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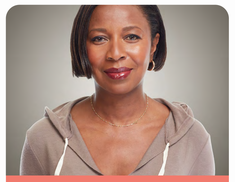


Andrea - Primary

Scenario

Andrea is Martha's daughter and lives one town over from her. Andrea is mostly responsible for Martha and her father. She has a teenage son and an adult daughter and no husband.

Behavioral Attributes

Information Seeker:	Hi
Strategic Planner:	Med
Aware Observer:	Low
Communicator:	Hi

Thomas - Secondary

Scenario

Thomas is Martha's husband and lives with her in a home that they've owned for decades. He suffers from a ABC disease and lives off social security and a modest pension.

Behavioral Attributes

Information Seeker:	Low
Strategic Planner:	Low
Aware Observer:	Med
Communicator:	Med

PHASE

PREDIAGNOSTIC

INITIAL DIAGNOSIS & TREATMENT

GOALS

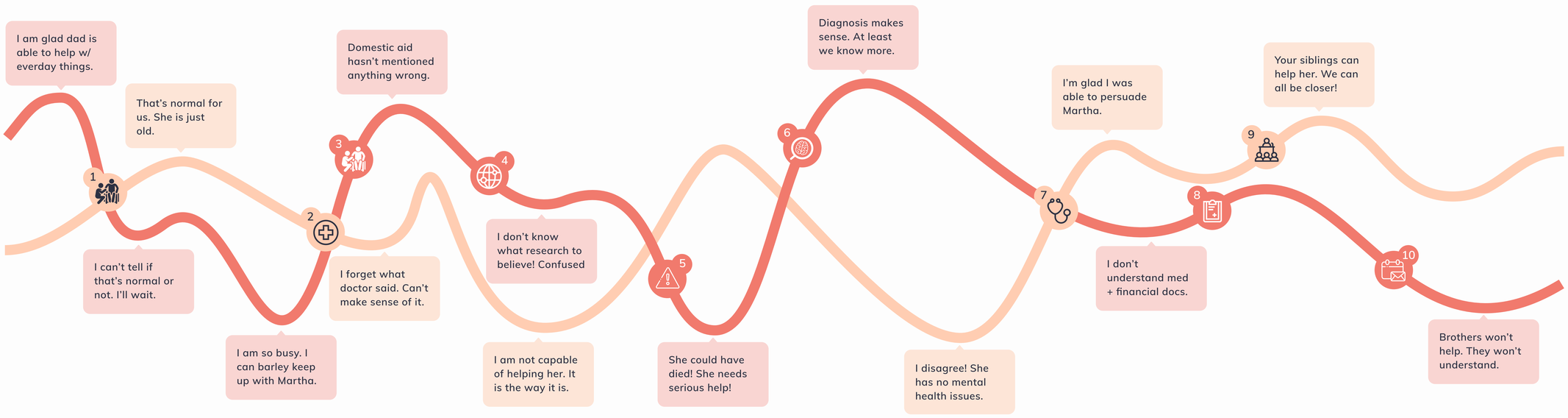
Know when it's appropriate to seek a professional's medical assessment

Process diagnosis and galvinize resources to implement care plan

ACTIVITIES

- Research and adminster self-service mental health tests
- Bring Martha to initial diganosis assessment
- Recieve and understand diagnosis and care plan
- Educate family on Martha's condition and family impact
- Help Martha with ongoing health and domestic needs
- Coordinate referral specialist assessment visits
- Identify and gather medical and financial docs/resources
- Coordinate family and community caregiving support

EMOTIONAL EXPERIENCE AND CHALLENGES



POINTS OF SERVICE

1. Helps Martha w/ intimate and low-intensity errands and activities.
2. Often goes w/ Martha to primary and specialist care visits.
3. A domestic aid assists Martha with labor-intensive, specialized chores.
4. Self-guided research to understand and adminster mental health assessments.
5. Martha has a dramatic psycho-behavioral episode that puts her/others in danger.
6. PCP coordinates the initial neuropsycholgical assessment
7. Martha is persuaded, after initial resistance, to receive PCP referral assessments
8. Recieves Care Plan and info on med, financial, legal docs needed for care.
9. Informs family about Martha condition and care expectations.
10. Emails family caregiving educ content and appointments to recruit their help.

