
		2) Source	Equipment donations	Medical supplier
		3) Financing	Client Family	Insurance Medicare Medicaid
		Specialized Transportation		Rescue Squad Private Ambulance Wheelchair equipped Seniors Van
		License plates for handicapped individuals		Department of Motor Vehicles
		Information re: local businesses and services with access for handicapped persons		Case Manager
		Correction of in-home architectural barriers 1) Evaluation		Contractor Rehabilitation Specialist
		2) Doing corrections	Family Friends	Volunteers Contractor
		3) Financing	Client Family	Housing Rehab Program Home Improvement Loan Bank for Reverse Mortgage Home Equity Loan Service Organization Insurance
		Relocation to handicapped equipped apartment 1) Information on available housing		Case Manager Local Housing Authority Local Housing Information Agency
		2) Application	Client Family Friend	Senior/Handicapped Housing Personnel
		3) Moving	Family Friend	Volunteers Professional Movers
		4) Financing of relocation	Client Family	Service Organization
		5) Assistance with rental payments	Client Family	Rental Assistance Program

OPTIONS FOR CARE PLANNING #24: CLIENT HAS DIFFICULTY WITH TRANSFERS (bed to chair, chair to commode, etc.)				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Has Difficulty With Transfers (bed to chair, chair to commode, etc.)	Client will transfer/be transferred at a frequency sufficient to maintain optimum mobility and to prevent adverse affects of immobility	Someone to transfer client	Family Friend	Home Health Aide CI
		Assistance with transfer	Family Friend	Home Health Aide CI
		Instruction in transfer techniques		PT VN Rehabilitation Facility
		Follow-up on instruction	Client Family	VN Home Health Aide
		Assistive equipment for transfer 1) Assessment of need/instruction in use		PT VN
		2) Source	Equipment donations	Medical Supplier
		3) Financing	Client Family	Insurance Service Organization Diagnosis Specific Organization

OPTIONS FOR CARE PLANNING #25: CLIENT UNABLE TO MAINTAIN INFORMAL SUPPORT SYSTEM				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Maintain Informal Support System	Informal caregivers will maintain their involvement in caring for client	Respite for caregivers	Family Neighbor	Volunteer Homemaker Companion CI Day Care Short Term Nursing Home
		Counseling/support for caregiver	Family	Support Group Case Manager Social Worker Mental Health Agency Private Counseling Service Diagnosis Related Organization

OPTIONS FOR CARE PLANNING #26: CLIENT UNABLE TO MAINTAIN SOCIAL CONTACTS				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Maintain Social Contacts	Client will have established social contacts on a regular basis	Social visitors in the home	Family Neighbor Friends	Church Visitor Volunteer Companion
		Attendance at social gatherings	Family functions	Support Group Church Activity Day Care
		Transport to social gathers	Family Friends Neighbors	Senior Transport Taxi CI Volunteer
		Escort for transport	Family Friends Neighbor	CI Volunteer
		Reassurance caller	Family Friends Neighbor	Church Group Volunteer Organization Formal Agency Service

OPTIONS FOR CARE PLANNING #27: CLIENT HAS DIFFICULTY WITH FINANCIAL RESOURCES				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client has Difficulty with Financial Resources	Income will be adequate to maintain standard of community living	Assistance in obtaining income entitlements		Case Manager Social Security Veterans Administration Municipal Welfare County Welfare Private Pension Plans Legal Aid
		Assistance in obtaining supplementary entitlements		Case Manager Medicare Medicaid Food Stamps Home Heating Allowance Pharmaceutical Assistance V.A. Aid and Attendance Insurance Claims Legal Aid Social Services Block Grant Area Agency on Aging Rental Assistance Housing Restoration Program Medically Needy Program Commission for Blind
		Assistance in obtaining donated goods or services		Diagnosis Related Organization Church Groups Fraternal Organizations Service Organizations Industry Publicity Request for Donations Community Agencies School Groups Merchants Unions Retirement Groups Senior Discount Program Clinics Local Transportation Programs
		Assistance with budgeting	Family Friends	Case Manager Social Worker Home Economist
		Supplemental Financial Support	Family	Bank for Reverse Mortgage

