

Governance & Senior Leadership Forum Palliative and End-of Life Care... A Joint Pledge

Spreading the Pledge | Roundtable Discussion (Summary)



Question #1 - What suggestions do you have to enhance the Pledge?

Exemplary palliative care that improves living and supports dying with dignity.

Empowering every person with a life-limiting condition to live fully and to die peacefully in a personalized environment.

Supporting life-limiting conditions with compassion, dignity and respect.

- Prefer the second statement ... like a personalized environment
- Like the third statement
- What's missing... patients AND their families
- Don't like the first statement ... challenged with the word "Exemplary"
- Not fond of "Empowering"
- Possible rework: "Supporting quality of life with compassion, dignity and respect for people with life-limiting illness and their families in a setting of their choice."
- Pledge needs to be simpler and address a broader audience – doesn't tell me what I need to do
- Engage Palliative PXs and families in developing pledge
- Who is the audience for the pledge... is it to motivate Health Care worker or, should it be for the whole community, or is it aimed at the Health Care staff to start with followed by the whole community later?
- Patient Feedback and Caregiver...keep it simplistic
- Move it upstream -> Palliative is more than end-of-life care from moment of diagnosis, not wait till dying... continuum care brought up to process
- 'Dying with Dignity' statement and 'Individualized'... this statement is taken over by the physician assisted suicide group.
- Organizations embrace palliative care at a strategic level
- Recognize spiritual aspect with the pledge
- Recognize diversity with the pledge including sub population e.g., marginalized people
- Keep it simple and straight forward
- A person's "choice" regarding palliative care should be recognized in the pledge
- Speak to the person – person or resident-focused.
- Guiding principles did speak to person.
- Life limiting of concern – duration not quality; terminal not limiting
- Live life you can... Live life to fullest
- The second statement stands out
- The word Palliative is problematic as everyone has a different opinion of what it means clinically and culturally

- Perhaps combine the second and third statement combining elements of empowering, personalized environment, compassion, dignity and respect
- Could look at wording about choice
- If palliative is in a statement, it needs to be defined and understood/ agreed to by all what it actually means
- Pledge for health care – provide opportunities for every person with a life-limiting condition by supporting compassion, dignity, respect and choice in a personalized environment
- Rewrite Part 2 – provide opportunities to every person with life limiting condition to live
- Give patients an understanding (put Hope in the wording)
- Speak not only to doctors, more to the public – schools, social groups, clubs...educate the public earlier in life
- Supporting people living with life limiting conditions
- Add spiritual care – celebrating their past – celebrate the circle of life - legacy work.
- Not enough knowledge on the rewarding aspect of care
- Education – on caring – of physicians (caregiver) □ Not part of pledge
- All pledges long; generational
- No one has to die alone!
- Palliative care is beyond – oncology
- “Advanced Progressive Conditions” incorporation
- “Dying with Dignity” faith-based issue – connection to personal choice to die
- Patients – choice of where they want to die
- “Supportive Care” – transitioning from care focus to support focus – “Compassionate Care”
- It needs to be in plain language... those offered are too long and too hard to remember
- It needs to be quotable (similar to no child will go to school hungry)
- It needs to be written from the perspective of the client and what would the family want to see a provider pledge (not what the provider wants)
- Elements that are needed in the pledge:
 - The notion of time
 - Incorporating the how as much as the what (although this was later debated and no consensus was achieved – some believed only the what belonged in the pledge and not they why or how, some believed both where needed)
- Language such as “life-limiting condition” is too policy jargon... it is not simple, understandable or relatable
- It should be focused on the person i.e., ‘no person shall/or will...’
- Statement 1 : standard statement that has stood the test of time ~ Has all of the right words
- Statement 2 : What does life limiting mean?
 - Is it only the last 1-2 years of life?
 - Live life fully – How do we define fully?
 - It’s about people’s preferences and respecting that preference
 - Many people assume that a personalized environment means they want to die at home; this assumption is not necessarily true
 - Rather than use personalized environment, use place of choice
- Statement 3 : Similar to statement #1, there isn’t any new information... consider revising wording to include advocacy – people don’t know what they don’t know
- Can these statements be reviewed by patients and their family/friends to ensure that it is representative of their needs? For example, have a focus group?
- Out of the three pledges, the second one was the preference, because it talked about the patient, rather than framing the condition (palliative care) as a disease

