



Institute for
Healthcare
Improvement

The Conversation Project

*Championing Conversations in Communities through the
Use of Stories*

November 18, 2020



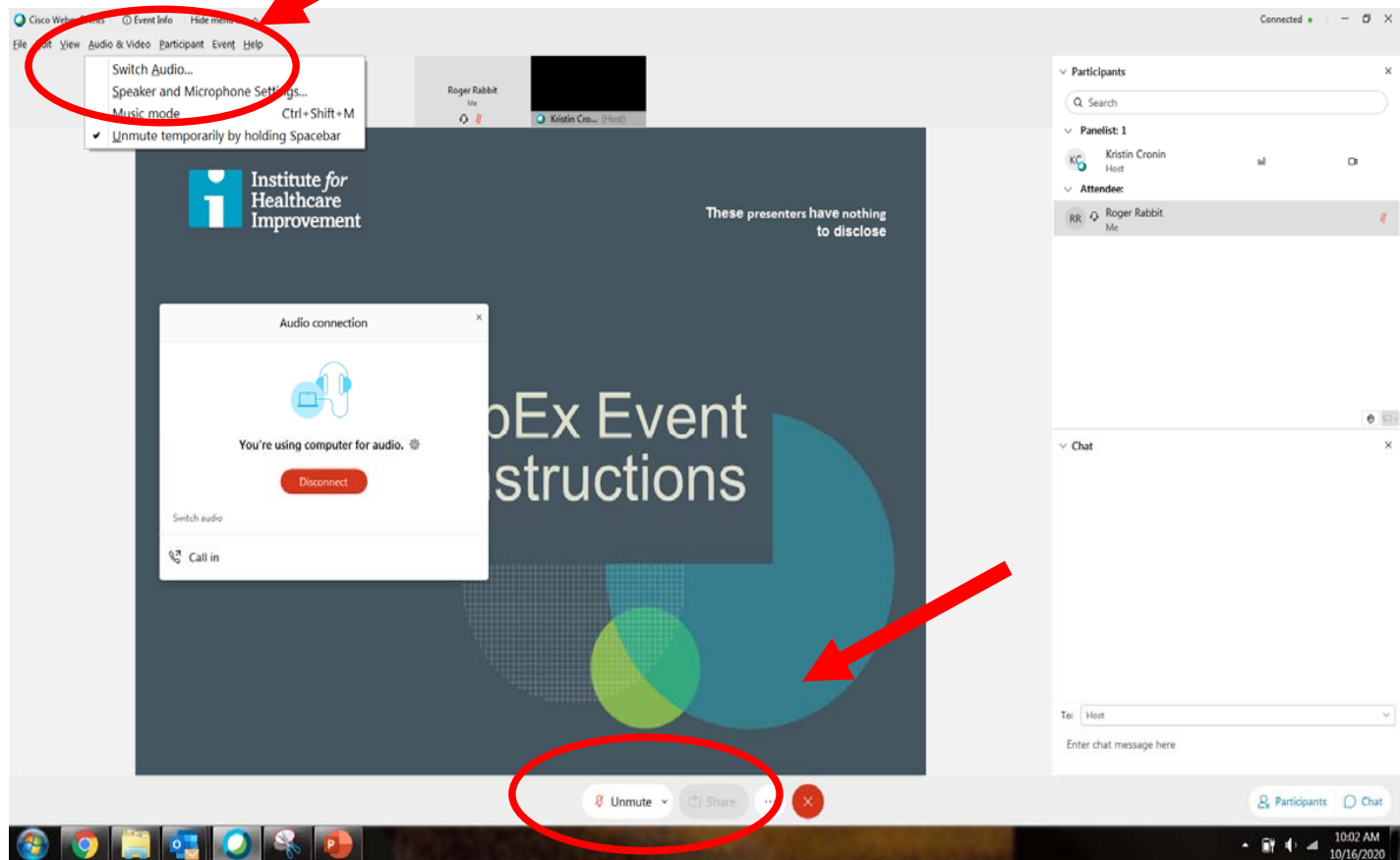
**Patty Webster
Krissy Cronin**

the **conversation** project

Audio Broadcast

2

You will see a tab at the top of the screen titled “Audio & Video”. Click “**Switch Audio**” to either Call in or to use your computer speakers for audio. You can also find this on the “unmute” tab at the bottom of your screen.



