Our Family Our Way

Family Meeting Guide

This guide belongs to:_____

Date:_____

Our Family, Our Way: A Communication and Care Coordination Guide for Caregiving Families

Created by Scripps Gerontology Center, Miami University
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Welcome to Our Family, Our Way

A Communication and Care Coordination Guide
for Caregiving Families

The goal of this guide is to **help your family arrive at the best possible care and support arrangement** when a parent or partner needs help at home. Let's define each part of this goal:

Your family

In this guide, by **family** we mean a person who needs care, their spouse or partner, adult children (including step-children and children-in-law) and other closely-involved family members or friends—no matter where they live.

Care and support

By **care** we mean direct help with daily living such as bathing, dressing, meal preparation, transportation and the like.
By support, we mean indirect help such as home modifications, information gathering, and financial or other resources.

Care and support arrangement

The care and support **arrangement** is the combination of *who* does *what, when, where,* and *how* in terms of care and support.

Best possible

By **best possible** care and support arrangement we mean an arrangement that takes everyone's needs, strengths, preferences, and limitations into account as a family makes decisions about the arrangement. The best possible arrangement is well-communicated and achieves the best possible outcomes for everyone involved—for **your family, your family's way**.

Care Partner vs. Caregiver

In these resources, we use the term **care partner,** rather than caregiver, to refer to family, friends, and others who provide care and support. We feel this language helps us all remember that persons with care needs should be considered active participants - partners - in their own care and support and not just passive "receivers."

Is This Guide Right for Your Family?

Not every family should use this guide. All families are different. Some families are better problem solvers than others. Some families have relatively uncomplicated relationships and others have more complicated relationships. Some families have a high tolerance for differences of opinion and some have very little tolerance. Some families openly communicate and others are more closed or guarded with each other.

There are three general types of families who will ask whether this guide is right for them, and we've provided some information below to help you decide:

Type One (NO) These are families who need more help communicating than a self-guided process can provide. You might worry that, without a professional involved, your family cannot handle the "can of worms" that topics of care and support might open. The last thing anyone wants is to create hurtful and counterproductive conflict that is not easily resolved. Even though we think this guide may not be right for such a family, we hope that your family doesn't give up on communicating with each other about your care and support arrangement! Instead, we recommend using a family counselor, a mediator, or a geriatric care manager to help your family navigate discussions about care and support. We offer resources for accessing such professionals in the ***Helpful Caregiving Resources*** booklet which can be downloaded and printed for free from the Our Family, Our Way website at ***www.MiamiOH.edu/ScrippsAging/OFOW.*** Any professional is welcome to use the Our Family, Our Way materials and process as they work with your family.

Type Two (MAYBE) These are families who may not think they need help communicating about the care and support arrangement. However, research shows that most families can improve their communication and care coordination.

Type Three (YES!) All other families. If you and most members of your family are committed to achieving the best possible care and support arrangement and are ready to have open and honest conversation, this guide is for you.

Before You Begin...Did You Know?

(What every family should know about care and support at home.)

» **You are not alone.** In 2020, an estimated 53 million adults in the U.S. (more than 1 in 5 Americans) had provided care to an adult or a child with special needs at some time in the past 12 months. (National Alliance for Caregiving and AARP, Caregiving in the U.S. 2020 Report)

» **Care at home is increasing and so is reliance on family and friends.** About half (43%) of older adults who receive care from family or friends live in their own homes. The more care that is needed, however, the more likely the older adult is to live with the care partner. (National Alliance for Caregiving and AARP, Caregiving in the U.S. 2020 Report)

» **Some families use a mix of family care and formal (paid) services.** Use of paid services in addition to family care was reported by one in three family care partners (31%) in a 2020 study of caregiving in the U.S. (National Alliance for Caregiving and AARP, Caregiving in the U.S. 2020 Report)

» **An increasing number of family and friends are caring for a person with memory problems.** In 2020, 32% of those providing care reported that the person with care needs had memory problems, and 26% reported that the person they cared for had Alzheimer's disease or dementia. (National Alliance for Caregiving and AARP, Caregiving in the U.S. 2020 Report)

» **Unpaid family care has economic value.** Unpaid help provided by family caregivers saves both family and public financial resources. Nursing home care can cost up to $100,000 per year and in-home services can cost up to $25.00 an hour. The ***Helpful Caregiving Resources*** booklet available on the Our Family, Our Way website includes information about available resources to help you estimate costs for long-term care in your area.

