

Underwriting 202

Moving To The Next Level
Of Underwriting

Areas of Discussion

- Function and activity level
- Use of Assistive devices
- Cognitive function and testing
- Co-morbid conditions
- Role of medications
- Case studies

Function & Activity

- Most reliable indicator of LTC risk
- Mobility
- ADL's
- IADL's
- Advanced Activities of Daily Living (AADL's)
- Cognitive function

ADL's

- Bathing
- Dressing
- Transferring
- Toileting
- Contenance
- Eating

IADL's

- Transportation
- Shopping
- Housework
- Using telephone
- Ambulation
- Laundry
- Self-medication
- Meal preparation
- Managing finances

AADL's

- Advanced Activities of Daily Living
- Hobbies
- Occupation
- Recreational Activities

Adaptive/Assistive Devices Concerns

- Continuous use
- Recent initiated use
- Recent change in use with increased dependency
- Use of devices that indicate the need for greater support such as a quad cane or walker

Dependency vs. Prevention vs. Convenience

- What is the presumed condition resulting in need for or use of equipment?
- What is duration of the dependency? Has the need recently changed?
- What is degree of dependency?
- What is degree of of current functional disability with and without use of equipment?

Cognitive Function

Clues to a possible impairment:

- Signature does not match rest of application
- Change in activities such as driving
- Tendency toward social isolation
- Stress and Anxiety

Common Cognitive Function Assessments

- Short Portable Mental Status (SPMSQ)
- Mini-Mental Status (Folstein Mini-Mental)
- Modified Short-Orientation-Memory-Concentration Test (Blessed)
- Delayed Word Recall (DWR)
- Minnesota Cognitive Acuity Screen (MCAS)
- Telephone Interview for Cognitive Status (TICS)

SPMSQ

- Ten standardized questions, easy to learn
- Focuses on orientation, short and long-term memory and mathematical serial subtraction
- Used in a variety of settings
- Approximately 25% of false negatives
- Does not discriminate well between normal and mild impairment
- Does not sufficiently test recent memory or recall

Folstein Mini-Mental

- Eleven standardized questions with multiple parts to most questions
- Used extensively in a variety of settings
- Approximately 20% false negatives
- Sensitivity is affected by education level
- Mild impairment difficult to detect
- Does not sufficiently test recent memory

Short Blessed

- Targets orientation, retained abilities and memory
- Scoring is weighted to give more importance to predictors of early impairment
- May not sufficiently test recent memory
- Quick, easy to learn, easy to administer

DWR

- Uses a repetitive encoding process
- Designed to differentiate early Alzheimer-type dementias from normal subjects
- Education does not appear to be a factor
- Visually impaired persons will have problems with the test

TICS

- 11 item, 41 point verbal question and response test which can be given over the phone
- Some false negatives are likely
- Recommend that a failed TICS have a face-to-face assessment

MCAS

- Currently being reviewed for use in several research projects related to dementia
- Face-to-Face or Telephonically administered with nine tests
- Includes: orientation, attention, delayed word recall, comprehension, repetition, naming, computation, judgment and verbal fluency

Co-Morbid Conditions

- Relationship between two conditions
- Evaluate each condition separately to determine functional impact & severity
- Impact of condition as co-morbid is considered secondarily

Determine Severity

- What is the etiology?
- Is condition stable or unstable?
- Is condition active or inactive?
- Is condition chronic or a new diagnosis?

Medication Considerations

- Frequency may indicate severity
- Physician preference
- Multiple medications for conditions
- High risk medications
- Adverse side effects
- Insulin: Use of and amount considerations

High Risk Medications

- Dementia Drugs
- Anti-Parkinson Drugs
- Antipsychotic Drugs
- Regular use of narcotics
- Oral Steroids
- Chronic Antibiotic Suppression

CASE STUDIES

Osteoporosis

- 74 yo Female; 5' tall weight 107 pounds
- No smoking, no ETOH
- Osteoporosis since 1996 with Fosomax
- No history of falls or fractures
- Bone Density in 6/00: -3.5 L2-L4
-2.55 femoral neck
- No assistive devices
- Active and independent
- Other history: stable HTN

COPD

- 64 yo Male
- COPD diagnosed in 9/00 w 2 inhalers
- MD notes SOB & DOE when running or lifting
- Quit smoking in 1996
- PFT's indicate severe COPD
- Active farmer

Rheumatoid Arthritis

- 61yo Male retired x 1 year
- Voltaren and Methotrexate for RA
- Rheumatologist visit monthly: note excellent control
- 12/98 lumbar fusion
- Hand deformity
- Independent, walks 3 mi per day

Cardiac Stenosis & HTN

- 73 yo Female; 5'3" 185 pounds
- HTN since 1990: Triam/HCTZ; 140-80's
- 1996 multiple TIA's w noted mild carotid stenosis, asymptomatic
- ASA daily, no further treatment planned
- Non-smoker
- Active: bowling, hiking, boating, camping
- Drives, very independent

Osteoarthritis

- 82 yo Female; 5'7" and 130 pounds
- DWR of 8
- No exercise, no driving x 3 years
- Osteoarthritis ankles and knees w ASA only
- Imbalance at times, holds on to spouse or chair at times to ambulate
- Independent in ADL's and IADL's
- Problems with anxiety and claustrophobia with no meds to treat

Diabetes and HTN

- 64 yo Male with DM for 20 years and HTN for 5 years; 6'2" 280 lbs
- Meds: Glucophage 2x/d and Zestril daily
- Average fasting blood sugar 150; Glycosylated Hgb is 8.2
- BP averages 140/80
- Works full time
- Weekly golf, belongs to health club

Stroke

- 71 yo Female; 5'5" 190 lbs
- Stroke 4 years ago with use of single point cane
- Lives with spouse in retirement community, provided one meal per day
- Independent in ADL's, drives weekly
- DWR of 4
- Husband manages finances: always has