



The Case Manager Corner – April 2018

Care Planning – An Integral Part in the Aging Process

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While studies show that most seniors are healthy and function at a high level, it's inevitable that as we grow older, issues will surface related to our health, safety, independence and quality of life.

Eldercare often requires a multi-disciplinary approach that encompasses many aspects of life such as healthcare, activities of daily living, transportation, finances, social, and emotional well-being.

To ensure the highest quality of life for the longest time possible, it's crucial that seniors people with special needs, and their loved ones begin a dialogue to discuss the topic of aging. This process needs to focus on the person's hopes and desires, short and long term goals, and their abilities and needs; while at the same time establishing a spectrum of resources that will address the person's evolving needs.

WHY ARE THINGS GETTING WORSE?

All too often, Linda Ziac receives a call at The Caregiver Resource Center from a family telling her that they hired an agency or someone privately to provide caregiving services for a loved one, only to have things get much worse.

Well-meaning families often see that a senior or person with special needs is struggling, and quickly jump into action in an effort to help, without considering all the facts. Instead of taking time to properly evaluate the person's abilities, needs, and developing an appropriate care plan, the family hires a caregiver to come in and help.

But help with what?

A CASE SAMPLE

Sally is married with three children, and just received a promotion at work in a high pressure job.

Sally has been helping her mother Mrs. Jones, visiting every couple of days, fixing dinner and paying bills.

Over the past several weeks, Sally has noticed her mother is more confused, argumentative, anxious, and repeating herself more.

Worried about her mother and believing her mother is developing Dementia, Sally calls a homecare agency, and the agency sends over a caregiver to work four hours a day.

The situation continues to get worse. But why?

Upon further investigation Linda learns that:

- Mrs. Jones has a urinary tract infection (UTI), which is known to cause confusion, anxiety and irritability.
- Mrs. Jones isn't taking her medication as prescribed – sometimes forgetting to take her pills and other times taking too many pills.

A PERSON'S CARE NEEDS

Evaluating a person's care needs is like putting a jigsaw puzzle together. The more pieces of the puzzle you have the clearer the picture.

Care for seniors and people with special needs often requires a multi-disciplinary team approach consisting of a variety of members such as the primary care physician, cardiologist, neurologist, physical therapist, occupational therapist, certified case manager, and caregiver, to name a few.

Linda often refer to the client's team as being like an orchestra, with each member having a unique set of skills and talents that they bring to the group. Linda's role as a board certified case manager (CCM) and board Certified dementia practitioner (CDP) is to serve as the conductor of the orchestra; ensuring that there is good communication, teamwork, and that everyone remains focused on the client and family's goals.

There are a number of steps involved in the development of a comprehensive care plan (road map) to help address a person's current and evolving needs – the "what-ifs".

To follow is an overview of four key steps in this process.

STEP 1 *The Senior's Wishes and Desires*

The first step in this process is to talk with the senior in order to understand their feelings related to aging, as well as their wishes and desires moving forward. It's important to recognize the senior's right to make their own choices related to their care; even if you don't agree.

Opening a dialogue may progress smoothly or pose a challenge depending on:

- your relationship with the senior (open and trusting vs. distant and strained).
- the senior's present mental status (ability to communicate and process information vs.

the presence of a disability such as depression or dementia).

- the senior's present functional status (independent and active vs. struggling to provide self care).
- the manner in which the discussion is initiated (genuine concern vs. intrusiveness).

To the extent possible, it's important to initiate this dialogue as soon as possible, and hopefully while the senior is able to openly voice their current and future wishes and desires. Of course, this won't always be possible, so if you encounter resistance or difficulties, you may want to seek assistance from a professional to help facilitate the process.

STEP 2 *Obtaining an Assessment*

Before you can begin to develop an appropriate care plan for a senior, it's first necessary to determine the senior's ability to remain safely independent, along with their strengths, weaknesses, and areas of concern. The best way to determine the needs of a person, is by means of a Comprehensive Geriatric Assessment, that can be provided by a number of trained professionals, including a board certified case manager.

A Comprehensive Geriatric Assessment is a multidimensional diagnostic process designed to evaluate the person's medical, mental, physical, social, environmental, and financial status.

This process is used to determine the seniors' capabilities, and will be used as a baseline, for moving forward in the development of an individual care plan.