OPTIONS FOR CARE PLANNING #28: CLIENT HAS DIFFICULTY OBTAINING ADEQUATE MEDICAL CARE				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client has Difficulty Obtaining Adequate Medical Care	Client will be at optimum level of health **or** Client accepts need for medical care **or** Client receives medical care	Medical home visit		M.D. Nurse Practitioner
		Information re: M.D.'s who make home visits		Medical Society
		Nursing Assessment		Visiting Nurse
		M.D. office visit for evaluation		Private M.D. Clinic Emergency Room
		Financial assistance for medical care		Medicare Medicaid Insurance Sliding Fee Clinics Public Programs Installment Payment Plan Diagnosis Specific Organization
		Transport to medical facility	Family Friend Neighbor	Rescue Squad Private Ambulance Volunteers Senior Van Public Transport
		Financing Transport	Family	Medicare (to E.R.) Medicaid Public Programs Diagnosis Specific Organization
		Counseling		Case Manager Visiting Nurse Social Worker

OPTIONS FOR CARE PLANNING #29: CLIENT UNABLE TO MAINTAIN A SAFE ENVIRONMENT				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Maintain a Safe Environment	Client will be protected from environmental hazards	24 hour supervision	Family Friend Neighbor Boarder	Volunteer Homemaker CI Day Care Live-In Companion
		Periodic Monitoring	Family Friend Neighbor Neighborhood Watch Program	Home Delivered Meals Program Clergy Volunteer Police monitoring Fire Department monitoring Mail Carrier Reassurance caller
		24 hours emergency signalling system		Lifeline Telephone Company Emergency cords in apartment
		Alternative living arrangement	Relative's home Friend's home	Senior Housing Share-a-Home Boarding Home Sheltered Housing
		Emotional support for client	Family Friends Neighbors Pet	Volunteer Counseling Reassurance Caller Case Manager Companion Church Visitor CI Homemaker Peer Group
		Respite for caregivers	Family Friend Neighbor	Volunteer Homemaker CI Day Care Nursing Home
		Support for caregivers		Support Group Counseling Case Manager
		Instruction in home safety	Family	OT PT VN Police Programs Fire Department Programs Homemaker CI Case Manager
		Building safety	Family Friend	Health Officers Fire Inspector Sanitation Department Landlord Handyman Program Housing Rehab Program Volunteer

#29 (*continued*)				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
		Safety equipment, locks, fire extinguishers, smoke alarms, grab bars, bed rails, ramps, table top appliances, gate, stair glides 1) Obtaining and installing	Client Family Friend Neighbor	Volunteer Handyman Program CI
		2) Financing	Family Client	Service Organization Insurance Donations Commission for Blind
		Legal Intervention		Lawyer Legal Aid Public Advance Protective Services Family Service Association

OPTIONS FOR CARE PLANNING #30: CLIENT UNABLE TO SECURE ADEQUATE HEAT				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Secure Adequate Heat	Client's environmental temperature will be maintained at a minimum of 68°F	Advocacy with landlord		Case Manager Legal Aid Health Department
		Housing relocation		See problem re: Inability to secure adequate housing (p. 44)
		Financial Assistance for installation/repair of heating system, home weatherization	Client Family	Housing Preservation Program Reverse Mortgage Home Improvement Loan Public Weatherization Programs Volunteer Programs
		Financial Assistance for bills	Family Church Group	Energy Assistance Program -- Local/ State Emergency Heating Assistance Program

OPTIONS FOR CARE PLANNING #31: CLIENT UNABLE TO SECURE ADEQUATE HOUSING				
			Service Provider Options	
Problem Type	**Outcome Standards**	**Common Types of Help Needed**	**Informal**	**Agency**
Client Unable to Secure Adequate Housing	Client will live in safe, sanitary, affordable housing	Information on available housing	Family Friends	Case Manager Local Housing for Planning Agencies Newspaper Community Agencies
		Financial Aid for housing	Family	Senior/Handicapped Subsidized Housing Section 8 Housing Program
		Physical Assistance moving or financial assistance for moving	Family Friend Neighbor	Volunteers Service Organization
		Assistance with application for subsidized housing	Family Friend	Housing Personnel Case Manager
		Representation in housing related legal matters (evictions, foreclosures)		Private Lawyer Legal Aid Tenants Rights Organization

APPENDIX A. CARE PLAN FORM

CHANNELING DEMONSTRATION
CARE PLAN, Part 1

Client _____ **Date** _____

I.D. _____

Address _____

Phone No. _____

Problems	Desired Outcome	Problem Revised/ Resolved-Date
1.		
2.		
3.		
4.		
5.		

Problems not addressed and why:

1.		
2.		
3.		

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CHANNELING DEMONSTRATION
CARE PLAN, Part 2

Client _____

Next Scheduled Reassessment _____

Initial Service Focus
1._____Maintenance in community
2._____Movement toward community
3._____Movement toward board & care
4._____Movement toward nursing facility

Service Providers		**Pattern of Delivery**	**Changes**
Informal	**Formal**		
1.			
2.			
3.			
4.			
5.			

