Project Title: Embedding Advance Care Planning in Care Transitions

Practice Change Leaders for Aging and Health Program
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Practice Change Leader Project: Bridge two coalitions, one provider-focused and one community-focused, to develop a shared vision and implementation strategy for advance care planning with older adults at risk of frequent/repeated transitions between care settings.

Goals of the Project: To help older adults communicate their goals of care by incorporating advance care planning across a regional continuum of care. The project targets older adults at risk of frequent/repeated transitions between care settings.

Key Activities:

(1) Work with care transitions coalition leadership to help expand the reach and influence of member organizations around advance care planning;
(2) Provide and coach care transitions organizations on the use of tools and materials to educate and engage older patients in advance care planning;
(3) Recruit and support care transition organizations in the design and pilot of protocols to refer older patients to trained advance care planning facilitators; and
(4) Develop a specific plan and timetable for care transitions organizations to provide advance care planning facilitation to compliment health care systems' advance care planning implementation.

Key Outcome: A practical, testable strategy to align advance care planning activities between community-based care transitions programs and two regional health systems.

Difference the Practice Change Leader project will make: Advance care planning is not the norm for Idaho's health care providers, community-based providers, patients and their families. This project is committed to creating an environment where advance care planning happens naturally within a community-wide system that encourages every older adult to be fully engaged and where all health systems honor their choices.