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INSIDE

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National Association of
Professional Geriatric Care Managers

To advance professional geriatric care management through education, collaboration, and leadership.

The Bumpy Road to Recovery: A Tale of Alcoholism & the Elderly

The Beginning

I was leery when the Elder Law attorney described the referral: 76-year-old, twice-widowed, depressed and bankrupt 20-year alcoholic with a history of personality disorder and dementia. She lived isolated in a cluttered apartment, alienated from her family. Moreover, she was on the brink of eviction from her luxury apartment for setting two fires and “harassing” building personnel. (She called them continually in a drunken stupor to request 911.) She was referred to Adult Protective Service (APS) and her estranged daughter and son-in-law agreed to assume Power of Attorney to avert guardianship or homelessness. The woman reluctantly consented, believing she was doing her children a favor. They did want to rescue her but only if I would take on the salvation work. I accepted this challenge and stipulated that I would co-manage with another care manager. They readily agreed.

Getting My Foot in the Door

Before my initial call to my new client “H”, her daughter had correctly warned me that I would be rejected. H asserted that she had never ignited a fire and needed no one. She declared she would get a job before anyone would be her guardian and she hung up the phone abruptly. I called earlier the next day, before she had begun drinking, and simply promised that I would help her to remain in her apartment. She relented and allowed me “one” visit.

I visited H later in the day, after she had started to drink, to get a sense of her alcoholic state. At first she fondled her glass of vodka and kept touching her pack of cigarettes; but her edginess lessened once she was “permitted” to have a cigarette. H presented as an attractive senior, dressed in a velour leisure outfit and looking younger than her years, except for her missing teeth and noticeable thinness.

Her kitchen showed evidence of partly burnt cinders and smoke-stained walls; the entire apartment reeked of fire and cigarette smoke. She sat on her sofa amid a mess of papers and other litter; I opened the windows to breathe. This was her headquarters where she watched TV all day, avoided bill collector calls and shopped on-line.



H was friendly but rarely gave a straight answer. She would either contradict what she had previously said or wander off on a tangent. For example, first she said she rarely drank; then she said she only drank wine; and finally, acknowledged that vodka was her beverage of choice. She simultaneously admitted and denied her drinking problem and could not fathom that her habit cost money she did not have.

She required constant refocusing to discuss either her present situation or her past history, yet she could retrieve most pertinent facts. She rummaged and found papers for me but she was stumped by what they meant (Power of Attorney, health proxy, eviction notice, Medicaid application). She seemed intelligent but histrionic—everything overwhelmed her.

She perceived her present situation as a “project” for research yet was unaware of its severity. “How dare Citibank sue me for my unpaid debt,” she complained.

H was horrified that APS would try to visit without an appointment or recommend Alcoholics Anonymous (AA) or Meals on Wheels. She was aware she had no money but was unbothered by this. Her husband had been a surgeon and she had always lived in the lap of luxury. Now she deserved to be cared for. She believed she’d be supported if she “worked the

system well enough.” Although H alluded to her family estrangement, she refused to explain why; it sounded as though she might have done something terrible while in an alcoholic stupor. During our lengthy visit she refilled her glass once. Ultimately she bared her soul and agreed to work with me. For better or worse, I now had a client with borderline personality disorder.

What to do first?

So much had to be done simultaneously. I immediately engaged APS to overturn the eviction. The building management insisted H have supervision. This meant securing a companion conversant with alcoholism who would also tolerate smoking and verbal abuse. H’s environment required detoxification. She needed nutrition, yet she was fussy about her food. She had agreed to see a psychiatrist, so I had to secure someone willing to accept her Managed Care Medicare in which she’d enrolled after squandering \$240,000. I began researching alcohol treatment options while her family urged me to identify affordable housing in the event she was evicted.

My greatest challenge, however, was to understand H’s capacity. How much was dementia? How much was alcohol? Could she reason and make decisions? Or would decisions need to be made against her will?

THE LONG AND WINDING ROAD

The Eviction

With H's permission I began my journey with APS and many discussions later, convinced them to accept her. Her family's private attorney contacted the APS Counsel to stave off guardianship and eviction, and got Housing Court to appoint a Guardian ad Litem (GAL) to represent her. Then came her opposition and resistance: H would neither allow APS to visit nor accept calls from the GAL. She claimed she was too busy researching Legal Aid and "did not need APS." With perseverance I was able to secure entry for their psychiatrist; his report characterized H as borderline, narcissistic, grandiose and demented. While she didn't fully comprehend the report, she did comment, "I am grandiose and I should be!"

