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Development of a Level of Care Assessment for the PACE Program

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A Capstone Project Entitled

Development of a Level of Care Assessment Using the Person-Occupation-Environment-Performance Model for PACE Program

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

By

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Abstract

Background/Purpose: At Franciscan Senior Health and Wellness PACE Program, the individuals served are 55 years or older and require skilled nursing level care. A programmatic need identified for the site included the creation and implementation of a tool to determine appropriate living environments for participants. Falls prevention was also identified as an area needing development. Falls commonly occur among the frail elderly and decreasing falls is a reoccurring challenge the PACE team faces with their participants.

Essential Features: A Level of Care Assessment was developed for the team to use when a participant asks about moving assisted living, or the team feels a participant may need to consider other living options. Once the tool was implemented, the student created and administered a survey to assess staff perception and acceptance of the level of care tool. The student also started the Center for Disease Control and Prevention (CDC) fall prevention Stopping Elderly Accidents, Deaths & Injuries (STEADI) program at PACE. The student gave presentations on implementing STEADI and use of the tool to increase staff understanding and acceptance.

Outcomes: The student effectively implemented the CDC's STEADI program at the PACE center to decrease falls by providing resources and consistent interventions for practitioners to follow. The student was also able to address the need for a level of care tool by creating the Level of Care Assessment. The student provided corresponding intervention charts, and protocols for use of the tool depending on the context. Acceptance of using the tool was high as determined by the survey. The survey results were presented to staff at an all staff meeting. A follow-up study is recommended to determine whether the changes at PACE decreased falls and increased participants quality of life over time.

Development of a Level of Care Assessment for the PACE Program

Literature Review

The Franciscan Senior Health and Wellness PACE Program is a member of the Program of All-Inclusive Care (PACE). PACE is a unique model of managed care available to individuals who meet the following requirements: 55 years of age or older, residing in one of the zip codes included in the PACE service area, require skilled nursing level care, defined as clinically eligible by the Indiana Area Agencies for Aging, and have the desire and ability to live safely in the community (Franciscan Health, 2018). Managed care in this setting is defined as an agreement between the service provider (PACE) and service recipient (PACE participant) agreeing to only receive health care services through Franciscan Senior Health and Wellness in place of Medicare and Medicaid benefits (Franciscan Senior Health & Wellness, 2014). The Franciscan PACE Program is one of 233 PACE centers located across 31 states. PACE provides all-inclusive healthcare to the participants of the program. PACE offers services including therapy (at home or in the clinic), attendance to the PACE adult day center, provides medications, medically necessary transportation, hospitalization or nursing care, durable medical equipment, doctors and nurses visits and more (National PACE Association, 2018).

The focus of the program is community-based treatment, so maintaining a participant's ability to live at home is very important. It is appropriate to address factors that promote independent living as well as factors that hinder it. While the PACE program strives to keep participants in their homes, some participants reside in assisted living and long-term care facilities depending on their needs. Safety is the main concern when working with participants and is the determining factor for staying in their homes. For this reason, home evaluations, home modifications, and falls prevention have been identified as areas influencing a participants' ability to live safely at home.

The Person Environment Occupation Performance theory (PEOP) was used to guide this research. The PEOP can be used to help understand how the person, occupation, and environment work together to produce the participants' occupational outcome or performance (Cole & Tufano, 2008). The participants' roles, tasks, and activities are important to consider when looking at performance and their ability to complete tasks is almost always influenced by the environment in which the activities are taking place (Cole & Tufano, 2008). With safety in the home being so important, the PEOP model can be used to assess and conceptualize occupational performance as the participants' environments are modified to be safer. With a safer functioning environment participants' occupational performance will improve as their daily tasks will be easier to complete. According to this model, dysfunction is viewed as a person experiencing limited occupational performance due to a restrictive environment, deficit in ability or health condition, or limiting barriers (Cole & Tufano, 2008). At PACE, therapists are working toward improving participants' overall function in the least restrictive and safest environment.

Falls are a common and reoccurring incident within the PACE population as well as the older adult population. According to the Centers for Disease Control (CDC), every second of every day an older adult falls and every 20 minutes an older adult dies because of a fall (CDC, 2017a). Falls result in a variety of injuries ranging from minor soft tissue damage to severe brain injuries and in some cases even death (Oliver, Healey, & Haines, 2010). Soft tissue damage, minor fractures, and even falls that do not result in injury have a negative impact on participants emotional and physical wellbeing. Falls have been shown to lead to increased anxiety, limited engagement within one's environment, and distress (Oliver, Healey, & Haines, 2010). Of the 104 participants who were enrolled in the PACE program for the entire 2017 year and did not dis-enroll or pass away, there were a total of 126 falls. Two participants fell seven times in 2017 and

three participants fell six times in 2017. PACE data revealed most falls occurred in August, with a record of 17 falls. The falls data was recorded by the site's quality coordinator.

There are many factors that influence falls, including both intrinsic and extrinsic factors. Intrinsic factors are defined as factors deriving from the individual, including age, diagnosis, cognition, other personal impairments, and previous falls (Grundstrom, Guse, & Layde, 2012). Extrinsic factors are outside of the participants control and may include: time of day, polypharmacy, or environmental factors such as home set up, or poor lighting (Grundstrom, Guse, & Layde, 2012). Furthermore, the CDC recognizes home hazards as one of the seven main risk factors linked to older adults falls (CDC, 2017b). Stevens, Baldwin, Ballesteros, Noonan, & Sleet (2012), state that risk factors for falls should be approached with great detail by addressing environmental factors, behavioral factors, biologic factors, and socioeconomic status. The PACE program does assess all aspects of the participants' personal factors, home-set up, and medical history, striving to address all factors using an interdisciplinary team.

With falls being such a prominent issue within the older adult population, interventions need to be implemented, especially considering that 78% of older adults' fall related injuries take place at or near their home (Pynoos, Steinman, & Nguyen, 2010). Research shows that the bulk of older adults in the United States want to remain in their homes and age in place (Fausset, Kelly, Rogers, & Fisk, 2011). Aging in place refers to a person's ability to remain in their own home safely as they age (Fausset, Kelly, Rogers, & Fisk, 2011). Home evaluations by skilled professionals are necessary for older adults with health conditions that may affect their safety and desire to reside in their homes (Stark et al., 2018). Home evaluations are completed to identify barriers in the home and influence recommended modifications to decrease environmental hazards (Pynoos, Steinman, & Nguyen, 2010). Home modifications may be

completed by occupational therapists as they have training and knowledge regarding home modifications, adaptive equipment, and the ability to assess the person, occupations, and the environment. When hazards are identified and removed by occupational therapists, falls are significantly reduced (Stark et al., 2018). A multifactorial assessment should be completed to determine safety in the home, not only a home evaluation, but also an occupational history, including falls, gait, balance, and cognition (Bradley, 2011). The PACE center does follow these common guidelines, completing initial evaluations that address falls, balance, home set-up, safety, and other related factors.

Home modifications are most beneficial to their intended audience when they consider the individual's current level of function, health status, and the way they interact with their environment (Pynoos, Steinman, & Nguyen, 2010). When modifications are suggested to be made to the home that are not client centered, the adherence rate can be as low as 33-40% (Stark, Landsbaum, Palmer, Somerville, & Morris, 2009). Individuals with home modifications have increased perceptions of daily task completion, increased activity performance, as well as demonstrate increased overall independence (Stark, Landsbaum, Palmer, Somerville, & Morris, 2009).

