STATE HEALTH IMPROVEMENT PLAN

Priority Area Workgroup 1

A PROFESSIONAL'S GUIDE

To Person-Centered Approaches for People Living with Dementia and their Caregivers

Elder Affairs FLORIDA

ELDERAFFAIRS.ORG

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Introduction

This toolkit provides examples of evidence-informed tools, programs, and practice considerations to support dementia care planning. It is intended for professionals such as medical providers, nurses, case managers, social workers, rehabilitation professionals, care coordinators, and other care team members who help develop person-centered care plans for people living with dementia, including plans that consider the needs of family caregivers.

How to Use This Toolkit

This toolkit is designed to be used flexibly. Professionals may reference individual sections based on their role, setting, and workflow demands. Not all tools or programs will be relevant for every person living with dementia or every caregiver, and sections may be used selectively as care needs evolve. Care plan components should be introduced incrementally to support workflow integration and avoid overwhelming care teams, people living with dementia, and caregivers.

When adapting toolkit content for caregivers, people living with dementia, or community partners, use plain, concrete language. Consider health literacy, preferred language, culture, and the amount of information that can reasonably be understood during a single encounter.

Resource names throughout this toolkit are hyperlinked in the digital version. For printed copies, users may search the resource title online or refer to the digital toolkit for direct links.

Key Components of Person-Centered Dementia Care Planning

Guiding Considerations for Care Planning

Effective dementia care planning addresses both the person living with dementia and their caregiver. Plans should be grounded in an understanding of the person's strengths, preferences, history, and sense of purpose, while adapting supports as cognitive and functional abilities change over time.

Person-centered dementia care planning is a phased and ongoing process. The components below are typically introduced gradually, addressed across multiple encounters, and revisited as needs evolve. Some components may involve separate conversations with the person living with dementia and their family caregiver.

Not all topics are appropriate to discuss in the presence of the person living with dementia. Care team members should use professional judgment, role-specific expertise, and organizational policy to determine the timing, setting, and audience for each component.

Practice Note
Person-centered dementia care planning is a phased and ongoing process. The components below are typically addressed across multiple encounters and may involve separate conversations with the person living with dementia and their family caregiver.

Not all topics are appropriate to discuss in the presence of the person living with dementia, and care team members should use judgment, role-specific expertise, and organizational policy to determine the timing, setting, and audience for each component.

Education & Skills Training (Caregiver)

Provide caregivers with practical education and skills training to support day-to-day care. Education should be tailored to the caregiver's role, the person's current abilities and needs, and the care setting. Topics may include dementia progression, communication strategies, daily routines, meaningful activities, symptom management, behavioral changes, stress-reducing techniques, and guidance on when to seek additional support.

See **Appendix A** for a printable caregiver handout.

Emotional Well-Being (Person and Caregiver)

Support emotional well-being by promoting dignity, autonomy, comfort, and engagement for the person living with dementia, while also addressing caregiver stress, grief, and emotional fatigue. Consider mood, anxiety, loneliness, loss of independence, caregiver strain, and changes in coping over time. Include supportive strategies, referrals, or follow-up

when emotional distress affects safety, quality of life, or caregiving capacity.

Behavioral Support & Problem-Solving (Person-Focused, Caregiver-Supported)

Behavioral changes in dementia are often the result of an unmet physical, emotional, social, or environmental need. Identify the person's abilities, routines, preferences, strengths, and possible triggers to develop individualized, non-pharmacological interventions that promote comfort, purpose, meaningful engagement, and quality of life. Consider screening for depression, anxiety, pain, delirium, sleep disturbance, or other medical contributors when behavior changes are new, sudden, or worsening.

When medications are considered for behavioral or psychological symptoms, clinicians should carefully weigh risks and benefits, especially for antipsychotic or other psychotropic medications.

Non-pharmacological approaches should be prioritized when appropriate, and medication decisions should account for diagnosis, safety risks, current guidance, and monitoring needs.

Caregiver Self-Care & Resilience (Caregiver-Focused)

Encourage caregiver self-care to reduce burnout and sustain long-term caregiving capacity. Care planning should consider respite needs, the caregiver's physical and mental health, and connection to peer or community supports, such as in-person or online support groups. When caregiver strain affects safety, health, or the ability to continue providing support, consider additional referrals, follow-up, or service coordination.

