

Care Planning and Geriatric Assessment

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Introduction

The process of geriatric assessment is like the method detectives use to solve a crime. Just as detectives meticulously sift through clues, leave no stone unturned, and ensure all evidence is taken into account before reaching conclusions, so must care managers. Like Sherlock Holmes, care managers conducting a geriatric assessment must strive to make sure all facts have been gathered and examined, both individually and in combination with one another, before writing a report and developing a care plan. However, unlike Sherlock Holmes, care managers often have to first meet a client because of an immediate crisis, and they sometimes have to begin to assist that client without being able to gather all of the information they might like.

Comprehensive geriatric assessment has been defined as a “multidisciplinary evaluation in which the multiple problems of older people are uncovered, described, and explained, if possible, and in which the resources and strengths of the person are catalogued, need for services assessed, and a coordinated care plan developed to focus on interventions of the person’s problems.”¹ Additionally, the resources and strengths of the older person must be ascertained and evaluated so that they can be part of the development of a care plan, in recognition

of the uniqueness and individuality of that person. Assessment of the impact of illnesses and the aging process on an older person’s physical, emotional, spiritual, and social functioning is a critical component of the provision of appropriate health care. Performing comprehensive geriatric assessments and care planning is a challenge for care managers.

Goals of a Geriatric Assessment

The care manager does a geriatric assessment to create a care plan, which proposes recommendations to repair the holes in the older client’s personal safety net using the family system and the continuum of care. The recommendations suggest services at the right time for the right amount of money.

The goals of a geriatric assessment, according to the Gerontological Society of America are shown in **Table 5-1**.²

The Comprehensive Geriatric Assessment Position Statement of the American Geriatrics Society includes the following statements: “Comprehensive geriatric assessment has demonstrated usefulness in improving the health status of frail, older patients. Therefore, elements of Comprehensive Geriatric Assessment should be incorporated into the acute and long-term care provided to these elderly individuals.”³ Notice that

Table 5-1 Goals of Geriatric Assessment

Goal Area	Examples
1. Education and referrals	Information and/or referral for home care, nursing home care, adult day care, rehabilitation services, support groups, and so forth.
2. Social/family relations/activity	Provide support to patient and/or family; encourage senior center participation or other activities; provide coping mechanisms for family and caregivers.
3. Functioning and independence	Improve activities of daily living or instrumental activities of daily living functioning; gait training; maintain independent living situation.
4. Supervision	Enhance supervision of functioning, finances, and so forth.
5. General health and well-being	Maintain health and well-being; enhance spirituality.
6. Medication issues	Stop, start, change dose of medications; enhance compliance.
7. Medical issues	Diagnose and/or treat problems of physical health or functioning.
8. Cognitive issues	Maintain memory, diagnose and/or treat cognitive problems.
9. Emotional issues	Diagnose and/or treat depression, anxiety, loneliness, and so forth.
10. Health behaviors	Improve diet; exercise; limit smoking or drinking, and so forth.
11. Behavioral issues	Diagnose and/or treat wandering, aggressive behavior, etc.
12. Caregiver burden	Reduce burden of care for family and caregivers, respite care, etc.
13. Driving	Evaluate, monitor, improve, or stop driving.
14. Safety	Maintain safety in living situation or in functioning.
15. Environmental modifications	Adaptations in the home (improve lighting, remove rugs, etc.)
16. Dignity and autonomy	Allow patient to make his/her own choices, adapt to impairments; no additional medical treatment; comfort care.
17. Economic stability	Maintain financial stability; assess financing of alternative living situations; obtain Title XIX, and so forth.

Data from Bradley, Elizabeth H., Sidney T. Bogardus Jr., Carol Van Doorn, Christianna S. Williams, Emily Cherlin, and Sharon K. Inouye. "Goals in Geriatric Assessment: Are We Measuring the Right Outcomes?" *The Gerontologist*. 2000; 40(2): 191–196. *Oxford Journals*. <http://www.oxfordjournals.org/en/> Accessed January 30, 2015.

the goals are for the elderly client but also to reduce burden on the family caregiver, provide support for the family, and maintain the financing of the alternative living situation. So, the goals are holistic and meant to offer support for the family caregiver and the elderly client.

The Affordable Care Act is now beginning to address the needs of family caregivers and cover them. First, the law includes individuals and their caregivers as decision makers about care options, and it recognizes the need to address the caregiver's own experience of care in assessments and quality improvement of services.

Second, it promotes new models of care that identify the family caregiver as a key partner. Third, it advances efforts to better prepare family caregivers to perform their care tasks. Last, it enhances opportunities to expand home and community-based services (HCBS) and provide better support to caregiving families. The law explicitly mentions the term *caregiver* 46 times and *family caregiver* 11 times.⁴

A comprehensive assessment is essential to provide the right services at the right time. Older people often have complex health problems with atypical presentations. Elders have cognitive and affective problems that make history taking difficult. They react strongly to medication, are frequently socially isolated, and can be economically compromised. If a comprehensive assessment is not done, older people may be at risk for premature or inappropriate institutionalization. Problems often involve more than one domain of the assessment. Treatment of a medical problem or living condition can sometimes affect cognitive or functional status. On the other hand, the client's cognitive and functional status and values must often be taken into account before deciding how aggressively medical problems should be approached.

The geriatric assessment should be carried out by an experienced care manager. This person is usually either a registered nurse (RN) or human services professional such as a gerontologist or social worker.

As more classes, certifications, and concentrations in care management evolve throughout the United States, care managers can actually have specific educational backgrounds in geriatric care management. Many have passed a certification exam in geriatric care management. To belong to the Aging Life Care Association (ALCA), formerly called National Association of Professional Geriatric Care Managers (NAPGCM) they must be certified as a geriatric care manager.

A team approach involving an RN and a social worker can be very effective, but a non-RN care manager using a functional assessment tool can gather both the health and psychosocial information needed for a comprehensive assessment.

The assessment process begins with a case-finding approach and employs screening instruments and techniques, unless this information is already available from the client's medical record. Based on the initial interview, more detailed assessments may be recommended. This may mean referrals to a number of professional disciplines, such as audiology, psychology, nutrition, physical therapy, occupational therapy, pharmacy, and speech therapy. The assessment should take account of the older person's physical and emotional health. It should reflect his or her ethnic and spiritual background and quality-of-life preferences, finances, and formal and informal support systems, especially the family caregivers, so realistic plans for long-term care can be made if necessary. The older person's own goals and wishes should be taken into account in the planning as much as possible.

The initial assessment is also the care manager's first contact with the client and family. First impressions are important, so the care manager should present him- or herself in a professional manner by being on time, well dressed, and thorough. The care manager must be the quality professional with whom the client and family want to work on an ongoing basis. This assessment is also the basis for getting paid a fee, so making an excellent initial impression is essential if you want to do further work with the client and family.

Elements of the Assessment

The first care manager goal of a written geriatric assessment is to convey in an organized and thorough manner the information gathered and recorded with the assessment tools, interviews, and observations. These pieces of information are all the clues. The second goal is to draw conclusions from that information or clues and present them in a persuasive manner. The final goal is for the care manager to prepare recommendations based on the conclusions. These conclusions are presented to the client, family, or third party who requested

the assessment. It is hoped they are convincing enough that the family or third party will agree with those needed solutions to the documented problems. By preparing a thorough, well-reasoned geriatric care assessment, the care manager has begun the process of developing an ongoing relationship with that client and family.

The first step the care manager takes in a basic geriatric assessment is looking at the client's physical and mental health and social, spiritual, economic, functional, and environmental status. Much like Sherlock Holmes or his new sleuthing wife, Mary Russell, you observe the clients through the lens of a magnifying glass that is the care manager's assessment tools.

You measure change in an assessment—change in the client's present problems; change in the client's present functioning; change in the support system that might necessitate need for different solutions. As an example of this process, consider a client we will call Mamie Nixon, who lives in Santa Cruz, California. Her son calls you and asks you to assess his mother because she drove to the grocery store, got lost, and was picked up by the highway patrol, disoriented and confused. Mamie has actually had difficulty driving for 20 years, first ameliorated by eyeglasses and then, 10 years later, she agreed not to drive at night.

But now a new problem has developed. Her original visual issue is now complicated by mental confusion. So, a client has a long-term change in functional ability. Twenty years later, she can't remember well enough to drive from home to the supermarket.

Mamie also experienced a change in appearance. She dressed appropriately a year ago, and now is always dressed in dirty, unmatched clothes. A year ago Mamie walked around unaided, and now she needs to use a cane. Twelve months ago she was mentally clear enough to execute a will, but now her mental status has declined to the point where she may not have the capacity to change her will. She could pay her bills a year ago, but now she can't. Twelve months ago she regularly

attended the Live Oak Senior Center, but last month she stopped going to the classes in current affairs she has always loved. During the course of the geriatric care assessment, you discovered and reported all these changes in Mamie.

