Changing Face of Care Management
Opportunities for GCMs

Working in a Hospital-Based Geriatric Care Management Practice

A Collaborative Approach to Patient Care: the GCM and the Physician

Insights of a Health Care Innovator

Creative Care Management in a Non-Profit Setting

Sound the Bell: Revolutionizing Client Care – 2013 Conference Coverage
Fox is a professional private practice of full-time physical, occupational and speech therapists specializing in geriatric rehabilitation. We believe older adults deserve the best life possible regardless of past and current medical conditions. Fox collaborates with Geriatric Care Managers to ensure successful outcomes. Our clinicians treat your clients in the comfort of their own homes while providing proactive, evidence-based clinical care to work with the body, encourage the spirit, and restore their lives.

Fox has developed customized services for care managers and their clients including:

- Individualized therapy services under Medicare Part B
- Dementia management programs for patients and caregivers
- Adaptive equipment education and environmental modifications
- Home assessments and fall risk reduction programs
- Driving rehabilitation

Why settle for “some improvement” when your clients can regain more of the life they love? For more information on how you and your clients can benefit from a partnership with Fox, please call 1 877 407 3422, visit us at foxrehab.org, or email GCMpartnership@foxrehab.org.
Features

Working in a Hospital-Based Geriatric Care Management Practice ................................................................. 7
Janet Sobel-Medow

A Collaborative Approach to Patient Care: the GCM and the Physician ................................................................. 9
Jennifer E. Voorlas

Insights of a Health Care Innovator ................................................................. 11
Eileen Nevitt

Creative Care Management in a Non-Profit Setting ................................................................. 12
Kate Granigan

Care Managers Keeping Up with Technology
HIPAA on-the-go: Securing your mobile devices ................................................................. 14
Tasha Beauchamp

Sound the Bell: Revolutionizing Client Care
2013 Conference Coverage ................................................................. 16

A Call to Action: The Power of Research for the Future of Care Management ................................................................. 20

Book Review: Switch, How to Change Things When Change is Hard ................................................................. 27

Book Review: Connecting with Socially Isolated Seniors: A Service Provider’s Guide ................................................................. 31

Change is the law of life.
And those who look only to the past or present are certain to miss the future.

~John F. Kennedy
Welcome to our Summer edition of Inside GCM! Change is in the air and the face of care management is changing as we know it. A paradigm shift is occurring which is shaking up traditional models of healthcare, and for many of us, this means we are forced to re-evaluate our position as Care Managers, and where we fit in to the continuum of care.

With change comes uncertainty, but as professionals this can lead us through new windows of opportunity, challenging us to think outside of the box in order to help the elders we serve. To thrive as a profession, we must focus our energies on how we as Care Managers are part of the solution to the complex issues that lay head for our patients and families in meeting a higher standard of care.

In this edition we start to address new opportunities for GCMs working in different settings: creative care management in nonprofit organizations, care management programs within hospitals, and GCMs partnering with physicians in medical practice. We also explore how physicians in general are viewing the changes in healthcare, the ongoing dilemmas, and the value of GCMs. Lastly, we look at how new technologies are being used more than ever, and how as practitioners and business owners, we can ensure HIPAA compliance.

To continue this important dialogue, please look forward to our Journal coming out in the fall which will address in more detail the Affordable Care Act and its impact on geriatric care management. On behalf of the Inside GCM Committee we hope you enjoy this edition.

Happy reading!

Jullie Gray

President’s Message

It’s always so exciting to attend our annual conference, and this year, Philadelphia was no exception! Attendance at the conference was the highest ever in our Association’s history. Exhibitors vied for limited space and many have already eagerly expressed interest in exhibiting again at our 2014 conference in Nashville, Tennessee! As our membership grows steadily, we are gaining momentum, credibility, and influence in the marketplace.

We have so much to celebrate and at the same time, we have so much to do! At our annual business meeting in Philadelphia, I had the pleasure of speaking to members about a grand vision for the future where care managers are fully recognized and sought after for their expertise in the field of aging. To achieve that vision, we need more data about the impact of care management services. I called upon members to make a firm, personal commitment to support NAPGCM’s research efforts. Supporting research means that members respond to surveys, help gather data with tools developed by the Association, and work together to reach common goals. If you missed the conference, you’ll find more information in this edition of Inside GCM with specific details about our research agenda.

Speaking of goals and agendas, every year, the Board develops a strategic plan to provide a roadmap for the year ahead. We will be meeting in November in San Antonio, Texas to hammer out the details. Strategic planning is serious business because it identifies priorities for our budget and committee work for the coming year. Since planning starts with our membership, I want to take this opportunity to invite you to share your thoughts, ideas, and wish list with the Board before strategic planning starts. To let your voice be heard, email me directly (jgray@agingwisdom.com) or any Board member to share your thoughts.

Together, we can make good on our commitment this year to revolutionize client care!

To see the video of Jullie Gray’s address to the membership, click here.

WHEELCHAIR RAMPS & MORE...

Welcome to our Summer edition of Inside GCM! Change is in the air and the face of care management is changing as we know it. A paradigm shift is occurring which is shaking up traditional models of healthcare, and for many of us, this means we are forced to re-evaluate our position as Care Managers, and where we fit in to the continuum of care.

With change comes uncertainty, but as professionals this can lead us through new windows of opportunity, challenging us to think outside of the box in order to help the elders we serve. To thrive as a profession, we must focus our energies on how we as Care Managers are part of the solution to the complex issues that lay head for our patients and families in meeting a higher standard of care.

In this edition we start to address new opportunities for GCMs working in different settings: creative care management in nonprofit organizations, care management programs within hospitals, and GCMs partnering with physicians in medical practice. We also explore how physicians in general are viewing the changes in healthcare, the ongoing dilemmas, and the value of GCMs. Lastly, we look at how new technologies are being used more than ever, and how as practitioners and business owners, we can ensure HIPAA compliance.

To continue this important dialogue, please look forward to our Journal coming out in the fall which will address in more detail the Affordable Care Act and its impact on geriatric care management. On behalf of the Inside GCM Committee we hope you enjoy this edition.

Happy reading!

Jullie Gray

Editor’s Message

With change comes uncertainty, but as professionals this can lead us through new windows of opportunity...
Calendar of Events

**JULY 2013**

2013 American Psychological Association 121st Annual Convention
July 31–August 4, 2013
Honolulu, HI

**SEPTEMBER 2013**

NAPGCM Business Webinar –
What You Don’t Know CAN Hurt You – Streamlining & Perfecting the Hiring Process
September 11, 2013
4PM ET
www.caremanager.org
Sponsored by

New Jersey Chapter
Annual Down the Shore Retreat
September 20, 2013
Red Bank, NJ
www.njgcm.org

**OCTOBER 2013**

Western Region Chapter Annual Conference
Recharge, Refocus, Reflect and Reconnect
October 3-5, 2013
Talking Stick Resort
Scottsdale, AZ
www.westerngcm.org

New York Chapter
How to Succeed in Business with Really Trying!
A Forum for Care Managers
October 7, 2013
Kimmel Center
Manhattan, NY
www.nyngcm.org

2013 National Conference on Guardianship
October 12 – October 15, 2013
Grand Hyatt Tampa Bay
http://www.guardianship.org/

NAPGCM Clinical (CE) Webinar –
Allowing Natural Death
October 16, 2013
4PM ET
www.caremanager.org
Sponsored by

**NOVEMBER 2013**

Southeast Chapter Annual Conference
November 1-3
North Carolina
www.caremanager.org/regional-chapters/southeast-chapter

South Central Chapter Annual Conference
November 7–9, 2013
Location TBA
www.gcmsouthcentral.org

11th Annual National Memory Screening Day
Alzheimer’s Foundation of America
November 19, 2013
www.alzfdn.org

**MARCH 2014**

ASA Annual Conference
Aging in America
March 11-15, 2014
Manchester Grand Hyatt Hotel
San Diego, CA
http://asaging.org/general-info-aia

**APRIL 2014**

NAPGCM 30th Annual Conference
April 3–May 3, 2014
Sheraton Music City Hotel
Nashville, TN
www.caremanager.org

**MAY 2014**

NAELA Annual Meeting and Basics Workshop
May 14-16, 2014
Scottsdale Camelback Inn
Scottsdale, AZ
www.naela.org
Board Bits

NAPGCM Board of Directors Meeting, April 17, 2013, Philadelphia, PA

Legislative Consultant Susan Emmer reported on Public Policy Committee activity, including support of changes to observation status, the Care Coordination for Older Americans Act, and monitoring of possible changes to the companionship exemption under the Fair Labor Standards Act.

New PR Consultants, Peter Reinecke and Noel Gerson introduced. Noel will be the contact for incoming media inquiries, as well as providing media outreach. Peter will assist in the areas of PR and Research and help NAPGCM identify possible funding sources for research.

Dr. David Nash, 2013 Conference Keynote Speaker
In addition to suggesting ways we might work together in the future with him and the Jefferson School of Population Health at Thomas Jefferson University, he shared his perspective on the value of research.

Expanded “Member Get a Member Program” was introduced. Program will run all year long and gives members the chance to earn a free membership.

Treasurer reported that 87% of our dues revenue has been collected as of February and that advertising and sponsorships for webinars are already sold out.

Strategic Planning will be held November 6, 2013 in San Antonio, TX.

“Education Central” -- a new comprehensive web-based collection of all NAPGCM educational resources -- was introduced. All these resources are now found under one home page button in an easy-to-navigate format.

Board Members signed up to attend Chapter Conferences this year; Jullie Gray already attended the Florida Chapter Conference.

Southeast Chapter has filed all necessary paperwork with the State of Georgia. Chapter submitted budget for inclusion in the 2013 National Budget; board approved.

Proposed Nominating Criteria for Re-Nomination to the Board was reviewed and approved. Guidelines will go into effect immediately and become part of the Nominating Committee processes and procedures.

Business Alliances Committee submitted a screening process to respond to inquiries for business relationships. Board approved and suggested immediate implementation to test its effectiveness.

Research Development Committee developed list of data points based on three areas: Member Demographics, Client Demographics, and Business practices. Their next step is to identify system(s) to collect information on an ongoing basis.

Member and Chapter Relations Committee submitted a revised version of their Areas of Practice Proposal; board approved, but we will delay implementation until the Research Development Committee has finalized their data collection plan.

Executive Director’s Message

Kaaren Boothroyd

We’re half way through the year and in the middle of summer, but the work of NAPGCM, our chapters, and our members hasn’t slowed down for a minute! Lots is going on--

Visit www.caremanager.org and click on the new section called “Education Central” – here you’ll find, all in one place – all the educational offerings that NAPGCM has to offer. And more are on their way!

Check out our calendar for upcoming Business Webinars, Clinical Webinars, and Chapter Conferences, Retreat and Forums.

While plans are already under way for our conference next year in Nashville (April 30-May 3), we hope you’ll enjoy the wrap-up from this year’s Conference Co-Chairs and the photos of our happy attendees!

And if you missed the conference, and the inspiring address by NAPGCM President Jullie Gray, you can click here to see and hear her address to the membership.

Board Bits will quickly bring you up to date on what’s going on at the national level, including the addition of Public Relations Consultants to our team.

We are particularly pleased with the inauguration of our new instaPOLL. The purpose of the instaPOLL is to quickly gauge the “collective wisdom” of NAPGCM members on a range of timely topics of interest to NAPGCM and/or the public and those interested in aging issues. Our first instaPOLL resulted in news we distributed nationally in a press release. We also created a press release template for our members to use in your communities. We hope these will be helpful in marketing your own practices. For more information on the instaPOLL, please click here.

Coming soon – in August, the Nominating Committee will announce the slate for our upcoming election for the Board of Directors. Watch your e-flashes for this announcement! If you do not regularly receive e-flash newsletters from NAPGCM please contact jwagner@napgcm.org.

