inside gcm

A look back...

...and a look forward

INSIDE

Our National Association History

Care Managers as Challengers: Adapting to a Changing Economic Landscape

Voices of NAPGCM Past Presidents

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There are certain events in life that provide us with an opportunity to contemplate our journey through life. For some individuals it may be triggered by a certain birthday; for others it is an annual undertaking at the end of each year. Regardless how often or the reason for the consideration, looking back affords us the unique opportunity to take stock of events and in turn hopefully improve our lives. This is why the editorial committee of Inside GCM has put together an expanded edition to take a “look back” at the history of our organization.

2012 was a year of positive transition for members of NAPGCM, we... the members opted to begin the year by becoming self-managed and, in addition, the organization revealed the newly revised and improved Code of Ethics and Standards of Practice which help guide the professional geriatric care manager and advance this growing profession. I became a member in 2000, and yes there have been many changes for the better. I had the opportunity to sit down and talk about the changes to this organization at the 2011 annual conference in New Orleans with several founding members. We hope you enjoy looking back at the history of our organization.

2012 Calendar of Events

APRIL

National Healthcare Decisions Day
April 16, 2012
www.nhdd.org

NAPGCM 28th Annual Conference
Reaching New Heights: The Power of Compassion
April 18 – 21, 2012
Grand Hyatt Seattle, Seattle, WA
www.caremanager.org

NAELA Annual Conference
April 26-28, 2012
Renaissance Seattle Hotel, Seattle, WA
www.naela.org

JUNE

CMSA Annual Conference
Spanning the Waves of Change in an Ocean of Opportunities
June 19-22, 2012
Moscone Center West, San Francisco, CA
www.cmsa.org/conference

OCTOBER

2012 Midwest Chapter Conference
Racing Toward Excellence
October 19-21, 2012
Indianapolis, IN
www.midwestgcm.org

National Guardianship Association
2012 National Conference
October 20-23, 2012
Portland, OR
www.guardianship.org/calendar.htm

2012 Mid-Atlantic Chapter Conference
October 28-30, 2012
Sheraton Baltimore North, Towson, MD
www.midatlanticgcm.org

NOVEMBER

2012 Western Region Chapter Conference
November 1 – 3, 2012
Santa Rosa, CA
www.westerngcm.org

2012 Southeast Chapter Conference
November 2-4, 2012
Charleston, SC
www.caremanagersoutheast.org

2012 New England Chapter Conference
GCMs Embracing Change: Nourishing Mind, Body and Practice
November 4 – 5, 2012
Best Western Royal Plaza, Marlborough, MA
www.gcmanewengland.org

10th annual National Memory Screening Day
Tuesday, November 13, 2012
www.alzfdn.org

This list includes NAPGCM events and other items that may be of interest to NAPGCM members. Please see the NAPGCM Web site for more information.

May is "National Geriatric Care Manager Month"

by Linda Fodrini-Johnson, Chair, Public Relations Committee

The Public Relations Committee, with the assistance of our PR consultant Ann Krauss, is proud to introduce a new program designating May as National Geriatric Care Manager Month.

This is a great opportunity for you to get local press and/or set up speaking dates for you to communicate just what wonderful value a Geriatric Care Manager can bring to families juggling the stressors of aging family members and life.

You can start to set up your own speaking engagements for the month of May and we will have:
• A Press Release template for you to use with your local media (news and television)
• Tips for working with the press
• Ideas for seminars and special events
• An E-flash with links to the documents you might need will be sent to all members as well

This is a great opportunity for all of us to do outreach for our profession. Your national PR Committee will be doing a PR Newswire press release and contacting national media as well. Together we can get the word out – Families don’t have to do this alone.

So, put on your creative hats and prepare for new clients!
As I write this, the New Year is still very fresh, though my fitness resolutions are already in serious jeopardy of becoming distant memories. I have stepped off the treadmill more than on it. I am back to sugar and starches – and chocolate. I love chocolate. I see my old patterns returning all too quickly. This issue of Inside GCM is taking a look at the history of our national association. I think this is such a great exercise for us all; to examine where we have been, thus, giving us perspective. Winston Churchill said it well, “The farther backward you can look, the farther forward you can see.” I do believe we can set stronger future-sighted goals when we have been motivated by seeing how far we have come.

NAPGCM has certainly come a long way. Our association has grown from those few pioneers meeting in New York, into a strong new profession that is the recognized voice for care management! While other associations struggle in recent turbulent financial times, we have managed to keep consistent membership numbers. We have just finished our first year of self-management. I would like to take a minute to thank our very dedicated, and all-volunteer committees and board of directors for making the past year work so well. Under the leadership of the 2011 President, Susan Fleischer, NAPGCM has charted new territories with so few scrapes along the way. We have set some amazing goals for 2012. One incredible step has been to engage a Legislative Consultant, Susan Emmer. I hope you have been finding her Public Policy News E-blast useful as we try to wrap our arms around the issues that affect our profession and clients.

She negotiated a lease, moved bank accounts, re-engineered our phones and implemented new software (just to name a few). Bet you didn’t know Kaaren is also a movie star – Google or IMDB her! But our national office could not run without the help of all our staff and contract help; Amanda Mizell, Julie Wagner, Sarah Garcia, Pam Carlson and (welcome) Callie Daters. Have you seen our new website with improved search functioning? That was all staff. Have you ordered anything from the NAPGCM store only to see it ship the same day – staff! Have you participated in one of the many great webinars – staff? When you call into national or see these wonderful ladies at the Seattle conference, please take a minute to tell them thanks for all their hard work.

While my fitness goals are anything but in good shape, I am still on fire about the resolutions within my business and NAPGCM. I would like to challenge all of you to take a hard look at your future and some of the things you can do for your practice. Maybe it’s a new branding campaign, expanding your services to another region, or just updating your website. And as much as NAPGCM has come a long way with the help of the board, staff, and Executive Director…..our association’s real history and future are nothing without you, the member. As we move into this exciting year, I challenge you to get more active. Join a committee, attend a conference, or invite a new member to join. Sophocles reminds us, “Let him that would move the world first move himself.” So, thank you for all you do to make NAPGCM such a wonderful place to learn and grow. I look forward to seeing you all at the national conference in Seattle. I hope they have chocolate.
Board Bits

Collected from September 2011 and February 2012 Board Meetings

NAPGCM has entered into an agreement with both CMSA and NAELE to exchange exhibit space at one another’s 2012 Conferences; NAPGCM will also make a presentation on geriatric care management at the CMSA conference.

It was agreed to make Chapter Conference Visits and increased collaboration and communication with Chapters a priority in 2012.

Two “firsts” for the Advanced Practice Retreat: a member-sponsor—Senior Care Management, and CEs were offered for two panel presentations.

Stephanie Swerdlow reported on a the new Peer Review Committee, replacing the Dispute Resolution Task Force, including its two subcommittee; Audrey Zabin is chair of the Ethics Subcommittee and Phyllis Brostoff the chair of the Business Practices Subcommittee.

Farewells and thanks were delivered Linda Fodrini-Johnson, Mary Kay Krokowski, and Connie Rosenberg, whose terms on the board ended December 31.

Board agreed to take a neutral position on the Department of Labor’s proposed rulemaking to revise the current exemption of home care workers under the Fair Labor Standards Act (FLSA).

Legal Counsel Hugh Webster reviewed Board of Director Legal and Fiduciary duties. Also presented was a proposed Whistleblower Policy, which was adopted by the Board.

The Board requests that the Member and Chapter Relations Committee create a task force to prepare a proposal for updating areas of practice categories along with a definition of each for use by both consumers and members.

The Board Approved:

2012 Strategic Plan

2012 Public Policy Agenda, presented by Legislative Consultant Susan Emmer on behalf of the Public Policy Committee.

Dissolution of the NAPGCM Guild, which has been inactive for several years.

Formation of an Insurance Task Force to research and make recommendations for both cyber liability and other types of insurance for members.

Reserves policy, as presented by Treasurer Carol Heape.

Posting of the GCM Journal on the public website pages for a six-month period.

Making May “National Geriatric Care Manager Month” beginning 2012.

Creation of an Outstanding Affiliate Company Member Award, proposed by the Business Alliances Committee, to be presented at the Annual Business Meeting at the conference.

Use of the tagline “Geriatric Care Managers...coordinating services to optimize health and quality of life” for immediate use by the Public Policy Committee.

Policy for members’ protocol when representing NAPGCM at others’ speaking or conference events, as presented by Public Relations Committee.


Executive Director’s Message

Kaaren Boothroyd

Your beliefs become your thoughts. Your thoughts become your words. Your words become your actions. Your actions become your habits. Your habits become your values. Your values become your destiny.

—Mahatma Gandhi

In this issue of Inside GCM we’re taking a look back and a look forward. No doubt there are volumes more that could be written on how the profession of geriatric care management — and NAPGCM — has evolved. However, I think you will find these pages enormously rich in personal accounts of thoughts turning into words, and words turning into action. You’ll hear the voices of the chapters, past presidents, and members – telling stores of sharing and helping one another in so many ways. This is a community of professionals who know how to care and how to get things done.

And the stories lead us into the expanded and enhanced world of geriatric care management. You’ll see habits and values reflected in standards, planning tools and contracts, conferences and meetings, and award recognition. And finally, we are pushed to the future – our destiny, one might say – with articles challenging us to be “challengers” and to serve in the work of the association.

All of these things – beliefs, thoughts, words, actions, habits, and values – will be addressed in a variety of fascinating ways in Seattle in April. Adding to an impressive line-up of speakers on clinical, business, legal, ethical, and policy topics, is a hands-on pre-conference intensive on the arts and dementia with staff from the Frye Art Museum, a special session on slow medicine, and an abundance of opportunities to experience the cultural and culinary life of the Emerald City!

Of course, NAPGCM is also addressing these and other topics of interest to GCMs through webinars, teleconferencing, social media, publications, e-flashes, and the listserv. The opportunities expand every year. Indeed, in 2012 the Board of Directors has set the association on an ambitious road that brings value and the imprimatur of excellence for members, the profession, and the public. We hope you’ll be an active participant in the association and enjoy all the benefits of membership!
Today the National Association of Professional Geriatric Care Managers is a professional organization with almost 2,000 members nationwide. The origin of the organization is quite interesting, and as you ponder the sequence of the events that brought forth the founding of the association it is today, it is almost impossible not to feel some awe.

In December 1983 Glenn Collins published an article in The New York Times titled “Long-Distance Care of Elderly Relatives a Growing Problem.” During the process of writing the article he contacted Rona Bartelstone as a resource; she had recently published an article about her fledgling Geriatric Care Management Company. It was during this interview, that Glenn informed Rona about other individuals located in the New York State area who were doing similar work. With this introduction, the founding members seized the opportunity to meet and began building the foundation of what is now known as the National Association of Professional Geriatric Care Managers. Reflecting back, Rona states she flew to New York and discovered a group of “amazing women” who had knowledge of each other and had been collaborating about private care management services, they were: Sarah Cohen, Leonie Nowitz, and Adele Elkind. After several trips to New York and meeting other people such as Lenise Dolen and Eleanor Rubin, Rona recalls that the small group began to wonder if others may be doing similar work outside of New York, New Jersey, and Florida. At this time the group decided to reach out by placing advertisements in professional publications such as the NASW newsletter and nursing and psychology journals to probe interest for having an “informal conference where likeminded people could come together to explore this emerging phenomenon.”

In 1985, the first informal conference was held in New York at the Summit Hotel, with 50 to 60 people in attendance. Most participants were from the northeast, but there were others such as Susan Fleischer, 2011 NAPGCM President, who at that time was working for the Jewish Vocational & Family Services in Louisville Kentucky. Attendees were enthusiastic; therefore, the group decided to meet again the following year in Philadelphia. During this conference a Steering Committee was formed to begin the process of becoming an organization. Sarah Cohen was the chair of the committee and the first President of the fledgling association serving 1986-1988. The organization became known as the “National Association of Private Geriatric Care Managers” which consisted of approximately 50 members made up of mostly nurses and social workers and who had a minimum of a Master’s Degree in Human Resource Management and two years of supervised experience in a geriatric setting.

