LTS PLANNING COMMITTEE
COP VARIANCE REQUEST

Case Manager: Jane Lanpher **Date: January 29, 2018**

FUND COP SERVICES FOR PARTICIPANT RECEIVING RECUPERATIVE SERVICES IN AN INSTITUTION (UP TO 90 DAYS).

The purpose of this variance is to maintain a participant's support network during relatively brief institutional stays. No variance is needed for recuperative stays of 30 days or less. When a recuperative stay exceeds 30 days a variance is necessary to allow the use of COP funds to continue to pay for noninstitutional community service expenses for up to 90 days for current COP recipients.

1. INSTITUTION NAME: The Villa at Middleton Village

2. EXPECTED DURATION: Up to 90 days (from date of initial 11/22/17 hospitalization)

3. PARTICIPANT INFORMATION

- Male ___ Female **X** Age **81** Time on COP/Waiver programs **14 ½ years** Protective Placement No
  Current living arrangement: **X** home
  ___ AFH
  ___ CBRF (name, size) _____
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- Health & medical problems (please use non-medical terms): **Program participant's medical diagnoses include: Metastatic breast cancer, Radiation Dermatitis (non-healing wound on chest from past radiation), non-healing hip fracture from 11/5/13 fall, Diabetes Mellitus – type II (insulin dependent), anemia / coagulation defects, severe Osteoarthritis, chronic pain / chronic lower back pain, Spinal Stenosis, HTN (high blood pressure), Lymphedema (right arm), Colon Polyps, Glaucoma, back fusion (2002), history of DVT (Deep Vein Thrombosis), Hyperlipidemia, Esophageal Reflux, history of Cellulitis, Depression, Peripheral Neuropathy, placement of pacemaker due to Cardiac Arrhythmia.**
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- Situation requiring rehabilitation and desired outcomes: **The program participant fell out of bed onto the floor during the evening of 11/22/17. As she couldn't get up after falling, despite assistance from her husband, 911 was called. When EMTs responded, the program participant appeared to be in distress so she was transported by ambulance to the ER at UW Hospital. There she was diagnosed as having Cardiac Arrhythmia, necessitating placement of a temporary pacemaker followed a few days later by insertion of a permanent one.**

  After nearly a week in the hospital, the program participant was discharged to The Villa at Middleton Village nursing home for a rehabilitative stay. Once there, she participated in Physical and Occupational Therapies on a daily basis. Steady progress was noted by therapists until 12/27/18 when a plateau was reached, triggering discharge from their services.

  Discharge planning, meanwhile, had focused on the program participant's return home. However, this plan was stalled after her daughter, who had been her primary personal care and supportive home care provider for the last 14 ½ years, notified this SW that she could no longer provide care services to her mother, effective with the program participant's move back to the community. In response and still planning for a discharge home, referrals to other agencies were made with several declining due in part to the number of support hours needed.

Then, as efforts were still underway to develop a new community care plan, the program participant's physician recommended that she remain at the nursing home long-term. This recommendation was based on the program participant's continuing skilled nursing care needs due to her multiple, complex medical conditions, including a terminal cancer diagnosis. The program participant ultimately agreed with her doctor's assessment, deciding that permanent nursing home care would be in her best interest. With her decision, the program participant was closed for our program services. COP close date 2/22/2018

Services to be funded during rehabilitation: Case Management **X (22.3 hrs for total cost $2272.82),** Lifeline **X ($114.00)**, other: **3 home delivered meal at a cost of $8.90 total $26.70 (for 11/24/17, delivered on 11/22/17).**

LTS Committee action: Chair approval date _____; Full committee approval date _____;

Non approval date _____; Reason _____

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Consumer Name: _____