



CARE PLANNING & AVAILABLE RESOURCES

ADRC Participant Appreciation Day
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OBJECTIVES

- Assess for care needs
- Develop a care plan
- Identify and access available resources



What's Next: After the Diagnosis

- **Assess needs** of the current situation
- Form the **Care Team**
- **Develop a plan**
- **Take Action**



ASSESS NEEDS OF THE CURRENT SITUATION

- Biggest concern at this time?
- Other medical conditions?
- Current living situation?
- Advance Health Care Directives?



ASSESS NEEDS OF THE CURRENT SITUATION

- What can your loved one still do for themselves?
 - **Activities of Daily Living (ADLs):** Bathing, Dressing, Grooming, Toileting, Transferring, Feeding, Ambulating
 - **Instrumental Activities of Daily Living (IADLs):** Shopping, Meal Preparation, Housecleaning and Home Maintenance, Manage Finances, Manage Medications, Manage Communication (telephone, mail), Transportation

ASSESS NEEDS OF THE CURRENT SITUATION

- Exercise and Physical Activity
- Well-Being:
 - **Identity** – having personhood; individuality
 - **Growth**- enrichment; opportunities to evolve
 - **Autonomy**- freedom; independence
 - **Security**- free of anxiety and fear; dignity
 - **Connectedness**- belonging; engaged support system, socialization
 - **Meaning** – purpose; significance; value
 - **Joy**- happiness; contentment; enjoyment

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ASSESS NEEDS OF THE CURRENT SITUATION

- What is your families' understanding of the disease and disease process?
- Has your loved one and family discussed potential future plans?
- What support structure is in place for you or the primary caregiver?



FORM YOUR TEAM: Who Should Be Included?

- **The person you are caring for!**
- **Who can you rely on?**
 - Family Members
 - Friends
 - Neighbors
- **Important Team Members:**
 - Medical Providers- Doctors, Nurses, Therapists, Social Workers
 - Dementia Specialists
 - Geriatric Care Managers
 - Elder Law Attorneys
 - Financial Planners
 - Caregiving Agencies
 - Adult Day Programs



DEVELOP A PLAN

1. Structured daily schedule

- Meaningful engagement
- Cognitive stimulation
- Healthy Diet
- Exercise
- Proper sleep hygiene

2. Home, personal, and driving safety

- Medication management
- DME/home modifications
- ERS
- Transportation



DEVELOP A PLAN

3. Advance Care Planning:

- Advance Health Care Directives (Living Will, Trust, Durable Power of Attorney for Health Care and Finances)

4. Palliative Care or Hospice Care

5. Support for the Care Partner

- Education
- Support Groups
- Respite care
- Quality sleep
- Health Needs



DEVELOP A PLAN

6. Connect with Resources:

- | | |
|--|--|
| ▪ Geriatricians (primary care or consult) | ▪ DME and Home Modifications |
| ▪ Social Services- MSSP, IHSS | ▪ Medication Management |
| ▪ Geriatric Care Managers | ▪ Transportation |
| ▪ Dementia Specialists | ▪ Senior Living- Independent Living, Assisted Living, Memory Care, Board and Care, SNF |
| ▪ Social Workers/Therapists | ▪ Respite Care |
| ▪ Home Health and Home Care Agencies | ▪ Hospice Care |
| ▪ Adult Day Programs | ▪ Palliative Care |
| ▪ Legal/Financial- Attorneys, Financial Planners, Bill Paying Services | |
| ▪ PT/OT/ST | |
| ▪ Meal Delivery | |



TAKE ACTION

- Implement your Care Plan
- Be flexible
- Ask for help – Free Services at Stanford

Aging Adult Services

www.stanfordhealthcare.org/agingadultservices

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