1. As an Honoring Choices Massachusetts Alliance member, the **American Cancer Society**, New England Division has committed to providing their 70 regional forum members with educational materials and programs to enhance the knowledge and skills of their 20 care providers and staff.
2. The **American Nurses Association Massachusetts** makes the following commitment:
    a. On October 4, 2016 Curry College School of Nursing will host a discussion event for all 800 students, 90 full and part time faculty, and all nurses from Milton Hospital at Curry to review the aims of the Coalition and to share stories that will encourage all to have the conversations, identify proxies and learn more about how to share our work with their patients and their families.
    b. The leaders from ANA MA will also encourage all of the Massachusetts schools of nursing to do the same.
    c. They will also share the Coalition's work with all 122,000 RNs in the state and are eager to share this work at their November 4th Wellness event.
3. By 2017, **Ariadne Labs** pledges to improve training and systems of care to assure that at least 30,000 patients in Massachusetts have clinicians who provide more, earlier, and better goals of care conversations.
4. **The Association of Independent Colleges and Universities in Massachusetts** commits to bringing together senior leaders from member health sciences schools by the end of 2016 to explore opportunities to increase advance care planning training and education for clinicians across the Commonwealth.
5. As an Honoring Choices Massachusetts Alliance member, **Atrius Health** has committed to providing their 30 practice groups with educational materials and programs to enhance the knowledge and skills of their 50 care providers and staff.
6. **Baystate Health (BH)** shares the Coalition's goal to ensure that everyone receives health care that honors their goals, values, and preferences. BH commits to promoting and supporting advance care planning and care for those with serious illness through the following initiatives:

    As a healthcare provider, via a multidisciplinary team, BH will develop a multi-year enterprise-wide road map for ACP advancement that includes:

    - Developing a plan for a future "single source of truth" for ACP that can be shared with healthcare providers both inside and outside of BH
    - Adapting our current EMR structure to better file and track ACP documents and goals of care conversations so they are more readily accessible
    - Improving ACP through Interprofessional Geriatric-Palliative Care teams who work with frail high-need elders in the pilot home care program and in the community health centers (Outcomes to date include a 13% increase in HCP documentation in the chart)
    - Performing Goals of Care conversations and completing advance care documentation as appropriate on the ACE unit to ensure understanding and compliance with patients' wishes
    - Participating in the Center to Advance Palliative Care (CAPC) accelerator in November 2017
    - Participating in meaningful ACP pilots with vendor partners focused on key audiences (e.g., employees, advanced HF patients, etc.)
    - Participating as a member organization in the IHI Conversation Ready Collaborative to, by April 2018, use quality improvement methods to develop and test more and better ways to **(a)** capture (and make accessible) more accurate and actionable HCP documents on a pilot

inpatient unit; and **(b)** explore and electronically steward "What Matters Most?" to patients on the same pilot unit

- Leading and participating in the Western Massachusetts Transitions in Care Cross Continuum (TICCC)/Honoring Choices Workshops and Training sessions (as an Honoring Choices Alliance Partner)
- Participating in National Healthcare Decisions Day, in conjunction with our Health New England colleagues
- Holding ACP community presentations to Baystate Health's Senior Class, churches, synagogues, etc.

As a teaching institution, BH is committed to advancing ACP education and practice improvement via:

- Educating medical students about ACP
- Providing residents with a palliative care curriculum that includes detailed education on ACP and ACP documents
- Training all internal medicine residents and hospitalist teaching faculty to conduct effective goal-oriented conversations (including end of life management) with patients and families that align with patients' goals, values and preferences -- first through simulated role-playing scenarios, followed by bedside skills evaluation and ongoing practice improvement

