Learn and apply Leadership & Quality Improvement principles from experts!
Share and get practical tips from colleagues!

Project ECHO University of Hawaii
Long-Term Care Learning Action Network
A Collaborative Partnership to Provide Education from Quality Improvement and Leadership and Implementation Experts with Case Discussion to build a Community of Learning

Long-Term Care Learning Action Network

This series is made possible through GWEP funding to the University of Hawaii Department of Geriatric Medicine from the Health Resources and Services Administration (HRSA): Grant Nos. U1QHP28729 and T1MHP39046 and the support from generous our donors- AlohaCare and UnitedHealthcare
Confidential & Safe

We commit to maintain and safeguard the confidentiality of information shared. All case presentations are required to be de-identified and HIPAA compliant. In order to create a safe learning environment, we will foster a culture of mutual learning and encouragement, rather than negativity, shame and blame.

ECHO case consultations do not create or otherwise establish provider-patient relationships between any ECHO specialists and patients whose cases are being presented in an ECHO setting.
Learning Objectives

• Explore strategies for well-being during the Pandemic and recovery
• Practice Age Friendly Health Systems strategies
• Identify QI strategies to improve nursing home care.
• Increased knowledge for regulatory guidance for COVID and QMs
The Hawaii Consortium for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This program is approved by the National Association of Social Workers - Hawai'i Chapter (Approval HI62792021-190) for up to 1 Social Work continuing education contact hour(s).

In order to receive CMEs please:
1. Register: [https://echo.zoom.us/meeting/register/tJUqcuysrjsvGtE2kdnnVkJ4iAu9cPoOGB](https://echo.zoom.us/meeting/register/tJUqcuysrjsvGtE2kdnnVkJ4iAu9cPoOGB)

** Some systems do not allow access to google forms. Fillable PDFs can be found on our website. Please send to Jon at Nakasone@hawaii.edu
# What Matters Series - 4 Parts

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**Session Topics subject to change**

**LTC ECHO LAN**  
**Schedule**  
2nd Tuesday of each month  
2:00-3:00 pm
# Introducing: The Hub Team

*Our speakers report that they have no conflicts of interest.*

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Aida Wen, MD, CMD</td>
<td>UH Dept of Geriatric Medicine</td>
<td>Course Director</td>
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<tr>
<td>Ritabelle Fernandes, MD</td>
<td>UH Dept of Geriatric Medicine</td>
<td>Speaker</td>
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<tr>
<td>Jim Pietsch</td>
<td>Professor, UH Law School</td>
<td>Speaker</td>
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<tr>
<td>Gayle Rodrigues, MSN, RN</td>
<td>Director of Nursing, Oahu Care Facility</td>
<td>Facilitator</td>
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<tr>
<td>Dana Mitchell, RN</td>
<td>Mountain Pacific Quality Health</td>
<td>QI Coach</td>
</tr>
<tr>
<td>Lori Henning, LNHA</td>
<td>HAH-Quality &amp; Education Program</td>
<td>COVID and Regulatory updates</td>
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Regulatory & COVID-19 Updates
Healthcare Association of Hawaii
Compliance Dates

By January 27, 2022:
- All staff must have received at least a single dose or first dose of a multi-dose vaccine
- Precautions implemented for staff who are not fully vaccinated
- Process for tracking and documenting staff vaccinations and boosters
- Procedures for requesting medical or religious accommodations
- Contingency plans for staff who have not completed their primary series

By February 28, 2022:
- All staff must have completed their primary series or have received an accommodation
February 3: CMS released updated Nursing Home Visitation FAQs. Included is information on the following:

• Suggestions on how to conduct visits that reduce the risk of COVID-19 transmission
• Best practices for improving air quality or managing air flow during visitation
• Facilities can request CMP funding to purchase portable fans and portable room air cleaners with HEPA filters
  ➢ A maximum use of $3,000 per facility including shipping costs may be requested
• States can require visitors to be tested prior to entry if the facility is able to provide a rapid antigen test
What Matters Series – Part 1

Who Knows What Matters Most?
Why do we need to plan for incapacity?
Capacity

An individual is usually considered to have decisional capacity when the individual is sufficiently able to receive, understand, and evaluate information and to communicate a particular choice.
Capacity for what?

Examples include:

Activities of daily living
Finances
Wills, Powers of Attorney
Healthcare decisions, e.g., dialysis, chemotherapy, medication management
Advance Directives
Driving
Who decides

• Capacity and Competency are often used interchangeably but “capacity for what?” is the key question.

• Most day-to-day issues relating to capacity are determined without medical or court intervention.
Decisional Capacity

Medical doctors (geriatricians, neurologists, psychiatrists, primary care physicians) and psychologists are experts in determining decision-making capacity.

Competency

Judges (Courts) determine legal capacity in such court cases involving guardianship, conservatorship, and protective services and require expert medical evidence.
Who needs a guardian or conservator?

