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Geriatric Care Management and the Development of a Long-Term Care Facilities Database

Patricia J. Iverson

GERIATRIC CARE MANAGEMENT
AND
THE DEVELOPMENT OF A LONG-TERM CARE FACILITIES DATA BASE

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Abstract Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fulfillment of the
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Abstract

The purpose of this project was to investigate the professional field of geriatric care management. Information was obtained by reviewing the needs of the caregiver and the aging adult and the dynamics of the relationship which exists between them, by exploring the reasons why this relationship sometimes inhibits the caregiver from pursuing the services that are needed, and by examining the role of the geriatric care manager in helping the caregiver and aging adult sort through the fragmented web of services in order to match the caregiver and the aging adult with the appropriate services.

Locating and selecting appropriate services is a major function of the geriatric care manager. An efficient geriatric care manager needs to have resources easily and quickly accessible. To help meet this need , a long-term care resource inventory data base project was developed. The long-term care facilities in the St. Louis and surrounding counties area were researched and the data regarding each facility was entered into a data base program customized for the geriatric care manager. This project allowed information pertaining to over 200 facilities to be readily available to the geriatric care manager searching for appropriate placement for a client.

Further research is needed to develop a service provider resource inventory for the geriatric care manager. Being able to access information about appropriate services in the community through a data base inventory would provide a much more comprehensive, accurate, and time efficient service for the client.

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DEDICATION

This project is dedicated to my parents, Clyde L. Foster and the late, Mary Helen Foster, who inspired in me the value of education, the satisfaction of achievement, and the love and respect of the older adult.

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Chapter I

Introduction

Geriatric Care Management is a process whereby a professional care manager assists an older adult and his or her caregiver to identify needs, plan for services to meet those needs, coordinate available services and monitor and reassess the care plan on a routine basis. Older adults often have significant disabilities that limit their capacity to locate assistance on their own, to bring services together in a coherent way, to negotiate with providers, and to sustain services over time (Moxley 11). Geriatric care management is widely recognized as an important component of an effective process for delivering health and human services to seniors and their caregivers (Capitman, Haskins and Bernstein 401; Moxley 10; Steinberg and Carter 33; Weil, Karls, and Associates 2).

The goals of care management are multiple in number but primarily client oriented in nature: (1) To assure that services given are appropriate to the needs of a particular client (2) To monitor the client's condition in order to guarantee the appropriateness of service (3) To improve client access to the continuum of long-term care services (4) To support the client's caregivers (5) To serve as bridges between institutional and community-based care systems (Applebaum and Austin 7).

The research literature indicates that the term "care manager" is often used interchangeably with the term, "case manager." However, the technical definition of the two terms does vary. Case management is, "a collaborative process that assesses, plans, implements, coordinates,

monitors, and evaluates the options and services that meet an individual's health care needs during a particular episode of illness or incapacity. Practice is based on a medical model." On the other hand, care management is "a collaborative process that assesses, plans, implements, coordinates, monitors, and reevaluates the options and care plans that meet an individual's health and long term care needs over an extended or protracted period of time. Practice is based on a continuum of life service model (Elder Link 1996).

Capitman, Haskins and Bernstein define case management as:

> an administrative service that directs client movement through a series of phased involvements with the long-term care system. . . . (It) attempts to integrate the formal long-term care system with the caregiving provided informally by family members, friends, and community groups. (399)

Long-term care case management differs from case management that is service-centered and provided in conjunction with direct services in that it is more intense, has a broader breadth of services and a longer duration (Applebaum and Wilson 172). Private practitioners that provide comprehensive long-term care case management, such as geriatric care managers, have caseload sizes that allow them to provide intense involvement with their clients. They are also able to involve a broad span of services to meet their clients' needs and are able to stay involved with their clients through formalized, scheduled reassessments and regular, systematic monitoring of the client's condition and care plan. These characteristics are what distinguish geriatric care managers from case managers such as hospital discharge planners, home health agencies,

and county social service departments. These agencies are usually considerably limited in intensity, breadth and duration of service provision (Applebaum and Austin 6).

Long-term care case management has its roots in social casework (White 93). It evolved in the 1970's and 1980's in response to the need for effective delivery of services to seniors (Joshi 567). The senior population was increasing, nursing home costs were rising and the preference of elders to stay in the community was gaining in popularity.

Today, many families are turning to geriatric care management to help them meet these needs. Stoller and Earl report that many non-institutionalized elderly receive regular help from family members in meeting their non-personal daily needs such as housework, shopping, yard work and transportation. The family is also the major source of support during times of illness. Also, friends and neighbors often provide support in the form of compensatory support by relieving some of the burden from the family caregiver. But, willingness to help can not be equated with competence and ability to meet the needs of the older adult over a long period of time. Todays' families don't always have the structural or economic support to provide such care. With more women in the work force and the decline in the size of families, more strain is put on the family's ability to meet the needs of its older members (Stoller and Earl 64).

Social services and long-term care health services are complicated and fragmented. A geriatric care manager can help sort through the complex web and assist in arranging the needed services for a dependent senior or a frustrated caregiver. An older adult often has

more than one need. The geriatric care manager can coordinate services from multiple providers and work within the existing system of community services without restructuring the relationship between providers and the system (Applebaum and Austin 4).

This fragmentation of service has been a problem all across the world. The most obvious separation is between health and social care even when they are provided by the same organization. Different assessors and providers for each service can make for a very frustrating experience for an elderly person and his caregiver (Challis 776). Care management is:

> a strategy for organizing and coordinating care services at the level of the individual client. Its objectives therefore involves mobilizing and coordinating a set of various agencies and services to achieve a clearly formulated goal, rather than each service or agency pursuing separate and diverse goals. (Challis 776)

The purpose of this paper is twofold. First, an overview of geriatric care management is presented by: (1) reviewing the needs of the caregiver, the aging adult, and the dynamics of the relationship which exists between them, (2) exploring the reason why this relationship sometimes inhibits the caregiver from pursuing the services that they and their aging loved one may need, and (3) examining the role of the geriatric care manager in disentangling the fragmented web of services available and matching up the caregiver and the aging adult with the appropriate services. Second, a long-term care resource inventory data base project is presented that has been designed to aid the geriatric care

manager in researching and arranging for the delivery of long-term residential care services for the elderly.

The process of selecting the appropriate software and customizing the software to meet the needs of the geriatric care manager are discussed. The long-term care data base project has been developed as one way to broaden the knowledge base of the geriatric care manager and increase accessibility to resources in order to meet the increasing needs of the elderly in our society.

Chapter 2

Review of the Literature

Caring For An Aging Loved One

Greg is forty-five years old. He is a business owner and his wife is a lawyer. They have three teenage children. Greg's mother is 83 and suffers from macular degeneration and mild confusion. She is on medication for her heart. She lives in another state, six hours from Greg, in a limited assistance living facility. The Social Worker has told Greg that his mother is declining and may soon no longer be appropriate at this facility. He should be considering other arrangements.

Louise is forty and divorced with one child. She works as a police dispatcher on the 3 - 11 pm shift four nights a week. Her sixteeen year old daughter stays at home by herself while Louise is at work. Louise's father has been living independently but the doctor has just diagnosed him as having early stage Alzheimer's disease. There is no way he could move in with Louise and her daughter and he certainly couldn't live alone. Where can she turn?

Sharon's father insists on staying on in his old house long after his wife's death, even though the neighborhood is no longer pleasant or safe. He refuses to accept invitations from Sharon and her family to move in with them. Sharon is constantly worried and phones her father every day to make sure he is alright. She feels guilty and inadequate that she can't provide for her father in his own home and take care of her own family as well.

These three situations are about separate people, with different lifestyles, different incomes and different careers. However, they all have

one thing in common. They belong to a special generation that is caught in the middle of trying to rear their children, live their own lives, and help their aging parents. They are commonly referred to as the "sandwich generation" (Silverstone and Hyman 4).

Chronic illnesses, such as Parkinson's disease, Alzheimer's disease, and severe cardiac or pulmonary problems are high among the elderly. However, as a result of these conditions, the caregivers suffer as well as the older adult. Caregivers often develop problems in response to the stresses they face in the caregiving role. The greater the perceived burden of caregiving, the higher the likelihood of a caregiver breakdown or early departure from the caregiving role (Gallagher 89).

"Elder care is a burdensome, unrewarding, personally costly, and physically hazardous task" (Koch 2). The adverse affects of caregiving increase the longer a person cares for another. Koch states that individuals progress along a trajectory that starts with a desire to help in a medical crisis, through a period in which alcohol or drugs are used to control anxiety and stress, to a state where medical and emotional problems are an expected side effect. By these remarks, it would seem that caregiving is a debilitating disease (Koch 2-3).