The next step is to recommend ways to repair the holes in Mamie's safety net: a secure way to shop, get to church, and attend to her activities of daily living (ADLs) such as bathing, grooming, and washing her clothes. In preparing your recommendations, you will consider her strengths and what resources she has to fill these holes. For example, Mamie's resources include her son Pete Nixon, the geriatric psychiatrist at Dominican Mental Health Center, the home care aides available through Senior Network Services, and adequate financial resources from Mamie's income and assets to pay for these services.

Physical Health

The first element of a geriatric assessment is a physical assessment that identifies specific diseases or symptoms for which curative, restorative, palliative, or preventive treatment may be available. Special attention is directed toward visual or hearing impairment, nutritional status, incontinence, and conditions that may contribute to falling or difficulty in ambulation. Of course, any actual physical examination should be done by a nurse practitioner or a physician. Gathering health information about the client and reporting it to the physician, through assessment tools, can be done by the care manager who has a background in gerontology, the health sciences, or social work or psychology.

Psychosocial Status

The care manager evaluates the cognitive, behavioral, and emotional status of a client. Identification of signs of dementia, delirium, and depression is particularly important. A range of assessment instruments is available for screening and differentiating among these conditions. Following screening, the care

manager may refer clients for a thorough psychiatric or neurological consultation.

Caregiving and Ethnic, Social, Spiritual, and Economic Status

Identification of present and potential family caregivers and assessment of their willingness, competence, and acceptability to the older person is determined through interviews with the client's family and the social network. Caregiver stress and burden are evaluated. Use the Caregiver Assessment in Chapter 9, *Assessing and Supporting the Family Caregiver*, to do this. You can see from Table 5-1 that goals 2, 4, and 14 are especially for the caregiver. Because the caregiver and care receiver are one homeostatic system, doing both a caregiver assessment and geriatric assessment is the way to see this entire system and arrive at a geriatric assessment and care plan for both caregiver and client. (See Chapter 22 on the family and Chapter 9 on caregivers.)

Assessment of the older person's cultural, ethnic, and spiritual values should also be included in a geriatric assessment. The older person's concept of what constitutes quality of life should be assessed. End-of-life decisions and verification of written advance directives should be included as well, although this information may not be appropriate to gather in an initial interview. (See also Chapter 3 on psychosocial assessment, Chapter 6 on ethnic assessment, Chapter 8 on spiritual assessment, Chapter 9 on family assessment, and Chapter 10 on quality of life.)

Economic resources also need to be evaluated because they are crucial for planning for the provision of personal care and making living arrangements for the client, and they can be a factor in compliance with medical treatment. The economic factors are also critical to what level of care the client can afford if the client needs to move to a higher level of care. You cannot suggest Jaguar care if the client can only afford Hyundai care. Financial assessment is included in your psychosocial assessment. (See Chapter 3.)

Functional Status

A functional assessment is a measure of the person's ability to adequately and safely perform basic ADLs, including bathing, dressing, toileting, transferring, and feeding. Instrumental activities of daily living (IADLs), such as meal preparation, shopping, housework, financial management, medication management, use of the telephone, and driving, are evaluated by direct observation in the home, interviews with the client and family, and administration of standardized questionnaires. (See Chapter 4 on functional assessment.)

Environment

Evaluation of the client's physical environment is essential. Home safety must be evaluated. Problem areas must be identified and corrected if the client is to remain in the home environment. (See Chapter 4 and Chapter 7 on late life relocation.) Evaluating the physical environment in combination with an understanding of the client's ability to perform the ADLs enables the care manager to understand the level of care the client needs. This is the basis for recommending when a client should consider a move to another setting.

Care Plan

After the initial assessment information is gathered, a comprehensive list of the client's problems and interventions should be generated at a multidisciplinary team conference with other care managers on staff. This list is called a care plan. If you practice alone, having an agreement with a more experienced care manager, mentor, or a consultant to review your care plans is an excellent idea. In an agency setting, this should be done as part of your supervision. You need an outside reader.

A care plan is a strategy to repair the holes in your client's web or safety net. Your client is experiencing problems because the web of support or his or her own functioning has

deficits or holes. The care plan suggests a way to repair those holes by recommending the right services at the right time for the right amount of money. Again, you are Charlotte, the crafty spider from *Charlotte's Web*, using the large continuum of care in your community to recommend ways to repair holes in the older person's personal web.

The care plan is also like a prescribed remedy. The care manager identifies each problem the client is experiencing in the problem section and gives an intervention for each problem in the intervention section of the care plan. You, the care manager, are like a health practitioner. You examine your patient—using your psychosocial and functional assessment tools plus any other needed assessments (spiritual, dementia, etc.). You then make a diagnosis based on your assessments—the problem list in the care plan. Then, you prescribe the solution to the client's problems—the interventions or solution in the care plan. (See **Exhibit 5-1**.)

How do you create a care plan or your professional opinion of what the family ought to do to solve its problems? You begin by gathering all of the data with your assessment tools: your functional assessment data and your psychosocial assessment data. You then add additional data you have gleaned from any specialized assessment you have done, such as depression, spiritual, or quality of life.

Multiple Interventions

The next step is to sort through these data, like Holmes. This is where you sift through clues, leaving no stone unturned, to ensure that all evidence has been taken into account before

reaching conclusions. You must examine the clues closely. Talk to each person in the formal or informal support system and make sure all evidence is taken into account. Everyone has a different version of what happened. Analyze the client's problems from all perspectives and then synthesize all the opinions into one truth, which will form your professional opinion. Collect all the data, and then look at each person's point of view to come up with your own professional care manager point of view.

As a care manager, you should start your care plan with the problem you were asked to solve initially. Why was your agency called in? For example, was the client very dirty and unable to shower alone when the out-of-town son visited? Start there. This becomes your first problem in your care plan. Always start with the initial presenting problem.

How do you find the remaining problems in the care plan? After addressing the first problem, continue by listing the client's functional problems. What are the deficits you discovered in your functional assessment? A few examples might be the following: unable to prepare meals, unable to walk without a cane, unable to bathe, in pain, or poor diet.

Next, list problems you found through the psychosocial assessments. Some examples are as follows: unable to handle finances, unable to drive to the store because driver's license was taken away, or unable to participate in activities as a result of depression.

Frequently, many older clients have similar deficits as they age. See **Exhibit 5-2** for a sample problem list that presents problems older people often develop when they become more frail and vulnerable. Most care plans will include one or more of these problems, and it is good to incorporate this list into your assessment tools.

Next, you look at any supportive assessments you have done, such as a caregiver assessment that suggests respite care for reducing burden of care for family caregivers. You may have done a geriatric depression scale and can add that problem if the client scores as depressed. Or you may have done a quality of life assessment and found that

Exhibit 5-1 Care Plan

1. Examine the client = Assessment
 2. Come up with a diagnosis = Problems list
 3. Prescribe the solution to the problems = Intervention list
- 2 + 3 = Care Plan

Exhibit 5-2 Sample Care Plan: Problem Checklist

Below is a list of the most frequent problems older people experience. If an assessment tool does not address these problems, keep this list handy to draw from when you create a care plan.

- Self-care deficit
- Impaired home management
- Alteration in nutrition
- Impaired mobility
- Knowledge deficit
- Alteration in bowel elimination
- Alteration in urinary elimination
- Impaired skin integrity
- Loneliness
- Depression
- Pain
- Caregiver stress
- Driving problems

the client's daily joy and happiness could be enhanced by engaging in activities that they formerly loved.

Interventions in the Care Plan

Where do you get the interventions or solutions for the problems listed in your care plan? In part, you take them from the continuum of care. As noted in Chapter 22, "Just as no man is an island—no care manager stands alone."

Every care manager must know a staggering array of other experts who make up the web of senior services in the community. These experts practice in areas where care manager skills do not reach (attorneys, trust officers, moving companies, plumbers). It is the care manager's expert knowledge of the continuum of care in the community that is the heart of the care management role. As stated previously, a care manager is like Charlotte, the friendly spider. The care manager runs

across the web of senior services (continuum of care), linking services, repairing gaps, spinning new solutions, and coordinating answers. You need to know how to locate all these services to implement your care plan and find interventions to the problems you have uncovered.

Finding Interventions for the Care Plan

How do you find this continuum? As a care manager, you should already have significant experience in this continuum before you open your care manager door for business. This is what is meant by your core competence to open a geriatric care management business. You need to know your community's continuum of care from day one.

However, because the web billows, expands, compresses, and changes constantly, you need the World Wide Web to help you keep up. You can access most areas of the continuum of care and all its changes (new businesses, new senior services offered) through the Internet. You can access your county's or area Agency on Aging website, which will usually list all current senior services available in your town. You can review your business plan and find all the sources you listed there, such as the National Association of Elder Law Attorneys website. In 2015, most organizations serving seniors maintained a website. Of course, you should only recommend services that you know to be competent and able to solve the particular problem you are seeking to ameliorate. For example, if you recommend a local conservator or guardian, there should be an organization in your county of guardians with a website. You can expand your knowledge beyond your local continuum of care nationally by using the Eldercare Locator.⁵

If the problems involve removing caregiver burden, then you can grow your knowledge base of caregiver resources available in the continuum of care in your own community,

such as a caregiver support group. Eldercare Locator can help you find caregiver resources nationally or locally as well.