Wishing you all a fun, safe, and relaxing summertime.

P.S. Be sure to follow us on Facebook, LinkedIn, and Twitter.
For the past ten years, Massachusetts General Hospital (MGH) has had a geriatric care management practice called Massachusetts General PrimeCare (MGPC). The geriatric care managers in the practice are members of the National Association of Professional Geriatric Care Managers and the New England Chapter. As a registered nurse and GCM for over five years at MGH, I feel I am in a unique position to discuss the similarities and differences to private practice since I have worked in both settings.

In 2001, I started a successful GCM practice in Columbus, Ohio with a social worker. Six years later I relocated to Boston, Massachusetts, which is home to a large number of GCM practices. Shortly thereafter, I joined Massachusetts General Hospital.

Background
Massachusetts General Hospital is a large academic medical center in Boston. It’s a founding member of a large not-for-profit medical system, called Partners HealthCare. MGH is an innovative hospital known for excellent patient care, having been ranked the #1 hospital in the nation by U.S. News and World Report in 2012. Currently, MGPC is the only fee-for-service GCM within the Partners network, but MGH has and does participate in a number of other initiatives. Prior to 2012, MGH enrolled in a Medicare Demonstration Project (CMP) utilizing practice-based case managers to help manage and coordinate the care of high-cost Medicare patients. Since January 2012, MGH has become part of a large Accountable Care Organization (ACO) within the Partners network. They have expanded their case management initiative to include all high-risk patients with the goal of improving the quality of care and patient satisfaction and reducing hospital readmissions and health care costs.

Massachusetts General PrimeCare was developed by a long-standing RN/Case Manager at MGH with the guidance of an external Community Advisory Board and internal Steering Committee. Presently, MGPC is growing and self-supporting after receiving initial funding (continued on page 8)
Working in a Hospital-Based Geriatric Care Management Practice

(continued from page 7)

from a Ventures Committee to start the practice. The premise behind the development of the program within a complex healthcare system is as follows:

- New product line for MGH to support patients, families, and clinical providers
- Name recognition to enhance marketing
- Opportunity for an internal referral network
- Existing infrastructure to support the Practice (finance, billing, computer systems, legal support, etc.)
- Collaborative relationship with the hospital-based Case Management Department with shared opportunity for staff development, mandatory training, knowledge sharing, etc.
- Weekly salary and benefits as an MGH employee

Structure of MGH PrimeCare:

- Fee-for-service program charging an hourly fee.
- The responsible party signs a simple contract agreeing to our fee and paying for our services and a release of information/HIPAA form is completed.
- 70% of our practice is affiliated with MGH and 30% are non-MGH patients in the community.
- We offer free 30-minute consultations which can take place on the MGH campus.
- Referrals come from a variety of sources -- physicians, social workers, case managers, elder law attorneys, assisted living facilities, private home care agencies, Internet, and word-of-mouth.
- The GCM team is made up of nurses and a clinical social worker. Since the majority are nurses, we tend to serve a lot of medically complex clients.
- Discounted rates are offered to MGH employees and to several Village networks (virtual assisted living communities).

Pros of a GCM practice in a hospital setting:

- We have access to the resources of a large hospital system. This includes the electronic medical record once a release of information is signed, case management resources and websites, hospital financial services, educational materials, to name a few. As a result, care coordination is more efficient and productive.
- Because we are part of the network we have easy access to staff and can email and page as needed.
- When a client is hospitalized, we work collaboratively with the medical team. Upon discharge we work to prevent unnecessary readmissions to the hospital and have access to the discharge notes and plan.
- Since we work within a large network, we have easy access to affiliated home care agencies, skilled nursing facilities, and rehabilitation hospitals.
- We have a steady stream of referrals from a variety of sources within the institution and health care system.
- We are cost effective for MGH clients since we are on-site.
- Ongoing training/education with CEU programs and other educational programs offered by the hospital. CCM credits are often offered.
- GCMs as employees are entitled to an excellent benefits package including retirement benefits. We also have a competitive salary structure with annual and market increases. Generally, the GCM’s would make more money than non-salaried GCM’s in the community.
- The hospital benefits by listing our program as one of the geriatric services it offers.
- Access to comprehensive occupational health services.
- Assistance is available to non-affiliated clients to be seen by MGH physicians if desired.
- Resource to inpatient and practice-based case managers.

Cons of GCM practice in a hospital setting:

- MGH owns the business; therefore, we can't expand the services we offer to home care or guardianship.
- Less flexibility regarding billing systems and electronic care management programs. We need to have our billing system work with the hospital system and any electronic program needs to be approved by Partners Information System with the firewall and HIPAA concerns.
- Overhead costs are high relative to the high costs of living in the Boston area.
- Being part of a non-profit, revenues are subject to the laws governing non-profits.
- The GCMs in the hospital make less money than a GCM who owns his or her own practice (either sole or group).
- MGPC must be exceedingly careful not to contract, provide, and/or charge for services that are “covered” under health care insurance. (For instance, we will not provide any services covered by Medicare, such as discharge planning or skilled services).

Case Example:

A 55-year-old woman was referred to MGPC from her Primary Care Physician at MGH. She had recently undergone surgery for a brain tumor and was having memory difficulties as a result. In addition, she is single without any children or close friends. Her family lives out of town and can only provide limited support. Previously she was working as a professional in a high-level position, and it was unclear if she could ever return to work. Once she became a client of MGPC, the GCM was included on the medical team’s email strings regarding follow up treatments/ (continued on page 9)
Working in a Hospital-Based Geriatric Care Management Practice

(continued from page 8)

plan, and the GCM reported back to the team any concerns and updated them on her progress. The patient underwent successful radiation treatments at MGH after the GCM arranged for transportation for her. This was a difficult task since she lives 45 minutes from MGH. The GCM also attended her Oncology, Palliative Care, and Neuropsychiatry appointments on the MGH campus and followed through with all the providers so they were kept abreast of the latest developments. In addition, the GCM made sure the appropriate physician completed all necessary paperwork so she would qualify for long-term and social security disability. The GCM in this continuing relationship can look in the electronic medical record and review appointments and follow-up tests with client making sure that transportation is arranged and that preparation for the tests occur.

Since the GCM is part of the medical system, we are able to provide cost-effective but high-quality care coordination. This collaboration has been a win-win for the client, enhancing the delivery and quality of care.

Potential Ethical Issues

Clients and families could have concerns that as hospital employees, we are less likely to serve as advocates for our clients when issues arise with MGH providers. However, we are independent, impartial advocates who are hired by the clients and families, and we strive to protect their interests. Along this line, we will not refer clients to affiliated home care agencies or skilled nursing facilities unless we feel they are the best providers. Clients are always given other choices or options.

Overall, the practice operates as a traditional fee-for-service GCM practice, which happens to be housed in a hospital. However, it’s an exciting place to work since the institution is a dynamic place in an active city. The GCMs are a part of something larger than our individual small practice. We have busy periods and sometimes slow months, and as all of you know, it’s an up-and-down business. We have to continually market to get clients just like any other practice, and spend a lot of time educating people on what a GCM is and does. In our case, the hospital really doesn’t market our program in any substantial way, so it’s up to the GCMs to do this at all times.

We have the same concerns as other practices: referrals and marketing; payment for our services; challenging clients and families. I would highly recommend that GCMs explore this option with their local hospitals, since it’s a valued service which benefits the patients in the healthcare system.

We have the same concerns as other practices: referrals and marketing; payment for our services; challenging clients and families. I would highly recommend that GCMs explore this option with their local hospitals, since it’s a valued service which benefits the patients in the healthcare system.

A Collaborative Approach to Patient Care: the GCM and the Physician

Jennifer E. Voorlas

GCM Partnered with Physician Practice — A Beginning

Background

In 2007 I met a neurologist through a mutual friend. Dr. L was chief-of-staff for a local hospital located in the Los Angeles area. In addition, he had a successful neurology practice which was established in the early 1980’s. I was told Dr. L was considering expanding his practice to include a multidisciplinary team of professionals committed to working with the Alzheimer’s population. When I first met Dr. L, he had no idea what a care manager was or how I could benefit his practice. I found him to be skeptical and a bit aloof, but nonetheless interested.

Despite his skepticism, he was willing to take a chance with adding a GCM to his practice, even though it was on a tentative, contractual basis. In the beginning, the multidisciplinary team would meet on weekends, working together to create a business plan by using flow charts and envisioning how we would work together. The union was successful, and after six years, we are still sharing a mutually rewarding partnership.

Janet Sobel-Medow RN,CCM

Janet graduated from the University of Michigan with a Bachelor of Science in Nursing, Magna Cum Laude in 1982. Since 1991, Janet has worked exclusively with older adults in a variety of settings. She was a case manager at Jewish Family and Children’s Services in Minneapolis and at Jewish Family Services in Columbus, Ohio. Janet joined NAPGCN in 2001 when she started her own GCM practice, Golden Guidance LLC in Columbus, Ohio with a GCM partner. Since moving to Boston over five years ago, she has practiced as a GCM at Massachusetts General Hospital and is a CCM.

(continued on page 10)
A Collaborative Approach to Patient Care: the GCM and the Physician
(continued from page 9)

Introduction
Care managers have unique opportunities to partner with physicians for successful outcomes in patient care. While doctors in the recent past have felt threatened or even territorial regarding a GCM “managing” their patient’s care, the tides may be changing. With HMOs dictating patient care, doctors often feel compelled to limit their time with each patient. Consequently, the doctor is hard pressed to review medications, changes in status, and address patient/family concerns. There is often incomplete information and gaps in knowledge, especially if the elder has cognitive impairment, or the family does not regularly attend appointments.

Once a diagnosis is given and a treatment plan is developed, many times patients and family members have concerns and questions regarding care, especially when the patient has Alzheimer’s or dementia:

• How do I know if mom or dad can continue to live at home?
• Who do I hire and what are the associated costs?

While this is familiar terrain for the GCM, for the physician it is not so. Here is where the GCM comes in.

Window of opportunity for the GCM
Doctors may be reticent to hire a GCM simply because they have not been educated as to how a GCM would be beneficial to their practice. Examples of the ways a GCM can benefit a medical practice include:

1. Reduction in the amount of after-hour calls regarding care issues that may not be related to medical care per se.
2. Continuity of care from the time the of the physician’s visit to the next appointment; this is important especially for complex medical cases.
3. Tracking patient progress between appointments.
4. Communication with the doctor as urgent medical needs arise.
5. Communicating with busy family members as to changing status and treatment plan of patient.
6. On Call—being at the hospital or available for urgent matters when the physician is unavailable.

When the GCM and the doctor are in alignment with achieving these goals, the patient (and family) can feel the sense of a “team” advocacy. Families are often relieved when they know GCMs can be reached when the physician can’t, and this collaboration of expertise can make families and patients feel more secure that a team of “experts” is tackling the problem.

Ethical dilemmas — Who is the client?
Working as a GCM within a medical practice is far different from the freedom you have with your own private practice. From the inception of service, the doctor must deem your service necessary as part of the treatment plan for the patient, before the GCM begins the first home assessment. In addition, the GCM must document their findings into an assessment which is usually a shorter version of the more comprehensive care plan that we create for our clients; it must convey the essential facts and problems of the elder.

The assessment is what the physician will rely upon to open the line of communication between the GCM and the doctor as to the problem areas that need to be resolved. Because the physician will need access to the completed assessment before they see the patient/family at the next appointment, all documentation of identified issues and recommendations must be more compact, excluding details the physician may find extraneous. This can force the GCM to prioritize identified issues making a clear delineation of urgent vs. non urgent interventions. (Unlike private practice, the GCM write-up is not considered billable time by Medicare standards.)