Guide Design

This is a self-guided process. That is, it doesn't require the involvement of a professional. Instead, written guidelines are provided to support your family through the process. There are four stages in the process: thinking about who should be included in the family meeting, accessing and preparing the materials, completing the Individual Tools, and holding a family meeting.

Thinking about who should be included in the family meeting

Include everyone who is closely affected by the care and support arrangement. In addition to the person with care needs (PWCN), the care and support arrangement often deeply impacts adult children (including step-children and children-in-law). Siblings, grandchildren, nieces, nephews, friends, neighbors, and even paid care providers may also play a part and might well be included in a family meeting. There are two tip sheets on the Our Family, Our Way (OFOW) website that might be useful in this stage: ***Who should be involved in our family meeting?*** and ***Should the person with care needs attend the family meeting?***

Accessing and preparing the materials

All the materials needed for this process can be downloaded for free from the OFOW website After the materials are downloaded, they can either be printed and completed on paper, or saved and completed electronically. The OFOW website provides instructions for how to download, print, assemble, and navigate the materials in the ***Preparing Your Family Meeting Materials*** document.

Completing the Individual Tools

Each family member completes their set of Individual Tools ahead of your family meeting.

The Individual Tools provide a way for each family member, including the PWCN, to think about what's needed, what's happening now, what's wanted, and what's possible in terms of the care and support arrangement. Taking the time to reflect on your perceptions of your family's care and support arrangement and how it affects you will help prepare your family to have open, honest discussion in your family meeting.

Holding a family meeting

Using the Our Family, Our Way guidelines, your family holds a meeting.

At the meeting, you and your family members will discuss your completed Individual Tools with each other. By completing a Shared Assessment, you will identify where you see eye-to-eye, and where more conversation is needed. Then, you'll create a shared goal statement and a Family Care and Support Plan. Finally, you'll decide on a follow-up plan for resolving remaining differences and unfinished business, and for ongoing communication and care coordination.

It's time to complete your Individual Tools!

If you haven't already, download the appropriate version of the Individual Tools from the Our Family, Our Way website *www.MiamiOH.edu/ScrippsAging/OFOW* and complete them.

After you've completed your Individual Tools:

- Review pages 10 - 12 in this guide to help you start planning your family meeting.
- Share your completed **Individuals Tools** with the family members who will be attending your family meeting. Whether your family is meeting in person or virtually, taking the time to share your tools with each other before your meeting will help you acknowledge and understand each person's view of what's needed, what's happening, what's wanted, and what's possible. If it doesn't work for your family to exchange your Individual Tools before beforehand, take time at the beginning of your meeting to exchange and review each other's completed tools.
- Be sure to bring your completed **Individual Tools** with you to your family meeting.

Your Family Meeting: Guidelines and Tools

Overview

This family meeting is self-guided. That is, it's designed for you to talk and make decisions without the involvement of a professional. We've included guidelines at every step, including guidelines to help you decide, as a family, whether you are ready to move from one part of the meeting to the next. You do not have to complete both parts at one time. Do what works for your family.

There are two parts to the family meeting:

Part A: Your Family Care and Support Plan:

- **Step One:** Achieving a shared assessment of what's needed
- **Step Two:** Working toward a shared goal statement, that is, what you want as a family
- **Step Three:** Arriving at the best possible care and support arrangement, through learning what's possible as a family

Part B: The Follow-Up Plan: You'll decide as a family how to communicate and coordinate going forward.

Preparing for Your Family Meeting: Some Guidelines

Getting ready for your family meeting…

Set the time and place. Designate one family member as a coordinator to determine the family meeting time and place. Choose a time when everyone can attend. Some family members may have to phone, Zoom, or FaceTime in from a distance, or, your entire family may need to meet virtually, and that's okay. Often it is best to meet where the PWCN lives, but choose a place that works for your family.

All family members should complete and exchange their Individual Tools before the family meeting. Completed Individual Tools should be sent ahead to each family member, or sent to the person coordinating the meeting to disperse to others. The tools can be mailed via postal service, or sent electronically attached in an email…whatever works for you. All participating family members should get a copy of each others' completed Individual Tools.

The purpose of the Individual Tools exchange is to **acknowledge and understand each person's view** of what's needed, what's happening, what's wanted, and what's possible.

