

Meeting Minutes

A Backup Plan for Solos Task Force

Tuesday, April 10, 2018 – 7:30 to 9:30 AM
Wilder Center, St Paul, MN

Task Force Members Present: Joyce Edwards (by phone), James Falvey, Genevieve Gaboriault, Ellie Hands (co-chair), Darla Kashian (by phone), Karen Peterson, Mark Peterson (co-chair), Peter Rothe, Patty Thorsen, Martin Wera

Members Not Present: Kathleen Dempsey, Susan Henry, Greg Owen, Sabina Sten

Staff & Staff Support Present: Matt Bryne, Linda Camp, Julie Roles

Overarching Goal

Stimulate the development of a supportive infrastructure to help solo adults, particularly older solo adults, successfully navigate health related events and, therefore, be less likely to become vulnerable adults—with its accompanying loss of self-determination for the individual and high costs to society.

Expected Outcomes of the Project

- General profiles of solo older adults (situation, needs, perceived barriers)
- A description of the current Minnesota infrastructure to support solos health decision making
- Description of the core elements of a health decision “backup plan”
- A list of important resource gaps and potential solutions
- A list of recommended priorities for future action and preliminary work plan

Proposed Outcomes for This Meeting:

Learn about the role of social workers in navigating health events; begin assessing Minnesota’s long term care planning tools

Welcome/Negotiate Agenda

Co-chair, Mark Peterson, called the meeting to order. Asked for additions, deletions, changes to the minutes of the 3/13/17 meeting. Minutes were approved with one change: Martin Wera was present.

Updates and Check-ins

- Member told group that his mother was going to be moved to an assisted living facility and they require a POLST. Told by the director that the health care directive doesn’t count if they need to transport her to the hospital. Seems to be a real push toward the POLST. A lot of misinformation floating around.
- Member: Anytime a person is moved to a facility where care is provided, the person needs to provide a code status. Differs from a directive. It is a medical order. A lot of facilities use a POLST for that reason. EMTs only follow medical orders; they won’t follow a health care directive.
- Member: Requiring a code status is a very practical rule. They have legal responsibility and need to know what to do in case of an emergency.
- Member added that the POLST should reflect the healthcare directive. Too difficult for medical staff to go page by page through an advanced directive.
- Julie provided an update on the ad hoc advisory group, providing a list of people who have been invited to participate in two meetings. The first on May 22, from 11:00 to 1:00 at Wilder

will provide background information. The second on Sept 9 will provide an opportunity for participants to react to the task force's preliminary recommendations.

Guest Presenter

Carl Hokanson, Director of Social Services, Social Worker, Capital View Transitional Care in Regions Hospital (Health Partners)

Doing transitional care social work for about 14 years. Working with a patient in transitional care (also called sub-acute care) gives a little more time working with an individual. Average length of stay is two weeks. Not as much time as a long-term care social worker or a community social worker but longer than an hospital social worker.

The social work profession would address this issue using a "person-first" approach including using person-first language. We wouldn't call a person a "solo." It tends to label the person and doesn't define a person. We would say "a person with a limited social support system." What we have in common is more than our differences. Another important concept from a social work perspective is patient or client self-determination. People have a right to make their own decisions and determine what's right for them. For some people, not having social supports is not an issue. It's their choice. We also look at people from a strengths perspective rather than from the point of view of barriers.

There are very few people that come through our system for whom we can't find someone who can provide support.

Member: How many need support in finding the right people who can support them?

We have conversation about support with everyone, not just with solos. Everyone has problems identifying who will help. People don't want to ask for help. Social workers help people come to understand that it's time to ask for help. We do psychosocial assessments. This week I was working with a woman who has nine children. She didn't want me to engage any of them. We have become so individualistic in our society that we feel shame or guilt in asking for help. How can we help people reduce that feeling of shame or guilt? Just throwing resources at the problem won't fix it. We need a bigger conversation in our homes, churches, in society to model accepting help and making it okay to ask for help.

Member: How did you engage the family in the situation you described?

We usually have a care conference. Family is almost always very interested in helping.

Member: Is there a difference between message and messenger? Do social workers and doctors who validate the need change the dynamic?

Having a social worker initiate the conversation makes a difference. Coming from a professional makes it more legitimate.

Member: Have you encountered the reverse where the professional is set on what the patient needs, not listening to patient?

Comes back to idea of self-determination. We need to be able to support a person's goals. Because of our training we sometimes think we know what's best for someone. We are working against doing that.

I often use the State of Minnesota Probate and Planning Guide from the attorney general to help get the discussion going. In transitional care people are often realizing for the first time that they might have a limited circle of social support.

Member: My husband's sister was at Capital View. They have a notary on staff allowed her to do a health care directive on site. How often do you get people to completion on a health care directive?

Because of the short-term nature of people's stay with us, we rarely actually do a POLST or health care directive with someone.

Member: What happens if someone has very unrealistic goals.

Comes back to gentle social work discussion to help people readjust their goals. People have the right to make bad decisions. I support that. We work as an interdisciplinary team and try to help people make informed decisions.

Member: Do you have enough resources to refer people to the right place?

There are never enough resources. We are good at making do with what we have. There are continuum of care services for commercial and Medicare payers that help people make transitions home. We also can connect to person to community social workers.

Are you familiar with the Return to Community initiative from the Metropolitan Area Agency on Aging? For people who are in placement and want to move back into the community. These community social workers can work with the patients longer. They meet with any person who has been in nursing care for 40 days. It's a free service. No income requirement. It is triggered through an in-hospital or facility stay. Run by the same people who run the Senior LinkAge Line.