The following year, the group met in Boston, MA; and the steering committee became the first board of directors. The association adopted Standards of Practice on October 20, 1990 at the sixth annual meeting, which was held in Washington, DC. In time Standards were developed as a guide for members to use in order to adhere to ethical principles in all aspects of practice. It was also during this time that Bob O’Toole and Adele Elkind created the “Geri-Gazette,” which later becomes Inside GCM, the association Newsletter. During the early years the association was recognized as a trade association, which promoted member practices.

(continued on page 8)
The New NAPGCM Code of Ethics
(continued from page 7)

Under the strong leadership of the board of directors, the association took the direction to be a professional association with the primary purpose of advancing the profession.

The association members and board of directors recognized that Geriatric Care Management as not exclusively in the entrepreneurial arena. It was also noted that non-profit agencies had been providing services. With this in mind, the members voted to change the name from National Association of Private Geriatric Care Managers to the National Association of Professional Geriatric Care Managers in 1993. The association also expanded the voting membership base to include members who provide care management in all practice settings with a minimum of a baccalaureate degree.

The Association continued to work toward development of the profession and in 1996, along with Connecticut Community Care, a credentialing program for Care Managers was formed. The National Academy of Certified Care Managers (NACCM) was created. To this end, the association voted in 2006 to require all members in the care manager category to hold at least one of four approved certifications. This requirement became effective on January 1, 2010.

The association continues to grow and change for the betterment of the profession. We are now self-managed with our own proficient staff who work on the behalf of our members.

1983

Articles in New York Times "Long-Distance Care of Elderly Relatives a Growing Problem." By Glenn Collins.

1984

The first private care manager’s conference in NYC at the summit Hotel "Private Geriatric Care Management in the 21st Century: A Call to the New Profession."

1985

Steering Committee was formed at the Philadelphia Conference.

1986

Standards and Credentialing Committee developed recommendations upon in Philadelphia conference; also members voted to name our organization NAPGCM.

1986

New England chapter forms.

1986

Publication group was formed to produce the quarterly newsletter for "opening and maintaining ongoing National Dialogue."

1987

The third conference "Building a National Network" Lenox Hotel in Boston, MA. (NAPGCM officially established with board of directors and bylaws).

1988

Fourth conference "Private Geriatric Care Management: A Response to Consumer Need."

1989

Fifth conference Westgate Hotel, San Diego, CA focusing on national policy initiatives for long-term care and the "The Third Step to Dignity." Newly formed publicity committee engages vendor exhibits and articles on geriatric care management appear in nationally recognized publications such as the Wall Street Journal and New York Times.

First local chapters chartered.

1990


1991

Seventh conference St. Anthony Hotel, San Antonio, TX, "Creating a Larger Vision."

1992

Eighth conference Doubletree Hotel, Tucson, AZ "Trailblazing a New Frontier." "The Business of Becoming a Private Geriatric Care Manager" is published for sale by NAPGCM to members. Membership voted in favor of members in non-profit organizations be full voting members, changing the name of the organization to National Association of Professional Geriatric Care Managers.

South Central and Greater Philadelphia chapters formed.

1993

Ninth conference in Pittsburgh, PA, "Diversity in Care Management." Membership approved broadening entry level membership to Baccalaureate degree persons with requisite experience, certification, and practice as a GCM.

Midwest, Western Region, and Greater Pittsburgh chapters formed.

1994

Tenth conference and 10th Anniversary of the organization, celebrated in style in Paradise Island, Bahamas with the theme "Sailing into our Second Decade."

1995

New Jersey and Greater New York chapters formed.

1996

Supported formation of credentialing program (NACCM)

Mid-Atlantic, Florida, and Southeast chapters formed.

2006

Members voted to approve certification requirement for membership.

2010

Enhanced Benefits & New Levels of Membership introduced

First annual Chapter Presidents Retreat held in Tucson.

2011

NAPGCM became a self-managed organization

New Code of Ethics introduced

27th Conference held in New Orleans.
In the last few years, all businesses have felt the sting of the recession. No one has been left untouched. While many care management businesses have maintained and even grown during this period, the general sentiment is that everyone is working a lot harder for their revenue.

Current Situation — So, what has changed?

Have the client’s needs changed? Are people not requiring the kind of services that a care manager provides? NO! In fact, the needs are becoming more complex.

Are clients and family members waiting longer to engage a care manager? YES!

Are families becoming more involved, attempting to self-care manage situations? YES!

Are clients and family members purchasing fewer services, for shorter periods of time? YES! and

Are clients scrutinizing services more, prior to starting services? YES!

Due to these changes that many care managers have experienced, a new approach to one’s business may be indicated. The goal of this article is to explore one specific strategy that will lead to increased business in a challenging economic environment.

A Strategy for Consideration... Reexamining our Role

Looking at the world of sales, much attention has been spent on identifying distinct styles of sales people and their varying degrees of success in this current economic environment. Five styles have been identified:

The relationship builder

The hard worker

The lone wolf

The challenger

The problem solver

As I read about this, I was intrigued, due to the fact that I feel that the same styles are employed in the world of care management... So which of the styles proved to be most successful? Clearly it had to be “the relationship builder.” However, in the sales field, it is “the challenger.” Intuitively this did not make sense, as it went against everything that I believed was true.

So who is the Challenger, and how does this translate into the world of Care Management?

In learning more about the role of the challenger, it started to come together. Let me attempt to lay out the basic premise:

To truly be an effective challenger, you need to build this role upon the basis of a strong relationship with a client. The challenger has a deep understanding of the client’s needs and isn’t afraid to share his/her views even when they may be different from the client’s views. The challenger is assertive in dealing with internal and external stake holders, tending to push people outside of their comfort zones. The challenger does this with grace, presenting the information in a manner that others can take in – based on a trusting relationship, as well as always being driven to do what is genuinely in the client’s best interest.

There are times in which a care manager has a clear idea of what is the right direction to take, and when it differs with the client’s view, the care manager may choose to back off from their initial recommendation based on...

- the importance of the issue
- risk of losing the client
- honoring self determination
- assessment of the client’s ability to accept differing views
- desire to avoid conflict
- desire to strengthen relationship based on perceived alliance or having the same views

For a “relationship builder,” the primary focus is on interventions that enhance the relationship. Sometimes the best interventions are not employed in the name of not wanting to jeopardize the relationship.

In our current economic environment, we need to evolve to the next level of the relationship with our clients/families... building upon the relationship, we need to challenge our clients, helping them to understand why they should take action.

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Care Managers as Challengers (continued from page 9)

For a “challenger,” the primary focus is to help the clients to understand the value of taking action as well as the impact of their inaction regarding the issue that has been identified. It isn’t always a popular position to take; however, when delivered well, it often strengthens the relationship between care manager and client.

As a “challenger,” the care manager can exert the expert voice to provide value and help introduce solutions that may have never been considered prior.

What are the three essential characteristics of a challenger?

Teach
Tailor
Assert

Challengers teach clients something new and valuable. They compel clients with a unique perspective that differentiates them from the competition. They educate by demonstrating expertise and value. Challengers teach by telling stories that resonate with their clients/families. They use questions wisely to help their clients make connections between identified problems and the value of taking action to resolve them. Lastly, challengers provide innovative ways to address perceived problems, at times demonstrating/modeling alternative approaches.

Challengers tailor their interventions to the specific needs of their clients. Once the challenger truly understands the needs, expectations, and preferences of the client, the interventions chosen are always tied to what is of value to the client and presented in a manner that reinforces the expertise of the care manager. When talking about care management services, the challenger begins with what is important to the client and ties the value of care management specific to these issues, as opposed to speaking about general features of care management.

Challengers assert and maintain an appropriate level of control during the intake process to help guide the client to a place where they understand the value of taking action and engaging the care manager. They are able to stand firm with confidence when clients push back, in a fashion that is not perceived in a negative light. They challenge the client’s ideas in a positive way leading to better outcomes. In face of risk aversion by clients, challengers can move clients outside of their comfort zones in order for them to take action, positively affecting their quality of life. Challengers appropriately assert themselves by asking the right questions; feeling comfortable when tensions arise; having confidence in the solutions they have in mind; and having the skills to set and manage their clients’ expectations.

Expectations and the Challenger

Satisfaction = E (Expectations)

Satisfaction is a function of expectations

Client satisfaction is often linked to length of stay. The more satisfied a client is with a service, the greater likelihood that the client will stay with that service. So as we look at strategies for strengthening our businesses, we should attend to satisfaction.

There are clients who come to the care manager with very set ideas of what needs to be done, how it should be done, and what is the right course of action. They look to the care manager to be the implementer versus the expert. There are times that their view is clouded, and the care manager may have ideas of alternative options that could result in more positive outcomes. Oftentimes the care manager strives to develop the trusting relationship and chooses to work within the confines of the expectations that have been laid out by the client/family. After all, we all have learned the adage “you begin where the client is at. But is there another way?”

Client Example: An adult daughter calls the care manager for help in finding an appropriate assisted living facility for her father. She has set the expectation of what she is looking for, and in her mind there are really no other options. “Can you – the care manager help me?”

As a relationship builder/implementer the care manager could respond: SURE! And the focus of the interventions would be set.

As a challenger the care manager could respond: “SURE! I’d be glad to help, but as someone who has (credentials and years of experience inserted here) I want to make sure that the A/L option is the right choice for you and your father. I have worked with so many families who have set ideas of the optimal solution, but due to the specifics of their situation, in a plan that they initially had in mind “blows up,” creating more problems for all involved. Therefore I’d like to ask just a handful of questions just to ensure that this won’t happen to you. The last thing I’d want is for you and your dad to have a less-than-positive experience.”

In Summary

Strong relationships do matter, but they are not enough. Sometimes relationship builders will focus too much on the relationship and compromise on the specific recommendations made to avoid perceived tension/conflict. From a client’s perspective, relationship builders might make interactions feel good; however, not always memorable or valuable. Challengers, in general, would prefer to be respected than liked.

High-performing challengers have excellent relationship-building skills. But once the relationship has been formed, they continue to stretch it, and add value by asking questions, challenging the status quo, all within the context of wanting to positively impact the client’s/family’s quality of life, reduce risk, and enhance the care experience.

Challengers create a constructive tension within the confines of the relationship. They offer their clients a unique perspective with passion and precision that draws their clients into the relationship deeply. Client value is more important than client convenience to the challenger.

As we all strive to thrive in the current economic landscape, I challenge you to consider the impact of assuming more of a “Challenger” style in strengthening your relationships with new clients (to achieve higher conversion rates), as well as with existing clients (to achieve higher retention rates).
It was an honor to serve the association as the President during our transition year 2010 – bringing us to “self-management” was a huge accomplishment for the entire board. The skills of our outstanding executive director and hard-working board helped us accomplished the coming of age and maturity of a full-grown organization. I also saw during my term the Ethics Committee complete a wonderful revision, and I saw the chapters being more connected to one another and national which will only strengthen us going forward. Prior to being President in 2010 I chaired the Certification Committee, and I am so proud to say that now over half of our entire membership is certified; this fact adds to our credibility with the press and referrals. I continue to have passion for our profession and encourage all members to become active and help us grow to serve the aging boom.

I am proud to say that I have been involved with NAPGCM since 1990 – 21 years...

I had opened the doors of my GCM practice the year before, and was reluctant to join an association made up of my competition. Being new to the field, I felt a bit intimidated by the likes of professionals whom I had heard of, and had seen their success as they had been the pioneers who created the professional road on which I was just beginning.

I was coaxed to attend my first conference in San Antonio, Texas by Harriette Grooh, who helped me to overcome my initial fears, with the promise it would help me to meet others who did what I did, learn from their best practices, and begin to develop a professional support network.