- Dignity is subjective, needs to be clarified or defined
- Be simple... the more wordy the less popular.
- There should also be a focus on the family
- The pledge should also touch upon the continuum, from the beginning of palliative care to bereavement
- Add the concept of “Comfortable and compassionate” care
- Consult patients about what Pledge statements resonate with them or how to enhance them
- Extend to include the support that families require
- Normalize broadly across the community the idea that death and dying are natural parts of the life cycle
- Preferred the second pledge since it speaks to making most of life and looks at the full continuum of palliative care
- Prefer statement #1 because it extends palliative care beyond dying
 - People need a palliative approach to their care while they are living
 - Palliation is about care vs. cure
 - Palliative care can apply to people of any age
- “Life-limiting” seems restrictive and suggests period leading up to death; should be broader
- Intended audience should be health and community care providers (including physicians); inspire and engage this group first and leverage them to spread the message to patients, clients, caregivers and the general public
- Wording suggestions:
 - “Exemplary” – find a simpler, more meaningful term
 - “Dying” can be a scary word
 - Keep the statement short and quotable
- Needs to be part of each organization’s strategic plan
- Simplify and support people not conditions and adding spiritual care
- Honouring patient wishes
- Dying with dignity – word individualize could be misconstrued with physician assisted suicide
- Start with community care providers initially
- Through integration, partnership and innovation, we will provide exemplary person centred palliative care
- From cure to compassionate care
- More about those we are serving, less about the process
- Patient advocacy – need to find out what the patient wants, then advocate for it
- Suggest pulling the word ‘palliative’ out – has different meanings for different people
- Need patient and family input on developing the pledge
- Supporting quality of life with compassion and respect for ...
- Normalize death and dying as part of life
- Something in the pledge that it is not just about the patient, but about the caregiver
- Can’t empower someone, you can provide opportunity to empower them – need to redo the statement in terms of opportunities for every person with life limiting conditions– change that notion
- Should add that this not just about the person dying but their families and caregivers
- Wanted to ensure that a holistic approach is fundamental i.e., this is not just about pain and symptom management (the medical side) there is a whole psycho / social aspect
- Don’t like the term “empowering” – perhaps... Providing opportunities for....
- Wanted to ensure equitable access for every person who wants it
- The idea of honouring the patient’s wishes needs to be clear – or at least understood
- The idea of combining it with the “living lessons quote” made sense – but it becomes too long for stand alone
- Needs to call out that this is for Central west – this could be accommodated by including that in the header footer.
- For the public – needs to be simple language – referenced the Ireland example “Dying for a Pint”

- Lots of discussion with no consensus on using “palliative care” language rather than people with a life limiting condition – thinking on the pro side was that we need to educate the public about death – it’s not “passing on” its dying... the cons were that “palliative care” is not a known word to most – so let’s keep it in lay terms.

Question #2 - How can we begin to action the Pledge together?

- Having acute care talk to homecare: Improve communication, more seamless transitions, talk to each other, share information, sharing goals of care
- Give people permission to push boundaries to serve the patient better
- Care coordinator follows the patient cross-sectionally
- Shouldn’t be differences in cross boundaries e.g. CCAC supports
- Preventive – Rehab supports sooner before patient gets to the hospital
- Getting information of Substitute Decision Maker – education
- Education around palliative care (advanced care planning)
- Action item: Early identification
- Registry: once a patient is identified as palliative in the system
 - Suspend the file as supposed to closing it (the idea is that the care plan never closes – Continuity of care plan)
- A lot of Health Links clients are Palliative
- Sustainability at workplace
 - PSWs
 - Leveling of playing field hospital vs. community
- Make it more attractive for 1 care physicians to follow their patients... hospitals require to be more open to this
- Community Hospice can be involved early
 - Are they the primary contact – clinics at the hospice in the community – Windsor is a good model
 - Direct admit as opposed through emergency
 - Respite services and the 2417 support-coordination
 - Basing a system on caregivers that don’t exist
 - The openness to stay home for the older generation
- Understand the services available so we can assess in transition
- Identify and reduce roadblocks (gaps)
- How do we support Central West Palliative Care Network
- Eliminate duplication
- Innovation and Creativity and simplification to eliminate silos. Need to be flexible in our thinking to accommodate rural ↔ urban, etc. View through a Health Equity lens
- Referrals
- One way into assessment/ single assessment – patient not having to repeat information
- Real network of coordinated care – single care plan (Health Links)
- Promote inter-operability (?) across computer system
- Engage family physicians
- Embrace palliative care in a collaborative integration manner with other partners in the health system
- Disseminate the pledge throughout organizations at all levels – staff, physicians, board, etc.
- Communicate the pledge and awareness of resources to access and support palliative care services
- Educate within the system – building palliative care knowledge and capacity – providers and community
- Providers should commit to palliative care services by signing individual “pledges”
- Incorporate palliative care goods/ process in organization quality improvement plans