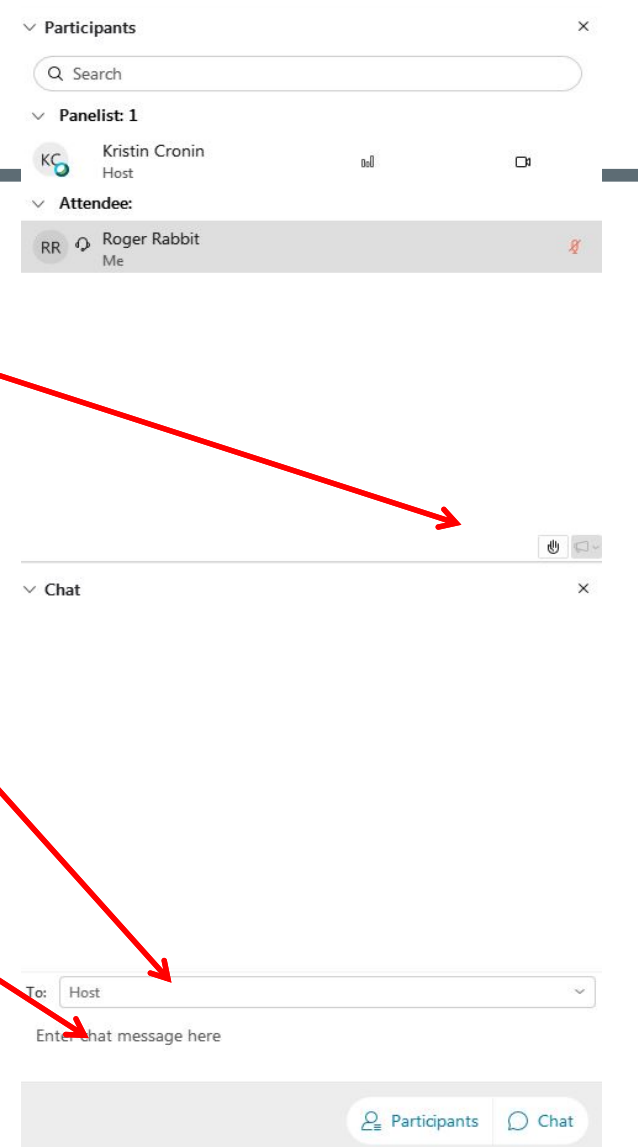
WebEx Quick Reference

- Please use chat to “**Everyone**” for questions
- For technology issues only, please chat to “**Host**”

Raise your hand

Select Chat recipient

Enter Text



Intros/Chat Warm Up

Type into the chat box:

- Your *name*
- Your *location, organization and type of organization?*
(*faith, healthcare, community, government, volunteer, etc.*)

Make sure you send your message to
“Everyone.”



On Today's Call



Patty Webster
Advisor, Community
Engagement



Krissy Cronin
Project Coordinator

COMING SOON!



Conversation Starter Kit



What Matters to Me Workbook
for people with a serious illness



Starter Kit for Families and Others of People with Alzheimer's Disease or Other Dementia

Being Prepared in the Time of COVID



Who Will Speak For You?
How to choose and be a health care proxy



Starter Kit for Having the Conversation with Your Seriously Ill Child

New and improved guides
coming soon!
January 2021
ENGLISH, SPANISH, CHINESE

www.theconversationproject.org

the conversation project



Upcoming Event: November 23rd 3pm PST/ 6pm EST



<https://collective.round.glass/the-endless-table->

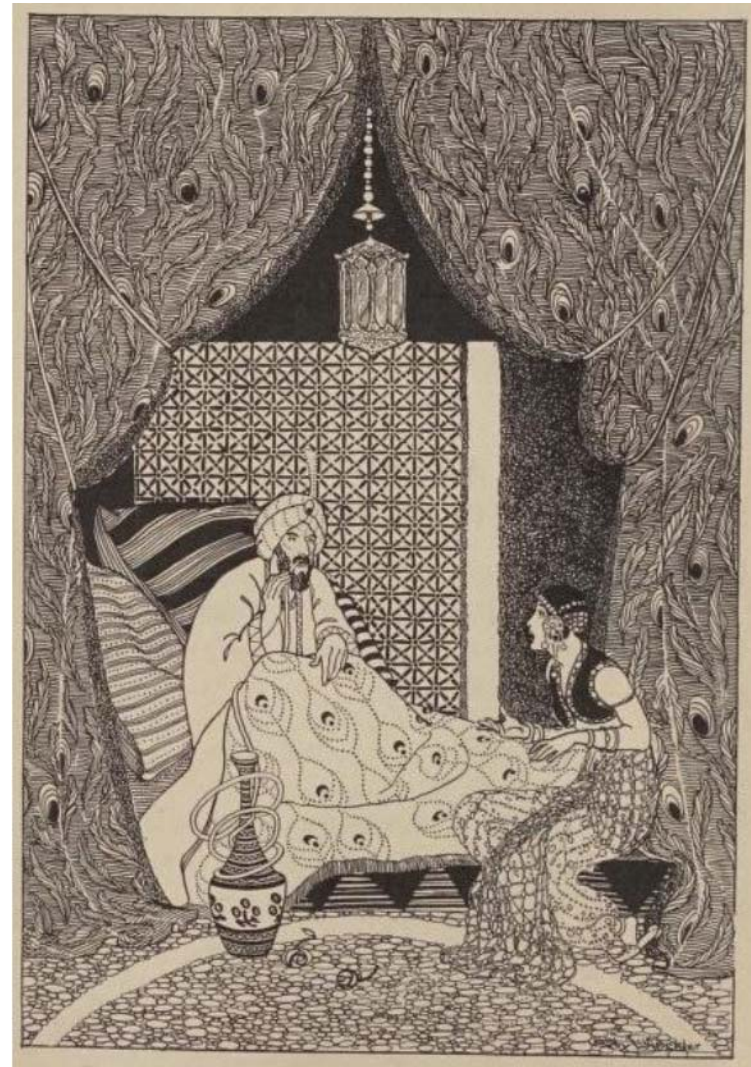
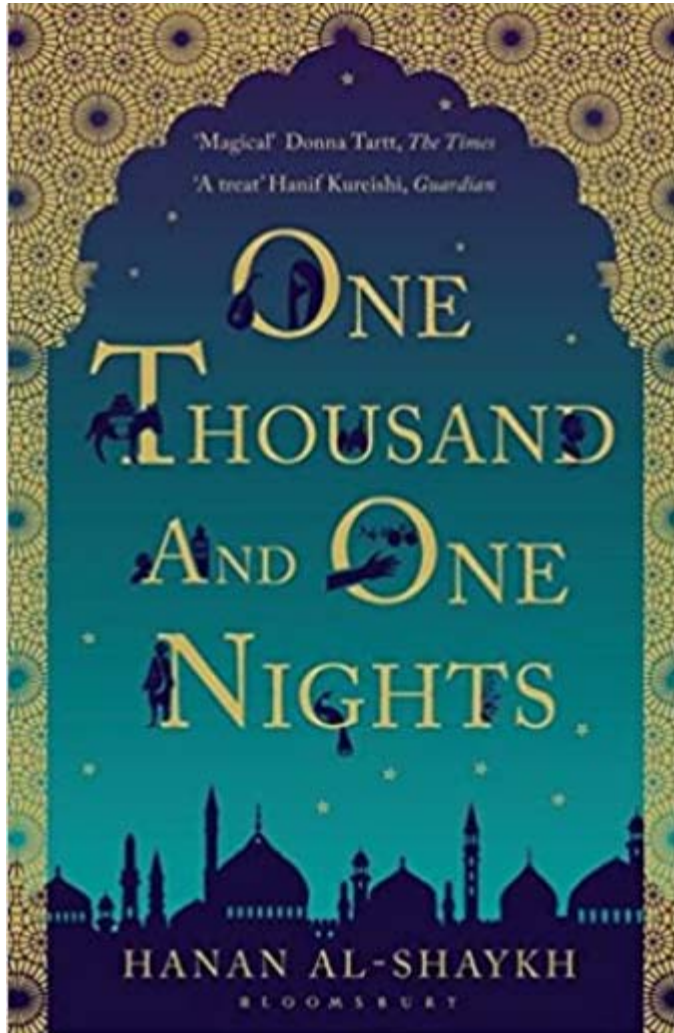
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Agenda