I remember, sitting in the lobby of the hotel, and Rona Bartelsrone, the president of the association sat next to me asking me about my practice. I don’t recall one word that she or I said to one another…but I do remember rushing off to call my wife…”Guess who I just met and spoke with!!!” While my wife was not quite as impressed as I clearly was, she shared in my excitement as I started my journey with the right kind of support, guidance, mentorship, and education.

Over the last 20+ years, I have been involved with the association as an active committee member, serving on more than a dozen committees, as a frequent speaker at the national and chapter conferences, as a president of our local chapter, as a board member on both the chapter and national level, as the President of the Association, as a Fellow, as the recipient of the Adele Elkind and Rose Kleiner annual awards, and as an annual conference attendee where I have the opportunity to learn, network, and reconnect with my cherished professional colleagues and friends all over the country.

What I have taken away from my involvement is that the more I become engaged in the advancement of our burgeoning profession, through active committee work both on the national and chapter level, the investment pays off in so many ways. I encourage newer members to take as active role in the association as you can afford. You will see the impact on your business, your professional growth, and your success!

Steve Barlam, 2003 President
The most memorable event of my 2001 Presidency was that the terrorist attack on the World Trade Center on September 11, 2001 was just days before our Annual Conference in Nashville. Trying to make a joint decision with Laury Gelardi, our executive director, and with Alan McBroom, the conference chair, about whether or not to cancel the conference was like trying to make a major decision in the middle of a nightmare from which you were not able to wake up! I practice in New Jersey, and I remember talking to Claudia Fine, President-Elect, on the telephone trying to get a sense of what was really happening in New York City in order to be able to make an informed decision. Ultimately the conference was canceled and rescheduled to March 2002. I wrote in the fall 2001 “Inside GCM” about the experiences of New York care managers and how their clients coped with the catastrophe.

Connie Rosenberg, 2001 President

I have been a member of NAPGCM since 1988 and served on the board for nine years. I treasured every moment of my involvement in the association and made lifelong friends. It’s been ten years since my presidency and ten years since 9/11. This was a unique and terrible time in our country and for NAPGCM. I was faced with having to make the difficult decision to cancel our annual conference which was scheduled for the following week. The financial impact on NAPGCM was tremendous. Thankfully, I had a supportive and optimistic board of directors. Their response was to aggressively focus on increasing the association’s visibility in the world of aging, to build the membership, and attract sponsors and partners.

Sadly, the challenge of growing our membership and being a financially sound organization still remains. The decision to require certification for full membership was essential if we as geriatric care managers want to be perceived as truly professional. At the same time, the decision has limited the pool of GMCs who meet the criteria for full membership.

Hopefully we will overcome these challenges as we have others — by creating value-added products that associates can purchase to more readily attain full membership; by developing other services and products that can enable GMCs, GCM practices, and businesses to differentiate themselves in the consumer and professional market.

Note that I say “we.” I continue to perceive NAPGCM as my professional “family.” I encourage my professional colleagues to “get involved” and to derive the emotional and professional satisfaction from the experience.

Claudia Fine, 2002 President

Voices of NAPGCM Past Presidents (continued from page 11)

A Look Back

A History of Members Helping Each Other: The Gelardi Fund

by Lisa A. Moody

After the devastation of Hurricane Katrina, NAPGCM members and staff worked together to create a support fund to help each other. This support fund is called the Gelardi Fund and it operates as a 501(c)(3). It was created to distribute funds to members who find themselves in need of assistance due to medical or natural emergencies or are experiencing unusual financial hardship. The fund is possible solely through generous donations from NAPGCM members. NAPGCM members Dianne Boazman and Betty Landreaux were deeply affected by Hurricane Katrina. The following is their account of what the assistance from the fund meant to them.

During Katrina our homes were flooded and we were temporarily living in Baton Rouge, LA while they were being renovated. In addition to the loss of our homes, our business was unable to reopen for more than 5 months due to the widespread devastation in New Orleans and the displacement of our clients and our caregiving staff. This was truly a catastrophic experience—both personally and professionally!

Laury Adsit Gelardi, NAPGCM’s Executive Director at the time, was a very good friend of ours and stepped up to respond to our crisis. Immediately following Katrina, she began raising funds within our national association to help us during this period of unemployment and loss of income. The support we received through our wonderful NAPGCM colleagues got us through a very tough period in our lives.

There are two aspects to the fund: donations and requests for assistance. Donations may be made in the form of cash, check, or credit card. All donations are tax deductible and receipts for your donation will be mailed to you. To make a donation, you can visit the NAPGCM website at www.caremanager.org. Requests for assistance are handled on an application basis. If you know of someone who is in need of assistance, contact Kaaren Boothroyd, Executive Director of NAPGCM, to request an application, by calling the staff office at 520.881.8008. Applications are reviewed by the Gelardi Fund Committee, who makes the final determination. All information on the application remains confidential to the Gelardi Fund Committee members only.

NAPGCM is made up of generous members who look after each other, especially in times of need. Please consider donating to the Gelardi Fund as part of your annual giving plan.
Thanks to everyone for another educational, inspiring, and energizing **Advanced Practice Retreat**. We hope you took away some new ideas that will benefit your care management practices, your clients, your employees, and yourselves. All of us at Elder Care Guides appreciate the opportunity to learn from and collaborate with our colleagues from around the country.

--Amy Abrams & Norman Hannay  
Advanced Practice Retreat Co-Chairs
Florida

Joanna Davis
In 1993, six care managers gathered together in south Florida and developed the bylaws for the Florida Geriatric Care Management Association; it was with this document and initiative that FGCMA was issued a chapter charter of NAPGCM by then President Peter S. Belson. Since then, the Florida Chapters has hosted 19 successful annual meetings throughout the state, has had nine Board of Director Presidents, of which seven are still very active in committees and their respective units. We have over 230 Chapter members and eight active units. In 2008, the board of directors met at their annual retreat and drafted the chapter’s Mission and Vision statements which are intended to direct the organization’s membership.

Vision Statement:
The vision of the Florida Geriatric Care Manager’s Association is to be recognized as the dynamic organization promoting excellence in the practice of professional care management.

Mission Statement:
Our mission is to be responsive and supportive to our members by providing opportunities for collaboration, education, and the promotion of ethical standards of practice.

We continue to develop and expand our membership and look forward to further our profession as care managers.

Mid-Atlantic

Regina Curran
The Mid-Atlantic Chapter was incorporated in Virginia on February 23, 1995. The initial officers were: Blair Blunda, President, Linda Aufderhaar, Vice President, Susan Veltri, Secretary, and Arlene Saks, Treasurer. At the time of incorporation the chapter included members in Maryland, Virginia, and the District of Columbia. In 2006, Delaware and West Virginia were added to the Mid-Atlantic Chapter’s area. In June 2009, the former Pittsburgh Chapter dissolved and its members joined the Mid-Atlantic Chapter. On January 1, 2010, the Philadelphia Chapter also dissolved and its members joined the Mid-Atlantic Chapter. Thus, as of 2010, the Mid-Atlantic Chapter includes members in Maryland, Virginia, the District of Columbia, Delaware, West Virginia, and Pennsylvania.

The initial meeting of NAPGCM members in the Mid-Atlantic area was held at the Classic Residence by Hyatt on September 1, 1992. Thirteen NAPGCM members attended this initial meeting. (Six—Lynn Carr, Marilyn Fall, Debra Levy, Ann O’Neil, Joan Richardson, Arlene Saks-Martin—are still chapter members.) Joan Richardson was elected chair of the group. The dues were $5. At a follow-up meeting held on October 17, 1992 at the NAPGCM conference in Tucson, it was agreed that a letter of intent to form a chapter would be sent to the national NAPGCM office. NAPGCM recognized the Mid-Atlantic Chapter in 1994.

The Mid-Atlantic Chapter initially met quarterly—one at the annual NAPGCM conference and three times at retirement facilities in the Mid-Atlantic area. The meetings were held at mid-day and a tour of the host facility was included. The chapter now meets twice a year—once at the annual NAPGCM conference and once at the chapter conference. Chapter meeting schedules must meet the needs of the chapter members. Being geographically smaller, the former Philadelphia Chapter initially met every other month at a member’s home for dinner. Eventually these meetings were moved to a retirement facility. The Philadelphia Unit continues with the meeting schedule established by the former chapter—every other month at a retirement facility for dinner and a tour.

The Baltimore Unit was the first Unit established for the Mid-Atlantic Chapter. The first meeting was held on January 15, 1998. The chapter now has five Units.

Chapter conferences:
“Challenging Client Situations”—April 9, 1997 in Arlington VA (co-sponsor Manor Care Health Services)
“Defining Quality: Putting the Pieces of Eldercare Together”—May 13, 1999 in Arlington VA (co-sponsor George Washington University Hospital and Forest Pharmaceuticals)
“Keeping Seniors Safe: Working Together to End Elder Abuse”—September 27, 2007 in Springfield VA (Co-sponsors MD/DC/VA NAELA Chapters and Elder Law Committee of DC Bar Association)
“Care Management Leads the Way”—November 9-10, 2010 in Fairfax, VA

Mid-Atlantic Chapter Presidents
1994-1998—Blair Blunda
1998-2002—Linda Aufderhaar
2002-2005—Joan Richardson
2006-2009—Stephanie Thomopoulos
2010-2011—Regina Curran

Philadelphia Chapter Presidents
1995—Annetta Kraus
1996-1997—Shelia Saunders
1998-1999—David Levy
2000-2001—Joyce Gray
2002-2003—Aimee Stewart
2004-2005—Joyce Gray
2006-2007—Beverly Bernstein Joie
2008-2009—Dolores Magid

Pittsburgh Chapter Presidents
1995-1996—Juanita Nealer
1997-1998—Paula Tchirko
1999—Ann Meglio
2000-2001—Mindy Shaw
2002-2003—Patricia Boyer
2004-2005—Kathy Seeman
2006-2008—Lynn Mercurio
2009—Jami Pazuchanics

Midwest
Jan Welsh

The Midwest chapter was formed in September 1990 and had its first meeting in Louisville on March 3-4, 1990. The next meeting was in Milwaukee September 13-15, 1991.

Chicago initially wanted to form its own chapter, but in the end stayed with the rest of the Midwest. Cheryl Smith Rizyk from Kansas City was the first president in 1990. Marianne Ewig, Milwaukee, was the Chapter President in 1991, and June Ninnemann was on the original board. Cheryl signed the articles of incorporation as did June Ninnemann as vice president. (For anyone who is keeping track, June just finished another term as Midwest Chapter president in 2010) The Midwest Chapter sent a Position Paper to the national Board that was published in the November 1991 “Inside GCM,” and was answered, point by point, by Rona Bartelstone, as President of the National Board, in the same issue. The last point in this paper was, “Utilize the newly formed President’s Council of Chapter presidents to distribute minutes and board information to the chapters.”

So you see, improving communication between National and Chapters was discussed from the very beginning! The driving issue was to have a Midwest presence, since the organization was heavily represented on the east coast. It also grew out of a sense of holding the organization accountable and making it more transparent. We had some “rockin’” business meetings at national in the early days.

New England
Mary Jo Boynton

The roots of the New England Chapter began in 1985 when a group of care managers in the Boston area started meeting informally. The meetings focused on support, peer supervision, and sharing “tricks of the trade.” Initially the meetings were held in a variety of places, including the Arlington, MA Council on Aging, a local Stop ‘n Shop grocery store meeting room, members’ homes, and infrequently a nursing home or assisted living facility.

By the late 1980s the group moved to the most-remembered location: member Peter Belson’s father’s warehouse in Waltham, MA where the group met over takeout pizza and Chinese food. Also in the late 1980s the “Soup Group” started—providing a forum for peer consultation over dinner.

Simultaneously, two local care managers, Robert O’Toole and Peter Belson, were actively involved with the emerging national organization. The Boston area hosted a National Conference in 1989, which was attended by 100 people. Because of the enthusiasm created at this conference, in 1989 the local group voted to formalize the New England Chapter of the National Association of Private Geriatric Care Managers. There were approximately 30 members; most were from Massachusetts; however, Connecticut, Maine, and New Hampshire also were represented. Susan Turner was elected the first President of GCMNE.