Caring for an aging parent while raising a family and maintaining a successful marriage is draining - physically, financially, socially, and mentally. Ken Dychtwald reported the following statistics:

* 25% of caregivers rearrange their work schedules or lose work to provide elder care.

* 13% of caregivers have left the work force to care for an elderly parent full time.

* On any given day, 5 million Americans are actively providing elder care. This number is estimated to increase to 10 million by the year 2005.

* Caregivers are usually adult children commonly the daughter or daughter-in-law in their mid-forties. (Dychtwald 247)

As the number of people over age 65 increases and the needs for caregiving grow as never before in history, this new generation, the sandwich generation, is increasingly caught between the responsibilities of caring for their aging parents, the needs of their growing family, and their own careers and lives (Levy xviii).

Not all adult children are confronted with problems associated with aging because their parents remain active and self-sufficient until death. Some lose their parents early in life and miss the experience of seeing them grow old (Adams & Armstrong 1). Many elderly people take aging surprisingly well and need little help from the younger generation.

Just as the future is unpredictable, so is the process of aging. Aging does not follow any uniform calendar. Parents of young children seem to know what will come next in their child's early development. Within reason, they know when their children will walk, talk, when their first teeth will come, and when they are likely to start kindergarten or high school. Even some of the emotional stages can be predicted such as "terrible two's" and "rebellious adolescence" (Silverstone and Hyman 6).

In contrast the stages of growing old have no such predictable pattern. It is not possible to look at someone and know that at age 65, 75, or 85 they will begin to decline and be unable to handle their own life.

In addition to the irregular and unpredictable calendar of physical aging, emotional and personality problems intervene and confuse the picture. Hearing loss or severe arthritis may be overcome by will power and personal strength by one elderly individual, who continues to live and function independently and even productively. By contrast, another person with the same afflictions, may retire quickly into invalidism and total dependency (Silverstone and Hyman 7).

Many families are willing and eager to help when their aging parents are in trouble. These grown-up, usually middle-aged children, often over sixty-five themselves, may be motivated by a sense of responsibility, of duty, and of guilt. But just as often, they are motivated by genuine concern and love. However when elderly parents become more dependent and the problems of daily living multiply, their children soon discover that love is not enough (Silverstone and Hyman 10).

If love is not enough, what else is there? While many of the solutions can be found in the outside community if families know where and how to look, other solutions may be found much closer to home. Sons and daughters naturally must understand their parents' needs before they can help them, but they must also understand themselves and their own feelings (Silverstone and Hyman 11).

Special Reactions to Aging Parents

Mid-life is a time of reassessment. It is a time of reviewing and reevaluating one's life in terms of goals and accomplishments. The transitions of mid-life may involve a new independence, self-direction

and the pursuit of goals postponed during the child rearing years. However, these new found freedoms may be sharply interrupted when the needs of an aging parent increase. Having to take on the caretaking role again, can stimulate a host of negative emotions such as resentment and anger (Myers 85).

While many of the feelings we have about our parents can be traced back to childhood, we also continue to experience new ones. Successes and failures in adult life can strongly affect the way we feel about our parents. Our parent's circumstances in life or some new understanding of our own can stimulate unaccustomed feelings of love and compassion we never knew before. "When contradictory feelings coexist with equally high intensity toward the same person, a painful conflict results" (Silverstone and Hyman 17). New stresses can produce angry or fearful reactions we would never have believed we were capable of feeling. Some of the most common feelings that enter into the relationship betwen grown children and their parents and often spark an emotional tug of war are love, compassion, respect, tenderness, and sadness, indifference, fear and anxiety, anger and hostility, shame, and guilt.

The Relationship between Aging Parents and Their Children

When love, respect, tenderness, compassion and sadness are present in a relationship, they serve as a vital source of support and strength for both generations. When these feelings have always existed between parents and children, it usually indicates there has been a long

pattern of mutual concern.

While children are growing up, they look to those closest to them for models of behavior and they tend to copy what they see. If children grow up witnessing and experiencing love, caring, unselfishness, and consideration, they will most likely show some of these feelings to their parents when they are old. However, children who have never witnessed such tenderness in action have no models to copy and never learn how to feel or show these emotions. Patterns of behavior are often passed on from generation to generation (Silverstone and Hyman 18).

However, even if ones' parents were distant and cold and it was thought that they were unfair and unreasonable while growing up, adult children may come to understand later in life why their parents acted the way they did. Ones' experiences put a different perspective on past behavior. "Strong feelings of love, compassion, tenderness, and respect are likely to be accompanied by sadness, as the younger generations realize that elderly parents are no longer the people they used to be and death is coming closer every day" (Silverstone and Hyman 19).

It may be that love, affection, respect, compassion, and concern all have equal intensity in a relationship between grown children and aging parents. However, some emotions may be stronger than others. A child may respect his parents and care about them, and because of these feelings may want to help them, but never have loved them or felt much real affection for them. He may have felt apathy or indifference. Lack of feeling may be very painful. Love and affection are not essential to a helping relationship (Silverstone and Hyman 19). Cohen and Eisendorfer state, "Love is a potent force, but love does not always lead

to effective caring. It is not necessary to love your parents to care for them, but it is essential to deal with them effectively" (3).

Some children live in fear of either or both of their parents even when these parents are weak, helpless, frail, or terminally ill. They may be afraid of disapproval, of losing love, of death, and also of losing out on an inheritance. Continual, irrational fear or anxiety in relation to a parent is likely to have its roots in early childhood experiences. Small children are totally dependent on their parents. They make them feel safe, they set the rules and enforce them. As children mature, that fear seems to subside and feelings of affection and trust emerge as between close friends. Children who never resolve that dependent relationship may continue to suffer fear and anxiety in one form or another throughout life. A child may fear that he will not live up to his parents' expectations. When he grows up, he may be afraid that he is not the kind of person they want him to be (Silverstone and Hyman 21).

The development of angry feelings in childhood is often caused by dramatic events such as death or chronic illness of a parent, divorce, abandonment, loss of a job, or a remarriage. These feelings are often unavoidably stimulated through the early years of day-to-day family living. Once a resentful child grows up, he may forget those angry feelings. Just as the frailities and uncertainties of their old age can awaken feelings of tenderness and compassion, a parent's dependence on his adult child can rekindle old feelings of anger and resentment long thought to be gone. Years later one can still feel angry and resentful about his parents' behaviors in the past. Just because they are old and frail now may not lessen those feelings. Failure to help them now may

be a form of unconscious retaliation: "You need ME now. Where were YOU when I needed you?" (Silverstone and Hyman 22)

There are different forms of shame. The simplest and most common form of shame comes when children feel they do not do enough for their parents. Perhaps a son doesn't visit his parents enough. Perhaps he is unable to help his parents financially; perhaps he allows others, siblings or even strangers to provide solutions to problems he feels he should be handling (Silverstonen and Hyman 22). Another form of shame is when sons and daughters are ashamed, not of themselves, but of their parents for their failings such as being illiterate, uneducated, or alcoholic. An adult child may be ashamed of his parents because he fears that their shortcomings will reflect badly on him in his social circles at church, in the neighborhood, at work, and even with in-laws. A third level of shame is a combination of the first two. The adult child may be ashamed of himself because he is ashamed of his parents. This is the most painful form of shame and the most difficult to cope with. It creates great emotional conflict in sons and daughters, prevents them from offering constructive help to their parents, and forces them to bear a continual and heavy burden of guilt (Silverstone and Hyman 23).

"Guilt is usually the end result or the prime mover of many of the other uncomfortable feelings from past and present" (Silverstone and Hyman 28). Guilt can be an endless, self-perpetuating cycle. Guilt may stem from the uncomfortable suspicion that one has not behaved responsibly to his parents, and then, the more guilt he feels, the more difficult he may find it to behave responsibly. There is also the guilt sons and daughters feel when they wish an elderly mother or father would die.

Most people who feel this "death wish" consider it too terrible to admit, particularly if they are angry with their parents. There are two kinds of death wishes. One is for a parent who is terminally ill, in constant pain, and has no chances of recovery. Another one, which is less acceptable, is directed toward a parent who is not terminally ill but merely difficult or incapacitated, draining the physical and emotional strength of the family. "I wish she would die and then I'd have some life for myself at last." There is also a guilt generated by the uneasy knowledge that one may not be able to provide for his elderly parents as they provided for him when he was young (Silverstone and Hyman 30).

Some feel that adult children act out of a sense of obligation. They feel as though they somehow owe their parents who, when they were children, held the responsibility for their lives. However, Koch feels that caring for an aging relative is not done out of a sense of indebtedness but rather an altruistic choice that is difficult to explain. He points out that an adult child is free to move away or to deny the act of caring because of his own professional obligations or the needs of their own growing family and family life. He feels that the force behind caring must lie in the history of the relations between two people and the lessons learned from it (Koch 4).