Another dilemma for the GCM may arise when it comes to referring resources on the recommendations portion of the care plan. This is a sensitive area for most physicians since they do not want their client base to be taken from another professional, even if they think the patient could benefit from another service. Many doctors have their own referral network if other tests / evaluations need to be done, and so the referrals / recommendations for medical providers need to be more general than specific (i.e instead of another doctor’s name given, what service is suggested).

When services are covered by Medicare, there is often a prioritization of what the doctor thinks the patient should have vs. what the GCM may think is medically necessary. For example, the doctor may have an aversion to recommending physical therapy when physical therapy may use up Medicare dollars that would otherwise be used to see the physician.

Fee Structure
Having both a private practice and an additional source of income through the physician practice has enhanced both my knowledge and expertise. While GCM services are not generally covered by Medicare, under the auspices of the physician practice this is possible. When the doctor orders it, Medicare will cover it (one home visit per year, per patient), as long the GCM is providing the “arm of care” for the doctor. When starting out, it is up to the GCM to negotiate a wage (which would be less than private practice) and convince the doctor to hire on a contract basis providing home assessment / consultation as the need arises.

One of the challenges for a beginning GCM is how to negotiate a wage either as a contractual agreement or to be directly on payroll. The distinct advantage for many doctors may be to start on a contract basis until they get comfortable with how you fit within their practice; however, this is not always advantageous for the GCM unless they have their own liability insurance policy.

While in the future cost containment models of GCM services may be available for families on a regular basis in various settings, there may well be limitations on the scope of services we can provide within the physician practice. However the beauty of starting with the physician does not end there.

(continued on page 11)
A Collaborative Approach to Patient Care: the GCM and the Physician
(continued from page 10)

In my experience, many times families want / need more services, which provide them the freedom to contract with me privately, (since the doctor cannot accept private pay from a Medicare patient). Thus, in many instances, what turned out to be a single home visit through the physician, turned into a long-term case that lasted many years.

Conclusion
There is little doubt that GCMs are becoming more valuable to busy physicians trying to keep up with the volume while providing quality of care for patients, but education of what a GCM is and does is still lacking. This is where the GCM has to be proactive and let their talents be known. We must help the doctor envision how they can become the solution to the problem, creating a collaborative approach to meeting patient care.

The GCM’s decision to partner with a physician must be weighed carefully. There are many opportunities for professional growth, but relying upon this as an only income source may not be realistic. Despite the fact that working within a physician practice may bring forth ethical and financial considerations, the exposure to new patients and ongoing referrals is endless.

While the ethical and financial complexities are not entirely resolvable, new opportunities for GCMs must be paved and realized; this is especially important in light of new healthcare policies opening up new windows of opportunity for GCMs and closing others.

Jennifer E. Voorlas MSG, CMC Jennifer has been in the field of gerontology since 1996, incorporating many disciplines integral to understanding quality of life issues for elders and their families. For many years during her graduate studies she worked at the Alzheimer’s Disease Research Center at the University of Southern California where she co-authored the first training manual for teachers based upon a pilot study—Memory Enhancement Seminar for Seniors—for at-risk seniors in the community. She founded Geriatric Care Consultants LLC in 2007 and is primary GCM practitioner for a neurology practice in Southern California.

Insights of a Health Care Innovator
Eileen Nevitt

On May 2, 2013, Inside GCM committee member, Eileen Nevitt LCSW, ACSW, CMC interviewed Dr. Michael Kern, MD, Senior Vice President and Medical Director of John Muir Health’s Physician Network.

John Muir Health is a health care system, which includes the two largest medical centers serving Contra Costa County. Since its inception in 1996, the John Muir Physician Network has become one of the largest medical groups in Northern California, with more than 900 primary care and specialty physicians (source Wikipedia).

Eileen: Dr. Kern, could you please summarize John Muir Hospital System’s response to the Affordable Care Act (ACA) and, specifically the recent innovations stemming from the ACA?

DR. KERN: The ACA is an ambitious law which has shifted the focus of everyone’s attention and concern to comprehensive care, with the goals of increasing efficiency of our services and improving care outcomes through such innovations as Accountable Care Organizations (ACO). Here at John Muir Health, we are building an ACO in which the hospitals and physicians can work together with increased efficiency and better patient care. Participating ACOs have the “triple aim” of cost saving, better care, and a better experience by the patient. There are 33 required quality standards focused upon patient satisfaction, care coordination of chronic health conditions, and preventative services. There are many unknowns and I am not sure that the government has a clear view of what will happen in three to five years.

The ACA is also about the expansion of health care insurance. In 2014, there will be a massive increase of people eligible for health insurance coverage through the insurance market exchanges. Here in California, the program is called “Covered California” and subsidies will be available for those who qualify and would not be able to otherwise afford the premiums.

Again, no one knows exactly the results and impact of this massive expansion of health care coverage; all we can do is prepare incrementally and make contingency plans. Later the shortcomings will be identified and John Muir expects to see many.

Eileen: What is John Muir doing to prevent unnecessary re-hospitalizations and avoid the penalties for readmissions of patients with congestive heart failure, heart attack, and pneumonia?

DR. KERN: John Muir Health has done a great deal to improve safety. For example, our outcome on reducing hospital-acquired infection among our inpatient population is among the best in California.

Re-admissions to acute care are more of a problem. We are applying our resources to addressing this problem. For example, our case managers screen for high-risk patients for readmission using the LACE score system (Length of hospitalization, Acuity, Co-morbidities, and Emergency Department use frequency). A high LACE score translates to a three times the risk of readmissions. By using such scoring systems, case managers can intervene early and apply all resources to preventing unnecessary hospital readmissions.

(continued on page 12)
Insights of a Health Care Innovator
(continued from page 11)

Eileen: In a previous conversation, you spoke very highly of the profession of Geriatric Care Management. What has been your experience working with GCMs and what role can you envision GCMs playing in the monitoring of your patients in the community?

DR. KERN: Broadly speaking, I think that the volume of frail and needy elders who could benefit from community-based geriatric care management is much greater than the resources to serve this population.

Medicare has not addressed keeping people stable in the community. One important way in which geriatric care managers could help keep our patients monitored in the community is by communicating patient needs and status with the primary and specialty care providers. At John Muir Health, we are implementing the EPIC system to help with direct communication with our patients or their surrogates.

Eileen: How do you think that GCMs can positively impact patients and the delivery of their health care or add value to the hospital?

DR. KERN: One area of positive impact would be helping the frail elderly and their families understand the patient’s goals at the end of life. At the Gundersen Clinic in Wisconsin, upwards of 90% of patients complete Advanced Health Care Directives with a compliance rate of upward of 90% of following the patient’s wishes at the end of life. Such planning should begin at the age of sixty.

Eileen: What do you see as the barriers for more collaborative work with patients between hospital or physician practices and GCMs?

DR. KERN: There are four issues facing the frail elderly which can cause barriers: social isolation, psychiatric conditions, access to care when it is needed (for example, after normal business hours), complex medical needs.

Eileen: Do you think that John Muir Health System or the John Muir Hospital Group would ever consider contracting with outside Geriatric Care Managers for services?

DR. KERN: It is a question of whether it is more practical to rent or buy services. John Muir has a tradition of “buying,” which means building the services ourselves.

Eileen: What statistics of data do you think that GCMs should keep to prove our value to health care systems and physician groups?

DR. KERN: How many of your clients have completed Advance Health Care Directives and have discussed their goals for the end of life? What needs studying is how GCMs can help with the management and controlling risk of your clients’ common health care conditions. If your client is a diabetic, is his blood pressure controlled by antihypertensive, does he take aspirin, and is his cholesterol and blood sugar well controlled? For the chronically ill, the goal is to reduce risk, make health care more self-supported, and to make the goals of treatment explicit.

Creative Care Management in a Non-Profit Setting
Kate Granigan

As a Social Worker for a Visiting Nurse Association in 1996, I recognized early on I wanted to do things differently. Instead of being engaged with my “patients” only when they were ill or after the crisis, I knew I would have a bigger impact, and be more valuable to them and their overwhelmed families, if I could be proactive. At the time, in my little coastal south shore town of Scituate, Massachusetts, I had no knowledge that this was called Care Management. After years of doing the work, following a nurse into a case, and leaving when the “wound healed,” and because of the changes in the Medicare system that were limiting my interaction and impact with my “patients,” I decided to go out on my own and provide the service I believed would make a difference, and started CARE LLC in 1999. As a mother of two small children, I began my Care Management practice (the first in my area), and told a friend over coffee I would be happy if I could help “just one client.” Little did I know the popularity of what I would offer, the need for families and elders in my town and the surrounding areas to have a support and an advocate that could work with them despite logistic challenges. Soon thereafter, I brought on other Social Workers to join me in meeting this need.

In 2008, imagine my surprise when I was approached one day by a state-wide non-profit organization for a friendly lunch meeting. By the end of that meeting, they made very clear they saw Professional Care Management as a critical part of meeting the needs of the elders they served throughout their health system, and saw it as a critical part of the future. That lunch led to many discussions and negotiations over the course of a year, and ended with an acquisition of CARE LLC in 2009. My new role would be the Vice-President of Care Management for Overlook CARE, part of the Masonic Health System of Massachusetts (MHS).

I did not take this transition lightly, and it took countless hours of soul searching to determine if this was the right decision for me. One of my biggest con-
Creative Care Management in a Non-Profit Setting
(continued from page 12)
cerns was the ability to keep the integrity and core values so critical to my success. I was not willing to compromise the best interests of my client for the good of a larger organization. My ability to voice this repeatedly and clearly in negotiations helped that cause, as well as helped those at MHS get a better understanding of exactly what made care management so valuable to our clients.

As an organization and profession, we are being asked to make these same soul searching decisions in the face of Health Care Reform and a changing environment for consumers. Each one of us needs to explore what might work to succeed in this new environment. In the non-profit setting there is “free” care management through grants and insurance providers, as well as “Care Managers” and “Care Coordinators” in many other settings that look, at face value, much like a privately hired GCM. We as Professional Care Managers must now explore the pros and cons of these arrangements which lay before us, and follow a number of guidelines to be open to potentially rewarding opportunities.

Key considerations in the new Era of Care Management
With this new environment of ACOs, Medical Homes, and other Medicare Innovation projects, many who have practiced the art of “pure Care Management” are wondering where they now fit in. Having joined an organization with a continuum of care that includes Certified Home care, Hospice, as well as facility-based care, I have chosen to be creative about packaging our Care Management services. I looked for opportunities to offer our skills and expertise to the organization at large, as well as create a variety of opportunities for the Care Managers to show their expertise and have better consistency in their otherwise fluctuating caseload.

This same opportunity exists for those Care Managers who are interested in offering their skills “wrapped in a different package” to meet the needs of the variety of emerging programs and settings that will desperately need them. These opportunities will come in many forms, such as consulting to physician practices as they struggle to provide unprecedented coordinated service for their patients’ hospitals that are challenged to reduce readmissions; Visiting Nurse Associations that are in need of Social Work Services provided in new and creative ways; or as a sub-contractor to an ASAP that has received Federal Grants to provide coordination of care, and many more.

Although the “pure” practice of Care Management may be all some of us will ever do, there are others who desire the opportunity to think creatively and continue to use our exceptional skills in new ways. In this case, there are a few tips you should consider as you evaluate your options, and make your decisions:

• Never lose yourself in the deal: Your integrity and values must always be in the forefront.
• Be clear and concise: Put your goals and values on the table immediately, and do not waver from them.
• Be open minded: Opportunities are out there and available to those who are willing to see themselves broadly, in a skill set, not a rigid “job description.”
• Be creative: Take what you know you do well, and look at it in pieces, not as a whole, that may have value to different segments of the population.
• Be collaborative: Be willing to work as a team with others who you might not initially be drawn to.
• Be willing to walk away: No matter how good the deal is, if it compromises your integrity, be willing to walk away.