Common home modifications may include inexpensive measures such as removing throw rugs, removing clutter, adding additional lighting, grab bars, incorporating memory reminders, and addressing safety hazards. More expensive modifications may include equipment for bathroom safety, building a ramp, or extending doorways to accommodate a wheelchair. It is a common occurrence for older adults to be unable to identify all of the risk factors in their homes as identified by Horowitz, Nochajski, & Schweitzer (2013), finding that older adults looking for risk factors did not initially consider something in their home a safety concern, until it was put

into context by an occupational therapist. This provides further evidence for the importance of occupational therapists identifying hazards in the home and also providing recommendations for devices that may help keep participants safer.

Screening/Evaluation

Screening was completed over the course of two weeks. This was completed by observing treatment sessions with every discipline, attending meetings and gathering information on commonly mentioned concerns. Evaluating the site occurred through a needs assessment. A needs assessment is a combination of collecting, analyzing, and distributing information about an organization to understand and identify its needs (Scaffa & Reitz, 2014). The student completed a thorough needs assessment with the (IDT) to determine the needs of the site. The IDT includes an occupational therapist, physical therapist, physical therapy assistant, social workers, quality coordinator, nurse, nurse practitioner, recreational therapist, and home care coordinator. To complete the needs assessment, the student discussed the needs of the center in a group setting and one on one interviews, asking facilitating questions to determine concerns related to participant care. The student also aimed to identify the effects of the concerns on the participants. During a team meeting, it was brought up that multiple participants or their families had recently inquired about moving to an assisted living facility. A common concern among the interdisciplinary team was that there was not a standardized assessment to determine if a participant should move into an assisted living facility.

With PACE, all participants require nursing level care to qualify for the program, so every participant qualifies for assisted living (Franciscan Health, 2018). While this is true, the vision of PACE is to help participants remain in the community with the highest level of independence possible (National Pace Association, 2018). This means helping participants live

in their home for as long as possible and as safe as possible. Many PACE participants requiring a high level of care are successful at home when provided with home care hours and other recommended services. Providing the right supports in the home are crucial to maintain a participants' safety and ability to live at home (Fange & Ivanhoff, 2009). The PACE program nationally keeps about ninety percent of their participants living in the community, and this is the goal of all PACE programs (National PACE Association, 2018). Living at home is often considered safer for individuals with physical and cognitive impairments due to their familiarity with the environment (Fange & Ivanhoff, 2009). However, many studies also support modifying and changing home environments to increase safety and occupational performance.

If a participant is determined unsafe at home after all interventions have been implemented, then other options are discussed. Typically, the next step is to move into an assisted living facility. But, assisted living facilities are often costly, with research showing that many Americans cannot afford to move themselves or a family member into the types of assisted living facilities they prefer (Ball, Perkins, Hollingsworth, Whittington, & King, 2009). PACE provides subsidized housing rates for their participants residing in assisted living, and the participant pays a fixed amount out of pocket each month. This is a major benefit for individuals who need assisted living services to remain safe. Unfortunately, some PACE participants inquire about moving to assisted living only because of the cost, as the rent for assisted living may be less expensive with the subsided rate than what they are currently paying for their home. Without the subsidized rent, it is more cost effective for an individual to remain at home with both formal and informal caregivers than it is to move to an assisted living facility (Chappell, Dlitt, Hollander, Miller, & McWilliam, 2004). Participants are not able to move into an assisted living only for the cost break, they must also require the services provided. With PACE paying the

majority of the assisted living costs, it is imperative that the individuals moving to assisted living really require the services offered to be successful and safe.

After further research and an in-depth discussion with the quality coordinator and occupational therapist, the decision was made to begin working on a tool to assess appropriate living situations. The needs assessment also revealed a need for corresponding interventions including a program to address falls. The tool to determine living environments includes interventions to increase safety at home based on how participants score. This will improve quality of care, participant outcomes, and increase occupational performance. The tool provides clear guidelines to assist practitioners in determining the least restrictive environment for PACE participants and what interventions should be taken. The student analyzed current falls statistics, observed the current decision-making process, and collected information on the requirements for assisted living. The student also reviewed current policies and procedures regarding home safety, qualifications for home care hours, falls prevention, and transition services offered. The tool addresses the need for standardized procedures when determining if assisted living or other home environments are the least restrictive environments for the participants. The corresponding interventions ensure that there is consistency with implementation and the falls prevention program will keep people safer in their homes longer.

Determining whether someone is safe to live at home is a common service that occupational therapists and other health care providers provide. PACE, however, has a unique amount of stake in the decision. PACE is not only the service provider but also the insurance provider. Providing managed care gives PACE the ability to have skilled professionals determine what is necessary for their participants. Safety and quality care is always the goal during the decision-making process. The PACE team and the participant make the ultimate decision when

determining where a participant will live. In a traditional setting, a therapy team may make a recommendation for assisted living, but that does not mean that the individual will be able to afford it or will qualify. This form of service delivery varies from other models of care in terms of services and items covered. In most settings, a therapist may make a recommendation for a modification or device but that does not mean that the request will be fulfilled. PACE completes requests after they have been agreed upon by the interdisciplinary team as necessary to improve quality of life or provide greater care. PACE also offers many types of equipment and services that a standard insurance would not approve. For example, PACE will order lift chairs, pay for caregiver respite days, order blenders, pay for someone to help a participant pack their items in preparation to move, and cover types of adaptive equipment not covered by a standard insurance.

The PACE occupational therapy program runs similarly to a variety of other settings offering occupational therapy services. The occupational therapist (OT) working at PACE has outpatient therapy sessions with PACE participants who attend the adult day center. The OT also completes home visits for those who do not come to the adult day center or the clinic for treatment. This is a different service model than most, as the OT completes home visits, hospital visits, monitors participants' overall health status, and completes administrative insurance related tasks. To ensure quality of care is provided, treatments outside of the OTs comfort level or expertise, are referred to an in-network professional that can provide the appropriate care. Another difference between PACE and other centers, PACE therapists do not bill insurance for their time, as they are the insurance company and all services are covered. Instead therapists only document the time spent with the participant and the treatment details. PACE is a unique setting where the participants can receive therapy as needed, regardless of the progress they are or are not making. Occupational and physical therapy also hold a restorative daily exercise group for

those who attend the adult day center. For those who do not attend, they are provided with a custom home exercise program and frequently visited and re-assessed by members of the interdisciplinary team. This ensures quality care by skilled professionals even if they are not currently on caseload for skilled services.

Implementation Phase

Program Planning

After the student completed the needs assessment and identified the need for a tool to help determine the most appropriate living environments for PACE participants, program planning began. Program planning included first evaluating the current outline of information suggested by the quality coordinator. The student obtained a level of service form used by the assisted living facility that houses most of the PACE participants. This tool is used to determine how much care the assisted living facility must provide to PACE participants (Altenheim Health and Living Community, 2013). The quality coordinator reported that a portion of her original outline was adapted from this form. The student reviewed forms the team were already required to complete during IDT meetings. This was done to ensure the team would have time to complete an additional form and to better understand the standard scoring systems. Then the student discussed implementation with the staff to develop a timeline and completion date. Meetings were set for the interdisciplinary team (IDT) to examine the tool and make suggestions for edits as necessary. A projected completion date was set for three weeks from the date the student began working on the project. Meetings were held each Friday to determine the status of the tool until the tool was completed.