- Public promotional materials distributed at key touch points for public i.e. Pharmacies.
- Knowledge transfer and sharing of success
- Get LTC sector members involved – 80,000 people are PC; LTC in their home
- Educate family on cycle of life
- Primary physicians understand and work with family – Talk about PC before they come to LTC
- Doctors need to get beyond current patients - look at quality of life
- Family physician OR LTC home physician
- Client is the patient/ resident/ family -> relationship goes past death
- Present it as a wraparound plan i.e. Health Links versus a specific palliative care plan; this will allow all of the partners to be involved in living the pledge through a collaborative effort
- Pledge agreed to by all would allow the system to focus on the individual, not the system or individual provider
- Implement a “nobody dies alone”
- How can we action the pledge together as a collective?
- Educate the community, all partners; EMS, police, public health, ODSP -> include in mailing something about palliative care
- Schools trans-sectoral; curriculum introduced in school – elementary school – as part of life skills journey -> continuum
- Enhance education in all professional schools
- Identify gaps, prioritize, implement based on priority
- Look at this from a system approach – embrace advanced care planning. Advanced and implement fifth vital sign
- Environment scan of what’s available
- Education of the whole community, every facet of the “community.” All caregivers. Shifting boxes to Angles -> care providers.
- “Social shift in how we view death
- Taking it upstream in thinking of care earlier
- “Exchange” wearing of seniors – all aspects of community “Hub” “Health Food and Diet”
- “Common messaging”
- “Primary Education” connection to children and youth
- “Care Planning” – For all Family -> mandated
- Campaign “Palliative care as everyone’s Business”
- Physician recommendation bonuses – Palliative Care Plan
- Next step is to operationalize the pledge for agencies – concretely what can the HSP do to achieve it
- Given the massive amounts of information regarding palliative care, agencies who are not experts in palliative care but play a role could use a ‘tool kit’ or starter kit to help them implement the pledge (change management tools)
 - This would help synthesis and organize the information agencies need
 - This could also be a guide to help action the pledge
- Have a palliative care service directory for each LHIN similar to Mississauga Halton that includes all agencies, hospitals and HSPs providing palliative care
 - It should be accessible on the web and maintained on an ongoing basis
- Funding for LEAP for physicians and nurses to increase palliative care knowledge and education
 - Focus on currently practicing HSPs who are providing palliative care to patients
- Help to build capacity and sustainability:
 - Physicians, NPs and other HSPs that provide continuous support to patients (for example: neurology, respirology) should be able to follow-up with patients when they become palliative. They have an already established relationship with these patients and they can develop/implement advanced care planning to move forward. This way, care doesn’t have to go up tiers (referring to Dr. Marshall’s pyramid slide diagram). Palliative leads can provide consultation to all teams and provide mentorship/coaching