In order to make the decision I did, I needed to realize and evaluate what it meant to be something different than what I currently was, and accept some changes in the way I did things. This is not for the faint of heart; because it may include having to negotiate red tape and bureaucracy, and other frustrations you may not be currently experiencing in private practice. Now, four years later, I believe that the decision I made to be part of something bigger and different has been extremely rewarding, and a decision I would gladly make again. For those considering jumping into this new environment, I would say, come on in, the water is fine!

About CARE
Overlook CARE is part of the Masonic Health Care System of Massachusetts (MHS). Overlook CARE provides traditional Geriatric Care Management Services that are private pay. The staff also provides a number of other services through MHS, including InfoSource, a free information and referral service that offers resources, support, and guidance by a Care Manager to the caller. This is sponsored by the Masons of Massachusetts and is at no cost to the user. In addition, those Care Managers who are Social Workers provide the Social Services support through the certified Visiting Nursing division of MHS, Overlook Care at Home. This service is covered by the patient’s insurance, Medicare, or in some cases, covered at no charge by the Masons. Overlook CARE is also utilized to consult with other aspects of the MHS system, which recognizes the high value of the Care Manager’s perspective when striving to provide the best service and care possible to the aging population.

Kate Granigan, MSW, LICSW, C-ASWCM, Overlook CARE, Vice President of Care Management
Ms. Granigan is a licensed Independent Clinical Social Worker and a Certified Advanced Social Work Case Manager. Ms. Granigan received her Master’s degree in Social Work from Boston College in 1994. She worked as a clinician at Bay State Community Services and as a medical social worker for Special Care Visiting Nurses Association and Managed Health Care prior to starting her own Professional Geriatric Care Management practice. Ms. Granigan founded CARE in 1999.

In June of 2009 C.A.R.E. merged with Overlook Visiting Nurse Association, Inc. & Hospice Services, a member of the Masonic Health System. Ms. Granigan is now the Vice-President of Care Management for Overlook CARE.

A member of NAPGCM and NASW, Ms. Granigan is active in the elder care community serving as a current Board Member of Massachusetts Guardianship Association; past President of the New England Chapter of NAPGCM, a former Board Member for the Scituate Council on Aging and the Education Committee of South Shore Coalition of Workers with the Elderly. Ms. Granigan lectures regularly on topics related to aging, caregiving, and elder care.
While extremely convenient, the question arises: Are all these mobile devices safe from a HIPAA point of view? The answer is, “They can be.” But you clearly need some technology and policies in place.

This is where I need to make a personal / professional disclaimer: I am not a lawyer, and I am not a credentialed IT specialist. I am a web designer who provides Internet services very specifically to elder care professionals and other “covered entities” that must comply with HIPAA regulations. As a business associate of covered entities, I have to follow all the same regulations myself, so I think it’s fair to say I’m smarter than the average bear when it comes to these issues. Before you make any final business decisions, however, please consult with your attorney and your IT advisors. They will know about your particular business needs and any specific regulations that may be in place in your state. This article is simply intended to give you an overview.

The focus of this article is on HIPAA issues pertaining specifically to portable devices such as smartphones and tablets, but also to some extent laptops and even flash drives. The pragmatic theme is to share what you can do to avoid security breaches at the device level, essentially items 1 and 2. This is based on the recommendations of Health and Human Services (www.HealthIT.gov/mobiledevices).

When talking about safeguarding protected health information on-the-go, one needs to consider several aspects:

- Where the data is stored (“natively” on your mobile device or computer; or “in the cloud” on a server).
- What types of protections are guarding the storage locations (e.g., firewalls, authorized logins with passwords, encryption of the data…).
- How the data are transferred, traveling through cyberspace from their source to your devices.

To begin with, what needs to be protected on your devices? Any files stored on your devices that have protected health information (PHI) within them require special precautions against unauthorized access. If the device stores data with unique identifiers such as a name, contact info, birthday, Medicare number, or a photo or video of a patient, then the device itself needs to be protected.

Even if all your records are “in the cloud,” if your mobile device is set to log you in automatically (e.g., enter your password for you), then you are at extreme risk for a breach, especially if you share your device with others (spouse or children) or it gets lost or stolen. Similarly, if you store a file on your tablet with all your passwords to cloud services, then if anything happens to the tablet, your data are at risk. The thief will essentially have the keys to the kingdom.

According to a 2012 Ponemon Research Institute study (http://bit.ly/VzBKoN) lost or stolen equipment accounts for 46% of HIPAA security breaches.

And don’t think the government isn’t looking! HIPAA violations we hear about in the press have tended to be the big players, but small businesses are also being watched. They are the most likely to NOT have security policies and

(continued on page 15)
Care Managers Keeping Up with Technology
(continued from page 14)

procedures in place should a device be lost or stolen.

For instance, in January of this year, HHS announced its first settlement for a breach involving less than 500 patient records. Hospice of Northern Idaho was fined $50,000 because an unencrypted laptop was stolen and it was discovered that the organization had never done a risk analysis and had no policies in place regarding protection of electronic protected health information. (Read the HHS press release about this case at http://1.usa.gov/VvkEnE.)

Clearly, mistakes will be made. Flash drives and smartphones will be lost. Laptops and tablets will be stolen. We are all human. It is not expected that there will be zero events. But to be safe from legal action, HHS is looking for pre-planning and a conscientious effort to mitigate risks should a problem arise.

There are four major mobile device risks

• A lost or stolen device.
• Unintentionally downloading a virus or malware.
• Sharing your mobile device with someone else.
• Using an unsecured Wi-Fi network.

Here are some physical protections for offsetting the risk of unauthorized access to PHI:

• Physically lock the device to a table or other large object.
• Keep the device with you at all times.
• Use a screen shield when working in a public place.

Here are some procedural precautions:

• Refrain from storing actual patient information, or passwords, on the device.
• Set strong passwords. Include capital and lower case letters, numbers, and special characters (e.g., @, #, $, & _ -> * ).
• Avoid sharing your device with friends, family, or co-workers.

While extremely convenient, the question arises: Are all these mobile devices safe from a HIPAA point of view? The answer is, “They can be.” But you clearly need some technology and policies in place.

Here are some tech ideas:

• Encrypt the device. (Think of this as a program that requires a special key to code and decode the information into human-readable form, like the digital versions of the Cracker Jack Spy De-coder Ring you may have played with as a kid, but this is automated and on steroids. I would suggest consulting with an IT professional to have them add the appropriate type of encryption for the device in question.)

• Require authentication to log-in to the device.
• Refrain from the convenience of auto log-in to protected files or services. Similarly, set your device to automatically log-off if there has been no activity over a certain period of time.
• Enable remote-wiping or remote-disabling so you can get rid of or hide information from far away (in case your device gets stolen).
• Put some sort of inventory- and GPS-tracking system in place so you will at least know what equipment you have and where it is if it goes missing.
• Install a firewall. (Again, this is something you will want an IT professional to do for you.)

Lastly, you may wish to consider issuing “business only” devices to your employees rather than allowing BYOD (Bring Your Own Device) access to your sensitive records. More and more of the larger health care players are simply not allowing employees to use their personal devices for business. It’s too difficult to be sure everyone’s personal devices are up to snuff technologically with all the right apps, encryption, GPS-tracking, etc. Plus, it’s difficult to request and enforce that employees never let family or friends use their personal phone or tablet. If employees are given a device that is specifically for use in their work context, then the chances of a breach due to sharing a device are greatly reduced.

This article covers protections needed on the device-level. Subsequent articles will cover protections that are needed for transmitting data from your device to someplace else (e.g., entering into an electronic health record on the cloud), and protections you want to ask about if you will be hiring someone to provide services that store your data outside your office and in their computer banks instead.

Tasha Beauchamp, MSc is the Research Scientist and Webmaster at Elder Pages Online, a company that creates Internet marketing tools for elder care professionals. Tasha received her graduate certificate in GCM from the University of Florida. She is a frequent presenter at NAPGCM conferences and an active participant on the NAPGCM Listserv.
Everything was “Revolutionizing” at the NAPGCM National Conference in Philadelphia! We had more Member and First-time attendees than ever before! For the first time, our Keynote Speaker Dr. David Nash spoke to our Board of Directors in a private session about the interplay of NAPGCM and the role of research in Care Management to promote our value with families and the medical community! We had more Sponsor and Exhibitor interfacing than ever before! Sessions included: Technology with Apps to assist clients, Electronic Health Records, the Rehab Insurance maze, how to get paid by LTC insurance, the evolution of the Guardianship Standards, Determining Capacity, Mediation, a medical understanding of CHF, a riotous discussion about Observation Status that was on par with the debates over the wording of the Declaration of Independence!! Incorporating Holistic Health with Care Management, a personal re-balancing session for Care Managers, and an informative panel discussion that addressed the emotional and medical issues specific to aging LGBT individuals, all were interesting topics that demonstrated the varied aspects of our roles as GCMs. We also had a wonderful presentation by our NAPGCM Legislative Representative, Susan Emmer, on how to impact policy and influence our Representatives.

Whether one was involved in taking in the sights of this historic city, having a private tour of the magnificent Barnes Museum, or participating in the Rocky Run to the Philadelphia Museum of Art, there was time to renew friendships, advise new GCMs at Xtreme Mentoring, and participate in the largest Certified Roundtable ever!

Our President Julie Gray gave insight into the Strategic Plan for our Association. She stressed that we are on the crest of a wave of issues that make our roles as Geriatric Care Managers an increasingly important and ever-dynamic one.

Our National Conference is one of the most valuable opportunities that our Association brings to our members. We look forward to seeing many of you next year in Nashville!
2012 OUTSTANDING CHAPTER MEMBER AWARDS
FLORIDA | Catherine Rowlands
MID-ATLANTIC | Ellen Platt and Denise Valerio
MIDWEST | Gail Lee
NEW ENGLAND | Debbie Gittner
NEW JERSEY | Stacey Joyce
NEW YORK | Kristin Surdej
SOUTH CENTRAL | Doug Reuschel
SOUTHEAST | Gretchen Geagan
WESTERN REGION | Steve Barlam

2012 AFFILIATE COMPANY MEMBER AWARD
Disposables Delivered, Lucille Levine

2013 CONFERENCE CHAIR AWARD
Mary Kay Krokowski and Joyce Gray

NAPGCM 2012 PRESIDENT’S AWARD
Joyce Gray

ADELE ELKIND AWARD
Suzanne Modigliani

(continued on page 18)
In closing the tribute to Debra Levy, Susan Murphy read her poem, “Change.”

**Change**  
by Susan Elder Murphy

As simple as fashioning a silk purse out of a sow’s ear.  
Re-imagine your emotions.  
Let old hurts become the dust they deserve to be,  
rather than the precious objects they have become  
from frequent, close examination.  
Find the joy in loneliness,  
the hope in sorrow,  
the comfort of strangers.  
Think of caterpillars and weave your own cocoon,  
from which you can emerge  
a butterfly whose destiny you alone have chosen.  
© Susan Elder Murphy
A Call to Action: The Power of Research for the Future of Care Management

During the 2013 National Conference in Philadelphia, keynote speaker Dr. David Nash, founding Dean of the Thomas Jefferson school of Population Health, spoke eloquently about the opportunities and need for information about the effectiveness of care management services.

Measuring our work is thought to be the single most important key to advancing the practice of care management.

Because research is so critical to the future success of the profession, NAPGCM President, Jullie Gray, asked members at the conference business meeting for a “firm, personal commitment to help develop a vibrant research culture.”* The first steps towards this new culture require members to develop a new practice mindset, fully engage in the process, and coordinate efforts. Gray pointed out that it is only through research that we can demonstrate the power of care management to diverse constituents. She urged members not to worry about lacking research skills. “The Association is preparing the tools to help you seize this moment,” she said.

