



Planning for Future Medical Care Needs

Tara Ackley, LVN, CMC

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✉ Tara@AgeWellCC.com



*Trusted by families
across Orange County*

Tara Ackley, LVN, CMC

Expert Geriatric Care Manager
20+ Years Experience

Clarity. Advocacy. Peace of Mind.
Support for Navigating the Care
Needs of Older Adults.

What I Provide:

- ✓ Care Coordination & Advocacy
- ✓ Crisis Navigation
- ✓ Aging-in-Place Planning
- ✓ Medications & Medical Guidance
- ✓ Family Support & Communication

Experience You Can Trust. Compassion You Can Feel.

With over 20 years of professional and personal care manager experience, I offer a whole-person approach to care for older adults. I bring clinical expertise and compassionate guidance to help families find peace of mind as they navigate the challenges of aging and caregiving.

You Don't Have to Navigate This Alone.

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🌐 www.AgeWellCC.com
📍 Serving all of Orange County



What is a Geriatric Care Manager and what service do they offer?



A Geriatric Care Manager is a licensed professional with experience, knowledge and expertise on issues related to:

- ✓ Geriatric Health
 - ✓ Quality of Life
 - ✓ Serious Illness or Disability
 - ✓ Navigating Changes Associated with Aging
 - ✓ Offer Support to Families and Caregivers
- 

The Value of Geriatric Care Management



The Senior Care Ecosystem

Coordinating Care for Older Adults



How a Geriatric Care Manager Helps

Navigate the Complex Journey of Aging with *Confidence and Support*



**Assess Needs
& Create a Plan**



**Coordinate
Medical Care**



**Manage
Medications**



**Navigate
Senior Living
Options**



**Advocate
at Appointments
& Hospitals**



**Support
Family
Caregivers**



**Plan for
the Future**



**Provide
Peace of Mind**

Tara Ackley, LVN, CMC, CDP
Your Trusted Care Advocate



Age Well
Care Consultants



Reduce Stress



Save Time

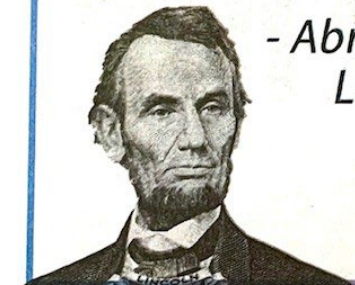


**Make Informed
Decisions**



Ensure Quality Care

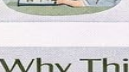
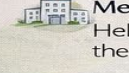
**"In the end,
it's not the years
in your life that
count.
It's the life in
your years."**



**- Abraham
Lincoln**

Who Is Managing Your Loved One's Care?

Understanding the Difference

Medical Nurse Case Manager	Private Nurse Care Manager
Who They Work For  Hospital, insurance company, or healthcare system	Who They Work For  The client and their family
Primary Focus  Cost control, discharge planning, and medical necessity	Primary Focus  Comprehensive care coordination, advocacy, and quality of life
When They Are Involved  During hospital stays or short-term medical episodes	When They Are Involved  Ongoing, before, during, and after health changes
Length of Involvement  Short-term, episodic	Length of Involvement  Long-term, continuous support
Role in Decision Making  Follows system guidelines and insurance policies	Role in Decision Making  Provides personalized recommendations based on client needs
Advocacy  Represents the healthcare system or payer	Advocate  Advocates for the senior and family
Care Coordination  Focused on immediate medical needs and discharge	Care Coordination  Home care, assisted living, memory care, medical appointments
In Simple Terms:  Medical Nurse Case Manager Helps manage, care within the healthcare system  Private Nurse Care Manager Helps families navigate, everything outside and beyond the healthcare system	Why This Matters for Families ✓ continuity of care ✓ personalized attention ✓ advocacy ✓ peace of mind 

CARE CONNECTIONS OVER TIME

HOW CARE CHANGES AS NEEDS INCREASE



Find a Local Care Manager

Visit www.AgingLifeCare.org

The website of the **Aging Life Care Association**,
to find a qualified Care Manager in your area.



The **Aging Life Care Association** helps families:

- ✓ Assess needs and create care plans
- ✓ Coordinate and manage care services
- ✓ Provide guidance and support
- ✓ Monitor evolving situations

Search by **ZIP Code** to find a professional near you.