Development

The development process included first reviewing what the quality coordinator wanted in the tool and speaking with OT, PT, nursing, and social work to determine what factors they assess when evaluating safety at home. All of the suggestions were researched and added to the tool as they pertained to home safety and function. Items added to the original document included locomotion, transfers/bed mobility, stairs, and conditions or services that warrant an increase in level of care. Each item was divided into four scoring levels with corresponding percentages in the scoring definition to ensure valid scoring. The scoring of each item was rated based on the participants functional ability. A score of independent was worth zero points and was given when a participant could complete the task independently or modified independent. A score of minimal assistance was worth one point and was given when the participant requires supervision or set up to complete the task and performs 75% or more of the task. A score of moderate assistance was worth two points and given when the participant completed 50%-74% of the grooming task. A score of maximum assistance is worth three points and given when the participants completes less than 50% of the task. The student and the quality coordinator wanted a low score to indicate a lesser level of care for easy interpretation. The scoring and wording went through many stages of change throughout the creation process.

The sections of the new tool were established after speaking with the team and reviewing multiple different types of assessments and documents. Documents reviewed include: Medicaid Level of Service Assessment/Evaluation, The Occupational Therapy Practice Frameworks definitions of Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs), PACE Home Care Assessment Tool, Altenheim Functional Assessment, review of the FIM, and the AM-PAC "6-Clicks" (CMS, 2017; AOTA, 2014; VanderVeen, n.d.; Altenheim Health and Living Community, 2013; UBFA, 2001; Jette, et al., 2014). Once the tool was

completed, maximum points were totaled, and five levels of care were determined. The Level of Care Assessment was created and reviewed by multiple parties, including the student, PTA, quality coordinator, and OT to ensure all relevant areas of evaluation were included in the new tool. Wording and formatting errors were addressed by the student prior to presenting the tool to the entire team.

Levels were determined to give a clearer understanding in which environments the participants might be the most successful. The student established the total score for the tool, not including additional points given for falls and hospitalizations. The total was established by adding the total points. After determining the highest score, the student and the quality coordinator determined a need for levels including: home, assisted living, and long-term care. After assessing a total of 20 participants at various levels using the tool, the need for 5 levels were established. The total points were distributed between five levels with the first two levels consisting of one more point each. Levels 1 and 2 participants will be most successful at home, levels 3 and 4 most appropriate for assisted living, and level 5 most appropriate for long term care. Consistent with the PACE mission, everyone who can live at home will have the opportunity to try with the correct supports (National Pace Association, 2018). Therefore, interventions for each level were created with recommendations or requirements to keep a participant in their home. The team determined that if all interventions were implemented and the participant was still not successful at home, then the IDT would reassess and consider assisted living (See Appendix B and C).

Inter-rater reliability is established when multiple raters use the same tool and then compare their results to ensure scoring is synonymous across all raters (Sullivan, 2011). Determining inter-rater reliability differs in this setting as the tool is meant to be completed as a

team. The tool would not produce accurate results if each team member completed the assessment individually, as every team member brings different information about the participant to the discussion. There were no duplicate positions, so the student was unable to have different teams complete the tool and compare results to determine reliability. Test-retest reliability is present when an assessment tool produces the same results each time it is completed without change in the participants status (Sullivan, 2011). Test-retest reliability was established by completing the tool, measuring the same participants functional abilities at different times and producing reliable and consistent results. Test-retest reliability was also established after comparing the initial participant's assessments that the student and the quality coordinator completed to the official participant's assessments completed as a team. While the scores varied slightly, the level the participant was placed in remained consistent.

Content validity is achieved when a test measures what it is was designed to measure (Sullivan, 2011). Content validity was agreed upon as established by the team after completing the tool and assessing ADLs and IADLs consistent with the OT evaluation, mobility consistent with how the PT evaluated the participant, and the cognition questions consistent with what social work assessed. The scoring was valid because the student completed training with the staff to ensure they were competent and comfortable using the tool and understood how to complete the scoring. Validity was also addressed through the feedback survey given by the student. One question of the survey addressed how accurately the Level of Care Assessment determined the correct level of care. Sixty-seven percent of staff strongly agreed the tool accurately determined appropriate levels of care and thirty three percent agreed. Full results of the survey are disclosed later in the paper.

The tool was utilized with PACE participants to determine the validity of the results. The IDT used the tool, assessing many participants of the PACE program. Participants were chosen to be scored based on their known need of assistance level and ranged from needing low levels of care to high levels of care. The assessments were completed multiple times over multiple days, showing the tool to be reliable and valid. (See Appendix A).

The student also addressed the concern of needing a falls prevention program and began researching the Center for Disease Control and Prevention (CDC)'s program Stopping Elderly Accidents, Deaths and Injuries (STEADI) (CDC, 2017b). The student took the online STEADI certification course and received a certificate of completion. The student then compiled the STEADI resources and created a short presentation to present to the therapy team and gain interest in incorporating the program.

The student created a flowsheet formula that will auto populate into participant flowsheets in the sites documentation system. The flowsheet will list the screening questions that STEADI suggests practitioners first ask. The flowsheet then provides a number based on how the participant answers the screening questions to determine if the participant is a fall risk. The student also created a smartnote in the facilities' documentation system outlining what steps need to be taken per STEADI protocol after a fall. The smartnote has an outline of which assessments need to be completed with the participant. A second smartnote was created to outline what preventative fall interventions should be implemented after screening. The interventions provided by STEADI vary based on how at risk the participant is for falling. These interventions were woven into the Level of Care Assessment mentioned above. This was done because the CDC STEADI program is highly regarded in terms of falls prevention, provides standardized

gait and balance assessments, effective screening tools, and includes methods to incorporate STEADI into practice (CDC, 2017b).

Implementation

Implementation of a program is the progression of beginning a new process or use of a new tool. Starting a new program functions best when the current staff is interested in a change, leaders are intent on improvement, a need has been identified, and there is a means for action (Hebert, Thibeault, Landry, Boisvenu, & Laporte, 2000). At PACE, implementation of the new Level of Care Assessment was simple to incorporate into current practice. The staff was receptive to the use of the tool and had previously expressed a desire for a tool of this type. The tool was ready for use with the IDT after educating the IDT on how it worked and what each category encompassed.

The form will be completed once a year by the IDT using their collective knowledge of the participant; meaning that the tool will be completed without the participant present. The tool was also completed within the first month of a new participant joining PACE to establish a baseline. The tool may be completed more frequently if participants are eligible for a level of care re-assessment, if the participant or their family has inquired about moving to assisted living, or if the participant has experienced a significant change. In this setting a significant change is classified as two or more disciplines in the IDT identifying a significant change relevant to their discipline. IDT meetings occurred once a week and the quality coordinator sent out a list of participants that were due for review. The IDT completed the tool collaboratively determining the appropriate score for each item listed. The tool included information ranging from number of falls and hospitalizations to the amount of assistance a participant needed with ADLs, IADLs, and mobility. The team used their clinical judgement to select the appropriate interventions from

the interventions lists based on the participant's score and corresponding level. These interventions are recorded at the bottom of the tool and the tool is uploaded to the participants' chart. Once the tool has been completed, the results of the tool will be conveyed to the participant and their family both in person and in writing.