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**NAPGCM Chapter Histories**  
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In the early 1990s, with the membership growing, the Chapter focused on generating referrals by compiling the first New England Chapter directory listing 30 members. Because of the lean budget, members had to pay to be included. Members also mimeographed the pages and stapled them together! In 1994 under the Presidency of Meredith Patterson, the Chapter continued developing its professional presence by having a Chapter telephone number, letterhead, and method for responding to inquiries. Also at this time, recognizing the importance of care managers, nursing homes and assisted living facilities starting hosting the monthly Chapter meetings. All of this set the stage for how the Chapter currently functions.

Many dedicated members made the New England Chapter the dynamic group it is today; unfortunately in this short article it is impossible to accurately list everyone and the roles they played. The Chapter would like to acknowledge the New England Presidents from 1989 through 2011. In chronological order the Presidents were: Susan Turner, Susan Townshend, Marjorie Osheroff, Meredith Patterson, Nancy Peters, Emily Saltz, Patrick Devine, Jace Tilton, Audrey Zabin, Suzanne Modigliani, Sharyn Russell, Susan Lewin, Sally Kaitz, Jill Lebar, and Kate Granigan. I sincerely apologize for any omissions or inaccuracies.

Thanks go to the “very early members” for their recollections: Susan Turner, Peter Belson, Robert O’Toole, Meredith Patterson, Carol Westheimer, and Frank Baskin.

**New York**

**Nancy E. Avitabile**

The evolution of the New York Chapter begins in the early 1980s with a group of social workers, psychologists, and nurses meeting regularly at the Manhattan home of Adele Elkind to discuss their work with elderly people in the private sector. Out of these meetings emerged the Greater New York Network for Aging. Their group was profiled in a New York Times feature, “Private Teams Help in Care Of Elderly” in June 1981. Meetings continued and three years later, in 1984, another New York Times article, “Care for Far-Off Elderly Relatives Sources of Help” appeared. Many of the members of the GNYNA were mentioned, yet the article also gave awareness to the group that there were others across the country engaging in similar professional work. These individuals, who would eventually form the New York Chapter, were also the founding members of NAPGCM.

With commitment and persistence many of the following individuals from New York, along with care managers across the country, began organizing: Adele Elkind, Babette Becker, Jerie Charnow, Maureen Clancy, Sarah N. Cohen, Lenise Dolen, Jacquelyn Effram, Vanessa Gang, Leonie Nowitz, Ellen Polivy, Bernice Shepard, Gloria Scherma, Miriam Scholl, Mary Ellen Siegel, and Vera Themal. Some of these early pioneers are still involved in the New York Chapter and currently maintain successful practices.

Organized primarily by Sarah N. Cohen and Bernice Shepard, over 100 care managers attended the first national conference at the Summit Hotel in Manhattan. This meeting stimulated the group present to organize committees and work on a second conference the next year, in Philadelphia, where NAPGCM became official. GNYNA continued on with their group and their 1986 nomination’s slate included: Adele Elkind- President, Jerie Charnow-Vice-President 1, Lenise Dolen-Vice President 2, Gloria Scherma- Recording Secretary, Sarah Cohen-Corresponding Secretary, and Bernice Shepard-Treasurer. The earliest GNYNA directory listed approximately 20 practices.

The founding group produced a newsletter called the Geri-Gazette which many years later became Inside GCM. Peter Strauss, the father of NELA, offered trainings in elder law and information on how to avoid liability. Members reported that it was challenging to be a private geriatric care manager in New York in the 1980s. Agency social workers didn’t understand the profession and considered it unethical to charge for services offered for free by non-profits and city and governmental agencies. Early members worked tirelessly on community public relations and education. They found great validation in networking with one another, and after the first National conference, the local chapter started to grow.

Our chapter, The Greater New York Chapter of Private Geriatric Care Managers received their Chapter Charter in October 1990 and continued to welcome individuals from New York, New Jersey, and Southern Connecticut. In October 6, 1994, the Chapter incorporated becoming The Greater New York Chapter of Professional Geriatric Care Managers. Approximately four years ago, we became The New York Chapter of the National Association of Professional Geriatric Care Managers. Past presidents in chronological order include Adele Elkind, Leonie Nowitz, Connie Rosenberg, Miriam Zucker, Helene Bergman, Edith Bayme, and Debbie Drellich. Since 2010, we have slowly begun developing Units on Long Island and in the upstate regions of New York. Today, instead of listing 20 care management practices, we hope to have 200 in our new directory.

**Contributors:** Leonie Nowitz, Ellen Polivy, Miriam Scholl, Connie Rosenberg, Mickey Zucker and Lenise Dolan.
South Central

During the October 1991 NAPGCM conference, Joyce Robbins with Geriatric Services, Inc. of San Antonio and an NAPGCM Board member, inspired a small group of geriatric care managers to meet and consider forming a chapter. Geri Sams of Geri-Options, Denton, Texas gathered names of potential members and followed up with Joyce; Louise Jennings of Basic Aid for the Elderly in Oklahoma City contacted National but learned that National was in the process of developing procedures for developing a chapter and could not forward forms to begin a chapter. Not to be thwarted, an organizational meeting on May 9, 1992 with six care managers (Louise Jennings of Oklahoma City, Jere Reiser of Dallas, Leah Cohen of Austin, Geri Sams of Denton, Dodie Harrington of Houston, and Charlotte Clarke of Tyler) met in Irving, Texas with the purpose of determining “the feasibility of forming a ‘southwest chapter’ and to provide a supportive network among geriatric care managers in this area of the country.” Officers were elected with Jere Reiser as President, Geri Sams as Secretary, and Leah Cohen as Treasurer. The next meeting was held on July 26, 1992 and included a business meeting and a continuing education program. The care managers focused on meeting National’s guidelines for setting up a chapter. Highlights of the meeting: changing the name to “South Central” to better reflect the area we serve; developing a chapter membership survey; determining boundaries; completing forms for National and pertinent legal/IRS forms; developing Chapter bylaws; selecting five members to initiate formal request to National (Louise Jennings, Jere Reiser, Geri Sams, Sharon Fitch, and Joyce Robbins). On October 17, 1992 at the NAPGCM Conference in Tucson, AZ, the South Central Chapter was approved and held its first formal meeting. The number one goal of the chapter was to increase membership by developing plans to recruit new members.

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Over these last 20 years, our South Central Chapter has flourished and grown to almost 90 members. Two of our members have become President of our National Association: Dianne Boazman of Metairie, Louisiana and now Byron Cordes of San Antonio. Our Chapter is developing strong units, especially in Dallas and Houston. Our chapter conferences are outstanding in content and bring our members together for support and camaraderie. Myra Johnson of Houston and Geri Sams of Denton facilitate chapter peer review teleconferences. Our current President Doug Reuschel of Houston is enthusiastic about our chapter. Professional Geriatric Care Management in the South Central Chapter is strong, especially in Texas and Louisiana. Our chapter seeks expansion of a GCM presence in Oklahoma and Arkansas as well as preaching the word about the value of geriatric care management as our elderly population explodes, as numbers of Alzheimer’s rises, and as family members become increasingly stressed in their caregiving roles. We look forward to our next Chapter conference in Grapevine, Texas.

Current officers: Doug Reuschel, President, Byron Cordes, Past President, Dianne Boazman, Vice President, Chris Clausen, Treasurer, and Myra Richmond, Secretary. Directors include: Angela Thomas, Patty Funck, Michele Orshol, Janet Jackson-McCulloch, Geri Sams, Frances Mir, and Leah Cohen.

Southeast

The first meeting of the Southeast Chapter of NAPGCM was held April 21, 1995 at the Commerce Club in Greenville, SC. Attending were Sally Gold (Greenville, SC), Greta Shelton (Asheville, NC), Jane Hamil (Atlanta, GA), Cheryl Hawkins Theriault (Raleigh, NC), Karen Knutson (Charlotte, NC), William Hughes (Tryon, NC), and Jane Hamil (Atlanta, GA). Jane Hamil was named President, Sally Gold was named Vice President, Cheryl Hawkins Theriault was named Treasurer, and Susan Daggett was named Secretary. Membership and Program Committee will be chaired by Sally Gold, Financial Committee by Cheryl Hawkins Theriault, and Nominating Committee by Karen Knutson. Dues were decided at $30 per year per member.

The next meeting took place in September 1995 at the NAPGCM National Conference in St. Louis and the chapter hoped to receive their charter from NAPGCM at that time.

- November 3, 1995 in Greenville, SC. Bylaws have been submitted to NAPGCM for review and we have attained 501(c)(6) status thanks to Jane Hamil. We are incorporated in the state of Georgia. Sally Gold, Sandra Kremer, Cheryl Hawkins Theriault, Marjorie Howe, Allison Martin, and Jane Hamil were in attendance. Plans were made for a joint chapter conference with the Florida Chapter in Boca Raton, FL May 9-10, 1996. Susan Daggett is no longer working as a GCM and Cheryl Hawkins Theriault agreed to serve as Secretary/Treasurer.

- January 26, 1996 meeting in Charlotte, NC. Sara Thompson, Karen Knutson, Allison Martin, Jane Hamil, Sally Gold, Cheryl Hawkins Theriault, Maureen Maguire, Nancy Tuttle, Bill Hughes, and Jeb Bolton attended. There are 11 paid members of the chapter. It was decided that the Southeast Chapter will have four meeting annually. One will coincide with NAPGCM National Conference, one will coincide with Southeast Chapter Regional Conference, and there will be a meeting in January and another in August.

- August 23, 1996 Greenville, SC. Attending Maureen Maguire, Karen Greer, Mary Peters, Cheryl Hawkins Theriault, Sally Gold, Jane Hamil, Allison Mowery, Lynda Briggs, Greta Shyelton, and Karen Knutson. There are 12 paid members. A checking account has been opened with Regions Bank and there is a balance of $188.78. Next meeting scheduled for NAPGCM Annual Conference in Tucson, AZ, October 31-November 3, 1996.

- December 21, 1997 Jane Hamil resigns as president of the chapter as it is fledgling and not much is happening.

- July 12, 2002 – reconvene to try to resume activities as a chapter. The only chapter meetings have been at NAPGCM Annual Conference. Next meeting to be in Denver, CO, October 2002. Karen Knutson elected president, Maureen Maguire elected Vice President, Mary Peters was elected Secretary, and Cheryl Hawkins Theriault will remain as Treasurer.

Chapter Presidents
- Karen Knutson 2004 – 2005
- Maureen Maguire 2006 – 2007
- Cheryl Hawkins Theriault 2008 – 2009
- Lisa Laney Kendrick - 2011 – 2012

Retreats/Conferences
- 2004 Isle of Palms Coastal Retreat Center
- 2005 Kanuga Conference Center
- 2006 ?
- 2007 St. Christopher Retreat Center – Seabrook Island, SC
- 2008 Haywood Park Hotel – Asheville, NC
- 2009 Atlanta, BA
- 2010 Greenville, SC

Western Region

The Western Region Chapter (WRC) has its roots in a meeting held in 1988 in the San Diego living room of B.J. Curry Spitler. In addition to B.
J., other founding members were: Rose Kleiner, Deborah Newquist, Susie Goldsmith, Harriette Grooh, Paula Hurn, Evelyne Hutkin, and Joyce Marvin Hyman. WRC was the first Chapter to be recognized by the National Association in 1989 and was officially incorporated in California in 1993. At that time it included 11 Western States. The first Chapter meeting was held May, 1989 in Palo Alto, California. The first annual Chapter Conference was held in Palo Alto, California, in May of 1990. An annual conference has been held every year since 1990 with the exception of 2002. The conference is rotated among the states within our Chapter.