- What we've learned, what the research says
- Two champions share - how/why they leverage stories
- Q&A
- Share what you've learned / your stories!
- What's coming up
- Wrap up





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How we've seen stories work

- TCP origins
- TCP Conversation Starter Kits/Guides
- Starter Kit/Guide Workshops
- Latest Blog series



1 of 6 Key Messaging Principles*

- **Use stories.** Aspirational and positive is compelling.
- Don't lead with death and dying, or the negative impact/gloom and doom of not having conversations.
- **Speak from 'we'** –and focus on our human connectedness and a person-centered approach.
- **Emphasize caring.** Messages about love, caring, and connection motivate individuals to engage.
- **Talk up the benefits of conversations.** Taking *and listening*
- **Invite dialogue—and not just once.** Above all, the call to action is to encourage conversations

* From research from The John A Hartford Foundation



Death is life, it's
not a curse. It
reminds us of time
and what it's worth

~Miley Cyrus



*In the end, we all
become stories.*

Margaret Atwood



On Today's Call



Hope Young
Advance Care Planning
Coordinator
Kokua Mau, HI
hope@kokuamau.org



Mary Spencer Dockery, RN
Care Team Supervisor,
Alameda County Care Alliance, CA
mspencer-dockery@accac.phi.org

Let's Talk Story
Kōkua Mau

Hope Young
Advance Care Planning Coordinator



Who is *Kōkua Mau*?



- ▶ A Movement to Improve Care
- ▶ 501(c)3, community benefit org., statewide (not a state agency)
- ▶ Membership -health plans, hospitals, long term care, hospices, Churches, and Senior living communities
- ▶ Passionate volunteers across the state

Three areas of activity

1. Work with people who may be facing serious illness & their loved ones to understand the decisions they may need to make - as early as possible!
2. Provide professional networking & training
3. Change the System - Policy & Legislation