Implementation of the STEADI protocol was not near as seamless as implementation of the Level of Care Assessment. The PT and OT on site were very excited and receptive to introducing a falls prevention program. The program was implemented once the therapists completed the online training course, the smartnotes were ready for use, and the student had provided therapists with all relevant handouts. The student and dietician created a Vitamin D and Calcium protocol for the nurses to implement with new participants and participants at risk for falls. The protocol includes dosages and frequencies of labs and recommendations based on falls status. However, the student continued to receive slight push back from nursing staff despite education and the rest of the team being on board. to The OT and PT began implementing the STEADI protocol by completing the algorithm and screening questions provided by STEADI to determine how at risk a participant was for falling. The current goal is to begin using the algorithm on those who have just fallen and new participants. Eventually the site hopes the screening will have been completed with every participant. Once screened, the PT then completes a gait and balance test with the participant, and OT completes a vision screen as part of their initial assessment. If a fall has occurred, therapists review the interventions and complete as appropriate. STEADI classifies older adults into categories of low risk, moderate risk, and high risk with individualized interventions for each and these responsibilities were divided between disciplines for even implementation (CDC, 2017b).

Leadership

The student demonstrated leadership skills by developing a detailed plan for completion and review of the Level of Care Assessment tool. The student was also responsible for establishing and facilitating discussions to decide upon completion and implementation dates for the tool. The student further demonstrated leadership skills by requesting meetings with involved parties to review the use of tool and when it should be completed in the care plan process. As an independent student, it was imperative to schedule meetings with other disciplines to ensure collaborative and interdisciplinary input. As a student, it was important to ensure that the meetings were on track, purposeful, and always occurred on time. This type of project is very independent and self-initiated therefore, it is important to remain focused and on top of the project at hand. The student maximized time by delving into the literature to provide practitioners with relevant information and to better understand effective interventions for participants. Having effective leadership skills improved not only the quality of the tool produced but also made the implementation phase seamless. Building rapport with other professionals at the site during the doctoral capstone experience also assisted in the implementation of the tool.

To market the tool, the student requested time to speak to the team during an IDT meeting. The student emphasized that the new tool may take time to complete but it has many of the same components as the forms required for the Levels of Service Assessments and the Functional Assessments to be completed for an assisted living community. Having this information in one central location makes it easier for the social work team to complete these forms. The social work team will no longer have to take time out of their days to speak with each discipline separately. The student explained that the tool with corresponding interventions will also simplify the Home Care Coordinators evaluation of needed home care hours. The home care

coordinator reported she did not prefer using the current home care assessment tool and was excited to have the levels of care tool help determine hours. With the help of the PTA and the home care coordinator, suggested home care hours were built into the intervention section of the new Level of Care Assessment based on the participants' level. A benefit of the tool is that it provides a score and concrete reasons as to why a certain participant may or may not be appropriate for assisted living. It also provides a simple way to indicate to a participant or their families why assisted living is the recommendation of the team. The last piece of information the student presented during the IDT meeting was the benefit of having an electronic template that can be easily saved into the participant folder and updated as needed. This allows for a simple update to be made to the form when the participant is re-evaluated.

To market the STEADI program, the student gave a short presentation during an IDT meeting. The student worked through the algorithm and explained the benefits of starting a specific falls prevention program. The student also showed the team how to access the online training and how to submit their post test results to earn continuing education credits (CEUs). Most staff members were intrigued by the free online course and CEUs. The quality coordinator was receptive to beginning the program as she will now have specific interventions to include with her falls tracking. The quality coordinator is responsible for tracking and enforcing the STEADI portion of the falls interventions.

Staff Development

Staff development was addressed by explaining the Level of Care Assessment in great detail. The student and the quality coordinator explained how to complete the tool, how to work the auto-totaling features, determine suggested level of care, and read the intervention charts. This form was completed during IDT meetings, with one person controlling the computer and

inputting the data while it was projected on the screen. This was done to ensure that every discipline was involved and understood how each section was being rated. Staff development was promoted by requiring the forms to be completed as a group. This was also achieved through the continuous knowledge gained by reviewing participants' needs and other disciplines' treatment approaches. The team was asked to review participants before they attended the IDT meetings. This has always been a requirement and the staff did a good job of knowing their participants and arriving prepared. Staff members were competent in their job descriptions and capable of completing the tool accurately and efficiently. The quality coordinator was required to come with data on the participants being reviewed, including number of falls, hospital admissions, and number of medications. The quality coordinator was also in charge of tracking intervention implementation and sending out reminder emails to review certain participants before the meetings. She was responsible for continued staff education and management tasks related to completing the tool once the student left.

Further staff development was incorporated by educating the staff on the number of falls occurring each month and per participant on average at PACE. This was followed up by giving brief information about the implementation of the STEADI protocol. The student strongly suggested all participants of the IDT completed the online certification training for STEADI falls prevention. The course not only offered CEUs but valuable information that was very relevant to everyday practice at PACE.

Outcome/Discontinuation Phase

Outcome

During the outcome phase, the student established how the changes to the PACE Program had been received by the staff. The Level of Care Assessment will be an ongoing tool that will

continue to be used after the student has completed the capstone experience. The goals behind creating the Level of Care Assessment include creating a standardized tool that will be completed once yearly to help determine appropriate living situations, decrease falls, increase quality of care, and establish a way to provide consistent and effective interventions. It is not possible to effectively determine participant outcomes after use of the tool and interventions now. These outcomes will need to be determined longitudinally.

During the student's time at the site, five participants were transitioning from their homes into an assisted living facility per the results of the tool. However, the student was unable to determine if the interventions have decreased falls or resulted in increased quality of life for these participants due to the recency of implementation. The student did, however, administer a survey to the members of the IDT requesting information about the new tool (See Appendix D). The survey was brief, containing five questions. Four questions required members of the IDT to rate each question using a Likert scale, rating each item on a scale from one to five. A score of one indicates the IDT member strongly disagrees with the statement, while five indicated they strongly agree. The questions on the survey covered ease of use of the tool, accuracy, relevance, and whether utilization would improve quality of care. The fifth question asked for a narrative response, asking the members of the IDT for suggestions and comments regarding the implementation or use of the tool.

The paper survey was dispersed to the ten members of the IDT. The student and the quality coordinator did not take the survey to avoid bias. The results of the survey are as follows: out of the ten surveys, nine were returned. Staff members were asked to complete and return the survey within five business days. Overall, there was good acceptance of the Level of Care Assessment. Questions three, and four had the same results, 55.6% of staff members reported

these items as a 5, strongly agree. For questions three and four, 44.4% rated these three items as 4s, meaning they agree. The lowest rated item was the first question regarding the language used on the tool, with 55.6% of respondents reporting they strongly agreed that the tool was easy to use, 33.3% agreed it was easy to use, and one respondent, accounting for 11.1% reported a 3, neutral. The highest rated question was question two, with 66.7% of staff members reporting they strongly agreed the tool accurately determined levels of care, and 33.3% stating they agreed. The qualitative data obtained from the last question had a common theme with two members of the IDT leaving comments related to determining the consistency and goals of the tool and the interventions. One IDT member wrote, "So far it [the tool] is very useful and helpful." After the results of the survey were analyzed, the student took the results to the IDT meeting and asked for more feedback from the IDT to assure that the tool was something they felt comfortable using and to address common themes identified by the survey. The team came up with the idea to also use the tool to establish a baseline at initial evaluation, as this was not an initial consideration of the student and the quality coordinator. Using the tool at evaluation and throughout the year will help track changes in participant independence levels over time. The team also requested specific protocols be developed for each situation that they tool may be used in, so they would know exactly how to proceed. The student created protocols for each of the four situation the tool would be used. The protocols were approved by the quality coordinator and agreed upon by the team. The protocols were sent via email to the team containing specific protocols. The team reported the protocols made using the tool much simpler, as they now know in what order to complete the preliminary work.