PRODUCT IDEAS

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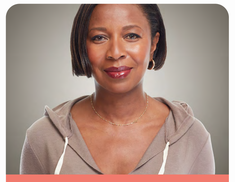

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Behavioral Attributes

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Strategic Planner:	Low
Aware Observer:	Med
Communicator:	Med

PHASE

CARE MONITORING & MANAGEMENT

CARE TRANSITION & END OF LIFE MANAGEMENT

GOALS

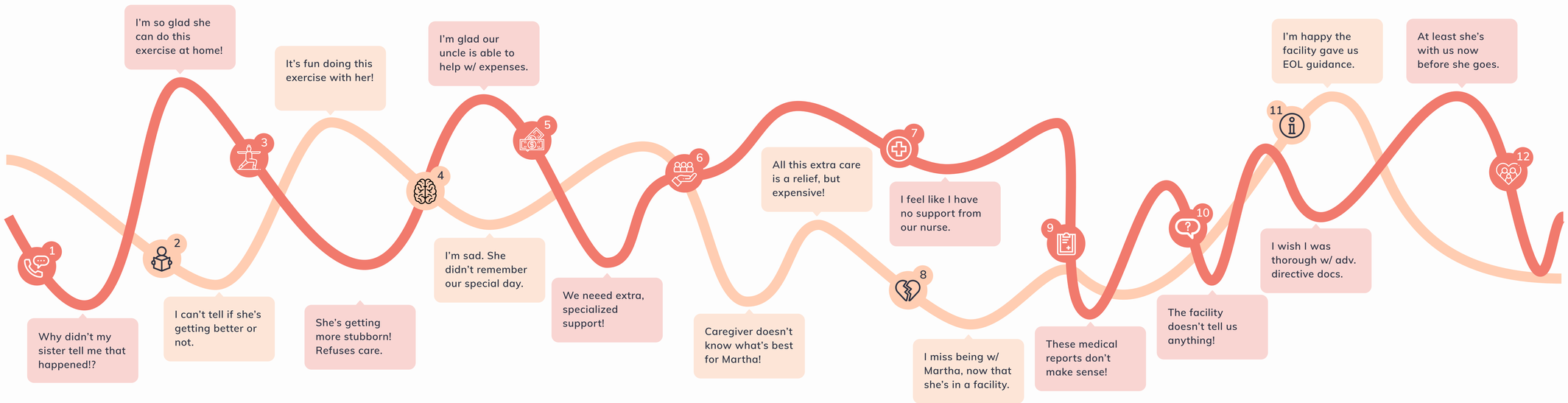
Ensure patient physical and mental health is managed and improves

Mitgiate health and financial harm to patient and family

ACTIVITIES

- Coordinate w/ family on caregiving schedules + updates
- Find + manage specialized caregivers
- Coordinate med, fin, legal docs transfer to facility
- Maintain relationship w/ Martha
- Attend to Martha thru EOL
- Coordinate care plan progress monitoring w/ provider
- Adminster care tasks + communicate w/ care team
- Remote + in-person follow-up on care progress w/ facility
- Setup EOL docs, services, + location

EMOTIONAL EXPERIENCE AND CHALLENGES



POINTS OF SERVICE

1. Forgotten or missed phone calls + messages between family
2. Routine cognitive tasks, reading news paper, between Marhta + Thomas
3. Physical therapy sessions conductedover video conference
4. Emotional, life events that are complicated by dementia
5. Uncle uses community connections + own $ to help w/ caregiving costs
6. Search, identify, + validate specialized caregiving services
7. In-frequent + difficult to schedule check-ins, chats w/ provider
8. Thomas + Martha separate in transition to facility
9. Health assessment + advanced directive docs are confusing
10. Facility updates + comms are limited and infrequent
11. Family bring Martha home. Facility gives EOL guidance
10. Facility updates + comms are limited and infrequent

PRODUCT IDEAS

Carmen - Facility

Scenario

Carmen works at an assisted facility having had 6 years experience as an nurse for the elderly in El Salvador. She supports 15 patients a day with help from facility staff.