A Movement for Change

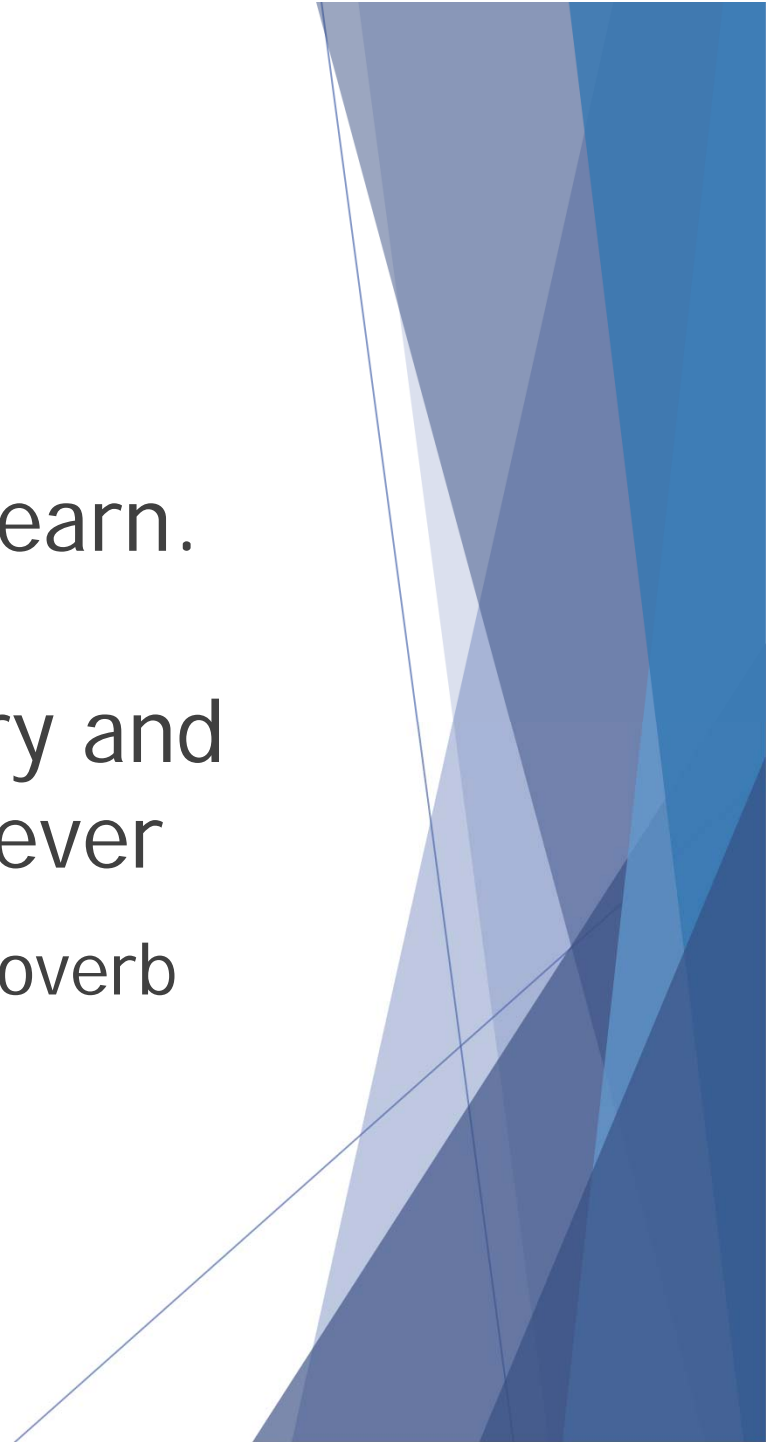
Kōkua Mau is leading a *movement* that aims to make advance care planning and open communication about care and support for those with serious illness and their loved ones, including end-of-life care

the cultural norm

The power of storytelling:

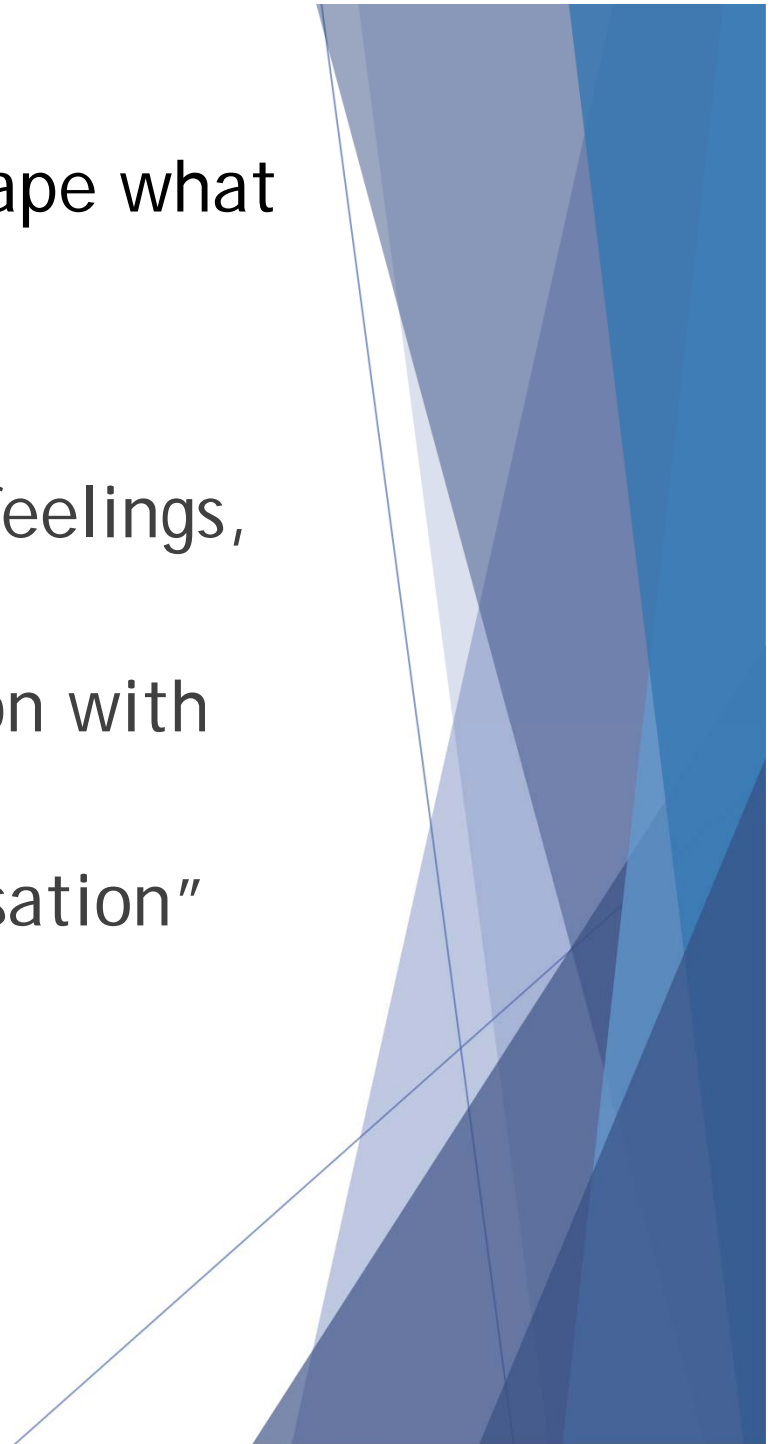
Tell me the facts and I'll learn.
Tell me the truth and I'll
believe. But tell me a story and
it will live in my heart forever