Crafting Interventions

In a care plan interventions to be implemented in the older person's residence and followed by care providers are less complex at times than interventions in a written geriatric assessment sent to a judge. The judge and attorneys are not healthcare providers and may need jargon-free interventions.

Once you know where to find the interventions for your care plan, tailor these interventions to the client. For example, consider another of Mamie Nixon's problems in her care plan—her self-care deficit, namely, that she is apparently unable to bathe without supervision. The intervention to this problem might be hiring a paid care provider to come for 2 hours, 3 days a week to bathe Mamie. Each intervention must have a clear plan. You must state in your intervention who will carry out the intervention, how it will be carried out, the number of times it will be carried out, and how you will measure that it was carried out.

Make Interventions Doable

In the example of recommending an aide to bathe Mamie 3 days a week, you could suggest that the family call a private duty home care agency in the community that provides bonded care providers for 2-hour blocks of time. Also, someone has to carry out the intervention or you risk that it will not be done. Who will carry it out? Your intervention could specify that the family will locate care providers by calling three home care agencies as recommended by the care manager. But before you recommend this, check with the family and confirm they will do this. It may be that the family wants you to interview the paid care providers and recommend which one they should hire. So, remember to create a solution based on facts. This makes the solution doable.

Make Interventions Measurable

Your recommended interventions should be measurable. This means you should specify the number of times an intervention will be carried out. For example, the private-duty home care agency will send an aide 3 times a week, for 2 hours each time. You need to show the family exactly how to measure whether the intervention was completed. For example, the paid care provider might fill out and sign a charting page for the shift. This also provides the care manager monitoring the care of the older person a basis to review both the status of the older person and whether the care provider was present. If the paid care provider has come only once a week, you know you need to follow up. If the family wants to monitor the care, this approach also tells them how to measure the care.

Make Interventions Understandable

Each intervention must be written in straightforward and objective language so that the person carrying out the plan can understand it. It is important to communicate clearly to families and family care providers, who need jargon-free language. Paid caregivers, who may think in another language, need you to use simple, straightforward sentences. The family and paid care providers should read the care plan and understand it completely because they are the people who will carry it out in many cases.

Make Interventions with a Timeline

Your intervention should have measurable goals based on a timeline. For example, the problem of loneliness:

Mrs. Virden recently lost her husband of 50 years, and she is not socializing and resists outside help.

Intervention: The care manager will visit weekly for 1 month to help Mrs. Virden accept community services to relieve some of her loneliness and ongoing grief.

Multiple Interventions

The care manager can recommend more than one intervention to solve a single problem. For example, additional interventions to assist Mrs. Virden could be as follows:

Intervention: Care manager will arrange a friendly visitor to visit Mrs. Virden weekly for 6 months.

Intervention: Care manager to call the Blessed Christian Church to ask whether a minister could visit Mrs. Virden weekly for 1 month and offer spiritual comfort and encouragement to attend church on Sundays after that month.

Intervention: Care manager to encourage Mrs. Virden to attend weekly adult exercise class at local senior center within 1 month.

Because older clients often have chronic diseases, the absence of disease, a cure for the problem, or a return to normal is rarely a goal. Mrs. Virden may not fully recover from the death of her husband, but the care manager can fashion interventions that will help her better accept his death over time, and these interventions can be written in a way that you, the client, and her family can measure.

Care Plan Is Subject to Change

Everyone who follows the care plan must understand that it is subject to change. Mrs. Virden may start to attend her church on Sundays, make a male friend at the Blessed Christian Church, and decide to remarry, or she may refuse to accept the friendly visitor you have arranged.

Care Plan Needs to Be Acceptable: Dealing with Rejected Interventions

Sometimes the family or third party may not accept your intervention. For example, you discover that Mrs. C is pouring wine brought in by the cleaning lady down her gastrointestinal

tube. The intervention you advise: The trust officer is to replace the cleaning lady within 24 hours, and all alcohol is to be removed from the home by the care manager.

However, the care manager may find that a planned intervention cannot be carried out. For example, Mrs. C may call her attorney, who may insist that a geriatrician hired by the court has tested Mrs. C's competency. The test shows that she is competent and has the right to drink alcohol if she wishes. In this case, the care manager has developed an intervention that the client rejects and will not carry out. When care plans are rejected, the care manager may have to wait until the client or the family will accept the solution. If they do not, the care manager will have to accept the wishes of the legally competent client and family. If the care manager believes that not carrying out the solution will seriously endanger the client's health and safety, the care manager can report the situation to Adult Protective Services. The care manager should consult with Adult Protective Services and an attorney about mandatory reporting state laws.

Care Plan Needs to Be Affordable

The care plan must be something that the older person's assets and income can afford or that the family is willing to pay for. If your client has a self-care deficit, cannot bathe or groom without assistance, and requires ongoing oversight to remain safely in her home, you may recommend 24-hour care. However, if the client cannot afford 24-hour care, you must offer other, cost-effective solutions, such as having the client move in with a family member or be cared for by the informal support system. This is why a financial assessment is needed before you can prepare your care plan. Financial resources should be investigated on the psychosocial intake form.

Consider this example: Mrs. Scott is unable to get to the Happy Trails assisted living dining room every night. A solution would be

for the daughter to hire a paid care provider from a private-duty home care agency to take Mrs. Scott to the dining room 7 nights a week. However, the family says they cannot afford a paid care provider. You may have to ask the assisted living facility if it provides a free service to transport clients, or you may have to ask a neighbor in the assisted living facility (part of her informal support system) to escort Mrs. Scott to the dining room. Finding an affordable solution is one of the challenges to the creativity of the care manager in preparing the care plan.

Care Plan Needs Consensus: Getting Family, Client, and Third-Party Buy-In

The care manager always needs to remember that the care plan is about solving the problems and meeting the goals of the client and/or family. Listening to family members, fiduciaries, and legal representatives during the assessment process can help the care manager understand how to craft a care plan that is most likely to be accepted. The greater number of interested individuals who support the plan, the better chance the plan has of being implemented. However, the care manager must seek primary approval from the party who requested the care plan initially and who is paying for the assessment. If the assessment and plan were ordered in a court case by the court, the care manager must provide the answers to the questions the court has asked and should have an attorney review the geriatric assessment before it is submitted to the court. Ask an attorney what to do in this type of situation.

If you have the permission of the client or of the client's power of attorney or guardian, and if the client does not make a decision, a way to get support for your care plan from all involved parties may be to present it at a family meeting or on a conference call with all parties. If not, you may call all parties and present your care plan or fax it to all parties with a follow-up phone call. If you can gain

consensus for your care plan by these steps, you have a much better chance of having the family members help the older person accept it, and you have a lesser chance of family members sabotaging the care plan.

Care Plan Needs to Be Impartial Yet Creative

Given the same set of problems, several care managers may come up with different care plans. It is important that the care plan be suitable to the particular client. Because most clients come to care managers because they or their families have been unable to solve problems themselves, care plans often involve creative problem solving. A creative care plan is crafted by thinking about the client's identified problems imaginatively and using your experience with, and knowledge of, community resources to suggest a unique solution. However much creativity it involves, the care plan must begin with standardized assessment tools that have been developed with multiple-choice answers that result in objective information with which to develop the care plan. For example, if a client is bored and unstimulated and needs quality of life enhanced, you may suggest that the client go to the opera with a family member because opera was a former passion. Getting the person to the opera may be difficult because of health problems.

Then, creativity can come in. You can have the client listen to opera on the radio, stream opera on Medici TV, watch the Metropolitan Opera on demand TC, or listen to opera on Internet radio.

Refer to the assessment tools discussed in various chapters. Also, the ALCA offers standardized assessment tools through its care manager Forms CD or seek a care manager Operations Manual and forms through the ALCA website for Corporate Partners and Care Management Business Services and Products.

For example, you are asked to consult with a couple. The wife has had Parkinson's disease

for a number of years, and the couple lives in a house that they retrofitted for her care with a wheel-in shower, lower counters in the kitchen, no steps, and everything, including the laundry, on one floor. The husband is now confronted with having an operation that will require 6 to 8 weeks of rehabilitation. They are trying to figure out if they should hire a live-in worker, try to get their current help to commit to 24/7 care for a month, or hire a new agency to fill in the extra hours. You use standardized functional and psychosocial assessment tools to assess their problem. Then, in discussing their options, you suggest the creative solution that both of them move to a facility for 6 weeks because they do not seem very eager to have a live-in.

Why Add a Budget to a Geriatric Assessment and Care Plan?

It is a good idea to send a projected budget along with your geriatric assessment. Many families need to budget for care management expenses, the majority of which are not reimbursed by insurance (private or Medicare). These families likely ask during the initial consultation about the expenses they can expect to incur. Families of older persons usually need an estimate of the number of hours you predict it will take to repair the older person's safety net. They also need to know how much money they will spend to fix the issues or concerns in the older person's life.

Creating a Monthly Budget

What are the steps you take? First, you have the client sign a service agreement with the understanding that you will complete a geriatric assessment and care plan, in which you will make recommendations for next steps for care management. You need a process to estimate the amount of time and fees the client will be billed. You should complete this task for each new client, whether you share the estimate with the family or not.