Changes in the Personal World of an Aging Adult

Just as it is important to understand all the various emotions involved in a relationship between an aging parent and their adult children, it is equally important to consider all the various changes in the

aging adult's personal world. It is important to stop and wonder how old age has affected their overall lives. One word can sum up the varied catalogue of problems that do appear in old age. That word is loss (Silverstone and Hyman 63). Some older adults may be able to adjust without much trouble to the losses they suffer. Others may need help.

Loss of physical health to chronic and disabling diseases such as Alzheimer's disease, atherosclerosis, arthritis, bronchitis and lung diseases, cancer, congestive heart failure, coronary artery heart disease, diabetes, drug misuse, ear diseases, eye diseases, hypertension, malnutrition, neuritis, osteoporosis or stroke can be the underlying cause of other problems of aging such as depression, decrease in intellectual functioning and a reduction in the satifactions of living. If an older adult does not suffer from a particular physical loss, there may be daily concern that it could be forthcoming (Silverstone and Hyman 63).

Other losses include the loss of social contacts due to changes in human relationships and changes in environment and the loss of familiar roles such as the role of a parent, breadwinner, homemaker, spouse, church member or athlete. Retirement is the end of a close relationship between one's life style and one's job and the beginning of a new role. Unfortunately, that new role has few positive role models. and far less social approval than the role of a "worker." Retirement is the end of employment and the beginning of a jobless life - a decrease in social status (Myers 97). An aging adult may experience the loss of financial security and sometimes find out that the struggles and labors of their earlier years are not being rewarded as they had expected in their later years by comfort and security. The loss of independence and power can

be a stunning blow to an older person's self esteem. They are qualities which are highly regarded personal assets today (Silverstone and Hyman 70-77). To the elderly, a car is a symbol of independence not only a means of transportation. A survey conducted by the Automobile Association of America (AAA) showed how important driving is to the elderly. They found that 70% of older drivers with memory loss, cataracts, heart conditions, vision and hearing problems or episodes of dizziness admitted that they continue to get behind the wheel (Alberts 93). And finally, the loss of mental stability and functional ability or the psychological problems resulting from losses as well as those triggered by other threats, real or imaginary, are often the most difficult to handle. In dealing with an aging parent, children often find that dealing with their psychological problems places the heaviest demands on their own emotional resources.

Older adults often experience a number of feelings and emotions. Feelings of anger often have their roots in failure or a subjective sense of failure. Forgetting a birthday or dropping something of sentimental value can make the older adult angry because he feels he has failed. Also, feelings of fear: fear of dying, falling over, being alone, and becoming senile, are common in old age. Fears about death are common. However in most cases the fear is probably not so much about death itself but the act of dying. Everyone wants to die quietly, peacefully, painlessly and without guilt. The older adult fears his death may not be this way (Leng 20-22).

How To Help Aging Parents

Perhaps the most effective help an adult child can give his parents while they are still independent is preventive help or planning along with them for the future. Easier said than done, the best way to initiate planning discussions is in the context of open, respectful, relaxed conversations. Some parents are happy to talk about what they will do or want you to do if they become sick, if their money runs out or when one of them dies. Others will be very angry or secretive about their resources and any thoughts they have about the future. Of course underneath the anger may lie their own fear which they cannot face (Silverstone and Hyman 142-143).

Nonetheless, it is important to initiate this discussion and approach the topic frankly, including other family members if possible. Family members should know each others' concerns. It is useful to discuss prevention and planning before a crisis occurs. It is important to explore the options of where ones' parents will live if they can no longer live alone in their own home (Adams and Armstrong 16).

When the casual approach doesn't work, a more direct approach may be necessary. Shared decisions usually produce the best results. It is important to discuss topics calmly and examine all possible approaches. When decisions have to be made about a place to live, medical treatment, finances and safety, is may be helpful to consider the views of another person such as a minister, a good friend, or a specialist. It is important not to make a promise that may not be able to be kept such as, "We'll never put you in a nursing home." That may be what is felt but

it is best to be left unsaid because broken promises hurt (Adams and Armstrong 18). If nothing works, and the parent continues to refuse to talk about future plans at all, the adult child can do some planning on their own so as to be ready with some reasonable alternatives if a sudden crisis does occur (Silverstone and Hyman 144).

Adult children who live far away from their aging parents, which in this day and age is quite common, have many of the same concerns as family members who live near them. "Long distance caregivers face a few more challenges than caregivers whose loved ones live nearby. They will likely work harder to get the same results and spend a little more money in the process" (Smith 53). The adult child may all of a sudden realize that their parents rely on them and that new or changing circumstances call for them to start to help whether they are ready or not. They may feel guilty or anxious about their parent's situation and feel stuck because they don't know what to do. Or, they may be oblivious to the major changes or concerns of the older adult. Others do more than they need to do alone and risk exhausting and frustrating themselves. It is difficult to know if an older person is having a problem when the caregiver lives far away. At times they may belittle their problems but at other times they may exaggerate them. The way that a long distance caregiver responds to the needs of their distant relatives varies as well (Heath 15).

In their book, Caring For Your Aging Parents, A Planning and Action Guide, Cohen and Eisdorfer discuss seven steps to effective caregiving (8). These steps are intended to provide a framework to cope effectively with the changes in the adult child's life when caring for an

aging parent. These steps are:

Step 1. Recognize and prioritize problems

Step 2. Overcome denial

Step 3. Manage emotions

Step 4. Build collaborative partnerships

Step 5. Balance needs and resources

Step 6. Take control in a crisis

Step 7. Let go and move on

In step 1, Cohen and Eisdorfer suggest that the caregiver must realize that there are acute problems and gradual problems. It is necessary to decide which need first attention. In step 2, the caregiver must accept that there is a problem. Step 3 reminds the caregiver to learn to recognize when his emotions are clouding good judgement and to seek help if necessary. Mace and Rabins state:

> Fatigue, discouragement, anger, grief, despair, guilt, and ambivalence are all normal feelings that may come with caring for a chronically ill person. Such feelings may seem overwhelming and almost constant. The burden you carry can be staggering. Sometimes one's coping skills are overwhelmed and things can drift out of control. You may want to seek professional help if this happens. (290)

Step 4 suggests that one must identify needs and resources that are available and use them. Step 5 is a reminder that the goal is to assist the parents while minimizing the disruption in the caregiver's own life. Step 6 is the importance of taking control of one's own life and developing a strategy for care of the aging parent. In step 7 the authors reinforce the

importance that the caregiver must change expectations of themselves and set limits on what they can do. Letting go may mean spending less time together or it may mean realizing that the caregiver can not solve every single problem. Help such as day care, assisted care living, financial help or if approriate, nursing home care may be needed (Cohen and Eisdorfer 18).

The Role of Geriatric Care Management

It is never easy to take on the burdens of someone else's life. There is help. There is a vast array of services and service organizations for the elderly and their caregivers. But knowing that the services are available does no good unless the caregiver is able to locate the right services to meet their needs or the needs of their aging loved one. Many seniors and their families are troubled in trying to find the right services to meet their needs because the services are complicated, fragmented and often unattached to one another. There is paperwork, eligibility criteria, and waiting lists that block the path to the right source of help.

Since it has become so complicated to find outside help, families are often turning to geriatric care management for assistance. Often times, families do not have the time and knowledge to work through the web of services when trying to find help for a loved one. Geriatric care management is a service designed to help families and individuals deal with issues and decisions they must face when an elderly loved one is at risk. It is hard to know and understand all the options available. A qualified geriatric care manager is aware of all these options and can

successfully match the client and his family with the right services. The care management process provides structure to what appears to be an unmanageable situation to a person caring for another human being.

According to Geriatric Care Manager, Constance Deschamps, "a Private Geriatric Care Manager (PGCM) is a member of the specialized group of professionals who have extensive training and experience in working with older people and their families and who know the services network of the community" (5). Deschamps identifies the services that a Private Geriatric Care Manager can provide:

* arranging and monitoring home health services, companions, and live-in help;
* locating day care and alternative living situations;
* assisting in nursing home placement;
* locating specialized services such as transportation, socialization programs, and errand services;
* assisting in routine financial matters such as bill paying and record keeping; and,
* providing counseling to the older adult and the family.

Deschamps remarks that Geriatric Care Managers have information on available and suitable services at their finger-tips that may take a family member days or weeks to gather (5).

