Create Engaging Programs: Unite with Community Professionals to get ACP Message to Public

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Objectives:
1. Identify challenges surrounding advance care planning public health education
2. Review process of creating engaging inter-agency public health programs
3. Provide examples of four SW Michigan collaborative programs & lessons learned

Key Terms
Advance Care Planning
Term used for the healthcare planning process of understanding and sharing their personal values, life goals, and preferences regarding future medical care.

Advance Directive
is the legal document where any adult can indicate who they would want to make medical decisions and what their life-sustaining goals of care wishes are if they are ever unable to make medical decisions on their own.

Patient Advocate
is the person(s) which patient trusts and names on the advance directive document to make medical treatment decisions for them if they are ever unable to make their own healthcare decisions. Also known as healthcare agent or power of attorney for healthcare.
ACG Guides Patient Care

Advance care planning conversations clarify the patient’s goals of care with loved ones and medical providers. They promote autonomy and are the foundation that guides a person's medical decision.

Benefits of Advanced Care Planning:
- Increase likelihood person’s wishes are followed because decisions understood by their healthcare agents.
- Decrease use of intensive treatments at end of life.
- Increase use of Hospice, decrease hospitalization

Family/lived ones:
- More satisfied with the care
- Have less emotional stress with difficult decisions
- Have less complicated grief following the death of their loved one

Advance Care Planning Conversations

Future Healthcare
- Medical Care Decisions
- Advance Care Planning
- Education & Documentation
- Goal of Care Conversations
- Healthcare Decision-
  - Making

Medical/Legal/Community
- Educate, encourage and assist adults make healthcare choices, discuss with family and complete an advance directive document.

Ongoing ACP Conversations guide healthcare decisions over time

Healthcare decisions

A: Self: Own Person

B: Patient-Designated: Patient Advocate
- Empower/empower advance Directive/DPOA Healthcare
- Only after 2 physicians deem person lack ability to understand, express choice, appreciate/apply facts to own situation and use reasoning.

C: Court-Appointed: Guardian
- Guardianship letters of authority signed by judge
- No advance directive/Healthcare DPOA, unable to make decisions

D: Default/Surrogate: Surrogate decision maker
- Emergent only- generally hospital only
- Often-life-sustaining treatments, code status, surgery & discharge
• Just over 1/3 or 36.7% of Americans have an advance directive

• Less than half of severely or terminally ill people have an advance directive

• Approximately 70% of older adults will have a time in their life where they need assistance/cannot make own decisions

ACP Outreach

Barriers; Community Perspective:

- Lack of awareness
- Cultural differences
- Confusion
- Denial/death-denying culture
- Multiple types of advance directive forms
- State-specific & laws change over years

Barriers --- Provider Perspective

Practitioners report several common barriers:

- Time
- Personal discomfort with the topic and patient emotions
- Lacking confidence to say the right thing
- Lack of training

Interestingly, a May 2018 survey by University of Massachusetts showed that while 96% of people say they’ve discussed that end-of-life wishes with their doctor, 60% of the time it is the patients or the family who initiate the conversation with the medical practitioner.
ACP Outreach Themes

• It takes many times of hearing message before people will act
• Mortality makes people uncomfortable and they avoidance or ‘not me’!
• While individual ACP facilitated conversations are ideal, many are more comfortable in small-group settings
• There is confusion regarding advance care planning, forms, terms and decision-making roles. There is additional misunderstanding between the different types of planning: 1) Healthcare 2) Financial 3) After-Death
• Bad experiences/story: Community & professionals not understand advance directive empowerment & no consistent processes

Find others similar or related interests - Network

• Brainstorm
  Who audience? Consider under-served
  Theme - Title - Content
• Create program
  Place/Venue
  Time – of day & length of event
  Cost (organization, grant?) – food, room rental
• Spread word – pamphlet, social media, team
• Implement
• Evaluate – participant evaluation form
  Meet after: good, changes, adaptations?

Ethnic Minorities
African Americans
Hispanic Americans
American Indian
Regional? SW Michigan: Burmese

Under-resourced
Rural
Low-income
Disabled
LGBT
Regional? SW Michigan: Migrant workers
Community - General public
- Four Pillars of Planning
- ACP Workshops – collaborative
- Daylight & Darkness; Unthinking Mortality
- Aging Road Map Series

Professionals - inform, update & share resources
- ACP Champion - 2 hour training
- First Steps Respecting Choices ACP Facilitator training
- Update: End-of-Life Perspectives TED event

Examples

Lessons Learned
- It takes more time & meetings than you think! Start 6 months prior to event.
- Each event: Leader, use responsibility chart & action items
- Have 3 people outside your group review brochure check message & errors
- More heads (talents) are a definite asset & inter-agency excellent for community & organizations
- Advertise multiple ways to catch audience and consider different generational preferences
- Create memory stick with master program details

Resources

Create effective paper advertisements
Simply Put:

Community Health Programs Event Planning Guide
For Oct Health Literacy month, but concepts apply

Awareness & Cultural Competence:
Cultural/Faith Groups Summary Resource
Brochures help guide discussions, communication, decision-making
http://cancercontrol.cancer.gov/publicationsandtraining_agespecific

A few good articles to reference...
Do YOU have an advance directive?

I am healthy now, why should I worry?

Life can change in an instant
Accidents happen, health can decline

Autonomy - Live life your way
Opportunity to voice your choices

Best time to share your values and goals
Empower loved ones when you are well

No one can honor your wishes if they do not know what they are.

Steps of advance care planning

DECIDE: Explore key issues and decisions
DISCUSS: Choose and equip a patient advocate
DOCUMENT: Create advance directive legal document
DISTRIBUTE: Make plan available/accessible
UPDATE: Review with life changes. It is a living document.
Pass the Word on to loved ones about the importance of advance care planning

- Spouse
- Parents
- Adult Children
- Siblings
- Friends

Accidents and changes in health happen. Advance care planning is for all adults.

References—October 15, 2019
Great Lakes Health Connect Conference – Hilary Kerr, Created 10/18, 2019


10/18/2019


(8) Slide 9: University of Massachusetts Goals of Care Survey (May 2018). Obtaining document from library (but found within http://www.wbur.org/commonhealth/2018/05/15/gawande-end-of-life-conversations)