7. **Beth Israel Deaconess Medical Center (BIDMC)** shares the Coalition's goal to ensure that everyone in Massachusetts receives health care that honors their goals, values, and preferences. BIDMC has been working on a number of projects to further that goal and will make additional commitments as described below.
    - BIDMC's primary care practice (Health Care Associates) serves approximately 42,000 patients each year. Over the last 2+ years, we have developed a process to help patients designate a health care agent, properly complete the health care proxy form, and ensure the information is accurately captured in the electronic medical record. A pilot project in one area of the clinic refined this process which has now spread to all areas of the clinic. Data show that in the area doing this work for the longest, the percentage of patients who have completed a HCP form has increased from 39% in the summer of 2014 to above 80% by October 2016. **We commit to increasing that percentage to 95% by June 2017. In the remaining areas we commit to significantly increase the percentage of patients who have completed a HCP form by June 2017.**

    - To more formally and scientifically learn from our efforts described above, **BIDMC commits to conduct an IRB-approved study to describe** the process and evaluate its effectiveness. In addition to seeking publication of the study, **BIDMC will share its findings with any Coalition members who are interested**.

    - **BIDMC also commits to conduct an IRB-approved study** of the healthcare proxy forms stored in its electronic medical record system to determine the associations between patient and health-system factors and the likelihood that the completed form is both legally enforceable (e.g., signed by two witnesses, neither of whom are the named agent, etc.) and completed with sufficient information to be useful to medical providers.

In addition to seeking publication of the study, **BIDMC will share its findings with any Coalition members who are interested**.

- As a teaching hospital of Harvard Medical School, BIDMC plays an important role in the education of future physicians. **BIDMC commits to teaching all internal-medicine residents how to communicate with patients about advance care planning and serious illness, which will include a session at regular intervals dedicated to understanding the importance of a health care proxy, how to complete the form, and how to counsel patients about planning a conversation with their named agent.** By exemplifying the work residents will better understand the benefits and challenges of advance care planning.

8. **Blue Cross Blue Shield of Massachusetts** commits to surveying all our employees about health care proxy completion, to offer training and advance care planning resources to all associates and support 100% of associates who are interested and ready to complete health care proxies. BCBSMA further commits to launching an advance care planning learning module on our wellness platform, which is available to more than 1.5 million BCBSMA members, by the end of 2016.
    a. BCBSMA is also an Honoring Choices Alliance member committed to providing their 3700 employees with educational materials and programs to enhance their knowledge and skills in order to make a personal health care plan.
    b. As an Honoring Choices Massachusetts Alliance member, **Cape Cod Healthcare** has committed to providing to providing their 75 collaborating groups with educational materials & programs to enhance the knowledge & skills of their 375 care providers and staff.
    c. As an Honoring Choices Massachusetts Alliance member **Caregiver Homes / Seniorlink** has committed to providing their 15 branches with educational materials and programs to enhance the knowledge and skills of their 141 care providers and staff.
9. **Cake (joincake.com)** pledges to leverage our digital tools and technology to increase access to advance care and end-of-life planning for people of all ages.
10. Among other ongoing activities, **Care Dimensions** commits to actively support Healthcare Decisions Month. Examples of outreach and communications include:

    External Professional Outreach

    - Webinars and in-person programs on meaningful conversations, advance directives, MOLST, etc.
    - MOLST Conference panel presentation – with Care Dimensions chaplain on panel
    - Original video featuring role playing and how to complete a MOLST

    External Community Outreach:

    - Community cable shows on the importance of advance directives
    - Community programs at Reading and Peabody Libraries – Making Decisions When It Matters Most

    Care Dimensions Staff Outreach:

- Decisions Month signage throughout offices and forms for staff: “Have you completed your advance directive?”
- Staff emails / newsletter on advance care planning; email signature
- Email to all volunteers with links to Honoring Choices materials

Media/Social Media Communications:

- Outreach to newspaper/TV/radio
- Weekly social media campaign
- Letter to the Editor from Care Dimensions leadership