A month of negotiations and delays followed during which H's anxiety and drinking escalated. Also, my co-care manager quit, unable to tolerate H's constant verbal abuse. After several extensions, APS's counsel finally overturned the eviction with an 18-month proviso: no fires, no harassment. Although she still drank, in sober moments H was beginning to see that perhaps she could emerge from her despair. She reluctantly agreed to be kind to the 4-to-8 p.m. aide and declared she wanted to become sober. Knowing the characteristics of borderline personality disorder, I was dubious.

One Step Forward, Two Steps Back

Treat the alcoholism or the depression? Either was a starting point but H was more willing to begin with a psychiatrist. She had all the classic symptoms of depression, especially anxiety and somatization; she couldn't breathe, sleep, had constant pain, and since a recent emergency room (ER) visit to Bellevue after fainting in the street, never left home. The therapist H was seeing (when she didn't cancel) begged me to transfer her elsewhere. Every clinical social worker in her mental health service book had refused her insurance. Her primary physician gave her free samples of Zoloft every six months. Her depression was untreated and psychiatric care was inaccessible.

The only option was for H to re-enroll in traditional Medicare and, fortunately, her family agreed to pay for a supplemental policy. Now I could use a reputable Memory Disorders Center to evaluate her dementia and treat her depression. Test results showed mainly impairments in attention and executive functioning, probably due to multi-infarcts and possible Korsakoff's syndrome. Their neuropsychiatrist recommended immediate sobriety to stave off further brain damage.

Her next visit was with a private geriatric psychiatrist who also believed her alcoholism was the first priority for treatment. While waiting for regular Medicare to start, H began treatment at the Addiction Institute of New York (formerly Smithers) covered by her present

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Election Results Are In!

We are pleased to announce the winners of the NAPGCM Election to the Board of Directors for 2010-2011.

Heather Frenette
Jullie Gray
Mary Kay Krokowski
Stephanie Swerdlow

Officers elected for the 2010 term are:
President Linda Fodrini-Johnson
President-Elect Susan Fleischer
Treasurer Miriam Oliensis-Torres
Secretary Carol Heape

Continuing on the Board, by ascension, is
Phyllis Brostoff, as Past President

Also continuing in the second year of their terms are:

Helene Bergman
Dianne Boazman
Byron Cordes
Joyce Gray
Cheryl Theriault
Audrey Zabin

*Congratulations
to all!*

Inside the NAPGCM Mailbox

October 18, 2009

Hello Ms. Boothroyd,

I am relatively new to the NAPGCM, but wanted to share my perspective that the organization is right on target with setting a high level of expectations in attaining professional credentials. It is wise to do this, and the NAPGCM has given fair warning to the membership that their designation may be impacted should they choose not to pursue certification. I feel strongly that it is the best way to increase the credibility of the profession and therefore help geriatric care management grow and prosper. Thanks for the excellent articles in the Journal that was distributed in the Fall which also supports this premise.

Pamela Cronin, RN, BSN, MS, CCM
ElderCare Options, LLC

insurance. The program was not geared to seniors and she was placed with younger narcotics addicts; she could not identify with the population. She reluctantly went to AA twice with her aide but, again, could not identify with the population. I contacted her primary physician who simply told her, “Stop drinking.” By now H was desperate and so was I. She wanted a magical cure and detoxification seemed the only way.

At the advice of an alcohol ‘specialist’, we went to a Beth Israel Hospital for a voluntary psychiatric admission—the “best” option for detoxification. I was promised we would not need the ER but upon arrival we were directed straight to the ER and had to wait there more than four hours. As H clutched her bag with her pillow and stuffed animal, she looked terrified. Staff demanded she relinquish these items and change to hospital garb. She begged to leave and I was tempted to comply.

They eventually relented about her clothes and at 5 p.m. sent her upstairs. Once there, no one at the nurse’s station looked her way as they did not want a new arrival at that hour. I advocated as gently as I could and H agreed to stay. Two days later she checked herself out when another resident cursed at her and pulled her hair. They referred H for outpatient rehab, but the rehab center did not return my calls.

