

## SASH Healthy Aging Plan (Template)

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ DOB \_\_\_\_\_ Date Completed \_\_\_\_\_

PCP: \_\_\_\_\_ Other MDs \_\_\_\_\_ Interview completed: \_\_\_\_\_

<u>Core Area to Address</u> (List concerns/deficits identified on screening in each section for this participant.)	<u>Level of Need</u> (H/L)	<u>Participant's Goals</u> (Possible outcomes listed below from matrix)	<u>Interventions</u> (Possible interventions listed below from matrix)	Lead to work with participant	Date Completed
<b>1. Lifestyle Barriers to Good Health to include:</b>					
<b>a. Physical Activity</b>		1. Independence and function will be improved or maintained.	1. Encourage daily activity and setting goals through Action Plan 2. Enroll in SASH programs as appropriate		
<b>b. Nutrition</b>		1. No nutritional deficits	1. If deficit, develop possible plan for improvement, set goals through Action Plan. 2. If deficit, consider opportunities for improved meal planning or access to nutritional meals 3. Enroll in SASH programs as appropriate		
<b>c. Access to regular health screenings/ immunizations</b>		1. No barriers to access for appropriate screenings. 2. Immunizations completed.	1. Review Diagnoses/concerns with PCP 2. Review dental health, vision, hearing screenings 3. Review and encourage protection against seasonal flu, pneumococcal, tetanus, zoster		
<b>d. Transportation</b>			1. Refer to appropriate community resources- SSTA, etc.		
<b>e. Transitions Care/Discharge Planning</b>		1. No gaps in communication between service providers.	1. Coordination of care with Participant, PCP, VNA and others 2. Discharge planning protocol will be in place with hospitals, nursing homes. 3. In-home visit to review discharge orders, care needs, medication, etc. 4. SASH Team coordination/health record.		

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f. Personal Care/ Homemaking Needs		1. Participant will receive appropriate level of support and assistance. 1. Improved quality of life.	1. Assessment of need by team 2. Service provided if assessment indicates need		
g. Isolation/ lack of social contact			1. Enroll in SASH programs as appropriate 2. Referral to community resources such as CVAA, UW telephone reassurance program.		
h. Personal financial Management			1. Refer to CVAA for eligibility for state programs. 2. Volunteer financial counselor		
i. Advanced Directive / Living Will		1. Advance directive in place	1. Review advance directive/ Living will 2. Encourage/assist with on-line Registry if not completed		
j. Other					
2. Falls		1. No avoidable falls	1. Conduct in-home falls risk assessment and prevention 2. Evaluate use of assistive devices. 3. Enroll in SASH programs as appropriate (MOB) 4. Encourage life-line		

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(First) \_\_\_\_\_

Date Completed \_\_\_\_\_

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<b>3. Medications</b>		<ol style="list-style-type: none"> <li>1. Medications taken by participant are safe and appropriate,</li> </ol>	<ol style="list-style-type: none"> <li>1. Review Medications with PCP</li> <li>2. Provide Medication Passport</li> <li>3. Review Self Administration as appropriate</li> <li>4. Update medication lists every 6 months and/or if changes</li> <li>5. Provide education in self-management and enroll in programs as appropriate</li> </ol>		
<b>4. Chronic Diseases and Conditions (list):</b>		<ol style="list-style-type: none"> <li>1. Level of function will be maintained or improved</li> <li>2. Participant will have fewer ED visits / Hospitalizations</li> <li>3. Participant will have appropriate levels of support and assistance.</li> </ol>	<ol style="list-style-type: none"> <li>1. Confirm Diagnoses with PCP</li> <li>2. Seek guidance to help reinforce goals</li> <li>3. Promote involvement with SASH programs as appropriate</li> <li>4. SASH team coordination</li> </ol>		
<b>5. Cognitive Deficits and Mental Health</b>		Safety and quality of life will be improved.	<ol style="list-style-type: none"> <li>1. Refer as appropriate to PCP and community resources (CVAA, VNA, Memory Center, etc.)</li> <li>2. Provide education as needed</li> <li>3. Provide supportive environment for participant and family</li> <li>4. Enroll in SASH programs as appropriate</li> </ol>		
<b>6. System issues: Cost, access to services, social services</b>					

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7. Coordination and communication deficits					