11. **Commonwealth Care Alliance** embraces the importance of shared decision making and our absolute responsibility to ensure that patient and family decisions around serious illness and end of life care are enabled, realized and supported. To this end, Commonwealth Care Alliance pledges to: Develop individualized care plans with all of our members that incorporate and recognize their needs for medical, behavioral health, and social supports that are focused on the individual member and their family at all points along the trajectory of their care pathway. We will stay engaged throughout our members’ lives, supporting them fully, respectfully, and in the place of their choice, with such supports embedded through every aspect of our model of care. In cases of serious and end of life illness, work tirelessly to determine the place, context, and level of care that members and their families desire and to both deliver and partner with other health care and social support providers to guarantee that member autonomy and voice is foremost at all times. We will honor our members’ choices and keep the promises we have made.
12. **Conversation Project** commits to increasing awareness about the importance of having end-of-life care conversations with loved ones and clinicians by holding fifty community conversation workshops/educational programs for both the public and health care organizations.
13. We at **End With Care** are pleased and honored to be members of the Coalition and commit to the following activities to advance the Coalition mission and goals:

    We will create a presence on our website for the Coalition, and we will state the mission and goals of the Coalition as they appear in the “Core Message” document.

    Every grant application proposal that we file will include a description of the Coalition and our intent to use the grant award to work in collaboration with other Coalition members toward common goals and specific targets.

    In any of the email blasts to our various stakeholders during 2016 and ongoing, we commit to including a statement about the Coalition and the importance of this collaboration.

    The final stated goal of the Coalition is the following: All Massachusetts health care providers have systems in place to share patient goals, values and preferences across care settings, to ensure they are accessible regardless of place of care. At End With Care, we believe that we will contribute to the achievement of this goal by providing this free, online portal to information regarding services and supports, a community forum for issues and best practices, and a source for original and creative content on news and topics regarding end of life care.

14. **Fallon Health’s Program of All-Inclusive Care for the Elderly (PACE), Summit ElderCare,** has goals that align with those of the Massachusetts Coalition for Serious Illness Care:

- With six sites and over 1,200 enrollees, Summit ElderCare is the largest PACE program in New England, and the 5th largest nationwide.
- Our over-arching goal is to provide holistic medical and social supports for people with serious illnesses to help them continue living safely in the community—and avoid nursing homes—through the end of life whenever possible. To this point, conversations regarding serious illness care and progression, end of life, the dying process, wishes and goals begin at enrollment and continue throughout their Summit experience.

Additional examples of ways in which Summit ElderCare promotes the goals of the Coalition include:

- We have developed, and consistently use, a Participant Quality of Life Preferences Assessment tool to help ensure that we are addressing individual values, quality of life determinants, specific interventions desired and not, spiritual preferences and preferred setting at time of death.
- We conduct initial conversations with our participants following enrollment with our physicians, nurses and social workers to identify goals for care. Functional goals, longevity and comfort/palliative care are discussed.

  Reflecting these efforts:

  - Over 91% of our participants have identified their goals.
  - Nearly 90% have a completed MOLST form
  - Over 95% have a health care proxy on file

Further work includes:

- Our End of Life Program is initiated when we anticipate a participant may pass away within 12 months due to disease progression. This program provides greater focus on phases of end-of-life—including Actively Dying and Death Imminent—to be sure we are directly addressing our participant and family needs with modifications to the individual's Care Plan. Families and participants are provided educational materials including important contact information, what to expect, etc.
- All staff are required to receive annual education supporting competency in all these areas.
- The Summit End of Life Committee oversees the entire program, providing education, training and updates, and working with the Quality and Risk Department to measure and support effectiveness and continued improvement.

More broadly, Fallon Health has a number of programs in place consistent with the goals of the Coalition. Examples include:

- A program run in collaboration with the Alzheimer's Association for Improving Memory
- An Advanced Directives program which includes working with providers and their patients to ensure advanced directives are in place
- A Safe Transitions Program in which a pharmacist makes home visits to individuals post-hospital discharge to reconcile their medications

15. **Greater Boston Interfaith Organization** commits to continue to work with the Conversation Project to get as many of our 40 or so congregations to do the initial training, as well as for those

who have completed the initial 2 sessions and who manifest a desire to go further to support congregants in their Serious and Advanced Illness care and planning efforts—that we would aim to work with Conversation Project to plan some follow-up sessions tailored to the needs and desires of those congregations.