Care Coordination & Service Navigation (Shared)

Assist with referrals to and coordination of medical, social, rehabilitation, and community-based services, including home health, adult day care, respite services, and long-term care planning. As indicated, consider early referrals to physical therapy, occupational therapy, and speech-language pathology to address mobility, fall risk, safety, communication, swallowing, caregiver training, and participation in daily activities. These professionals may also contribute assessment findings and treatment recommendations that support the broader care planning process. Build partnerships with service providers to support clear and timely referral processes.

Assessment Tools to Inform Dementia Care Planning

Assessment Tools for Individuals Living with Dementia

These tools support understanding of cognition, behavior, comfort, function, safety, and quality of life to inform individualized care planning. Select tools based on the person's needs, clinical setting, workflow, and professional judgment.

Consider potentially modifiable contributors to cognitive, functional, or behavioral changes, such as pain, depression, delirium, medication effects, sleep disturbance, and uncorrected hearing or vision loss.

Assessment findings should be used to identify individualized risks and next steps, such as fall prevention, wandering or elopement precautions, medication support, caregiver education, referrals, or environmental modifications.

Delirium Screening

Confusion Assessment Method (CAM) – The CAM is a brief, evidence-based screening tool used to help identify possible delirium in clinical settings. Screening for delirium is important because sudden confusion, behavior changes, or worsening cognition may reflect an acute medical issue that requires timely evaluation.

Resources:
The Confusion Assessment Method (CAM) Overview | CAM-short Resources

Cognitive Screening and Dementia Severity Tools

Mini-Cog® – The Mini-Cog® is a brief cognitive screening tool that uses three-item recall and a clock-drawing task to assess memory and executive function. It may help identify when further cognitive evaluation, care planning, or referral is needed. Other cognitive screening or dementia severity tools, such as the Saint Louis University Mental Status Examination (SLUMS) or Dementia Severity Rating Scale (DSRS), may be used based on clinical setting, training, workflow, and organizational preference.

Resources:
Mini-Cog® Instructions & Scoring Guide | Printable Mini-Cog® Assessment Form (PDF)

Mental Health and Depression Screening

Validated tools such as the **PHQ-9, Geriatric Depression Scale (GDS),** or **Cornell Scale for Depression in Dementia** may be used, as appropriate, to assess depression and related mental health concerns. Use clinical judgment to consider anxiety, grief, sleep disturbance, pain, medication effects, delirium, and other factors that may worsen cognition or be mistaken for cognitive decline. New or changing symptoms should prompt further evaluation.

Resources:
PHQ-9 Questionnaire Form | Geriatric Depression Scale (GDS) Long Form | Cornell Scale for Depression in Dementia Form

Behavioral Assessment

Cohen-Mansfield Agitation Inventory (CMAI) – The CMAI helps assess the type and frequency of agitation or other challenging behaviors. Understanding behavior patterns can help clinicians and care partners identify triggers, unmet needs, and non-pharmacological support strategies.

Resources:
CMAI Full and Short Forms

Quality of Life

Quality of Life in Alzheimer's Disease (QOL-AD) – The QOL-AD measures quality of life from the perspective of the person living with dementia and, when appropriate, the caregiver. It can help care teams consider comfort, mood, relationships, daily activities, and overall well-being when developing or updating the care plan.

Resources:
QOL-AD Assessment Form (PDF) | National Library of Medicine: QOL-AD Literature Review

Pain Assessment

Pain Assessment in Advanced Dementia (PAINAD) – The PAINAD helps identify possible pain in people who may have difficulty verbalizing discomfort. Assessing pain is important because untreated pain can contribute to distress, agitation, sleep problems, reduced mobility, and changes in behavior.

Resources:
PAINAD Overview (PDF) | National Library of Medicine: PAINAD Research Article

Sleep Assessment

Assess sleep patterns, nighttime waking, daytime sleepiness, sundowning, sleep apnea risk, pain, medication effects, and caregiver sleep disruption. Sleep problems can contribute to distress, behavioral symptoms, caregiver burnout, and safety concerns.

