Age Well
Care Consultants

Planning for Future Medical Care Needs

Tara Ackley, LVN, CMC
(949) 878-5466
Tara@AgeWellCC.com

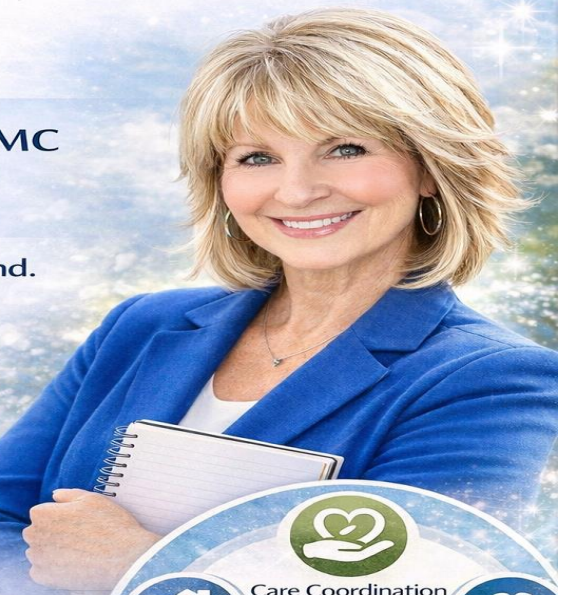
Age Well
Care Consultants

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.

(949) 878-5466
Tara@AgeWellCC.com
www.AgeWellCC.com
Serving all of Orange County

Age Well
Care Consultants

Planning for Future Medical Care Needs

Tara Ackley, LVN, CMC
(949) 878-5466
Tara@AgeWellCC.com

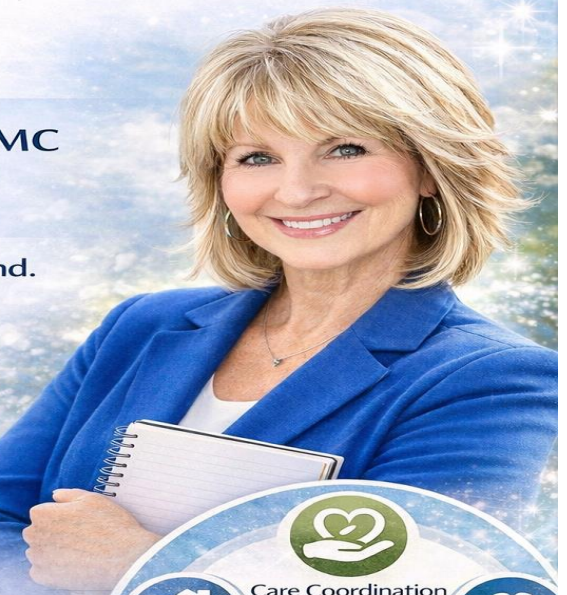
Age Well
Care Consultants

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.

(949) 878-5466
Tara@AgeWellCC.com
www.AgeWellCC.com
Serving all of Orange County

New health conditions can develop along the way while managing other issues related to chronic illness, medications can increase, visits with physicians and specialists become more frequent, staying on top of managing symptoms such as pain, fatigue, limited mobility, or cognitive changes can become quite a burden.

And navigating a very complex healthcare system only makes the aging process more of a struggle.

Gaining clarity and understanding about the importance of being prepared and having plans in advance can offer much support for the journey.

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
Stability
Peace of Mind
Advocacy
Expertise
Dignity
Quality of Life
Compassion
Respect


The Senior Care Ecosystem
Coordinating Care for Older Adults
Primary Care Physician
Specialists
Healthcare Providers
Adult Children
Spouse & Family Caregivers
Family Support
Geriatric Care Manager
Home Care & Therapists
Friends
Professional Advisors
Senior Living & Community Resources
Tara Ackley, LVN, CMC, CDP
Geriatric Care Manager
Elder Law Attorney
Assisted Living
Wealth Manager / Fiduciary
Memory Care
Estate Planner
Community Services
Hospitals & Rehab
Age Well
Care Consultants