STEP 3 *Developing a Care Plan*

Once the person has undergone a comprehensive assessment, the information obtained will be used to design a care plan (road map).

The care plan will identify 1. each senior need (e.g. medication compliance), 2. goals (e.g. ensure that all medication is taken as prescribed), 3. a specific action plan to address the need (e.g. a monthly pill box will be set up noting daily medication, and a checklist to use to record times when medication is given), and 4. the team members responsible for this aspect of the care plan (e.g. daughter will set up monthly pill boxes, and the homecare agency caregiver will cue the senior to take her medication).

It's important to have the certified case manager and team review and modify a client's care plan every 60 days, or when there's been a status change in the client (e.g. fall, heart attack, increased cognitive decline).

Based on the individual senior, it may be possible for the individual to remain in their own home with family or paid caregivers, or they may need to look at alternative housing, such as an assisted living facility or nursing home. It's important to continually monitor the client, and as their needs change, the care plan will need to be modified to address their evolving needs.

STEP 4 *Important Legal Documents*

Have you ever wondered what would happen if a person became incapacitated, and was unable to communicate their wishes, related to their medical care or financial affairs?

All too often a person becomes incapacitated, and their family scrambles to locate important financial and legal documents, in an effort to ensure that they receive necessary care. You may not even be sure if the senior ever put their wishes in writing.

What now! Unfortunately, if the senior has not taken a pro-active approach prior to this point, their loved ones are bound to face a very stressful and overwhelming task.

Advance directives are a written document that provides medical personnel with clear and legal instructions about medical care decisions, should a patient be unable to make decisions on their own behalf. These documents combined with a healthcare agent/ medical power of attorney help medical professionals treat a patient by honoring the patient's wishes, and minimizing discrepancies between what the patient wants and what the family wants.

A health care Advance Directive, also called "Medical Power of Attorney," gives instructions for health care in the event that, in the future, a person is unable to make their own decisions for whatever reason (e.g. traumatic brain injury, unconsciousness, cognitive impairment).

It doesn't take much, for a senior and their loved ones, to ensure that all their personal affairs are in place. By having an attorney, prepare a set of documents in advance, the senior or person with special needs can ensure that their wishes will be honored.

THE ROLE OF A BOARD CERTIFIED CASE MANAGER (CCM)

Certified Case Managers (CCM) are specialists who assist seniors, people with special needs and their families; in planning for and implementing ways to allow for the greatest degree of health, independence, safety and quality of life.

CCMs meet with the client and /or family members to assess their needs, develop a Care Team, and work with members of the Team to formulate a comprehensive Care Plan (a road map).

Once a plan is in place, CCMs are available to serve as the point person to monitor and coordinate services, and revise the plan as needed. The CCMs' role is similar to the conductor of an orchestra; ensuring that there is good communication, teamwork, and that everyone remains focused on the desired goals.

Case management is a collaborative process that consists of four steps:

1. Assessment
2. Development of a Care Plan (based on the unique needs of the client)
3. Implementation & Monitoring of the Plan
4. Ongoing Evaluation of the Plan Effectiveness, and Plan Modification as Needed

Photo from Microsoft

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Please consult your health care provider for an appointment, before making any healthcare decisions or for guidance about a specific medical condition.

Linda Ziac is the owner and founder of The Caregiver Resource Center. The Caregiver Resource Center is a division of Employee Assistance Professionals, Inc. which Linda founded in October 1990. The Caregiver Resource Center provides a spectrum of concierge case management and advocacy services for seniors, people with special needs and families.

Linda's professional career spans more than 40 years in the health and mental health field as a CT Licensed Professional Counselor, CT Licensed Alcohol and Drug Counselor, Board Certified Employee Assistance Professional, Board Certified Case Manager, and Board Certified Dementia Practitioner. In addition, Ms. Ziac has 15 years of experience coordinating care for her own parents.

Linda assists seniors, people with special needs and their families; in planning for and implementing ways to allow for the greatest degree of health, safety, independence, and quality of life. Linda meets with individuals and family members to assess their needs, and develop a Care Team, while working with members of the Team to formulate a comprehensive Care Plan (a road map).

Once a plan is in place, Linda is available to serve as the point person to monitor and coordinate services, and revise the plan as needed. This role is similar to the conductor of an orchestra; ensuring that there is good communication, teamwork, and that everyone remains focused on the desired goal.

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