The National Association of Professional Geriatric Care Managers (GCM) is an association of private practitioners whose purpose is, "the development, advancement, and promotion of effective and dignified social services, psychological evaluation, and healthcare for the elderly and their families through counseling, treatment, and the delivery of

concrete services by qualified, certified providers" (Standard of Practice for Professional Geriatric Care Managers 13). For over ten years, GCM has provided assistance to families struggling with the stressful challenges of aging. This organization has a nationwide network of geriatric care managers in 47 states and has developed a constitution and bill of rights that set ethical standards to protect client rights. These standards are outlined and discussed in the organization's pamphlet, "Standard of Practice for Professional Geriatric Care Managers:"

> Standard 1: While the "primary client' usually is the older person whose care needs have instigated the referral to a professional geriatric care manager, all others affected by her/his care needs should be considered part of the"client system."
>
> Standard 2: To the greatest extent possible, the professional geriatric care manager should foster self-determination on the part of the older person.
>
> Standard 3: The professional geriatric care manager should respect the older person's and, when applicable, the family's right to privacy by protecting all information which is given in confidence and all information of a confidential nature. It should be made clear to the client the limits of confidentiality as appropriate.
>
> Standard 4: The professional geriatric care manager should define her/his role clearly to other professionals.
>
> Standard 5: The professional geriatric care manager should strive to provide quality care using a flexible care

plan developed in conjunction with the older person and other persons involved in her/his care.

Standard 6: The professional geriatric care manager should act in a manner that insures her/his own integrity as well as the integrity of the client system.

Standard 7: All fees for professional geriatric care management services are to be stated in written form and discussed with the person accepting responsibility for payment prior to the initiation of services.

Standard 8: Advertising and marketing of services should be conducted within all guidelines and laws governing the advertising of professional management services as they relate to the provision of professional geriatric care management.

Standard 9: The professional geriatric care manager who accepts a fiduciary responsibility should act only within her/his knowledge and capabilities and should avoid any activities which might comprise a conflict of interest.

Standard 10: The professional geriatric care manager should be familiar with laws relating to employment practices and should not knowingly participate in practices that are inconsistent with these laws.

Standard 11: The professional geriatric care manager should provide full disclosure regarding business, professional or personal relationships she/he has with each recommended business, agency or institution.

Standard 12: The professional geriatric care manager should participate in continuing education programs and be a member of her/his respective professional organization in order to enhance professional growth and to provide the highest quality care management.

Standard 13: The GCM should not exploit professional relationships with clients and families for personal gain. (1-13)

Geriatric Care Managers do not usually perform the hands-on services. They evaluate what services are required and then select, supervise, and monitor their implementation. They find the right person for the job and work closely to see that it is done right. A geriatric care manager can save a caregiver hundreds of hours of research time thus alleviating frustration by making order out of chaos and panic (Wexler 30).

Training and Certification of Geriatric Care Managers

Applebaum and Wilson classify the training needs of care managers into three categories (Joshi 569) . The first category relates to the need to understand the client. This category includes the knowledge of health and disability limitations, health conditions, morbidity and mortality patterns, and mental health needs. Care managers need information about how to recognize signs of cognitive impairment, affective disorders, and long-term personality disorders and how to work with older adults and their caregivers who are experiencing these

problems (Applebaum and Wilson 173).

The second category of training includes the understanding of the older adult's environment, awareness of service providers, eligibility criteria, costs for services, and methods of negotiating and monitoring providers, ability to work effectively with medical professionals, and understanding the support mechanisms for informal caregivers. Care managers spend a considerable amount of time contacting formal and informal providers to arrange appropriate care for their clients. Being familiar with medical conditions and terminology is necessary in order to effectively communicate with other providers. Also important is effective interaction with the clients' informal support systems. Although the impaired older person is often the identified client, care managers often recognize they are working with families and friends whose needs also become significant. Given the importance of informal caregivers in the lives of the older adult, care managers need training in how to work with them as decision makers and service providers, yet always recognizing them as persons also in need of support (Applebaum and Wilson 174).

The third area of training needs of care managers focuses on the techniques of care management. The care manager must be trained to use standardized and comprehensive assessment tools and know how to solicit information through objective interviewing and observation of the client and through contacts with the support networks of the older adult. The care manager must be trained to design comprehensive care plans that include a range of formal and informal services (Applebaum and Wilson 175).

Although there is very little research on how to effectively train

geriatric care managers, Applebaum and Wilson cited results from a study of case management conducted as part of the National Long-Term Care Demonstration, a 10 state research and demonstration program in which the effects of case-managed community-based long-term care were examined (Applebaum and Wilson 172). This demonstration concluded that care management practice involved a significant amount of individual effort. In addition to comprehensive, multi-disciplinary training of the professional care manager, the program staff recommended that more time and resources be provided for training care managers after they have gained some working experience. In-service training sessions should include opportunities for group discussions and sharing of common concerns with other professional care managers and outside consultants (Applebaum and Wilson 176).

There are different types of gerontology students in higher education. Peterson and Wendt discuss two categories of the liberal arts gerontology student (362). One is the general education student. This student is the general liberal arts student who enrolls in a minimum of one course or who achieves a degree in gerontology. These students are typically seeking overall knowledge and understanding of aging, basic vocabulary, and an awareness of the process of aging in themselves and members of their family. Course content emphasizes scientific and humanistic knowledge, identification of sterotypes and myths about aging, understanding the diversity and complexity of the aging process, an introduction to theories of aging, and an awareness of local services providers so they could help someone they know in locating an appropriate service provider.

The second type of general liberal arts student is the general practitioner in an existing profession. These are students who belong to a profession, such as social work, nursing, occupational and physical therapy, counseling and clinical psychology in which they serve older adults. These professionals need both pre-service training such as that achieved through the general education gerontology program and continuing education on such topics as sensitivity to the unique character of the older adult, awareness of the changing world demography, differences between normal and abnormal aging, knowledge of the service delivery system and being aware of appropriate referrals for older adults (Peterson and Wendt 362). The professional geriatric care manager falls into this category. The geriatric care manager must have extensive training in the general field of gerontology as well as opportunities for in-service and continuing education training in order to be effectively trained to meet the needs of the client.

The National Academy of Certified Care Managers (NACCM) is a nonprofit organization established in 1994 to "support a high level of competence in the practice of care management through the development and administration of a formal certification and recertification program" (NACCM Handbook 4). NACCM offers a certification examination for the credentialing of long-term care managers. NACCM recognizes the diversity of the practice of care management and uses the term care management to include the wide variety of roles, functions and responsibilities of care managers regardless of educational background, work setting, or duration or intensity of services provided. The exam for certification was established

to advance the practice and quality of care management in the following ways:

* Professional validation - An increasing number of individuals and organizations are offering care management services. Certification will ensure they meet certain minimum standards of education and practice.
* Self-Regulation - Certification will promote accountability among care management practitioners to ensure that they meet required service delivery standards.
* Competitive pressure - Certified care management practitioners will have a competitive edge in a marketplace where consumers are increasingly shopping for the services they need.
* Third Party Reimbursement - As care management becomes incorporated into public and private insurance products, a care management credential may become a criterion for third party reimbursement.
* Malpractice Protection - By clarifying what care management is, who may do it and under what circumstances, certification will make liability insurance more available to care managers.
* Expected Outcome Research - Certification will set a baseline for defining the job functions, skills, knowledge and ethical values of care managers. With these in place, research studies can more clearly define protocols and demonstrate that interventions for specific problems will

result in expected outcomes. (NACCM Handbook 5-6)

A successful applicant must have full-time direct experience with persons with chronic disabilities and supervised care management experience. Candidates to take the exam must meet one of the following criteria:

> (1) two years of supervised care management experience subsequent to obtaining a Master's degree in a field related to care management such as social work, counseling, nursing, psychology, or gerontology, or (2) four years experience in social work, nursing, mental health, counseling or care management, two of which must be supervised, subsequent to obtaining a BA/BS degree in a field related to care management such as social work, counseling, nursing, mental health, psychology, or gerontology, or (3) six years of full-time experience with clients in fields such as social work, nursing, mental health, counseling or care management, two of which must be supervised, full-time care management, subsequent to obtaining a minimum of a high school diploma or any degree unrelated to the field of care management. (NACCM Handbook 7)

All individuals who meet the academy criteria and pass the examination are credentialed and acknowledged by the Academy as Care Manager, Certified, C.M.C. NACCM will publish a list of candidates who pass the examination every three months and will maintain a current listing of Certified Care Managers (NACCM Handbook 23). Certification

is valid for a period of three years. If the certification lapses, all requirements for initial certification must be met in order to qualify again for certification. A Certified Care Manager can be recertified by (1) providing a minimum of 1500 hours, during a three year period, of care management or (2) earning fifteen contact hours per year in educational activities (NACCM Handbook 24-25).

The certification is new to the field of Geriatric Care Management. It is not currently mandatory that an individual be certified, C.M.C., in order to work as a Geriatric Care Manager. However, Standard 12 of the National Association of Professional Geriatric Care Mangers Standard of Practice states that professional geriatric care managers should: "be certified, if applicable, and/or licensed, as required, in her/his area of expertise" (GCM 12).