How a Geriatric Care Manager Helps

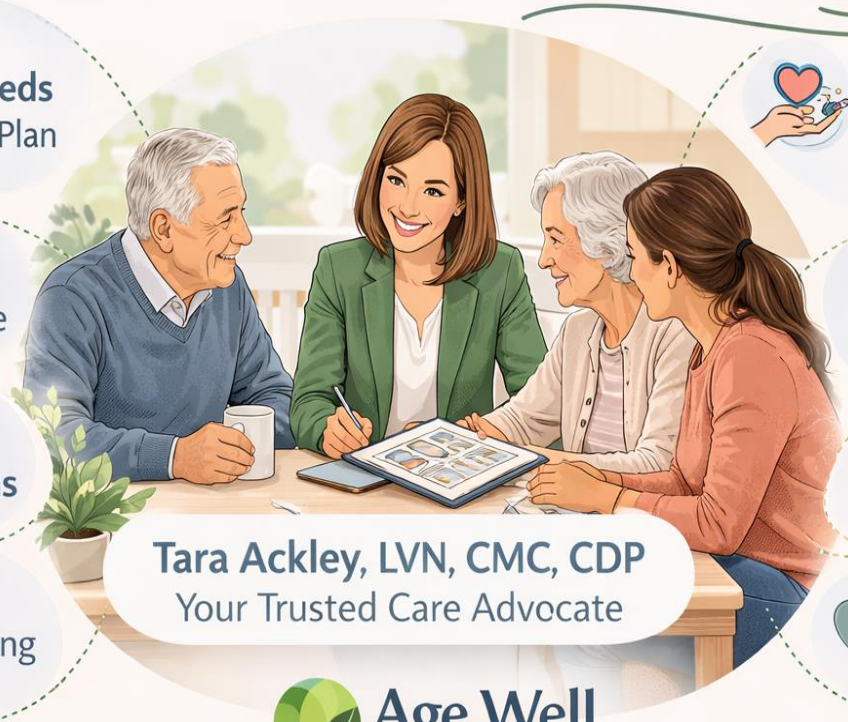
Navigate the Complex Journey of Aging with *Confidence and Support*

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

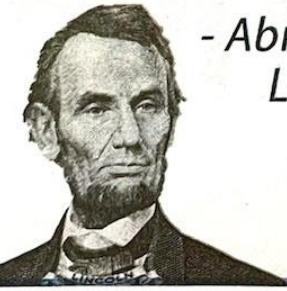
Tara Ackley, LVN, CMC, CDP
Your Trusted Care Advocate

Age Well
Care Consultants

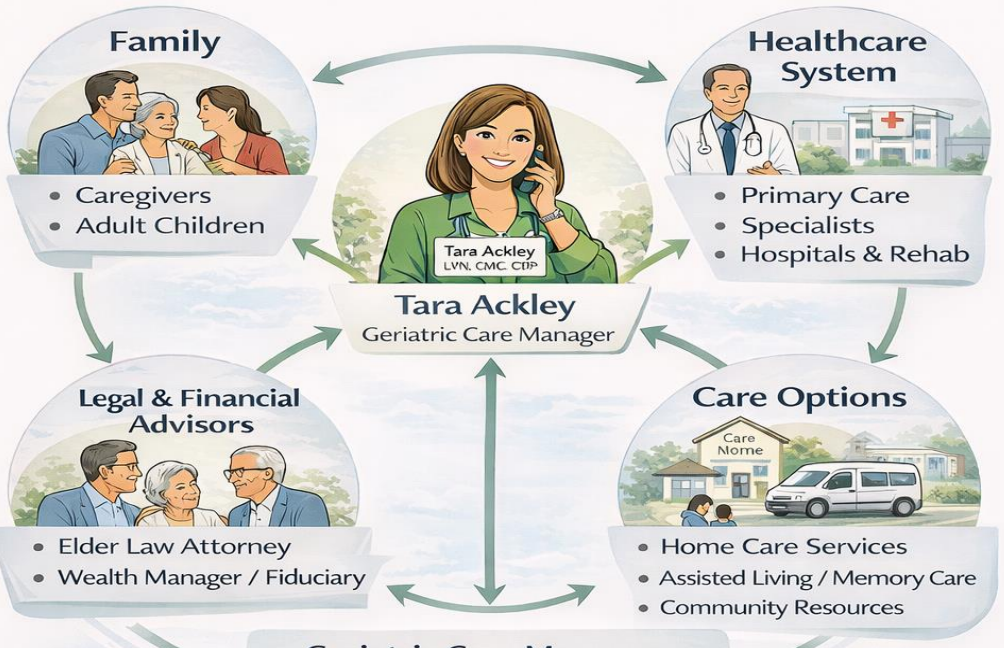
Reduce Stress | Save Time | Make Informed Decisions | Ensure Quality Care