As you review each other's Individual Tools in advance of your family meeting, you'll get a better sense of what others are currently doing and how the care and support arrangement affects each of you. When it comes time to think about what's possible, you'll be able to approach the care and support arrangement with each other's abilities, limitations, and preferences in mind.

Use your pen and paper to make any notes about what you are reading. What caught your eye? Where is there common ground? Where are there important differences?

All family members should bring this Family Meeting Guide with them to the meeting so they can follow along with the process.

The person coordinating the meeting should have ONE copy of the Family Meeting Record on hand during the meeting.

On the Day of Your Meeting…

Have on hand:

- » each family member's completed **Individual Tools**
- » one copy of the **Family Meeting Record**
- » a pen and paper for each person
- » some sort of timing device (phone, watch, clock)
- » your favorite beverages and/or snacks

Make yourselves comfortable. Around a table will be best, but work with what you have.

- » If you have family members phoning or Zooming in, or you're holding a virtual meeting, get connected.

Name a family member to perform the following tasks. We recommend a different person for each task.

- » a **Reader** who reads the instructions for each section out loud to the group
- » a **Recorder** who documents family agreements and decisions in the **Family Meeting Record**

Now you're ready to begin your meeting.

(The guidelines for your family meeting begin on pg. 13.)

Welcome to Your Family Meeting!

The family meeting is an opportunity to share frankly with each other and to be open to hearing from each other. No more guessing, imagining, wondering, or presuming. You'll be able to identify where you see eye-to-eye about what's needed and happening and where there are differences that require more conversation or professional assessment or consultation.

Before you begin, agree to some ground rules, like "Everything is 'on the table,'" or "No raising voices," or "Everyone gets a chance to talk"—whatever will help your family have the smoothest possible conversation. We do recommend one universal ground rule: Use "I" messages. Begin sentences with **"I need…," "I hope that…," "I'm afraid that…"** rather than **"You should…," "You always…," "You never…"** Once your ground rules are set, move on to Part A.

Part A: Your Family Care and Support Plan
Step One: Achieving a SHARED ASSESSMENT of What's Needed

The **Shared Assessment** includes underlying health and environmental considerations, as well as what help is required, who is helping now, and when they are helping.

The best care and support arrangement starts with agreement about what's needed. This is not always easy! Families don't always see eye-to-eye, not only about what's needed and what's happening, but also about how much risk to take, like staying alone, driving, preparing meals, or bathing alone. By sharing your Individual Tools, you have openly communicated how you see things and where you stand. That's an important start.

Referring to your completed Individual Tools and notes, go through each item and **complete the Shared Assessment as a family.** Examples of how to complete each tool are provided in this guide.

As you go through each tool, the Reader should start by reading their responses from their Individuals Tools, then each of the other family members can share their own responses. The **Recorder** will write your family's agreements in the **Family Meeting Record** which will serve as your family's "official" record of your meeting. The Shared Assessment begins on **pg. 5 of the Family Meeting Record**.

A few notes as you move from item to item:

- Be ready to talk about those things that caught your eye when you were reveiwing each other's Individual Tools — where you see eye to eye and where you have differences.
- If you have major differences on some of the items, see the ***How Do We Deal With Major Differences During Our Family Meeting?*** tip sheet located on the OFOW website.
- When all is said and done, you may still be left with areas where you **can't agree** or are **undecided** right now. You'll have an opportunity to include these areas in your **Family Care and Support Plan** and you will also address them in **Part B** when you discuss your **Follow-up Plan**.

Shared Assessment: Underlying Health Considerations

Incorporating the information from each family member's Individual Tools **(Individual Tools pg. 7)**, create a shared assessment of how limitations in the following areas affect the PWCN's ability to carry out daily living and self-care activities. Check the column that best describes the PWCN's current health situation. If everyone can't agree right now on whether the PWCN experiences limitations in a certain area, check the "Can't agree" column.

Here's an example:

Health Consideration	No limitation	Some limitation	Major limitation	Can't agree
Hearing				✓
Vision		✓		
Taste/Smell	✓			
Diet/nutrition	✓			
Dental health	✓			
Bladder or bowel control		✓		
Hand dexterity (ability to easily use hands to do things)		✓		
Physical mobility			✓	

The **Recorder** should document your agreements in the Shared Assessment on **pg. 6 of the Family Meeting Record**. There may be places where you can't agree right now, and that's okay.