Resources:
National Institute on Aging Sleep Problems in Alzheimer's Disease Information | Alzheimer's Association Sleep Issues and Sundowning Information

Functional Mobility and Fall Risk

Consider functional mobility, balance, transfers, gait, home safety, assistive device needs, caregiver injury risk, and referral to rehabilitation services. Fall prevention strategies may include medication review, vision and footwear considerations, strength and balance support, home modifications, and caregiver education on safe assistance.

Resources:
CDC STEADI Fall Prevention Tools | CDC Home Fall Prevention Checklist Brochure

Assessing Caregiver Mental Well-Being

Caregiver stress, burden, depression, and emotional fatigue can affect care planning, safety, and the caregiver's ability to continue providing support. In addition to standard depression screening tools like the PHQ-9, the following caregiver-focused assessment tools can help identify stress, emotional distress, support needs, and mental health concerns that may impact the care plan.

These tools are intended to support care planning and identify areas where additional follow-up, referrals, or supports may be needed. They should be used alongside professional judgment and are not a substitute for clinical evaluation when significant mental health concerns are identified.

Zarit Burden Interview

Assesses caregiver burden, including emotional, social, financial, and physical strain. Results can help guide referrals for respite, counseling, education, support groups, or other caregiver supports.

Resources:
Zarit Burden Interview Overview | Full and Short Form Copies

Caregiver Self-Assessment Questionnaire

Helps caregivers reflect on their own stress, health, and support needs. It can identify distress early and guide timely adjustments to the care plan, including caregiver education, respite planning, and connection to community resources.

Resources:
Caregiver Self-Assessment Overview | Assessment Copy

Recommended Programs, Models, and Support Tools for Dementia Care Planning

Caregiver-Focused Evidence-Based Programs and Support Tools

Many programs and tools can support person-centered dementia care planning and help integrate caregiver needs into the care process. The following examples are not exhaustive and should be selected based on the person's needs, caregiver circumstances, local availability, payer requirements, and organizational workflow.

Savvy Caregiver® Program

The Savvy Caregiver® Program is a structured, multi-session training that helps caregivers understand dementia-related changes, respond effectively to behaviors, and build practical caregiving skills while preserving dignity and promoting caregiver well-being.

Application:
Identify local availability using the program locator. Encourage caregiver participation and integrate program principles into individualized care plans and caregiver education.

Resources:
Savvy Caregiver® Official Website

Powerful Tools for Caregivers®

Powerful Tools for Caregivers® is an evidence-based program that equips caregivers with skills to manage stress, improve communication, make informed decisions, and maintain their own health while providing care.

Application:
Refer caregivers to local workshops or virtual sessions. Reinforce program concepts during care planning to support caregiver resilience and long-term sustainability.

Resources:
Powerful Tools for Caregivers® Official Website

T-CARE®

T-CARE® ((Tailored Caregiver Assessment and Referral) is an evidence-based caregiver assessment and risk-management tool that evaluates caregiver burden, stress, and support needs, generating individualized recommendations and targeted referrals.

Application:
Use T-CARE® where available to assess caregiver risk, prioritize supportive interventions (e.g., respite, counseling, education), and integrate caregiver needs into the overall dementia care plan.

Resources:
T-CARE® Official Website

Trualta

Trualta is a digital caregiver education and support platform that provides short, practical training modules, live education sessions, and peer support to improve caregiving skills and reduce caregiver stress. It may be useful for caregivers who need flexible education and support between clinical visits or community referrals.

Application:
Recommend Trualta to supplement care plans with ongoing education and support between clinical visits. Encourage caregivers to engage with available training modules and support communities.

Resources:
Trualta Official Website

Care Coordination and Healthcare Delivery Models

GUIDE Program

The GUIDE (Guiding an Improved Dementia Experience) Model is a CMS Innovation Center initiative that supports dementia care coordination, caregiver education, 24/7 support access, and respite services through an interdisciplinary care approach.

