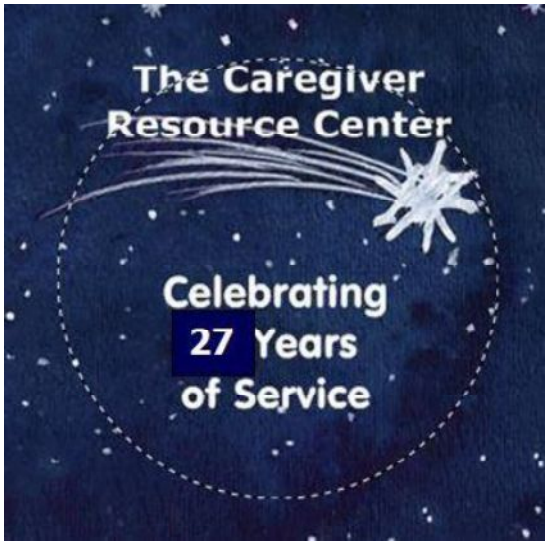
The Caregiver Resource Center

Concierge Case Management & Advocacy



www.CaregiverResourceCenter.com

The Caregiver Resource Center's Commitment

The Caregiver Resource Center makes the following commitment to our clients.

We will:

- ✓ Provide services that are individually designed to meet the unique needs of the client and their family
- ✓ Be available 7 days a week by appointment, and 24/7 for emergencies
- ✓ Develop and execute a signed "*Informed Consent - Client Service Agreement*" for each client before providing any services; which clearly outlines the agreed upon services, confidentiality, fees, payments, commencement of services, references, cancellation of services, etc.
- ✓ Ensure client confidentiality per state and federal confidentiality laws
- ✓ Provide only those services authorized by the client or their legal representative
- ✓ Provide regular verbal and written updates to the client and members of the Care Team; highlighting pertinent information, concerns, suggestions, and agreed upon action plans
- ✓ Execute all services with the focus being on the client's healthy, safety, independence and quality of life
- ✓ Acknowledge the client and their family's role as an integral Care Team member, and be open and receptive to their input in the Care Plan development
- ✓ Provide a detailed invoice for all services rendered
- ✓ Obtain written permission from the client or their legal representative, prior to using email as a means of communication
- ✓ Use password protected documents when sharing information about a client's health, mental health or finances, via email

We will NOT:

- ✓ Benefit financially from any referral we make to care providers or community resources
- ✓ Provide direct services, such as home care services (e.g. caregivers), or nursing services
- ✓ Provide financial management or fiduciary services for the client
- ✓ Act as a guardian, conservator, or power of attorney for any client or their relatives
- ✓ Accept gifts or tips from clients
- ✓ Provide services that The Caregiver Resource Center is not licensed and qualified to provide

Table of Contents

What is a Board Certified Case Manager

A board-certified case manager must hold a current, active, and unrestricted licensure or certification in a health or human services discipline that within its scope of practice allows the professional to conduct an assessment independently and/or a baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being.

After preparing for and passing the national Certified Case Manager (CCM®) examination, board-certified case managers demonstrate they have the expertise, knowledge and professional experience to provide the right services to patients across the continuum of care. They are committed to uphold the highest professional and ethical standards.

To maintain their CCM credential, a board-certified case manager must comply with the Code of Professional Conduct for Case Managers, which is enforced by the Commission. In addition, a certified case manager must apply for recertification every 5 years, which requires a minimum of 60 hours of continuing education credits.

The Role of a Board Certified Case Manager

Seniors, people with special needs, caregivers, or professionals who are feeling uncertain as to what to do, are increasingly using the services of a certified case manager (CCM) to assess and implement plans that address a client's day to day needs. CCMs provide a consistent contact for family members, and they can do everything from creating an overall care plan to intervening in case of a crisis or emergency.

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

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

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

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

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

Linda Ziac

Linda Ziac, LPC, LADC, BCPC, CEAP, CCM, CDP is the owner and founder of Employee Assistance Professionals, Inc. a CT corporation located in Greenwich CT; which has been serving the community since 1990. The Caregiver Resource Center is a division of Employee Assistance Professionals, Inc.