Shared Assessment: Environmental Considerations

Incorporating the information from each family member's Individual Tools **(Individual Tools pgs. 8 - 10)**, create a shared assessment of environmental considerations. If the category is not applicable (for example, there are no stairs), check "N/A." If everyone generally agrees with the category, check the "Yes" column. If everyone generally disagrees with the category, check the "No" column. If everyone can't agree right now, check the "Can't agree" column.

Here's an example:

The home...	N/A	Yes	No	Can't agree	Notes
has rooms and hallways clear of clutter.				✓	Mom does not feel "her papers" are a problem
has adequate outdoor lighting.			✓		front porch light is burned out
has an emergency response system (e.g., Lifeline)		✓			
has smoke alarms installed, tested.		✓			
has carbon monoxide detector installed, tested.			✓		
has accessible interior doorways.			✓		Dad's wheelchair does not fit through bathroom door
has lawn care/snow and ice removal when necessary.			✓		

The **Recorder** should document your agreements in the Shared Assessment starting on **pg. 7 of the Family Meeting Record**. There may be places where you can't agree right now, and that's okay.

Are there any other environmental concerns unique to life in the home (oxygen, shared spaces, etc.)? The **Recorder** should include them on **pg. 9 of the Family Meeting Record**.

Shared Assessment: What Care and Support is Required and Who's Helping Now?

Incorporating the information from each family member's Individual Tools **(Individual Tools pgs. 11 - 13)**, create a shared assessment of what help is required and who's helping now. If the activity does not apply to the PWCN, check "N/A." If you can't agree right now about what help is required, who is helping, or what devices are used and needed, check the "Can't agree" box in each of those sections.

Here's an example:

(For this example and others we'll be using the Brown family. Robert (Dad) is the PWCN and his caregivers are his wife Maria (Mom), his adult daughters Diane and Tonya, his son-in-law Jack, and his son John and daughter-in-law Shahla who live several states away).

Care or support activity		What PERSONAL help is required?				Who is helping now?			What DEVICES are used and needed?		
How much personal help does your PWCN require with the following activities:	N/A	Requires no help	Requires some help	Requires much help	Can't agree	Who provides the help?	No one is helping, but help is needed.	Can't agree	What devices are USED?	What devices could be helpful?	Can't agree
Bathing or showering				✓		Mom and Tonya - Tue,Thur, Sat	Mon, Wed, Fri, Sun			shower bench	
Dressing		✓									
Medical or nursing tasks (changing bandages, injections, colostomy/ catheter)	✓										
Going to medical appointments				✓		Tonya					
Taking out trash/ bringing in trash cans			✓				✓				

The **Recorder** should document your family's agreements in the Shared Assessment starting on **pg. 10 of the Family Meeting Record**. There may be places where you can't agree right now, and that's okay.

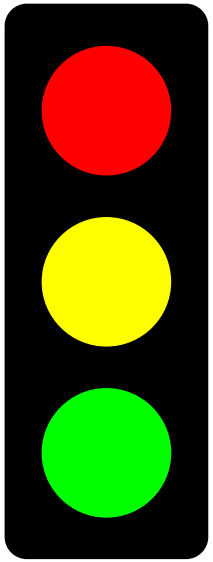
Shared Assessment: When is Help Being Provided?

Using the information from each family member's Individual Tools **(Individual Tools pg. 14)**, you will create a shared assessment of WHEN help is being provided NOW. For times of day **when no help is required**, place an X in the box for those times. For times **when someone is helping**, write the name(s) in those times. For times **when no one is helping but help is needed**, leave those times blank.

Here's an example:

	Early Morning	Late Morning	Early Afternoon	Late Afternoon	Early Evening	Late Evening	Overnight
MONDAY	Mom		X	X	Mom	Mom	X
TUESDAY	Mom	Tonya and Mom	X	X	Mom	Mom	X
WEDNESDAY	Mom		X	X			X
THURSDAY	Mom	Tonya and Mom	X	X	Mom	Mom	X
FRIDAY	Mom		X	X	Mom	Mom	X
SATURDAY	Mom	Tonya and Mom	X	X	Mom	Mom	X
SUNDAY	Mom		X	X	Mom	Mom	X

The **Recorder** should document your family's agreements in the Shared Assessment on **pg. 13 of the Family Meeting Record**.