The student also tracked the use of the Level of Care Assessment and recorded who the tool was used with by documenting the participants' private PACE ID number. The student kept

a password secure excel document and recorded the level each participant was placed in, their current living situation, number of falls in the past year, interventions chosen by the team, and the participant outcome.

Integrating the STEADI program was an ongoing component of the student's project. Therapy staff was been receptive to using the smartnotes and smartphrases designed for following STEADI protocols in EPIC. The PT reported, "I really appreciate having the STEADI smartnotes, it helps me know exactly what to assess" (Major. J, personal communication, February 26, 2018). The long-term goal of implementing the STEADI protocol was to decrease falls. This cannot be determined at this time due to the how recently the STEADI protocols have been accepted into practice.

The student met goals established in the memorandum of understanding (MOU). The MOU went through several revisions as the student identified needs of the site. The student developed a level of care assessment tool utilizing aspects of home evaluation tools, literature, assisted living facility requirements, and effective interventions. The student also met the goal of becoming certified in the CDC STEADI Falls Prevention Program and implementing STEADI protocols. During the project, the student assisted with the development of a database, compiled evidence related to falls prevention and created a binder of literature for the site. The student was also able to research alternative living models including the Emerson House, Green House Cottages of Carmel, and review literature regarding alternate and successful living models globally.

Discontinuation

The ongoing process for quality improvement once the student has left the facility will be completed by the quality coordinator. As mentioned above, the student is currently tracking

when the Level of Care Assessment was completed, and other important information. The excel document will be given to the quality coordinator for her to continue the tracking once the student has completed the project. The program changes that were implemented to ensure quality of services included starting to use the new tool and implementing more interventions after falls. The student worked closely with the quality coordinator to modify the previous administrative process for determining appropriate living environments. The previous process included filling out a Resource Allocation Decision Form (RAD) and bringing it to the IDT meeting. The team would then discuss the request to move to an assisted living facility. The team would collaboratively determine whether the participant was appropriate and would relay the information to the participant. The IDT recognized that this was not the most effective way to determine such an impactful decision. With the tool, the team has a concrete number to give to participants when delivering the news of if they should move or stay home and directly correlated interventions to promote community living. The changes to the process were discussed with the IDT during a level of care meeting to promote a team approach to completing the tool and selecting the interventions.

The student consulted with the PT and the OT and they agreed to continue incorporating the STEADI protocols into their evaluations and treatments after the project is done. With the treatment and assessment smartnotes already in EPIC, and staff proficient in following all STEADI protocols, it will be easy to continue use. The quality coordinator is tracking the STEADI interventions implemented after a participant falls. She will continue to track implementation of STEADI interventions and determine whether or not using STEADI has helped PACE reach the goals set prior to beginning the program. The main goal attached to

implementing the STEADI program was to decrease falls. Falls are tracked by the quality coordinator and the student and PACE hope to see a decrease over time.

Societal Needs

It was important to the student that the tool was both occupation and performance based. The student used the PEOP model to guide understanding of how client factors, occupations, and the environment, influence overall performance. It was imperative that participant function was captured through the tool, as the participants' functional abilities are the greatest influencer of their success and safety at home. This project greatly impacted the needs of society by assisting the PACE program in completing their mission of keeping their participants safe at home. Creation of the tool responded to the needs of the IDT and to the needs of the participants. Intervention charts provided are aiding the staff in developing consistent and effective interventions for participants and is also improving quality of services provided. Starting the STEADI program is also responding to society's need of decreasing fall in older adults. The STEADI program presents as a simple tool to help ensure that the staff is consistent across the board when completing fall risk assessments and treating at high fall risk participants.

The student used this opportunity to further advocate for occupational therapy and occupational therapy's role as a consultant. Identifying as a consultant was a strategy the student used to build trust and positive relationships. Other disciplines and staff members appreciated being consulted on current practice and new policies.

Overall Learning/Communication

Overall Learning

This DCE focused on program development, policy development, and education. The student worked with multiple disciplines to develop a level of care tool and corresponding

interventions to be used with participants to determine their most successful living environment. The student established protocols for use of the Level of Care Assessment to decrease confusion on how/when to use the form. The protocols were developed after analyzing the feedback from the survey distributed to the staff. The student also completed implementing the STEADI protocol for Fall's prevention. She created notes in EPIC, held a short in-service on the benefits of the fall prevention program for both PACE staff and management, and started a balance group with the PT. The student also created a body of knowledge for the site. She included information on falls prevention, home modification, cognitive interventions, and the STEADI program. All literature included in the binder is peer reviewed and provides evidence to support the interventions the student implemented.

The student gained knowledge throughout the doctoral capstone experience that will be utilized in future practice. The student developed her critical thinking skills while problem solving through the site's needs assessment and daily problems. Critical thinking skills were also developed during extensive exploration into building the Level of Care Assessment and interventions. Critical thinking skills will be essential to practice when evaluating patients, treating, and producing new interventions. The student also increased her research skills. The student spent weeks researching articles on topics related to the project. The time and effort spent on research gave the student insight into how to determine key words, identify relevant articles, and request articles from external sources. Effective research habits will be extremely helpful in practice. The student will be able to use her knowledge to further her practice skills and successfully implement evidence-based interventions into practice. This will also assist the student in maintaining her professional licensure as she has the skills to search and identify relevant information.

The Doctoral Capstone Experience was unique in the fact that the student had to be very self-directed in her leaning and self-sufficient in identifying resources. The ability to work independently and remain focused is a great skill to have in any practice setting the student may work in. Time management skills were also essential to complete all projects at the site, assignments for the school, and attend all required meetings. The ability to manage time efficiently is a skill that is consistently utilized during treatment sessions and documentation. The student also had the opportunity to plan, develop, organize, and market her tool. This is something that not everyone has an opportunity to do and will be beneficial in the future if the student sees a need for a problem in her future employment. The student demonstrated leadership and advocacy when explaining the project that she would like to complete at the PACE center. She advocated for the participants by choosing to implement a falls prevention program, STEADI to improve quality of life. Creating a level of care tool to help accurately determine living situations based on participants occupational performance in their current environment was also a way for the student to advocate for the best outcome for PACE participants.

The student participated in weekly forum posts with her classmates. These forum posts helped the student become a more reflective practitioner by prompting her to think about where she was at, what still needed to be done, and why the project was important. To help establish competency in implementation of a program and gain a better understanding of the practice area, the student completed other assignments including a scholarly report for presentation and her doctoral capstone paper. Overall, the student had exposure to working with many disciplines in an emerging area of practice, experienced a variety of treatment styles, and met many passionate individuals.

Communication

The student interacted professionally and effectively when communicating with individuals at the PACE Program. The student had the opportunity to interact with clients during treatment sessions and home evaluations. The student offered her expertise in fabricating custom orthoses, ordering pre-fabricated orthoses, and making adjustments as needed. The student also interacted verbally with the participants when leading balance group, stretching group, and exercise group. The student had the opportunity to interact with the participant's families and significant others during care plan meetings and home evaluations. This was an important piece of the student's project, as the aim was to implement long lasting interventions.

Oral and written communication was utilized with colleagues as the student collaborated with various disciplines on the project. The student delivered presentations on the STEADI program, use of the Level of Care Assessment, and implementation of additional fall prevention interventions. The student utilized written communication when discussing the Level of Care Assessment with another PACE program in Indiana. The student provided a detailed email of how to use the Level of Care Assessment and the corresponding interventions.