~ancient proverb



Our own stories develop and shape what matters most

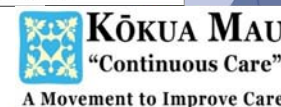
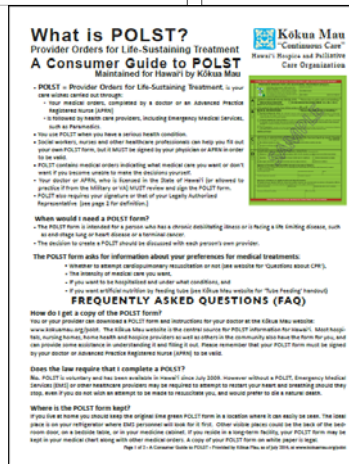
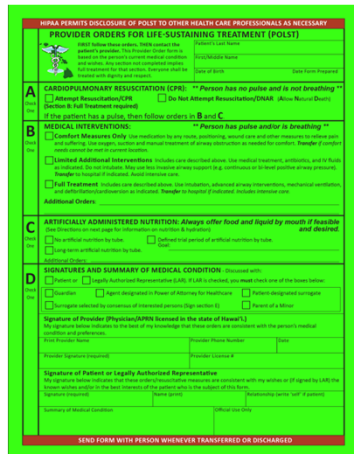
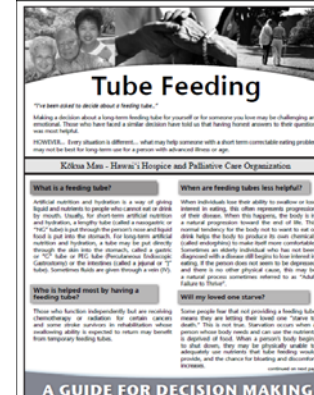
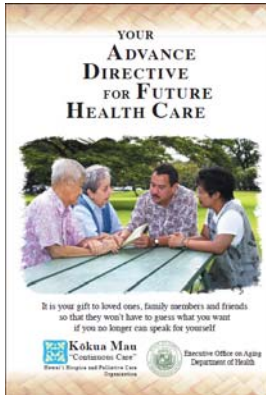
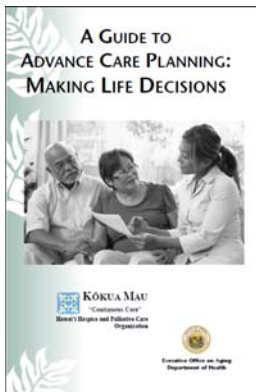
- ▶ Stories can evoke memories, feelings, and emotions
- ▶ Stories can create a connection with the audience
- ▶ Stories can make “the conversation” not-so-scary



Telling our stories creates a connection



Kokua Mau Resources



<http://www.kokuamau.org/>

Until it's safe to travel again, please enjoy this view of Hawaii.

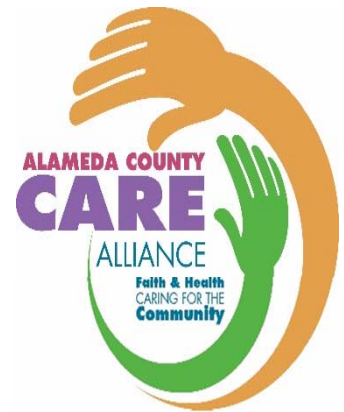


Questions?



KŌKUA MAU
Continuous Care

A Movement to Improve Care



Alameda County Care Alliance Advanced Illness Care Program

Mary Spencer-Dockery, RN, Care Team Supervisor





ACCAC Advanced Illness Care Program™

Series of 8-12 meetings between the Care Navigator and PNC or Caregiver over 6 months