The overall process involves translating the care plan into a monthly breakdown of hours across the primary category of tasks recommended in the care plan.

The care plan is your strategy to repair the holes in your client's safety net. In this sense you are like a mechanic working on a car. The car has problems, like your client's life and safety net. Your time, skills, and care manager tools as a human services mechanic will, it is hoped, fix the older person's problems and provide an estimate of the time and fees over the next 2–3 months it will take to implement your solutions.

You then do your geriatric assessment and create your care plan, including specific recommendations and next steps. Then, for each following month, you group the activities into four to six categories. For instance, the recommendations from the care plan for the first month may include home visits, medical advocacy in helping obtain a diagnosis, lining up home care, and communicating with the adult children regarding the issues, recommendations, and outcomes. The activities in this example form four categories for Month 1: home visits, doctor visits, communication, and home care. You then estimate the amount of time you will spend on activities in each category.

Don't forget to address travel—either include it within the estimates for each category or make travel its own category if you bill separately for travel time. Then, add up all the estimated time for Month 1 and multiply it by your hourly rate to provide the estimated fees for that month. Repeat this process for Months 2 and 3.

What if there is a change in health status that requires a higher level of commitment, time, coordination, and communication? You are giving the family a general idea of what you think it will cost to fix the problems at hand. There might always be a crisis after the time you do your initial assessment, care plan, and budget. You cannot predict the future, and you must set the expectation up front with the family that you will notify them if circumstances change and require

additional care manager resources and costs. In other words, your budget is not set in stone. This is similar to the situation of going to a mechanic to have your car’s transmission fixed. The mechanic estimates the cost of the transmission repair, but later when the car is in the shop, the mechanic discovers that the brakes should also be replaced. The mechanic could not have predicted the additional problem with the car and so is justified in revising the estimate of costs on the basis of the new situation. The key is not being able to predict future exigencies but instead to provide frequent updates to families if circumstances and assumptions about recommended care change.

Once you provide the family an estimate, you then manage your time against this estimate. You may want to create a calendar for each client and add appointments and estimated activities to it (see **Table 5-2**). Periodically throughout the month, you also need to check your progress against your estimate; you can do this by running a quick report in your time-tracking software to determine the number of hours spent. To do this, you need to ensure your tracking software contains the latest activities for your clients. Finally, if you find that you have exceeded the estimate, contact the family members as quickly as possible to communicate the cause for the overage (e.g., more complex medical issues than anticipated) and a revised breakdown. This helps

prevent any unpleasant surprises for the clients when you send an invoice; it also helps you ensure you collect on all amounts you invoice.

Care Monitoring: Updating Your Care Plan

Care monitoring is measuring whether your care plan is really working. As an example, consider Mrs. Weaver, whose case example appears later in this chapter. The problem you identified in her care plan a year ago was need for 24-hour care because of hospitalization from a fall, resistance to care providers, and caregiver daughter taking the brunt of caregiver burden in spite of her own health problems. Care was hired and the daughter, Ms. Plantlove, learned through the care manager and care plan to take care of herself and relieve her own caregiver overload. With the self-care tools the care manager taught her, she developed a reasonable approach to her mother’s caregiving needs by setting limits for herself. She also began to understand to what extent she could be directly involved and when she could rely on hired help or services to ease the burden of caregiving.

Ms. Plantlove reduced care manager services to once a month after a medical crisis with her mother, but now there is a new crisis with increased memory loss. So, through your monitoring visit you are changing the care plan. The

Table 5-2 Care Management Monthly Fee: Estimate

Budget (hours per month)	Month 1	Month 2	Month 3
Care manager home visits	4	3	3
Care manager doctor visits	10	4	4
Care manager establishing home care	6	2	2
Care manager communication/reports	3	3	3
Other	0	0	0
Total hours/total fees	23 hours/\$2,300	12 hours/\$1,200	12 hours/\$1,200

Note: Estimate assumes no significant change in health status.

new care plan has the care manager visiting once a week. New problems in Mrs. Weaver's mental and physical deterioration are in the care plan to trigger an increase in paid care providers. You will use this updated care plan and visit once a week.

Your solution or intervention is to make a weekly care manager monitoring visit and check on weight loss, depression, physical appearance, and caregiver stress to trigger an increase in paid caregivers.

Monitor Your Client to Measure Change

Care managers monitor the services they have recommended to find out whether the client's needs have changed, whether the services originally arranged are still appropriate, and whether the client needs new services or needs to stop receiving services. You monitor to find any holes in the care plan, and then rewrite the care plan and follow up to create new interventions.

Monitoring visits are usually done by appointment with the client. However, it may be appropriate to drop in to visit the client or make unannounced visits if your purpose is to oversee the quality of care being provided. For example, you can drop in to observe the care in an assisted living facility outside of regular office hours. When you make a home visit, use a form to record your monitoring visit (see **Exhibit 5-3**).

The purpose of a monitoring visit is to observe how the client is doing and to see whether the care plan is being implemented. After you have met with the client, you should also speak to any care provider in the home, paid or unpaid. If the client lives in a residential care setting, you could speak to the residential care provider, and if the client lives in a skilled nursing facility (SNF), you could speak to either the director of nursing or the social worker and/or the direct service worker if possible. In addition, in a facility setting, you can review the written record.

In all of these conversations, discuss the previous time period between visits by

reviewing historical problems in the care plan. For example, if the older person was wandering but has not wandered for months, ask whether there has been a reoccurrence of wandering. Discuss ongoing psychosocial and functional problems included in the care plan, and probe for any new psychosocial or functional problems, any problems with patient care, any problems with care staff, and any household problems.

During a monitoring visit, check the condition of the environment, cleanliness of the home, and whether there are enough supplies (adult diapers, food, etc.). Check the client's physical condition, mental condition, new medications, and compliance with the current medication regimen. Chart the medications each time you visit. You should then record on the care monitoring form any specific concerns and actions you plan to take. If you find any changes in the client's situation, update the care plan and make sure the new version is given to the care provider responsible for implementing the plan or to the residence (SNF, board and care, etc.). If you create an updated care plan and no one is aware of the changes, it will, of course, fail to be implemented, and your care monitoring will flounder.

New recommendations are integrated into a plan of care as interventions. The goal is to achieve the outcomes that the team has determined are desired despite any changes that might occur in a client's situation. Recommendations must then be communicated to the appropriate care providers and to the client if possible. Periodic reassessment and modification of the care plan are critical to the success of the plan.

Writing a Geriatric Assessment and Care Plan

Normally, the care manager creates the care plan after the intake and then begins service. A written geriatric assessment occurs only when a client requests it. Usually, you do your psychosocial and functional assessments, complete your care plan, and start solving the problems.

Exhibit 5-3 Care manager Field Evaluation/Care Management Service

Date: 1/27/15

Client Name: Norma Weaver

Care Manager Name: Miss Fullcharge

(1-excellent 5-poor)

General Home Environment: **1** 2 3 4 5
 Apartment in Maple Tree House was pleasant. Mrs. Weaver was seated in her rocker needlepointing with dog Daisy by her side. The unit was neat, clean, and inviting.

General Home Cleanliness: **1** 2 3 4 5

Supplies: **1** 2 3 4 5
 (Food, cleaning supplies, adult diapers, dog food, expense \$, Ensure, etc.)
 Refrigerator filled by daughter yesterday. Daughter Claire Plantlove had gotten food, dog food, meds, diapers. Daughter shops for all supplies once a week and calls each day at 5 p.m. to check if her mother is out of anything and how her mother is.

Client's Physical Condition: **1** 2 3 4 5
 (Personal grooming, overall condition, behavior, etc.)
 Mrs. Weaver was neatly dressed in a pink Jones of New York pants suit with a matching scarf. She appeared tired with dark circles under her eyes.

Client's Mental Condition: 1 2 **3** 4 5
 (Oriented, moderately confused, and very confused)
 Mrs. Weaver showed signs of depression and said her daughter did not love her now and her dog Daisy did not like her. Mrs. Weaver is oriented to person and place, but not time. She became agitated talking about her daughter Claire. Daughter calls each day at 5 p.m. Yesterday, Mrs. Weaver had forgotten her daughter had called her in the morning instead of the normal 5 p.m. time. Mrs. Weaver stated was very upset, feeling that her daughter was mad at her and she was a bad person.

New Psychosocial Problems: 1 2 **3** 4 5
 Reports did not sleep last night as feels she is a bad person because of phone call with daughter this morning that hurt her.
 The perceived missing call from the daughter, Ms. Plantlove, had agitated and depressed Mrs. Weaver. She expressed remorse at being such a bad person that her daughter had not called. Reports she called her daughter this morning. Mrs. Weaver believed her daughter was angry with her because she had forgotten daughter called earlier in day yesterday.
 Mrs. Weaver had let the care providers go several months ago except for a care provider 3 days a week for 4 hours a day. GCM is contracted to go once a month. Continues to deny need for care providers. Daughter has not accepted that the GCM should go more often.