Non-verbal communication was essential when interacting with both participants and colleagues. Many PACE participants do not speak English or have progressed dementia and no longer understand verbal communication. Remaining sincere and kind was necessary when communicating with these individuals. The student was also aware of nonverbal communication when discussing implementation of the STEADI program with colleagues. The student did not always get the responses or the results she was aiming for. Maintaining a professional stance and awareness of nonverbal communication helped preserve rapport and respect.

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Appendix A.

Franciscan SENIOR HEALTH & WELLNESS
Program of All-Inclusive Care for the Elderly – PACE

PACE Level of Care Assessment

Participant Demographics	
Participant Name:	Date completed:
Medical Record Number/PACE ID #:	
Current Living Environment:	
Is participant able to participate in medical treatment decisions:	
If non-decisional, who is active POA for healthcare, finances:	
Reason for request:	☐ Service Request ☐ Yearly Assessment ☐ Significant change ☐ Initial Assessment

Assessment of Needs

Define the issues surrounding the request for placement based on current situation and issues, not risk projection.

Hygiene and Grooming		POINTS	***Mobility (Walking or w/c)***		POINTS
Independent	Self-completes grooming tasks including brushing teeth, combing hair, washing hands etc., with no assistance or cues. May use assistive device or aid.	0	Independent	Able to walk minimum 150 feet with or without adaptive equipment, or 150 feet of locomotion using w/c or motorized chair if primary means of locomotion.	0
Minimal	Requires supervision or set-up to complete task. Performs 75% or more of grooming tasks.	1	Minimal	Performs 75% or more for minimum of 150 feet with use of w/c or motorized chair, or requires setup or supervision while ambulating.	1
Moderate	Completes 50%-74% of grooming tasks.	2	Moderate	Performs 50-74% of locomotion effort to go a minimum of 150 feet.	2
Maximum	Assisted with all aspects of hygiene with participants completing less than 50% of grooming tasks.	3	Maximum	Performs less than 50% of locomotion effort, or requires assistance of two people. Walks or wheels less than 50 feet.	3
	Score			**Score**	

Transfers/ Bed mobility		POINTS	***Stairs***		POINTS
Independent	Safely approaches and transfers from a chair, w/c, bed or other surface and returns safely. May use adaptive or assistive device or require additional time.	0	Independent	Safely goes up and down 12-14 stairs indoors, may use assistive devices, side support, hand rail, cane or requires additional time OR participant does not have stairs in their home.	0
Minimal	Requires supervision (stand-by or cuing) or set-up (moving foot rests, positioning), or minimal contact while performing 75% or more of transfer and bed mobility.	1	Minimal	Requires supervision (stand-by or cuing) or set-up or minimal contact while performing 75% or more of the effort to go up and down one flight of stairs. OR able to go up and down 4-6 stairs independently with or without device.	1
Moderate	Requires more help than touching or performs 50-75% of transfer and bed mobility.	2	Moderate	Requires consistently contact guard or steadying assistance to go up/down 12-14 stairs.	2
Maximum	Performs less than 50% of transfer and bed mobility or requires use of mechanical lift, or helper providing most of lifting effort.	3	Maximum	Performs less than 50% of effort to go up/down 4-6 people or requires assistance of one or more helpers, or goes up and down fewer than 4 stairs.	3
	Score			**Score**	

Dressing		POINTS	***Bathing***		POINTS
Independent	Chooses appropriate clothing and dresses self, including footwear and prosthesis or orthosis, may use assistive device.	0	Independent	Safely bathes (washes, rinses, dries) may use adaptive equipment, require additional time, or have minor safety concerns.	0
Minimal	Requires supervision or set-up to complete task, cuing to complete, performs 75% or more of dressing task. May need help with buttons, zippers.	1	Minimal	Requires supervision or set-up, initial preparation of materials, or minimal contact assistance, performs more than 75% of task.	1
Moderate	Performs 50-74% of dressing tasks.	2	Moderate	Performs 50-74% of bathing task, assistance with hard to reach areas.	2
Maximum	Performs less than 50% of dressing task, unable to choose clothing, or perform basic activities.	3	Maximum	Performs less than 50% of bathing task, including assistance with holding washcloth and towel to wash and dry.	3
	Score			**Score**	
Toileting		POINTS	***Incontinence***		POINTS
Independent	Safely adjusts clothing before and after toileting, may use adaptive equipment.	0	Independent	Controls bladder/bowel completely and intentionally, may use assistive device for for bladder/bowel management or medication, with no accidents.	0
Minimal	Requires supervision or set-up, initial preparation of materials or minimal contact assistance. Performs more than 75% of task. Uses protective pads or garments.	1	Minimal	Requires supervision, cuing, or set-up of bladder/bowel management equipment, or occasional assistance managing devices, with 1-2 accidents in last 7 days.	1
Moderate	Performs 50-74% of task. Requires hands on steading assistance while adjusting clothing or cleansing self or assistance. Uses protective pads or garments.	2	Moderate	Assistance maintaining external device, able to manage 50%-74% of the time, with 3 accidents in the past 7 days.	2
Maximum	Performs less than 50% of toileting task, assistance adjusting, cleansing, or incontinent of bowel and bladder.	3	Maximum	Performs less than 50% of bladder/bowel management tasks, helper managing all equipment, or 4 or more accidents in past 7 days.	3
	Score			**Score**	
Medications		POINTS	***Cooking***		POINTS
Independent	Independent with MAK pack.	0	Independent	Safely prepares meals, may use assistive devices, may take extra time to complete without assistance or cues.	0
Minimal	Occasionally seeks guidance from caregiver/RN or may use medication reminder/dispenser devices.	1	Minimal	Completes simple meal prep with minimal assistance, able to microwave meals, may require supervision or set-up.	1
Moderate	Requires physical assistance and daily cuing to take medications.	2	Moderate	Performs 50-74% of meal preparation, needs assistance cutting food.	2
Maximum	Caregiver gives all medications.	3	Maximum	Performs less than 50% of cooking tasks or total assistance with meals required.	3
	Score			**Score**	

Finances		POINTS	***Eating***		POINTS
Independent	Able to manage own finances.	0	Independent	Safely eats a variety of foods independently, may use adaptive or assistive devices.	0
Minimal	Needs minimal assistance from caregivers with finances. May require supervision or set-up.	1	Minimal	Requires supervision or set-up, cuing, or help to open containers, cut food, or placement of utensils.	1
Moderate	Needs continual cues and reminders from caregiver regarding finances.	2	Moderate	Requires more assistance with eating, performs 50-74% of eating task.	2
Maximum	Caregiver manages all finances.	3	Maximum	Cueing and physical assistance to complete meals.	3
	Score			**Score**	

Health Management					
Home Care Services	POINTS		***Condition/Service***		POINTS
Light House Keeping	☐ 1		Respiratory	Inhaler/Breathing Treatment	☐ 1
Grocery Shopping	☐ 1		Oxygen/CPAP	PRN/Continuous	☐ 1
Meal Prep	☐ 1		Orthopedic Appliances	Orthosis/orthotics	☐ 1
Bathing Assistance	☐ 2		Pain Management	PRN/Scheduled	☐ 1
Incontinent Care	☐ 2		Bleeding Precaution	On Blood Thinner	☐ 1
Occasional ADL Assistance	☐ 3		Redirection	Dementia	☐ 1
Unable to make needs and wants known	☐ 3		Diabetic Care	Accuchecks	☐ 1
24/7 Monitoring Required	☐ 4		Catheter	Maintain on own	☐ 1
Add points above manually for this section -->			Dialysis		☐ 1
Current Home Care Hours	POINTS		Scheduled/skilled treatments		☐ 1
1-5 Hours a week	1		Ostomy	Maintain on own	☐ 1
6-12 Hours a week/ Level 1	2		***Add points above manually for this section -->***		
13-20 Hours a week/Level 2	3				
21 or more Hours a week/Level 3	4				
Score					

