

Meeting Minutes

A Backup Plan for Solos Task Force

Tuesday, August 14, 2018 – 7:30 to 9:30 AM
Wilder Center, St Paul, MN

Task Force Members Present: Joyce Edwards, James Falvey, Genevieve Gaboriault, Ellie Hands (co-chair – on phone), Susan Henry, Darla Kashian, Greg Owen, Karen Peterson, Mark Peterson (co-chair), Peter Rothe, Sabina Sten, Martin Wera

Members Not Present: Kathleen Dempsey

Guest: Diane Graham-Raff, Metropolitan Area Agency on Aging

Staff & Staff Support Present: Linda Camp, Marit Peterson,

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:

Develop a preliminary list of recommendations for the Final Report.

Develop a preliminary list of stakeholders.

Check-in and Updates

Co-chair, Mark Peterson, called the meeting to order. Asked for additions, deletions, changes to the minutes of the 7/17/18 meeting. Minutes were approved as submitted.

- Ellie had knee surgery and checked in on how she is doing. She shared insights about doing so as a solo. Medical staff referred to her friend as “your loved one.” Her friend is not a “loved one.” Organizations need to be careful about the language they use.
- Member said that he was happy to see the first draft of the report. Heartening to me to see that we have done quite a bit of work. Linda has done a good job of laying it out. (Heads all nodding.)
- Member said that the framing issues brought it into focus for her. Solos are looking for a plan, a person and support. Having that crystallization has been helpful. That was captured in the last meeting minutes.
- Meeting coming up on September 6 with the Ad Hoc review committee. Intention is to get additional perspectives from people representing diverse communities. Group met in May to lay foundation. We will share draft recommendations with them prior to the meeting and ask them to provide feedback. If you would like to come to the meeting, let Linda know prior to

the end of this meeting. The meeting will be 11:00 to 1:00 with lunch provided. Ellie, Martin and Greg said they would like to attend.

Review of Project Goals and Creating Preliminary Recommendations

Linda noted that she and Pahoua have worked with Bush Foundation to make a plan for using some remaining budget money. We hope to provide some small awards of money to help do capacity building in some organizations to carry some of the ideas forward.

What are the actionable things that we would like to see happen and who would be the right people to make it happen. What can we do to stimulate the infrastructure needed to support solos?

One of the most important concepts that has come out of the work so far is the framework for thinking about solos and solo-ness. The other piece that Linda thinks is critical is recognizing the importance of pulling the decision-making role out as a significant role for support.

Linda noted four strategic areas to consider: Planning, People, Laws and Policy, Education and Awareness.

Linda gave two examples. In the area of awareness – Who needs to know about solos? For example attorneys – What do they need to know? Linda and Marit have done a workshop at the annual law and aging conference, followed up with webinar and an article.

Second example. Who are the professionals who can help solos with health care decisions? Linda interviewed the executive director of the Alliance of Professional Health Advocates (APHA) and she invited Linda to be a part of a monthly conference call where members dial in. People work with solos all the time but usually through a family member. I helped them think about reframing. The executive director was very please because she said they learned something that is important, and they have an action item—putting together a piece about how to market to solos. There are no APHA members in Minnesota.

These types of steps might seem small but they will help to move the ball forward.

There are many people in the medical system working with people at critical junctions and could have a big impact. How would be reach them within a system? Hospitals have discharge planners, social workers, care transition coordinators. Start with the head of social work in each hospital. What might be some action steps? Awareness about what to do when some one identifies as a solo. May need additional services. Could do lunch and learns and seminars with CEUs. Soft selection of people who might be willing to be personal champions.

Member asked us to define what we hope will shift as a result of awareness raising. When we talked to the social worker he said he is aware (doesn't call it the same thing but is aware of the issues). A lot of these contacts are pretty short term. Can they make a much of an impact?

Member said the desired shift is that they are alert to recognize the signs of solo-ness. We need to provide tools to help them more effectively support the solo.

Good line of discussion. If you think about how you get people to do things, one way is the opt-out concept. You have to opt out of doing something rather than opt in. If you want to get people to enroll in deferred compensation you automatically enroll them and then they can opt out. For something like this it seems that health plans ought to have an opt out. As you enter the system, you have a form that asks for substitute decision maker. Everyone is immediately engaged in the conversation. May even extend to naming a caregiver. This approach isn't foreign in health care systems, but they are not universal and it's not opt out. The state is interested in supporting

the idea of “health care homes.” If we could influence the standards for health care homes and have helping people identify health care decision making support a part of it, we could make a big impact. In order to qualify as a health care home, you need to help people immediately identify a substitute decision maker, a caregiver. Minnesota Board on Aging and Minnesota Department of Human Services have been involved in pushing the health care home idea.