Readiness for Step Two

Step Two is working toward a **shared goal(s) statement** for your family.

How ready do you feel to move on to Step Two?

Do you need to take a break...a few minutes?...a few days?

Is it time to call in a professional counselor or mediator?

Step Two: Working Toward a Statement of Shared Goals

Now that you have a shared assessment of what's needed, including who's helping and when, it's time to talk about **what's wanted** in your family's care and support arrangement.

In your Individual Tools, each family member was asked to write their ultimate goal for your family's care and support arrangement and to list 3 realistic changes that could be made by them to help achieve that goal.

Take a moment now for each family member to share their "ultimate goal" from pg. 20 of their Individual Tools.

Shared Goal(s) Statement

Now, taking into consideration the ultimate goals of each family member, you'll create a shared goal(s) statement.

Here's an example:

As a result of our family's care and support arrangement, we want the following to happen:

> We want Dad to live at home as long as possible and be careful with how we spend money, and at the same time, we want to pay attention to the effects on mom's health and on time with our own families.

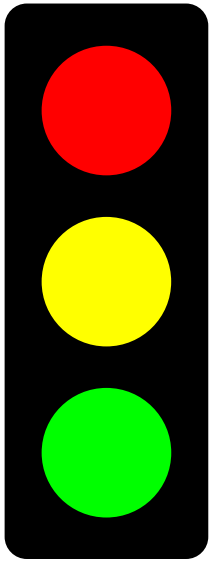
Now, do your best to come up with a shared goal(s) statement for your family that takes into account everyone's ultimate goals. Where there is disagreement, or where your goals compete with each other, leave those issues alone for a while. For now, only write a goal(s) statement that everyone can agree on, no matter how brief or incomplete it may seem.

The **Recorder** should document your Shared Goal(s) Statement on **pg. 15 of the Family Meeting Record**.

What changes do you want in the care and support arrangement?

Now that you have determined what you want as a family, think about what needs to change in the care and support arrangement in order for that to happen. **Take a moment now for each family member to share the 3 realistic changes they wrote on pg. 20 of their Individual Tools.**

As you prepare for Step Three, keep these possible changes in mind as you make your family decisions about the care and support arrangement. This is an opportunity to make decisions based on straightforward communication—no guessing, imagining, wondering, or presuming.



Readiness for Step Three

Step Three is arriving at the **best possible care and support arrangement** for your family.

How ready do you feel to move on to Step Three?

Do you need to take a break...a few minutes?...a few days?

Is it time to call in a professional counselor or mediator?

Step Three: Arriving at the Best Possible Care and Support Arrangement for Your Family

Now you're ready to create a **Family Care and Support Plan** that will designate *who* will do *what* and *when* for the areas you've addressed in your Shared Assessment. Your plan will also include a **back-up plan** for when the unexpected happens, an opportunity to think about when some family members or others could provide **occasional help**, and how some family members may be able to **contribute financial or other resources**.

Take a few minutes to review what you read in each other's Individual Tools about **what's possible** (**Individual Tools pgs. 23 - 26**).

As you prepare to complete your Family Care and Support Plan, **keep your shared goal(s) statement in mind,** and pay attention to the following:

- Where are the gaps in the arrangement?
- Where do we have differences? (The places where we **can't agree** or are **undecided.**)
- What physical, emotional, social, and financial impact does the care and support arrangement—as it stands—have on each family member?
- What are each individual's abilities, availability, limitations, resources, and preferences? What changes do they think they could make?
- Are we missing opportunities for each family member to be involved?

When you're ready, turn the page and start creating your Family Care and Support Plan.

Plan for Addressing Underlying Health Considerations

Now, referring to your Shared Assessment on **pg. 6 of the Family Meeting Record**, review the underlying health considerations. Are there underlying health limitations that could be improved? If so, for those limitations only, indicate what steps you might take, who will take the lead, who else will be involved, and when the steps will be taken. If you still can't agree, or are undecided about what to do, check the "Can't agree or Undecided" column. You will revisit "Can't agree or Undecided" areas later in your Follow-Up Plan.