Cognitive/Behavioral					
Communication		POINTS	***Cognitive Ability***		POINTS
Independent	Understands and able to communicate without difficulty.	0	Independent	A&O, makes consistent and reasonable decisions.	0
Minimal	Responds appropriately, may require verbal cues, able to express daily needs and ideas.	1	Minimal	Needs verbal orientation, makes safe decisions in familiar situations, judgement inconsistent.	1
Moderate	Responds appropriately, requires frequent verbal cues and reminders, requires assistance at times to express daily needs and ideas.	2	Moderate	Memory loss and confusion, possible dementia, requires supervision throughout the day, occasional redirection, poor judgement, difficulty with complex commands, potential issues with others.	2
Maximum	Participant unable to respond appropriately (rambling, aphasic, repetitive speech).	3	Maximum	Severe Memory loss and confusion, requires frequent supervision, potentially disoriented to time, place, and purpose, needs constant verbal direction and instruction, makes unsafe decisions, emotional state not easily altered by staff after non-pharmacologic intervention.	3
	Score			**Score**	

Mood/Behavior		POINTS	***Psychosocial Well Being***		POINTS
Independent	Consistent, pleasant, reasonable, and controlled moods.	0	Independent	Interacts with others, healthy mental attitude.	0
Minimal	Episodes involving physical/verbal/ disruptive behavior, anxiety, sad moods, agitation, sexual inappropriateness, aggression, difficult to reason with at times especially in unfamiliar or stressful situations.	1	Minimal	Needs verbal orientation and direction at times, occasionally exhibits inappropriate mood, needs encouragement to interact with others in a group setting.	1
Moderate	Episodes involving physical/verbal/ disruptive behavior, anxiety, sad moods, agitation, sexual inappropriateness, aggression, difficult to reason with, requires ongoing monitoring and intervention to alter the episode.	2	Moderate	Occasionally exhibits inappropriate mood changes, difficulty to reason with, tearfulness, requires regular cuing and direction to participate in activities, encouragement to initiate appropriate interactions with others.	2
Maximum	Episodes have become routine, requires one on one monitoring and interventions.	3	Maximum	Does not interact with others, internal wandering, emotional state potentially upsetting to others, judgement is poor, requires constant verbal reminders, disoriented to time, place, and purpose.	3
	Score			**Score**	
Other Concerns					
Elopement Risk	***YES= 1 point***		***Ongoing substance abuse (including nicotine)?***	***YES= 1 point***	
Documented non-compliance with intact cognition?	***YES= 1 point***		***Physical Agitation/violence that does not respond to tx?***	***YES= 1 point***	
Hospitalizations/ ED visit in the past year	***Each hospitalization= 1 point***		***Falls in the past year***	***Each fall= 1 point***	
Medications	***Taking 9-15 medications= 1 point***		***Medications***	***Taking 16+ medications= 2 points***	
Outcome		**0**			**0**
Total Points:			**0**		

Levels		Interventions (Identify as appropriate for participant)
Level 1	**0-17**	
Level 2	**18-35**	
Level 3	**36-52**	
Level 4	**53-69**	
Level 5	**70-86**	
Re-assess in ____ months.		

Appendix B.

Intervention Guidelines for Level of Care - For Home

Level	Home Care Hours	Attendance Assessment	Multidisciplinary Home Safety Evaluation	Nursing Medication Management	Fall Risk Evaluation STEADI
1	1-5 Hours/7 wk -IADL support -Informal supplemental care recommended	1-3 Days/7 wk -Socialization -Restorative program -Nursing/MD appts	-Assess home equipment needs for ADLs, IADLs & O2 -Assess home equipment needs for mobility -Assess bathroom safety -Assess kitchen safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication check-ins bi weekly or monthly -Medication management plan established with participant, family and home caregiver.	-Low to Moderate fall risk -Home exercise program -Home safety modifications
2	6-12 Hours/7 wk -IADL support -Basic ADL support -Fall supervision -Informal supplemental care recommended	2-3 Days/7 wk -Socialization -Restorative program -Nursing/MD appts	-Assess home equipment needs for ADLs, IADLs & O2 -Assess home equipment needs for mobility -Assess bathroom safety -Assess kitchen safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication review -Medication check-ins bi weekly -Medication management plan established with participant, family and home caregiver.	-Moderate to High fall risk -Home exercise program to do with informal/formal ca -Home safety modifications -Outpatient PT/OT -Foot care/Footwear check -Visual testing and clearanc
3	13-20 Hours/7 wk -IADL support -ADL support -Fall supervision -Informal supplemental care recommended	2-5 Days/7 wk -Socialization -Restorative program -Nursing/MD appts -Showering at center -Regular vital sign checks -Skincare checks	-Assess home equipment needs for ADLs, IADLs & O2 -Assess home equipment needs for mobility -Assess bathroom safety -Assess kitchen safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication review -Medication check-ins 3-4x/7 month -Medication management plan established with participant, family and home caregiver.	-Moderate to High fall risk -Home exercise program to do with informal/formal ca -Home safety modifications -Outpatient PT/OT -Foot care/Footwear check -Visual testing and clearanc
4	21-26 Hours/7 wk -IADL support -ADL support -Fall supervision -Informal supplemental care required	3-5 Days/7 wk -Socialization -Restorative program -Nursing/MD appts -Showering at center -Regular vital sign checks -Skincare checks	-Assess home equipment needs for ADLs, IADLs & O2 -Assess home equipment needs for mobility -Assess bathroom safety -Assess kitchen safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication review -Medication check-ins weekly -Medication management plan established with participant, family and home caregiver.	-High fall risk -Home exercise program to do with informal/formal ca -Home mobility modificatio -Home safety modifications -Outpatient PT/OT -Foot care/Footwear check -Visual testing and clearanc
5	>27 Hours/7 wk -IADL support -ADL support -Fall supervision -Informal supplemental care required	3-5 Days/7 wk -Socialization -Restorative program -Nursing/MD appts -Showering at center -Regular vital sign checks -Skincare checks	-Assess home equipment needs for ADLs, IADLs & O2 -Assess home equipment needs for mobility -Assess bathroom safety -Assess kitchen safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication review -Medication check-ins weekly -Medication management plan established with participant, family and home caregiver.	-High fall risk -Home exercise program to do with informal/formal ca -Home mobility modificatio -Home safety modifications -Outpatient PT/OT -Foot care/Footwear check -Visual testing and clearanc

Appendix C.