Behavioral Attributes

Information Seeker:	Med
Strategic Planner:	Med
Aware Observer:	Hi
Communicator:	Hi

Jason - Agency

Scenario

Jason is a recent nursing program graduate and workd for an elder care agency. He spent a few summers taking care of his grandma, but has no professional eldercare experience.

Behavioral Attributes

Information Seeker:	Hi
Strategic Planner:	Hi
Aware Observer:	Low
Communicator:	Low

PHASE

PRE ADMISSION / PATIENT INTRODUCTION

PATIENT CARE ONBOARDING

GOALS

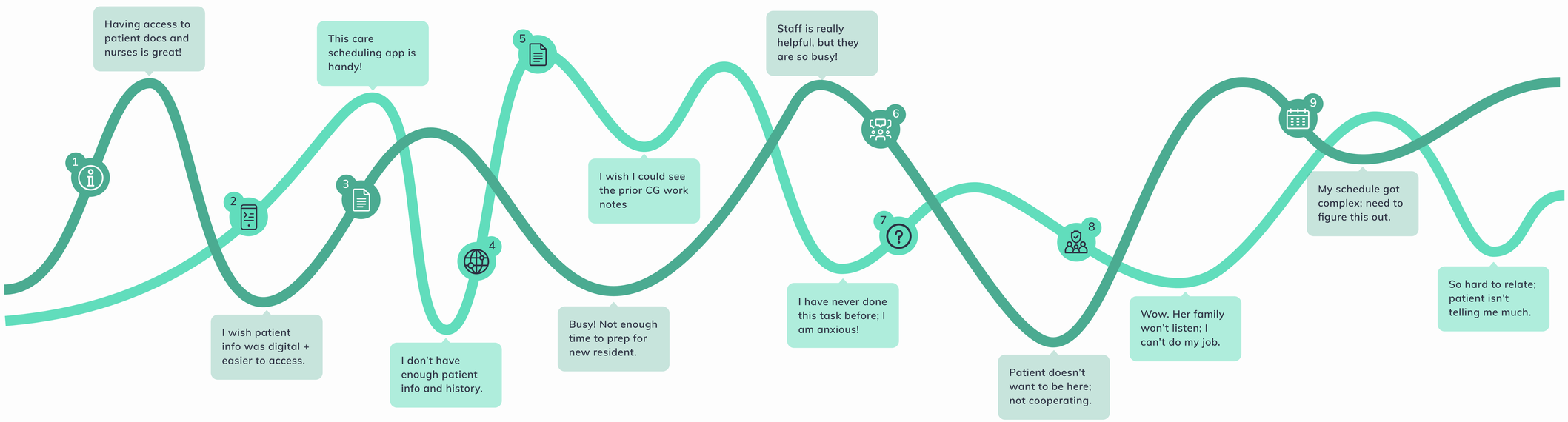
Be prepared to properly receive and provide care to new resident/client

Develop rapport with patient and operationalize care plan interventions

ACTIVITIES

- Recieve assignment schedule and task list
- Speak with facility manager and review care plan
- Learn new caregiving skills
- Develop rapport + relationship w/ patient
- Contact family to learn about patient
- Review previous CG written notes
- Develop care routine for patient
- Coordinate + negotiate caregiving tasks w/ family
- Proactively seek info + help from staff

EMOTIONAL EXPERIENCE AND CHALLENGES



POINTS OF SERVICE

1. Care plan information made available to facility management staff and systems.
2. Agency app to help with basic scheduling and care task list mgmt services.
3. Interact w/ working and patient paper docs, posted on walls, and clipboards.
4. Self-guided research to address info gaps due to lack of patient info provided.
5. Ad-hoc chats or post-it notes to learn about prior CG work and patient updates.
6. Daily stand-up meetings w/ colleagues to address patient updates and info gaps.
7. Complex tasks leave CGs to learn by trial-error or thru self-guided research.
8. Family assert their authority and bias over CG which makes work difficult.
9. Daily work schedule is memorized and printed on worksheets.

