Care Managers Help with Relocation

One of the important tasks the professional Care Manager performs is assisting our clients to relocate. Most often the move is from one level of care to another here in San Diego. More dramatic are the moves a substantial distance away from a long-established residence. Typically the need for long distance relocation is to be closer to family members when more care is needed.

Since we began Senior Care Management, Inc. in 1996, we have helped clients move to various locations: northern California, the Midwest, Northwest, even as far as Washington DC. In these cases, our job was to work ourselves out of the job - a role we assumed with pleasure, because it was in the client's best interest.

The Care Manager's responsibility is to help the client achieve maximum function and quality of life. This often means involving the support system as the client's abilities decline. In many instances, living nearby a relative who can act as an advocate is the best long range plan.

Timing is also important. Helping the client to determine *when* the best time to move is something a professional Care Manager can do. We evaluate the benefit of staying in familiar surroundings (with established doctors and friends) versus moving an entire household closer to a family member. You want to stay in the familiar setting as long as possible, but move while you are still can. It's a difficult balancing act and the professional Care Manager's experience can be invaluable.

No question about it - a move across the state or the country will be *disruptive.* There is no way around that fact. However, it doesn't have to be chaotic and disastrous. When the client's mental status is in decline, the effect of the move may be more pronounced. But on the other hand, when the memory isn't working, the client may more readily forget where s/he has been for years and be very accepting of the new situation. We have seen both extremes.

Here are a few tips we have found through our years of experience in long distance moves:

Find a Care Manager to help at the receiving end-

A Care Manager who lives in the community where the client is moving is a great asset. If the family is already accustomed to the services of a Care Manager, they will also appreciate the resources and support that a GCM will bring in the new home setting. Your current GCM may be familiar with someone on the receiving end because of the networking available at national conferences, but if not, the National Association of Professional Geriatric Care Managers (NAPGCM) maintains an outstanding website to assist in locating a GCM in the new community.

The local professional can assist in locating appropriate facilities or services. Additionally, the GCM will be able to partner with the client's GCM to make the move as stress-free for the client and the family. There will be lots of questions on both ends, and the local GCM is the best person to address these questions. Once the client is settled in her new home, there may be a reduced need for on-going care management. Every family is different. GCM's are always flexible about our involvement. We provide the service that is needed, not something that is dictated by outside forces.

Begin the planning months in advance

Once a decision has been reached that a move is necessary, much can be done before a date for the move is

determined. A household of many years will have boxes of "stuff" that can be discarded a little bit at a time. The sooner the junk starts being eliminated, the better for everyone. Clothes that don't find or are no longer useful can be donated. A weekly trip to Goodwill or the hospital thrift store can be a good goal.

Keep a "Move Notebook" and make lists every time bills are paid to trigger future notifications of services to be terminated or transferred. Begin to let physicians know that a move is being planned. Decide which medical services will be continued in the new location and provide those physicians with HIPPAA release forms to put together the medical records necessary for continuity of care. If the client is moving to a nursing facility, an appointment with the primary care physician will be required for paperwork within 30-days of admission. Consultant physicians will be asked for pertinent dictation.

Involve the client in decisions about the move as much as is appropriate -
If the person moving is cognitively intact, s/he should be involved in all decisions possible. This can be painful but the process of letting go at this stage will help in the relocation. Don't try to "protect" the client now from difficult decisions because the lack of involvement can resurface in on-going resentment and make settling in the new home more difficult. Also, it has been our experience that the older person can handle more emotional issues than the family may think. You may be surprised that Mom is ready to give away that box of Dad's old work clothes that she has held on to for years. The act of involving her in the decision reaffirms her value as a human being. Additionally, when the GCM is the objective third party that is posing some of the difficult questions, we don't bring our own emotional attachment to the box of Dad's things that would color the discussion from the beginning.

If the client is ***not*** cognitively intact, the questions will be different. The professional GCM will have information about what can be moved into the new residence and the client should be asked what s/he wants to have near.

Four categories for "stuff"- The client and the primary caregiver and can start thinking in terms of four categories:

1. Move with client;
2. Bequeath now;
3. Try to sell or donate;
4. Throw away.

Maintain the client's residence in an orderly state until the move-
The move may be imminent and boxes can be cleared out, but leave the big things to be moved *AFTER* the client is out of the house, as much as possible. This is particularly significant for the person in cognitive decline.

Use the valet services at the airport -
The transportation transitions can be some of the most stressful times of the move. The Care Manager can contact airport authorities to reserve valet and disabled services that prevent the client and the accompanying caregiver from being separated during the transfer from car to airport. The GCM can then arrange to have cars moved to more economical areas after the valet services have been utilized.

Allow a knowledgeable caregiver to orient new caregivers-
Involve the current caregiver in the move to assist new caregivers in the nuances of the client's care. If the caregiver can't actually travel to the new location, the family needs to invest significant time (taking written notes) regarding how s/he reacts to difficult situations; how the caregiver has managed difficult physical tasks; generally, how life has been managed 24 hours a day. Of course, the cognitively intact client can greatly assist with this - but most people who need to move closer to family are doing so because s/he can no longer advocate adequately for him/herself.

To summarize, utilizing the knowledge and experience of the professional Geriatric Care Manager can be one way

to help a move be a gentle transition and not a chaotic dislocation!

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