List of Medications:
 (Include quantity and expiration date)
 Aspirin 81 mg/daily postsurgical aortocoronary bypass 3/15/15
 Bisacodyl 10 mg/daily constipation 2/17/15
 Bupropion 300 mg/day depression 4/10/15
 Cholecalciferol vitamin D₃ 1,000 IU/daily osteoporosis 3/1/15
 Citalopram 10 mg/daily depression 4/1/15

continues

Exhibit 5-3 Care Manager Field Evaluation/Care Management Service (continued)

Levothyroxine 50 mcg/daily hypothyroidism 2/20/15

Pantoprazole 40 mg/daily acid reflux 2/14/15

Crestor 20 mg/daily cholesterol 6/10/15

Senna 8.6 mg/daily constipation 5/10/15

Specific Concerns:

Care manager Ms. Fullcharge believes that Mrs. Weaver's agitation over misconception that daughter did not call yesterday signals her memory deteriorating and some level of paranoia. Stress is being placed on both older client and family caregiver, daughter Claire, who is already burned out by level of mother's care. Since Claire is only daughter nearby, she has struggled with her mother's increasing needs, own family's need, her job, and increased diabetes symptoms as a result of stress.

Actions:

Ms. Fullcharge spoke to the director of Maple Tree Home, Ms. Sweet, who reported they have an aide who comes every 2 hours to pass meds to Mrs. Weaver, including Tylenol for pain from spinal stenosis. Client has a history of abusing Tylenol or forgetting meds. So daughter and doctor ordered meds passed by facility. Director Ms. Sweet said delivery of meds going well with no problems. Ms. Sweet feels care could be increased to stimulate and support client and caregiver daughter, but client continues to believe she does not need care. Care provider checks in and out of facility with her every time they come 3 days a week.

Ms. Fullcharge called Ms. Plantlove to discuss visit. Ms. Plantlove explained yesterday she was in Portland visiting with son and called mother at 10 a.m. instead of 5 p.m. Mother forgot. Mother had called her today, agitated that she had not called, and said she could not sleep last night. Ms. Plantlove's new kitten was just placed in the vet hospital and she was already stressed, so she was abrupt with mother's call. She reported that Mother called again, feeling she was a very bad person for forgetting.

We discussed a future plan. Ms. Plantlove: She will continue to chart calls to mother in her caregiver journal. We discussed benchmarks for increasing care and reducing her caregiver stress. If mother forgets daughter has called for 4 days, starts losing weight (symptom of forgetting to eat), forgets to shower (measured by her appearance), seems depressed over daughter and dog not liking her, and/or Ms. Plantlove demonstrates extensive high insulin pump swings because of severe diabetes, Ms. Plantlove would call the primary physician, Dr. McGrew. She will discuss whether she should increase care or daughter should go more often. This is noted in the revised care plan.

If she makes a decision with doctor to increase care again, the care providers will be there each day when daughter calls to prompt Mrs. Weaver to remember call and offer more stimulation and support. Daughter, who is already experiencing caregiver stress and increased health decline with diabetes symptoms through stress, agreed to increasing care manager visits to once a week instead of once a month, to have care manager problem solve for issues that Ms. Plantlove has been solving, such as increased memory loss. Ms. Plantlove will then visit weekly as a daughter to take Mom to lunch, shopping, and for a walk so they can be mother and daughter again and not caregiver and care receiver.

Plan:

Care manager will call daughter Ms. Plantlove and discuss plan to increase care again and care manager will call Dr. McGee to report symptoms of confusion and possible paranoia.

At times families, trust officers, attorneys, or other third parties ask the care manager to integrate the care plan into a more in-depth written report called a written geriatric assessment. When this request occurs you do not start to implement the care plan until the written geriatric assessment is delivered and approved by the family or court.

What triggers a written geriatric assessment? A problem prompts it. As a care manager, you are a problem solver, and you solve an older person's problems through a geriatric assessment. You take the same steps to discover the client's problems and solutions as you use during assessment.

The purpose of a written assessment is to impart to families the information you gathered using the assessment tools to help them know what the next step in care of the client may be. Frequently, a written assessment is used by attorneys and judges as an outside professional opinion about how to solve the client's problem: Should the person be conserved, should the person move from the home, or which adult child would serve best as a guardian?

A written assessment also transmits information from other sources, such as court records, facility records, medical records, and conversations with family members or others that you documented in service notes. Most important, the written assessment communicates all this information in an organized and convincing manner. Here, you are much like an attorney: You are making a case to convince the family, physician, court, and so forth (jury) that the older client has X problems and they can be solved by Y solutions. Last, the purpose of the geriatric assessment is to complete the first significant task the client asked you to do.

Consider Mrs. Hurricane. Her daughter, Miss Tornado, hires you to write a geriatric assessment because Mrs. Hurricane has had several falls. You begin your written geriatric assessment stating that GCM Care Solvers was hired by Miss Tina Tornado to do a geriatric assessment on her mother Hannah Hurricane because the mother has fallen five times at

home in the past 2 weeks and refuses to accept care or move to a different level of care.

To begin the written assessment, you take the steps as outlined in this chapter to gather data. You perform the assessments. Gathering the information to write the geriatric assessment is done as outlined in Chapter 3 on psychosocial assessment and Chapter 4 on functional assessment. Once you have gathered all the information, you must analyze it in a systematic, logical manner. Written assessment questionnaires assist in the categorization of data. Data can be classified according to a number of different parameters, including identified problems, functional deficits, chronic or acute illnesses, and coping mechanisms and deficits. The sorting and classification of data lead to the identification of areas of intervention. Intervention strategies must be individualized in a geriatric assessment. Included in **Exhibit 5-4** is an outline of Phyllis Brostoff's assessment and care plan recommendations, which was presented in her report "How to Write a Professional Assessment and Recommendations" at the Geriatric Care Management National Conference in 2004. This can be helpful in categorizing your data into problem types and areas of intervention before you write your geriatric assessment.⁶

Writing the Presenting Problem Section

The report always begins with a statement describing the presenting problem. Why did someone ask you to write the assessment? Take the example of Mrs. Hurricane again. Following is a sample Presenting Problem section.

Tina Tornado contacted GCM Care Solvers concerning her mother, Hannah Hurricane, and asked that we complete a geriatric assessment. Ms. Tornado is concerned because her mother has fallen five times during the 2-week period from October 15 to October 31. She states Mrs. Hurricane refuses to have help at home and refuses to move from her home to a higher level of care.

Exhibit 5-4 Assessment, Care Plan, and Recommendations Outline

1. Date assessment and care plan and recommendations were prepared: _____
2. Client demographic information:
 - a. Name
 - b. Address
 - c. Phone number
 - d. Current living arrangement
 - e. DOB
 - f. Marital status or primary relationship
 - g. Gender
 - h. Primary language if not English
3. Information on individual who requested assessment:
 - a. Name
 - b. Address
 - c. Phone number
 - d. Relationship to client
4. Informants other than client who provided information, relationship to client, and dates of contact:
5. Presenting problem (the problem that precipitated the referral for this assessment):
6. Social network status (include current activities and interests, occupational background, spiritual life, living arrangements, nature and frequency of significant social relationships; describe a typical week in the life of the client such as outings, contacts with others):
7. Physical and mental health/medical status (include current medical diagnoses; medications; name of primary care physician, other specialists, dentist, podiatrist; any problems with sleeping, vision, hearing, elimination, speech, respiration, nutritional status, and diet). When listing current conditions, observe whether they are stable, worsening, or improving.
8. Activities of daily living status (include assessment of ability to ambulate, bathe, dress, communicate, eat, maintain continence, shave, maintain oral health, toilet, transfer alone or with assistance; if assisted, indicate by whom or with what equipment):
9. Instrumental activities of daily living status (include ability to shop, prepare meals, do housekeeping and laundry, use telephone, manage medication, do own finances alone or with assistance; if assisted, indicate by whom or with what equipment):
10. Legal status (include whether there are signed healthcare and financial powers of attorney and who the agents are in these documents, whether there is guardianship, whether a living will is signed, whether a current will is in place):
11. Financial status (include current income and assets to determine eligibility for state/federal programs or Veterans benefit programs; include how the client is managing daily money matters and whether there is a trust administrator):
12. Insurance coverage (include information on primary and secondary insurance, long-term care insurance, VA benefits):
13. Summary of concerns and identification of risk factors (specify concerns uncovered in the assessment under the following areas and identify any potential problems of which you are aware regarding possible solutions to these problems, such as client resistance, limited financial resources, or family conflict):
 - a. Safety concerns (include risks identified in the home setting such as hazards on stairs, in kitchen, in bedroom, in bathroom, in living room):
 - b. Mental health, behavioral, or cognitive concerns (include outcome of mental status assessments such as depression screens, mini-mental screens, suicide potential, relevant psychiatric history):
 - c. Driving safety concerns (include whether there is evidence that the client may be driving unsafely):
 - d. Nutrition concerns (include information on change in weight, unhealthy/unbalanced diet, difficulty preparing food):
 - e. Fall risks (include information on fear, clutter, medications, balance, strength, specific conditions):

Exhibit 5-4 Assessment, Care Plan, and Recommendations Outline (continued)

- f. Abuse risks (include information on physical, emotional, financial, psychological, neglect, or self-neglect issues):
- g. Medications/substance abuse/smoking risks (note any compliance issues, polypharmacy issues, obstacles to attaining medications or taking them appropriately, alcohol or over-the-counter medication abuse):
- 14. Care plan and recommendations (identify each problem/concern uncovered in the assessment. Explain your rationale for each recommendation, and provide at least two alternatives and the cost associated with each alternative). Include referrals needed to any medical or other specialists.