AGING (i)fe CARE®
A S S O C I A T I O N
———— **MEMBER** ————

Understanding Acute, Skilled Nursing, and Custodial Care



Acute Care	Skilled Nursing Care	Custodial Care
Stabilize the Crisis	Recover & Rehabilitate	Support Daily Living
✓ Hospital & ER ✓ 24/7 Intensive Medical Attention ✓ Provided by Doctors & Specialists	✓ Skilled Nursing Facility or Rehab Center ✓ Medical Rehab & Monitoring ✓ Provided by Nurses & Therapists	✓ Home/Assisted Living ✓ Help with ADLs (Bathing Dressing etc.) ✓ Typically Provided by Aides

Each type of care plays a crucial role in the care continuum, addressing different needs at various stages of illness or recovery.

Presented by
Tara Ackley, LVN, CMC

Understanding Activities of Daily Living (ADLs)



ADLs are basic self-care tasks that are essential for daily self-maintenance and independence.
Including Cognitive Impairment/Dementia



Understanding Medicare

What Does Medicare Cover?



Medicare Part A
(Hospital Insurance)

- ✓ Inpatient Hospital Care
- ✓ Skilled Nursing Facility Care
- ✓ Hospice Care



Medicare Part B
(Medical Insurance)

Medicare Part B (Medical Insurance) Covers:

- Doctor visits
- Outpatient care
- Preventive services
- Durable medical equipment
- Lab tests
- X-rays and imaging
- Ambulance services
- Mental health care



Medicare Part C
(Medicare Advantage)

- ✓ Medicare Advantage Plans
- ✓ Combines Parts A & B
- ✓ May Offer Additional Benefits
- ✓ Managed by Private Insurers



Medicare Part D
(Prescription Drug Coverage)

Monitoring ADLs is crucial for ensuring proper support and planning for care needs over time.

Go to website:
www.Medicare.Gov

Also, Medicare assistance is provided by:

The State Health Insurance Assistance Program (SHIP)
Offers free, personalized, and unbiased counseling to Medicare beneficiaries, families, and caregivers across the U.S.

www.shiphelp.org

Call (877) 839-2675



Health Insurance Counseling & Advocacy
Program (HICAP)

www.coasc.org
(714) 560-0424

A local public resource where you can speak with an
unbiased community volunteer with knowledge and facts
about all types of Medicare insurance plans.

This program is offered by the Council On Aging
Address: 2 Executive Circle, Suite 175, Irvine, CA 92614

**The
Council On Aging
is your local resource.**

The Trusted Resource Guide for Older Adults and Their Families

2025-26

answers.

www.coasc.org

**Rita
Moreno**
Aging with
Rhythm & Style



• Healthcare & Wellness • Aging My Way • Fraud Protection • Caregiver Resources

RESOURCES FOR
HEALTHCARE | CAREGIVING | HOUSING
FINANCE | LEGAL | AGING | COMMUNITY

 **caregiver OC**
RESOURCE CENTER

 **PUBLISHED BY
Council on Aging**
Southern California



Ways To Cover the Costs of Custodial Care

Criteria for proving the need for care often includes:



Purchase a LTC Policy

- Has risk and benefit



Self-Insure

- Requires net worth
- Cash flow



Move In with Family Members



Apply for Veteran Benefits

(Aide and Attendant)



Apply for State Welfare

Government Program
(Medi-Cal)



Understanding Acute, Skilled Nursing, and Custodial Care Progression of Care



Presented by Tara Ackley, LVN, CMC

Who pays for each level of care?

Families often face confusing decisions about care...

I can help you navigate options and understand what coverage is available.



Why Activities of Daily Living (ADLs) Matter

ADLs are fundamental self-care tasks that impact a person's ability to live independently.



Key Measure of Independence

Difficulty with ADLs is a primary indicator that caregiver support is needed.



Eligibility for Assistance

Ability to manage ADLs is used to determine qualifications for long-term care services and financial aid programs.



Quality of Life

Help with ADLs maintains dignity, reduces stress, and improves life satisfaction.



Health and Safety

Inability to perform ADLs can lead to health decline and increased risk of falls or injuries.