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

- Abraham Lincoln



How a Geriatric Care Manager
Helps Families Navigate the Senior Care System



Geriatric Care Manager:

- ✓ Expert Guidance
- ✓ Compassionate Advocacy
- ✓ Coordinated Care

Age Well
Care Consultants
Guidance through the Journey of Aging

Who Is Managing Your Loved One's Care?

Understanding the Difference

Medical Nurse Case Manager	Private Nurse Care Manager
Who They Work For	**Who They Work For**
Hospital, insurance company, or healthcare system	The client and their family
Primary Focus	**Primary Focus**
Cost control, discharge planning, and medical necessity	Comprehensive care coordination, advocacy, and quality of life
When They Are Involved	**When They Are Involved**
During hospital stays or short-term medical episodes	Ongoing, before, during, and after health changes
Length of Involvement	**Length of Involvement**
Short-term, episodic	Long-term, continuous support
Role in Decision Making	**Role in Decision Making**
Follows system guidelines and insurance policies	Provides personalized recommendations based on client needs
Advocacy	**Advocate**
Represents the healthcare system or payer	Advocates for the senior and family
Care Coordination	**Care Coordination**
Focused on immediate medical needs and discharge	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

Age Well
Care Conaultants

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.

AGING (ife CARE®
ASSOCIATION
MEMBER

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 (ife CARE®
ASSOCIATION
MEMBER

A Roadmap for Aging Well

- ✔ Understand wants, wishes and needs
- ✔ Understand tools and resources for aging in place

- ✔ Review health and medical needs
- ✔ Review financial sustainability

- ✔ Establish legal documents to protect decisions and assets
- ✔ Review health and medical needs

Aging in Place :
What Families Need To Know

1 Assess Needs & Preferences

- Evaluate health, mobility, and daily living needs
- Discuss preferences for aging at home
- Create a personalized care plan

2 Create a Safe Home Environment

- Adapt home for safety and accessibility
- Reduce fall risks and add grab bars or ramps
- Medical alert systems for emergencies

3 Coordinate In-Home Care

- Find trusted home care aides
- Arrange help with bathing, dressing, meals, etc.
- Schedule home health visits if needed

4 Plan for Healthcare Needs

- Choose primary care and specialist doctors
- Review medications and health conditions
- Arrange transportation for appointments

5 Manage Finances & Legal Issues

- Plan for costs of in-home care
- Ensure wills and powers of attorney are in place
- Organize important documents and keys

Aging in place requires planning and support so seniors can live safely and independently in their homes.

Understanding Acute, Skilled Nursing, and Custodial Care

Acute Care	Skilled Nursing Care	Custodial Care
Stabilize the Crisis	Recover & Rehabilitate	Support Daily Living