This care plan has been discussed with the client and/or significant family members or friends.

_____
Case Manager Date

_____
Supervisor Date

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APPENDIX B. SUMMARY OF THE CHANNELING PROGRAM CONTEXT

by Nancy Wilson and Linda Sterthouse

History and Background

The problems and limitations of the current long-term care system have been described many times during the past decade. Policy-makers at all levels of government have stressed the need to resolve critical problems such as increasing public costs, excessive reliance on medical and institutional care, inadequate community resources, fragmentation, and service inaccessibility.

Since these problems affect a growing population of impaired elders, public officials and legislators have initiated a variety of long-term care demonstration projects to evaluate new approaches to services, increase understanding of the needs of impaired clients, and gather information about the costs of caring for them in the community.

To answer important remaining policy questions, Congress authorized funds for the National Long-Term Care Channeling Demonstration (known also as “Channeling”). From 1980 to 1985, three agencies within the Department of Health and Human Services jointly administered this demonstration project in ten states. The office of the Assistant Secretary for Planning and Evaluation coordinated and implemented the program, cooperating with staff from the Administration on Aging and the Health Care Financing Administration, the two principal funding sources.

The Channeling program has tested two organizational models of community-based long-term care for the functionally impaired elderly. Both models were tested as alternatives to institutional care and included these common features: a central point of intake, a standardized assessment process, and ongoing case management to arrange and monitor the provision of community-based services.

In the basic Channeling model, case managers coordinated existing community resources to meet individual needs. The complex (or financial control) model had additional authority and funding to purchase services for clients. These case managers had access to pooled funds from Medicare, Medicaid, Title III and Title XX and could authorize the amount, duration and scope of services for all of their clients within established site limits on total care plan costs.

Channeling Participants

Through DHHS contracts with ten states, ten community agencies were selected to carry out the Channeling demonstration. The basic case management model was tested in five sites: Eight counties in Eastern Kentucky; Portland, Maine; Baltimore, Maryland; New Brunswick, New Jersey; and Houston, Texas. The five complex model sites were operated in Miami, Florida; Greater Lynn, Massachusetts; Troy, New York; Cleveland, Ohio; and Philadelphia, Pennsylvania. All ten sites began operating in early 1982.

The official closing date of the Channeling Demonstration was March 31, 1985. Each of the ten sites has gone through a termination/transition process designed to safely discharge clients to existing agencies or to move program staff and clients to other sources of funding.

During the course of the demonstration, the ten channeling sites identified through outreach efforts over 9,000 very impaired older adults and served over 6,000 of these individuals as clients.

Design of Channeling Demonstration

Channeling was developed to achieve the following objectives:

- Improved targeting of service resources to those in greatest need.
- Improved matching of clients needs to formal and informal services.
- Improved client outcomes.
- Less costly, more efficient use of services.

Target Population for Channeling

Emphasis was placed on targeting those older people who would be institutionalized in the absence of community-based services.

The standard criteria for participation in the project were based on three factors (in addition to client interest):

- Residence -- must reside in the service area, or if institutionalized, must be certified as likely to be discharged to a non-institutional setting within three months.

- Functional Disability -- must have a minimum of two moderate ADL disabilities, or three severe IADL impairments, or two severe IADL impairments and one severe ADL disability.

- Unmet Needs or Fragile Informal Support -- must have an unmet need expected to last at least six months for two major personal care or in-home services (meals, housework/shopping, medications, medical treatments at home, personal care), or must have a fragile informal support sytem that may no longer be able to provide needed care.

Utilizing these eligibility criteria for a defined target population, the Channeling sites recruited and screened applicants for services. The profile of Channeling clients selected using these criteria reveals a very impaired population. Most of the clients were unable to leave their homes without human assistance and many were bedbound. Most needed assistance with activities of daily living.

Core Functions of Channeling Agencies

To achieve improved client and caregiver outcomes and reduced costs for more appropriate services, the designers of Channeling prescribed seven essential core functions that each site was to carry out:

A. Outreach to identify and attract appropriate clients. Channeling sites utilized a variety of outreach strategies including: written referral agreements with hospitals, home health providers and other agencies who referred clients, community education activities aimed at clients and families (such as letters to clergy and group presentations); and public information such as media announcements and brochures. The major sources of referral were hospitals, home health agencies, and families.

B. Screening to determine whether an applicant was part of the target population. Designated staff typically conducted a telephone interview of 15-20 minutes with a client or referral source, using a standardized screening instrument. The instrument included questions designed to establish an individual's eligibility for the program based on the criteria previously discussed. Screeners decided when to rely upon a family member or other referral source instead of a client as a respondent to the screening questions.

