The Care Management Process

Comprehensive Assessment
This is a multi-step process that includes the following:

1. Initial telephone inquiry where I can get some information about the client's needs and discuss my potential role as a GCM for that client.

2. Mailings to the client or responsible party regarding Coaching Caregivers LLC, care management services including a brochure, business cards and a service agreement.

3. After I receive a signed service agreement and retainer, I begin the comprehensive assessment process which includes a thorough medical, financial, psychological and social history. The overall goal of the initial assessment is to learn of the client's current and potential future needs and to identify any current gaps in the care that the client is currently receiving. Family members, particularly those with a past or current caregiving role, are asked to provide as much detailed information as they can. Contributions from long distance family members can be done over the phone or via email.

Formulating and implementing a plan of care

1. In collaboration with the client and the care circle (i.e., family members and others such as friends or other professionals close to the client) a short-term and longer term plan of care is formulated. A written version of the assessment findings and recommended care plan is available.

2. With my health care and social work background, I utilize my professional expertise to put the care plan in place. The typically involves the following activities:

- Consulting with physicians and other health care providers on the client's behalf.

- Making the arrangements for facility admissions, transfers, or discharges.

- Dealing with insurance companies for needed eligible services.

- Arranging for needed in-home evaluations, modifications, equipment and services.

- Arranging for comprehensive medical monitoring of frail clients.

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- Acting as a surrogate in the absence of family or for long distance family caregivers.

Ongoing GCM role

1. Once the plan of care has been in place my role turns more toward providing routine monitoring of the client. Performing client advocacy and ongoing problem solving to caregiving staff or with physicians and other health care providers is pretty regularly needed. I often attend care plan meetings for clients residing in nursing homes or assisted living facilities.

Reevaluating and looking ahead

1. Over time a client's needs may change and a revised plan of care will be needed. Change may involve increasing or sometimes decreasing the kind and/or amount of care that a client receives at home. Often a change in a client health or functional status or the loss of a spouse requires relocation to a continuing care community or an assisted living or nursing facility. As a GCM, I provide ongoing assessment to my clients around status changes and guide posts to clients or their decision makers as to when it's time begin rethinking the care plan. My aim is to always assist with proactive decision making. This is done through ongoing client assessment and exploration and education around future care plan alternatives.

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