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

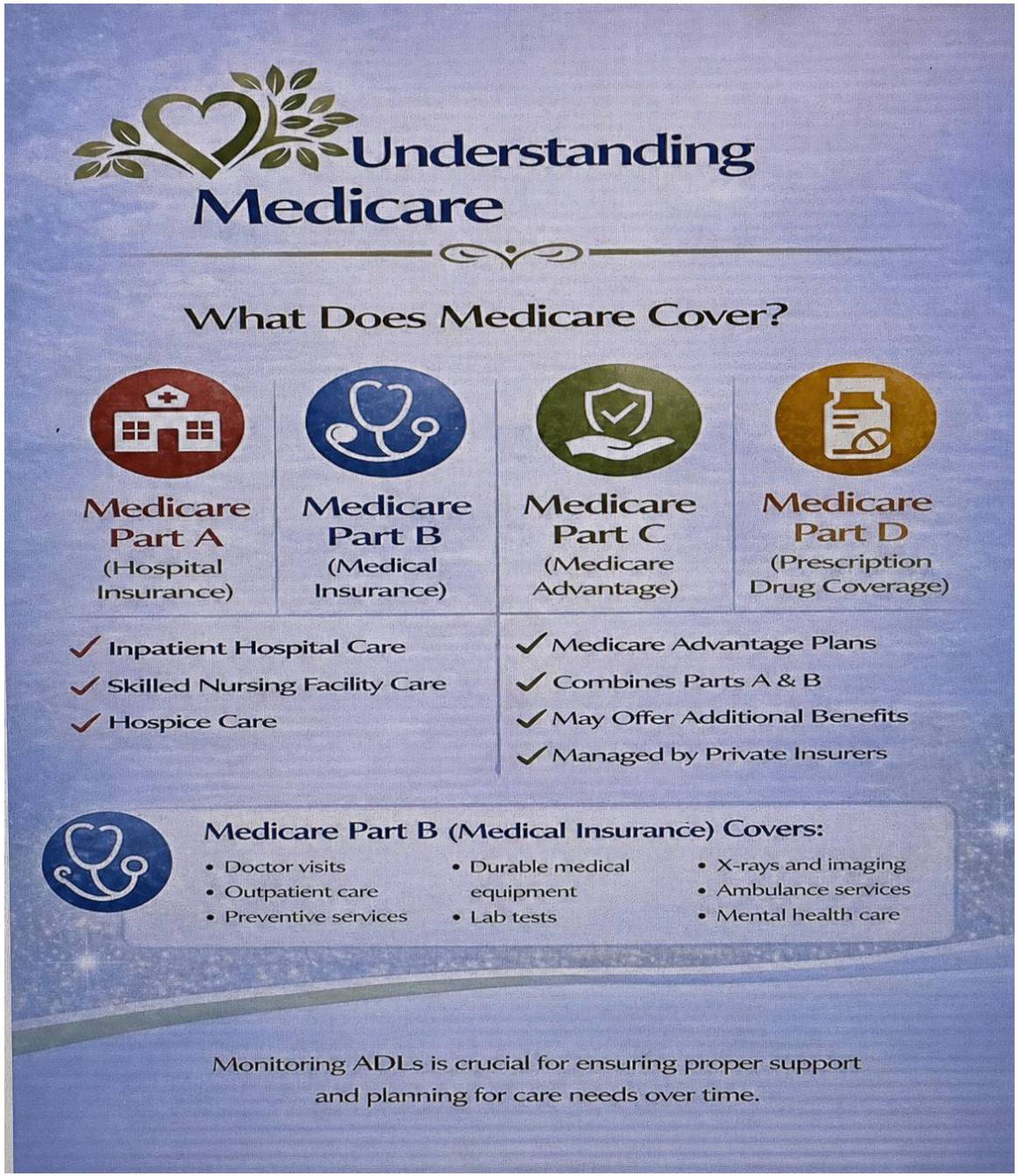
Each type of care plays a crucial role in the care continuum, addressing different needs at various stages of illness or recovery.

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



Go to website:

www.Medicare.Gov

Here is where you can find everything you need to know about your Medicare benefits.