Here's an example:

Who will do what and when to address...	N/A	Steps we might take	Who will take the lead	Who else will be involved	When we will take these steps	Can't agree or Undecided
Hearing		hearing test for Dad				✓
Bladder or bowel control		Dad wants a urinal next to his bed at night.	Mom will order a urinal from the pharmacy and make sure it's by Dad's bed at night.	Tonya will pick up the urinal from the pharmacy.	Mom will order the urinal this week and let Tonya know when it's ready for pick-up.	
Physical mobility		Physical therapy	Dad will talk to Dr. Mullins about therapy at his next appointment.	Tonya will drive Dad to the therapy appointments.	Dad's next appt. with Dr. Mullins is August 2nd.	

The **Recorder** should document your plan for addressing underlying health considerations in your **Family Care and Support Plan** starting on **pg. 19 of the Family Meeting Record.** There may still be places where you can't agree or are undecided, and that's okay.

Plan for Addressing Environmental Considerations

Referring to your Shared Assessment on **pgs. 7 - 9 of the Family Meeting Record**, review the environmental considerations. Are there environmental considerations that could be improved? If so, for those considerations only, indicate what steps might be taken, who will take the lead, who else will be involved, and when the steps will be taken. If everyone still can't agree, or are undecided about what to do, check the "Can't agree or Undecided" column. You will revisit "Can't agree or Undecided" areas later in your Follow-Up Plan.

Here's an example:

How we will address the concerns in the home...	N/A	Steps we might take	Who will take the lead	Who else will be involved	When we will take these steps	Can't agree or Undecided
Adequate outdoor lighting		Replace burned out bulb in front porch light.	Jack	N/A	Jack will stop by the hardware store after work this week.	
Emergency response system installed (e.g., Lifeline)		Mom and Dad will consider getting a Lifeline system.	Mom and Dad will discuss.	Diane will find out about pricing.	Diane will get pricing this week and let Mom and Dad know what it is.	
Lawn care/snow and ice removal when necessary		Ask neighbor kid Tim if Mom and Dad can pay him to mow grass and shovel snow.	Mom	N/A	Mom will ask Tim within the next week or so.	

The **Recorder** should document your plan for addressing environmental considerations in your **Family Care and Support Plan** starting on **pg. 24 of the Family Meeting Record.** There may still be places where you can't agree or are undecided, and that's okay.

Extended Family or Friends or Community Services

Take a moment to revisit extended family (family other than the spouse/partner and adult children), friends, or community services and others (neighbors, faith organization/clergy) who may be able to provide some of the care and support **(Individual Tools pg. 26**). Identify the individual(s) or the community service(s) and the care and support they might provide. Your local Area Agency on Aging or other resources in the **Helpful Caregiving Resources** booklet (located on the OFOW website) can assist you in identifying community services available in your area.

Here's an example:

Who else is available to provide care and support?			
Extended family or friends	**What might they do?**	**Community Services/Others**	**What might they do?**
Neighbor Dean (Tim's dad)	mow lawn or shovel snow when Tim's not available	Meals on Wheels	provide lunch so mom doesn't have to cook during the day
Cousin Kathy	drive Dad to appointments when Tonya isn't available	Home Care Agency	help with bathing Dad
Mom's friend Margie	take Mom out to lunch so she can get a break		

The **Recorder** should fill in who else is available to provide care and support in your Family Care and Support Plan **on pg. 31 of the Family Meeting Record.**

Plan for Care and Support Activities

Referring to your Shared Assessment on **pgs. 10 - 12 of the Family Meeting Record**, review the care or support activities required and use this tool to plan your care and support arrangement. If the item doesn't apply, check "N/A." If the PWCN will do the care themselves, check "PWCN Self-care." If the care or support will be provided by a spouse/partner, adult child, extended family or friends, or formal services, write the name in the appropriate column. Care and support can be provided by more than one person. If you are unable to decide on certain care and support activities for now, check "Can't agree or Undecided." You will revisit "Can't agree or Undecided" areas later in your Follow-Up Plan.

Here's an example:

Who will provide the following care or support activities	N/A	PWCN Self-care	Spouse/partner and/or children (Names/s)	Extended family or friends (Name/s)	Formal Services (Name/s)	Can't agree or Undecided
Bathing or showering					aide from Home Care Agency	
Grooming (e.g., hair care, shaving, teeth-brushing, nail care)		✓				
Preparing meals			Mom (breakfast & dinner)		Meals on Wheels (lunch)	
Transportation			Tonya			
Managing legal matters (e.g., estate planning, POA, etc.)			John??			✓
Taking out trash/bringing in trash cans				Tim (neighbor kid)		

The **Recorder** should fill in your plan for addressing care and support activities starting in your Family Care and Support Plan on **pg. 32 of the Family Meeting Record.** There may still be places where you can't agree or are undecided, and that's okay.

