

**Advance Care Planning: Goals of Care Team's Logic Model – April 2008 – March 2009**

*Purpose: To nurture quality of care within a person's experience at the end of life*

Objectives	Activities	Outputs	Short Term Outcomes 1 yr. (Apr. '08 – Mar. '09)	Long Term Outcomes 2 - 5 yrs. (Apr. '09 – Mar. '13)	Impacts 6 – 10 yrs. (Apr. '13 – Mar. '18)
<b>Systematize consistent ideal practice in Advance Care Planning</b>	Continue and expand implementation of "My Voice - Planning Ahead" as the CHR and Calgary community's vehicle for facilitating advance care planning (ACP) discussions, in target populations where opportunities exist	<ul style="list-style-type: none"> <li># of programs implementing "My Voice - Planning Ahead"</li> <li>% of targeted patients that have ACP discussions</li> <li>% of targeted patients that have Advance Directives</li> <li># resources distributed</li> <li># internal/external website hits</li> </ul>	<ul style="list-style-type: none"> <li>Patients find the discussions beneficial (ongoing)</li> <li>Clinicians find the ACP process and accompanying documents beneficial (ongoing)</li> <li>Increase in the number of programs/service units implementing the "My Voice - Planning Ahead" program</li> <li>Increase in % of targeted patients having ACP discussions</li> </ul>	<ul style="list-style-type: none"> <li>Patients' families find the ACP process beneficial</li> <li>Increase in % of targeted patients completing Advance Directives</li> <li>Increased systemic support for ACP across the CHR</li> <li>Increase in awareness and use of ACP in community</li> <li>All chronically ill patients are provided the opportunity to have an ACP discussion</li> </ul>	<ul style="list-style-type: none"> <li>Support from community leaders and engagement of community partners is evident through uptake of CHR's ACP activities</li> <li>75% of seniors, acutely ill patients, and healthy adults are provided the opportunity to have an ACP discussion</li> </ul>
	Continue and expand implementation of a training program for "My Voice - Planning Ahead" in target areas, based on a 'train the trainer' model	<ul style="list-style-type: none"> <li># of clinicians who receive ACP skills enhancement training</li> <li># of trainers trained</li> </ul>	<ul style="list-style-type: none"> <li>Increase in clinicians' ACP awareness/basic knowledge</li> <li>Increase in clinicians' comfort, confidence, knowledge, and skill in ACP facilitation (ongoing)</li> <li>Increase in the # of clinicians who receive skills enhancement training</li> <li>Clinicians integrate training into practice</li> <li>Decision Support Resources are established</li> </ul>	<ul style="list-style-type: none"> <li>Every program/service unit serving chronically ill patients has a inter-professional health care team prepared to facilitate ACP discussions</li> </ul>	
<b>Develop regional policies related to end of life care that are standardized across the Region and support best practice for care at the end of life</b>	Implement the Advance Care Planning: Goals of Care Designation (Adult) Policy (ACP: GCD Policy)	<ul style="list-style-type: none"> <li># clinicians trained (fundamental and in-depth)</li> <li># trainers trained</li> <li># of tools and forms developed and Regionally available</li> <li># and type of calls made to Health Link for ACP/GCD information</li> </ul>	<ul style="list-style-type: none"> <li>Electronic Health Record and paper records adapted to meet ACP: GCD Policy needs</li> <li>80% of clinicians receive fundamental policy education</li> <li>Clinicians increase their awareness, knowledge, and application of the policy</li> <li>Systemic support for policy in place</li> <li>Shift from levels of care to new Goals of Care Designations (all sectors)</li> <li>ACP: GCD Policy tools and forms are developed and Regionally available</li> <li>Processes for determining, documenting, transferring, and carrying out Goals of Care Designations determined</li> <li>Patients identified as "appropriate" within the new policy have: <ul style="list-style-type: none"> <li>A Goals of Care Designation Order (75%)</li> <li>Outcomes of ACP discussions documented on the ACP Tracking Record (75%)</li> </ul> </li> <li>Information related to future health care decisions transfers with patients - Acute Care/ED ↔ LTC/DAL (50% – 75%)</li> <li>When medically appropriate, patients' wishes as identified in their medical charts and/or advance directives are followed across the continuum of care (90%)</li> </ul>	<ul style="list-style-type: none"> <li>ACP: GCD Policy is fully implemented and supported</li> <li>Patients identified as "appropriate" within the new policy have a GCD Order (95%)</li> <li>Information related to future health care decisions transfers with patients - Acute Care/ED ↔ LTC/DAL (75% – 90%)</li> <li>Decrease in inappropriate transfers across the continuum of care</li> <li>When medically appropriate, patients' wishes as identified in their medical charts and/or advance directives are followed across the continuum of care (95% target)</li> <li>Clinicians find the policy process and tools beneficial (50% at 6 months post policy implementation; 75% at 1 year post policy implementation)</li> <li>Increased patient and family awareness of ACP: GCD Policy and Goals of Care Designations.</li> <li>Effective use of ACP: GCD Policy tools and forms by clinicians</li> <li>Increase in % of appropriate Goals of Care Designations</li> </ul>	<ul style="list-style-type: none"> <li>Regional policies consistently address issues related to care at the end of life</li> <li>Appropriate acute care utilization by Long Term Care and Designated Assisted Living patients</li> </ul>
<b>Collaborate with other groups to advance the work of Advance Care Planning</b>	Collaborate with the Office of the Public Guardian (OPG), Health Quality Council of Alberta (HQCA), Health Canada, and other Health Regions	<ul style="list-style-type: none"> <li># of collaborations established</li> <li># of planned collaborative activities accomplished</li> </ul>	<ul style="list-style-type: none"> <li>Public education campaign in Calgary region underway (with OPG)</li> <li>Regional framework for the provincial Personal Directive registry established (with OPG)</li> <li>Opportunities re: provincial ACP work are identified and/or acted upon (with HQCA)</li> <li>2nd National Symposium re: ACP is planned (with Health Canada)</li> <li>Provide support to other health regions re: ACP</li> </ul>	<ul style="list-style-type: none"> <li>To be determined</li> </ul>	<ul style="list-style-type: none"> <li>To be determined</li> </ul>