C. Comprehensive needs assessment to determine individual problems, resources, and service needs. Using a standardized assessment tool, the channeling staff made an in-person visit to collect information about a client's current functioning and support system. Staff used one version of the tool for clients assessed in an institution (hospital or nursing home) and another version for community clients. Both instruments explored aspects of the client's physical health, mental health, social functioning, activities of daily living, financial resources, living environment,

current services and support and unmet needs. Additional information was collected as needed from other formal and informal providers involved with the client.

D. Care planning to specify the types and amounts of care to be provided to meet the identified needs of individuals. At this stage, case managers translated identified needs and problems into a plan for services. Working with a standard care plan format, staff outlined problems, goals to be achieved, type of help to pursue in support of goal attainment, and sources and cost of services.

   Case managers were trained to be cost-conscious in their selection of service packages. They were encouraged to consider the full spectrum of public and private services available to a client before choosing an appropriate package. This included maximizing informal care already in place or potentially available to the client, and seeking volunteer help.

   An important aspect of the care planning process was establishing an agreement with the client and significant family members. In Channeling, a care plan agreement form was signed by clients signifying their knowledge and cooperation with the plan.

E. Service Arrangement to implement the care plan through both formal and informal providers. Case managers had to be knowledgable about service availability in their respective communities. This step sometimes required extensive communication with client, family and providers to assure that quality help would be provided and services were scheduled appropriately.

F. Monitoring to assure that services are provided as specified in the care plan. To monitor service provision and the circumstances of their frail clients, case managers maintained contact by telephone or in person with providers, clients, and family members. They encouraged informal and formal providers to call in the event of problems with services or changes in client status. Case managers relied on in-home providers to provide information about clients in crisis. Clients with no functioning informal care system often required more intensive follow-up.

G. Reassessment to adjust care plans to changing needs. In Channeling, reassessment was conducted on a scheduled basis, three months after program entry and every five to six months thereafter. In addition, a client's status changed suddenly in some major way, an "event-based" reassessment was conducted to revise the care plan. The case manager conducted an in-person visit and, utilizing a structured form, re-examined the client's situation and functioning. The reassessment was the basis for continuing, revising or discontinuing services and for determining whether the client continued to need case management services.

Variations in Models

The channeling demonstration added other features to these essential functions to define two program models: the basic case management model and the financial control model.

Basic Case Management Model. The basic model sites relied primarily on the existing services and resources in their communities to meet long-term care needs of their clients. The Channeling site in each community represented a focal intake point for services to impaired elders and provided trained case managers to help clients and families utilize their entitlements fully and gain access to the best package of these available services.

One additional feature established as part of each basic model site was a "gap-filling" or service expansion fund. Project staff were allowed substantial flexibility to use these discretionary dollars for the purchase of non-traditional items (talking clocks, large print books) as well as more routine direct services (personal care, transportation).

Complex or Financial Control Model. The five complex sites combined the essential Channeling functions with six additional features that increased the case manager's access to services as well as the program's ability to control overall service costs:

1. Expanded Service Coverage.

   In the complex model, nineteen different service categories were reimbursable under the Demonstration. The included:

   - Day health and rehabilitative care
   - Day maintenance care
   - Home health aide
   - Homemaker/personal care
   - Housekeeping service
   - Chore services
   - Companion service
   - Home delivered meals
   - Respite care
   - Skilled nursing
   - Physical therapy
   - Speech therapy
   - Occupational therapy
   - Mental health services
   - Transportation
   - Housing assistance
   - Adult foster care

- Non-routine consumable medical supplies
- Adaptive and assistive equipment

2. Pooling of Government Funds.

   The pooling of Medicare, Medicaid, state and in some cases local funds allowed all clients (who were eligible for Medicare, Part A) to be eligible for all of the services, based on the decision of the case manager that the service was necessary.

3. Case Manager Authority Over Payment for Services.

   Case managers authorized payment from the funds pool and determined the amount, scope, and duration of the services. This allowed the case manager to increase and decrease amounts of service, to change services, and to change providers whenever necessary.

4. A Cap on Aggregate Service Expenditures.

   In order to control the expenditures of Channeling sites from the funds pool, a cap was set for each site which limited average service expenditures to sixty percent of the average nursing home rate in the local area.

5. Limits on Cost of Individual Care Plans.

   Individual Channeling clients were allowed to have plans that cost over 60% for relatively short periods of time. Case managers could write plans which kept annual costs at 85% or below. This meant that other clients had to average less than 60% in order to balance the extra spending.