Spiritual Needs

Prayer, support group, and church ministry recommendations



Health Needs

Empowerment, medication lists, provider communication, safety



Planning for Advance Care

Understanding preferences for advance care planning



Social Needs

Transportation, meals, housing, socialization

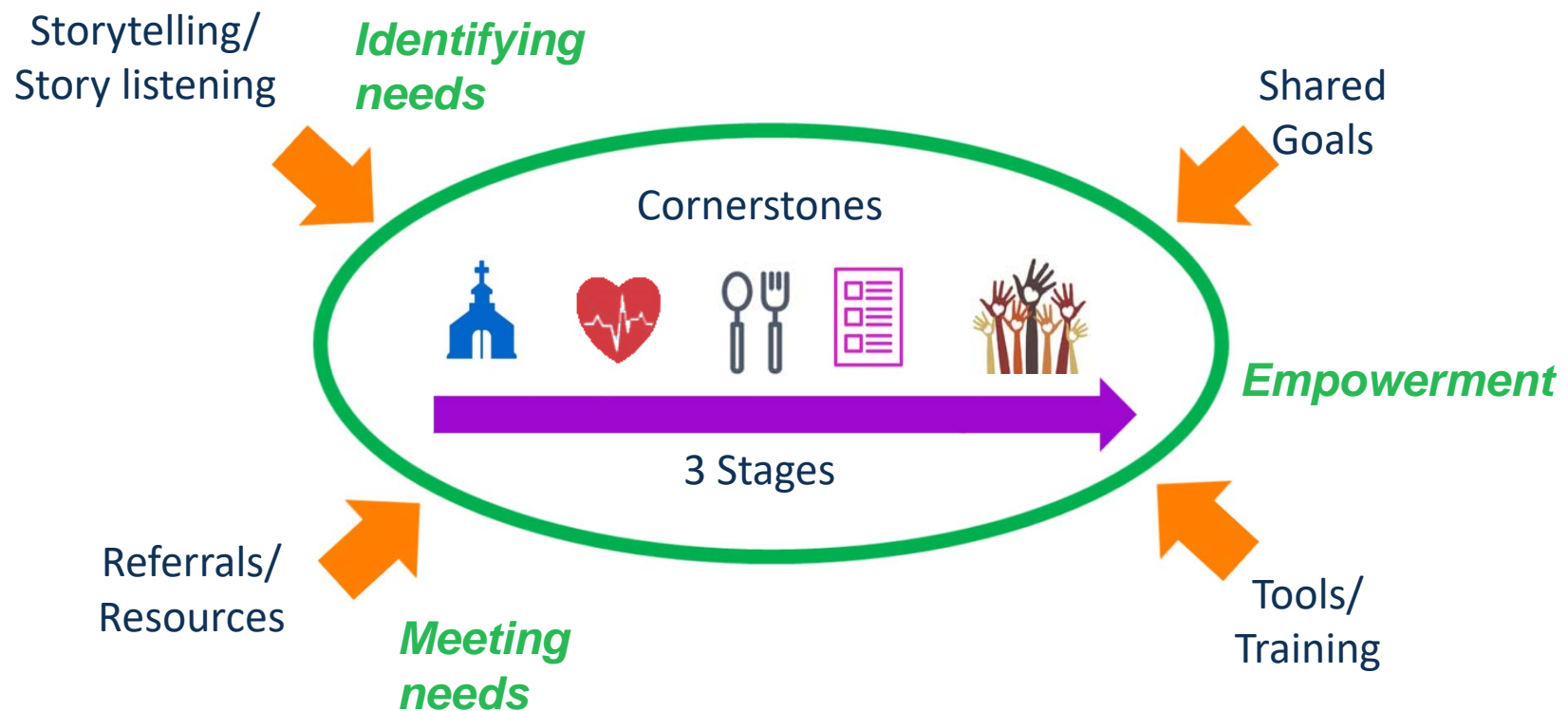


Caregiving Needs

Respite care, support groups

Identify needs, provide trusted referrals and resources, empower individuals with tools & training

The Work of the Care Navigators





Care Navigators

Care Navigators are trusted, well-respected individuals in ACCA churches and/or the community. They are not medical professionals nor are they trained to provide clinical guidance.

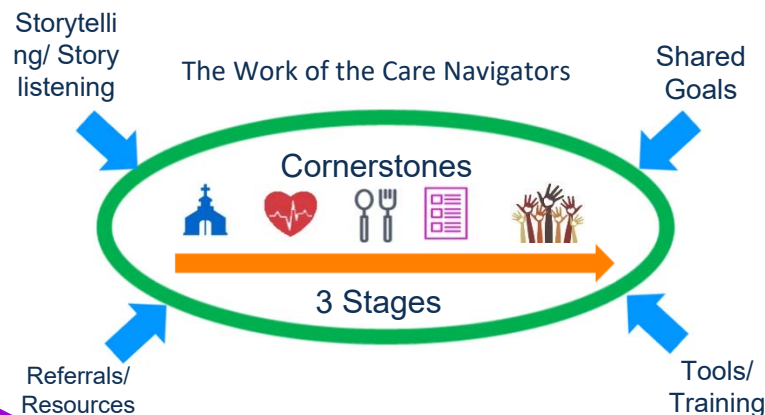
Navigators are almost always able to form **trusting relationships** with participants

Goal Setting

- Navigators work with participants to identify goals that are specific, achievable and important to the participant.
- Goal Setting discussed at **77%** of all visits.

A Blessing to Serve

The Care Navigators universally shared their gratitude for being involved in this important work and the opportunity to give back to and serve their community. All find the work rewarding; none reported burnout or related concerns with their role.