16. **Hallmark Health VNA and Hospice, Inc.** commits to educating clinicians, community agencies and consumers about advance care planning by:

- Offering a Community Palliative Care Nurse Practitioner Program, whose core goal is to promote end of life/goals of care planning with patients/families/health care providers
- Participating as an active member of Hallmark Health System, Inc.'s End of Life Committee, which annually participates in National Healthcare Decisions Day, providing both education and educational material to our clinicians, and consumers
- Speaking annually to the leadership of Hallmark Health System, Inc. to provide education about the importance of advance care planning
- Offering educational programs to area nursing homes, assisted living facilities and community agencies we partner with regarding advance planning and end of life care options

17. **Health New England** commits to:
    - Monthly meetings of an Advanced Care Planning (ACP) multi-disciplinary group with the goal to develop quality process and outcome measures, and report on our ongoing initiatives as well as to develop on line resources for associates and members alike. These resources will include the Coalition for Serious Illness Care Website, Conversation Project and tools from CAPC.
    - We are committed to ensuring that 100% of our case managers receive yearly training on Advanced Care Planning (ACP). This will enable them to help our members develop care plans which address goals of care and stress the importance of completing ACP paperwork.
    - We are working with our parent health company on system wide initiatives to educate employees, providers and patients on the importance of ACP.
    - We are holding an all associates event during the National Healthcare Decisions Day (NHDD) to educate and highlight the importance of advanced care planning for associates, their families and the members they serve. Associates will have the opportunity to complete their own HCP as well as the opportunity to ask questions.
    - During the NHDD week, we are also holding an education session for seniors on the importance of ACP and provide materials they can take home to discuss with their families and PCPs.
18. **Hebrew SeniorLife (HSL),** an Alliance Partner of the Massachusetts Coalition for Serious Illness Care, commits to 100% participation from its entities in support of the Coalition's goals. As such, each entity will develop an entity-specific pilot focused on person-centered efforts aligning the delivery of care with values and preferences for patients, residents, family members and staff. HSL commits to creating a series of HSL best practices by December, 2017 through the inventory of current tools and learning from each entity's pilot.

    <u>Actionable first steps include:</u>

- Receive approval from Senior Leadership Team (September 2016)
- Create a consultant body/resource to the HSL organization with a set of goals and outcome measurement tools for HSL pilots (October 2016)
- Announce the effort to senior staff, generate awareness and buy-in (October 2016)
- Lou announces the effort to entire HSL organization and external key audiences (November 2016)
- Steering committee creates an inventory of existing best practices/tools/efforts (November 2016)
- Steering committee member to meet with each entity to get leadership buy-in and shape an outcome driven/measurable pilot, engaging patients/residents, families and staff (November 2016)
- Provide mid-year updates on efforts at annual Coalition gathering (May 2017)
- Create/establish HSL best practices based on the outcomes of pilots (December 2017)
- Shape next step based on learning

