Care Manager Meeting Highlights 03/14/2019

Handouts from presentations attached to email and on website (handouts and highlights under Care Manager User Group, handouts also under Care Manager Resources)

ACP Presentation

Stephanie Van Slyke, BA, RN, Advance Care Planning Coordinator & Ethics Coordinator at Munson Medical Center

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shared how ACP culture has changed for the better from only initiating related documents to patients when they were already aged or ill to starting initiation of documents to healthy patients even at age 18. Stephanie is always available for questions.

She shared examples of several documents Care Managers will see and discussed these documents.

"Plant seeds" with conversations to encourage that every person over the age of 18 starts the advance care process. Munson no longer uses Five Wishes, but it is still accepted; Munson has a Workbook with some tools to support its use. These can be ordered from Munson (attached as handouts and a document "MMC ACP – How to order forms and access in MMC systems" which gives form ordering directions).

An annual wellness visit in the PCP office, long before the person is overwhelmed in "Crisis mode" as an inpatient, is the best opportunity to start the conversation and gather completed documents. Care Managers have the opportunity to establish relationships and really understand the patient's intentions; those in the hospital, at an end of life situation, don't have that same opportunity.

Advanced Care Planning Workbooks notes

- Help people think of ACP, and death, as a process
- Differentiate treatment wishes involved with ACP, such as Life Support vs. Do Not Resuscitate (DNR) vs. CPR. Patients are often confused about these differences and don't really understand the ramifications.
- Help people specify what they value personally in setting criteria for a "Meaningful Life"
- May be added on to document person's specific wishes i.e. patient wants to hear specific music played or wear their signature lipstick.
- Pages 5 and 6 of the "MMC-ACP Workbook Form 11649" has a good worksheet to help patients clarify their desires
- Including family as much as possible is helpful so everyone on the same page
- She emphasizes not starting with directive; more general discussion first

Overcoming Bumps in processing progress:

- **Really Common Bump:** "It's on my to-do list…" (every year), "I'm not old enough yet," "I'm not sick enough; I'm pretty healthy." Possible solutions:

- Reiterate that in life people just cannot know when they will near death because life, and ALL the people in life, are not predictable i.e. traffic accident, sudden illness, medication mix-up etc. Avoid presenting it as a scare tactic or threat.
- Encourage people that while they are well and of sound mind is the perfect time to record these wishes, not when they are not.
- Bring up the person's family and mention how helpful it would be to them to not be pressured to make such personal decisions for the person.
- Educate them that Michigan does not have a Family Consent Law, and without these documents patients will often be sent to the system for court-appointed guardianship, often in the form of a stranger.
- Inform that a person can revoke their ACP or Patient Advocate at any time.
- Address unfinished ACP again at hospital discharge, reminding the person that he/she had not planned on being in the hospital either.

- **Touchy Bump**: "My family and I don't get along," or Spouse too emotional to be objective (when designating patient advocates). Possible solution:
    - Educate that patient advocates do not have to be a spouse, adult child or family member.
    - Explain how sometimes better choices can be found among non-relatives or friends.
    - Explain that an Advocate's proximity to the patient's hometown also is not regulated.
    - **Considerations for Providers as mental health determinate**
    - If a provider does not want to be listed as the person's mental health determinate because the relationship isn't there, or isn't strong enough, reach back to the (patient) and ask for more detail on why they listed the provider over others.

- **Confusion Bump:** People can misinterpret the POA to mean the financial POA and are not willing to share information they deem private. Possible solution:
    - Clearly explain that the POA for health care has to do with capturing a patient's physical wishes should they be in an end-of-life stage. Refer to them being empowered that their final wishes will be honored.

Where to locate AMD documents on Powerchart is detailed in the attached "MMC ACP – How to order forms and access in MMC systems" document.

Stephanie provided a 2019 schedule of ACP Workshops for the public ("MMC ACP Workshops_2019"). The format lends itself to experiences-sharing and really gets people thinking as they hear the various circumstances described by others. Stephanie also discussed MI POST and shared some documents.

Next Meeting:

- **May 2 – CHANGE: Wendy Weckstein, PT, MEd, will be presenting on Mindfulness - An evidence-based model for integrating mindfulness and healthy lifestyle approaches into your practice (you and your patients!). Many NPO physicians saw this presentation on Feb 20 and asked that it be shared with Care Managers.**
- June 27
- Aug 1
- Sept 12
- Oct 31
- Dec 5

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