Application:
For individuals with traditional Medicare, consider whether a local GUIDE participant is available and appropriate to support ongoing care coordination, caregiver education, and connection to support services. The GUIDE Model currently applies to eligible individuals with traditional Medicare and may not be available under Medicare Advantage plans or in all service areas.

Resources:
CMS GUIDE Model Overview

Alzheimer's Association Eligibility and Participation Information for the GUIDE Model

PACE

PACE (Program of All-Inclusive Care for the Elderly) is an integrated Medicare and Medicaid program that provides comprehensive medical and social services for eligible older adults who need a nursing home level of care but are able to live safely in the community with supports.

Application:
When clinically appropriate and available locally, consider PACE as a care coordination option for eligible individuals who may benefit from interdisciplinary services, adult day health supports, transportation, medication management, rehabilitation services, and caregiver support. PACE availability and eligibility vary by service area, so clinicians should refer patients and caregivers to official Medicare, Medicaid, or PACE program resources for current enrollment information.

Resources:
Medicare PACE Information Page

National PACE Association Find a PACE Program

Safety, Support, and Future Planning Considerations

The following considerations may apply across dementia care planning and should be addressed based on the person's needs, risks, care setting, available supports, and stage of disease. These topics may be introduced over time and revisited as cognitive, functional, safety, and caregiver needs change.

Safety and Risk Monitoring

Assess for risks related to medication management, nutrition, hydration, wandering, falls, mobility, transfers, swallowing, and home safety. Consider the need for increased supervision, structured support, rehabilitation referral, home modifications, assistive devices, or training for formal or informal supports. Falls, unsafe transfers, and mobility concerns can increase injury risk for the person living with dementia and anyone assisting with care. As indicated, consider balance assessment, mobility training, home safety review, safe assistance education, and referrals to physical therapy, occupational therapy, or speech-language pathology.

Emergency Preparedness

In Florida, emergency preparedness should be addressed early and revisited regularly. Discuss evacuation plans, sheltering options, medication and supply needs, identification, transportation, caregiver backup plans, and how dementia-related needs may affect safety during hurricanes or other emergencies.

FloridaDisaster.org provides state emergency preparedness information, and the Florida Special Needs Registry may help individuals with special needs, including cognitive impairment, connect with local emergency management for disaster planning and sheltering support.

Transportation and Driving Safety

When transportation or driving safety is a concern, consider referral for a driving evaluation or driver rehabilitation specialist, when available.

In Florida, Safe Mobility for Life provides resources for older driver safety, transportation planning, and driver rehabilitation referrals.

Assessment of Decision-Making Capacity

Evaluate the person's ability to understand, appreciate, and communicate decisions about care, finances, living situation, safety, and legal planning. Capacity may vary by decision type and should be reassessed as cognitive or functional changes occur. When concerns arise, consider appropriate clinical, legal, or protective service referrals.

Future Planning and Legal Considerations

Encourage early discussion of advance care planning while the person can participate as much as possible. Topics may include health care surrogate designation, durable power of attorney, advance directives, emergency contacts, financial planning, and guardianship considerations when appropriate. Professionals should refer to legal, social work, or Area Agency on Aging resources as needed.

Florida's Agency for Health Care Administration provides advance directive information that may be shared with individuals and families for further education.

Abuse, Neglect, Exploitation, and Self-Neglect

Screen for signs of abuse, neglect, self-neglect, and financial exploitation, particularly when the person has limited support, impaired decision-making, dependence on others, or unexplained changes in finances, care access, safety, or living conditions. Follow organizational policy and Florida mandatory reporting requirements.

Suspected abuse, neglect, exploitation, or self-neglect of a vulnerable adult can be reported to the Florida Abuse Hotline at 1-800-962-2873, or online through the Florida Abuse Hotline reporting portal. Call 911 if the person is in immediate danger.

Connection to Formal Supports and Services

Connect people to community-based services such as:

- Home and community-based services (HCBS)
- Case management programs
- Adult day services
- Meal delivery programs
- Transportation services
- PACE programs, when available and appropriate

Area Agency on Aging (AAA) and Aging and Disability Resource Center (ADRC) navigation resources may help connect individuals and caregivers to local home- and community-based services, transportation, meals, case management, and other supports. Visit elderaffairs.org to find the local Area Agency on Aging serving your area.