Member mentioned that financial advisors need to ask for a trusted individual to be a part of their record. Linda asked would people who have a hard time naming someone be a good target population for increasing awareness. You can't assume that people will have this person and the financial advisors need to know how to help someone who does not have someone to name. Is there a professional organization that might help with that? Associations of certified financial planners?

Another stakeholder should be Senior LinkAge Line. They are preparing kiosk card. What about one for health care directives? Could be a resource for solos. For example, “if you were a solo senior – if you experience solo-ness this is something you should think about.”

Since we have established that solo-ness can happen to anyone, it might be a better strategy to look at more universal solutions. If we just targeted solos, you will only catch a very few people. Can we make it part of protocol to ask if you have considered a health care directive? Have you identified a supportive decision maker for yourself? Worry that too targeted solutions will not sweep up enough people.

Members said, I agree, but if you have solutions that work for solos they will also work for others. If you focus on hospital and transitional care social workers you are at the end of the line. If we can offer a language that helps people understand the idea of solo-ness. They need tools and the process brought upstream into clinics and housing settings. I don't think you can require some of this stuff but need to make it broad and upstream. Minnesota Medical Association might be a possible partner.

Member added parish nurses as stakeholders. About 30% of people in Minnesota attend worship services once a week. A woman came to my attention this week who has no one. Church members were able to help her. Fairview's faith community. Park Nicollet has one. Minnesota Council of Churches. Churches know who the solos are. They are doing okay until a problem comes up. Then there is a whole army of people within the church to respond.

The Faith Community Nurse Network has about 50+ parish nurses as members. They do online training.

Wherever there is a point of entry into an organization there should be a question about the person's support system.

One of our recommendations should be that everyone should plan, and many organizations can be an entry point into that process. I am having a little disconnect about what tools we are offering to help solos. Generally we can recommend planning. When you enroll in Medicare or other program maybe we could recommend some funding for helping people find a support person. Need a social worker to help them think it through. Need some other pool of people who would meet the need for a supportive decision maker for people who don't have them.

How would we go about creating that pool of people? What do organizations like AARP think about that role? Professional guardians and conservators who want to expand service line might be a part of the solution. It seems to be a burgeoning cottage industry.

That works for people who are able to be proactive. When a person gets in an emergency situation they will not be able to tap into those resources. I think a significant part of the solution has to be to backfill for people who haven't planned or can't plan. Seems to me that that is the big problem. 75% or more of the need is there.

If there is a pool available, this would be something physicians and others could refer people to. Would be great if there was some kind of organization that would take on providing healthcare agents, volunteer or paid. Is there such an organization?

What would the scope look like? Can we do this with 10 people, 100, 1000?

What are we asking of these people? It is not a cookie cutter solution. If something happens to me who know what I would want? It's a harder ask of people to provide support for ongoing decisions and needs. Be the person who know what so and so wants, yes. But be there for someone no matter what they need, that's a bigger ask.

In case of faith communities, the infrastructure is already there for connecting with solos. Could easily add the question of do you have a health care agent and if you don't, I help you find one or I could act in that role for you. We could create a model for doing that in faith communities. Mark had the necessary connections and said he could easily pull a pilot together.

We should recommend that people should complete a health care directive even if they don't have an agent. When we work with people in doing directives, that's what we tell people to do, do the directive even if you can't name an agent. How would be get that word out? On Senior LinkAge Line cards, put on Honoring Choices website, other?

Could we recommend that hospitals expand their offices of medical ethics to have a pool of people to help with people in situations that need help?

Every hospital has an office of ethics and they also have people trained in advance care planning. Housed in different places but that would be a good target. Need a tool that helps people know how to help people. Reminder that people shouldn't let the lack of an agent be a barrier. Is there an existing tool for helping people think through the options of people for agent? Honoring Choices has a guide for picking a health care agent on its website: https://www.honoringchoices.org/images/pdf/HCM_Info_Agent_2015.pdf. It is available in every health care system (not sure if they use it). Could easily tweak the tool to say if you don't have one, some options for finding one and to still complete health care directive.