Components of Care Management

The Care Management process is composed of five basic steps. Step 1 includes the assessment. During the assessment, the care manager meets with the client and the caregiver, if possible, to collect as much data as possible in order to get a clear picture of their needs. It is helpful to observe the client in his own home to observe how he functions within the family structure and to assess the relationship between the caregiver and the client. The care manager must identify the support system, strengths and weaknesses of the client and the support system and physical and mental limitations. It is also very important to discuss the role of the care manager so that all parties involved have clear and

realistic expectations. To prevent any misunderstandings regarding fees or services, a signed service agreement is highly recommended at the close of this initial meeting.

Step 2 involves developing a plan of care. The care manager will review and coordinate the information obtained during the initial interview and develop a plan with options of how to solve and/or manage the situation based on the support system and strengths of the client and family. It is important to review this plan with the client and caregiver and revise it as necessary.

Step 3 is arranging for and coordinating services. This step may be one of the most time consuming and comprehensive components of the care management process. Often times the client may need several different services. Deschamps states that the advantages to the private practice approach of geriatric care management include:

* assurance of full access to community resources;
* the availability of the care coordinator beyond traditional work hours;
* the convenience of working with a single, skilled person who becomes familiar with the elderly person's and the families' circumstances. (5)

A thorough knowledge of the services available in the community is paramount to effective care management. "A comprehensive and accurate inventory of existing services is an essential tool for care planning by case managers" (Steinberg and Carter 70).

Step 4 in the care management process is monitoring. The care manager must monitor the client's care to assure the client is receiving

quality care. Monitoring can be provided daily, weekly, bi-weekly, or monthly depending on the client and caregiver's needs and situation. Monitoring should be discussed with the client and family and provisions for monitoring should be included in the servcice agreement.

Step 5 is the reassessment and revision of the plan of care. The elderly are a changing population. Their strengths and limitations can change from moment to moment. The care manager must be aware of the client's changing needs and revise the plan of care as necessary in order to meet those needs.

Importance of the Resource Inventory

Although each component of care management is essential to the success of the program, the care manager must be fully trained and experienced in knowing the resources available in the community in order to effectively manage the care of their client. Arrranging for and coordinating services is a critical area for the successful care manager. The care manager must consider whether the needed services exist in the community and if not, whether they can be created. Also to be considered are waiting lists, eligibility, opinions by other care managers who have used the services with their clients, cost limits of the program and the client's acceptance or refusal on the basis of past experience or prejudice (Steinberg and Carter 24).

Being able to promptly access information about available services for one's client can be achieved through proper advanced research and inventory. This inventory can be organized into a printed

directory or a resource file. In the larger communities, where the number of resources and service agencies is immense, this inventory can be most effectively maintained through computerized data base management.

Through this writer's experience as a geriatric care manager with a geriatric consulting firm in St. Louis, Missouri, it has been found that there are well over two hundred long-term care facilities in the greater metropolitan St. Louis area. The information regarding these facilities can be found in several locations at the agency. One location is an extensive facility resource file which contains brochures on many of the facilities in the area. They are filed alphabetically with no immediately visible designation as to type of facility or location of facility. Another resource is the Aging Consults Community Resource And Retirement Apartment Manual For Seniors. This book contains a collection of information about different services, agencies and facilities. These facilities are divided by location but the contents are incomplete and do not include all facilities. Also, available is the Ombudsman Guide to Long-Term Care Facilities. This guide is an alphabetical listing of facilities and a brief paragraph on address, phone, and type of facility. The Alzheimer's Association also provides a listing of facilities in the area and this list is updated regularly and can be found in the resource files at the agency. Unfortunately, it is not entirely inclusive of all facilities in the area. The Next Step/Elder Assist produces a Bed Availability Report which is updated and distributed to area hospital social work departments every day. This report is a very helpful resource for finding skilled and residential care facilities, however its content is limited by the

number of facilities that choose to subscribe. The final resource, and the one found to be used most repeatedly, is the personal knowledge of the other care managers and social workers at the agency. Admittedly, these resources contain the most accurate information as far as professional opinions of the facilities but are lacking in the comprehensiveness of the choices and options available.

Since a major part of a geriatric care manager's job is to assist caregivers in finding suitable and available long-term care housing for their aging loved ones, it can be frustrating to sort through all of the varied printed resources in an attempt to find the facility that meets the needs and criteria of the client. In addition to finding the names of the facilities, many hours can be spent on the phone with the facilities asking them questions regarding their availability and services which are not illustrated in their brochure, if a brochure is even available. It was felt that a more expedient and comprehensive method of securing this information was necessary.

It appeared that everything except the care manager's resource needs were being met via computer. By creating a computerized data base file for the long-term care facilities in and around the St. Louis area, it was felt that a positive stride could be made in bringing the resource inventory in to the new age of data management. The following chapter focuses on the development of a long-term care facility computerized resource inventory.

Chapter III

Method

Steinberg and Carter state:

> A comprehensive and accurate inventory of existing services is an essential tool for care planning by case managers. The development of an inventory is not merely an accumulation of data to be organized into a printed directory, a resource card file, or a computerized data bank. It requires an ongoing process of updating, verifying, and expanding of data, and periodic assessment of whether the form and content facilitate case management. (70)

The development of a long-term care resource inventory involves much research and review of existing printed materials, personal contacts with facilities and the exchanging of information between other geriatric care professionals. This researcher used several methods to obtain the information necessary for the data base resource file.

The first step of this project was to present the idea to the Executive Director of the agency for consideration and approval. This researcher proposed that a data base resource file will:

(1) Provide an "at-the-fingertips" resource for care managers researching long-term care facilities for their clients.

(2) Save time expended on research thus saving money for the company and the client.

(3) Provide a more thorough and comprehensive report for families.

(4) Provide a sharp image to the clients.

The Executive Director agreed that having the long-term care resources on data base was a worthwhile and much needed endeavor. He expressed an interest in this project for the expansion of technology which would benefit the client as well as the geriatric care manager.

The next step was to develop a survey of information that would be helpful for the geriatric care manager when researching long-term care facilities. This researcher developed a list of potentially useful information and presented it to the staff at the agency for their review. (See Appendix A). It was requested that each staff member review the list and comment on any information listed and to add any other areas that they would like to see available on the data base file. Staff returned the list to this researcher with added ideas for inclusion.

Based on this information, a Facility Information Survey was developed. (See Appendix B). This survey was designed to be a guide for the researcher in securing information for the data base.

The primary source of information was the printed materials and brochures on file at the agency. Quite an extensive file was available which included long-term care facility brochures on facilities in the St. Louis and surrounding county area. This file included facilities located in St. Louis City, St. Louis County, St. Charles County, Lincoln County, Jefferson County, Franklin County, Washington County, and Perry County. Some facilities in nearby Illinois were also available. Each brochure or pamphlet was reviewed and the information was transcribed to the Facility Information Survey.

The next source of information was theSt. Louis Alzheimer's Association's printed lists of skilled nursing facilities, assisted living and residential care facilities, and progressive care facilities. These lists are updated periodicaly by the Alzheimer's Association and available for the public. Information concerning the facility's name, address, and phone number, level of care, method of pay, costs, type of rooms or apartments and Alzheimer's unit availability were presented on these lists. This information was either added to the survey of the facilities already researched or a new facility information survey was started if no previous information had been obtained.

The next resource accessed was the Aging Consult Community Resource and Retirement Apartment Manual For Seniors. This guide was printed in 1995 by the geriatric consulting firm, Aging Consult. The information found in this guide was divided by location and included name of facility, address, phone, and pertinent information about the facility. Again, any additional information found in this resource guide was added to existing data or a new facility information survey was begun if no previous information had been obtained.

The Next Step/Elder Assist produces a Bed Availability Report which includes the names of skilled and residential care facilities which have chosen to subscribe to the service. Subscribers pay for the daily advertisement which is sent to social work departments at area hospitals. This report is updated daily and includes information on the facility name, location, contact person, daily or monthly rates, and some of the services offerred. The facilities listed on this report are limited to those who choose to subscribe. Any new information found on this bed availability

report was transferred to the existing data or a new survey report was begun for any facilities listed on this report that had not previously been reviewed in other research. The staff member at The Next Step/Elder Assist who is responsible for the management of this Bed Availability Report, visits facilities in the area on a regular basis. The notes which she obtained on each facility were filed in the facility resource file. These notes provided another source of information but most importantly provided a report of the facility's condition and any areas of concern or areas of particular strength helpful to the geriatric care managers when reviewing the facility for consideration for a client's placement. These specific notes were also transferred to the Facility Information Survey.

The Long Term Care Ombudsman Program is an information service that is funded by individuals, corporations, foundations, and the Mid East and St. Louis Area Agencies on Aging under the Older Americans Act. The Information Center at the Long Term Care Ombudsman Program prints a directory of skilled nursing facilities, intermediate care facilites, and residential care facilities. This guide was also reviewed for new information to add to the Facility Information Survey for the data base project.