- Immediate need: Have conversations with the patient and their family in the hospital to begin the advance care planning
 - These conversations should occur sooner and more often to begin ACP with the patient and family to help them prepare
 - The conversations should occur with all service providers – hospitals, nurses, FPs, etc.
- As a system, obtain input from patients/clients and their caregivers regarding the delivery of service
- Educate the public re the term “palliative”. Ensure that the public gets the correct information
- Determine where each organization fits in the continuum of care. What are the integration points with other organizations?
- When the information is obtained, look at opportunities to model, build on or replicate good practice, and reduce duplication of activities/efforts where appropriate
- There should be integrated supportive resources... Are there enough resources? Are there enough to go around?
- Consultation with the patient and family at the beginning of any process
- Identify barriers by surveying patients and family, including any cultural differences and requests
- Personalize the care
- Identifying palliative care patients earlier in the process to initiate discussion between patient and family
- Asking the goal of the patient before any care (i.e. wellness, palliative, etc.)
- Cultivate “thought” leaders in every sector that will model the practices you want to see
- Start with those who are currently providing palliative care
- Need a wide spread philosophical shift across all sectors
- Resources required to ensure the pledge is fully realized - the lack of resources makes it challenging
- Identify palliative individuals as early as possible in order to be able to bring forward the resources/care they need
- Develop partnerships with family physicians since they are the first point of contact. Also connect with e-health, pharmacists and social services leading to the development an integrated system
- Create a system to support residents who do not have the family to support them through end-of-life or don't want to go to hospice care
- Develop or share resources to educate people on palliative care, since sometimes family members often insist that doctors continue to treat patients beyond the point of benefit/cure. Attention should be paid on the messaging of palliative care.
- Establish accountabilities
- Develop a central service hub within the community
- Leverage the CW Palliative Care Network to bring other providers into the effort
 - Could include PCN outreach to LTC homes to establish connections
 - Consider how existing resources could be combined across organizations/ amplified through collaboration
- Communicate:
 - Share progress, stories and efforts in this space to inspire others to join the effort
 - Report back on progress at a regular interval by asking organizations, “what have you done to support the pledge?”
 - Hold a joint learning session in six months to help others see how they could take action
- Focus on building participation by making it easy, yet meaningful, to sign on
 - “Barriers to entry” should be low enough that nobody could say no on the basis of expected effort, but high enough that signing on requires participants to do something concrete
- What are the resources available to the patient and the family
- In terms of looking at gaps, what services are being provided across the continuum of care, what is being duplicated that can be changed?
- Campaigns that palliative care is the responsibility of everyone
- Wrap around care as opposed to just palliative care
- No one dies alone

- Giving permission to push the boundaries
- Sustainability of our work force
- Before you can begin, need to find a way to talk to community and patients and find out what's not working for them – what's broken?
- Suggesting leveraging existing network – roll out to primary care, etc.
- Share the success stories going forward and hold a learning lab session about six months down the road
- Model practices that we want to see
- Use the health equity lens
- A single assessment, an integrated computer system, i.e. Health Links so there is one shared system
- Need to build our base of primary care, non-clinical practitioners, and way to do that is LHIN to fund the base
- Back to Denise Marshalls 15 Steps – and identify what we can specifically carve out as concrete actions – generally felt the 15 steps were very clinical
- Liked the concept of this being a public health issue
- Public/provider campaign – Palliative Care is everybody's business
- Ensure providers are asking the “would I be surprised” question as a way for identifying the need for a specific care plan development
- Awareness Campaigns to target specific age groups / cultures
- Developing Advanced Care plans mandatory for getting a mortgage or for admission to a LTC Home
- Advanced Care Plans are a requirement of every physical exam
- Make the “speak up” and advanced Care Plans broadly and visibly available
- Provide LEAP courses (with CME Credits) as a way of educating physicians, nurses and other providers about how to have the conversation – Fundamentals of palliative care
- Need to set standards for what is available – starting with PSWs – currently no standards
- Develop an education program for school – targeting children – who then go back to parents and grandparents with questions about care plans.
- Need to organize physician groups to provide coverage 24/7 – group on call plans
- Immediately begin to involve the family along with the patient in care planning – need a frank conversation about the individual's and families goals are
- Figure out how to share individual plans among providers in the circle of care – electronically ideally
- Enroll all Palliative Care patients as a Health Link patient resulting in the generation of a Comprehensive Care Plan.

Question #3 - We all have a role... how do you see your organization committing to advancing the Pledge?

- Education and symptom management
- Building capacity of front line service providers
- Organization can come into the hospital to do a blitz
- Hospice can be there – small organization can change things a lot faster than a larger organization
- Move towards case management
- Need for good education for families
- All needs to be prepared to challenge ourselves as to what's the best to happen
- If palliative care programs to keep primary care as a shared partnership
- Be willing to test new methods... first need PX and family input through focus groups (PX advisory group)
- Educate youth to start changing public health view of dying