Gray then asked participants to, “come back to the present now but don’t let that grand vision of our future fade away. Remember that we hold the power in our hands to transform the way we practice by imagining the future, coordinating our efforts, and committing to the process.”

She noted that in the coming months and years, “members will be asked to provide information about yourselves, your clients, and your businesses.” Even though members are all pressed for time, she implored the audience to make gathering data and answering surveys sent out by the Association a priority.

Finally, Gray cited a proverb: “It is said that thoughts become words, words turn to action, actions become habits, habits breed character, and character leads us to our destiny.” She ended the session by asking everyone to “think, act, and reach our destiny together by making this grand vision of the future a reality!”

*Click here to see the video of the live address at the Annual Business Meeting in Philadelphia, P.A.

“I’m a firm believer in creating a vision, setting goals, and dreaming big,” Gray proclaimed. She then asked members to go on a visioning journey with her by closing their eyes, engaging their imagination, and letting all of their preconceptions about research go:

“I’d like you to imagine that you just sent out and received back survey results from 25 of your clients. The results tell you the importance of care management in your clients’ lives. You learn from this survey that clients feel extremely satisfied with your work. They say their quality of life has dramatically improved. Their adult children communicate better and miss fewer days at work. Family members report they are less stressed and overwhelmed than before they began service with you. In fact, the entire family system reports feeling empowered and able to make better decisions now that you are involved. They say that you’ve helped them find creative solutions to their most difficult problems. Their healthcare services are better coordinated, medical compliance has improved, and they are engaged in life like never before.

You would have a lot to say about the good work you have done and have reason to feel proud.

Now imagine that eight other care managers at your table this morning administered the exact same survey to 25 of their clients and found comparable results. You pool the information and instead of 25 participants you now have two hundred.

But what if 300 care managers in this room replicated the survey and discovered the same thing? With close to 8,000 participants now, the results are becoming ever stronger.

Let’s dare to take it one step further! Envision a time where every single NAPGCM member administered the exact same survey, regardless of their Chapter affiliation. Care managers across the country ask 100,000 clients the same questions and discover their results are valid, reliable, and extremely compelling.

Can you see in your mind’s eye the headlines that might follow this landmark research? The front page of the Wall Street Journal proclaims—Professional Care Management Improves Worker Productivity. The New York Times declares—A Broken Health System Looks to Professional Care Managers for Fix. Your local news outlets scurry to find their own angle, your phone starts ringing with requests for interviews and eager clients line up to work with you.

Suddenly, legislators also begin to take notice and ask members for advice on all subjects related to aging. Care managers are now fully recognized as innovative leaders. Institutions of higher education adjust their curriculum and attract more students who in turn become better prepared to meet the needs of our aging population.

Together, our members are linking arms around a mutual commitment and have positively influenced the lives of people across the nation. Not only are our clients impacted by this effort, but care managers improve their outcomes, develop benchmarks, increase revenues, and can now articulate and implement best practices so businesses thrive like never before.
Chapter Updates

Mid-Atlantic Chapter
Janice M. Duffin, President-Elect 2013

The “Sounding of the Bells” from the national conference continues to echo in the Mid-Atlantic chapter. Members who attended were energized at the conference and are now focused on keeping the momentum going. We thank NAPGCM for bringing the conference to Philadelphia and look forward to visiting Nashville in 2014.

We congratulate Joyce Gray on receiving the 2012 President’s Award from NAPGCM. It is well-deserved! The recipients of the Mid-Atlantic Chapter Award were Ellen Platt and Denise Valerio for their continued dedication to the chapter and weathering the storm as Superstorm Sandy battered their conference plans.

Carla Payne is stepping down as the Philadelphia Unit leader. Janis Hamilton has agreed to take on this leadership role for 2014. We thank Carla for using her boundless energy to lead the unit and look forward to her future contributions to the unit and the chapter.

On November 1, 2013, we are having a fall event in Richmond, VA. In collaboration with the local Alzheimer’s Association, members are invited to attend the Alzheimer’s Association conference, followed by our Chapter Meeting and a reception, hosted by SeniorBridge. We thank Louise Mohardt for her efforts in planning this event. Visit the Mid-Atlantic website for more information!

Midwest Chapter
Debra D. Feldman, President

The second quarter of 2013 began with our Chapter meeting in Philadelphia, PA with 23 members in attendance. For two of the attendees it was their first time at an NAPGCM conference, and we greatly enjoyed their company at our chapter meeting. During our meeting we reviewed how our 13 units have been actively meeting. They are hosting educational presentations for their own growth as well as hosting events for professionals in their communities. Our newly formed Illiana unit held its first informational meeting in February, and they are working to create and develop their unit. Our Kansas City Unit has reconvened and is beginning their planning for hosting the Midwest Chapter’s 2014 annual conference; while our Detroit Unit is busily organizing our 2013 annual conference to be held in October in Ann Arbor, Michigan.

At our Philadelphia Chapter meeting we also reviewed what our Board Member chairs are doing with each of their committees. We encouraged general membership to join our committees as we can always utilize new ideas and assistance from our members. It is a great way to become more involved in our organization.

Our newest change for the 2013 calendar year is that we will be going electronic for much of our future correspondence. Our last printed Newsletter was distributed at the end of April, 2013. Going forward our Newsletters will be electronic. We will also be having our first electronic election at the end of 2013. We are pleased to become more “Green.”

Our Membership Co-Chairs along with their committee members have been actively reaching out to our new members as well as contacting our non-renewed members to encourage their continued participation in NAPGCM.

We are looking forward to our next opportunity to gather in person in the fall.

New England Chapter
Deb Fins, President

The members of GCM-New England were happy to say goodbye to a long and snowy winter. The beginning of Spring was challenging with the events at and following the Boston Marathon. We all appreciated the outreach from our colleagues during that difficult time.

We have been busy here in New England. It was great to see so many members and potential members of our Chapter at the National conference in Philadelphia. More than 35 members, including eight members of the Board, were present.

The Chapter congratulates our own Suzanne Modigliani, who was awarded the prestigious Adele Elkind Award, the highest award offered by NAPGCM. We also congratulate Debbie Gitner who was selected as our 2012 Chapter Member of the Year. Deb has been the leader in establishing three units in the past two years with two more units in development. She also served as secretary for two years and was an important part of our transition to a consent agenda format for our Board meetings.

We have been working hard on putting written policies and procedures into place to guide future Board and Chapter members on a variety of issues.

Our Program Committee continues to organize and present regular programs throughout the year. Our 2013-14 schedule is nearly complete and will be posted on our website soon. In collaboration with the Massachusetts Guardianship Association, we are planning a mini-conference in November 2013 on “GCMs and Guardians, Who’s on First: Protecting our Clients and Ourselves.”

Our Maine, New Hampshire, and Connecticut units are meeting regularly. We are working to establish additional units in Rhode Island and Western Massachusetts.

GCM-NE is the first chapter to establish a LinkedIn page as a subset of NAPGCM’s LinkedIn Group. We are assisting our members to link their individual pages and our webmaster will assist members to develop pages as needed. We hope to start to provide content to the page through the work of our Board Members.

We look forward to continuing our work here in New England and learning from our colleagues across the country.

New Jersey Chapter
Trish Colucci, President

Things continue to move forward in New Jersey. Our chapter’s focus this (continued on page 21)
Chapter Updates

(continued from page 20)

eyear is on Public Relations. Our newly assembled PR Committee is working on ways in which to educate the public about geriatric care management and to promote our New Jersey chapter. Plans are underway to develop a member directory which will be distributed at presentations and talks by members of our chapter and also by our PR consultant. We are very excited to get out in the public eye and spread the word about the value of geriatric care management. As I once heard Julie Gray, our current National President, say, “When the tide rises, it raises all ships.” We know that what we do in New Jersey to promote the field of geriatric care management helps care managers everywhere.

Having the National conference so close to our border made it possible for a whole lot of New Jersey members to participate. For most of us, Philadelphia is under two hours away by car. It was great to get to meet with so many New Jersey Chapter members. We were proud to know that one of our own, Mary Kay Krokowski, was one of the co-chairs of the big event. Congratulations on a successful endeavor!

Our New Jersey Chapter Member of the Year, announced at the conference, was Stacey Joyce. Currently, Stacey is our chapter’s treasurer and a highly valued member of our chapter. Stacey is doing an outstanding job as our treasurer, always thorough and making sure that our records are impeccable. We nominated Stacey for the honor to acknowledge her valuable contribution to the success of our chapter.

Coming up in June, the New Jersey Chapter members have been offered an opportunity to have formal training in the care and management of clients with hoarding disorder. The program which was developed by our own Marcie Cooper (NJ Chapter past-president), through her institute, The Hoarding Disorder Institute, will provide members with important information about hoarding, what causes it, and most importantly, what we as care managers can do to assist clients who have hoarding disorder. We are planning a press release after the training to let the local public know that the New Jersey geriatric care managers are expanding their knowledge in this area and are now resources for help and assistance.

We wish all of our colleagues around the country a very safe and happy summer!

New York Chapter

Arleen Stern, Vice-President

As in the famous Philadelphia Mummer’s Parade, an amazing number, forty-seven, New York members strutted their stuff and rang the Liberty Bell in Center City. We came from Manhattan, Rochester, Buffalo, and beyond to have a memorable experience filled with learning, dining, and just getting to know each other. We thank Mid-Atlantic for all of their gracious efforts. We are now gearing up for next year in Nashville, and expect to be there in full force ready to check out the Grand Old Opry!

We hope however to see you way before Nashville! The NY Chapter invites you to and is proud to announce-- our annual full day conference dedicated to sophisticated business and clinical issues wrapped together and topped off with a touch of Broadway......

How to Succeed in Business WITH Really TRYING... A Forum for Care Managers.

On October 7, 2013, nationally known speakers and distinguished NY members will focus on growing your practice-- integrating and interfacing the new challenges and innovations confronting GCMS in 2013 while maintaining the highest level of ethical and clinical professional excellence.

Come to the Big Apple for a weekend of frolicking and then join us on Monday in Manhattan’s Greenwich Village at New York University, a beautiful and easily accessible area of New York. We hope to host some of our out of state/upstate members who need accommodations in our homes... so let us know. We will celebrate the conference by ending with a lovely cocktail party for more networking and fun. Please see our website for the coming attractions, registration form, and details.

Several of our most fit GCM members will be running in the NYC Corporate Challenge Race on Thursday, June 13th. You will spot them huffing and puffing wearing our Chapters new T-Shirts which read “Care Managers DO IT 24/7.” See www.nygcm.org for more details on how to root for our team if you plan to be anywhere near Central Park early that evening.

The NYC Chapter continues to make efforts to network and reach out to organizations and the general public, educating them on the benefits of GCM. We recently tabled two events-- one at a Wellness Expo, which brought in many older people in lower Manhattan and another in Brooklyn, giving us exposure in the local Jewish community.

Southeast Chapter

Kristy Robinson, President

The dissolution of the Southeast Chapter is complete and our chapter is now officially part of National.

We had 32 members attend the National conference in Philadelphia. Gretchen Geagan was voted Southeast Chapter Member of the year. Our fall conference will be in Raleigh-Durham the first weekend in November. Our local units are going strong and continuing to grow, these include: Nashville, Asheville, and Atlanta.

Western Region Chapter

Colleen Van Horn, President

The Western Region Chapter continues to grow and prosper. We now have 439 members representing 11 states and British Columbia. The majority of our members are in California, (252) followed by Washington (53), Arizona (42), Colorado (30) and Oregon (28). Our members are gearing up for our conference Oct 3-5 in Scottsdale, AZ. Our western chapter is now offering the conference chairs and co-chairs registration discounts for participation.

