Establish a system that delivers on all four quadrants of the ACP Deployment Model

- The Structure
  - Embeds connected networks

- In order to
  - Establish a system that delivers on all four quadrants of the ACP Deployment Model

- So that
  - The leadership, education, systems and quality process are in place

- To ensure that
  - People who live in New Zealand experience ACP enriched lives & deaths, having their values underpin their care and receive care in the place & manner they prefer.
HQSC

National ACP team / Coop

MoH

Regional Alliance Teams

LOCAL __DHB ACP KEY LEADS
• Clinical leader
• Portfolio mgr (if non a Service mgr)
• ACP Coordinator / A Champion L2

Local ACP networks / working groups
• DHB Provider
• DHB rehab
• PHO
• GPs
• Community
• ARC
• Hospice
• NGOs
• CTC
• communicators

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One named stream for each DHB in the region

• These are the connected networks that operate within each district
• Fostering a health workforce culture of continuous quality improvement
• Developing and testing measurement and evaluation tools, take lessons learnt and apply to practice improvement
• To ensure treating clinicians and other health care workers are aware of the person’s preferences and Advance Directives
• Organisational - Getting and retaining the support & involvement of health care leadership
• Community – reaching out to the general public to engage them in ACP development, deployment and participation

- People, patients, families & whanau
- Continuous quality Improvement
- System infrastructure
- Education
- Engagement

• Health workforce – engage, train and support to initiate, participate and facilitate ACP – provide tools and information resources
• People – inform them of ACP and the benefits – provide information resources and tools to guide and record ACP
• Fostering a health workforce culture of continuous quality improvement
• Developing and testing measurement and evaluation tools, take lessons learnt and apply to practice improvement

Underpinned by a conducive policy environment and availability of human & financial resources

Advance Care Planning Deployment Model
Adapted from Health Canada, March 2008
Consumers are:
- Aware of ACP
- Thinking & talking to families/whanau & others in the community
- Raising or seeking ACP from healthcare providers & relevant others
- Being supported to do ACP
- Expecting to have ACP conversations as part of whole person care
- Expecting compassionate communication & to be informed of prognosis

Organisations providing health & social care are
- Advocating & prioritising ACP
- Documenting & reporting ACP activity
- Releasing time for ACP activity
- Setting staff/performance expectations:
  - ACP L1 training is mandatory
  - All staff have an ACP Ambassador role
  - L2 Practitioners are training & supporting other staff in ACP activities.
- Funding appropriately to ensure ACP deliverables are met
- Generating awareness in & outside their organisation/s of the importance of ACP
- Empowering consumers with information, tools & referrals where needed
- Ensuring sufficient ACP trained staff

System infrastructure

People
Individuals are
- Experiencing ACP enriched lives & deaths
- Having their values underpin their care
- Receiving care in the place & manner they prefer.

Families/whanau are
- Empowered to participate
- Experiencing less depression & anxiety before & after the death of their loved one.

Engagement

Education

Quality improvement

Underpinned by a conducive policy environment and availability of human & financial resources

Policy requirements include:
- Clear and documented ACP pathways
- Mandated ACP training at local, service & organisational level
- National targets & incentives for ACP activities
- Accreditation requirements
- Consistent policies across the country
- Collaboration across health, social & other sectors.

Resourcing:
- Sufficient funding & support to:
  - Make ACP training attractive & sustainable
  - Empower consumers & communities
  - Develop & role out an Information Technology solution
- Fund research

What will good look like for ACP 2025?

• Consumers are:
  - Using website & tools
  - Participating in CtC community meetings
  - Volunteering to become Conversations That Count (CtC) Communicators & Trainers
  - Empowered through the CtC training to co-lead ACP Programme

Health & social care workforce are:
- Documenting all ACP activity/conversations
- Using the ACP resources
- Championing/being an Ambassador for ACP
- Feeling capable & are competent in their use of ACP
- Role modelling ACP methods & are effective communicating
- Have integrated ACP into everyday practice
- Know how to & use ACPs
- Initiate early conversations

• Resources, processes & service is continually improved upon by & with consumers
• Engaged research community evaluating & assisting with the delivery of ACP.
Support each DHB to:
• understand the need for and benefits of training
• develop processes for
  – advertising the training
  – recruitment of appropriate participants for training
  – review applications for the training
  – support trained staff
• release staff to attend training and build post-course conversation tracking into their post-training roles
• promote the importance of in-team training for sustainability
• access and distribute ACP printed and other resources
• promote website and tools
• support CtC Communicators/volunteers

Deliver Level 1A training

Keep on point with messaging -
• importance of consistency across DHBs and across the country – better for patients/families, better from the system
• equity of access for individuals/the general public includes access to a healthcare workforce who have resources, skills and competencies to support them to have ACP conversations and plan ahead
• we need further research: outcomes of the training for participants and the impact of ACP on a person’s choices and our ability to support patient wishes
• the need to change the way in which we deliver care so that it is patient centred and individuals are offered and supported to make healthcare decisions which are aligned to their values
• if we can get this right for people as they approach the end of their lives, we can get it right for the entire healthcare system
• the training is the cheapest evidence based communication training in Australasia and is viewed as one of the five leading programmes in the world. effective communications training is expensive because it has to be experiential.

Support each DHB to:
• appoint someone at E suite level to own ACP
• collect stories from clinicians and patients for promotion of ACP/story telling
• get the most out of CtC Day (as an awareness raising activity), suggesting/promoting the utilisation of CtC Day and ACP resources
• engage clinicians early by including ACP at orientation/induction
• mandate Level 1 training
• include ACP promotion and advocacy for the patient voice in job descriptions
• find and provide ACP clinical leads with sufficient time allocated to lead ACP
• create the expectation that those who are undertaking ACP activity are supported by the organisation to make this part of everyday practice
• drive collaboration across health, social & other sectors.

Support each DHB to:
• consider and agree how ACP conversations and plans are captured and accessed
• set target setting of ACP activity (conversations, plans, training, etc)
• agree reporting and monitor activity

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Drive for policy improvements including:
• clear documented ACP pathways
• targets and incentives for ACP activity

Resourcing - consistently note that the complexity and required quality of changing care to be delivered as a closed loop system takes funding! However, the return is worth the investment.