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.

1. Make ACP resources easily accessible to community groups.
2. Provide education and facilitation opportunities for community groups and professionals.
3. Simplify healthcare system processes and increase support for conversations.
4. Use stories/make use of personal experiences.
5. 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)
- Access to content from third parties (The Conversation Project etc.)

Their roles may differ; visionary, facilitator or networker
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*

- HAMV
- MV Hospital
- Island Healthcare
- Vineyard Medical
- MV High School
- All-island Clergy Association
- MVCS
- Horizons Geriatrics
- NAACP
- MV Hospice
- Center4Living
- Consumer Activists

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

<table>
<thead>
<tr>
<th>GETTING STARTED TOOL KIT</th>
<th>NEXT STEPS TOOL KIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCP</strong></td>
<td><strong>DPOA</strong></td>
</tr>
<tr>
<td>Health Care Proxy</td>
<td>Durable Power of Attorney</td>
</tr>
<tr>
<td><strong>PD</strong></td>
<td><strong>CC/DNR</strong></td>
</tr>
<tr>
<td>Personal Directive (Living Will)</td>
<td>Comfort Care/Do Not Resuscitate</td>
</tr>
<tr>
<td></td>
<td><strong>MOLST</strong></td>
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<tr>
<td></td>
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</tr>
</tbody>
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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.
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.
References