(continued on page 22)
in the planning process. It promises to be a conference you won’t want to miss. The Talking Stick Resort is the perfect southwest setting for our theme: “Recharge, Re-focus, Reflect, and Reconnect.” We hope all members will take notice of the theme and apply for our conference scholarships that will be offered this year to at least two and possibly three members. Check our website www.westerngcm.org in the near future for scholarship updates.

Congratulations to Steve Barlam, of Los Angeles, who received the Outstanding Chapter Member Award for 2013 which was presented to him at the NAPGCM conference in Philadelphia. Steve is a true leader and has been active in the WRC and nationally for many years. Thank you Steve for all you have done for our organization.

We invite all members to join us for our first 2013 free webinar on June 14th at 1pm pdt. The topic “Being Fully Present for Our Clients: Mindfulness Based Dementia Care for Care Managers.” The practice of mindfulness can reduce care manager stress, help forge connections with clients, and provide a new lens for problem solving disruptive behaviors. Care managers can share this approach with family caregivers helping reduce their stress and enabling them to be more present for their loved one. Marguerite Manteau-Rao is the CEO of Presence Care Project and Founder of the Mindfulness-Based Dementia Care Program (MBDC) at UCSF OSHER Center for Integrative Medicine.

Our 10 local units are now connected through LinkedIn with National. We are slowly moving forward with our social media connections. We encourage everyone to LIKE National’s Facebook account and interact on line with this group. Our chapter is also moving forward by establishing cloud-based storage of our past, present, and future WRC documents and records. We look forward to having this completed in the next couple of months with the help of our administrative assistant.

We are also moving forward with our accounting system moving to an online system. This will be useful for present and future treasurer transitions and oversight.

As you can see the WRC has been busy and we are only half way through the year. Stay tuned for the second half of the year with some new and exciting events planned.

Looking For the Right Care Resources? Search No Further.
Search for local care resources with our online search tool or discover the value of listing your services or facility in our directory.

Care Resources Include:
- Home and Support Services
- Professional Services
- Public/Non-Profit
- Outpatient Facilities
- Hospital & Long Term Care
- And more!

Claim your listing for free
CareLike.com/providers

Hearing & Vision Loss?
You, or someone you know, may qualify for FREE technology

For information visit iCanConnect.org or call 1-800-825-4595, TTY 1-888-320-2656
NAPGCM Members in the News

- Kay Paggi was quoted in “Advance directives help you control your end-of-life care” which was published in the Columbus Dispatch on June 9, 2013

- “Waveny Care Center Leads Way In Reduced Medication For Patients” was published by the New Canaan Daily Voice on June 4, 2013

- Jill Rosner authored an article “Navigating Health and Aging: A healthy brain starts with prevention techniques” which was published in the Carroll County Times on June 2, 2013

- Elizabeth Swider was quoted in “School’s Out! Care is There Geriatric Care Management Takes the Heat off Sandwich Generation Caregivers” which was published by the Albany Times Union on May 29, 2013

- Barbara Garwood was mentioned in “Business Roundup” published by the Salisbury Post, May 26, 2013

- Kay Paggi was quoted in “Advance directives let you have say before you’re unable to” which was published by the Dallas News on May 24, 2013
  http://www.dallasnews.com/business/health-care/20130524-advance-directives-let-you-have-say-before-youre-unable-to.ece

- Suzanne Modigliani and Miriam Zucker were quoted in “How to Handle Your Parents Moving in With You” which was published by Fox Business on May 22, 2013
  http://www.foxbusiness.com/personal-finance/2013/05/22/how-to-handle-your-parents-moving-in-with/

- Marion Somers was mentioned in “Apps help care for the elderly” which was published by Syracuse New York Times on May 20, 2013

- Carol Franzen was quoted in “Is helping adult children good for them?” which was published by the Dallas Morning News on May 13, 2013
  http://www.dallasnews.com/health/headlines/20130513-is-helping-adult-children-good-for-them.ece

- Angela Thomas was quoted in “The elder-care crossroad: How do you know when you’ve reached it?” which was published by the Dallas Morning News on May 13, 2013

- Ann Cason was quoted in “How To Avoid The Goldilocks Syndrome” which was published by Forbes on May 10, 2013
  http://www.forbes.com/sites/nextavenue/2013/05/10/how-to-avoid-the-goldilocks-syndrome/

- Buckley Fricker was quoted in “Make your heirs happy: Update your will” which was published by MarketWatch on May 8, 2013

- Rosemary Allender was interviewed for the “Caring for Elderly” by the Bowie Business Journal on May 7, 2013
  http://www.youtube.com/watch?v=L_InWFryIc4&feature=youtu.be

- Pam Feinberg-Rivkin started “Feinberg’s Ask the Care Manager Program” in honor of National Geriatric Care Manager Month which was posted on her website on May 6, 2013

- Don Grimes posted “Geriatric Care Manager - an expert you need” on YouTube in honor of National Geriatric Care Manager Month on May 6, 2013
  http://www.youtube.com/watch?v=Csg-BXb-O08

- Jennifer Browning held a free seminar to Promote National Geriatric Care Manager Month which was posted on her website on May 5, 2013

- Lauren Watral issued “May is National Geriatric Care Managers Month” press release which was released on May 5, 2013
  http://www.prlog.org/12131053-may-is-national-geriatric-care-managers-month.html

(continued on page 24)
Members in the News

(continued from page 23)

- Sound Options Celebrates National Geriatric Care Manager Month was posted on their website on May 4, 2013 http://www.soundoptions.com/blog/sound-options-celebrates-national-geriatric-care-management-month

- Charlotte Bishop celebrated National Geriatric Care Manager Month in “Charlotte’s Blog” which was posted on May 2, 2013 http://www.creativecaremanagement.com/senior-care/may-is-national-geriatric-care-manager-month-2/

- Janice McCurdy and Barbara Bristow posted an article on their website in honor of National Geriatric Care Manager Month on May 1, 2013 http://www.seniorcaremgmt.com/2013/05/01/national-geriatric-care-manager-month/

- Mary Jo Saavedra and Susan Cain McCarty were mentioned in “Fireside Group Offers Clients an Elder “Safety & Comfort” Home Inspection and Assessment During “Older Americans” Month” which was published by Seattle Post Intelligencer on May 1, 2013 http://www.seattlepi.com/business/press-releases/article/Fireside-Group-Offers-Clients-an-Elder-Safety/4476232.php

- Carole Larkin was quoted in “Memory Café offers coffee, companionship, peace” which was published by WFAA on May 1, 2013 http://www.wfaa.com/story/70441/

- Byron Cordes was quoted in “Retirement: Financial planning for Alzheimer’s” which was published in the Chicago Tribune on April 2, 2013 http://www.chicagotribune.com/business/sns-201303211830--tms--kplngmpctnkm-a201303402-20130402,0,744472.story

- Suzanne Modigliani was quoted in “Should Your Aging Parents Still Have A Gun In Their Home?” which was published in Forbes on April 1, 2013 http://www.forbes.com/sites/janetnovack/2013/04/01/should-your-aging-parents-still-have-a-gun-in-their-home/

- Linda Fodrini-Johnson was quoted in “What to do when parents lose their money minds” which was published in MarketWatch on March 26, 2013 http://www.marketwatch.com/story/what-to-do-when-parents-lose-their-money-minds-2013-03-26

- Lisa Meeks, was interviewed for a Business RadioX® Show on March 5, 2013 http://www.digitaljournal.com/pr/1140365#ixzz2PvDdRJ3z

Many Seniors To Age In Place” which was published in the Jewish Times on April 19, 2013 http://www.jewishtimes.com/index.php/jewishtimes/news/local_news/home_health_care_makes_it_possible_for_many_seniors_to_age_in_place/35383

- Bunni Dybnis was quoted in “How to Find Care Amid a Shortage of Nursing Aides” which was published by MarketWatch on April 14, 2013 http://www.marketwatch.com/story/how-to-find-care-amid-a-shortage-of-nursing-aides-2013-04-14

- Colleen Van Horn was quoted in “Van Horn Recognized by Senator” which was published in the Village news on April 11, 2013. http://www.thevillagenews.com/story/70441/


NAPGCM, the NAPGCM Website and geriatric care managers were listed or noted as resources in:


- “Reliable home aide can be hard to find” was published by the Sun Sentinel on June 11, 2013 http://www.sun-sentinel.com/health/fl-jips-aide-0612-20130611,0,2616556.story

- “Mom’s Meals Insights: How to Know When It’s Time for a Geriatric Care Manager” was published by Watch List News June 4, 2013 http://www.watchlister.com/news/2013/06/04/moms-meals-insights-how-to-know-when-its-time-for-a-geriatric-care-manager/

- “Caregiving tips to avoid a family feud” was published in the Times Union on May 28, 2013 http://blog.timesunion.com/seniors/caregiving-tips-to-avoid-a-family-feud/370/


- “What are Geriatric Care Managers and How Can They Help Me?” was published as part of the Art of Aging Blog by The Summit at Brighton on May 21, 2013 http://artagingblog.com/

- “What You Need To Know About Assisted Living Facilities” was published by Forbes on May 17, 2013 http://www.forbes.com/sites/howardgleckman/2013/05/17/what-you-need-to-know-about-assisted-living-facilities/
Members in the News
(continued from page 24)

• “How To Avoid The Goldilocks Syndrome” was published by Forbes on May 10, 2013
http://www.forbes.com/sites/nextavenue/2013/05/10/how-to-avoid-the-goldilocks-syndrome/

• “National Association of Professional Geriatric Care Managers Announce that May is National Geriatric Care Managers Month” was published by San Francisco Chronicle on May 3, 2013

• “Top Career Path for Nurses: Geriatric Care Manager” was published by Health Callings on March 29, 2013
http://career-news.healthcallings.com/2013/03/29/top-career-path-for-nurses-geriatric-care-manager/

• “Frightening Facts About Aging Parents in Assisted Living” was published by Forbes.com on March 28, 2013

• Anita Peca: Women Living in the ‘Sandwich Generation’ was published by Noozhawk.com on March 21, 2013
http://www.noozhawk.com/article/032113_anita_peca_women_living_in_sandwich_generation/

• Brown Introduces Legislation To Ensure Skilled Nursing Care For Seniors

Awards and Recognition

• Chandelle Martel was awarded the third place prize in the Heroes of Geriatric Care Story Contest by the John A. Hartford Foundation, June 2013
http://www.jhartfound.org/get-involved/heroic-stories-contest

• Carol S. Heape was awarded the prestigious “HealthCare Hero” award by the Sacramento Business Journal, May 2013


• Stowell Associates was chosen as one of The Journal Sentinel’s 2013 Top Workplaces in Southeastern Wisconsin, May 2013

• James Siberski was presented with the Alzheimer’s Association Greater PA Chapter Community Outreach Volunteer Award on May 8, 2013

• CareForward was awarded the Case/Care Manager – Independent Practice and an honorable mention for Case Care Manager - Patient Outreach at the Dorland 4th Annual Case In Point Platinum Awards on May 7, 2013.

• Laurel Felsenfeld received an honorable mention for Individual Professional Categories - Geriatric Care Manager at the Dorland 4th Annual Case In Point Platinum Awards on May 7, 2013

• Colleen Van Horn was recognized by Senator Joel Anderson for her efforts in ensuring the well-being of elderly citizens on April 5, 2013

With BAYADA Home Health Care...
“I can keep my high school sweetheart safe at home.”
– Irv T., Client’s husband

BAYADA Home Health Care provides exceptional nursing, rehabilitation, and assistive care services with 24-hour clinical support. Our thoroughly screened health care professionals are committed to keeping people of all ages safe at home.