Once all available information on the long-term care facilities in the St. Louis and surrounding counties area was obtained, this researcher began the process of reviewing and customizing data base software and securing adequate hardware for the project.

Chapter IV

Procedure/Project Description

The process of selecting the appropriate software for the long-term care data base project involved reviewing available data base software and software customized for the care management professional, and customizing the chosen software for this project. The procedures for choosing the software and customizing the software are included in this chapter followed by a manual of operations for the long-term care data base developed.

Choosing the Software

There were numerous flexible data base programs available. Excel, DB IV, Alpha V, and File Maker Pro were several mentioned by Merrily Orsini during her presentation to the National Association of Geriatric Care Manager's annual meeting in St. Louis, Missouri on September 16, 1995. In Orsini's presentation entitled, "Hardware, Software, and Cyberspace . . . What's Up For Geriatric Care Managers," she discussed software she had considered for data base management in her practice. She recommended Microsoft Office because of its interrelationship capabilities with word processing and spreadsheets.

Several software programs that have been customized for the Geriatric Care Manager were available. Among those were CareMS by MarCin Enterprises, 1412 South Douglas Ave. Springfield, Il. 62704; CASEWATCH by Automated Case Management Systems, Inc. 3301 Barham Blvd. #202, Los Angeles, Ca. 90068; and, LINC II by Liaisons

In Negotiating Care, 424 N. Lake Ave. #200, Pasadena, Ca. 91101 (The Case Management Resource Guide F27).

Although the concept of purchasing an already customized for care management software was tempting to this researcher it was decided to use existing software available in the agency office and customize it for the long-term care data base. The software selected was called, ACT! For Windows, by Symantec. ACT! was being used in the agency office as a contact management program tracking client referrals and case activity. It was successfully being used as a computerized appointment book, calendar, and to-do list program.

By customizing the field attributes, this researcher discovered the ACT! program could successfully fit the criteria for the long-term care data base. The following discussion focuses on the customization of the ACT! data base for use as a resource inventory of long-term care facilities.

Customizing the ACT! Software

System Requirements

In order to run the ACT! software, one's hardware system must have the following system requriements:

* Microsoft Windows 3.1 or later
* PC with 80836 or higher microprocessor
* 4 MB of system memory and 5 MB of free hard disk space
* Mouse or other Windows compatible pointing device optional.

This researcher ran the ACT! software on a Packard Bell Legend

401CD with Pentium Processor. This computer had 8 MB of RAM onboard standard and 16 KB internal cache standard with Windows Version 3.1. It met all systems requirements for running the ACT! for Windows software. The printer used was a Hewlett Packard Office Jet Model 350.

Preventing Unauthorized Access

Care must be taken to prevent unauthorized access to the ACT! database being created. This was done by installing a password. The Password dialog box appears when a new ACT! data base is being created.

To assign a password, the password was typed in the Password dialog box and clicked OK. ACT! asked that the password be reentered. The password was reentered and clicked OK. Everytime the ACT! program is selected from the menu, the user must type in this password in order to activate the program.

Customizing Field Attributes

The ACT! program offers a standard screen for entering contact information. However, in order to customize this database for this researchers' purposes, it was necessary to make some changes to the standard format and the field labels. To access the Field Attributes dialog box for a specific field, the cursor was placed on the field's label, and the

mouse's right mouse button was double clicked. The Field Attributes dialog box appeared. Any field on the ACT! contact screen can be modified or changed. To modify or change a field, this researcher highlighted the field to be changed and typed in the new label. Clicked OK. This process was repeated until all fields had been customized. The following changes were made for this researcher's customized data base:

User 1 - Type of Facility

User 2 - Special Unit

User 3 - Size of Facility

User 4 - Availability

User 5 - Pets

User 6 - Costs

User 7 - Method of Pay

User 8 - Buy - in or Endowment Plan

User 9 - Type Rooms

User 10 - Location

User 11 - Age of Facility

User 12 - Services

User 13 - Skilled Services

User 14 - Smoking Policy

User 15 - Brochures available

ACT! has eight different types of data that can be entered into a field: Character, Uppercase, Data, Phone number, Numeric, Currency, 0-9 only, and Time. This researcher chose to customize the field labelled, Phone as "Phone Number" and the field labelled Zip Code as "Numeric."

All others fields were customized as "Data" allowing numeric or alpha characters to be entered. See Appendix C for an example of the customized contact report.

Customizing Pop-Up Dialog Boxes

ACT! also has a Pop-up attribute for particular fields in order to provide the opportunity to have a dialog box pop up on demand. These pop-up boxes contain lists of available entries for a specific field. When an entry is selected from a pop-up dialog box menu, ACT! automatically inserts it into the field. This saves the time required to type the information. Every field in ACT! can have a pop-up dialog box. To customize a pop-up dialog box, this researcher first selected the field to edit. By pressing F2 or double clicking on the field to edit, the dialog box appeared. Edit was selected, and Add, Modify, or Delete was chosen. Additions, modifications or deletions were made and clicked OK.

This researcher customized the following pop-up dialog boxes:

Field	Pop-Up Options
Type of Facility	ICF, ILU, RCF I, RCF II, SNF
Special Unit	Alzheimer's, Dementia, None
Pets	No, Unknown, Visitors Only, Yes - Any, Yes - Type limit, Yes - Weight Limit
Method of Pay	Cash Grant, Medicaid, Medicare, Private, Sliding Scale, Subsidized
Type of Rooms	1 BR, 2 BR, Apartments, Private, Ranch Homes, Semi-Private, Studio, Ward

Location	Central St. Louis County, Franklin County, Illinois, Jefferson County, Lincoln County, North St. Louis County, South St. Louis County, St. Charles County, St. Louis City, Washington County, West St. Louis County
Services	Activities (A), Beauty/Barber Shop (Beauty), Bring own furnishings (Furn O), Cleaning (C), Dental (Dental), Furnishings Provided (Furn P), Handicapped Transportation (Hand T), Hospice (Hospice), Incontinent Patients OK (Incon), Laundry (L), Medications Dispensed (Meds), Personal Care (PC), Podiatrist (Podiat), Psychiatrist (Psych), Rehabilitation (Rehab), Resident Parking Available (Park), Respite (Respite), Secure for Wanderers (Secure), Transportation (T), Walkers OK (Walk), Wheelchairs OK (Wheel).
Skilled Services	Contract Out (Contract), Dialysis (DI), Intravenous Feeding (IVS), Occupational Therapy (OT), Oxygen (Oxygen), Physical Therapy (PT), Speech Therapy (ST), Trachea Tube (Trach), Tube Feeding (Tube), Ventilation Therapy (Vent).
Smoking	Designated Areas Only, No, Unknown, Yes, Outside Only.
Brochures on file	Yes, No.

Once all the fields and dialog pop-up boxes were customized, the contact screen was suitable for receiving data for this project. The following will cover the procedures for entering, modifying, and deleting data into the Long-Term Care Facilities data base. Also to be covered is how to conduct a search, view notes, prepare a report, print a report, prepare a directory report, format a letter to a facility, print an envelope, write a memorandum, and prepare mailing labels.

The Long-Term Care Data Base Project

Manual of Operations

Entering New Data

In order to develop the long-term care data base, the data must be entered into the computer. To enter a new facility into the data base, select Edit (ALT E), New (N), and Default (D). A blank contact screen will appear. Type information in to each field progressing from one field to the next by pressing Tab. To go back a field, press Shift - Tab. A Pop-Up Screen will appear in the fields of Type, Special Unit, Pets, Method of Pay, Type Rooms, Location, Services, Skilled Services, Smoking, and Brochures. When a Pop-Up Screen appears, click on the selection desired and press Enter. If more than one entry on the Pop-Up Screen is desired, hold down the CTRL key and click on all entries desired. Click on OK. Those entries will appear in the corresponding field on the contact screen and the cursor will advance to the next field ready to receive data. When all entries have been made in each field, press Save. The facility is now saved in the long-term care data base file.

Entering Notes

To enter comments or notes about a particular facility, when the facility is still on the contact screen, click on View (V), Notes (N). The Notes screen will appear with the name of the operator who entered the notes and the date they were entered. This is a very helpful place to include observations, directions, concerns, or any other information about the

facility which other care managers in the office would find helpful. After entering comments, press File (F), Save (S), Window (W), FACIL. The computer will now return to the Facility Contact Screen.

Modifying Existing Data

If information on a facility needs to be edited or modified after having been saved in the data base, click on Lookup, Company. A Dialog box will appear. Type the name of the facility which needs to be modified. Click on OK. The facility contact screen will appear. Highlight the change(s) that need to be made and type in the correct or new information. Go to File and select Save.