Ms. Ziac has more than 40 years of experience in the health and mental health field as a licensed professional counselor, licensed alcohol and drug counselor, nationally board certified professional counselor, nationally certified case manager, nationally certified employee assistance professional, and a board certified dementia practitioner. In addition, Ms. Ziac has 15 years of experience coordinating care for her own parents.

Ms. Ziac assists seniors, people with special needs and their families; in planning for and implementing ways to allow for the greatest degree of health, safety, independence, and quality of life. Ms. Ziac meets with individuals and family members to assess their needs, and develop a Care Team, while working with members of the Team to formulate a comprehensive Care Plan (a road map). Once a plan is in place, Ms. Ziac is available to serve as the point person to monitor and coordinate services, and revise the plan as needed. This role is similar to the conductor of an orchestra; ensuring that there is good communication, teamwork, and that everyone remains focused on the desired goal.

The Caregiver Resource Center

The Caregiver Resource Center offers a spectrum of case management and advocacy services with flexible options to help plan for a client's current and evolving needs.

We are specialists who assist seniors, people with special needs and their families in planning for and implementing ways to allow for the greatest degree of independence, safety and quality of life.

Our mission is to assist seniors, people with special needs, and their families in understanding care issues, facilitating open communication; and providing information, support and guidance through the care process.

Our services strive to plan for and implement ways to allow for the client's greatest degree of health, safety, independence, and quality of life.

Some Benefits of Our Services

- Well respected company serving the community since 1990
- Assistance for seniors, people with special needs, and families; who are dealing with health and mental health challenges
- All services are individually designed to meet the unique needs of the client & their family
- We are available 7 days a week by appointment, and 24/7 for emergencies
- Our services are provided onsite across the continuum (e.g. home, doctor's office, ER, hospital, assisted living facility, nursing home)
- Professional Support & Guidance

The Caregiver Resource Center's Process

The Caregiver Resource Center's services are individually designed to meet the unique needs of the client and their family.

All services are available on a request basis, and all services are billed on a fee for service basis.

The Caregiver Resource Center services are available 7 days a week by appointment, and we are available 24/7 for emergencies.

Phase 1 - Initial Consultation

When a client and/or their family are interested in The Caregiver Resource Center's services, the first step is to schedule an initial consultation meeting. There is a fee for the initial consultation.

Initial Consultation

The case manager would provide an on-site initial consultation with the client and their family member(s) if available, at the client's current place of residence. The case manager and the client would discuss and agree to a set fee for the initial consultation meeting, prior to this meeting taking place. The client and/or their family would be asked to read and sign an Initial Consultation Meeting Agreement, prior to the start of this meeting.

This meeting would include an introduction of the services of The Caregiver Resource Center, a discussion regarding the client's abilities, concerns, needs and wishes; as well as the family's concerns and wishes. The case manager would also review topics such as needs assessments, care plans, healthcare proxies, advance directives, power of attorney, estate planning, etc.

There is no obligation for the client or their family to work with The Caregiver Resource Center beyond the initial consultation.

If the client and their family request to retain the services of The Caregiver Resource Center, appropriate release of information forms would be obtained; and the case manager, client and family member (if appropriate) would discuss and determine the desired services, execute an Informed Consent - Client Services Agreement, and establish a plan of action moving forward.

Phase 2 - Case Management and Advocacy Services

Each human being is unique, and as a result each person experiences aging differently. Some individuals may experience mental and physical limitations that limit their level of functioning, while others will remain relatively high functioning.

The Caregiver Resource Center's role is to work with the client, their family and healthcare professionals; to help assess, plan for and implement ways to allow for the greatest degree of health, independence, safety and quality of life.

This process involves identifying a client's abilities and needs, and helping to design a care plan that is composed of a spectrum of services, that best meets the unique needs of this client.

A client and their family select the services that they want, and they only pay for those services.

Menu of Service Options

All services of The Caregiver Resource Center are individually designed to meet the unique needs of the client and their family.

The Caregiver Resource Center services are available 7 days a week by appointment, and we are available 24/7 for emergencies.

When a client or their legal representative decides to retain the services of The Caregiver Resource Center, the client or representative would be asked to read and sign an Informed Consent - Client Services Agreement.

