***Primary Care Provider***

You will participate in a care planning meeting for Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of the **primary care provider (Physician or Nurse Practitioner)**. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

The Primary Care Provider diagnoses and manages common and chronic illnesses, performs physical exams, orders and interprets diagnostic tests, provides health counseling and education and prescribes medications.

Your participation in the care plan meeting should include the following:

* After the Community Health Navigator opens the meeting, ask her daughter, Tammy, what she understands about Mary’s disease progression to access her level of knowledge and understanding and make sure everyone has the same information.
* Reinforce that Ms. Hamilton has progressed into moderate stage dementia and now needs more supervision in the home.
* Emphasize the importance of person-centered care aand honoring the decisions Ms. Hamilton made earlier in her illness.
* Demonstrate compassion and understanding for the stresses and needs of the caregiver, Tammy.
* Be sympathetic but firm about the need for supervision for Ms. Hamilton related to her safety
* Explain that you consulted with the pharmacist in regard to Ms. Hamilton’s medications and have made adjustments so that she can take as few medications as possible while still providing for her comfort and good symptom management.
* Express concern about the caregiver’s health and the need to make sure she takes care of herself, gets needed check-ups and screenings, etc. so that she will remain helathy enough to care for her mother

***Community Health Navigator***

You will participate in a care planning meeting for Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of the **community health navigator**. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

The community health navigator serves as the link between the primary care team and the community based team. You assist the older adult in managing their chronic disease and advocate for the patient’s health, psychosocial, spiritual and cultural needs. You have knowledge of community resources, make referrals and coordinate services. You can help the older adult with health insurance issues and public assistance.

Your role in the care planning meeting includes the following:

* You open the meeting which you have organized. Ask the team and patient’s daughter, Tammy Martin, to introduce themselves.
* The primary care provider will then review the patient’s medical condition.
* You report that you made a visit to Ms. Hamilton’s home and you are concerned about her increasing needs and her personal safety.
* You encourage the group to come up with solutions.
* You make sure every team member participates during the session.
* At the end of the meeting, you summarize the plan going forward.

***Tammy Martin, Ms. Hamilton’s Daughter***

You will participate in a care planning meeting for Ms. Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of **Tammy Martin, Ms. Hamilton’s daughter and caregiver.** . Your job is to represent her and make sure her concerns are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

As Tammy, you:

* are anxious and tearful about your mother’s decline and fearful about what will happen in the future.
* state that you must work and have your own family to care for. You get no help from your brother who is in a workcamp due to his drug-related offenses.
* state that Ms. Hamilton does not have money for sitters around the clock or placement in a nursing facility and you don’t know how you can provide the care she now needs.
* complain of being tired, stressed and depressed.

***Dental Professional***

You will participate in a care planning meeting for Ms. Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of the dental professional seeing her at the dental clinic. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

As the dental professional, you have already seen Ms. Hamilton in the clinic and have scheduled her for an appointment with an oral surgeon and a general dentist during which she will be place under anesthesia and perform needed dental procedures. .

During the care planning session, you:

* review Ms. Hamilton’s recent visit and the palns for her dental care.
* stress the need for ongoing dental care – both daily care and periodic professional care..
* Explain that the dentistry you will be providing is palliative in that it will address her current dental issues in a manner that is comfortable for the patient and attempts to prevent further painful situations like what she has just experienced.

***Case Manager/Social Worker from Local Area Agency on Aging***

You will participate in a care planning meeting for Ms. Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of the **case manager/social worker from the local Area Agency on Aging** who isworking with the community health navigator and Mary’s caregiver, Tammy, to provide needed resources. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

As a case manager/social worker for the Area Agency on Aging, you assess and assist persons 60 years or older with functional disabilities who are at risk of becoming institutionalized. The goal of the services offered is to maintain elderly residents in their homes by providing needed assistance and case management. Services include: assessment and case management; homemaking (assistance with tasks such as light cooking, cleaning and laundry); personal care (assistance with activities of daily living); escort services for persons going to their doctor, dentist or other healthcare services; respite for caregivers, and home delivered meals.

As the case manager for Ms. Hamilton, you participate in the care planning session by:

* giving an overview of the services of your agency as described above.
* sharing the findings from the caregiver assessment (with Tammy’s permission) you completed with Tammy and express your concern for her.
* explaining that your services are available on a sliding scale basis and that Ms. Hamilton would be eligible for some free services based on her age and income*.*
* suggesting that Tammy be assigned a peer mentor – someone who has successfully cared for a relative with advanced Alzheimer’s Disease. This can be done through the local community Organizer.

***Pharmacist in the Community***

You will participate in a care planning meeting for Ms. Mary Hamilton. This is a second care plan meeting precipitated by the progression of her dementia and increasing care needs. You are to assume the role of the **community pharmacist** where Ms. Hamilton is receiving care**.** Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

Ms. Hamilton has been getting her medications at your pharmacy for years.

As the pharmacist, you participate in the care planning session by:

* stating the need to again look at Ms. Hamilton’s medications and verify that all are appropriate. Noting that as she declines, some of her medications may no longer be needed and the important thing is to keep her as comfortable as possible. For instance, if her blood pressure stabilizes and is in acceptable range, she may no longer need blood pressure medication.
* recommending continued medictionmonitoring. Taking as few medications as possible with the leat amount of side effects will improve her quality of life.
* suggesting that she change her Medicare Part D provider during the open-enrollment period to get better coverage for the medications she is taking.