Source: "How to Write a Professional Assessment and Recommendations." Phyllis Brostoff at GCM National Conference in 2004.

Writing the History Section

The History section follows the Presenting Problem section. It should include a brief history of the client from birth until the time of this current problem. Use the psychosocial assessment form to gather these data. The data should include birth date, where the client grew up, education, job held through most of life, and marriage date. The important part here is to describe this elder as a person who had a life before this major problem or crisis. You do this to give him or her three dimensions. It also gives the attorney and/or family members reading the written assessment a quick history of this person. The history must be brief, succinct, clear, and no more than three paragraphs but contain all relevant information. Following is an example History section.

Hannah Hurricane was born on September 12, 1918, and grew up in Monterey, California. After Hannah graduated from high school, she attended San Jose State Teachers College. After graduation she worked as an English teacher in the Monterey school system for 10 years. She married Mr. Harold Hurricane in 1942, began to raise her family, and gave up her teaching career to become a homemaker for more than 50 years.

Mrs. Hurricane has three children: Tina Tornado, and James and Steve Hurricane. Steve and James live in Washington, D.C., and Tina lives nearby in Santa Cruz, California. Hannah was widowed when her husband died 13 years ago.

Mrs. Hurricane moved to Park Lane, a residence for seniors in Monterey, after her husband died. Approximately seven years ago, she moved to a condominium in Carmel, where she presently resides. Until recently, she tutored students in English as a second language. Mrs. Hurricane also attended social activities and lunches at the Carmel Foundation, a senior center in downtown Carmel. Mrs. Hurricane is a Christian Scientist.

Writing the Functional Assessment Section

Write the chronological history of functional problems that led to the main problem. Describe the health history, including the diagnosis, physician's evaluation, and information from the functional assessment tool. Include present medications and assessment of ADLs and IADLs and home safety. Describe your observations on gait, environment, and so forth as recorded in service notes or a functional assessment form. Following is an example Functional Assessment section.

Carolyn Hellsapoppen, a care manager from Care Solvers, made a home visit to the client on November 27, 2014, because Mrs. Hurricane had a recent history of five falls. The care manager observed Mrs. Hurricane ambulate. She watched the client rise from the couch and walk to the kitchen with difficulty, assisted by her cane. The Get Up and Go Test was administered by asking Mrs. Hurricane to get

up from a kitchen chair, stand still, walk forward 10 feet, turn around, walk back to the chair, and then turn and be seated. The care manager noted Mrs. Hurricane's sitting balance, transfers from sitting to standing, pace, and stability of walking. Mrs. Hurricane scored a 3 on this test, indicating she needs to be further evaluated by a primary physician.

Mrs. Hurricane's daughter, Tina, reported to Carolyn Hellsapoppen in a phone conversation on November 26, 2014, that her mother had fallen on the dates October 15, 20, 21, 26, and 31. The first two falls happened while she was putting her laundry in the washer, which is located down the stairs on the lower level of the house. The last three falls were reported to have happened in the kitchen, as Mrs. Hurricane rushed to get to a boiling teapot. Ms. Tornado stated that there were no apparent injuries from these falls but that her mother did lie on the ground for 3 to 4 hours after the first fall. However, in all instances, Mrs. Hurricane was not able to summon help.

Mrs. Hurricane is slightly hard of hearing. The care manager had to repeat some questions before she understood them. She has no hearing aid.

On the home visit of November 27, Mrs. Hurricane told the care manager she was depressed. She identified depression as the cause of her symptoms of a burning sensation in her upper back, neck, and both arms. Mrs. Hurricane stated these feelings come upon her at night and are quite uncomfortable. Mrs. Hurricane also stated to Carolyn Hellsapoppen that she had not seen a physician since these symptoms began.

Mrs. Hurricane was administered a Katz ADL by the care manager, which identified that she needs assistance with bathing because of her balance problems and that she should be watched on transfers. She is independent in dressing, continence, and feeding. She was administered an IADL test by the care manager. Mrs. Hurricane is independent in telephone use, managing medication, and financial management.

Mrs. Hurricane needs assistance with food preparation, housekeeping, driving at night, doing laundry, and shopping

because of ambulation difficulties and recent falls. A physician's report, received on December 7, 2014, was completed by Mrs. Hurricane's physician, Dr. Feelbetter. The report stated Mrs. Hurricane has diabetes, high blood pressure, a history of interstitial cystitis, and is noncompliant with doctor's appointments and orders. Mrs. Hurricane was also reported by her doctor to be mentally clear.

Carolyn Hellsapoppen reported that Mrs. Hurricane is a non-insulin-dependent diabetic and, according to Mrs. Hurricane, her blood sugar values are "quite high" despite her avoidance of sweets and the use of the prescription drug Glucophage (metformin). She feels this drug has caused a 2- to 3-week bout of diarrhea, which she says is now resolved. She stated to Ms. Hellsapoppen that she has discontinued taking this drug.

As reported to Carolyn Hellsapoppen of care manager Care Solvers by Mrs. Hurricane, Mrs. Hurricane had one of her kidneys removed in 2000 and had a urostomy performed in 2001 following several years of interstitial cystitis. (Dr. Olsen's physician's report stated this as well.) Mrs. Hurricane stated to Ms. Hellsapoppen on her visit of November 27, 2014, that she can usually manage her urostomy well but has had some episodes of skin irritation of the stoma and the surrounding tissue to the point of bleeding. In March 2014, Mrs. Hurricane was admitted to Community Hospital Emergency Room in Santa Cruz. She had an irritation of her urostomy. After treatment, she was released and sent home. There have been no other hospitalizations before this or after this incident, according to Tina Tornado. These periodic irritations of her urostomy prompted Tina Tornado to request a home health aide, who Mrs. Hurricane discharged after two months. Mrs. Hurricane reported to Carolyn Hellsapoppen that she is now using a moisture barrier before applying the urostomy bag and has had good results with it.

As examined by care manager Carolyn Hellsapoppen, RN, on her visit of November 27, 2014, Mrs. Hurricane's lungs were clear; abdomen was soft; ankles were without swelling. Her blood pressure

was elevated at 160/100 mm Hg; pulse was 88 and regular; respirations were 20 per minute. She stated that she feels she needs to lose weight. Her daughter, Ms. Tornado, reported to Amber Helpall, social worker for GCM Care Solvers, that her mother has lost approximately 20 pounds and weighs approximately 180 pounds. This weight was confirmed on the physician's report. Mrs. Hurricane also stated to Carolyn Hellsapoppen that she is not eating as much as she used to and is losing weight.

As was also reported to Carolyn Hellsapoppen, Mrs. Hurricane's doctor, Mabel Olsen, discharged Mrs. Hurricane as a patient approximately 3 months ago for missing three medical appointments. According to Mrs. Hurricane and her daughter, Dr. Ted Tittlemouse, endocrinologist, has also discontinued his services as her physician for noncompliance. The doctor recommended she either have 24-hour care or move to a board and care. Carolyn Hellsapoppen recommends that Mrs. Hurricane be evaluated as soon as possible by a new physician because of her elevated blood pressure and the recent falls. The fact that she is a diabetic also puts her at high risk of heart disease, according to Carolyn Hellsapoppen.

On a home safety check, the care manager found the following: There is no handheld showerhead installed nor shower chair for safety in the bath. Smoke alarms are not working throughout the house. There are outside obstructions, such as tools and planter boxes, in the pathway that would make it easy to trip and fall. There is no cordless phone, which would prevent the client from rushing to answer phones. Teapot on stove needs to be replaced by an electric teapot so she does not have to hurry to turn it off.

Mrs. Hurricane's care plan needs to be monitored on an ongoing basis.

Writing the Psychosocial Assessment Section

Write the chronological history of psychosocial and psychological events that led to the main problem. This could include mental status.

If dementia is a part of the problem, break this out as its own section. The Psychosocial Assessment section should include information about moving from one level of care to another, death of a spouse, substance abuse, economic and legal issues including conservatorships, financial assets, insurance, both informal and formal support systems, activities, spiritual beliefs, recent life changes and life satisfaction, and ethnic background including preferences and needs. Following is a sample Psychosocial Assessment section.

Mrs. Hurricane has a history of noncompliance with doctors' orders and safety issues. She is a Christian Scientist, and because of her religious beliefs, she prefers to handle her medical problems by prayer first and medical care second. Mrs. Hurricane and her daughter asked for Carolyn Hellsapoppen's recommendation for physicians in the Monterey area. Carolyn was able to provide them with three names, one being Carl Handsome, MD, an internist in Carmel. Mrs. Hurricane has an appointment with Dr. Handsome on December 13, in 1 week.