Care Planning

Assessing ability to perform ADLs helps to develop personalized care plans and identify the right level of care.

Monitoring ADLs is crucial for ensuring proper support and planning for care needs over time.

Medi-Cal Qualification Criteria in California

To qualify for Medi-Cal, you must meet the following criteria:

- ✓ Be a California resident.
- ✓ Be 65 years of age or older, blind, or disabled.
- ✓ Have limited income, typically below \$1,642 per month for individuals (as of 2024).
- ✓ Have limited assets, typically below \$2,000 for individuals (excluding a home, vehicle, and essential personal belongings).
- ✓ Be a U.S. citizen or a qualifying resident alien.
- ✓ Meet specific medical needs requiring long-term care or assistance.



www.AgeWellCC.com



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Advance Care Planning
for your future medical
and care needs can
reduce stress, ensure
autonomy, support your
wishes, desires and
quality of life.



What is Advance Care Planning for Life and Healthcare Decisions?



Advance Care Planning is focused on making a plan for choosing a specific person, whom you trust has the capacity to represent you if and when an unfortunate event occurs that leaves you unable to communicate your wishes and desires.

This carefully chosen person(s) is **legally assigned** and made legally responsible for carrying out **decisions and actions** that support your directives for your healthcare, quality of life, and also for overseeing your **finances and estate**.

The action for **setting up your legally appointed person, in advance**, empowers you to **maintain control** even if you become unable to communicate, assures autonomy and control for making difficult decisions regarding you and your estate.



The 5 Conversations Families Should Have Before a Crisis



1 Wishes & Healthcare Preferences

- What life-sustaining treatments do love ones **want**?
- Where do they want to **receive care**?
- What will best support their comfort and **dignity**?



2 Power of Attorney for Healthcare

- Choose a trusted person to make healthcare decisions.
- **Select** a backup decision **maker**
- Discuss wishes with decision **makers**



3 Financial & Legal Preparations

- Prepare a will, living trust, or POLST/DNR
- Establish durable power of attorney for finances
- Organize financial, insurance & legal documents



4 Living Situation & Care Needs

- Plan for in-home care or facility if needed
- Discuss how to pay for long-term care
- Assess mobility, safety, and daily living needs



5 Legacy & End-of-Life Planning

- Talk about end-of-life wishes & preferences
- Important accounts and passwords
- Property and asset instructions



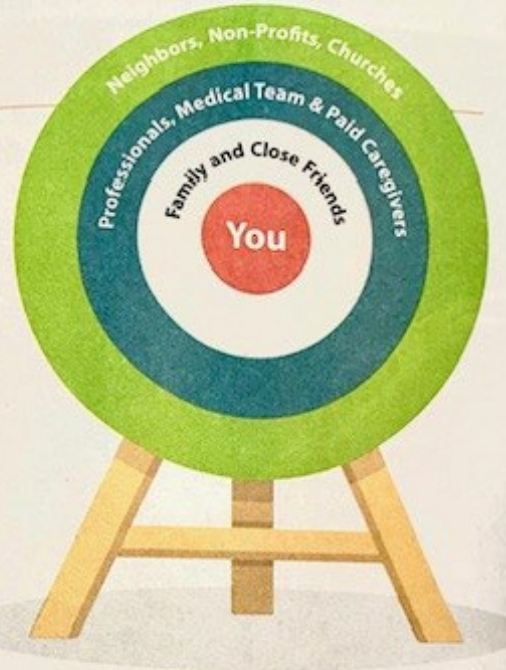
These conversations can bring families peace of mind, reduce uncertainty, and ensure loved ones are cared for according to their wishes.

Assembling Your Care Team

As you get older, it is important to have a trusted care team to collaboratively support your health and well-being. Your team should include loved ones, friends, and professionals. Care team members can provide a range of help including transportation, bill paying, cooking, medication management, advocacy, appointment scheduling, emotional/social support and personal care. Consider forming your care team before a crisis occurs.