Master Calendar

Referring to the calendar in your Shared Assessment on **pg. 13 in the Family Meeting Record**, complete the calendar to make decisions about who will provide care and support. For times of day **when no help is required**, place an X in the box for those times. For times **when someone will help**, write the name in those times. **Where you still have gaps**, leave those times blank. You will address those gaps later in your Follow-Up Plan.

Here's an example:

	Early Morning	Late Morning	Early Afternoon	Late Afternoon	Early Evening	Late Evening	Overnight
MONDAY	Aide	Aide	X	X	Mom	Mom	X
TUESDAY	Mom	Mom and Tonya	X	X	Mom	Mom	X
WEDNESDAY	Aide	Aide	X	X	Jack	Jack	X
THURSDAY	Mom	Mom and Tonya	X	X	Mom	Mom	X
FRIDAY	Aide	Aide	X	X	Mom	Mom	X
SATURDAY	Mom	Mom and Tonya	X	X	Mom	Mom	X
SUNDAY	Mom		X	X	Mom	Mom	X

The **Recorder** should document your master calendar in your Family Care and Support Plan on **pg. 37 of the Family Meeting Record.** There may still be places where you can't agree or are undecided, and that's okay.

Note: Making sure that a person's physical and personal care needs are addressed is often the main focus of a family's care and support arrangement, but it's just as important to think about how to keep the PWCN—and the primary care partner—socially and emotionally engaged with others. The ***Engagement Calendar,*** available on the OFOW website, is a resource that can help ensure that the PWCN and/or the primary care partner is staying connected and help find the "gaps" where more engagement might be needed.

Back-up Plan

Sometimes the unexpected happens (illness, emergencies), and the care and support arrangement you've agreed to falls apart. Other times, the usual care partner(s) is not available because of vacations or important events (for example, weddings, graduations). Take a few moments to think and make notes below about a back-up plan for when the "usual" care partner(s) is not available.

The **Recorder** should document your back-up plan in your Family Care and Support Plan on **pg. 38 of the Family Meeting Record.**

Occasional Help

When all is said and done, some family members can only help occasionally. What are some things those family members could do to add to the care and support arrangement? Some examples include taking the PWCN out for a drive or to lunch, visiting, and helping to find out more about a needed resource.

Here's an example:

WHO	TYPE OF HELP	WHEN
Diane	Call Mom and Dad to check in, deal with Medicare and insurance stuff	Anytime
John	repairs around the house	when he and Shahla visit every few months
Cousin Kathy	drive Dad to appointments	on Mon, Wed, and Fri mornings when Tonya is not available

The **Recorder** should document who might help occasionally in your Family Care and Support Plan on **pg. 38 of the Family Meeting Record.**

Contributing Financial or Other Resources

When it comes to care and support decisions, discussing finances can be tough. When you each thought about What's Possible in your Individual Tools **(Individual Tools pgs. 23 - 25)**, there was a space to indicate financial or other resources you might contribute. Take a few moments to discuss what that looks like. You do not need to write down specific amounts, and writing it down does not mean that the person is required to provide it. This is just to get you thinking about ways that family members might contribute other than, or in addition to, providing hands-on help.

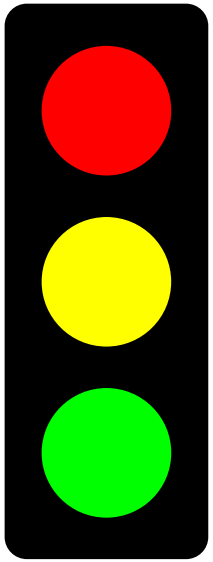
For example,

- Dad says "Since I'm no longer driving, you can use my car to take me to appointments and run errands, and I'll pay for the gas."
- Siblings who live at a distance help pay for home care services to give the usual care partner(s) a break.
- Daughter agrees to help with the cost of a Lifeline.
- Siblings pay health care premiums for their brother who gave up his job to care full-time for mom.
- Son-in-law loans his old laptop to Mom and Dad to help them stay in touch.

