Island-Wide ACP Integrated Strategic Plan

Educate-Engage-Activate

February, 2021

Advance Directives Matter

Advanced care planning contributes to the following outcomes;

- Honors individuals wishes
- Reduces family conflict and stress
- Eliminates unwanted expenses
- Reduces stress for caregivers and physicians

Data demonstrates greater satisfaction with end of life care by families, improvement in anxiety and depression symptoms and an increase in patient satisfaction in the presence of Advance Care Directives.

Goals for an Island-Wide ACP Program

Educate

Educate everyone on what ACP planning is and why it is important.

Engage

Connect island residents to ACP program resources.

Activate

100% of island residents have completed ACP documents in the medical records system.

Current Island Activation

16% of island residents with MVH PCPs have ACP documents in the medical records system.

25% of island residents over age 65 with MVH PCPs have ACP documents in the medical records system.

COVID-19 has been a distraction to our education campaign. At the same time it has raised the need for ACP.

Evolving partnerships with MVH and other healthcare providers underway.

Best Practices to Engage-Educate-Activate

A study recently done in Alberta Ca in 2019 identified **5 Synthesized recommendations for engaging participants in ACP.**

Make ACP resources easily accessible to community groups.

Provide education and facilitation opportunities for community groups and professionals.

Simplify healthcare system processes and increase support for conversations.

Use stories/make use of personal experiences.

Include business partners in ACP (e.g. the Conversation Project etc.)

Partner and Resource Requirements

Paid Coordinator

Partnership with Healthcare Providers on the Island

Interested, educated community thought leaders (ACP coalition)

Their roles may differ; visionary, facilitator or networker

Access to content from third parties (The Conversation Project etc.)

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The Consumer Role

Who is the consumer for Advance Care Planning?

- All adults 18+ should be knowledgeable about ACP.
- Older adults with chronic illness are especially at risk from not benefitting from prior planning.
- Adults with completed ACP documents who want to learn more about what their decisions mean and why they matter.

The Healthcare Worker Role

Healthcare workers have responsibility to ensure their patients are completing ACP documents with as much knowledge as possible.

Most Healthcare workers feel strongly about a need for planning and are in support of island efforts. There are various degrees of involvement by PCPs on the island at this time.

Practitioners may “refer” patients to the Island ACP Coalition or the hospital website for video resources regarding ACP planning.

The Employer Role

A model used successfully in other locations although limited involvement on the island at this point.

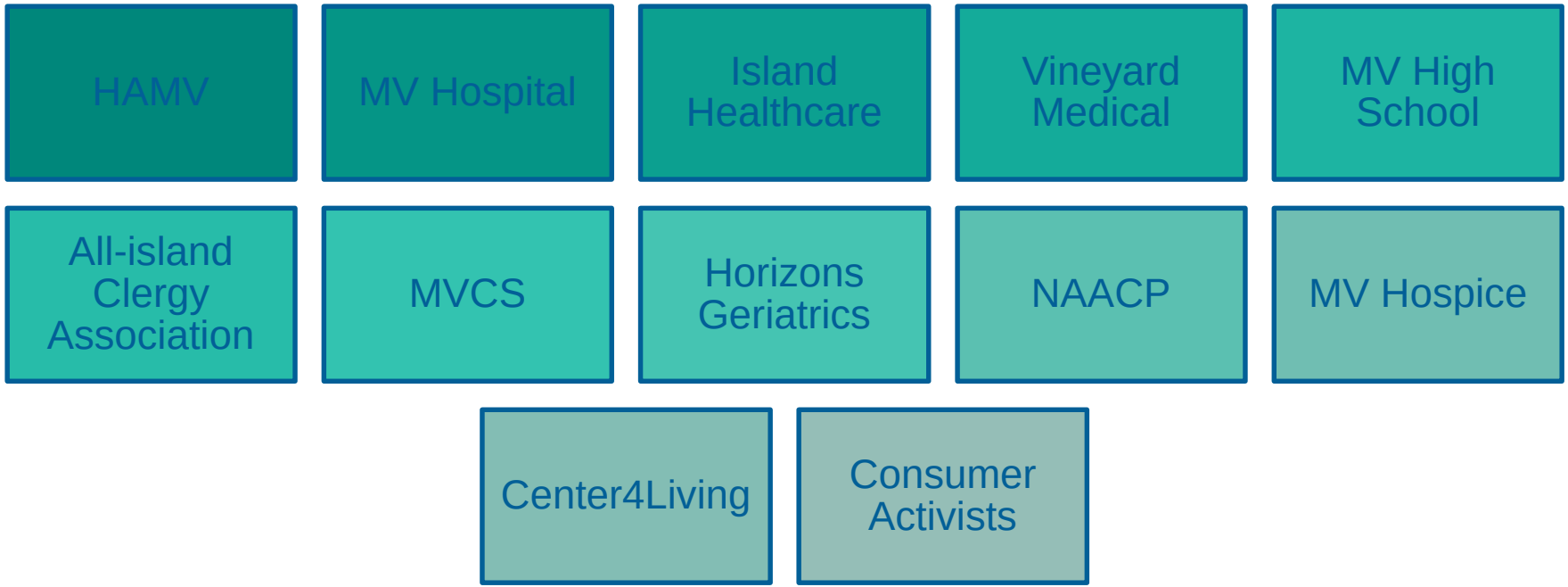
Potential employers to consider: MVCS, Hospital, school system, MV bank. Employers offer access to ACP to their employees.