"I am a woman who seeks after God's own heart and this is a faith-based organization – spiritually, it's important for me to help families realize there's something more." - Care Navigator

"(I see the program) . . . as an opportunity for the community to come together and uplift itself." – Care Navigator



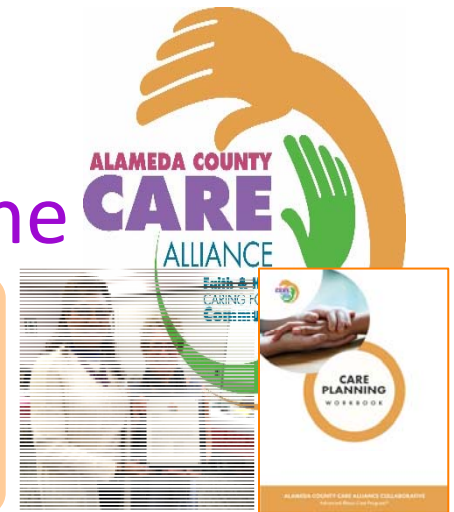
Advance Care Planning Cornerstone

The advance care planning cornerstone focuses on introducing the concept of ACP, activities to help individuals think through their wishes if they are unable to speak for themselves, selecting a health care agent, documenting their wishes in an advance directive and sharing their wishes with friends, family, Health care agent and their clinician.

60%
of
participants
completed an
advance
directive

49%
of all visits
addressed
the ACP
cornerstone

39% of participants have completed a POLST form or are in discussions

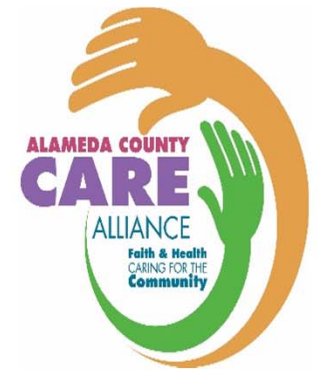


The Care Planning Workbook – This tool was developed specifically for the faith-based African American community with input from ACCA Leadership, Care Navigators and Pastors. This 3-step workbook features multiple worksheets to help participants think through what is important to them and what makes their life meaningful. Participants can select where they want to start the process and what they want to review and discuss. The workbook also features information on what treatments are available at the end-of-life, how to have discussions with family, friends, and their clinicians and how to select a health care agent. The participant can document their wishes in the included advance directive and learn how to store and share this information.



“(Now) we can go in there and already have a plan. We don’t have to wait for the doctor to tell us the plan. . . You don’t have to just listen to what the doctor says, you have a say.” – Person needing care

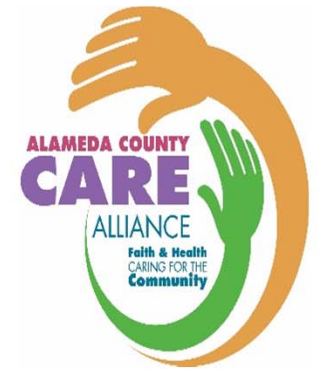
“A lot of the wording was throwing me off [like] your health care agent. [My Navigator] explained that to me, and I was like, See that... When she explained it to me, it turned out to be my sister.” – Person needing care



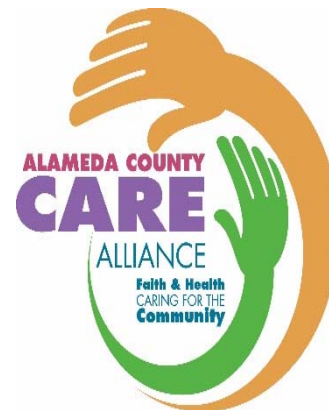
Workbook for Caregivers



Alameda County Care Alliance Collaborative



A supportive guide for caregivers.
Because your well-being matters.



Thank You!

Mary Spencer-Dockery, Care Team Supervisor
510-415-1251



Q&A and Sharing

- Any questions? Reactions?



Flood the Chat (or raise hand!)

- How are you using stories to teach/draw people in?
- Any COVID stories to share?



Additional Resource



Faith-Based Care Navigators: Promoting Well-being of Individuals with Serious Illness and Caregivers

Successes of the Alameda County Care Alliance (ACCA) Community Care Navigator model within communities, in particular Black and Brown communities. The talk spotlights the ACCA Care Planning Workbook developed by the Faith-Based African American Community which includes a free advance directive along with identifying “What Matters Most to You.”

Public Narrative: Call to action



Marshall Ganz. 2009. What Is Public Narrative: Self, Us & Now (Public Narrative Worksheet). Working Paper.

<http://www.ihl.org/education/WebTraining/Webinars/Leadership-Organizing/Pages/default.aspx>

Collective Video Story Sharing!

TCP New Year's Wishes Video

Release: Mid-December

2-3 minutes, Answering 2 questions:

Why does this work matter to you?
What are you looking forward to in 2021?

We invite you to do the same!