- Under the Uniform Guardianship and Protective Proceedings Act, a guardianship or a conservatorship, is appropriate if that person, for reasons other than being a minor, is **unable to “receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate and reasonably available technological assistance.”**

- Petition with Family or Probate Court.
what is GUARDIANSHIP

Gives an individual the authority to decide on matters relating to the physical and mental well-being of a person.

Duties include:

- Deciding where the person will live
- Caring for clothing, furniture, vehicles, etc.
- Consenting or withholding consent to medical care
- Providing care, comfort and overall well-being for the individual
what is CONSERVATORSHIP?

Conservatorship grants one or more people the power to make estate planning decisions on financial matters for someone who is found to be unable to manage their affairs.

- Buying food
- Managing property
- Acquiring and managing assets
- Paying bills

Property or Protected person
Downsides to Guardianships and Conservatorships

There can be some downsides to a Guardianship or Conservatorship, including loss of autonomy, time, and legal fees.
Alternatives to Guardianships and Conservatorships

- Health Care Power of Attorney
- Financial/Legal Powers of Attorney
- Representative Payeeships
- Money Management
- Trusts
Powers of Attorney

1. Choose your Agent Wisely
   - Family Member
   - Trusted Friend
   - Lawyer

2. Choose the Type of Power of Attorney
   - Full legal and financial powers or limited powers
   - Taking effect immediately or upon incapacity
   - Effective through incapacity or terminates upon capacity

3. Revocation
   - Written Revocation or Execution of new PoA
   - Submitted wherever you submitted the original PoA
Financial/Legal Powers of Attorney - UPOAA

☐ General—Full Personal, Legal and Financial Powers

☐ Special or Limited. If Special or Limited describe powers to be granted:

☐ Durable—durable means that the power granted is effective during periods of incompetency or incapacity of the principal. (This is the default rule for the statutory form. See information on reverse side.)

☐ Not Durable—power is discontinued upon principal’s incapacity.

☐ Commencement/Termination of Power: ☐ effective immediately ☐ effective only upon incapacity

☐ Or other effective date, termination date, condition or situation, and describe:

☐ Any Special Instructions to be included? (Use additional sheets of paper if necessary.)
Uniform Power of Attorney Act (UPOAA)

- Ensures that a Power of Attorney will be accepted by banks, financial institutions.
- Ensures that a Power of Attorney validly executed outside of the state will remain valid in Hawai`i.
- Ensures that an Agent is liable for violations of the terms of the Power of Attorney or of the Uniform Power of Attorney Act.
Money Management - Electronic Financial Services

- Electronic Banking services are available at most Banks for a small or no fee
  - Automatic bill payments
  - View your balance, statement and bank activity
- The Social Security Administration strongly encourages beneficiaries to receive their benefits through direct deposit, rather than mailing a check.
- Filing State and Federal Tax Returns can be done using online services.
Money Management - Representative Payees and Fiduciaries

**Representative Payee**
- Appointed to manage government benefits, such as Social Security benefits
- Required to use the money for the needs of the beneficiary
- Responsible for keeping records of how the payments are being used

**Dept. of Veterans Affairs Fiduciary Program**
- Requires medical documentation or court determination that the beneficiary is unable to manage financial affairs
- Must undergo an investigation of suitability
Trusts

Transfer title of assets to the Trust:
- Home, Rental properties
- Vehicles, Jewelry
- Bank and Savings Accounts
- Anything else you can hold title to

Trustee

Manages assets for you and your beneficiaries according to the terms of the Trust agreement

Grantor

TRUST

Beneficiaries

Assets are only used as you instructed while in your Trust
Types of Trusts

- Testamentary Trusts
- Living Trusts
  - Revocable
  - Irrevocable
- Special Needs Trusts
Deciding What to Do and Why Not Now?

A Legal Handbook for Hawai‘i’s Older Persons, Families and Caregivers

By James H. Pietsch, JD and Lenora H. Lee, PhD
University of Hawai‘i Elder Law Program
William S. Richardson School of Law

RESOURCE

Available at www.hawaii.edu/uhelp/ or as hardcopy.
GENERAL POWER OF ATTORNEY

I, ________________________, the Principal, of _______________________, [street address], City of _______________________, State of _______________________, hereby designate _______________________, [attorney-in-fact’s name], of _______________________, [street address], City of _______________________, State of _______________________, my attorney-in-fact (herein referred to as “the Agent”) to act as set forth below, in my name, in my stead and for my benefit, and with such powers and authority as are necessary or convenient to act as attorney-in-fact and to execute any and all powers of attorney I may have executed in the past.
LOOK FOR 3 THINGS:

#1

GENERAL POWER OF ATTORNEY
OF

__________________________

Jane Doe

I, ____________________________, the Principal, of ____________________________ [street address], City of ____________________________, State of ____________________________, hereby designate ____________________________, [attorney-in-fact's name], of ____________________________, [street address], City of ____________________________, State of ____________________________, my attorney-in-fact (hereinafter known collectively as the "Representative") to act as set forth below, in my name, in my stead and for my benefit and to all powers of attorney I may have executed in the past.