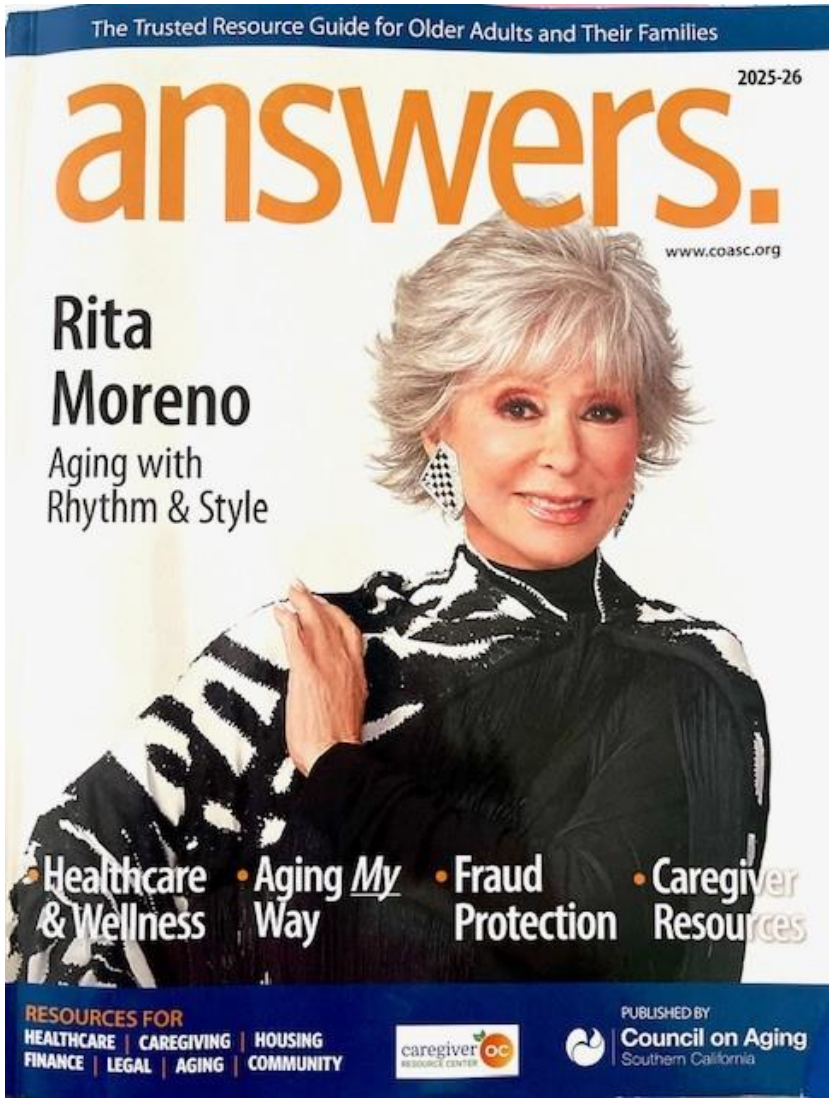
Health Insurance Counseling & Advocacy Program (HICAP)

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.



Places for Custodial Care

Home

Board & Care Home

Assisted Living

Assisted Living

Nursing Home

Places for Skilled Care

Hospital

Rehabilitation Facility

Home Health Care

Understanding *Acute, Skilled Nursing,* and Custodial Care

Progression of Care

Acute Care	Skilled Nursing Care	Custodial Care
Hospital	Rehab Center	Home/ALF
Stabilize a Serious Medical Issue	Recover and **Rehabilitate**	Support Daily Living Long-Term
✓ Hospital & ER	✓ **Skilled Nursing** Facility or Rehab Center	✓ Home or Assisted Living Setting
✓ 24/7 Intensive Medical Attention	✓ Medical Rehab & Monitoring	✓ Help with ADLs (Bathing, Dressing, etc.)
✓ Provided by Doctors & Specialists	✓ Provided by Nurses & Therapists	✓ Typically Provided by Aides

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.

Medicare

Medi-Cal

Private Pay

Age Well
Care Consultants

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 Bencfits
(Aide and Attendant)

Apply for State Welfare
Government Program
(Medi-Cal)

Understanding *Activities of Daily Living* (ADLs)

ADLs are basic self-care tasks that are essential for daily self-maintenance and independence.