By now H was on her third “companion” and vehemently opposed trying hospitalization again. She needed to recover from her hospital trauma and regain trust in me. Meanwhile her family and I attempted behavior modification. We presented a contract that clearly stated the consequences of drinking versus not drinking. She signed and ignored it. I scoured the tri-state area for options; if her age or insurance didn’t work against her, then her personality and depression did. We returned to the neuropsychiatrist who had begun to treat her at the Memory Disorders Center. The doctor offered Paine Whitney, another addiction program for detox. Weeks went by without an available bed.

And then — salvation! The psychologist who had originally evaluated H recommended a geriatrician with a specialty in alcoholism. During H’s initial visit with him, he asked her, “Are you ready to detox?” She nodded and was immediately admitted to a medical floor

at New York Hospital. From there it was relatively smooth sailing.

H loved the attention. She had her phone and television and responded well to treatment. Her insurance then covered two weeks at the Addiction Recovery Program, Payne Whitney Westchester. There, a professional and supportive staff embraced her borderline personality, including her grandiosity. She was dubbed “The Queen” and celebrated her 78th birthday amidst dozens of presents I brought from her daughter, who was too emotionally and physically fragile to visit.

H loved the attention. She was dubbed “The Queen” and celebrated her 78th birthday amidst dozens of presents I brought from her daughter.

Recovery

The next challenge was finding “appropriate” community after-care. A thorough search revealed that Medicare offered none, but once again the family came through. In addition to paying H’s rent, her insurance supplement, the part-time aide, and care management, they offered to pay for Intercare, a nearby group/individual substance abuse recovery program.

At Intercare, professional staff integrated her into individual and group treatment and she attended twice weekly for four months despite bumps in the road. With my support, she gradually withdrew from individual treatment and then group therapy. It was too much of a financial burden on her family, she said. And I knew she wanted dental work to regain her sense of self. H may have recovered from the alcohol but her manipulative narcissism remained. Her family was so grateful they wrote: “On New Year’s Eve, we remarked to each other that H’s redemption was the ONE really great thing that happened to us in 2008.”

Before terminating from Intercare, I found a Medicare-covered behavioral therapist who agreed to work with H. She secured Meals on Wheels, and we changed the companion to once a week. Luckily, I had a Hunter College Social Work intern who became her mainstay. H re-engaged as she began purchasing fruit from the street vendors, going to doctors independently, and walking through street fairs on the weekend. Gradually I

began to wean her from dependence on me...but we were not quite there yet.

A Year Later

I received this invite from H’s daughter: June 25th is the first anniversary of H’s sobriety. I will be coming into the city to have a celebratory lunch with her. (Place to be decided by H) Could you please join us? I would appreciate that very much and I’m sure H would be “honored”. It would mean a lot.

In Retrospect

What facilitated this successful ending? How can we as Care Managers advocate for elderly addicted clients when system resources are inadequate or inappropriate? Clearly, we must perfect our care management core competencies especially in Engagement, Communication, Collaboration, and Advocacy. We must be able to deal with issues like medical insurance and access to relevant community resources. In addition, a key element is the ability to gain the complete confidence of a family so they may trust an “outsider” and offer the client the ongoing support of their emotional and financial resources.

*Helene Bergman, LMSW, is a Certified Geriatric Care Manager (C-ASWCM) and owner of Elder Care Alternatives, a professional Geriatric Care Management business in New York City. She received her MSW from Hunter School of Social Work following a career in Education. She was previously affiliated with NYU Aging & Dementia Research Center, where she was a Family Counselor and a research associate. Helene has been a consultant with Nursing Homes and Day Care Programs to develop specialized programs for Alzheimer patients. She led many caregiver support groups for the Alzheimer’s Association and co-authored a book *Guiding the Alzheimer’s Caregiver: A Handbook for Counselors*. She was on the Advisory Board of the Brookdale Center on Aging Certificate Program in Professional Care Management and taught their seminar on Home Health Care. Helene frequently speaks on Memory & Aging, Alzheimer’s Disease, Caregiving, and Eldercare topics for Assisted Living Facilities, Nursing Homes, and corporations. She served as the President of the Greater New York Chapter of the National Association of Professional Geriatric Care Managers from 2000-2004. She presently serves on the Board of Directions of the National Association of Professional Geriatric Care Managers (NAPGCM).*