Call 800-305-3000 | www.bayada.com

Alumni Leadership Committee
Chair – Susan Fleischer
Committee Members are: Linda Aufderhaar, Rona Bartelstone, Norman Hannay, Kimberly Hand, June Ninnemann, Barbara Schuh, Miriam Oliensis-Torres

Our Committee continues to meet on a monthly basis. We are striving to encourage our alumni members to participate and stay involved in contributing their wealth of experience and knowledge to help grow our membership, mentor our members, and develop our Association.

Our main activities this past quarter have focused on:
- The review of existing FAQs to create standardized answers and talking points to be used by our Volunteer Career Counselors when speaking to potential new members.
- FAQs to be utilized in different areas of our website, on e-flash newsletters and in Inside GCM.
- Completing a Webinar PowerPoint presentation to orient our Volunteer Career Counselors to NAPGCM and professional care management. This presentation will provide talking points for standardized answers to the FAQs they receive.
- Reviewing and adding pertinent material for the Volunteer Career Counselors orientation tool kit.
- Writing designated articles to be published for Inside GCM. This involves collaborating with the Inside GCM Committee.

We are pleased to announce that the Peer Mentoring Program Proposal for the Peer Review Committee was approved by the Board. Also approved by the Board of Directors is our Committee’s Practice Consulting Proposal. The Practice Consulting Proposal recognizes that many care managers may wish to avail themselves of an advanced professional mentoring program. Now members will have the opportunity to choose a qualified NAPGCM member to act as their paid consultant to mentor them based on their own practice issues.

The Alumni Leadership Committee members continue working on the development of tools to promote best practice care management models to support the 2013 Strategic Plan.

Business Alliances Committee
Committee Co-Chairs: Nancy E. Avitabile and Steve Barlam
Committee Members: Liz Barlowe, Dianne Boozman, Phyllis Brostoff, Linda Fodrini-Johnson, Kate Granigan, Gladys Harris, Deborah MacArthur-Rapp, Holly McGlinn, Elizabeth Swider, Bob O’Toole

The Business Alliances Committee met its initial goal, to create a policy and process for evaluating potential business entities requesting a formal alliance with our association. Preliminary and secondary screening process forms were presented to the Board of Directors during the April 2013 Board Meeting. The Board of Directors approved the documents presented and asked the committee to begin using the screening process. They asked about next steps after the screening. Questions were also raised as to how we differentiate between an alliance, sponsor, and Affiliate Company Member. Overall, the process was very well received by the Board, and they look forward to its implementation.

The committee had the opportunity to use the new screening process with a prospective partner. In addition to evaluating the appropriateness of forming an alliance with the company, we are able to use that interview as a test for the process. Information obtained from implementing this evaluation helped the committee identify gaps in the process. The committee will resolve gaps in the screening process, create a timeline for growth, continue to identify and evaluate potential alliances, and define and evaluate our relationship with these entities.

Care for Yourself and Your Peers – Remember the Gelardi Member Support Fund!
Diane Hirschke, Chair

The Gelardi Member Support Fund was started in 2005 by our association after Hurricane Katrina to support some of our members in Louisiana who had homes and offices badly damaged by the storm.

However, there doesn’t have to be a natural disaster such as Hurricane Sandy or the tornado in Moore, OK, to cause you to suddenly need financial help in order to survive. It could be a major illness or physical injury threatening your ability to maintain your business and to care for your clients.

Our committee members were gratified by your generous donations to the Fund through the prize drawing at the National Conference in Philadelphia. $1500 was raised! And, your donations continue to come in throughout the year.

Remember that we are there for you and your peers if needed! A simple application can be downloaded on the National Website and submitted to Kaaren Boothroyd, our
Committee Reports

(continued from page 26)

Executive Director, at kboothroyd@napgcm.org. Every application is kept confidential.

We are seeking committee members to help up with this worthy cause. If you have an interest, please contact Diane Hischke at nurse@serving seniors.net.

GCM Journal Committee
Suzanne Modigliani, Editor In Chief

The GCM Journal, a great member benefit, is now presented electronically.

You probably are already perusing the Spring issue which features four excellent and pertinent articles on legal issues of interest to care managers. Emily Reese was the Guest Editor.

The fall 2013 Journal will be a timely one focusing on the Affordable Care Act and Health Care Reform. Carol Heape is the Guest Editor. Spring 2014 will feature incontinence, another learning opportunity for GCMs. The Guest Editor will be Mary Palmer, Helen W. & Thomas L. Umphlet Distinguished Professor in Aging at University of North Carolina at Chapel Hill School of Nursing and Interim Co-Director of the University of North Carolina at Chapel Hill Institute on Aging.

Phyllis Brostoff will be the Guest Editor of the fall 2014 issue on supervision with particular focus on supervision for GCMs.

Standards Committee
Charlene Proeger, Chair

We are putting the finishing touches on integrating our Code of Ethics with our revised Standards of Practice.

We have also started the process of drafting new standards, based on suggestions from the Ethics Task Force, our committee work, and ideas from our members. Our priorities are areas of practice where care managers sometimes run into difficulty. The first topics for new standards on our “task list” are “continuity of care” and “termination.”

Our committee members are: Nancy Avitabile, Deborah Fins, Miriam Oliensis-Torres, and Stephanie Swerdlow.

Research Development Committee
Amy Abrams, Chair

The Research Development Committee continues to meet monthly, and is making great progress toward our goal: developing a comprehensive research plan that supports geriatric care management utilizing internal and external sources for use by the association to meet public policy, public relations, and membership goals. This dynamic and very active committee is made up of Susan Birenbaum, (continued on page 28)

BOOK REVIEW: Switch, How to Change Things When Change is Hard
Authors: Chip Heath and Dan Heath
Publisher: Broadway Books (320 pages, available in print, Kindle, and audio versions)
Reviewed by Susy Murphy

“Switch, How to Change Things When Change is Hard,” was easily the most powerful book I read in 2012. The authors provide a simple template to follow whether you are trying to change your eating habits, influence the behavior of your employees, or create social change. They challenge the reader to view each dilemma as having three separate elements: The Elephant, The Rider, and The Path. The Elephant is the emotional side of our brain, hard to harness, impulsive, but powerful once it is fully engaged. The Rider is the rational side of our brain, motivated by reason, often in conflict with the impulsive, emotional Elephant. And the Path is the way towards the change. When the Path is clear, the Rider has an easier time directing the Elephant towards the desired change.

So how does this work in a GCM practice? The authors illustrate their premise in engaging stories that help the reader understand how to actually make use of the strategies that are described. As a care manager, when I am faced with a client who is struggling to live alone, yet insists that she does not need to move to a facility, I try to avoid expending unnecessary energy to motivate her Driver, but instead work to engage her Elephant. I was particularly challenged by a client who lived alone in a large condo and steadfastly refused to move. She had moderate dementia and macular degeneration. She continued to drive, despite the fact that the insurance on her car had lapsed, the registration had expired, and her license was suspended. She was very social but had lost contact with most of her friends. I cleared the Path by finding an assisted living community where I showed her a spacious “penthouse” apartment with large windows and room for her favorite antiques. When we ate in the dining room, she found herself the object of attention of several strategically placed male residents. Bingo. Her Elephant was fully engaged and we could proceed with the move.

I listened to the audio version of “Switch,” and as I did, I found myself constantly thinking of how I could re-frame challenges in my personal and professional life to be more successful at realizing the changes I wanted or needed to make happen. Unlike many business books, “Switch” is entertaining and humorous, and months later I find myself going back to re-read portions of it to give me a new perspective on a dilemma. As we prepare to meet the challenges of a changing health care industry and seek to redefine our role as care managers, this book will be an invaluable tool. I highly recommend it.
Committee Reports  
(continued from page 27)

Phyllis Brostoff, Byron Cordes, Bunni Dybnis, Jullie Gray, Deborah Newquist, Jeff Pine, Cheryl Theriault, and Monika White, and works in close collaboration with the Public Policy and Public Relations Committees. We were pleased to hear comments made by keynote speaker Dr. David Nash at the national conference in Philadelphia in April about the critical need for published research that distinguishes geriatric care management from other professions and services, demonstrates how we solve problems for our clients and their families, and validates our interventions. President Jullie Gray made a stirring entreaty during the membership meeting that demonstrated the power of individual participation in association-wide research efforts. We all know the value of what we do, both as individual practitioners caring for our clients, and as a profession addressing gaps in an increasingly complicated health care system. It’s time that we were able to prove it.

Earlier this year, we finalized a comprehensive list of research data points that detail the information we need to be able to collect on an ongoing basis about our member demographics, client demographics, business practices, and outcomes. The committee then formed several subcommittees that are now actively working on developing methods for collecting this data. I invite any member who is interested in participating on one of our subcommittees (Health and Utilization Outcomes, QA/Client Satisfaction, Business Practices and Benchmarking, Member Demographics, or Research Funding and Partnerships) to reach out. We would value your input and participation! Our goal is to make participating in research a manageable and valuable endeavor for all of our members, by providing tools that are easy to use for care managers in practices of all size and scope.

Best of Listserv

From Julie Menack some good information on Medication dispensers that can notify families:

There are now two pill dispensers offered by MedMinder - the original one is called “Maya” and there is also a new one called “Jon” (maybe the owner of the company had two children?). Both devices can notify family when the person takes their medications. Maya is “unlocked”, and Jon is “locked” and tamper-proof. Both have cellular connectivity so no land line is required. They are offered on monthly contracts. Both look like standard 7 day pill boxes with 28 compartments, for morning, noon, evening, and bed time. They are very nice units; the only issue might be is that someone needs to change the tray once each week. http://www.medminder.com/

There are a couple of other options - the Med Ready is a 28 compartment circular device with a carousel inside it, and is hooked up to a land line.

Depending on the vendor, it can either send alerts to a family caregiver, or send alerts to a call center which then would alert the family member. It is available from a large number of vendors (we can provide it). We offer it nationwide on our web site -- http://www.virtualcareathome.com/medicationmonitoring.html

Then, there are a few larger “Cadillac” (i.e. more expensive) models such as the Philips medication dispensing service which will hold up to 60 cups, accommodating up to 40 days of medication, 6 doses/day. It also provides reminders for non-pill medications. This one is also monitored via standard phone line. http://www.managemypills.com/content/

A similar large device called TabSafe holds a series of cartridges that can dispense the medications. http://www.tabsafe.com/

I think for simplicity and economy, the MedMinder products are good, as long as there is cell service in the residence and it can be refilled each week.

These products all work; it just depends on the details. Doesn’t everything we do hinge on that?!

Best of Listserv

Some helpful information from Cindy Schaefer on the transportation of bodies overseas:

After the past several posts, I wanted to answer the questions for myself, so I contacted one of our local funeral homes, and also spoke with two friends who are/have been flight attendants. The summary is pretty simple. If someone dies in the U.S. and wants their body sent home overseas, the first step, if not already done prior to death, is to contact the funeral home. They will then retrieve the body, and obtain the death certificate and paperwork for the U.S. side. Then they will contact the respective consulate.

Depending on the rules of the incoming country, the body will be prepared.

The incoming consulate gives the instructions and the paperwork to the funeral home. Most caskets are sent via commercial airlines. Approximate costs within the U.S., I am told are between $500-700 for the airline. Africa was $1700. I suspect that Western Europe would be around $1200. The funeral home at this end would charge between $3500-4000 for all the fees. Before shipping, the funeral home at the incoming end needs to also sign paperwork, agree to receive the body, and sign papers with the airlines. There is a fee at that end as well, but I do not know what the range is. Also, I am told that the body does not need to be accompanied. The process should take 5-7 days.