Deleting Existing Facilities from the Data Base

If it is decided that a certain facility or group of facilities is no longer wanted on the data base, those entries can be deleted. Look up one facility by clicking on Lookup, Company. The dialog box will appear. Type in the name of the facility. Click OK. The contact screen for that facility will appear. To look up a group of facilities that meet same criteria, such as, all facilities in Illinois, Press Lookup, State, or Keyword. Type in Illinois. Click on OK. All facilities located in Illinois will be grouped together and can be viewed by pressing the arrows in the upper left hand corner of the screen. When the facility or the group of facilities has been selected, press Edit (ALT E), Delete (D). The Warning box will appear on the screen. Press C to delete only this contact on the screen, or L to

delete all facilities in the current lookup. Click on OK.

Conducting a Search

One of the most important purposes of a long-term care data base file is to expedite the process of searching for facilities that meet particular criteria. The data base file has unlimited capabilities to search for specific criterias thus narrowing the selection of facilities to those that only meet the client's needs and preferences.

In order to conduct a Search, click on Lookup. A menu of choices will appear. These include: My Record, Everyone, Previous, Company, First Name, Last Name, Phone, City, State, Zip Code, ID/Status, Other, Priority, Keyword, and Custom. Select one of these choices that best fit the needs of the search. This researcher has found that most searches are successfully run by either choosing Company - if the name of the facility is known; Last Name - if the name of the contact person at the facility is known; or Keyword - which can include one or a string of criteria. Select one of the menu choices. The dialog box will appear. Type the information being searched in this dialog box. If performing a Keyword search, type in the criteria and include the word AND in capital letters between each criteria. For example, type SNF AND St. Louis City AND Alzheimers. The computer will search out all facilities that meet all of those criteria.

The box on the upper left side of the screen will indicate how many contacts were selected that meet the criteria. To view each one, click on the arrows to scroll through each screen. To view a select listing of all

contacts, click on View (V), Contact List (C). A listing of all the selected facilities will appear on the screen. Tag only those facilities desired for view by clicking Tag for the desired facilities and Untag for the undesired ones. Click OK. The contact screen will reappear. Click on the arrows in the upper left hand corner of the screen to scroll through the facility contact screens.

Viewing Notes

To view the notes entered in the data base for a particular facility, while the facility contact is on the screen, click on View (V), Notes (N). The notes which have been entered by the care manager will appear on the screen. To exit out of the notes, click on Window, FACIL. This will return the operator to the main contact screen window.

Preparing a Report

A report is a presentation whose purpose is to help the geriatric care manager review information in order to make better, more informed decisions. The Contact Report on the ACT! database presents a summary of all information entered into the database regarding a particular facility. Also included on the report are the notes entered by the care manager. This information helps the geriatric care manager to review information and present it to their clients in a report format regarding choices and alternatives for long-term care.

To prepare a report, click on Report, Contact Report. The Prepare

Report screen will appear. On the left side of the screen, three choices for use will appear: Active Contact - to be selected if wanting a report on the one contact on the screen, Active Lookup - to be selected if wanting a report on all the facilities in the selected criteria lookup, or All Contacts - to be selected if wanting a report on all the facilities in the entire data base. Click on one of the above selections. On the right side of the screen, the Output choices will appear. Click on Document if viewing the document on the screen only is desired, or click on Printer if a printed hard copy of the report is desired. Click OK.

Printing A Report

If the Print option was selected, the Print Screen will appear. Click ALL Pages or the number of the pages desired and enter the number of copies of the report desired. Click OK. The computer will command the printer to print out the pages specified and the number of copies of the report requested. See Appendix C for a sample of a Contact Report.

Preparing a Directory Report

If an abbreviated form of the report is desired which includes only the name of the facility, the name of the contact person, telephone number, and address including city, state, and zip code, press Report, Directory. The Prepare Report screen will appear. Make the choices for Use and Output and a directory report will appear. See Appendix D for a sample of a Directory Report.

Formatting a Letter to a Facility

The ACT! program has a letter-writing capability that automatically merges contact information such as the contact person's name, the facility name, and address, and salutation into a form letter. It also inserts the current data and the operator's name and title on the letter's signature line. This signature information is taken from the My Record contact record of the current database user.

To write a letter to a facility, select Write (W), Letter (L). A document will appear on the screen addressed to the facility. Type in the text. Select File (F), Save (S), File (F), Print (P) from the menu bar and the Print Dialog box will appear. Enter the number of copies desired. Click OK and the letter will print out. See Appendix E for a sample letter.

Printing an Envelope

After printing out the letter, the Finished Document message box will appear saying, "Do you want to log this message in the contact's history?" If an envelope is desired, select Yes in the Finished Document message box and the Print Envelope message box will appear. It will say, "Do you want to print an envelope?" Click Yes, put an envelope in the printer, and an envelope will be printed. If an envelope is not desired, click NO and no further dialog boxes will appear. The letter will return to the screen.

Writing a Memorandum

ACT! also has the capabilities of writing a memo. Select Write (W), Memorandum (M), the Memo screen will appear with the contact person's name opposite the word "To:" and the users name opposite the word "From:". The current date is also inserted automatically. Type the text and follow the above procedure for printing a letter in order to print the memo. See Appendix F for a sample of a Memorandum.

Preparing Mailing Labels

ACT! also has the capabilities to generate mailing labels for the entire data base or for a selected group of facilities. Select the facilities for which mailing labels are desired by following the procedures for conducting a Search. To create the labels, select Report (R), Other (O), and the Select Report dialog box will appear. There are nine predefined Avery Label templates compatible with the ACT! program. They are:

Avery 4014	Dot Matrix	1 1/2"x4"	1 label
Avery 4143	Dot Matrix	1"x4"	2 labels across
Avery 4144	Dot Matrix	1"x 2 1/2"	3 labels across
Avery 5160	Laser	1"x2"	3 labels across
Avery 5161	Laser	1"x4"	2 labels across
Avery 5162	Laser	1 1/3"x4"	2 labels across
Avery 5163	Laser	3 1/3"x4"	2 labels across
Avery 5164	Laser	2 1/8"x4"	2 labels across
			(rotary index cards)

Select the label template desired. Click OK. The Prepare Report screen will appear. Select the appropriate Use and Output desired. If Printer is selected as the Output, the appropriate mailing labels must be loaded into the printer. The Print Dialog box will appear. Select the pages and number of copies desired. Click OK. The labels will begin printing.

Maintenance of the Long-Term Care Data Base

A data base file of long-term care facilities is only as useful a resource as the information entered. As information changes or new information becomes available, it is imperative that the data base be updated to show the most accurate and current information available. This takes a joint effort of all care managers in the agency to share any new information with this researcher in order that the new data can be entered into the file. Such maintenance of the inventory takes continued commitment. Time must be allotted to update the inventory on a regular basis.

In order to keep the ACT! database in good condition, it must be compressed and reindexed at least once a week. The data base must be compressed and reindexed for two reasons. First, whenever a contact is deleted from the database, the disk space that holds that deleted contact is not usable. By compressing the data base, the wasted space is removed. If a substantial number of contacts have been deleted, there is a lot of wasted space and this causes the data base to slow down. Second, reindexing is the process of fixing the indexes. It is important

that the indexes are working properly or else ACT! may have trouble locating contact records.

To perform this maintenance, select File (F), and Maintenance (M) from the submenu. The Maintenance dialog box will appear. Select Compress and Reindex Database (C). Click OK. The process will begin. Depending on the size of the database, this process can take several minutes. Do not interrupt ACT! while this maintenance is taking place because considerable damage could occur.

One of the most disastrous events that can occur with any data base is to lose the data due to power failure or a crash of the system. If the data base has been backed up either on an automatic backup system or on floppy disks, the fear of this occurrence is lessened. Therefore, it is very important to back up the data base file at least every week.

The ACT! For Windows software has many more capabilities than those described above. However, the ones presented in this chapter are specifically geared toward the use of the Long-Term Care data base developed by this researcher. For further information on how to conduct other functions featured in the ACT! For Windows software, refer to, ACT! For Windows For Dummies by Jeffrey J. Mayer.

Chapter V

Discussion

The number of very old persons living in the community who are in need of some sort of assistance in order to remain independent is increasing. Persons age 85 and older make up one of the fastest growing groups of the United States population (Scharlach, Lowe and Schneider 29).

Researchers have shown that a woman 40 years old today has a 96 percent chance that at least one of her parents is still alive. This is opposed to a 70 percent chance if she had been 40 in 1900. A woman 50 years old today has an 80 percent chance that at least one of her parents is still alive. This is opposed to a 36 percent chance if she had been 50 in 1900. The average woman today can expect to spend eighteen years of her life with at least one elderly parent alive. A woman over the age of 30 is more likely to be caring for an elderly parent than a young child and will do so for more years (Scharlach, Lowe and Schneider 30).

