The Care Navigator

Embracing life's transitions with dignity, clarity and stability™

The Care Navigator: Client Care Examples

The Care Navigator helps caregivers and care recipients by serving as guardian, power of attorney, personal representative and by providing assessment, case management and care coordination services.

Services and support provided by The Care Navigator are broad in scope. Below are general descriptions and examples of client situations to provide you with an idea of the type of services and coordination of care we offer. All of the situations have been modified to protect the privacy of the client.

Guardianship

Description: For individuals who have no family, when family exists but feels unable to serve, or when family members prefer to have a professional act in the role of guardian, The Care Navigator is appointed by the court to serve in this role. Guardian is a higher level of responsibility than a medical durable power of attorney because a person with a guardian has a diagnosis of incapacity, meaning that he or she is unable to receive, evaluate, and to make appropriate decisions regarding health and well-being. As guardian, The Care Navigator is responsible for the total well-being of the person and the daily living situation.

Situation: Mary Smith has dementia and lives alone. She has difficulty managing her medications, has lost weight, and frequently misses medical appointments. Mail is stacked in piles all over the house. Mary mentions children who help but it doesn't seem like anyone has visited in quite some time. She recently had a car accident and while the car appears drivable, it is questionable whether Mary should still be driving due to health conditions and memory loss. Concerns have been expressed whether Mary should continue living alone in her home without support and assistance. A referral was made to The Care Navigator who worked with adult protective services. No family was available or willing to serve. The Care Navigator was appointed as Guardian to manage Mary's health and day to day needs.

Power of Attorney (Financial and Medical)

Description:
For individuals who have no family, when family exists but feels unable to serve, or when family members prefer to have a professional serve in the role of power of attorney, The Care Navigator serves as power of attorney. Relative to financial support, this means managing all money and property of the client including bill paying, completing annual income taxes and other related projects. Relative to medical this means being responsible for the health and well-being of the client including coordinating medical appointments and necessary care. In these capacities, The Care Navigator coordinates financial and medical services. The Care Navigator may also be responsible for assisting in identifying a care community, selling the client's home, and other aspects related to transitioning from home to a care community.

Situation: Denise lives alone with her dog and cat. Her husband passed away two years ago and was the major organizer in their lives. Denise's sister, Millie, has children and works full-time; while Millie cares about her sister, she does not have time to be a caregiver or organizer. Denise enjoys spending money on books and stuffed animals that fill her house. Denise's physician is concerned about her health, her ability to take and organize multiple medications, not eating and drinking properly, and a diagnosis of short term memory loss. A referral was made to The Care Navigator. It was agreed by all parties that a case manager was needed who could also serve as medical and financial power of attorney to coordinate medical care and ensure that Denise's bills are paid.

Personal Representative

In situations where individuals are near end of life or are planning for end of life, The Care Navigator is appointed as personal representative of an estate to take care of all matters after an individual's passing. A current example is a man on hospice care who does not want the responsibility of personal representative to be given to his family or friends. The Care Navigator is acting as both financial power of attorney and personal representative of the estate in order to make certain all financial matters are in order prior to the client's passing so that after death there will be a smooth transition and all wishes will be made known and executed.

Situation: John currently lives in a nursing home. He had a fall and was told he cannot return home. John's sister is 90 years old, in poor health, and is unable to help John with his health or living arrangements. A referral was made to The Care Navigator. The family agreed that John would benefit from an advocate to make health and financial arrangements. The Care Navigator was appointed as financial and medical power of attorney. The Care Navigator moved John from the nursing home to a small personal care home. His home was sold to pay for his care and he lived with a very good quality of life until he became ill and passed away 18 months later. The Care Navigator was also appointed as personal representative, made John's final burial arrangements, and closed out financial matters related to John's estate.

Case Management, Care Coordination, and Oversight.

The Care Navigator serves as case manager and care coordinator in a variety of situations.

Situation: Adult children living in various locations desire support in caring for their mother diagnosed with Alzheimer's disease who refuses to acknowledge the diagnosis and the need for care. We initiated in home caregivers and supervised care, coordinated and attended medical appointments, initiated attendance at adult day care and as time went on worked with the client to visit assisted living communities and completed a move. We remain involved to provide care oversight in the community where she lives and bill paying assistance.