**Post your own video on social media and share:
#NewYearNewConvo**



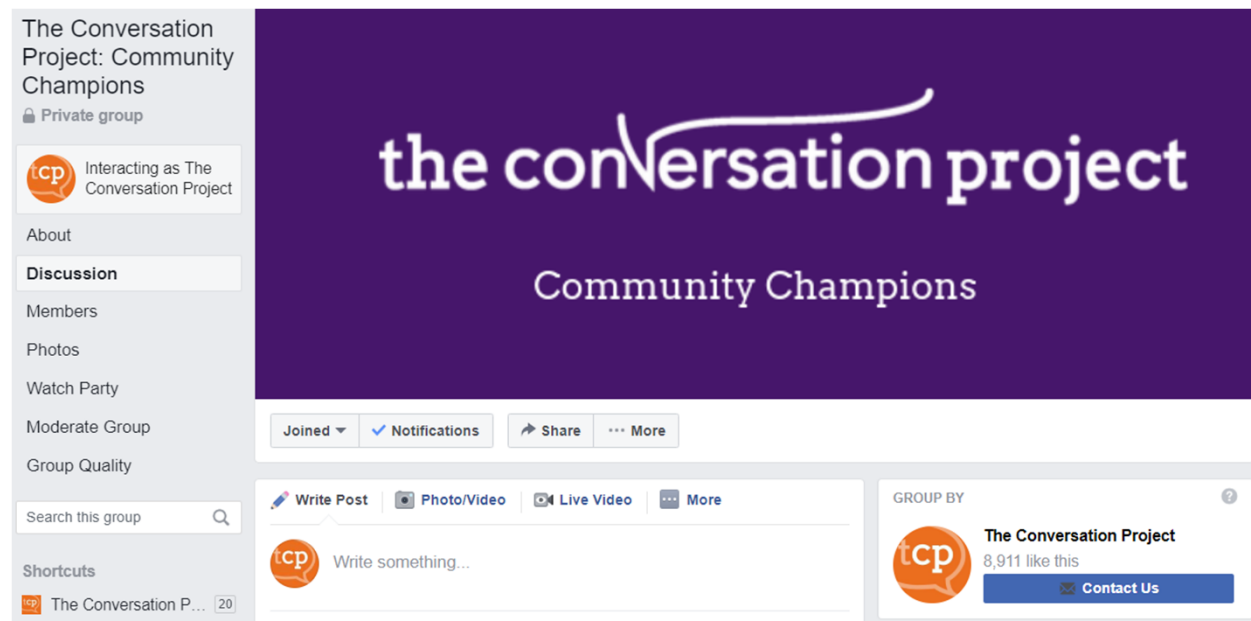
Ways to Engage with TCP's Network

- Tweet us, tag us on social media
 - ❑ Twitter: @convoproject
 - ❑ Facebook: The Conversation Project
 - ❑ Instagram: convoproject



Ways to Engage with TCP's Network

- Facebook discussion group



<https://bit.ly/2ukc7B0>

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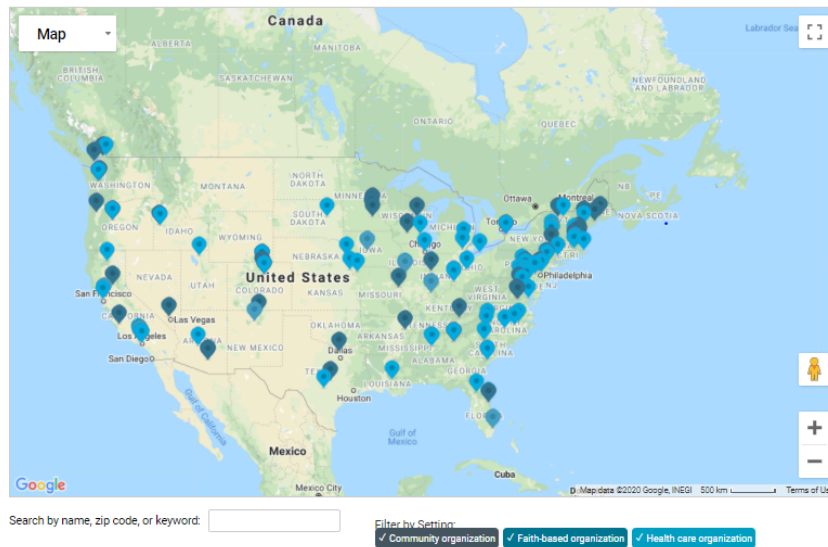
Ways to Engage with TCP's Network

- Search, connect/network and learn together

Conversation Champions Map

- Connect with others doing similar work in your area.
 - You can search by location, organization, name, and filter by setting: faith, health care, or community. Feel free to reach out directly to members on the map via their listed contact information.
- Apply here to be listed on the map if you are actively sharing TCP resources and/or messaging.

The Conversation Project (TCP) relies on the Conversation Champions, like the ones listed on the map below, to help spread the importance of end-of-life care conversations in their communities. These groups plan their own programming using TCP resources or messaging (in addition to their own). As a reminder, TCP has no preference for what someone's wishes for end-of-life care should be – we just want folks to start talking about it. Please read more about our principles [HERE](#).



<https://theconversationproject.org/get-involved>

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Ways to Engage with TCP's Network

- Monthly Newsletters
 - Community Engagement Newsletter
 - General Newsletter
- Sign up and share your events



<https://theconversationproject.org/get-involved>

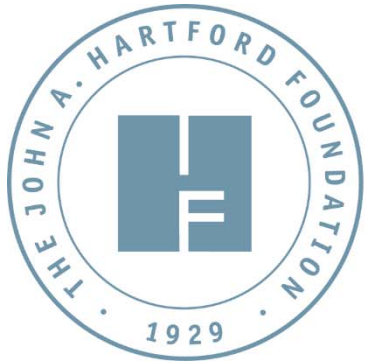
Upcoming Community Call

Date and Time	Topic
Wed, December 16 th , 12 – 1:00 pm ET	A Look Ahead: Planning for 2021
Wed, January 20 th , 12 – 1:00 pm ET	New Conversation Starter Guides! Overview of new guides and related resources

<https://theconversationproject.org/calls-and-recordings/>



Thanks and appreciation



The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults



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We want your feedback!

- After this call you will be redirected to a Survey Monkey form

Please take a few moments to answer the following questions:

- How useful was this session on a scale from 1-5?
- What would you like to learn more about?
- Any other comments on today's session?