Needs to be more than "pick" an agent but also how to "find" an agent. Needs to also work for people who are in the middle of a health care crisis.

We need to remember that there is a body of work that's been done around supportive decision making. There are a lot of resources to help you find someone if there is someone to find. When we think about the continuum of solo-ness, they are not the people we are talking about. We are talking about the people who cannot find someone. What can we offer them? The people question is a bigger question than the planning question.

Part of the problem is that people may have someone but don't think about it deeply enough to find them. That's where a tool might be helpful.

I hear both sides of that. It is time consuming and we need to fund the cost of someone helping. Sometimes we can find someone, but does a relationship actually exist? Often the person is estranged for a reason and won't be able to do the heavy lifting we are asking them to do. There

is a sense that we don't fund enough time to find the person but there are many people for whom that person does not exist.

Are community settings the place where these support systems might flourish? Can we create some pilots where people can support each other? Would this be possible in a Mill City Commons type of setting? It happens organically there now. Don't know that there is enough interest for an additional educational component.

Phillips Wellness 50+ group where we did a focus group is an example of community support that can be generated. It can be naturally occurring where people come together and have built trust with each other.

Can we build off the annual Medicare visit? Ask people for updated info each time they visit.

Respecting Choices works with health systems and medical providers and trains people to go out to the community and facilitate planning processes. Honoring Choices does that in MN. Could be sensitized to the role of solos.

Honoring Choices is well integrated into medical practices. Karen said they could add solo info to all materials. We can identify who to communicate with but what are we communicating? What is the tool? People are eager to add the information to their arsenal.

And what do we expect them to do with it? Because of ongoing conversations, I have had with a solo over time, I know that he has reconnected with his sister. Several visits with his physicians contributed to that outcome. Faith communities, Pillsbury United Communities, YMCA, etc. could help support.

Maybe we need to show what disaster looks like. What about a PSA that shows how things can go awry if you don't plan? What is the motivator? Few people plan to the degree that is very useful.

When you want someone to stop doing something fear works. Hope is more likely to get people to do something.

What percentage of people plan now? What are we hoping to get to? Does that address the problem?

The bigger problem is developing the people part of the equation. Medical systems pay people to talk about advance planning. Maybe some additional training is needed to help primary care physician to be able to complete and take solo issues into account. Honoring Choices is actively developing this training. Most physicians focus on medical choices not the agent. If there is no agent then what? What resources can we offer? How often can the physician code for health care directive discussions? Unlimited but must have a co-pay fee. CMS pays for initial half hour and for as many add on half hours as are needed. Recommend removing copay.

Need a reference tool for how to identify a person. Karen said she would work with Mark to create a pilot for faith communities. They are very receptive to health care planners. Hal's church model. How to build volunteers to do little chunks?

Discussion about indicator on MN Drivers Licenses that you have a health care directive. No one knows how it got going and what it means. They don't report to anyone. Karen and Honoring Choices have been working on this. If you strengthened it, maybe it has promise. We could link it to a source that medical people could access.

Next Steps

Linda will draft some recommendations that came out of our discussion and we will discuss at the September meeting. We will also want to talk about the stakeholders' meeting on October 16.

Evaluation

Evaluate the meeting on scale of 1 to 5.

- 5 – excited about distilling what we are doing.
- 5 – Good recommendations – challenge is to get into a format that people can take action on.
- 5 – Very challenging to help people who are unwilling or unable to help self.
- 5 – This is hard. Unsatisfying even if a good meeting.
- 5 – at next meeting there is a lot to do. The drafts have been good and representative. I am hopeful.
- 4 – Feel like we need to flush out the people part more.
- 4.5 – Agree with what people have said but scared with only one meeting left.
- 4.5 – Amazed that each month we find more that we don't know. Helps us know what we don't know.
- 4.5 – Frustrated. Would like to see more of a thread. A zillion different directions. Need to pull it together.
- 4 – Would like to see more focus but good information being shared.
- 3 – Frustrated. Coming up with solutions that might help for dominate culture but people I represent from Little Brothers who are economically marginalized won't be helped with these ideas. Not getting close to helping diverse communities.
- 4 – Share concern about not reaching less advantaged people.
- One member abstained because on phone.

Think about people that you would like to add to the stakeholder invite list.

Next meeting Task Force meeting is September 12.