PRODUCT IDEAS

Carmen - Facility

Scenario

Carmen works at an assisted facility having had 6 years experience as an nurse for the elderly in El Salvador. She supports 15 patients a day and help from colleagues.

Behavioral Attributes

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Strategic Planner:	Med
Aware Observer:	Hi
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Jason - Agency

Scenario

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Behavioral Attributes

Information Seeker:	Hi
Strategic Planner:	Hi
Aware Observer:	Low
Communicator:	Low

PHASE

CARE MONITORING & MANAGEMENT

CARE TRANSITION MANAGEMENT

GOALS

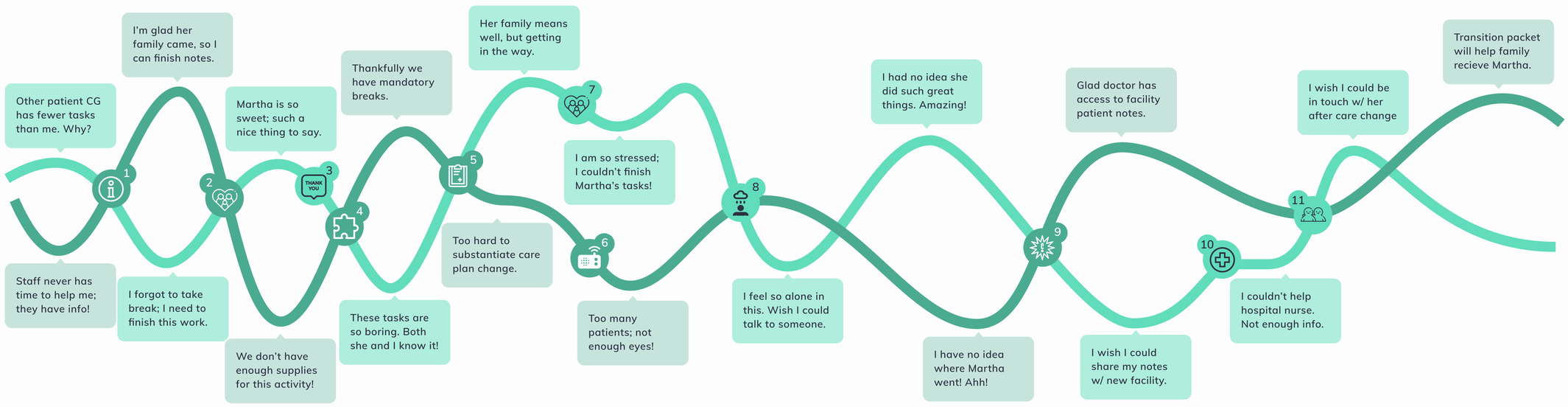
Ensure patient physical and mental health is managed and improves

Mitigate health and financial risk to patient and employer/self

ACTIVITIES

- Recieve assignment schedule and task list
- Coordinate w/ staff to ensure 15+ residents adhere to care plan
- Submite careplan change requests
- Fill out work/patient deliverables/forms before clocking out
- Review communication logs from other staff/CG
- Take breaks to avoid burn out
- Drive patient to docors, interact w/ them
- Help patient with physically intensive tasks
- Manage family input, CG experience

EMOTIONAL EXPERIENCE AND CHALLENGES



POINTS OF SERVICE

1. Staff rely on each other to learn + act on timely resident info.
2. 1hr family visit - gets update from patient + staff
3. CG recieves message from patient thanking her for service
4. Sometimes there are missing materials or no instruction knowledge for activities
5. Difficulty recalling prior events, metrics for change request form submission.
6. CG moves alot in facility to manage patients responding to device alerts
7. Family supports, informs caregiving activities
8. CG is often alone + isolated when caring for patient in home.
9. Resident goes missing. Everyone panics, searches.
10. Brings patient to docotors + can't help answer questions.
11. CG wants to keep in touch w/ patient after care transfer

PRODUCT IDEAS