CULTURE SHIFT

**Guiding Principles / Assumptions:** 1. Death is a natural and inevitable part of life. 2. The experience of dying and of death both includes and transcends the healthcare system. 3. Individuals living with advanced illness, together with their families, benefit from care that includes a focus on end of life care issues. 4. Individuals and their families bring unique sets of values and beliefs that guide them in making decisions regarding end of life care. 5. When provided with the appropriate education and skill development regarding end of life care, the quality of work experience for health care practitioners is enhanced. 6. Community collaboration is essential in developing a holistic understanding of death and dying for individuals within that community. 7. Providing **quality** end of life care is a cost shifting rather than a cost saving endeavour. 8. Both community and health system leadership are essential to influence the culture shift required for success in this project.

**Inputs / Resources:** **Internal** - .9 FTE Project Manager, .3 FTE Palliative Physician, .5 FTE QI Consultant, .62 FTE Admin Support (x2), 3.75 FTE Education Specialists, 1 FTE Policy Implementation Coordinator – Physical space and office infrastructure through SECP Seniors Health – Administrative Leadership from Director and Medical Director, Seniors Health and Palliative Care. **External** - Advisory Groups: CEOL Advisory Committee, CEOL Community Task Group, Policy Implementation Advisory Committee – Collaborative Partnership / Mentorship from Palliative Care, Fraser Health Services – Resource experts: CHR Legal Affairs, CHR Communications, CHR Health Policy, CHR Quality Safety & Health Information – Consultants from *Respecting Choices*™, Gunderson Lutheran, WI