19. **Home Care Alliance of Massachusetts** commits to: providing ACP planning conversation and documentation support to its member federally certified home health agencies so that within one year no less than 20% will have incorporated such into their workflow for all Medicare patients.
    a. Also an Honoring Choices Alliance member, the Home Care Alliance of Massachusetts has committed to providing their 185 member organizations with educational materials and programs to enhance the knowledge and skills of their 600 care providers and staff.
20. **Honoring Choices Massachusetts** commits to developing and supporting 6 Community Partner Regional Networks in Metrowest-Greater Boston, North Shore, South Shore, Worcester, Springfield, and Cape Cod, where health care providers and community groups work together to coordinate a continuum of proactive and quality care, and create safer, sustainable care transitions for adults and families in their region, by December 2018.
    a. **Also,** the Honoring Choices Massachusetts Alliance Partners are working together to create a unified health care planning language and Massachusetts tools to help engage adults and families in planning discussions and connect them to person-centered care. The 16 Alliance Partners commit to providing their 2766 member organizations and groups with educational materials and programs to enhance the knowledge and communication skills of their 10,647 care providers, staff and employees by December 2017.
21. **HopeHealth** commits to educate clinicians, community agencies and consumers on advance care planning through programs offered by Hope Academy. During the second quarter 2016, we trained 672 people, 562 of whom were clinicians and 110 were members of the community. Some of the courses we conducted were Shifting Hope, MOLST, The Road We Are All On, and Five Wishes.
22. **Hospice and Palliative Care Federation of Massachusetts** commits to building a searchable, informative, palliative care database for consumers and professionals by 2017.
    a. Also an Honoring Choices Alliance member, Hospice & Palliative Care Federation of Massachusetts has committed to providing their 800 member organizations with educational materials & programs to enhance the knowledge & skills of 400 care providers & staff.
23. As an Honoring Choices Massachusetts Alliance member**, LeadingAge Massachusetts** has committed to providing their 196 member organizations with educational materials and programs to enhance the knowledge and expects that at least 40 of their provider members will

participate in webinars and training. In addition, we will reach out to 100% of LeadingAge MA members to discuss and share how they can participate in this initiative. Volunteers have initiated phone calls with more than 90 provider members (and have engaged in conversations with close to 50 of them to date). During the calls, volunteers are informing members of resources available (such as Honoring Choices tools, Conversation Project, and now the Coalition for Serious Illness Care website), asking about practices that providers are engaged in regarding person-centered health care planning, and asking members what one step they can take toward the Coalition's goals in the year ahead.

24. We, **Indian Circle for Caring USA, Inc.**, enthusiastically support the goals of the Massachusetts Coalition for Serious Illness Care, and are pleased to play an active role in furthering these in the community we serve.
    Our signature initiative is to educate and empower everyone to prepare a health care proxy and living will (through the use of Five Wishes) as well as encourage people to have a conversation with loved ones about goals and preferences. We also use techniques from The Conversation Project, and have been trained to lead conversations. The following are our goals for mid-2019:
    - Hold 8-10 additional advance care planning workshops free-of-charge
    - Distribute more than 2,000 copies of "Five Wishes" documents and provide access via our web site
    - Train 4-6 teams within associate organizations to carry out similar programs in the geographic areas they serve
25. **The Institute for Healthcare Improvement (IHI)** is strongly committed to advancing the Coalition's goals. In addition being directly involved in the group's leadership, IHI will also:
    - offer sessions to all IHI staff on the Coalition's goals and how to use The Conversation Project toolkits to work with their friends and loved ones;
    - include several sessions at the IHI Forums and Summits focused on sharing the goals and tools widely; and
    - partner with the Coalition to share IHI's online course on end-of-life care. This course is offered free to both students clinicians.
26. We, the **Massachusetts Coalition for the Prevention of Medical Errors** commits to working with Coalition members to improve palliative care for patients with serious illness –with initial focus on inpatient care and discharge planning- and integrate this effort with existing work on palliative care (to avoid duplication/ confusion/burdens for participants). As Co-Chair of the Care Transitions Steering Committee, the Coalition Executive Director (with Lorraine Schoen from MHA – the other Co-Chair) is also keeping Palliative Care/Serious Illness Care an ongoing agenda item for communication and coordination among members of that group.
    a. Also an Honoring Choices Alliance member, the Massachusetts Coalition for the Prevention of Medical Errors has committed to providing their 65 member organizations with educational materials and programs to enhance the knowledge and skills of their 1000 care providers and staff.
27. As an Honoring Choices Massachusetts Alliance member, **the Massachusetts Conference of the United Church of Christ** has committed to providing their 369 churches with educational materials and programs to enhance the knowledge and skills of 738 congregation members.
28. As an Honoring Choices Massachusetts Alliance member, **the Massachusetts Executive Office of Elder Affairs, Home and Community Programs** has committed to providing their 26 ASAP's with

educational materials and programs to enhance the knowledge and skills of their 500 care providers and staff.

