



ANTICIPATORY CARE PLANNING

What it means and how to build a plan for future care

After An Alzheimer's Diagnosis

- It is normal to feel a wide range of feelings and emotions including:
 - Anxious
 - Overwhelmed
 - Denial
 - Angry
 - Sad
 - Relieved



**Focus on the things
we have control over:**

The thoughts we think
The images we visualize
and the actions we take

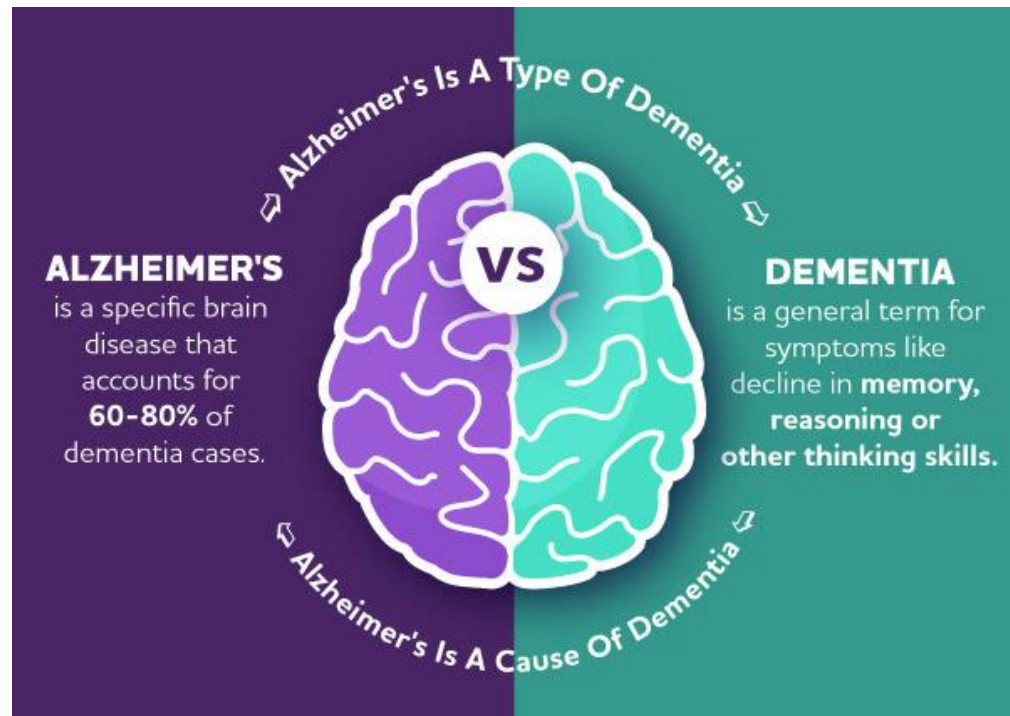
Jack Canfield

Knowledge is Power

- Learn as much as you can about the disease and what to expect.
- People and places to gather information:
 - Center for Excellence in Alzheimer's Disease
 - Healthcare providers
 - The Alzheimer's Association
 - National Institute on Aging

Dementia & Alzheimer's

- A progressive neurodegenerative condition that worsens over a number of years
- There is no cure for Alzheimer's disease or other related dementias, and they are ultimately fatal.
- In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment. On average, a person with Alzheimer's lives 4 to 8 years after diagnosis but can live as long as 20 years, depending on other factors.



<https://www.alz.org/alzheimers-dementia/what-is-alzheimers>

Build The Care Team

- If a primary healthcare provider is unable to answer questions or someone is interested in a second opinion, a referral to a specialist can be requested.
- Identify a care partner- someone to support a person on their journey and coordinate care on their behalf.
- Doctors, NPs, PAs
- Nurses
- Social Workers
- Mental Health providers
- Community support organizations

Anticipatory Care Planning (ACP)

- Sometimes referred to as Advance Care Planning.
- Helps adults at any age or stage of health understand and share their personal values, life goals, and preferences regarding future medical care.
- It is a gift you give your loved ones who might otherwise struggle during a medical emergency to make choices about your care.
- It is not a single decision but rather a process that occurs over the lifespan.