In today's society, it is common for caregivers, whether male or female, to work outside the home. This trend has created a big challenge for employees, employers, and society to find ways to balance the family and work obligations. Employers are becoming increasingly concerned about the impact of caregiving responsibilities on the productivity of their employees (Scharlach, Lowe and Schneider 139). Some companies are now offering elder care assistance as part of their benefit packages.

As more and more corporations and businesses recognize the need for elder care assistance as a benefit for their employees, and as

society as a whole recognizes that caregivers need assistance in caring for their elderly loved ones, geriatric care management will become a highly demanding field of the future. Connie Rosenberg states that care management will play an increasingly important role in the lives of older clients as funds available to pay for the needed services become more limited and as family systems change demographically (37). The professional in geriatric care management must be prepared and ready to face the increasing needs of the older generation and their caregivers.

Being properly trained to understand the history and social needs of the individual and how to assess and develop a plan of care are essential to the qualified geriatric care manager. The project developed by this researcher is one example of the ways to broaden the geriatric care manager's knowledge base and resource accessibility in order to meet the growing needs of the elderly population in our society. Technology can do many things to expedite access and thoroughness for the geriatric care manager. The development of the long-term care facility data base alleviates the need for the geriatric care manager to do manual research such as sorting through files and making repetitive phone calls to facilities.

The future demands that not only long-term care facilities be on a computerized data base system but that all components of the care manager's resource needs also be available in such an "at the fingertips" system. This researcher proposes that all resource files and client files should be entered into a data base system. The less time the geriatric care manager spends on research and looking through file cabinets, the more time there is to effectively plan and monitor the care of the client.

APPENDIX A

STAFF SURVEY

To: Staff
From: Patty
Re: Long Term Care Data Base Project
Date: August 14, 1996

Please see attached memo from me to Kendall and Carol regarding my new project on developing a data base for all long term care facilities in the St. Louis Metropolitan area. In order to make this project a success and a valuable tool for care management, I would appreciate your input regarding the information you would find most useful. Please review the following list and add any other areas that you would like to see appear on such a data base. Also, please feel free to comment on anything, anyway, anyhow! I really appreciate your input. Return to me upon completion. Thanks Alot!

Name of Facility
Address of Facility
County
Telephone Number
Fax Number
Name of Owner and address if available
Name of Administrator
Name of Social Worker
Name of Marketing Director/Admissions Counselor
Geographical Area of the Facility (West County, St. Charles South . . .)
Levels of Care (SNF, RCF, Retirement Community . . .)
Special Needs Unit (Alzheimers . . .)
Special Services (Transportation, Incontinence Care, Secure for wanderers. . .)
Size of the Facility
Number of Medicaid beds
Number of Medicare beds
Availability
Wait list
Cost
Method of Pay accepted (Private only, Medicaid, Medicare, Cash Grant)
Buy-In or Endowment Plans Available - Terms
Floor Plans (Studio, 1 Bedroom, 2 Bedroom . . .)
Brochures on file?
Care Managers most recent contact - Notes, concerns, recent placements

Please Add Others:
(Attach an extra page if necessary)

APPENDIX B

FACILITY INFORMATION SURVEY

Facility Information Survey

Name of Facility _____
Address _____
County _____
Telephone Number _____
Fax Number _____
Name and Address of Owner _____
Name of Manager _____
Name of Administrator _____
Name of Social Worker _____
Name of Marketing Director/Admissions Counselor _____
Geographical Area of Facility _____
Age of Facility _____
Levels of Care: ILU _____ Asst Liv _____ RCF I _____ RCF II _____ SNF _____
Special Needs Unit: Alzheimer's _____ Other _____
Special Services: Transp ___ Handicapped Van ___ Incontinence Care ___ Secure for Wand ___
Pool ___ Day Care ___ Laundry ___ Cleaning ___ Activities ___ Meds Dispensed ___
Personal Care ___ Furnishings Provided ___ Bring Own ___ Others _____
SNF: IVS ___ Tube ___ Trach ___ Vents ___ Therapy ___ Type ___ Days x week ___
Service ___
Religious Orientation _____
Pets OK? Yes ___ What _____ No ___
Smoking? Yes ___ Policy _____ No ___
Utilities included? Yes ___ Which? _____ No ___
Size of the Facility _____
Number of Medicaid beds _____
Number of Medicare beds _____
Availability _____
Wait list _____
Costs _____
Method of Pay accepted: Private _____ Medicaid _____ Medicare _____ Cash Grant _____
Buy-In or Endowment Plans Available: Yes ___ Terms _____ No ___
Application Procedure _____ Fee _____
Floor Plans: Studio _____ 1 BR _____ 2 BR _____ Private ____ Semi-private ___ Ward ___
Ranch Homes ____ Apartments ____ Other: _____
Brochures on file? Yes _____ No _____
Care Managers' Notes: _____
_____
_____
_____
Today's Date: _____

Entered _____ pji: 8/16/96

APPENDIX C

CONTACT REPORT

Contact Report

Patty Iverson
The Next Step/Elder Assist
12825 Flushing Meadows Dr.
St. Louis, Mo. 63031

Page: 1
Date: 11/25/96
Time: 3:15PM
Number of Contacts: 1

Company: Caregivers Inn
Contact: Robyn Franzen
Phone: 314-272-3005 Ext:
Title: Administrator
Assistant: Robyn Franzen, Admissions
Dear: Robyn

Address: 1297 Fiese Rd.
CC: 1
City: O'Fallon
State: Mo.
Zip Code: 63366

Call:
Meeting:
To-do:

RE:
RE:
RE:

Last Results:
ID/Status:

Referred by:

Type: ILU, RCF I
Special Unit: none-Early Alz ok-no secure
Size: 29

Availability: yes-1M,1F,1Double,1 ILU-
Pets: No
Cost: $65/Day RCF; $1500 ILU

Method of Pay: Private - No cash grants
Buy-In: No
Type Rooms: Private, Semi-Private, Ward

Contact: Robyn Franzen
Home Phone: Ext:
Address 1:

City:
State:
Zip:

Alt Contact1:
Title:
Alt Phone1: Ext:
Last Reach:

Alt Contact2:
Title:
Alt Phone2: Ext:
Last Reach:

Location: St. Charles County
Age: 1990
Services: A, C, Furn P, Meds, PC, T

Skilled Services: None
Smoking: Designated areas only
Brochures: Yes

History:
You have no history for this contact.

Notes:

9/30/96: (Patty Iver) Facility visit 9/16/96. Steps to ILU. Formal dress for dining. Very clean. No deficiencies on last survey. Not Medicaid certified. Provide more personal care than most RCFs.

Activities:
There are no activities for this contact.

APPENDIX D

DIRECTORY

Directory

Patty Iverson
The Next Step/Elder Assist
12825 Flushing Meadows Dr.
St. Louis, Mo. 63031

Page: 1
Report Date: 11/25/96
Time: 3:25PM
Number of Contacts: 4

Primary			Secondary
Caregivers Inn Robyn Franzen 314-272-3005 1297 Fiese Rd. O'Fallon Mo. 63366	Ext:	CC:1	**Assistant:** Robyn Franzen, Ad...
Lake St. Charles Retirement Community Elaine Bastle 314-947-1100 45 Honey Locust La. St. Charles Mo. 63303-5711	Ext:	CC:1	**Assistant:** Dave Starr, Scott...
The Gables at Breeze Park Michelle Quillo 314-939-5223 600 Breeze Park Dr. St. Charles Mo. 63304	Ext:	CC:1	**Assistant:** Terri Etling-Admi...
Twin Oaks Estates, Inc. Mary Ann Huber 314-240-6152 707 Emge Rd. O'Fallon Mo. 63366	Ext:	CC:1	**Assistant:** Tim Blattel-Admin...

APPENDIX E

FACILITY LETTER

Monday, November 04, 1996

Robyn Franzen
Caregivers Inn
1297 Fiese Rd.
O'Fallon, Mo. 63366

Dear Robyn:

Thank you so much for the tour of your lovely facility on September 16, 1996. I enjoyed meeting your staff and several of your residents.

I look forward to seeing you again soon. I will certainly refer any clients who are considering independent living or residential care in the St. Charles County area.

Sincerely,

Patty Iverson
Geriatric Care Manager

APPENDIX F

FACILITY MEMO

- Memorandum -

Date: Monday, November 04, 1996

To: Robyn Franzen

From: Patty Iverson

Subject: I have referred the Smith family to your facility. They are looking for Residential Care for their mother who is early stage Alzheimer's. If you have any questions, don't hesitate to call me at 831-9111.

- Memorandum -

Date: Monday, November 04, 1996

To: Robyn Franzen

From: Patty Iverson

Subject: I have referred the Smith family to your facility. They are looking for Residential Care for their mother who is early stage Alzheimer's. If you have any questions, don't hesitate to call me at 831-9111.

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