Social Connection and Isolation Reduction

Identify opportunities to reduce isolation and promote safe, meaningful engagement through community programs, senior centers, adult day services, faith-based or cultural groups, friendly visitor programs, or structured activities. Consider the person's interests, communication abilities, transportation needs, supervision needs, and comfort in group settings. When appropriate, connect individuals and caregivers to local senior center, adult day, or community-based programs that can support ongoing engagement.

Ongoing Monitoring and Care Coordination

Care plans should be revisited as cognitive, functional, safety, medical, caregiver, and social support needs change. Consider assigning a primary point of contact when available, confirming referral follow-through, and reassessing safety, nutrition, medication management, transportation, caregiver capacity, and changing support needs over time.

Additional Considerations for People With Limited or No Reliable Support

Some people living with dementia may not have an available or reliable caregiver. This may include people who live alone, are socially isolated, or have support systems that are limited or unable to meet care needs. In these situations, care planning may require greater reliance on formal systems of care and community-based supports.

When informal support is limited or unavailable, care planning should place added emphasis on safety monitoring, decision-making capacity, emergency preparedness, connection to formal services, referral follow-through, and ongoing reassessment. More frequent follow-up and coordination across providers, service systems, and community partners may be needed to help maintain continuity and safety.

Recommended Programs, Models, and Support Tools for Dementia Care Planning

Medicare Cognitive Assessment & Care Plan Service

Medicare provides billing guidance for a comprehensive cognitive assessment and care planning service, commonly associated with **CPT code 99483**. Because billing requirements, payer rules, and CPT licensing considerations can change, this toolkit is not intended to serve as a coding manual.

This service may apply to individuals with cognitive impairment, including but not limited to dementia, depending on current Medicare requirements and clinical circumstances.

Clinicians should consult current CMS guidance, Medicare Administrative Contractor guidance, payer policies, telehealth rules, and their organization's billing or compliance staff before billing for this service.

For additional guidance, professionals may:

- Review the CMS Cognitive Assessment & Care Plan Services
- Review the Alzheimer's Association's Cognitive Impairment Care Planning Toolkit: A guide to conducting a reimbursable clinical visit under CPT® code 99483

Comprehensive cognitive care planning may follow an Annual Wellness Visit or be scheduled when cognitive concerns arise, depending on payer rules and clinical need. See **Appendix B** for an example of a person-centered dementia care plan that illustrates comprehensive care planning principles. It should not be used as a billing checklist.

Emerging and Technology-Assisted Tools

Emerging technologies may support dementia care planning, assessment, documentation, education, and monitoring. These tools vary in accessibility, cost, usability, privacy considerations, and level of supporting evidence.

Examples may include:

- Digital cognitive assessment platforms
- Remote monitoring or safety-support tools
- AI-assisted clinical decision or documentation tools
- Personalized care planning technologies
- Digital caregiver education platforms

Practice Note
These tools are not required for high-quality dementia care planning and should not replace clinical judgment, caregiver input, or person-centered assessment. Professionals

should prioritize accessible, evidence-informed approaches and consider privacy, cost, digital literacy, language access, disability access, and organizational policy before recommending or using technology-assisted tools.

Implementation Strategies

To apply the tools, resources, and care planning considerations in this toolkit effectively:

- Match screening tools and resources to the identified needs of the person living with dementia and their caregiver.
- Introduce care plan elements over time rather than trying to address everything in a single visit.
- Consider culturally adapted programs, language access, and accessibility needs when selecting resources.
- Track simple outcomes, such as caregiver stress, safety concerns, referral completion, or changes in function, to guide care plan adjustments.
- Clarify who is responsible for follow-up, referrals, documentation, and sharing care plan updates.
- Build partnerships with community-based organizations to strengthen referral pathways and long-term sustainability.

Moving Forward: Supporting Sustainable Dementia Care

Supporting people living with dementia and their caregivers requires coordinated, evidence-informed, and person-centered approaches. By applying the tools, programs, and strategies outlined in this toolkit, professionals can support practical care planning, strengthen caregiver support, and improve continuity of care as needs change over time.