Intervention Guidelines for Level of Care – For Assisted Living and Long Term Care

LEVELS 1-3 Attempt to provide services for home per PACE Mission and Goals (See home guidelines sheet)

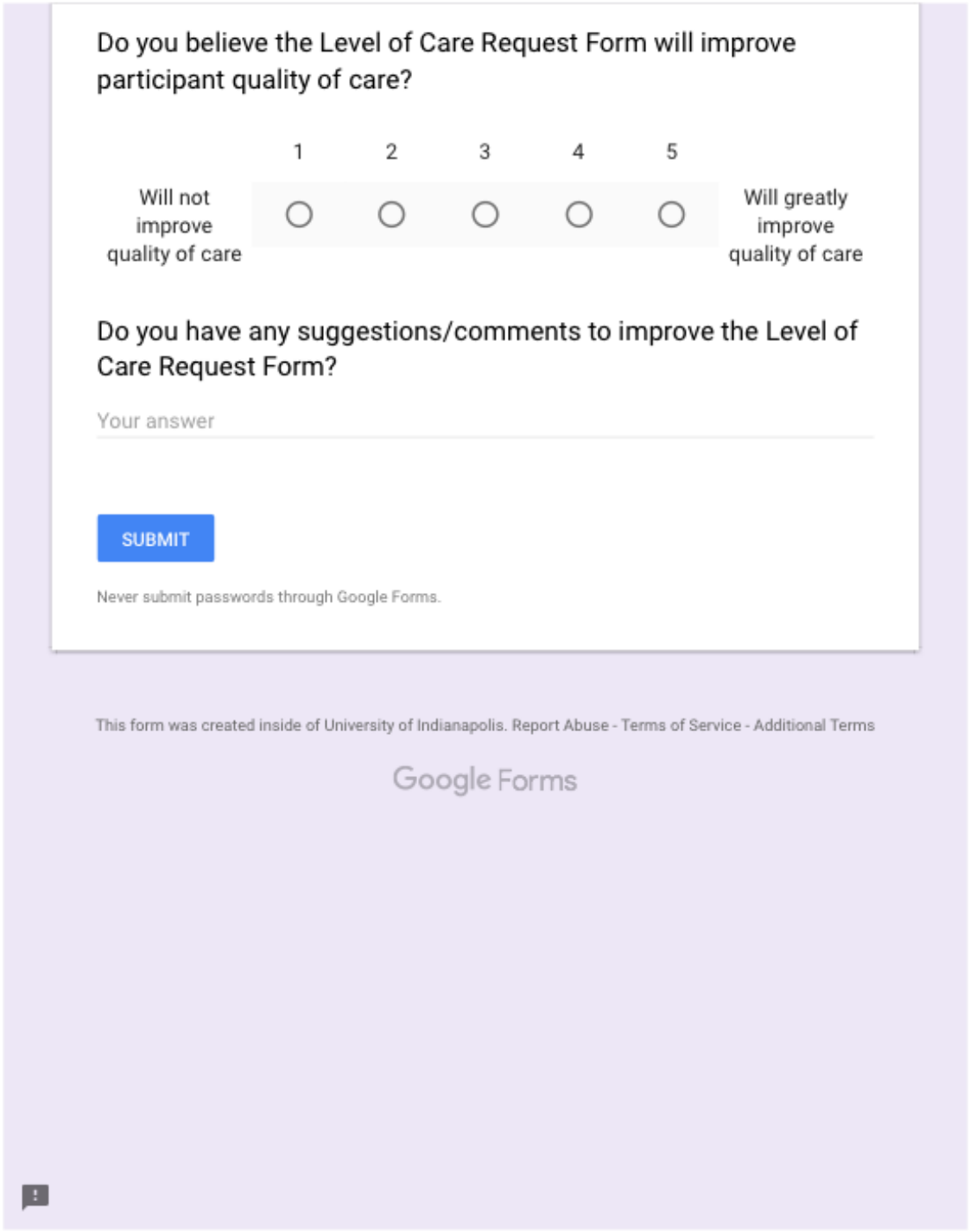
Level	Assisted Living Interventions **NO INFORMAL SUPPLEMENT CARE AVAILABLE**	Attendance Assessment	Multidisciplinary Safety Evaluation	Nursing Medication Management	Fall Risk Evaluation STEADI
1 Assisted Living	-IADL Support -ADL Support Independent to Setup for ADLs -Fall Supervision -Nursing Care 7/7 assistance available 24/7 -Socialization and group activities	1-2 Days/Wk -Socialization -Restorative program -Nursing/MD appts	-Assess equipment needs for ADLs, IADLs & O2 -Assess equipment needs for mobility -Assess bathroom safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication management plan established with AL nursing.	-Low to Moderate fall risk -Home exercise program -Home safety modifications
2 Assisted Living	-IADL Support -Basic ADL Support Standby to minimal assist with ADLs -Fall Supervision -Nursing Care 7/7 assistance available 24/7 -Socialization and group activities	1-2 Days/Wk -Socialization -Restorative program -Nursing/MD appts	-Assess equipment needs for ADLs, IADLs & O2 -Assess equipment needs for mobility -Assess bathroom safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication management plan established with AL nursing.	-Moderate to High fall risk -Home exercise program -Home safety modifications -Outpatient PT/OT -Foot Care/Footwear check -Visual testing and clearanc
3 Assisted Living	-IADL Support -ADL Support Minimal to moderate assist with ADLs -Intermittent mobility assistance for safety -Fall Supervision -Nursing Care 7/7 assistance available 24/7 -Socialization and group activities	1-3 Days/Wk -Socialization -Restorative program -Nursing/MD appts -Showering at center -Regular vital sign checks -Skincare checks	-Assess equipment needs for ADLs, IADLs & O2 -Assess equipment needs for mobility -Assess bathroom safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication management plan established with AL nursing.	-Moderate to High fall risk -Home exercise program -Home safety modifications -Outpatient PT/OT -Foot Care/Footwear check -Visual testing and clearanc
4 Assisted Living or Long Term Care	-IADL Support -ADL Support Moderate to Maximal assist with all ADLs -Moderate to maximal assist with mobility safety -Fall Supervision -Nursing Care 7/7 assistance available 24/7 -Socialization and group activities	1-3 Days/Wk -Socialization -Restorative program -Nursing/MD appts -Showering at center -Regular vital sign checks -Skincare checks	-Assess equipment needs for ADLs, IADLs & O2 -Assess equipment needs for mobility -Assess bathroom safety -Personal emergency pendant -Fall Sensor	-MacPack deliveries -Medication management plan established with AL nursing.	-High fall risk -Home exercise program -Home mobility modificatio -Home safety modifications -Outpatient PT/OT -Foot Care/Footwear check -Visual testing and clearanc
5 Long Term Care	-IADL Support -ADL Support Total assist with all ADLs -Maximal to total assist with mobility safety -Fall Supervision -Nursing Care 7/7 assistance available 24/7 -Socialization and group activities	1-3 Days/Wk -Socialization -Restorative program -Nursing/MD appts -Regular vital sign checks -Skincare checks	-Assess equipment needs for ADLs, IADLs & O2 -Assess equipment needs for mobility	-MacPack deliveries -Medication management plan established with LTC nursing.	-High fall risk -Home exercise program -Home mobility modificatio -Home safety modifications -Outpatient PT/OT -Foot Care/Footwear check -Visual testing and clearanc

Appendix D.

Do you believe the Level of Care Request Form uses language that is easy to understand/interpret?

Do you believe the Level of Care Request Form accurately determines appropriate levels of care?

Do you believe the Intervention Guidelines for Level of Care provide relevant/feasible recommendations to use with participants?


Do you believe the Level of Care Request Form will improve participant quality of care?
1
2
3
4
5
Will not improve quality of care
Will greatly improve quality of care
Do you have any suggestions/comments to improve the Level of Care Request Form?
Your answer
SUBMIT
Never submit passwords through Google Forms.
This form was created inside of University of Indianapolis. Report Abuse - Terms of Service - Additional Terms
Google Forms