Note: Includes Cognitive Impairment/Dementia

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 | Tara@AgeWellCC.com

Your Advance Planning 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 deires.

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.

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: _____

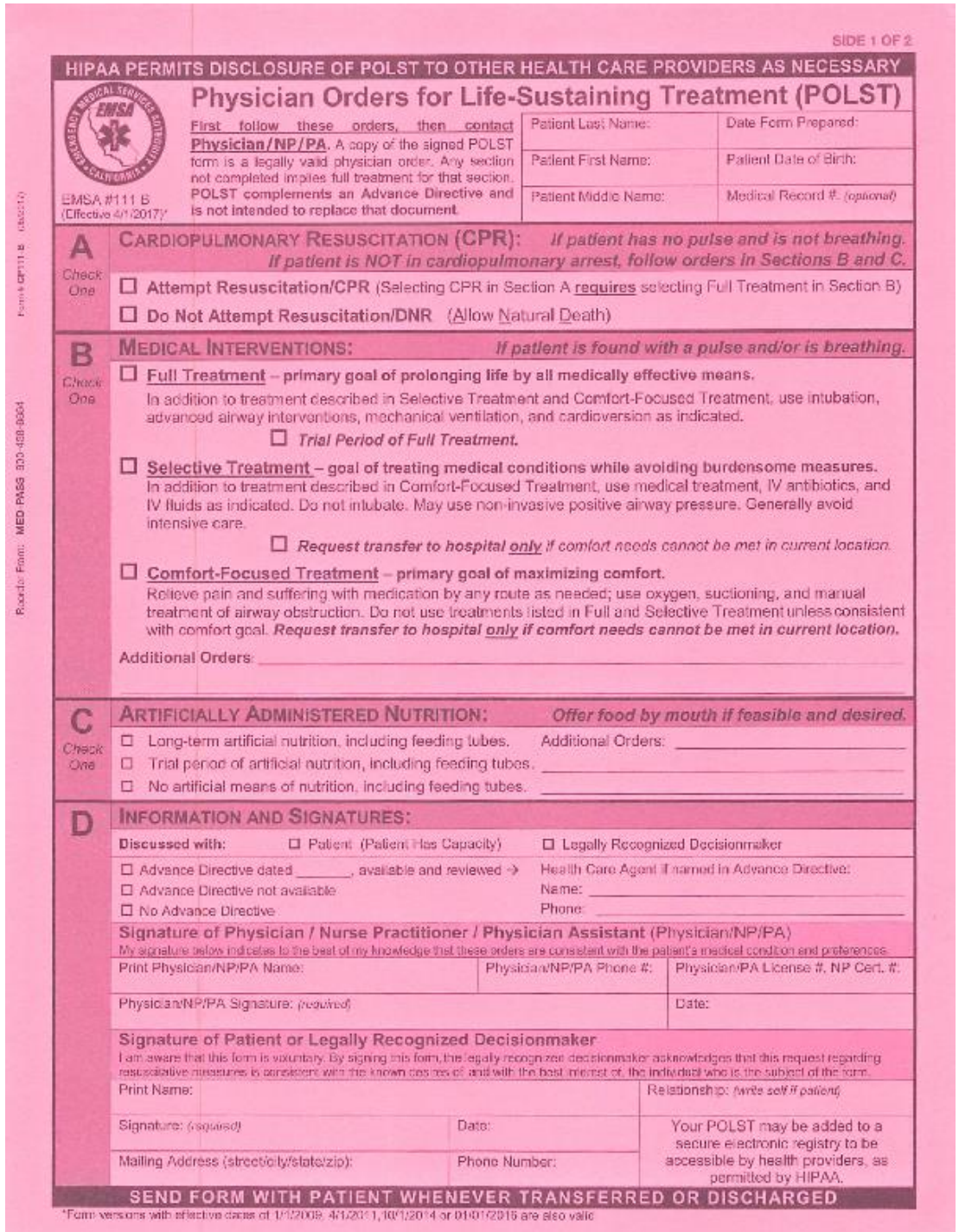
Home Phone: _____ Work Phone: _____

Sources for obtaining an Advance Health Care Directive document:

CA Medical Association
https://www.cmadocs.org
1-800-786-4262

H.E.L.P
Healthcare and Elder Law Programs Corp.
www.help4srs.org
Empowering Seniors, and their families, and caregivers to make better choices.

