**Why Was CARE Developed?**

House Bill 1908, passed in 1995, required that ADSA develop a new classification and payment methodology that would tie payment for services more closely to the client’s need. This new methodology needed to more appropriately and equitably provide funding to match the complexity of the care being delivered.

**Complying with Federal Mandates**

The funds for the care of these clients are approximately fifty percent federal Medicaid monies. Due to that fact, we are subject to periodic audits by the Centers for Medicare and Medicaid Services (CMS – formerly the Health Care Financing Administration). In 1997, the federal representatives audited our program to ensure that care was being delivered to clients who are truly eligible. The auditors found a number of mistakes and instances where payments were not authorized in accordance with the Medicaid program rules. A new system that standardizes documentation ensures that case managers properly allocate services and authorize payment according to program rules. Such an improved system would greatly reduce the risk of future severe audit findings.

**Ladd & JLARC Recommendations**

Under contract to the Office of Financial Management and the state Senate, an outside consultant reviewed the Washington long-term care system in 1998. The report produced is commonly referred to as the “Ladd Report”. The report notes “The present computerized CA does not take full advantage of the power of computerization to integrate eligibility, assessment findings, authorized hours, and the care plan.” Other key findings showed that the current Comprehensive Assessment (CA), while having some very good strong points, is lacking in several ways. Most of these are due to the fact that the tool was designed before it was computerized, and therefore unable to fully utilize computer capability. The report further noted that “It is probably not possible for the CA to be able to classify clients according to impairment levels, as it presently exists” – meaning the current CA tool is inadequate to meet legislative and payment system requirements.

Joint Legislative and Executive Task Force on Long Term Care also recommended major changes to the Comprehensive Assessment Tool such as including more detail on complex medical needs and cognitive impairment and behavioral problems; increasing the assessment’s “inter-rater reliability” to provide more consistent evaluations between assessors; and encouraging broader use of the CA throughout the Long Term Care System.
Building a system that will integrate the new payment methodology
For all the reasons outlined above, the Comprehensive Assessment Reporting Evaluation (CARE) was developed.

To develop the methodology, ADSA spent three years designing and conducting a time study to collect data on the time a caregiver spends on different types of clients for various care tasks. This data was then analyzed and a case-mix reimbursement system was developed, similar to how nursing homes are paid.

What is CARE?
The CARE tool is a new payment methodology that increases inter-rater reliability across different assessors looking at the same client as well as a payment method that more closely ties allocated resources to client needs.

The CARE tool has been designed to be an automated, client centered assessment system that is the basis for comprehensive care planning. The tool is compatible with the congressionally mandated Resident Assessment Instrument (RAI) used in nursing homes in the United States and several countries abroad. (The RAI is also referred to as the Minimum Data Set or MDS). The CARE tool assists assessors to gather definitive information on a client’s strengths and needs. It also aids staff to evaluate goal achievement and revise service plans accordingly by providing a tracking mechanism of changes in the client’s care needs.

Components of a CARE Case

Client Details
The Client Details section is where demographic information is kept. It also contains all of the client’s identified collateral contacts. This is a list of anyone who has contact with the client, including informal supports, doctors, religious representatives, family, friends, etc. Once entered here, this list can be used throughout the assessment, where appropriate.

Assessment
CARE takes the assessor and client/client representative through the process of identifying the care assistance that the client has received, the level of assistance provided, the continued assistance needed, and how the need will be met and/or continued to be met, either through informal provider(s), formal provider(s), or a combination of both.

The questions in CARE are designed to look at the client’s environmental issues, medical (medications; diagnosis; medication management; treatments; and pain), skin care indicators (foot care; skin care; and skin observation needs), communication (telephone use; vision; speech; and hearing), psychological/ social issues (cognition; memory; behavior; depression; suicide; sleep; relationships; interests; and decision making), personal elements (goals; legal issues; alcohol; substance abuse; and tobacco), the client’s activities of daily living  (mobility; toileting; eating; and hygiene) as well as instrumental
activities of daily living (transportation; shopping; wood supply; housework; finances; and pet care).

Within the assessment there are other standardized tools, such as the Mini-Mental Status Exam (MMSE), a depression questionnaire, and drug and alcohol questionnaires. These tools are designed to help determine whether the client may require referrals to other health or social service providers. There are also questions included in CARE that help to identify potential abuse or neglect issues, which if indicated would require a mandatory report to Adult Protective Services by the assessor.

**Care Plan**
Once the assessment has been completed, which includes the determination of ongoing client needs and how these needs will be met; the care plan displays the results of the eligibility and payment methodology algorithms. The level of care for residential settings and the hours for in-home care generated by CARE will determine the maximum payment to meet the client’s care plan needs.

The rate and level methodology is determined by a computer algorithm that evaluates the information entered into the CARE tool using the following four criteria: cognitive performance; clinical complexity; mood/behaviors; and activities of daily living (ADL).

In-home hours are then adjusted based on level of informal support available to assist client, which is determined during the assessment process.

**SER’s**
Any department representative with CARE rights is able to enter a Service Episode Record (SER), often referred to as a case note, for any client entered into CARE. This feature enhances communication between agency service providers who are providing services for the same client. The SER component to CARE is to document all contacts during the assessment, service plan, coordination, and monitoring of care, and termination of services.

**Reports**
Through CARE we have the ability to generate various reports, such as monitoring of assessment response times; the number of cases with nursing referrals; and a case management tickler system, to name a few. These reports will assist in internal monitoring and analysis of quality service delivery, risk management, and budgetary forecasting.

**Nursing Referrals**
If certain data elements or combinations of data elements are selected in CARE, they will trigger a critical indicator, which means the assessor needs to determine whether or not a referral to nursing services is warranted. Potential Critical Indicators include unstable/potentially unstable diagnosis; medication regimen affecting plan of care; nutritional status affecting plan of care; immobility risks affecting plan of care; and past
or present skin breakdown. The referring nurse has the ability to add nursing notes and SER notes to the joint serviced case.

**Implementing CARE Statewide**

CARE is systematically being implemented throughout the state of Washington. The roll-out of CARE began in June of 2003 in the Northwest Washington and will be fully implemented by February of 2004.