- Health Links can help us identify PXs early on who need the support
- Primary care needs to be brought in now
- Educate and support PX advocates and caregivers
- System needs to identify a navigator to help PX get through all the care transitions
- Individual care,
- Involve team – educate – empower resident family - engage staff, families, physician who are carrying for your residents
- Systems → Open up communication – know how we're doing across the system; by developing indicators then let people know how we are doing
- Should be seamless transitions – not getting same assessments over and over
- We should all commit to transitions that work.
- Communications across providers
- Education – try to develop more common understanding; address different perspectives
- Resource - Gaps?
- Establish palliative care as a strategic priority
- Communicate strategy through admission process and public pamphlets
- Linking back to the pledge
- By being part of LHIN and sharing successes and stories related to palliative care
- Where palliative care is not on organizations primary focus – determine how they “fit in” and align and support the pledge
- Better connection between front line staff and senior execs making decisions
- Support for staff who are in the early day; ED for front line staff to help with PC
- Get PSW's involved
- Check in with patient...are we right
- Implement a care plan (Health Links) that follows patients along their care journey, at this table that would mean from community programs to adult-day programs to long term care to end of life
- Care plan NOT palliative care plan
- Community health care organizations. Mobilize leadership. Non-medical groups....as – care/ respite, volunteers
- Hospital – Earlier identification of palliative care needs of patients case mining – ensure timely access to acute palliative access
- Create teams: - Primary Care (Back to the future – go back in time – 23% □ 10-80% house call... Social Contract – Provide tools support so they feel comfortable... Long Term Care (Educating, allied health...very common element of palliative care, but a leap for LTC... Physicians – Specialists (also part of the journey...i.e., Surgeons, GIMS, oncology, Rest., cardio; can all practice palliative med as well
- Utilizing existing networks to work a ministry-mandated education
- Include “Surprise” questions in all assessments
- “Osler” economic condition -> Moving \$ from hospital -? Community - ??
- Human + financial + Identifying
- Organizations – can maximize -> “Financial Resources”-> progress
- “Accountability to each other and one system.” Ex. ER->Family health units
- Interchange of one system “EMR”
- The role for the organization will be to ensure the cascading of the pledge to front line staff workers (both learning about palliative care and action items).
- An example was given as to how Wellfort CHC operationalized and gave staff an opportunity to take ownership of their Quality Improvement Pledge: they asked each staff members to take an individual pledge of 1 action they could do to implement the QI pledge. This could be repeated with the palliative care pledge

- Disseminate and apply Gold Standards Framework (from the UK ~ <http://www.goldstandardsframework.org.uk/>) and have them based on role
- Send staff to LEAP program and further their education
- Have mentorship of palliative leads to community practitioners
- Put the Pledge in the strategic plan of the organization. Identify individual(s) who will have “ownership” for auctioning the Pledge
- Meet with community partners to review processes and identify strategies, e.g. have a process mapping/value stream mapping day
- Encourage local organizations to embrace collaboration, innovation and partnership, and not fear change (e.g. fear of losing autonomy, role – there is enough work for everyone). Put “collaboration in the policy of the Board
- For any agency, transition between agencies is the most difficult part. To improve, there must be integrated information exchange
- The care coordinator should educate the patient on palliative care
- Warm-hand offs between agencies
- Buy-in from leadership for Connecting GTA
- Ensuring that community service organizations see themselves as part of the palliative care system and other see them that way
- Personally commit to the pledge and take ownership and ensure the message is communicated to others/team
- Understanding cultural differences/expectations of palliative clients. What does dying mean for the individual and his/her family and staff
- Implement an education campaign to promote the pledge among ER physicians, NPs, nurses and other team members and to encourage providers to ask the surprise question for early patient identification
- Make it easy for partners to sign on... share examples of actions that others have taken to show the range of ways that providers can contribute
- Ask each signing organization to set one goal... share progress against this goal in a common forum on a regular basis... regular forum could also help to spread ideas across organizations
- Further into implementation, successful innovations could be spread as best practices across the region
- Work together and establish some means of accountability
- We would all sign the pledge
- Importance of what it means to sign the pledge, must be meaningful not just for the sake of signing
- Would like each organization to set one goal and share successes six months down the road
- Volunteerism
- Ensuring timely access to acute primary care
- Make it 70-80% of physicians doing home care
- Allied health professionals and physician specialists – not only staying involved but remaining actively involved
- Information being shared across all providers – identify everyone has a role and seeking how to leverage solutions – we all need to come to the table
- Individual ownership, accountability beyond the leadership team was critical
- Make sure people have learned about it – what is the step they will action
- Embed and nurture the pledge within the culture of the organization – how to make it live
- How to spread the word
- Understanding the cultural differences and expectations and make sure they are taken into consideration
- Implementing Care Plans, i.e. Health Links, Adult Day Programs, End of Life
- Once we leave tonight, need to go establish pan goal

- All need to be prepared to challenge ourselves
- Value stream mapping, process mapping

Question #4 - How do we measure success?