Mrs. Hurricane was administered a short portable mental status questionnaire by the care manager, and her score of 1 error indicated she does not seem to need additional evaluation for memory loss. This was confirmed by Dr. Olsen's physician's report. There is no former or present substance abuse.

Upon discussion with Carolyn Hellsapoppen, Mrs. Hurricane stated that she is feeling depressed. The care manager observed she had a flat affect and appeared lethargic, and Mrs. Hurricane stated that she has felt depressed for days. She stated she did not want to go out of the house, hardly wanted to watch her favorite show *Jeopardy* anymore, and does not feel like going to the Carmel Foundation. Care manager Carolyn Hellsapoppen interviewed Miss Service, a social worker at the Carmel Foundation. Miss Service stated Mrs. Hurricane attended until 1 month ago, and repeated calls and follow-up home visits were made to find out what prevented Mrs. Hurricane from attending the foundation. Miss

Service said she will work with the family and the care manager to reengage the client in foundation activities. Amber Helpall, social worker, discussed the possibility of Mrs. Hurricane having a pet. Mrs. Hurricane stated she would like one but is unable to have a dog or cat because of restrictions in the condominium complex where she lives.

Ms. Tornado, the adult child who lives closest to her mother, is the primary family care provider. Although Mrs. Hurricane's sons James and Steve live on the East Coast, they have both agreed to offer their mother whatever support is required, which might include taking her as respite, helping financially, or whatever is suggested by the care manager. Mrs. Hurricane's other social support is her 92-year-old neighbor, Mrs. Charlotte Murphy, who encourages Mrs. Hurricane to go to the Carmel Foundation and visits her most days for tea and conversation. Ms. Hellsapoppen interviewed Mrs. Murphy, and Mrs. Murphy stated that Mrs. Hurricane seemed more "down in the dumps lately" and was staying in bed some days instead of watching *Jeopardy*. The two women have watched *Jeopardy* together for several years. Additional social supports were from the Carmel Foundation, where Mrs. Hurricane attended a women's support group, tutored English as a second language, and had daily lunches.

Daughter Ms. Tornado has the durable power of attorney for health care as well as the durable power of attorney for finances for her mother. These two documents were established in 2002 to prepare for her mother's future, according to Ms. Tornado. Mrs. Hurricane continues to handle her own finances, but Ms. Tornado "checks everything over" for her mother, according to Ms. Tornado. Mrs. Hurricane has adequate finances (about \$1 million in assets) to pay for care. She has long-term care insurance through PERS because she was a teacher, plus Medicare and a Medicare supplement.

Mrs. Hurricane asserts that she does her own housekeeping and laundry and that she needs a cleaning lady only once a week. Mrs. Hurricane's home was very

neat and clean, according to the observation of Carolyn Hellsapoppen. However, because of her balance problems, it is recommended that a care provider do the daily light housework for the client. Mrs. Hurricane drives, but she does not drive at night, according to her daughter.

Writing the Medications Section

List all current medications in this section, including dosage. You should get this information from the physician report you send to the client's doctor. You can also find out about all medications by asking the client or client representative if you can look at each bottle of medication in the client's possession. By doing this, you can make a list of current medications and also find medications that are out of date and discover any polypharmacy issues.

Writing the Level of Care Section

In the Level of Care section, you recommend a level of care. You might recommend the same level of care as currently provided with no supports or the same level of care but including additional support systems such as care providers. You might have to recommend the client move to a higher level of care, such as moving to an assisted living facility.

Your job as care manager is to be an expert in level of care. After you complete all your assessment tools, you should be able to state exactly what level of care your client needs. Again, evaluation of the physical environment in combination with an understanding of the client's ability to perform the ADLs enables a care manager to understand the level of care the client needs. Following is a sample Level of Care section.

Ms. Tornado is concerned because her mother has fallen five times during the 2-week period of October 15 to October 31. She states Mrs. Hurricane refuses to have help at home and further declines to move from her home to a higher level of care. She would like the care manager opinion on how to proceed in keeping her mother safe at her present level of care or on a plan to move to a higher level of care.

The care manager recommends that Mrs. Hurricane remain at home where she is in familiar surroundings, has a good neighbor, and is comfortable. If all home safety deficits are followed through and the client is provided assistance with her IADLs of food preparation, housekeeping, driving at night, doing her laundry, and shopping, Mrs. Hurricane can remain in her home with a live-in care provider. However, the care manager recommends that the daughter hire a live-in. Because Mrs. Hurricane is adverse to this level of care, the care manager suggests that she be allowed to counsel Mrs. Hurricane over a period of time to accept this assistance.

Writing the Care Plan Section

The care plan comes next. This care plan should include more details than the care plan you place in the home for care providers

and update on an ongoing basis. The care plan in the geriatric assessment must paint a clear picture of the client’s needs for a judge, attorney, family member, or third party, and others who are not care managers. The care plan should be written in clear English, without jargon, and should be concise and readable. Start as stated earlier with the problem you were hired to assess in the first place. The following is a care plan example that would be included in a geriatric assessment (**Exhibit 5-5**).

Narrative Explanation of Care Plan

After the actual care plan, include a narrative explaining the care plan. For example, if the care plan states that Mrs. Hurricane is depressed and needs to see a mental health provider to be evaluated for depression and

Exhibit 5-5 A Sample Care Plan

Problem

1. Ms. Tornado is concerned because her mother has fallen five times during the 2-week period of October 15 to October 31. She states Mrs. Hurricane refuses to have help at home and further refuses to move from her home to a higher level of care. Ms. Tornado would like GCM Care Solver’s opinion about how to proceed with her mother’s safety issues.
2. Washer and dryer are located down the stairs and outdoors and are one reason for recent falls.
3. Mrs. Hurricane presently has no primary physician because she has been noncompliant with doctor’s appointments in the past.

Intervention

1. a. Within 1 week, daughter Ms. Tornado to hire live-in care providers for Monday through Friday and Saturday and Sunday who can drive, through a list of home care agencies given to her.
- b. Care manager to visit weekly and as needed to help Mrs. Hurricane to accept care and problem solve with Mrs. Hurricane and care provider.
- c. Care provider to do standby assist at all times.
- d. Within 1 week, daughter to arrange for Lifeline alerts through Community Hospital of Mt. Peninsula or other source.
- e. Daughter to ask physician Dr. Handsome to evaluate reason for falls at next appointment on December 13th.
2. Daughter to have care provider do laundry 1 time a week in basement on an ongoing basis.
3. a. Daughter to take Mrs. Hurricane to appointment with Dr. Handsome on December 13th and confirm that he will be Mrs. Hurricane’s primary physician. *continues*

Exhibit 5-5 A Sample Care Plan (continued)

Problem	Intervention
4. Alteration in nutrition: recent loss of appetite. Mrs. Hurricane has lost approximately 20 pounds and weighs approximately 180 pounds.	<ul style="list-style-type: none"> b. If Dr. Handsome declines to follow up with Mrs. Hurricane on December 13 appointment, daughter to obtain a primary physician from list given by care manager within 1 week after December 13. c. After first appointment on December 13, care provider to keep track of all doctor's appointments and drive Mrs. Hurricane to each doctor's appointment.
5. Alteration in urinary elimination: Client has a urostomy.	<ul style="list-style-type: none"> 4. a. Daughter to have Dr. Handsome evaluate Mrs. Hurricane's weight loss at December 13 appointment. b. Care provider to prepare breakfast and dinner and drive Mrs. Hurricane to the Carmel Foundation for daily lunch on an ongoing basis. 5. Daughter to ask Dr. Handsome to evaluate Mrs. Hurricane's urostomy and urinary problems at December 13 appointment.
6. Alteration in bowel elimination: medication side effects of diarrhea.	<ul style="list-style-type: none"> 6. Daughter to ask physician to evaluate urinary medication side effects at December 13 appointment.
7. Mrs. Hurricane has elevated blood pressure.	<ul style="list-style-type: none"> 7. a. Daughter to ask Dr. Handsome to evaluate elevated blood pressure and monitor blood pressure at December 13 appointment.. b. Care provider to prepare low-salt meals on an ongoing basis.
8. Pain: Mrs. Hurricane complains of burning sensation and pain in back and neck.	<ul style="list-style-type: none"> 8. Daughter to ask Dr. Handsome to evaluate present pain and burning sensation at December 13 appointment.
9. Mrs. Hurricane is a non-insulin-dependent diabetic, and her blood sugar values are self-reported as "quite high" despite her avoidance of sweets and the use of the prescription drug Glucophage (metformin), which she has discontinued using.	<ul style="list-style-type: none"> 9. a. Daughter to ask Dr. Handsome to evaluate diabetes and present diabetic medications for side effects at December 13 appointment. b. Care provider to prepare diabetic meals on an ongoing basis. c. Care provider to monitor sweets intake and chart on an ongoing basis. d. Daughter to call Carmel Foundation and order diabetic meals week before client returns to Carmel Foundation. e. Daughter to investigate a diabetic support group for Mrs. Hurricane.