<https://www.uclahealth.org/programs/advance-care-planning/what-acp#whatisacp>

ADVANCE CARE PLANNING (ACP)?



WHAT

ACP is the process of planning for future health and personal care needs.



WHY

ACP allows you to be cared for according to your wishes and values.



WHO

ACP is for everyone, regardless of age and health condition.



WHEN

Best done when a person is healthy and of sound mind. ACP can be revised later.



NINKATEC

Right at home

Five Myths About Advance Care Planning

Get the facts about these common advance care planning myths.

Myth

I only need a plan if I'm very old or ill.



Fact

It's impossible to predict the future. An emergency can happen at any age. Creating a plan now helps ensure that someone you trust can make decisions that reflect your wishes.

Myth

My loved ones will know what I want when the time comes.



Fact

Not necessarily. In one study, nearly 1 in 3 people guessed wrong when asked to predict which end-of-life decisions their loved one would make.

Myth

I need a lawyer to create an advance care plan.



Fact

Most states offer free advance directive forms online, and you do not have to involve a lawyer.

Myth

An advance care plan only matters if I put it in writing.

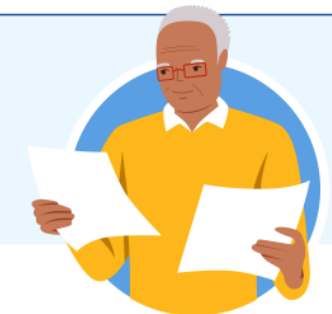


Fact

The most important part of planning is discussing your wishes with your loved ones. It can save them from worrying about whether they made the right decisions for you.

Myth

Once I put my plans in writing, I can't change them.



Fact

Your advance directives can be changed at any time. In fact, you should review your plans at least once a year and after any major life event like a move, divorce, or change in your health.

Ready to get started?

<https://www.nia.nih.gov/health/advance-care-planning>

Determining Goals for Care

- **Think**

- What are the treatment and care options?
- What types of decisions may need to be made?
- What is important to the patient?
- What would they like to have happen or not happen if they became unwell?

- **Talk**

- With Family and Friends about wishes.
- Identify someone to become a health care proxy and Power of Attorney. This does not need to be the same person.

Determining Goals for Care

- **Record**

- Write down wishes
- Complete Health Care Proxy
- Living Will
- MOLST
- Power of Attorney

- **Discuss**

- With care team.
- Make wishes known and update care plan throughout journey as needed.

- **Share**

- Store paperwork in a safe space
- Provide copies to those appointed to act of someone's behalf

HCP, MOLST, POA

- **Health Care Proxy (HCP):** A document that allows you to appoint someone to make healthcare decisions on your behalf in the event you are unable to make decisions for yourself.
- **Medical Orders for Life Sustaining Treatment (MOLST):** A way of documenting a patient's treatment preferences concerning life-sustaining treatment. Discusses things such as Cardiopulmonary Resuscitation, Intubation, Artificial Nutrition and Hydration.
- **Power of Attorney (POA):** A legal document appointing someone to make legal and financial decisions on your behalf.

Get Help As Needed

- What type of assistance would be helpful?
 - Assistance with IADLs such as cooking, cleaning, running errands, managing finances.
 - Assistance with ADLs such as bathing, dressing, and other personal care
 - Companionship: someone to provide supervision and oversight to a patient. Engagement in activities suited to a person's cognitive and functional status.
 - Day Programming: a place where patients go to receive supervision, assistance with ADLs, and participation in activities typically available during working hours.
 - Respite programs through Office for Aging, Veteran Services, and other community agencies.

Get Help As Needed

- Independent, Enriched, & Assisted Living Facilities
- Skilled Nursing Facility
- Hospice
- Mental and emotional support through local caregiver support groups.
- Care Managers
- Alzheimer's Association 24/7 helpline- 1-800-272-3900.



QUESTIONS?

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