Our Mission Statement in 1989: “The Western Chapter strives to encourage fellowship among Private Geriatric Care Managers within the Western Region. The Chapter strives to promote high professional practice standards in the field of geriatric care management. The Chapter promotes and provides education to its members as well as the opportunity to share experience and knowledge in our field of practice. The Chapter seeks to enhance community awareness and utilization of the services provided by our Chapter members.”

Two of our founding members consistently practiced these themes of high standards, education, and community service, and we are proud to offer annually the Rose Kleiner Award and the B.J. Curry Spitler Award to chapter members who embody these ideals.

We have grown! Membership in 1989 was 18, today it is a little over 430. Our Chapter covers the largest geographic area of all the Chapters. Additions since 1989 are Alaska, Hawaii, and Western Canada. Our mission is still active today as we strive to reach out in fellowship to our members and continue to host conferences and Local Unit meetings that provide educational, networking, and mentoring opportunities. Thank you for a wonderful 23 years!

Reflections on the NAPGCM Experience
By Deborah Newquist, 2005 NAPGCM President

A famous proverb says, “Give and you shall receive.” From my experience this could not be more true of service to NAPGCM. As President in 2005, I worked with an amazing dedicated group of colleagues to decide we would require certification of members. We also strengthened our administrative infrastructure in preparation for the transition from Management Plus to Kellen. And we had fun along the way. In that time period we had five Deborahs or Debras on the board. One year Debbie Barfield surprised “the Debs” with brightly colored tee-shirts with Deb1, Deb2, Deb3, and so on, printed on them for us to don at the board retreat. The following year I penned a rap for “The Five Debs” which we performed for the board as an ice-breaker for our annual board retreat.

I have noted, while on the nominations committee, that some members are hesitant to become fully engaged in service to NAPGCM. They feel they cannot afford the time. I want to assure them that they will find it a very positive investment—rewarding professionally, spiritually, and financially. I learned that the job of being President came with boosted staff support, which helped me focus on leadership issues for the organization. Thrillingly, NAPGCM has now graduated to our own management. I am certain this brings enhanced organizational capacity, overseen by our talented and dedicated staff. I am honored to serve NAPGCM and encourage others to do the same.

Remembering the Baltimore Hurricane
by Regina Curran

“Set Sail for Success—Achieving Quality in Care Management” was held on September 17-21, 2003 in Baltimore. The conference began with “A Day on Capitol Hill,” when attendees had the opportunity to meet with their Congressional legislators.

The speaker for the opening session was Dr. Peter Rabins (“36 Hour Day”). The Conference Committee worked very hard to develop a program that would showcase the Baltimore area. However, Mother Nature had her own plans. Tropical Storm Isabelle decided to visit Baltimore during the conference! Meeting planner Vickie Palmer was quite busy arranging for “plan B” (and “plan C”) when it was apparent that everything scheduled for outside the hotel would need to be rescheduled. The “Crab Feast Dinner Cruise on the Inner Harbor” set for Friday was rescheduled for Saturday because the Inner Harbor was flooded. (We planned to board the boat across the street from the hotel—not at the hotel front door!) Attendees who planned to tour Annapolis or Baltimore during the “free afternoon” on Friday stayed in the hotel and participated in unscheduled activities. Everyone in the Baltimore area remembers Tropical Storm Isabelle—I’m sure the attendees from other areas formed definite opinions of this area based on this conference.
Elder Law of East Tennessee (ELET) uses a unique approach to Elder Law called Life Care Planning. Elder Law of East Tennessee Attorney Amelia Crotwell and Elder Care Coordinator Connie Taylor, LCSW, NCG work as a team to address legal issues while designing a comprehensive long-term care plan that maximizes quality of life and independence for the older adult.

What was the determining factor in your decision to hire a GCM in your practice?

Two things prompted that decision – Clients were constantly asking me questions that I could not answer about how to fill their practical needs involved in aging. Which nursing home should mom be in? How do we best handle dad’s refusal to stop driving? Often, I was stymied. There was so much to learn about serving the needs of seniors that I didn’t have the time or the contacts to develop on my own. So I started thinking about working with a GCM.

A second factor was a desire to direct my practice into a new area. To leave behind the general civil trial practice that I had built, with all the limitations of using the courtroom as a problem solving tool, and transition into something collaborative, innovative, and generally non-confrontational.

How has hiring a GCM in your law practice enhanced the lives of your clients?

There are so many ways … our primary goal is to improve quality of life for our senior clients and a byproduct of that is better quality of life for the adult child caregiver. Connie assists with identifying and resolving safety concerns and helps clients in the prevention of the four big risk factors – falls, medication mistakes, isolation and depression, and dehydration and malnourishment. She has the ability to make referrals to resources in the community, to listen and guide, to help with access to care, to advise on benefits, such as Medicare, Medicaid, and to interface with care providers about billing. She becomes the first point of contact for all non-administrative issues – even legal issues. That doesn’t mean she gives legal advice, but she is the ear of ELET. She listens, reassures, and then forwards questions she cannot answer to me.

The client has an accessible, knowledgeable, and caring person to call when things seem overwhelming, or when something happens that they don’t understand. She also receives the calls when clients have accomplished something wonderful or had a meaningful improvement of health or cognitive function, due to her recommendations. The caregiver also benefits, the caregiver gets a sense of relief. The burdens of going it alone in the world of senior caregiving fall away and knowledge, confidence, and efficiency take its place. Connie also helps clients or family members manage their expectations by giving input on what is realistic and what may not be realistic. She is a tremendous advocate with care providers. Maybe we have a client who has decompensated and is in a psych ward, the family is confused and scared, Connie steps in and works directly with the social worker at the hospital. The social worker is so relieved that we’re involved, the family is relieved to understand what is happening to their loved one, and the client is getting the treatment needed to improve. So, perhaps what I’m trying to say is that she blends solid, practical real world advice with her professional training and experience to help clients and families get the best care possible and prevent or solve challenges efficiently.

How does the GCM enhance your law practice?

I have a consummate, warm professional as a representative. She also is one face of ELET in the community. She makes me look good within the senior community, which is where the majority of our business comes from. When other lawyers find out I have a social worker on staff, they understand immediately that we are a non-traditional law office, and it always prompts discussion to learn more about what we do. She has been one of the fundamental factors in the success of the firm since its inception. I could not do this Life Care Planning practice without her.
What roles in your practice does the GCM play?

- Relationship building – she handles all the intake calls from prospective clients, so she starts developing a relationship with clients before I ever meet them. She becomes the primary point of contact for all clients and prospective clients.
- Care assessments – she meets the client in his care setting and provides her professional opinion of the issues and potential hurdles, the needs, the desires of the family, and this continues over time with the relationship with the client.
- Care coordination – helping clients find the right care in the right setting at the right price.
- Collaborative problem-solving – I love having someone I respect and trust to talk with about a client’s issues and to seek real, practical answers outside the courtroom. Connie shines in this role.
- Advocacy – she coordinates with facility administrators, doctors, social workers, and other care professionals to be sure that the care the client receives is the best possible care.
- Care Transitions and Placement – she works with discharge planners, admissions personnel, and families to find the appropriate setting for the client.
- Medicaid or public benefits – she attends the appointments with the Department of Human Services or Veterans Affairs with our caregivers to ease stress of the unknown of that meeting, to provide information, and to ferret out and prevent problems with applications before they get past the case worker’s desk; her knowledge and professionalism develops credibility for the firm in that often complicated setting.
- Education – she educates the caregiver child about being a good caregiver and a good advocate.
- Communication – Connie shields the attorney and the paralegal so we can be more productive—often by the time the client’s questions, concerns, or problems arrive at my desk, Connie has comforted the client, reassured the family, managed expectations, and simplified the questions for me; that frees me up to focus on the legal work that I love and minimizes the interruptions or “drama” that can really impact productivity in the office.
- Marketing — Connie schedules speaking engagements and “meet and greet” appointments for me so that I can also generate a public face for the firm. Because of her contacts, I have access to Alzheimer’s and MS support groups, senior centers, professional social worker groups, community college teaching opportunities, financial planners, assisted living and nursing home administrators, and community organizations and churches. I am constantly being sought as a public speaker and Connie lends me this visibility.
- Blogging – Elder law Insights is Connie’s blog where she shares her thoughts and experiences as a resource for clients and the public and as marketing tool to drive interest to our website.

What services do you offer for the older adult and their family that you might not offer without the GCM?

Without a GCM, I would be confined to a traditional law practice selling commodities — that is, selling a last will or a power of attorney or a deed or representation in a court case. With a GCM I get to have a long-term relationship with the client and family... With no GCM, I would merely be dabbling at providing elder services beyond the focus of that purely legal.

How would you advise a GCM to proceed in approaching an elder care firm to become part of their practice?

Do your research about how to be an asset and how you fit in. Look at the Life Care Planning Law Firms Association for information about Life Care Planning. Talk to care coordinators who are doing the work you want to do, even in another city or state. Find out how invaluable they are to the law office environment and get a firm grasp of how much business you can bring to the firm. Be prepared to talk about the myriad of contacts you have in the senior community and how you can open doors for the attorney to market the practice. Stress the benefit you can bring to the client with your experience and advice. Consider approaching an attorney that is in a small firm rather than a large one. Solo practitioners may be more flexible and perhaps more innovative. Consider being flexible and innovative in your compensation arrangements until the work starts pouring in.

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An Interview with Amelia Crotwell, Esq.
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Do you feel it is advantageous for a care manager to work under the umbrella of a law practice rather than independently? Why?

Your nametag has the name of a law firm on it. When you’re talking to a care provider about issues or problems in the care setting, or when you are asking for an accommodation, the care provider knows you have the backing of a law firm. If legal action is needed, it will be taken. The care provider knows that you have the legal knowledge about the rules governing their industry and the rights of the client. Second, it may keep you busier. Third, if you become salaried, you may make more money without the hassles of trying to run your own business.

What would you recommend as a marketing strategy for a GCM interested in becoming part of the law practice?

Think about what you can bring with you that will result in immediate income to the firm or immediate exposure for the attorney:

- Line up a few opportunities for public speaking for an attorney before you ever meet the attorney, and
- Have some referrals ready to bring with you – current clients who have unaddressed legal needs
- Prepare a list of contacts in the senior community and be prepared to discuss your relationship with these people and how those relationships will benefit the attorney
- Prepare a list of “things” you can do for the attorney to enhance the practice – perhaps even share this article or something like it with the attorney
- Create a blog on caring for seniors and discuss how that blog can be a marketing tool for the attorney
- Prepare creative ideas for how to better serve clients, educational seminars, blogging, newsletters, workshops
- Stress how you can bring in revenue by increasing business but that a lot of the work would be done by you

How does having a GCM onboard help families deal with advanced planning for their loved ones with dementia/Alzheimer’s?

Okay, it’s not exactly like having a crystal ball because the course of dementia or Alzheimer’s is always different for every family, but there are patterns and progressions that the GCM can knowledgeably discuss with the family and that we can plan for. The benefit is a care plan that isn’t about crisis management—it’s about crisis prevention. For those who plan early, the GCM and attorney together, as a team, help prepare expectations, preserve resources, eliminate stress and worry for the caregiver, assure proper respite care, increase safety, and generally, help these families navigate emotional and practical challenges associated with this illness.

A Time to Share
by Amy Abrams

The Advanced Practice Retreat took place in San Diego from September 15-18, 2011, providing attendees with the chance to engage in thought-provoking discussions with colleagues from around the country, as well as invaluable networking opportunities. This year, the APR featured two structured discussions, Minimizing the Effects of a Public Relations Crisis, and an exploration of the opportunities for geriatric care managers in Preventing Hospital Readmissions. Expert panels led in-depth dialogues on both topics with a focus on how they impact our businesses and our industry. In addition, as at all APRs, there were many small group discussions on such diverse subjects as structuring employee compensation, insurance coverage, marketing strategies, and encouraging outside the box thinking in a care management practice. Attendees reported that they appreciated their colleagues willingness to share and discuss challenging topics.