- Be willing to test and fail
- Patient and family survey satisfaction
- 2-year measured study as part of CCO Palliative Care
- Patients who have been ID'd as Palliative and represented 30 days.
- Who and how did they get admitted
- More communication between emergency and (incomplete)
- Levels of care forms are not legally binding document
- Knowing what the client wants/ offer them what is appropriate to them. If not capable, substitute decision maker needs to be consulted.
- More people will be educated and have decision making done earlier.
- Number of patients who die in their place of choice
- If PT has to come back to hospital, make it a direct admit, not through ED (more direct admits if necessary)
- VOICES tool
- Need to determine PX priorities and then we can develop measures
- Percent of people referred to palliative care organization prior and death
- Client satisfaction with process
- Decreased rates of complicated bereavement
- Increase in donations to hospices
- Client and family satisfaction (follow up) during and post-palliative care services (audit) and after care
- Desire for palliative care services increase
- Positive informal "word of mouth" increase
- Improved access to service, improved patient experience, improved efficient uses of resources
- Resident passing where they chose – numbers
- Find accurate measured pre and post
- Through the development of an individual care plan we could measure: # of hospital transfers from LTC, reduced 30 day readmission, and attachment and access to primary care and specialty care
- When the shift moved well in the community
- When people go and make a will, they bring their advanced care plan
- Reducing number of expected deaths in hospital; death at home
- > 50% FP doing XXXX and palliative medicine... coroners not allowed....every neighborhood
- Don't need to have these types of meetings... no longer in health care's hands
- How many people died where they wanted?
- Outcomes are measurable within indicators?
- Reduction of ER visits
- How many nursing homes are sending to ED?
- Postal Code protocol
- "Quality of life"
- The reach of the pledge – i.e. how many agencies have signed the pledge and how many front line staff have signed on (i.e. Bramalea example)
- Client satisfaction in the form of the question: we aimed to (insert pledge) did we achieve this
- There are clinical indicators (as presented by Dr. Marshall) but the data is blurry ~ does it really measure what it needs to?
- Develop a patient and family satisfaction survey that asks questions about: Communication, Care Coordination, and was the ACP conversation initiated at the right time and place?

- If HSPs further their education, a post-evaluation should be completed (for example, 6 months, 1 year after the course) to determine if and how their practices have changed
- Client/patient satisfaction. Feedback from the client/patient and caregiver that their needs are being met. Implement a regional survey. Have questions at the end of each visit, or capture feedback during bereavement visit. Note: The Voices Survey is to be implemented provincially- should meet this need
- Increase in the number of physicians and other health care providers participating in LEAP education
- Measure that patients/clients are being identified and referred to palliative services earlier, and that they have a collaborative plan. Length of stay on various surveys could be tracked
- Measure public awareness
- “No one dies alone” plan was mentioned. (Manitoba has a “no one dies alone” program for hospital and long-term care homes.)
- Satisfied patient or family through surveying. The Voice’s survey is established, tested to be useful
- System metrics – those outlined by Dr. Marshall
- Engaging families early and this will be reflected by uptake of palliative care
- Influence the shared culture; this could be measured again by more patients choosing palliative care
- Client and family satisfaction
- HSP evaluations
- Repeat ER visits
- Tracking return visits to ER
- Follow -up with the family on timeliness of care received and overall satisfaction (indicated that people don’t like filling out questionnaires and suggested doing telephone follow -up)
- Track number of referrals to hospice
- Need to develop a standard set of measures to be used across the LHIN
- In the early stages, encourage participation and build support with the aim of achieving 100% participation. Measure:
 - Awareness
 - Providers who have signed on
 - Providers who can report taking action on the pledge
- Once providers have signed on, ramp up commitment over time:
 - Initially, HSPs, FHTs, CHCs, LTC physicians, then some % of family practices
- With enough participation, can promote the public expectation of support
 - Certificates (physical or virtual) and wall of signatories
 - “Has your provider signed the pledge?” campaign to build public support.
- People to die where they want to die
- 100% of care plans are accessible
- Shift in the community will recognize success – when people are well enough to make these decisions, they will bring their advance care plans with them
- Measuring how many ER visits during the last two months of life
- How many taxi drivers, etc., are aware of the condition of the patient
- Measure number of hospital transfers for long term care
- Referral/measurement to the hospice
- Patient family satisfaction – being able to determine how to get that measurement, by statistics, palliative/cancer diagnosis – would be able to survey them to see how their journey went
- Want 100% participation at some point
- Build support for the pledge in the early days
- Posting of pledge in hospital lobby, etc
- Evaluate themselves