#2

Advance Health Care Directive

You have the right to give instructions about medical care decisions to someone else to make health care decisions for you if you are no longer able to make them for yourself. You are encouraged to discuss all of the information given here with the designated health care agent or people who may be involved in making health care decisions for you. You may change all or any part of it. You are not required to sign this form to become a designated health care agent. Your health care agent may make decisions according to the written instructions you give.

#3
You will receive a link to fill out an online survey form to share how many of your residents have these 3 documents.

Please try have someone screen all your residents before our next session.

If you are too busy this month, its ok to do this next month as well.

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>HOW MANY HAVE?</th>
<th>TOTAL# RESIDENTS</th>
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<tbody>
<tr>
<td>Power of Attorney</td>
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<td>Advanced Care Planning</td>
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<td>(e.g. DPOA HC)</td>
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<td>POLST form</td>
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Please Share with our Team:

As we provide ideas to help your residents & families complete these we hope that all these scores will improve.

We will ask you to do this again at the end of May.

This will demonstrate that you are doing a good job helping residents achieve their wishes!

Completing this will help you get your Continuing Education Credits!
NEED HELP?

• FRIDAY 2/11/22
  • 10am
  • 2pm

• MONDAY, 2/14/22
  • 2pm

Mibrao@hawaii.edu
What matters to you?
Talking about what matters

February 8, 2022
Where did “What Matters to You” (WMTY) come From?

- The concept was first shared in the New England Journal of Medicine in 2012 as a way of implementing shared decision-making and patient-centered care
- It is about compassion and empathy
- WMTY relates to providers setting goals with patients/residents, but it could be a useful tool for other caregivers to know and understand residents

Person-centered care focuses on a meaningful life and how people are recognized as unique individuals, not as patients.

WMTY turns around the question “what’s wrong with you?” to make the caregiver-resident conversations more resident-centered.

We want to understand what motivates a resident, what their hopes for the future are.
Why does it matter?

Residents and loved ones want to feel:
- Included
- Respected
- Heard
- Clearly communicated with
- Have a say in their care plan
- In control
Tips for WMTY Conversations

Top Tips For a WMTY Conversation

- **Asking What Matters is for everyone.** Build a culture that supports curiosity, person-centeredness, and action. Work across roles and teams to bring patients’ requests to life.

- **Be vulnerable and approach the patient with curiosity** and give it a go: ask even 1 patient "What matters to you right now?"
The expectation is not to fix anything. Most requests are achievable.

- **Ask questions that spark conversation.** Use open-ended questions that make the patient feel safe to give feedback and ideas to solve pain points.

- **Be present and authentic by actively listening and practicing empathy.** Ask question(s) with patients and let them guide the conversation. Patients recognize authenticity when reflecting on their experience.

- **Show that you are listening; Make an action plan.** Incorporate your patients’ feedback into their plan of care. If you are unable to act on the request, explain why.

- **Close the loop. Share with the patient the action that you and the team are taking.** Demonstrate that they are part of the decision-making team and when to expect action.

- **Learn and iterate.** Reflect with the care team to learn if knowing What Matters changed the way that they delivered care. Are there common themes that patients report matter most? How might we anticipate patient needs and address them before?

What are potential issues?

• WMTY might be a “heavier” question for providers to ask in the context of a resident’s medical plan
• Care transitions/coordination across the continuum are tricky and may lead to conflicting goals
• Fear of unrealistic expectations
• Providers may experience uncertainty about their responsibility to fulfill all the needs and preferences of a resident with limited resources
Skills Needed

• Providers and caregivers must have/develop skills around communication, listening, empathy and reflection
• Providers must be able to elicit goals sensitively and have the conversations necessary to establish realistic and achievable goals
Discussion and Conclusion

When we take the time to build relationships with our residents and understand what makes them tick, we can provide them with meaningful care, which should affect both resident and caregiver satisfaction.

What tools have you used in your building to really get to know your residents and what matters to them?

When we take the time to build relationships with our residents and understand what makes them tick, we can provide them with meaningful care, which should affect both resident and caregiver satisfaction.
Thank you!
Wellness

Take Care of Yourself

...and your family
Dear Doctor,

My Doctor’s name

RE: What matters most to me at the end of my life

I have been reading and thinking about end-of-life issues lately. I realize how important it is that I communicate my wishes to you and my family. I know that you are very busy. You may find it awkward to talk to me about my end-of-life wishes or you may feel that it is too early for me to have this conversation. So I am writing this letter to clarify what matters most to me.

My name

What Matters Most to Me
Examples: Being at home, doing gardening, going to church, playing with my grandchildren

My important future life milestones:
Examples: my 10th wedding anniversary, my grandson high school graduation, birth of my granddaughter

Here is how we prefer to handle bad news in my family
Examples: We talk openly about it, we shield the children from it, we do not like to talk about it, we do not tell the patient

This will help everyone!

Take time to Plan for your own healthcare

Templates | Letter Project | Stanford Medicine about writing a letter to the doctor of what matters most.
THANKS FOR CARING!

Happy Valentine’s Day.