6. Cost Sharing by Clients.

   Based on income, some clients were required to contribute to the cost of their care.

Research in the Demonstration

The major policy questions were adressed by an extensive research effort. The evaluation contractor selected by DHHS, Mathematica Policy Research, used a randomized experimental design and conducted several studies examining service use, outcomes, costs and informal caregiving. In addition, an exploratory study of care plan practices was conducted by the technical assistance contractor, the Institute on Aging at Temple University. It examined questions of a more clinical nature which were not included in the overall evaluation.
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NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION

REPORTS

A Guide to Memorandum of Understanding Negotiation and Development
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PDF: http://aspe.hhs.gov/daltcp/reports/mouguide.pdf

An Analysis of Site-Specific Results
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HTML: http://aspe.hhs.gov/daltcp/reports/1986/qualtyes.htm
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PDF: http://aspe.hhs.gov/daltcp/reports/cbainstr.pdf

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HTML: http://aspe.hhs.gov/daltcp/reports/1984/baslines.htm
PDF: http://aspe.hhs.gov/daltcp/reports/1984/baslines.pdf

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PDF: http://aspe.hhs.gov/daltcp/reports/1986/atritn.pdf

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HTML: http://aspe.hhs.gov/daltcp/reports/1984/impaires.htm
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Tables Comparing Channeling to Other Community Care Demonstrations
HTML: http://aspe.hhs.gov/daltcp/reports/1986/tablees.htm
PDF: http://aspe.hhs.gov/daltcp/reports/1986/tablees.pdf

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The Channeling Financial Control System
HTML: http://aspe.hhs.gov/daltcp/reports/1985/chanfcs.htm

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HTML: http://aspe.hhs.gov/daltcp/reports/compares.htm
PDF: http://aspe.hhs.gov/daltcp/reports/compares.pdf

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HTML: http://aspe.hhs.gov/daltcp/reports/1986/casmanes.htm
PDF: http://aspe.hhs.gov/daltcp/reports/1986/casmanes.pdf

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Executive Summary: http://aspe.hhs.gov/daltcp/reports/1986/chanes.htm
HTML: http://aspe.hhs.gov/daltcp/reports/1986/chan.htm
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HTML: http://aspe.hhs.gov/daltcp/reports/1988/hsre.htm
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HTML: http://aspe.hhs.gov/daltcp/reports/1983/imple.htm
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HTML: http://aspe.hhs.gov/daltcp/reports/1986/proceses.htm
PDF: http://aspe.hhs.gov/daltcp/reports/1986/proceses.pdf

DATA COLLECTION INSTRUMENTS

Applicant Screen
HTML: http://aspe.hhs.gov/daltcp/instruments/AppSc.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/AppSc.pdf

Client Contact Log
HTML: http://aspe.hhs.gov/daltcp/instruments/ClConLog.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/ClConLog.pdf

Client Tracking Form
HTML: http://aspe.hhs.gov/daltcp/instruments/ClTracFm.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/ClTracFm.pdf

Clinical Assessment and Research Baseline Instrument: Community Version
HTML: http://aspe.hhs.gov/daltcp/instruments/carbicv.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/carbicv.pdf

Clinical Baseline Assessment Instrument: Community Version
HTML: http://aspe.hhs.gov/daltcp/instruments/cbaicv.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/cbaicv.pdf

Clinical Baseline Assessment Instrument: Institutional Version
HTML: http://aspe.hhs.gov/daltcp/instruments/cbaiiv.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/cbaiiv.pdf

Eighteen Month Followup Instrument
HTML: http://aspe.hhs.gov/daltcp/instruments/18mfi.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/18mfi.pdf

Followup Instrument
HTML: http://aspe.hhs.gov/daltcp/instruments/FolInst.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/FolInst.pdf

Informal Caregiver Followup Instrument
HTML: http://aspe.hhs.gov/daltcp/instruments/ICFolIns.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/ICFolIns.pdf

Informal Caregiver Survey Baseline
HTML: http://aspe.hhs.gov/daltcp/instruments/ICSurvey.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/ICSurvey.pdf

Screening Identification Sheet
HTML: http://aspe.hhs.gov/daltcp/instruments/ScrIDSh.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/ScrIDSh.pdf

Time Sheet
HTML: http://aspe.hhs.gov/daltcp/instruments/TimeSh.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/TimeSh.pdf

Twelve Month Followup Instrument
HTML: http://aspe.hhs.gov/daltcp/instruments/12mfi.htm
PDF: http://aspe.hhs.gov/daltcp/instruments/12mfi.pdf

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200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
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