The conference planning committee, Norman Hannay and Amy Abrams of Elder Care Guides and Colleen Van Horn with Innovative Healthcare Consultants, wish to thank the NAPGCM staff for their assistance in organizing and executing the event. Special thanks to sponsors Barbara Bristow and Jan McCurdy of Senior Care Management for their generous support, and to all of the NAPGCM members who were able to attend.

(top) Event Sponsors Barbara Bristow and Jan McCurdy of Senior Care Management
(bottom) Planning Committee Colleen Van Horn, Amy Abrams, Norman Hannay
Members of NAPGCM can count on our communities for exceptional care for your clients through:

- Immediate Response
- Personal Care Plans
- Reciprocal Referrals

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See our locations at www.seniornlifestyle.com
In the most traditional sense, Life Care Planning is a concept that began in the field of litigation. The International Academy of Life Care Planners defines the Life Care Plan as “a dynamic document based upon published standards, comprehensive assessment, data analysis and research, which provides an organized, concise plan for current and future needs, with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs.” While customarily utilized in the personal injury and litigation arena, the useful application of Life Care Plans is infinitely more far reaching with the client base of GCMs being a focus area.

While it is critically important not to define aging as a catastrophic event, it is well known that the costs of care associated with aging can be astronomical and therefore, planning for an elder’s wealth and health, demands a fluid, well defined roadmap. “Baby Boomers who have grown accustomed to middle to high income levels often have not thought about the costs associated with the care, lifestyle and housing options they will require during their retirement years. Such costs are not covered by medical insurance and Social Security” (Pabian and Enners, 2011). The majority of those approaching seniority desire to age in place, preferring to remain in their homes rather than succumb to being housed in the stigmatized institutional setting of a long-term care facility and even the beautiful grandiosity of today’s assisted and supportive living surroundings. Parents do not want to be a “burden” to their children, grandchildren, or neighbors. Our seniors often desire to leave behind a legacy inclusive of a financial portfolio to their loved ones including surviving spouses, children, and significant others. The reality, however, is that many seniors do succumb to that which they least desire, largely due to lack of proactive and thorough planning as illustrated in the data collected from MetLife Mature Market Institutes’ Retirement IQ Survey.

According to the 2011 MetLife survey, top retirement concerns include:
- Having enough steady income to cover essential expenses (32%);
- Being able to afford health care (18%);
- Declining health or significant health issue (10%);
- Being unable able to retire when I want (12%);
- Staying productive and useful (12%);
- Becoming dependent on others (10%).

According to a similar survey, those who have already retired wished they had:
- Focused more on how they wanted to live in retirement (38%);
- Started working with a financial adviser earlier (23%).

And advise those approaching retirement to:
- Decide what is most important to them in retirement (51%);
- Have a plan to manage income throughout retirement (47%);
- Account for unexpected costs and risks (38%).

Applying the essence of the original Life Care Plan to our aging clientele, a practical and complete forecast of life’s probable journey is developed enveloping these concerns and transforming them into a sensible roadmap. When working in conjunction with financial planners, elder law attorneys, physicians, and families alike, the Life Care Plan can include all necessary legal, financial, and investment documents as well as a comprehensive evaluation that integrates one’s wishes, goals, and current and projected costs of care into a roadmap for life. Done right, the process ensures that the individual have a smooth, trauma-free transition into older adulthood.

Failure to plan can and many times does result in the catastrophes that GCMs already manage well – urgent placements, unnecessary spend-down of assets, last-minute Medicaid applications, abuse and neglect, depression, repeated hospitalizations, negative health outcomes, lack of decision-makers leading to guardianship or litigation – all of which cost an extraordinary amount of money to remedy. Indicators for a Life Care Plan can help target a GCM’s work, proactively identifying clients who can be well served. For example, is the individual:
- Diagnosed with a progressive illness and uncertain about their future needs?
- Facing challenges of caring for a frail loved one?
- Aware of the best options for long term care and/or housing?
- Concerned about outliving life’s savings?
Life Care Planning with a Twist

Case Study:

• Worried about losing control of life's destiny?

GCMs are well equipped to answer all of these questions, bringing peace of mind to their clients. Whether marketed and composed independently or in conjunction with other professional practices especially in the areas of law or finance, Life Care Planning applied in this fashion allows GCMs the opportunity to work with, and not in, one another's professional practice. The outcome is a resultant deepening of relationships with experts proficient in their own primary practice areas (and perhaps a new referral base for your practice). The best results, in fact, come from the collaboration of each of these professionals working together purely for the benefit of the client as part of an estate plan.

The Elder Life Care Planning approach relies less on crisis management and more on the development of a practical roadmap for current and future care, right sized to one's needs and means. The client is able to anticipate the right care at the right time and price, enabling the efficient use of remaining dollars over a lifetime by anticipating needs that may otherwise render one vulnerable to an uncertain path of care and uncontrolled costs. If shared with adult children and significant others, families appreciate peace of mind through the anticipation of future needs for their loved ones, including the most appropriate care options, settings, and associated costs, and guidance with legal, health care, and long-term care decisions as age and circumstance(s) progress. If created in collaboration with estate planning professionals, the Elder Life Care Plan enables the client, family, and trusted estate advisors the security that available resources can and will be used wisely for the benefit of themselves, their spouse, and dependents according to plan.

Lori Lomahan, LCSW is the Chief Operating Officer of Lifecare Innovations, Inc. Burr Ridge, IL serving the greater Chicago land area

Shay Jacobson, RN, MA, NCG is the President and Founder of Lifecare Innovations, Inc. Burr Ridge, IL serving the greater Chicago land area

Opportunities for Peer Consultation

by Linda Fodrini-Johnson

The work we do is often fraught with ethical dilemmas and conflictual families. We are also confronted with the effects of the economy eliminating programs and services and families wanting more for less.

When faced with a problematic situation each of us needs to seek peer consultation. Some of us are fortunate to have that built into our practice, but many of our members work solo. I encourage each of you to seek consultation in one of these manners:

Find a peer GCM who might practice outside of your area – if competition is an issue. If not, just call a local GCM and ask for an informal discussion on the matter – protecting confidentiality.

You can seek someone to assist you on the listserv. If the two of you connect I recommend that you have a telephone call once a month to discuss cases – don’t wait for a problem.

Local Units – organized by chapters, often offer opportunities for case presentation. If yours doesn’t, start one.

Chapters – many chapters offer formal peer consultation in groups. Call you chapter officers and ask what is available in your area.

Pay for a consultant/mentor who is skilled in the clinical issues of care management. This can be on an as-needed basis or scheduled weekly or monthly depending on your current needs.

Peer Consultation is a requirement for certification – so remember to keep records of all these calls or meetings – the date, time and theme.
Most geriatric care managers will recognize the following scenario:

Mr. and Mrs. K. are in their early 90s and live alone in their own home. Mrs. K. is physically frail but cognitively intact following a stroke and requires assistance with bathing, dressing, medication management, meal preparation, groceries and toileting. Mr. K. has mild-to-moderate dementia, macular degeneration, and prostate problems and requires ongoing supervision and cues to complete tasks.

They have three children: daughter, Mary, provides assistance daily from 6:30 a.m. to 8 p.m. and one son, Mike, does all of the financial management tasks. A third son lives out of the area but does provide emotional support. Mary had been working part-time as a school occupational therapist but has given up her job to care for her parents. The family had been unhappy with the care they each received during stays in rehabilitation facilities, and they are committed to keeping their parents home as long as possible.

Mary and Mike meet with an elder law attorney seeking guidance regarding estate planning and also speak openly about Mary’s need for some income and respite. They want to understand other community care options for which the K's may be eligible. Mr. and Mrs. K. have stated that they understand what Mary has sacrificed, and they want to compensate her.

As elder care has become more complex, families are doing more and, combined with a sagging economy, more and more families are considering compensation for care that they or other family members provide to elderly loved ones. In addition, care recipients want more control in choosing their care providers. States such as Massachusetts and others recognize the wish for consumer-directed care and have initiated programs to support this. The Personal Care Assistant (PCA) program and Caregiver Homes, both here in Massachusetts, provide state funds to allow recipients to either hire their own caregivers or for caregivers to be paid for care that they are providing. Care providers can be family members other than spouses or persons legally responsible to provide care, such as parents of minor children or legal guardians.

If the states are paying family members to provide care to loved ones, why shouldn’t elders privately enter into similar arrangements with family members? This article will review family care or personal service contracts, explore the supporting assessment and valuation of services, and discuss the collaborative possibilities for geriatric care managers and elder law attorneys. Contracts are legal documents. Given the space constraints, all of the potential legal issues will not be discussed, and readers are advised to obtain legal counsel before proceeding with a personal care contract on behalf of a client.

What is a family care contract? It is an agreement between two people, the provider of the services and the recipient of services, which defines the services to be provided and the compensation to be paid. Contracts are recommended because they clarify the expectations of both parties as to the care to be provided, the responsibilities of the caregiver, and the compensation to be paid. It also provides documentation for other family members to avoid misunderstandings, especially when estates are settled after the death of the elder. These contracts may also be used to document that payments to caregivers are wages, not gifts, if there is a Medicaid application in the future.

Contracts may be initiated by the attorney, the care manager during the course of work with a family, the caregiver, the caregiver’s family, or the care recipient.

What is the role of the geriatric care manager in family care contracts? Because the contract must describe the services to be provided and the price to be paid, it should be based on a professional assessment which describes:

- the care recipient’s current situation - a narrative description of the client's situation and background, the family response, the need for services and how they have been provided to date. This is the place for the GCM to tell the client’s and caregiver’s story.
- the care recipient’s functional capacity to perform ADLs and IADLs - assessments should break these out in some detail.
- how services are provided and by whom, including how much time that it takes to perform these services, and whether tasks are shared with others.
- the costs to the caregiver including financial, time, health, lifestyle changes.
- the valuation of the services provided using local cost comparisons - assessments may offer several different models to consider (hourly, daily, weekly costs; live-in versus awake/overnight; agency vs. private rates); this is probably the most important piece of the assessment as it is used to set the compensation in the contract.

The assessment process also offers the opportunity to discuss other possible services that could benefit the client and can turn into ongoing care management work. The ability to produce concise, useful assessment documents and valuations is a niche for GCMs to consider adding to their practice toolbox and to market to elder law attorneys in their service area.

Deborah Liss Fins, LICSW, CMC is President of Deborah Fins Associates, PC.
If you’re struggling to care for a loved one with Alzheimer’s or other challenges with aging, we can help.

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Alumni Leadership Committee
Susan Fleischer, Chair

Wonderful News – The Alumni Leadership Task force is now a national Committee. This was decided by our 2011 Board of Directors due to the meaningful work and its purpose under the very capable leadership of Linda Aufderhaar and Rona Bartelstone.

The Leadership’s mission statement is to define and structure roles for individuals in NAPGCM leadership positions to encourage ongoing involvement for the purpose of maintaining organizational continuity; historical context and wisdom; and mentoring for emerging professionals and organizational transformation. In order to begin to accomplish this mission, the Alumni Leadership sent out a survey to all Fellows and Emeritus members, along with current and past leaders. The results were collected and collated by Amanda Mizell, NAPGCM’s Executive Assistant and submitted to the Committee. The group was very pleased that there were so many positive responses and willingness of its leadership members to stay actively involved with the Association.

Now the work of this Committee truly begins by matching up the skills and interests of our leadership members, identifying the committees that need their help, setting up the next steps and defining goals, structuring, and developing meaningful programs to meet our mission.

Our committee members are excited in working together to ensure that our alumni leadership stays actively involved in continuing to build and strengthen NAPGCM as it evolves and grows.

Please contact the Chair of this Committee, Susan Fleischer, with any ideas or creative thoughts that you feel we need to address. We look forward to your input.

Member & Chapter Relations
Bobbi Kolonay, Co-Chair

The Member and Chapter Relations Committee had quite a few notable accomplishments over the past six months that will directly benefit the Chapters.