29. **Massachusetts Chapter of National Academy of Elder Law Attorneys (MassNELA)** commits to increasing members' knowledge of and use of various tools that will enable clients to:
    - Relay their health care wishes to their named health care proxy agents,
    - Place their health care proxies on file with their medical providers, and
    - Discuss their care wishes with their medical providers.
30. **Massachusetts General Hospital** has embarked on a multi-year initiative, known as the Program in Palliative Care Education. The goal of the program is to develop interdisciplinary practice models for the key pillars of our palliative care strategy: 1) primary palliative care education, 2) advance care planning, and 3) patient engagement.

    Priority actions include:
    - Primary Palliative Care Education – Develop core competencies, training modules and skill building to educate front-line clinicians.
    - Advance Care Planning – Provide education to clinicians to give them the knowledge and tools to engage in high quality advance care planning conversations.
    - Patient Engagement – Develop programs to educate patients and families about palliative care and to empower them to have their palliative care needs met.
31. The **Massachusetts Health Policy Commission** is committed to the goal of the Massachusetts Serious Illness Care Coalition, that health care for everyone in Massachusetts is in accordance with their goals, values and preferences at all stages of life and in all steps of their care. We are advancing this goal through a number of policy and programmatic work including our investment programs (CHART and the Innovation Investment), our ACO certification program, and our research agenda.
    A. A number of our CHART awardees are focused on addressing serious illness care and planning as a means to achieve their goal of reducing readmissions. See below for more detail.
    B. The HPC will award a number of investments during two rounds of competitive funding for the Innovation Investment fund to eligible applicants, with the intention of implementing rapid, creative transformations in existing systems. Providers, provider organizations, and carriers that demonstrate their commitment to creating sustainable, innovative strategies through collaboration by targeting a challenge area together may apply for funding. One of the 8 challenge areas that applicants may submit a proposal for is an innovation to improve serious illness care.
    C. The HPC board recently approved the design of the ACO certification program. While patient-centered and designed care is an overall value that underpins the care delivery program, the HPC included a mandatory question for all systems seeking certification on if and how they support advanced illness care.
    D. The HPC has a focus on end of life care in our 2016 research agenda and plans to release research on the topic that presents novel analyses on the variation of costs and service utilization at the end of life for Medicare beneficiaries in Massachusetts. The HPC commits to continuing to track relevant claims-based measures in its annual dashboard.

32. We the **Massachusetts Health & Hospital Association** commits to educating our members (including hospitals, physician practices, and other provider types) in the appropriate use of advance care planning and palliative care following current state and other coalition requirements and policies by April 2017.
    a. Also an Honoring Choices Alliance member, Massachusetts Hospital Association has committed to providing their 100 hospitals and member organizations with educational materials and programs to enhance the knowledge and skills of their 200 care providers and staff.
33. We, the **Mass Home Care Association**, commit to engaging one-third of all our employees and board members (~1,000) people to: 1) have a discussion with someone willing to become their health care agent 2) sign and complete a Health Care Proxy form 3) give that Proxy form to their PCP, and 4) have a discussion with their PCP about their preferences, goals, and values for care if they were facing a serious and advancing illness.
    a. Also an Honoring Choices Alliance member, Mass Home Care has committed to providing their 26 ASAP's with educational materials and programs to enhance the knowledge and skills of their 1000 care providers, board of directors and staff.
34. We the **Massachusetts Assisted Living Facilities Association** commit to providing at least one educational session or resource for members regarding advance care planning and health care decision making by December 31, 2016.
    a. Also an Honoring Choices Alliance member, Massachusetts Assisted Living Facilities Association has committed to providing their 225 assisted living residences and member organizations with educational materials and programs to enhance the knowledge and skills of their 675 care providers and staff.
35. **Massachusetts Association for Mental Health** is prepared to convene stakeholders in the mental health community, including persons with lived experience, families, clinicians/providers, and legal advocates to discuss the sensitive issue of end of life planning. Our task would be to assist the mental health stakeholder community in framing an approach to addressing the need for identifying decision makers, establishing conversations on individual goals for end of life care, and determining unique training issues for clinicians caring for persons with major mental health conditions who are facing end of life care decisions. The MAMH Board has representatives of the key stakeholder groups, and we would begin the conversation with the Board before convening a larger group. Once the mental health stakeholder community framed an approach, we would want to work closely with the Coalition to discuss the findings and might seek support to take steps to implement the identified approach.
36. We, the **Massachusetts Medical Society** (MMS), will provide resources on designating a health care agent to our Board of Trustees members so that they may demonstrate leadership and personal commitment and, in turn, encourage colleagues, family members, and patients. Our goal is at least a 90% completion rate by the Board members by June 2017. We, the MMS, commit to surveying our membership regarding training on advance care planning and serious illness by the end of 2016 and thereafter providing educational resources to our members and encouraging participation in training. We, the MMS, commit to providing regular educational information on the benefits of completing a health care proxy to all employees between January and December of 2017, with a goal of a 50% increase in employees' self-reported execution of health care proxy forms.
37. **The Massachusetts Programs of All-Inclusive Care for the Elderly (MassPACE**) will commit to gathering the total number of individuals reached with MOLST by the Commonwealth's PACE programs.