Professionals are encouraged to:

- Apply tools and resources selectively and purposefully
- Center care plans on the person's strengths, preferences, routines, and lived experience
- Include caregiver needs as part of the care planning process
- Collaborate across disciplines, service systems, and community partners
- Revisit and update care plans as cognitive, functional, safety, and caregiver needs change

Additional Reference Resources

Alzheimer's Association:

Clinical Practice Guidelines & Evidence

Alzheimer's Association:

Dementia Care Practice Recommendations

Center to Advance Palliative Care:

Dementia Care Best Practices

Administration for Community Living:

National Alzheimer's and Dementia Resource Center

Agency for Healthcare Research and Quality:

Dementia Care Interventions Report

Healthy People 2030:

Dementia Evidence-Based Resources

APPENDIX A

Dementia Caregiving Tips & Trusted Support Resources

Practical Tips for Daily Care

These approaches can help reduce stress, support communication, and preserve dignity for the person you are caring for.

Focus on reassurance, not correction. Emotional comfort for people living with dementia often matters more than getting the facts right.

Keep communication simple and calm. Use short sentences and offer one idea or instruction at a time.

Meet the person where they are. Arguing or correcting can increase distress; validating feelings can help.

Include meaningful activities. Choose activities that reflect the person's lifelong interests, values, roles, culture, preferences, and current abilities. Meaningful activities can promote purpose, reduce distress, and support quality of life.

Maintain familiar routines. Predictable schedules can support safety and reduce anxiety.

Watch for unmet needs. Pain, hunger, fatigue, or overstimulation often affect behavior.

Take care of yourself. Your well-being matters and directly affects your ability to provide care.

Trusted Dementia Caregiver Education & Support Resources

Caring for someone with dementia can be both meaningful and challenging. Please know that support and guidance are available, and you do not have to manage this alone.

Caregiving is a learning process, and it is okay to seek support along the way.

The following organizations provide free, reliable dementia education and support resources for family caregivers.

ACTS2 Project Facebook Live Dementia Care Workshop Series
acts2project.org/videos.html

ACTS2 offers free caregiver skills training, dementia care education, and community support resources. Caregivers can access webinars, telephone-based skills-building programs, problem-solving support, and information and referral consultations for people living with dementia and their family care partners.

Alzheimer's Association – Caregiver Education & Support
www.alz.org/help-support/resources

www.alz.org/help-support/caregiving

www.alz.org/help-support/i-have-alz/plan-for-your-future

The Alzheimer's Association offers dementia education, caregiving tips, planning tools, support groups, and connections to local resources. Caregivers can also call the free 24/7 Helpline at **1-800-272-3900** for information, support, and help finding resources.

Family Caregiver Alliance (FCA)
caregiver.org

Family Caregiver Alliance provides practical information for family caregivers, including fact sheets, care planning guidance, self-care resources, and information about legal and financial topics. These resources can help caregivers better understand dementia care needs and find support for their own well-being.

Florida Department of Elder Affairs (DOEA) – Caregiver Toolkit (PDF)
https://elderaffairs.org/wp-content/uploads/SHIP-Caregiver-Toolkit-2025.pdf

The DOEA Caregiver Toolkit provides Florida-specific information, planning tools, and caregiver support resources. It can help caregivers learn about available services, prepare for changing care needs, and connect with local supports.

Florida State University (FSU) Resources and Education for Aging, Community, and Health (REACH) – Emergency Situations Involving Persons with Dementia Videos
reach.med.fsu.edu/dementia-resources-for-first-responders-and-family-care-partners/

FSU REACH provides videos that help caregivers prepare for and respond to emergency situations involving a person living with dementia. The videos include practical guidance on communication, safety, and ways to reduce stress during a crisis.

University of South Florida (USF) Caregiver Podcast Series
health.usf.edu/medicine/byrd/resources
The USF Caregiver Podcast Series includes conversations with experts about dementia care, caregiver stress, communication, and changes that may happen as dementia progresses. These episodes may be helpful for caregivers who prefer to listen and learn at their own pace.