State of CA Dept. of Justice
https://oag.ca.gov



SIDE 1 OF 2

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 — Check One

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.*

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

B — Check One

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

- ☐ **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 — Check One

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

- ☐ 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 — Name: _____
- ☐ No Advance Directive — 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:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

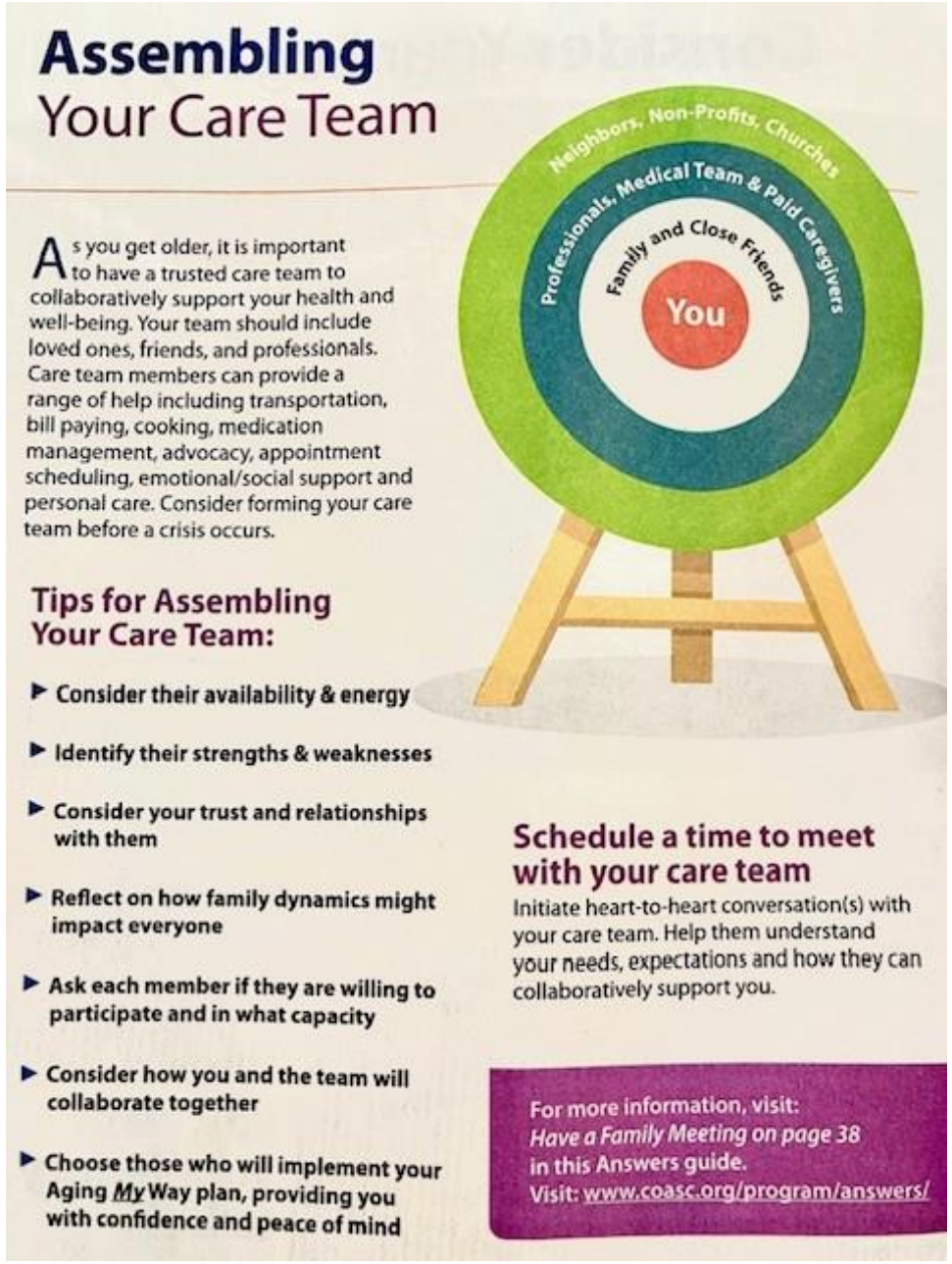
*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2015 are also valid.