Family members who live far away from the person with care needs often wonder what they can do to help. For guidance about how remote family members can be more engaged in the care and support arrangment, refer to the ***How can I provide meaning support from a distance?*** tip sheet on the OFOW website.

Some families actually decide to directly compensate family members for the care they provide. In the ***Helpful Caregiving Resources*** booklet, you'll find a resource about personal care agreements, "How to Compensate a Family Member for Providing Care," which was created by the Family Caregiver Alliance.

The **Recorder** should document how family members might contribute financial or other resources in your Family Care and Support Plan on **pg. 39 of the Family Meeting Record.**



Readiness for Part B

Part B is thinking about **What's Next** and creating a **Follow-Up Plan**.

How ready do you feel to move on to Part B?

Do you need to take a break...a few minutes?...a few days?

Is it time to call in a professional counselor or mediator?

Part B: The Follow-Up Plan (What's next?)

Now that you have completed your Family Care and Support Plan, what's next? It's important to have a plan for checking in with each other and revisiting the care and support arrangement; otherwise the work you've done so far may get lost in the busyness of daily life. Revisiting the care and support arrangement also ensures that you are staying up to date with changing needs and circumstances.

Plan for Ongoing Communication and Care Coordination

Ongoing communication and coordination is vital to keeping the care and support arrangement working for everyone involved. To have good communication, it's important to consider what kinds of information need to be communicated, what types of communication work for your family, and how often that communication should happen. Take a few minutes to consider the following:

- What kinds of information will be communicated and to whom?
- Is there information that the PWCN does not wish to share with other family members?
- Is there information that certain family members do not wish to know?
- What are the preferred methods of communication in your family? What methods work best for each of you (telephone, texting, email, FaceTime, Zoom)?
- How often should you communicate? Daily? Weekly? Monthly?
- Will there be a "point person" for communication? Will certain family members be responsible for communicating certain information to certain people? (whoever accompanies Dad to a doctor's appointment will communicate what happened, what was learned, any changes in medications, etc.)

Plan for Ongoing Revision to What's Needed, Wanted, and Possible

Care and support needs and circumstances can and will change over time. What's working today may not work further down the road. Thinking ahead may help your family to avoid making decisions in a time of crisis.

How will you revisit what's needed, wanted, and possible? Will you use these tools or some other system? The **Recorder** should document your plan for ongoing revisions on **pg. 42 of the Family Meeting Record.**

Plan for Meeting Again

Getting everyone together to discuss the care and support arrangement periodically is a good way to ensure that everyone's voices are heard. There may be unresolved items or issues that require further consideration. You may choose to set regular meetings (e.g., monthly, every 6 months) or plan your meetings one at a time. Not all meetings need to be face-to-face. Do what works for your family. **On the Our Family, Our Way (OFOW) website, you'll find a *Sample Agenda* for follow-up meetings.**

When will you meet again to review the care and support arrangement? The **Recorder** should document your plan for meeting again on **pg. 42 of the Family Meeting Record.**

Plan for Revisiting Unresolved Areas

Finally, it's important to list those areas that are unfinished or unresolved at the end of this meeting. To do this, go through your Family Care and Support Plan (**pgs. 19 – 37 in the Family Meeting Record**). Find those areas where you can't agree or are undecided, or where there are gaps in care and support and have the **Recorder** document them on **pg. 43 of the Family Meeting Record**.

For now, you have agreed to disagree, and that's actually a start! This is now a "to-do" list of sorts and becomes part of your Follow-Up Plan. Each time you meet, make it a priority to address these issues. It may be helpful to refer again to the ***How Do We Deal With Major Differences During Our Family Meeting?*** tip sheet on the OFOW website.

You may find that bringing in a professional to help you work through these unresolved areas can be valuable to all of you. Your local Area Agency on Aging can provide referrals for professionals such as counselors, social workers, or family mediators in your area. Some resources for locating professionals can also be found in the ***Helpful Caregiving Resources*** booklet.

You've completed your family meeting!

We hope this process has been helpful and that you continue working together to maintain the best possible care and support arrangement for your family, your family's way.

To access other tools and resources for caregiving families, visit the OFOW website:

www.MiamiOH.edu/ScrippsAging/OFOW

We would love to hear about your experiences using Our Family, Our Way!

Please visit the OFOW website and complete the brief survey to share your feedback.