Situation: A woman diagnosed with bi-polar disorder recently had a medical setback and desired assistance managing daily tasks i.e. bill paying, grocery shopping, ordering medications and general household management until she was able to "get back on her feet and manage these things again".

Situation: We supervise medical care for a developmentally disabled young adult because his family has moved out of town and they desire a local advocate to make sure that medical care is provided on a regular basis and that there is someone available on an emergency basis to attend to care and lifestyle needs.

Situation: A single older adult, mid 60's, recently diagnosed with Parkinson's disease wants occasional assistance with lifestyle management and household organization due to physical difficulties in accomplishing these tasks. The Care Navigator staff visits monthly to review needs and complete a list of projects that include bill paying, filing and organization and banking needs. We also support identification and development of a long term plan for care needs when health changes occur that may necessitate a higher need for care.

Situation: A family member contacted The Care Navigator because their cousin was experiencing significant health issues and the family member did not have the time to support their cousin. We met with the family, gathered medical records and set up multiple medical appointments to confirm health diagnoses and recommended treatment. We worked with referrals to specialists and skilled services (PT, OT). We currently visit this client monthly and attend medical appointments as needed.

Situation: Two sisters both out of town recently moved their father to an assisted living community. The father no longer drives, has memory loss, and requires frequent medical visits due to multiple chronic conditions. We visit the father twice monthly, check in with the community staff to determine needs and provide updates to his daughters.

Situation: A woman with macular degeneration lives alone and has difficulty writing checks and paying her bills. The Care Navigator staff visits monthly to support this client in completing this task and have automated as many deposits and payments as possible so that check writing is at a minimum. We will continue to support her as she needs other assistance.

Situation: A son who was blind needed a personal representative for his mother who was on hospice care. The Care Navigator became the personal representative and was able to manage her final disposition (cremation) and close out the financial details of her estate.

Other examples follow:

- Bill paying for an adult child who is power of attorney for his parents but who does not have the time to review mail, pay bills and coordinate paperwork.
- Completion of annual income tax returns for clients who need assistance in gathering information and delivering to a CPA to complete the taxes.
- We serve as an advocate for children living out of town who have parents living in independent, assisted living, memory care and nursing homes. We visit on a requested schedule, attend care conferences and medical appointments, purchase personal needs

items and send reports back to the adult children. We also provide general oversight and go to the emergency room when an unexpected event occurs and an advocate if beneficial.

- We act as an impartial source of information in family situations where there is significant disagreement about the care needs of parents or a loved one. In these situations we provide education and in some cases coordination of care for parents so that families can be "families" and not serve as caregivers or task providers.
- We complete and coordinate Medicaid applications for clients including identifying Medicaid care communities when this need exists.
- We coordinate long term care insurance policies and initiate claims for individuals who are unfamiliar with the paperwork or the process to implement a claim. We will review the policy, initiate the claim and complete the paperwork.
- We support individuals who realize it's time to move to an assisted living but who are too overwhelmed by the task of selling their home, eliminating excess property and who are unsure of the type of community they need. In these cases we review medical and financial needs to determine a care community that will be a good long term match and help coordinate all the details to complete the move. In many of these cases we remain involved with the older adult to monitor medical and related care after the move. ***
- We provide daily, weekly or monthly oversight of care needs for individuals of all ages. We work with clients who are living independently but want support managing in home care providers and coordinating other services be it health or property related. We set up lawn care, coordinate home repairs, and any projects necessary to allow individuals to remain independent at home.
- We attend medical appointments, collect and coordinate medical records and medication lists between providers and oversee general care.
- We attend care conferences at communities with family caregivers and care recipients in order to gather accurate information, to assess and make recommendations and to support implementation of care plan.
- We provide hourly consultation meeting for families investigating options relating to care.
- All other services are by request.

*** *We are not a free referral or placement agency. We do not accept or require referral fees from companies and communities with whom we work. We work in the best interest of our clients. Refer to article "State Gets Tough on Referrals for Eldercare" on our website.*

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