The initial “Business Development page” which was designed to offer advice on all the stages of developing your own GCM business evolved into “Building a Geriatric Care Management Business,” eight presentations and small group discussions. The board determined this information was so informative and encompassed so much useful material the task force who wrote the initial recommendations developed the material into a training program that was formatted into eight sessions, speakers were found, the price of $369 for the series of eight one-hour sessions was determined, and the dates offered over the months of Feb-March 2012. Additionally they prepared a draft to be reviewed by the board that offers an opportunity for all members to join in a monthly ‘themed’ e-blast of goods and services.

Certification - We are delighted to say this amazing Subcommittee wrapped up its efforts with the grueling task of development of and answering to certification issues on a Chapter level. Their final task was development of a handy grid that outlines the differing types of certifications/renewal requirements of each certification to choose from when a member is considering obtaining certification. This grid has now been posted to the National website.

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Task force on chapter membership/recruitment and retention - One of our committee goals for the year was to determine methods/strategies for membership recruitment/retention. A task force was formed that spoke to each Chapter for input into their methodology of recruitment and retention of members. After surveying all the chapters a “Best of the Best” on member retention/recruitment was developed for all Chapters to be able to utilize.

The Member-to-Member Commercial Opportunities – The board requested our committee look at ways in which Affiliate Company members could have more of an active role in our membership. One of the things this committee did was providing opportunities as speakers/presenters on their area of expertise in the “Building a GCM Business” weekly teleconferences occurring in Feb-March 2012. Additionally they prepared a draft to be reviewed by the board that offers an opportunity for all members to join in a monthly ‘themed’ e-blast of goods and services.

Checklist for Reference Letters for NAPGCM membership – We updated the current checklist that National uses for reference letters from prospective NAPGCM members.

Great appreciation goes out to all members of this committee for their commitment, time, and amazing intellect helping to bring our association forward.

Peer Review Committee
Stephanie Swerdlow, Co-Chair
Annice White, Co-Chair

NAPGCM recently developed a Code of Ethics which took us to a new
the establishment of a Peer Review Process. Our goal in developing this process is to elevate practice standards. We anticipate that this process will assist us to identify and categorize the type of challenges our members are experiencing in the field. This will be used as a tool to educate members via conference presentations, webinars, articles, etc. We will also have the ability to identify Standards of Practice that might need to be created or revised. We are fortunate to have very experienced alumni leadership who have offered to make themselves available as mentors, and we are working with the Alumni Leadership Committee to be able to offer mentoring if it is determined that a member might benefit by working with an experienced colleague.

The Peer Review Process allows formal complaints to be submitted alleging a violation of the NAPGCM Code of Ethics or Standards of Practice. Complaints generally may be filed with NAPGCM by any person, including NAPGCM members, related professionals, consumers, and other members of the public. However, complaining parties must submit materials to NAPGCM directly and not through an attorney or other representative. We will also not accept anonymous complaints.

Complaints must allege specific violations of the NAPGCM Code of Ethics or Standards of Practice. This process is not a forum for general expressions of dissatisfaction or for commercial disputes. For this reason, for example, fee and similar contract disputes involving consumers are generally outside the scope of this process.

Complaints may be submitted directly through the website by completing a professional review form which can be found by clicking on the “About Care Management” section and then on “certification and professional conduct.”

The care manager will be informed that a complaint has been filed and will be given the opportunity to respond and provide supporting documentation. There is also an appeals mechanism.

The Peer Review Committee will be meeting once a month to review the complaints which have come in to the office, together with the care manager’s response. Two subcommittees have been created -- an Ethics Sub Committee and a Business Practice Sub Committee -- and the Peer Review Committee will forward the complaints as needed to the appropriate subcommittee for their review and recommendations. Recognizing that we need to protect the confidentiality of our members and those filing a complaint, the members of the Peer Review Committee and its two subcommittees will sign a statement of confidentiality, and the information will be kept private within the committees.

We look forward to working with our members to make this process a productive and helpful tool in the effort to advance the practice of care management.

Public Policy Committee
Susan Emmer, Legislative Consultant
Understanding the difference between lobbying and policy education is important for any advocacy effort. While a gray area undoubtedly lies between the two, here are some tips for how to distinguish between lobbying and educating:

Lobbying
Lobbying is any attempt to influence any legislation through communication with:
- Any member of a legislative body
- Any staff person or governmental official or employee who may participate in the formulation of the legislation, only if the principal purpose is to influence legislation (usually specific legislation).

A key element of lobbying is:
- Communication referring to a specific piece of legislation and reflecting a view on that legislation.

Policy Education
Individuals may meet with policymakers to educate them on policy matters without engaging in overt lobbying, through activities such as:
- Meeting with a legislator to discuss issues, without mentioning a specific proposal
- Providing a legislator with informational materials
- Responding to a request for substantive, technical information
- Producing and disseminating research reports or studies that provide analysis on policy issues

Standards Committee
Charlene Proeger, Chair
Our committee members are Amy Abrams, Miriam Olienes-Torres, Stephanie Swerdlow, and Nancy Avitable. Our working group leader is now Debbie Drellich. Amanda Mizell, NAPGCM staff, rounds out our committee.

Since our last report, Standards 2, 3, and 12 have been revised a second time, per Ethics Task Force suggestions, and then approved by the board. In addition, the board has approved our revisions for Standards 7 and 8. The revised Standards are available on our Caremanager.org website, on the drop down menu under the “About Us” tab. A summary of the changes and the new wording follows.

Standard 2 was modified to include modifications requested by the Ethics Task Force regarding decisional capacity and the right to discontinue services at any time.

Standard 3 was also modified, per Ethics Task Force suggestions, to include electronic records and communication.

The rationale for Standard 7 was re-written to clarify that the care plan is to guide the work of the care manager.

Standard 8 had previously focused on the hiring of private caregivers. The new rationale focuses on protection of the client.

(continued on page 30)
Standards Committee (continued from page 29)

Standard 12 changes include the Ethics Task Force suggestions regarding periodic review of service agreements. The revisions provide helpful guidance for communication with clients regarding service agreements.

The revised and board-approved Standards 2, 3, 7, 8 and 12 follow:

Standard 2 - Promoting Self-Determination

Guidelines

A. The Geriatric Care Manager should involve the primary client and/or designated decision maker, to the greatest extent possible, in decisions that impact his/her life regardless of the client’s decisional capacity.

B. The risks and benefits of all options are presented and discussed and understood.

C. The client and/or designated decision maker is given the opportunity to make decisions, the Geriatric Care Manager should ensure that the following conditions are met:

1. The specific information needed to make decisions is discussed and understood.
2. The risks and benefits of all options are presented and understood.
3. The care manager encourages the client and/or decision maker to communicate, verbally or non-verbally, his/her wishes.
4. The client and/or designee consents to services, and the care manager respects the client’s right to discontinue services at any time.
5. The client’s decisional capacity should be evaluated if there are questions regarding his/her capacity.
6. If the primary client does not comprehend the factors involved in the decision-making process and, therefore, cannot make an informed decision, then the Geriatric Care Manager should see that all decisions concerning the primary client are made by the person(s) with the legal authority to do so.

Standard 3 - Right to Privacy

Guidelines

A. The GCM should consider all information in the client’s records confidential. This pertains to active and inactive clients as well as closed cases.
B. The GCM has a responsibility to be knowledgeable of, and abide by, all applicable state and federal laws and regulations regarding confidentiality and the client’s right to privacy.
C. The GCM should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.
D. The GCM should maintain a valid authorization to release information.
E. The GCM should act judiciously when sharing client information with others.
F. The GCM should not disclose identifying information when discussing clients for teaching or training or consultation purposes unless the client has consented to disclosure of confidential information.
G. The GCM should ensure that all communications are conducted in a manner that allows for the maximum amount of privacy.
H. The GCM should act judiciously in protecting the client from harming himself/herself or others.
I. The GCM should act judiciously in protecting the client confidentiality in the event of the GCM’s termination of practice, incapacity, or death.

Standard 7 - Plan of Care

Guidelines

A. The GCM should be based on an assessment.
B. The GCM should be based on an assessment.
C. The GCM should be based on an assessment.
D. The GCM should be based on an assessment.
E. The GCM should be based on an assessment.
F. The GCM should be based on an assessment.
G. The GCM should be based on an assessment.
H. The GCM should be based on an assessment.
I. The GCM should be based on an assessment.
J. The GCM should be based on an assessment.

The GCM should strive to provide quality care using a personalized care plan developed in consultation with the client and/or client system.

Rationale

The care plan guides the work of the care manager by addressing the immediate and long-term needs, wishes and preferences of the client and the client system, and clarifies the expectations of the care management role.

Guidelines

A. the care plan should:
B. be a result of collaboration between the care manager, the client, and the client system.
C. be flexible in order to address the client’s changing status.
D. address the need for the development of a contingency plan for circumstances such as
   a. Natural Disasters
   b. Illness or change in condition of client
   c. Change in client support system
E. be reviewed by the client and/or responsible party and included in the client file.

Standard 8 - Knowledge of Employment Laws

Standard
The GCM should be familiar with laws relating to employment practices and should not knowingly participate in practices that are inconsistent with these laws.

Rationale
As Care Managers, we should strive to prevent abuse of clients who may be vulnerable to exploitation.

Guidelines
A. The GCM should be familiar with the State and Federal agencies that regulate employment practices.
B. The GCM should recommend or employ only persons who are legally permitted to work.
C. The GCM should encourage payment of payroll taxes, or wages that meet minimum wage requirements.

Standard 12 - Fees for Service

Standard
All fees for geriatric care management services are to be stated in written form and discussed with the person accepting responsibility for payment.

Rationale
Billing is an integral part of the professional practice of care management. When billing issues arise, they may be an expression of our clients’ feeling that expectations were not met. To help manage expectations and prevent any misunderstandings regarding fees and services, billing practices should be provided and agreed to in writing.

Guidelines
A. Prior to the initial meeting, the care manager should clearly explain, verbally and in writing, the terms and conditions of care management services to the responsible party. This should include the cost of services and billing practices. If time does not allow for this, then all information should be verbally presented and followed up in writing.
B. The care manager should have a signed agreement for all services, even if it is for consultation only. The signed agreement should specify the scope of services to be provided. The signed agreement also should address and clearly communicate terms with respect to:
   • Fee structure and rates
   • E.g., hourly, monthly package, etc.
   • Out of pocket expenses and purchases made on behalf of clients
   • Charges for written and verbal communication
   • Travel time and/or mileage expenses
   • Fees for consultations, assessments and/or follow-up services
   • Payment terms
C. Invoices should be sent in a timely manner consistent with the terms of the service agreement and should be clearly itemized.
D. Service agreements should be reviewed and updated periodically or as client circumstances change. These may include changes in fees/rates; responsible parties; or capacity of the payer or responsible party.
E. A client with an established relationship with a GCM, but who can no longer pay for services, should not be abandoned. If it appears that care management services are not affordable, the care manager should offer referrals to resources consistent with the client situation. The GCM should make every effort to ensure that the client’s needs continue to be met.
F. The Care Manager should not participate in practices of fee splitting, accepting or giving referral fees or other similar arrangements with any other party providing services to the client. These practices may compromise the objectivity of the care manager and/or create the appearance of impropriety.

Call for Nominations

The Nominating Committee requests that voting members of NAPGCM submit their recommendations for candidates for the NAPGCM Board of Directors by June 29, 2012. (Before making your recommendation, please confirm with the potential nominee in advance that s/he would, in fact, like to serve on the Board.)

You may send your recommendations to Executive Director Kaaren Boothroyd at kboothroyd@napgcm.org or by calling her at 520.881.8008.

Calling All GCMs Currently Teaching at a University

Do you teach at a local university in a subject related to care management (i.e., nursing, social work, gerontology, care management)? If so, we want to hear from you!