Alternately, if the body is cremated, the ashes should be put into a box or container that will go through the airport security x-ray. A metal urn causes problems. It can be carried on with no notification to the airlines. The family carrying the ashes should have paperwork documenting the contents, when security checks. There are no fees. We have done this.

Cindy also gave great information about things we should know about transporting people with Parkinson’s disease:

There are many things that you should take a look at. First, I have found that travelers with Parkinson’s disease (continued on page 29)
need supplemental oxygen more often than the general older population, and often more than travelers with heart or mild lung disease. I think it may be due to their inability to compensate with increased rate and/or depth of their breathing. The problem is that no U.S. domestic flights offer supplemental oxygen any longer. I am not sure about flights from Canada. I would also look at medications, how long is the flight? What time of day is it? Will the caregiver be able to manage prn meds and regular meds during the flight? I assume he takes them via his g-tube. Regarding his bowels, I find that leaving them alone is better than stirring up trouble with enemas or such. Hydration will be an issue. Getting what he needs through security could be tricky with regards to feedings, and water to flush. I would take bottled water, as water on the planes is often not good. What time of day is he at his best? What does his paranoia manifest like? You might want to address this with seating options. Is it better in the morning or afternoon? Does he have other underlying issues?

Karen Kelly provided help with the “observation” status discussion:

A Board Certified Elder Law Attorney spoke in a presentation I attended today about this situation. She claims that it is the flawed computer program (a Medicare fraud screening mechanism) that detects that a patient is not meeting criteria for admission, and puts the patient into “observation status” instead. The doctor and the patient would not even necessarily know...unless they asked.

We need to ask each day if our patient is on OBS or admission status, because even if admitted by a patient’s attending physician, the status may reverse later (and retroactively) to outpatient observation status. She emphasized that we have the right to ask the doctor to advocate for the patient and over-step the system. Her point was: “The computer did not go to Medical School and get the medical degree” (and I add: “... nor examine the patient”).

She also mentioned calling ombudsman and hospital social workers. And you can ask for Medicare “appeal” (even if not on Medicare while on outpatient observation). Hospitals *do not* like this, because they are getting FAR LESS money from Medicare for OBS vs. admits. And think about it, while the patient is there in a regular room overnight several days, the hospital’s expenses for that patient would be just as much as if the patient were on “admission status.” So, it is to the hospital’s benefit to get them “admitted” officially. Perhaps if hospitals made full disclosure to the patient, and explained what that means in terms of insurance reimbursement, the public outcry would help correct the “flawed system.”

http://www.medicareadvocacy.org/ is a good resource for legal help (not-for-profit).

Carolyn added:

Karen, your point about continually checking on observation status is well taken. However, your information about the hospitals receiving LESS if patient is on OBS rather than admit is not correct, according to my experience.

One of my long-term clients asked me to look at her mother's ambulance bill to see why it was denied payment by Medicare, as the rule is that the ambulance SHOULD be covered if the patient is admitted overnight. While investigating this, she had given me the bill for the 4-day hospital stay post ambulance trip. Guess what. The charges were about $300 PER HOUR.

When I tried to figure out why she was being charged HOURLY for being on a regular medical wing bed, I found out that the charges were for OBS - observation, even though she was transferred from the main ER to a separate building in the extended campus and was in a 2-bed room for 3 overnights, four days. This charge, which amounted to approx. $7200 PER DAY, is far in excess of what a non-acute (i.e., non-ICU) bed would have been charged.

We challenged. Still pending...

From Susy Murphy:

Changes in the Medicare rules require us, as care managers, to be ever-vigilant as advocates for our clients and their families. The “observation” status is just one example of a way in which Medicare and hospitals are trying to “game” the system and avoid being penalized for repeat admissions. It also avoids that pesky SNF admission, because if you are never actually admitted, then you don’t qualify for...

(continued on page 30)
If a patient changed from Observation to full inpatient, it is NOT retro-active, inpatient started from the day the MD order was written. That said, the inpatient status can be retro-active, called Condition Code 44 (under Medicare). Never a good thing!

Bottom line, always ask from the time the patient hits the door - what is the level of care status!

A question from Wendy Liebling concerning elopement risk:

If you have any suggestions regarding the following that would be appreciated, elopement risk of concern; Client is 69 year old woman, very independent and headstrong. She was recently discharged from rehab following hip fracture/surgery/rehab to home with gentle soul of husband (POA) who is overwhelmed with responsibilities. Wife little to no awareness of limitations, up and down stairs in home without cane, declines to use hospital bed on first floor. According to husband, wife was diagnosed with Alzheimer’s disease recently and left house at night a few months ago, found wandering by police. She is often impulsive and historically unaccustomed to any limitations in any regard, has continued to work until recent hip fracture. Her work involves significant public notoriety and respect. Until this hip fracture, she was driving, (has not yet asked for the car keys).

In an effort to keep her secure at night we hired nighttime aide: (8pm-8am) in the home due in case of absence. Also contacted alarm company to check system and put in place CHIME feature.

Now only 48 hours since discharge, they want the caregiver out (her presence keeps him from sleeping and client resents her being there) and the alarm work is too expensive. Husband said this plan is not working.

I was thinking about a wearable GPS, but she will not agree to shoes or watch - wearable GPS equipment that I am aware of. It would have to be so discreet that she does not even know about it. I think the house alarm is going to have to be repaired, that would seem to be the most reasonable option at this time.

Julie Menack gave the following suggestions:

I am going to mention some systems that my company sells and more importantly can help you to design for just such situations. These systems do not need to be purchased from me (just want to make this clear in advance).

The “lowest” tech solution would be to use wireless floor mat(s) that connect to a pager that the husband would monitor. The pager could be set on “silent” so that when she steps on the floor mat, the husband would be alerted. The floor mat(s) could be placed either next to her side of the bed or in front of the door(s) to the house (either inside or outside). There are also bed pads that would alert the pager when she gets out of bed, but she might notice the bed pad. Someone as cognitively intact as this may notice the mat as well. (They could potentially be placed under a more decorative mat) I help people design custom systems to suit their needs - on my web site, these are the Smart Caregiver system products.

A higher tech solution would be a home monitoring system that would consist of door contact sensors that are programmed to send alerts by phone, text, or email to the husband (perhaps to his personal cell phone) or to someone outside the home. When the door is opened, the alert would be sent. The system can be programmed to send an alert at a certain time of day (such as between 8 pm and 8 am).

The system that I sell is the simplest one, the BeClose system; it is also generally available on the web. There are higher end, more expensive systems such as SimplyHome and GrandCare (LivHome offers a version of it). What you get with the higher end systems are more programming and tweaking options, as well as the option of videoconferencing and telehealth, which in this case is not needed at this point.

In either case a base unit needs to be plugged in somewhere. It would need to be put somewhere out of the way so that she does not see or dismantle it.

I would like to add that despite our best intentions, failures do occur in our attempt to use technology. In one case, I attempted to use a contact sensor (continued on page 31)
What have any of you used to classify a GCM business:

From Rebecca Wild-Wesley a question on team.
just a little better by working with her medical
better door locks as well as helping her sleep
doors, an outside lock on the side gate, and
solutions that included dismantling the garage
result was that we had to come up with other
the contact sensors which were placed high up
doors and removed most of them. The
impairment, this client is particularly aware of
has moderate dementia. Despite her cognitive
(continued from page 30)

What have any of you used to classify your GCM business:

Rebecca answered her own question:
I appreciate the feedback from several
owners of GCM businesses. As I am Inc., that
was not the issue. The banker was using the
North American Industry Classification System
(NAICS) and have had difficulty identifying
exactly what GCM businesses are.

BOOK REVIEW: Connecting with Socially Isolated
Seniors: A Service Provider’s Guide

Authors: Patricia Osage with Mary McCall
Publisher: Health Professions Press (120 pages)
Reviewed by Libby Kennard

Social isolation is associated with overall poorer survival rates
and higher disability. Seniors, whether living alone or in congregate
living, often feel lonely and lack emotional support systems. It is
common to feel frustrated with how to intervene with the underlying
problems of substance abuse, mental health issues, hoarding, or
poverty; yet, it is vitally important to engage seniors in regular
and meaningful contact with others. The authors remind us to be
persistent, diligent, and not to take it personally when a client refuses
our initial efforts.

This is a very handy resource book. It was created by the
Director of Resident Services at Satellite Housing, Inc. in California,
a non-profit providing affordable housing and services to seniors.
It covers each of the major contributing factors of social isolation
in a short chapter with concrete ways to intervene and resources. It
is a helpful read for clinicians, program coordinators, and essential
for activity coordinators and case managers. Designed for service
coordinators in senior housing programs, it can be easily incorporated
as a training program for all staff in a care facility. Formatted in
larger print with short chapters, each chapter concludes with a list of
practical applications to activities staff, personal care providers, meal
providers, or volunteers. The emphasis is on what to watch for, how
to engage with seniors, and when to get more help.

Citing research and surprising statistics about how social isolation
impacts the health of seniors, it drives home the value of addressing
this in your work. For instance, up to one-third of hoarders also have
major depression. It is thought that hoarding increases in seniors as
losses and traumas accumulate. A person replaces relationships with
possessions. As geriatric care managers, we know how difficult it is
for a facility, building manager, or family member to handle hoarding
seniors effectively. The outlined steps guide us to do so in ways that allows
the senior to maintain purpose and control.

The emphasis is on the role
of relationships even breaking
it down with actual examples
of what to say for instance to a
grieving widow. We all have the
responsibility to engage seniors
in our lives in a way that conveys
respect and develops trust. The
authors speak to this in effective
eyeday language. Tolerance
and sensitivity for individual
differences in regard to beliefs,
lifestyles, and backgrounds is
presented in each subject area.

Libby Kennard, MA, CMC, provides
assessments, consultations and care
coordination services to seniors and their
families located in Oregon.
Save the Dates!
April 30-May 3, 2014

The National Association of Professional Geriatric Care Managers is Celebrating THE 30TH ANNUAL CONFERENCE in Nashville, Tennessee

Sheraton Music City Hotel
777 McGavock Pike Road Nashville, TN 37214
615-885-2200 | www.sheraton.com/musiccity

Room Rates: $169 Single/Double
Cut-off date for special rate: March 21, 2014

For more information visit www.caremanager.org

Member Get a Member CHALLENGE

The 2013 Member-Get-A-Member is off to a tremendous start! Twenty-seven of our newest members came to NAPGCM as referrals from current members. And two members are on the way to half-price 2014 membership.

Remember, there are two ways to win in the 2013 MGM Challenge*. Refer five (5) new members and you’ll receive a FREE membership for 2014! Or refer three (3) new members and receive a 50% discount on your dues for 2014. It’s never too late to start - you have until the end of the year to bring in new members.

Your participation strengthens the association and positions NAPGCM as the leading voice of the profession. Growing NAPGCM membership ensures consumers working with professionals committed to a code of ethics and standards of practice.

Thank you to these members:

Linda Fodrini-Johnson (2x)
Nancy Avitabile (2x)
Marjorie Koch
La’Keisha Phillips
Lisa Meeks
Karen Wasserman
Lue Taff
Althea West
Abby Beck
Julie Gray
Lisa Mayfield
Anne Sansevero
Karen Wasserman

Bobbi Kolonay
Harriette Groh
Mary Alice Butler
Ann O’Neil
Rowena Cole
Barbara Applegate
Doris Haas
Bethany Lawrence
Stephanie Sverdlow
Anne Pagano
Joan Garbow
Patricia Player Maxwell
Libby Kennard

*The fine print: The MGM Challenge began March 1 and lasts until December 31, 2013. Your name must appear in the “referred by” field on the prospective member’s application at the time of submission. Only accepted applications will count toward the final total. Only one student level membership referral will count toward your total referrals. No retroactive credit will be awarded.