This Agreement would clearly outline the agreed upon services, confidentiality, fees, payments, commencement of services, references, cancellation of services, etc.

The following service options are available on a request basis, and all services of The Caregiver Resource Center are billed at an hourly rate, in 6 minute increments

❑ Comprehensive In-Home Clinical Assessment

The case manager would meet in the client's home in order to conduct a comprehensive, on-site evaluation of the client's strengths, needs and preferences.

This step may require more than one visit, depending on the need and stamina of the client. This assessment process would include a medical history, functional status, and a psycho-social evaluation.

After obtaining the necessary release forms and with permission, the case manager would also speak with the client's family, doctors, and other care providers; in an effort to gather as much information (pieces of the puzzle) as possible.

❑ Home Evaluation Audit

Seniors age 65 and people with special needs are twice as likely to be killed or injured by falls or fires, compared to the general population. This number jumps to three times that of the general population for seniors who reach age 75, and four times for those who reach age 85.

A home evaluation audit would explore potential fire and fall risks, as well as modifications and repairs that can be implemented to help reduce or minimize accidents, as well as improve the client's overall quality of life.

Once the home evaluation audit has been completed, the case manager would create a written report for the client and/or their family, highlighting areas of concern, as well as suggestions. The case manager would be available to assist the client and/or their family, in arranging for home modifications; which may range from replacing cabinet doorknobs with pull handles, to the addition of assistive devices, to full scale construction projects that require installing wheelchair ramps and widening doorways. The client is responsible for the full cost of all modifications

❑ Development of an Individualized Care Plan

A comprehensive Care Plan is similar to a roadmap.

To follow is a sampling of what a care plan would look like.

Original Date	Areas of Concern	Goals	Estimated Date	Interventions	Disciplines	Resolve/ Review
6/1/13	**High Blood Pressure** As evidenced by: Medical exam and tests Blood Pressure Screening	Manage blood pressure through: - Monitoring - Medication compliance - Healthy eating - Physical activity Maintain a desirable body weight Exercise regularly	9/1/13	Medication: - Atenolol 25 mg (am) Evaluate blood pressure medication including adherence to prescribed schedule Monitor medication compliance Monday through Saturday Encourage the eating of nutritious, low fat, and low sugar foods at each meal Encourage daily walking	 Dr. Smith Dr. Smith Acme Home Care Agency, Caregiver Tracy All All	

The case manager would meet with client and family members to assess their needs, develop a Care Team, and work with members of the Team (e.g. primary care physician, specialists) formulate a comprehensive Care Plan. If the client is residing in a facility (e.g. SNF), this care plan would be developed in partnership with facility care team members.

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

❑ Household Management

The case manager is available to help coordinate and arrange for home maintenance and repairs, lawn maintenance, snow removal, house cleaning, and pet care. The case manager is also available to research licensed and qualified vendors and oversee projects if requested.

❑ Healthcare Coordination

Clients often feel overwhelmed by the number of doctors they have, the scheduling of appointments, filling multiple prescriptions, and navigating through the often chaotic and confusing healthcare maze.

The case manager is available to help monitor and coordinate services through the transitions of home, emergency room visit, hospital admission, short term rehab, home, assisted living, nursing home, or hospice care.

Some of the services we offer include:

- schedule appointments for the client with their primary care doctors, specialists, and other healthcare providers as needed
- arrange for the client's transportation to medical appointments
- communicate with healthcare providers and family members about health care issues and concerns
- help the client understand the doctor's recommendations, treatment plan, and options
- participate in family and healthcare provider meetings while providing guidance and support
- attend hospital and rehab facility care planning meetings and discharge planning meetings

❑ Insurance Claims Research & Assistance

Understanding and navigating the insurance claims process can be confusing, overwhelming and time consuming. The case manager is available to help research and explain the client's Medicare Summary Statements and insurance forms, and contact Medicare and Insurance companies should there be any questions, or need to request an appeal.

❑ Research and Selection of Community Resources

The Caregiver Resource Center is familiar with and collaborates with a wide spectrum of care providers in the community. The case manager is available to assist a client and their family in researching desired services, scheduling informational meetings, and helping to conduct reference checks on perspective vendors.

