EXAMPLE Community Health Worker (CHW) Best Practice Guideline for ADVANCE CARE PLANNING

"Advance Care Planning (ACP)…is a thoughtful process…to engage patients in discussions with loved ones about their desires and values for future health care treatment decisions."[1] Advance Care Planning Facilitators receive in-depth training to engage clients in effective ACP discussions. These conversations ideally result in identifying an agent to make health care decisions for the client if and when they cannot communicate or make the decisions for themselves. The discussions also facilitate completion of a written document called a health care directive.[1] The American Medical Association recognizes that Advance Care Planning is universally helpful to assure people receive care according to their preferences and values. "Although often thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable to everyone, regardless of age or current health status."[2]

The Centers for Disease Control and Prevention estimates that 70% of Americans **do not** have an advance care plan,[3] and black and Hispanic older Americans are less likely than white older Americans to possess health care directives.[4] ACP discussions using "open-ended questions that respect the values and beliefs of various cultures" is an important best practice in ACP completion,[5] and Community Health Workers conducting ACP discussions "are uniquely positioned to support ongoing efforts to optimize end-of-life care in historically marginalized communities."[6]

Educational Messages

[NOTE: This section is to outline ACP-related CHW educational messaging, keeping CHWs in their role providing health education and self-management support for clients. The messaging content must be consistent with established or recognized health care standards and can be modified as necessary to meet the clinical needs, cultural norms, and health literacy of the individuals begin served.[7] This section can be tailored to summarize the content and approach that a specific organization uses to train their CHWs, and to implement Advance Care Planning with clients.]

CHWs conducting Advance Care Planning (ACP) includes four key elements: (1) **being trained** as an ACP Facilitator; (2) **introducing ACP** and assisting clients to **identify an agent**; (3) **conducting the ACP conversation** with the client and their agent; and (4) **completing a health care directive** that outlines the client's values and preferences.

1. <u>Training as an ACP Facilitator</u>

CHWs must complete training on conducting ACP visits prior to assisting clients with completing their health care directives. Training includes the following elements:

- **Understanding ACP (30 minutes)**
- **Facilitating Meaningful Conversations (90 minutes)**
- **Guiding Completion of a Healthcare Directive (60 minutes)**
- **Understanding Laws and Regulations Related to ACP (30 minutes)**
- **Handling Special Situations and Sensitive Topics (60 minutes)**
- **Q&A (30 minutes)**

2. <u>Introducing ACP, and assisting clients in identifying an agent</u>

CHWs use the following messages to introduce Advance Care Planning to clients, help them understand the role of an agent, and assist them in identifying an agent.

- CHWs can share information about Advance Care Planning and identifying an agent in an introductory visit, and schedule a follow-up visit with the client and their identified agent to have an ACP conversation and complete the health care directive. CHWs must emphasize that having the agent present for the conversation is at least as important--if not more important--than completing the health care directive forms.
- "What would happen if you had a serious accident or illness that left you unable to make decisions or speak for yourself?"
- "While many people do not like to think they will ever need a plan, not planning can lead to confusion or disagreement among family members trying to speak for you if you cannot speak for yourself."
- "You do not have to complete a health care directive. You will receive medical care even if you don't have a health care directive."
- "For as long as you are able to communicate and make decisions for yourself, your health care providers will listen to you and follow your wishes."
- "If and when you are not able to communicate or make decisions for yourself, your health care providers will look to your agent and what you write in your health care directive to give you the care you want."
- "Your family and doctors cannot do what you want if they don't know what that is."
- "Advance Care Planning is a way to share your values, goals and choices with those close to you."
- "Completing a health care directive is a gift to your loved ones, relieving them of wondering if they did the right thing on your behalf."
- "Choose a health care agent you trust to follow your wishes, even when under stress."

3. <u>Conducting the ACP conversation</u>

One of the main points of ACP is to generate conversation between the client and their agent. The agent will have not only the health care directive, but also the conversation, to help them make decisions on the client's behalf.

- CHWs use techniques learned in ACP Facilitator training, and the Honoring Choices "Guide to completing your HCM health care directive," to explain sections of the health care directive and assist clients to complete each section.
- CHWs utilize open-ended questions to encourage clients to express their preferences in their own words.
- While conversation between clients and agents is the goal, CHWs also listen for agents who are making decisions for the client, and check-in with clients to make sure they are in agreement with what is being discussed and decided.
- If medical or other questions arise during the conversation that are outside a CHW's scope of practice, the CHW assists the client in contacting their medical provider(s) to have their questions answered.

4. <u>Completing a health care directive</u>

- CHWs and the client complete the Honoring Choices Health Care Directive form in the client's preferred language. If the form is completed in a language other than English, the CHW follows the organization's procedures to assure translation of the document is arranged.
- Have a notary or two witnesses sign the forms.
    - If the CHW is a notary, CHW signs and notarizes the forms (no need for witnesses).

    - If the CHW is not a notary, the forms must be signed by two adult witnesses. Only one witness can be connected to a health site or system providing care. (The CHW can serve as a witness, as long as the second witness is in no way a professional representing any organization providing care for the client.)
- CHW assists the client to make sure the forms are stored securely at home, and copies go to the client's clinical provider(s) and agent.
- CHWs share that health care directives are living documents, and encourage the client to make changes and/or fill out a new form as their circumstances and preferences change.

Resources

- ✓ Honoring Choices Minnesota (www.honoringchoices.org)
- ✓ The Conversation Project (www.theconversationproject.org)
- ✓ Mayo Clinic "Advance Health Care Planning: Making Your Wishes Known" (www.mayoclinic.org/documents/advance-health-care-planning-making-your-wishes-known/doc-20099583)
- ✓ CDC "Give Peace of Mind: Advance Care Planning" (www.cdc.gov/aging/advancecareplanning/index.htm)
- ✓ CHW ACP facilitator training (www.honoringchoices.org/events-training/training)
- ✓ ACP materials translated into multiple languages:
    - Honoring Choices Massachusetts (FREE) (https://www.honoringchoicesmass.com/resources/5-ma-planning-documents/translated-planning-documents/)
    - Prepare for Your Care (see California list) (FREE) (https://prepareforyourcare.org/advance-directive-library)
    - Five Wishes (https://www.agingwithdignity.org/five-wishes/translations)

References

[1] Honoring Choice MN website (June 14, 2018): http://www.honoringchoices.org/

[2] American Medical Association website (June 14, 2018): https://www.ama-assn.org/delivering-care/advance-care-planning

[3] Centers for Disease Control and Prevention website (June 14, 2018): https://www.cdc.gov/aging/advancecareplanning/index.htm

[4] Huang IA, Neuhaus JM and Chiong W (2016) Racial and ethnic differences in advance directive possession: Role of demographic factors, religious affiliation, and personal health values in a national survey of older adults. Journal of Palliative Medicine 19(2) 149-56.

[5] Zager BS and Yancy M (2011) A call to improve practice concerning cultural sensitivity in advance directive: a review of the literature. Worldviews on Evidence-Based Nursing 8(4) 202-11.

[6] Giftos J (2013) Community Health Workers: Key to reducing disparities in end-of-life care. GeriPal: A Geriatrics and Palliative Care Blog https://www.geripal.org/2013/09/community-health-workers-key-to.html

[7] MN Department of Human Services, MN Health Care Program CHW Provider Manual (June 14, 2018): https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357

Honoring Choices® MINNESOTA
An initiative of the Twin Cities Medical Society.

CHW Solutions
Community Health Worker services made easy