Boards: Form: MED PASS 800-488-8804

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.



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.

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.

Hospice Care

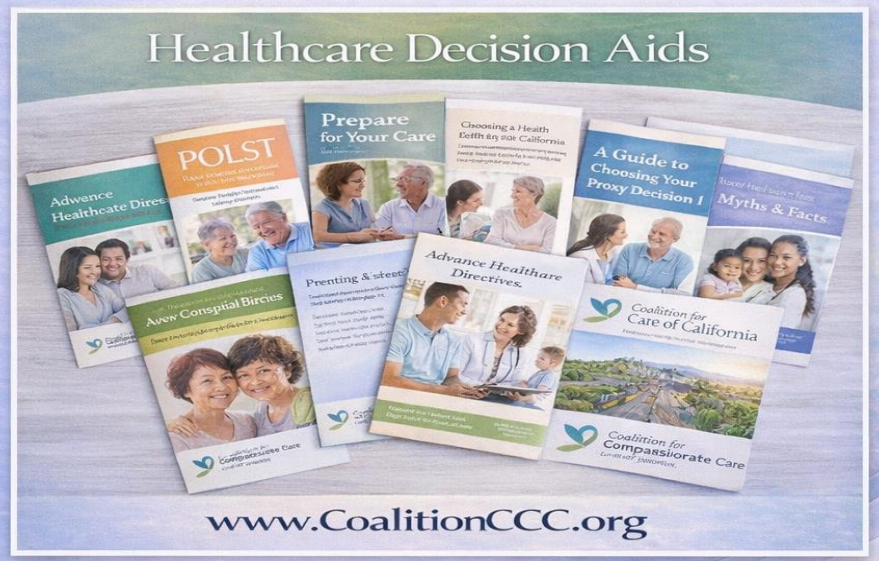
Hospice Care is designed for patients with a terminal illness who are nearing the end of life, typically with a prognosis of six months or less.
The focus is on comfort care and quality of life, without curative treatment, aimed at making the patient as comfortable and peaceful as possible in their final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

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.

Coalition for Compassionate Care of California

Website: www.CoalitionCCC.org



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

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.

AGING life CARE®
ASSOCIATION
MEMBER

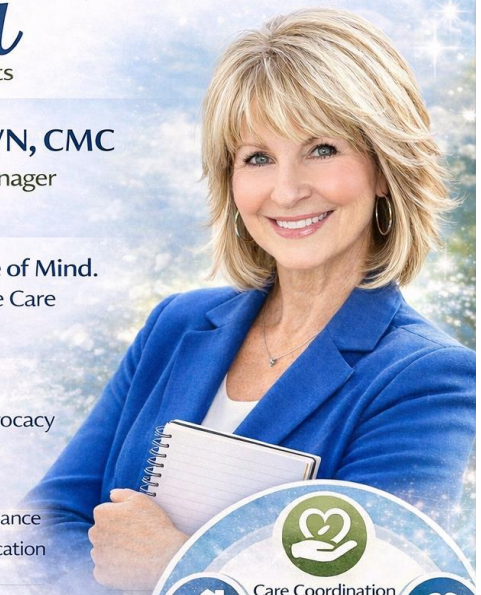
The **Aging Life Care Association** helps families:

- ✓ 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.

AgeWell
Care Consultants

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.

(949) 878-5466
Tara@AgeWellCC.com
www.AgeWellCC.com
Serving all of Orange County