Tips for Assembling Your Care Team:

- ▶ Consider their availability & energy
- ▶ Identify their strengths & weaknesses
- ▶ Consider your trust and relationships with them
- ▶ Reflect on how family dynamics might impact everyone
- ▶ Ask each member if they are willing to participate and in what capacity
- ▶ Consider how you and the team will collaborate together
- ▶ Choose those who will implement your Aging *My Way* plan, providing you with confidence and peace of mind



Schedule a time to meet with your care team

Initiate heart-to-heart conversation(s) with your care team. Help them understand your needs, expectations and how they can collaboratively support you.

For more information, visit:
Have a Family Meeting on page 38
in this Answers guide.
Visit: www.coasc.org/program/answers/

Your advance planning should include having meaningful conversations with your primary caregiver, family, and your person of choice who you give permission to speak on your behalf should you become incapacitated.

Give serious consideration to what is really important to you in the way you want to be medically treated, and how you do not want to be medically treated.

The ‘**Your Way**’ workbook, made available by **H.E.L.P** is designed to help you have these conversations with others.

Go to <https://www.help4srs.org/your-way>
Call (310) 533-1996 to request a free copy.

Understanding Power of Attorney



Healthcare Power of Attorney



- ✓ Makes Medical Decisions
- ✓ Chooses Treatment Options
- ✓ Manages Health Care



Health & Care Decisions

Financial Power of Attorney



- ✓ Handles Finances
- ✓ Manages Investments
- ✓ Pays Bills & Expenses



Financial & Asset Decisions

ADVANCE HEALTH CARE DIRECTIVE CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE (Appointing an Agent to Make Health Care Decisions)

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP. YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

My name is: _____

My address is: _____

In this document, I appoint one or more agents to make health care decisions for me. **My agent's authority shall begin immediately, even though I currently have the mental capacity to make my own health care decisions. (If I check here, my agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions).**

The following persons cannot be selected as your agent or alternate agent:

- Your primary physician.
- The operator of a community care facility or residential care facility where you receive care.
- An employee of the health care institution, community care facility or residential care facility where you receive care (unless you are related to that person, the person is your registered domestic partner, or you and the person are employed by the same facility or institution).

AGENT

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

2ND ALTERNATE AGENT (If Agent and 1ST Alternate Agent are unavailable or unwilling to serve.)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

**Sources for obtaining
an Advance Health Care Directive document:**

CA Medical Association

<https://www.cmadocs.org>

1-800-786-4262

State of CA Dept. of Justice

<https://oag.ca.gov>

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #, (optional)

A CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

- ☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

- ☐ **Full Treatment** – primary goal of prolonging life by all medically effective means.

In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

- ☐ **Trial Period of Full Treatment.**

- ☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome measures.

In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

- ☐ **Request transfer to hospital only if comfort needs cannot be met in current location.**

- ☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort.

Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

- Discussed with:** ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:

- ☐ Advance Directive not available

- ☐ No Advance Directive

Name: _____

Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: _____

Physician/NP/PA Phone #: _____

Physician/PA License #, NP Cert. #: _____

Physician/NP/PA Signature: (required) _____

Date: _____

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: _____

Relationship: (write self if patient) _____

Signature: (required) _____

Date: _____

Mailing Address (street/city/state/zip): _____

Phone Number: _____

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

Physician Orders For Life-Sustaining Treatment (POLST)

www.capolst.org

This document is a legal document in the form of a physician's order which supersedes any Advance Directive for Healthcare.

What is Palliative Care and Hospice Care? And How Do They Differ?

Palliative Care

Palliative Care provides relief from symptoms, pain, and stress of a serious illness at any stage of the illness. It can be **provided** alongside curative treatment and is appropriate for those with chronic or life-limiting conditions who need support to improve quality of life.

Key Differences:

- Palliative care can be provided at any stage of a serious illness, for those undergoing active treatment.
- Hospice care is specifically for the end-of-life stage when curative treatment is no longer pursued.
- Hospice focuses on comfort care and quality of life, while palliative care can be provided alongside curative treatments.

Hospice Care

Hospice Care is designed for patients with a terminal illness who are nearing the end of life, typically with a prognosis of six months or less. The focus is on comfort care and quality of life, without curative treatment, aimed at making the patient as comfortable and peaceful as possible in their final months.

Coalition for Compassionate Care of California

Website: www.CoalitionCCC.org



Resource:
National Hospice and Palliative Care
Organization
www.nhpco.org

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