Exhibit 5-5 A Sample Care Plan (continued)

Problem	Intervention
<p>13. Mrs. Hurricane states that she cannot drive at night.</p>	<p>c. Daughter to get a shower chair for mother at medical supply store or Carmel Foundation within 1 week.</p> <p>d. Daughter to arrange for repair person to hook up smoke alarms within 1 week.</p> <p>e. Daughter to have handyman remove outside obstructions in pathways, such as tools and planter boxes, within 1 week.</p> <p>f. Daughter to order Jitterbug cell phone so mother does not have to rush to answer phone, within 2 weeks.</p> <p>g. Daughter to buy electric teapot that automatically turns off, within 2 weeks.</p> <p>13. a. Daughter to take mother to have a thorough eye exam at an ophthalmologist within 1 month.</p> <p>b. Care provider to drive Mrs. Hurricane to all night events on an ongoing basis.</p>
<p>14. Mrs. Hurricane is opposed to medical treatment and thus is noncompliant because of her Christian Science beliefs.</p>	<p>14. a. Care manager to contact the local Christian Science foundation in Monterey and make arrangements for a church member who specializes in working with elders to help problem solve so Mrs. Hurricane's health, safety, and spiritual issues can all be met.</p> <p>b. Care provider to drive Mrs. Hurricane to Christian Science services once a week.</p>
<p>15. Daughter is stressed by caregiver burden.</p>	<p>15. a. Daughter to consider attending on first and third Fridays caregiver support group through Del Mar Caregiver Resources in Santa Cruz, where she lives.</p> <p>b. To monitor care plan, care provider, activities, health issues, spiritual issues, and compliance issues care manager will visit Mrs. Hurricane every week for the first 2 months and then every other week after that if Mrs. Hurricane is stable.</p> <p>c. Care manager to reevaluate weekly whether daughter is able to do all tasks and to take over tasks daughter wishes to delegate.</p>

possible medications, you can insert the additional information that Mrs. Hurricane has only one friend in her informal support system and that a care provider should be hired. You can explain some of the things the care provider can do to allay the client's depression, such as taking Mrs. Hurricane on visits to the Monterey County SPCA because Mrs. Hurricane likes animals but cannot have one and taking Mrs. Hurricane to plays at the local theaters.

Evaluating the Geriatric Assessment

Proofread the first draft of the geriatric assessment to make sure you have all the correct information and that the information is well written, grammatically correct, and spelled correctly. The following sections describe some tools to help you accomplish this.

What Makes You a Good Detective?

When you complete the first draft of your geriatric assessment, go back and check that all elements are in place. In other words, did you gather all the clues? Did you talk to every person who could give you a point of view about the crisis? In Mrs. Hurricane's case, the daughter, the two other adult children, the friend, the Carmel Foundation social worker, and Mrs. Hurricane's former primary physician were involved.

Check that every line of your assessment tool was completely and accurately filled out. This is where you keep track of your clues. Too many care managers are messy, leaving lines in assessment forms unfilled or skipping over lines or writing in haste. Don't miss any clues. As stated earlier, look at your assessment tools to make sure you slowly and meticulously sift through clues, leaving no stone unturned in your efforts to ensure that all evidence has been taken into account before reaching conclusions and announcing them. Following that, ask yourself these questions: Did you distill the sifted information into

your care plan? Does your care plan have complete and well-written problems? Does it have complete and well-written solutions? Is your care plan measurable? Does your care plan tell the reader who will accomplish the solutions?

What Makes a Good Written Assessment?

In a workshop titled "How to Write a Professional Assessment and Recommendations," Phyllis Brostoff discussed the 4 Cs of writing a geriatric assessment that are invaluable in checking your document.⁶ The first is clarity—make sure your facts are presented clearly. In Mrs. Hurricane's geriatric assessment, you would not say, "Mrs. Hurricane looked depressed." You would state, "When visiting Mrs. Hurricane on November 1, 2014, Mrs. Hurricane stated to the care manager that she was feeling depressed."

The second C is cohesiveness. This means organization. For example, don't put information about the client's depression in the Home Management section of your geriatric assessment. Follow the guidelines in **Exhibit 5-6**. Do not commingle sections. Write a tight outline, follow it, and make your written assessment cohesive.

The third C is completeness. You have conducted multiple assessments, but have you

Exhibit 5-6 Elements of a Geriatric Assessment

Problem

- Brief client history from birth to crisis that prompted care manager to intervene
- Written summation of functional assessment
- Written summation of cognitive assessment
- List of all medications
- Written summation of psychosocial assessment
- Written summation of home environment assessment
- Written summary of any other pertinent assessment
- Care plan
- Written explanation of the care plan
- Summary of recommendations

filled in every line, like a good detective? Have you answered every question fully? With Mrs. Hurricane, did you answer the question of why she was having falls? The answers were many: having no care providers, having to walk down a flight of steps to the laundry, having no cell phone, having a teapot that could not turn itself off, not attending the Carmel Foundation where she had supervision, and so forth.

The fourth C is coherence. Your geriatric assessment must lead to logical conclusions. In the beginning of Mrs. Hurricane's geriatric assessment, her daughter Ms. Tornado wanted you to find out why her mother had multiple falls and what level of care her mother belonged in. You need to offer a solution to these beginning problems in your conclusion section—why is Mrs. Hurricane falling, and where should she live?

Next, determine whether the items included in the geriatric assessment are actionable. When editing the first draft of your geriatric assessment, use Phyllis Brostoff's criteria to help you create an actionable care plan.⁶ The solutions in your geriatric assessment must be actionable, which means they should be affordable, acceptable, and doable.

- Are solutions affordable? In your geriatric assessment, you discovered that Mrs. Hurricane has about \$1 million in assets and Ms. Tornado, who has durable power of attorney for finances, is open to spending the money on care and services for her mother. So it seems you have an affordable care plan.
- Are solutions acceptable? Will Ms. Tornado pay for a 7-day live-in? Ask her. Will the daughter carry through with all the interventions you are recommending to her? Did you discuss these recommendations with her? Will Mrs. Hurricane be noncompliant with another doctor? Will she accept a care provider? You can check whether some of these interventions are acceptable just by asking the client and family members. Whether

interventions like the ones created for Mrs. Hurricane are acceptable will depend on whether the care manager can work with the client during care monitoring visits and the quality of the care provider. Some of these interventions take time to become acceptable to the client.

- Is your plan doable? Can Ms. Tornado get Mrs. Hurricane to the mental health assessment at the community hospital? Will Ms. Tornado follow through, or is her relationship with her mother so strained that Mrs. Hurricane might not go with her? Would it be better to have the care manager take Mrs. Hurricane?

Did You Sell Your Services Well?

Your written geriatric assessment is your geriatric care management product. If you were selling a car, you would never put a vehicle on the car lot with smashed windows, torn seats, and an empty tank. If you sold a car to someone, you would not deliver the car late. So, in your geriatric care management work, do not be sloppy. Check to see that you have gathered enough information to evaluate and solve the problems you were hired to solve without making errors. Don't present questionable or unfounded information in your written assessments. If you cannot check the facts, don't include them in the document. Make clear the source of the information and how reliable that source is. Do not include poor spelling, bad grammar, and awkward sentence structure. Have someone who knows how to write and edit review your document, even if you are a good writer. Organize your information by following the outline presented in this chapter. Base your conclusions on facts, not assumptions.

Also, make sure there is coherence between problems you have identified and interventions you are recommending. For example, if you are dealing with the problem that Mrs. Hurricane is depressed, don't simply recommend she go to a women's support group.

Although that might help, a more complete recommendation would be for Mrs. Hurricane to be assessed by a mental health professional. Include the name of the professional, his or her phone number and address, and a recommended time frame for the appointment as part of your recommendation.

Do not be subjective. Always be objective. “I thought she appeared depressed” should be reworded as “On the care manager’s visit of 6/6/14, care manager observed Mrs. Hurricane had a flat affect, appeared lethargic, and stated that she has felt depressed for days. She stated she did not want to go out of the house and hardly wanted to watch her favorite show *Jeopardy* anymore.” Also, do not be vague—present measurable statements: “She should be evaluated for symptoms of depression by Martin Skirt, LCSW, within 2 weeks,” not “She should see a mental health professional.”

Conclusion

Once the assessment is completed, mailed out to the party who requested it with copies sent to the other relevant individuals, and discussed with all concerned parties, the job of the care manager may be finished or just begun, depending upon whether the care manager is asked to carry out the care plan. In this chapter’s example, Ms. Tornado may say she will move forward with all the care manager’s suggestions, or she may say she will wait on some. At times, the client or family may resist the changes recommended in the plan and decide that their connection with the care manager is finished. If and when a crisis arises in the life of the client, the care manager may be called upon again to become involved, adjust the plan to fit the needs of the current situation, and implement and manage the care plan. If this occurs, because the care manager

has already acquired so much information about the client, the care manager is usually able to provide relatively quick assistance. In either case, the care manager has provided the client and family with a comprehensive blueprint of how to proceed and, it is hoped, has assisted them in seeing the value of using professionals for consultation and assistance.

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