Please contact Lisa Mayfield, Chair of the NAPGCM Educational Alliances Subcommittee at lisa@agingwisdom.com or 206.660.3276. This committee is looking to build relationships with universities around the country.

We look forward to hearing from you!
Florida Chapter Update
by Joanna Davis

The year has just begun and the Florida Chapter is already rising to the challenge! We hosted our 19th Annual Conference in Bonita Springs FL, the theme: “Rise to the Challenge” was a huge success! Many thanks to our conference co-chairs Emily Leibovitch, Linda Shuster and their hardworking committee. The conference was well attended and we received outstanding feedback from our attendees on location, speakers and choice of vendor/sponsor participation. Our 2012 Board of Directors was sworn in during the annual business meeting, which include:
- President: Joanna Davis, President Elect: Connie McKenzie, Past President: Linda Cramer, Secretary: Amy Seigel, Treasurer: Mark Leibovitch, Directors: Dee Wynn Cox, Catherine Rowlands, Barbara Ringgold, Emily Reese, Vicki Alkire, Advisors: Kelli Edwards, Stephanie Swardlow

The board of directors has set many goals for 2012 and look forward to a successful year!

Mid-Atlantic Chapter
by Regina Curran, President

2011 was a very busy year for the Mid-Atlantic Chapter. One highlight was our very successful conference “Geriatric Care Management: A New Era of Independence and Freedom,” which was held in Philadelphia on November 6-8. Congratulations to co-chairs Dolores Magid and Denise Valerio and their committee for a job well done.

We are now planning for our 2012 conference which will be held in Baltimore in the fall. Ellen Platt and Denise Valerio will co-chair this event.

2012 brought a new leadership team for the chapter. Two members of our 2010-2011 leadership team, Diane Schaefer and Teryl McCaffrey, did not seek reelection. Diane served as chapter Treasurer for five of the last six years. She was an at-large Board member for the year she was not Treasurer. Teryl was an at-large Board member for two years.

Our 2012-2013 leadership team is: Regina Curran—President; Gale Davis—President-Elect; Judy Grumbly—Vice President; Stephanie Thomopoulos—Past President; Janina Bognar—Secretary; Joan Richardson—Treasurer; and at-large Board members—Christina Dhir, Lynn Mercuro, Louise Mohardt, Ellen Platt, and Denise Valerio.

New England Chapter
by Nancy Euchner, President

The New England Chapter is proud to announce its 2012 Chapter Conference - GCMs Embracing Change: Nourishing Mind, Body and Practice. This event will be held on November 4-5 at the Best Western Royal Plaza Hotel in Marlborough, MA. Our Conference Committee, working under the leadership of Co-Chairs Esther Rothkopf and Susan Lewin, are planning a memorable event. All NAPGCM members are welcome. Details will be posted on our Chapter website – http://www.gcmnewengland.org/

Our New Hampshire Unit is up and running! Members held their second meeting and elected Co-Chairs (Ellen Curelop and Jane MacDonald) and their Secretary (Susan King Ecklund). Quarterly meetings are planned. The organizational meeting of our second unit, serving Maine, will take place in February. Special thanks to Debbie Gitter, who has been instrumental in helping to establish our foundation for bringing new units on board.

We continue to offer monthly educational meetings, which provide great opportunities for networking and welcoming new members. Upcoming programs include: Soldiers Stories at End of Life – Tools for Honoring Veterans; The State of the Art Learning Program for Persons with Memory Loss; Older Women and Sexuality: and Options for Moderate Income/Lower Asset Clients. The Program Committee has begun to plan our fall lineup under the leadership of its Co-Chairs, Celeste Ricci-Trahim and Kathleen Heery.

Our Public Relations Committee is continuing its work to raise public awareness about Geriatric Care Management. We plan to follow last year’s print advertising campaign with radio spots on one of our local public radio stations. Many thanks to Mary Ann Wonn for her research and guidance in this area.

New York Chapter
by Haley Glazer, Vice-President

In October, The New York Chapter hosted over 260 professionals working in the field of geriatrics for a full day of continued learning and networking for its Conference, All Things Aging...A Symposium on Care Management. The Conference afforded the non-member attendees the opportunity to become familiar with NAPGCM, generating interest in membership and laying the foundation for future recruitment. Our Chapter’s goal for 2012 is to build on the goodwill generated by the huge success of the Conference, promoting the role of the professional geriatric care manager to the general public at large and to other professionals dedicated to servicing the elderly and disabled populations. All of this was made possible by the many skills, creativity and extraordinary talents of our program chairperson, Mary Ann Grossinger, and we honor Mary Ann for her dedication and contributions. The Board is focusing on advancing our professional position beyond the Conference by increasing GCM exposure in the exploding world of NY elder care.

In an effort to bring together members from the northern portions of the Empire State, the newly formed Western New York Unit now enjoys networking and formal meetings. Pat Mulvey journeyed to Buffalo from Manhattan to offer support and guidance to our upstate colleagues. These gatherings have already generated new ideas for Chapter involvement as well as proposals for future state wide conferences. Although primarily devoted to building an organizational structure and goals for their Unit at this time, members are also exploring and are excited about developing innovative educational programs and marketing strate-
gies dedicated to the needs of upstate care managers.

Our new NYGCM Directory was published in January 2012 due to the efforts of committee chair Helene Bergman. Helene Bergman was awarded at our 2011 conference for her hard work and commitment on behalf of the Chapter. Ellen Polivy, Peer Supervision Coordinator, continues to coordinate two peer supervision groups that are held monthly, and Anne Pagano joined the NAPGCM Educational Alliances Committee.

Three scheduled programs remain from our 2011-2012 educational series: (1) Unique Mental Health Resources, (2) Who’s the Client? — Through the Lens of the NAPGCM Code of Ethics and Standards of Practice and, (3) Chronic Kidney Disease and Dialysis: What Care Managers Need to Know. In response to membership requests and as an outgrowth of the most popular topics presented at the October Conference, additional and related programs/seminars are being developed for the spring.

It’s no secret that having a computer crash creates unexpected stress and havoc in your day. Not only do you need to repair or replace the computer but you also have to get the programs reinstalled and the data restored to the computer. This process becomes doubly stressful when your data may not be properly backed up to a reliable device. As with all technology, advanced preparation is key to the rebuilding success. There are several methods available for preserving important computer data.

Flash Drive – A flash drive is a small USB-connected device that can be purchased in varying sizes, with the current largest being 256 GB. With this type of device your backup is a manual process, where you select the files that you want to back up and move them over onto the device. This is a good backup method for taking files with you on the go.

External Hard Drive – The price of external hard drive storage makes this a good method to backup your important files on a regular basis. Some of the drives come with backup software included where you select the files you want or just push a button on the device and it decides what is important to back up. It’s important to check with your software providers to make sure that the device is getting the files needed for specialized software. With IT assistance, you can also have a script written that will run at a scheduled time and will include the files that you don’t want to miss. The beauty of an external hard drive is that if you have an emergency, you can grab the drive and take it with you so that you have your backup in your own hands.

Online Backup Solutions – Today, there are several online backup solutions that install a small piece of software on your computer, and the software backs up files as changes are made to them to an Internet server location. Some of these services have their servers in the U.S. and others host their servers offshore. A couple of the main services are Carbonite (www.carbonite.com) and Mozy (www.mozy.com). These services have options for business and personal backups and charge a reasonable fee to query your computer and backup files that have changed since they were last backed up. If your computer crashes and you have to put a new one in place, then you log into your service and download the files from the backup to the new computer. The caveat is that they decide which files to backup, so there is still some work to make sure that you add other files to the backup that might be missed. You will also want to enquire about the type of encryption they offer for your backup so that you can protect private client information.

Regardless of the method that you select for backing up your data, you should check with your software providers to make sure that their files are included in your backup to make sure that you’re fully protected.

If your computer does crash and, after restoring files, you still find that you’re missing files, then a qualified IT person can usually take the hard drive from the crashed computer and put it in another computer and pull your files off of the old drive. Crashes are usually caused by a hardware failure, and hardware failures do not generally erase data files from your hard drive.

Taking the extra precautions at the outset will not completely erase the stress that occurs from having a computer crash, but it should minimize the fear of losing important data.
NAPGCM Members in the News

Nancy Avitabile was filmed in a video by Reuters “The Business of Managing Old Age” which aired on May 24, 2011.

Liz Barlowe was quoted in “4 Unpleasant Money Tasks You Can Outsource” which was published in More Magazine in the May issue.

Rona Bartelstone was featured in the “Nightly Business Report” aired on PBS August 1, 2011.

Frank Baskin authored an article “Coalitions on Mental Health & Aging: Lessons Learned for Policy & Practice” which was published in the June, 2011 issue of the Journal of Aging & Social Policy.

Pamela Braun was quoted in “Medication-Related Elder Fall Prevention” which was published in Social Work Today in the January/February 2012 issue.

Byron Cordes was quoted in “Tip: Geriatric Assessment for Mom and Dad” which was published in Newsday on December 15, 2011.

Byron Cordes was quoted in “Beware of “free” Referral Services for Elderly” which was published by Injury Board Blog Network, September 8, 2011.

Byron Cordes was quoted in “NY Times: A Better Model for Senior Housing Lead

“Tips for Managing an Elder’s Care from a Distance” which was published by Washington Post and the San Francisco Examiner, January 26, 2012.

“The Elder-Care Crapsheet” which was published by SmartMoney, January 18, 2012.

“How to Assess Your Loved One’s Situation” which was published by AARP News, January 18, 2012.

“Evaluating Your Parents’ Health Over the Holidays” which was published by Sacramento Bee, December 19, 2011.

“Helpful Ideas for Anyone Helping an Aging Parent” which was published by the Washington Post, December 6, 2011.

“Alzheimer’s Disease and Dementia: Learn More, Get Help” which was published on ABCNews.com, November 2, 2011.


“When Your Client Has Alzheimer’s” which was published by Insurance News Net, August 30, 2011.

“Easing the Stress of Daily Care-Giving” which was published by the New York Times, August 27, 2011.

“The Difficult Decisions Of Elder Care” was aired by KUOW NPR, August 24, 2011.
Lisa Mayfield was recently interviewed in the August 24, 2011 issue of Washington SmartCEO magazine.

Cathy Cress was a guest on the nationally syndicated “Staying Young” radio show. She talked about sibling rivalry and her book “Mom Loves You Best.” She mentioned NAPGCM and the NAPGCM web site on August 28, 2011.

Cathy Cress was featured in an article “PDHCA Talks with Cathy Cress: Agency Growth Through Economic, Demographic Changes” which was published by the Private Duty Source Newsletter, June 20, 2011.

Gale Davis authored an article “Modern Aging: Managing it all”, which was published in the Richmond Times-Dispatch, August 14, 2011.

Susan Fleischer was quoted in “How to Cope with a Caregiving Crisis” which was published in the AARP Bulletin on November 14, 2011.

Linda Fodrini-Johnson was quoted in “5 Steps to a Family Caregiving Agreement” which was published by U.S. News & World Report blog, September 6, 2011.

Debbie Gitner and Linda Sullivan authored an article “Senior Q & A: Worrying About His Wife” which was published by EveningTribune.com, September 19, 2011.

Kirsten Hartman authored an article “Employers Should Support Caregivers” which was published by Coloradoan.com, September 19, 2011.

Miriam Zucker was quoted in “Crown Point Business Helps Seniors with Daily Activities” which was published by Nwi.com, September 4, 2011.

Debra Levy was quoted in a Washington Post column by Petula Dvorak, which appeared on the front page of the August 16, 2011 Metro section.

Debra Levy authored a book review on “I Can See you Naked” by Ron Huff. The review was published in the August 2011 issue of Washington SmartCEO magazine.

Lisa Mayfield was recently interviewed on the radio and mentioned careman-
There is Still Time to Register...

...for the 28th Annual National Association of Professional Geriatric Care Managers Conference 2012

Grand Hyatt Seattle, 721 Pine Street, Seattle, WA

For complete schedule details, visit www.caremanager.org