Member: One of the themes in our earlier discussions has been a lack of trust. I don't trust the system to follow my wishes. How do you build trust?

Hard to gain trust because of shorter period of time. People can tell if you are genuine and that's important to building trust.

Linda: What is your experience working with diverse groups and people with low incomes?

We have diversity but not in large numbers. Everyone is insured. Capital View is not licensed to accept Medical Assistance.

Member: Capital View provides something like an overall geriatric assessment. Not many places you can go to do that. Can we suggest better structures in communities that would help people going through a similar process? People don't come willingly to the process but are in the end happy with it. People need an event to trigger their interest in these things.

Planning Tools Homework

Linda noted the four pieces that were a part of the homework.

Own Your Future handbook.

Member: Thought this was an excellent resource. Would be helpful to get to HR managers and financial planners. It would have been helpful to me to have this when I was in my 40s. Should be distributed to libraries.

Member: Great planning tool but how do you get people to use it? Reminds me of *Who Gets Grandmas Yellow Pie Plate* at U of M extension. It was a book and they would send people out to do presentations about it and support people in using the process. People just won't do it alone. Needs an educational component.

Linda shared a member's comments: Pros – content was comprehensive and usable for people with college education. Cons – too much information and steps for many people, particularly for people with cognitive impairment. Needs to be updated. It's five years old. Too long, too small type for aging eyes.

Member: Info about health care directives is in there but kind of buried. Reading level test would measure pretty high. For my purposes, I liked it.

Member: Speaking from the perspective of my low-income clients, no one has money for long-term care insurance or long term care. Planning is not a priority when day-to-day life is a struggle.

Member: Well organized but people probably won't use it. Needs an outside trigger. Trying to figure out the triggers is hard. They have a website that is also helpful.

Member: The photo looks like the task force. White, middle class. Needs diversity.

Senior LinkAge Line

Member: Wonderful service. Called three times. Calling from cabin with phone access. Woman was wonderful. Average length of time of call is 30 minutes. Everyone provides some info, name, birthdate, address, gender. Patient, knowledgeable, about quarter of callers fit definition of solos. Asked how you help solos. Said everyone has similar needs. Sometimes they will do a three party call getting someone else on the phone who can help. Do MN Choices assessment, financial planning, homeless callers, companionship programs, education and referral, SNAP program, hearing impaired, open enrollment for Medicare. Have language translation services. Thumbs up if you access it.

Member: I refer a lot of clients to the Senior LinkAge Line. Do trainings about it. I think they would be very open to working with us.

MinnesotaHelp.info

Member: Very impressed with it. Went through the profile they provide. Good questions. Going back and forth was confusing. Navigation was not easy. Information is excellent.

Member: Very comprehensive. Walked through with my mom in mind. Took a long time. My mom would have been frustrated. Walked away with list of organizations but the same organization over and over. Too much information.

Member: Very frustrating. Who is the user going to be? Lots of information but hard to access what you want. For a seventy-eight year old it is hard to use. Lots of information but not very accessible.

Linda summarized a member's comments provided by email: Overall, the website is a useful tool for identifying a range of options for particular program types in a given area, but without any review of quality, the number of options identified may be overwhelming for some older adults who are using the site. I generally think boomers will have a less difficult time using all of the site's features than those who are 80+, but boomers will definitely be looking for quality ratings, so they will need to go elsewhere for that kind of information.

Linda: Did search for Kathleen Dempsey's organization and First Fiduciary. Neither showed up. I went through the planning piece. Do you need help feeding yourself. If I did won't be able to navigate site. Seems like a mismatch between what is trying to do and what it achieves.

Health Directive Statute

Member: So many advance directives out there it is becoming overwhelming. Different formats no standardization. Makes very difficult for health care providers who are trying to follow. I am back to thinking of it as a tool for conversation with family and it doesn't work in health care situation. Something else needs to be used in health care settings.

Member: That is what the POLST is.

Member: Do I remember Marit saying that she is not fond of POLSTs.

Linda: Yes. It is because it does not require the signature of the principle (the patient).

Member: When Honoring Choices was started, one of our goals was a standardized form.- idea was to have standardized form. But that's not the reality today. We have taken the approach that getting one done is better than trying to get to standardization. We see it as a tool for the conversation. If you don't have someone to discuss with, that's a conundrum. Any form is legal. They are only as good as how people use it. Trained facilitator always will be result in a more informed more meaningful directive. Maybe we should consider tweaking one of the currently used forms to include specific questions that relate to solos.

Member: Only as good as time put in creating but also it is only good about as health care uses. Nine pages won't get read.

Next Steps

Next meeting we will be switching gears. End of discovery, starting analysis next month. Next month, painting the picture of solos.

Thinking Questions:

1. At the beginning of our process in September, what were your assumptions about solos?
2. What are two new insights you have gained about solos since then?

In preparation for next month's meeting, you might again look at the summaries of interviews and focus groups and the information that is in the handbook we gave you at the beginning of the task force sessions.

Report of Results Focus Groups Evaluation

5, 5, 5, 4.5, 4.5, 4.5, 4.5

5 – good info

5 – did what said we do

5 – enjoyed perspective of the social worker

4.5 – Feel like I am reentering – maybe on my shoulder

4.5 – enormity of the task is starting to weigh on me – maybe even our term of “solo” is off – trigger moments – big hill to climb.

4.5 – Carl's view is only one small slice – could have talked about more.

4.5 – assignment was helpful – homework is good idea – Carl did an excellent job