University of California, Los Angeles (UCLA) Caregiver Training Videos
uclahealth.org/programs/alzheimers/resources/caregiver-education

UCLA's caregiver training videos show practical ways to respond to common dementia care challenges. Topics include communication, agitation, repetitive questions, refusal of care, wandering, sleep issues, sundowning, and home safety.

How to Use These Resources

- Explore topics as questions or challenges arise
- Learn at your own pace—there is no right or wrong place to start
- Share resources with other family members involved in care
- Reach out for help early, before stress becomes overwhelming

You are not expected to manage dementia care on your own. Support is available.

APPENDIX B Example of Person-Centered Dementia Care Plan

Illustrative Guide for Comprehensive Dementia Care Planning

Purpose of This Example

This example is provided to help professionals visualize how person-centered principles, caregiver considerations, and comprehensive dementia care planning elements can be brought together in a clear and concise care plan. It is illustrative only and should be adapted based on clinical judgment, care setting, organizational requirements, and the needs and preferences of the person living with dementia and their caregiver.

Patient Information

Name: John Smith
Age: 78
Diagnosis: Alzheimer's disease, moderate stage
Living Situation: Lives at home with spouse
Independent Historian: Spouse present and actively involved

Cognitive & Functional Assessment

- Cognitive screening consistent with moderate cognitive impairment
- Requires assistance with medication management, meal preparation, and finances
- **Strengths:** Preserved long-term memory, enjoyment of music, comfort with daily routines

Behavioral & Neuropsychiatric Symptoms

- Occasional late-afternoon agitation
- Increased anxiety with schedule changes
- No hallucinations or aggressive behaviors reported

Identified Triggers: Fatigue, overstimulation

Effective Supports: Consistent routines, reassurance from caregiver
(Addresses Behavioral Support & Problem-Solving)

Meaningful Activities: Music after lunch, folding towels, short walks with supervision, and looking through family photos

Sleep Considerations: Caregiver reports occasional nighttime waking; sleep routine and environmental cues reviewed

Emotional Well-Being

- Mood, anxiety, comfort, and social engagement reviewed
- Caregiver reports increased stress related to late-afternoon agitation
- Supportive routines, respite options, and caregiver support resources discussed

Safety Assessment

- Home safety reviewed; no recent falls
- Functional mobility and transfer safety reviewed; caregiver educated to request help if lifting or unsafe transfers become necessary
- Stove use monitored by caregiver
- No longer driving; transportation provided by family

Medication Review

- Medications reconciled and reviewed
- No high-risk medications identified
- Caregiver educated on medication schedule and side-effect monitoring

Pain & Comfort

- PAINAD screening negative for untreated pain
- Caregiver advised to monitor for nonverbal signs of discomfort

Caregiver Assessment

- Primary caregiver reports moderate stress
- Zarit Burden Interview indicates mild–moderate caregiver burden
- Caregiver willing to continue role with additional support

Education & Skills Training

- Education provided on dementia progression and communication strategies
- Practical interaction tips and caregiver education resources reviewed (Appendix A)
- Importance of caregiver self-care and respite discussed
  (Supports Education & Skills Training)

Care Coordination & Community Supports

- Referral to local caregiver support program
- Information provided on Alzheimer's Association education and helpline
- Adult day services discussed as a future support option
- Rehabilitation referral to be considered if mobility, transfer safety, swallowing, or communication concerns increase
  (Aligns with Care Coordination & Service Navigation)

Advance Care Planning, Goals of Care, and Comfort-Focused Support

- Advance directives reviewed
- Goals of care emphasize comfort, safety, dignity, familiar routines, and caregiver support
- Palliative care needs reviewed; no specialty referral needed at this time

- Care team will revisit whether palliative care, hospice, or other comfort-focused supports may be appropriate as needs progress

Written Care Plan Summary

Goals:

- Maintain safety and comfort
- Support caregiver well-being
- Preserve dignity, routines, and meaningful engagement

Plan:

- Continue structured daily routines
- Monitor agitation triggers and adjust environment as needed
- Reassess caregiver stress and supports at follow-up

Follow-Up

- Care planning review scheduled within 180 days or sooner if concerns arise
- Written care plan shared with patient and caregiver

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