❑ Successful Aging Action Plan

Our "Successful Aging Action " Program helps evaluate your current life situation, and creates a road map that addresses your current needs, while preparing you for potential future challenges.

Our strategies focus on health and mental health, case management and advocacy, home safety, transportation, and advance care planning to name a few

❑ Team Communication and Coordination

A care team is developed based on the unique needs of the client. Team members may consist of the client, family members, primary care physician, medical specialists (e.g. cardiologist, psychiatrist), rehab providers (e.g. physical therapist, occupational therapist, speech therapist), homecare agencies, or a registered nurse to name a few.

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

❑ Screening, Arranging for and Monitoring of Needed In-Home Care Services

The case manager is available to assist the client and their family in researching available services, scheduling interviews, helping check references, and helping to oversee homecare services in the home or in a facility such as an assisted living facility or SNF.

❑ Emergency Medical Advocacy

If it's necessary for the client to seek immediate medical attention, the client and/or their family need to call 911 for assistance. In a situation such as this, the case manager can be reached 24/7 after 911 has been called.

The case manager is available to meet the client at the emergency room to ensure that the attending physician has all of the medical history and current medications, as well as to provide the hospital staff with the proper family contact information.

The case manager would be available to provide comfort and support to the client, help facilitate the care process with medical professionals, communicate with family members who may be at a distance, and help the client understand the events as they are unfolding in the ER.

❑ Research, Selection, Evaluation, and Transition to Alternative Living Options

A person may decide that they would like to explore other housing options for a variety of reasons; such as they no longer need as much space, potential lower housing expenses the desire to move closer to family, proximity to needed services, more social contact, reduced responsibility for maintenance, or the need for greater day to day assistance.

The case manager is available to help research assisted living facilities, rehabilitation centers, hospitals, and nursing home facilities. The case manager can also arrange for tours of various facilities, and be available to accompany the client and a family on the tour. If desired, the case manager would be available to create a list of questions that can be asked during the initial visit, as well as assist the client in completing an application.

❑ Referrals to Specialists (e.g. medical, legal and financial professionals)

Since 1990, The Caregiver Resource Center has been building working relationships with a network of medical professionals, elder law attorneys, financial planners & advisors, and insurance professionals whom we can help you speak with for guidance and services.

❑ Family Support & Counseling

The case manager is available to provide education, support, guidance, and counseling for the client, for a family member, or for the family as a whole.

❑ Healthcare Advocacy

- Healthcare can often feel overwhelming and confusing. The case manager is available to:
  - assist the client in researching appropriate medical professionals
  - schedule medical appointments
  - arrange transportation for the client to medical appointments
  - accompany the client to medical appointments if desired
- Prior to a medical appointment the case manager would be available to:
  - meet with the client to compile a written list of symptoms the client may be experiencing, the longevity of symptoms, and questions that the client may have for their doctor
- During an appointment the case manager would be available to:
  - provide the doctor with the client's written list of symptoms, longevity of symptoms, and questions that the client may have for their doctor
  - take notes of the medical appointment for the client, and request a doctor's summary prior to leaving the appointment
  - provide the client (and family) with the written notes and doctor summary, and review the information with them to ensure a clear understanding of the information

The case manager is also available to provide hospital advocacy while a person is in the hospital, which would include communication with all medical personnel, and participation in the hospital's discharge planning meetings.

❑ Family Issue Mediation

We all have our own unique perspective on things, and as a result, we often believe that we know what's best. In a family situation, this may lead to disagreements and conflict.

The case manager would be available to facilitate family meetings, assist family members in communicating their concerns and wishes, and helping to resolve conflict; while building consensus on what is the best course of action for the client's health, safety, independence and quality of life.

References

When requested, a list of professional references would be provided to perspective clients and their family members.

Additional Information

For more information, or to request an initial consultation, please contact:

Linda Ziac, LPC, LADC, BCPC, CEAP, CCM, CDP
The Caregiver Resource Center
Greenwich, CT

203-861-9833

www.CaregiverResourceCenter.com

LindaZiac@CaregiverResourceCenter.com