The ACP Coalition Role

Our ACP Coalition consists of island organizations who are committed to moving forward ACP in our community and who may conduct ACP for their clients and/or make referrals.

As Coalition members, these organizations meet regularly to discuss what is occurring in our community and how to increase awareness and engagement with a unified voice.

ACP Coalition Organizations*



*February, 2021

HAMV ACP Proposed Action Plan 2021

Make ACP resources easily accessible to community groups
- Promote ACP documents at local libraries, healthcare clinics, Schools (MVRHS)
- Workshops to promote learning in small groups
- Develop a marketing plan that supports diverse messaging that resonates with all audiences (HAMV newsletter, etc.)

Provide education and facilitation opportunities for community groups and professionals
- Honoring Choices Ambassadors
- Workshops through zoom or at local libraries
- Online videos to teach about ACP and how to have conversations with loved ones

Simplify healthcare system processes and increase support for conversations

Use stories/make use of personal experiences
- Online videos which showcase personal stories from ambassadors or local community representatives

Actively participate with key partners
- Honoring Choices & Conversation Project
- Coordination with MVH and other outpatient healthcare clinics

Identify funding sources for project coordinator and hire a coordinator

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Scorecard Metrics

Awareness of ACP island-wide

Attendance for ACP educational seminars

Website traffic/video viewing on the HAMV, MVH and other websites

# of coalition members and volunteer educational facilitators

Satisfaction ratings from patients, healthcare providers, and family members

Satisfaction ratings from seminar attendees and facilitators

Participation by healthcare providers in ACP education

The % of older adults who have ACP documents in medical records systems

APPENDIX

Honoring Choices MA

"Your health care. Your choice."

Partnering with Honoring Choices MA

The Getting Started Kit

MA Health Care Proxy, a legal document where you appoint a trusted person to be your Health Care Agent and make health care decisions; and,
MA Personal Directive, a personal document where you write down what's important to you and instructions for care.

The Next Steps Kit

Build on your decisions
-Durable Power of Attorney
-MOLST: Medical Orders for Life Sustaining Treatment
-CC/DNR: Comfort Care, Do Not Resuscitate Order

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Getting Started and ***Next Steps Tool Kits*** contain the 5 Massachusetts Planning Documents

GETTING STARTED TOOL KIT	 Health Care Proxy	 Personal Directive (Living Will)
NEXT STEPS TOOL KIT	 Durable Power of Attorney	 Comfort Care/ Do Not Resuscitate
		 Medical Orders for Life Sustaining Treatment

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The Conversation Project

"Discussing end-of-life care with your doctor, nurse or other health care provider."

Step 1

Get Ready

After having a conversation with loved ones, the next step is to have a conversation with your health care team.

Step 2

Get Set

When you are ready to talk to your health care team, start by thinking about the basics

- Who do you want to talk to
- When would be a good time to talk

Step 3

Go

When you are ready to talk to your doctor, here are ways to get started

- Call/email your doctors office before appointment
- Prepare your opening line "I want to have a conversation about my wishes for end-of life care
- Discuss important milestones to you
- Bring your health care proxy to the appointment

Step 4

Keep Going

Have follow up conversations to revisit issues that come up in these conversations. Your preferences may change as time passes.

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5 Care Planning Documents Used in Massachusetts

Massachusetts Health Care Proxy. A legal document in which you choose your Health Care Agent to make health care decisions on your behalf, if you are unable to make health care decisions yourself;

Personal Directive or Living Will. A personal document, not legally binding, to give your Health Care Agent instructions and information about the kind of care you want;

Massachusetts Durable Power of Attorney. A legal document in which you choose a trusted person to make financial decisions on your behalf, if you are unable to make financial decisions yourself;

Medical Orders for Life-Sustaining Treatment (MOLST). A medical order and form for adults with serious advancing illness to document their choices about life-sustaining treatments;

Comfort Care/Do Not Resuscitate Order (CC/DNR). A medical order and form to document your choice to receive comfort care measures, but not to have medical personnel attempt to restart your heart beat and breathing if your heart beat and breathing stop.

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