38. **MACIPA** has made a commitment to train all of its Primary Care Physician members and interested Specialists in the Serious Illness Communication Protocol; MACIPA is devoting its 2016 Primary Care Physician Forum series to "Conversations in Serious Illness." These trainings have already been held for primary care and will be offered to cardiology, oncology and pulmonology.
39. As an Honoring Choices Massachusetts Alliance member, **the Massachusetts Senior Care Association and Massachusetts Senior Care Foundation** has committed to providing their 420 members organizations with educational materials & programs to enhance the knowledge and skills of 1260 care providers and staff.
40. As an Honoring Choices Massachusetts Alliance member, **New England Quality Innovation Network-Quality Improvement Organization** has committed to providing their 150 care transitions organizations and members with educational materials and programs to enhance the knowledge and skills of their 45 care providers and staff.
41. **Newton Wellesley Hospital (NWH)** has set a goal to educate all NWH staff on the importance of having a health care proxy and of having conversations with your health care agent over time about your values and goals related to serious illness care. We are employing a number of strategies to reach this goal with many activities during Healthcare Decisions Month in April 2017:
    - Presentations to staff (Managers/Supervisors; Medical Staff and/or Chiefs and Chairs; Primary Care team meetings; Leadership Institute; Cancer Center, among others)
    - Brief presentation on nursing units during multidisciplinary rounds during the week of 4/24
    - Tables with staff/volunteers at the Main Entrance of the hospital and outside the cafeteria a few hours per day Mon-Thurs the week of 4/24 will provide info about proxies/conversations, samples of resources to help guide conversations and will have a daily raffle and candy to entice people to come to the table
    - Article in Hospital newsletter
    - Email info in "Daily Announcements"
    - Created a sticker that says #LifeGoals with NWH colors and will be given to everyone who stops by the table and gets info to help encourage word of mouth through hospital
    - Created an info sheet/checklist to hand out at tables and post on internet/intranet re: health care proxies and conversations
    - Updating intranet and internet resources/info about health care proxy/conversations
    - Digital signs related to National Health Care Decisions Day and MA Coalition for Serious Illness Care and NWH goal regarding health care proxy conversations
42. **Nina Rosenberg Consulting, in conjunction with the Families and Friends of 100 Centre Street and Hebrew Senior Life's (HSL) Center Communities of Brookline (CCB),** will coordinate gathering information from family caregivers about their interactions with health care providers and systems while functioning in the role of health care agent. The overall purpose will be to help identify healthcare system issues, barriers, as well as best practices that have had an impact on their ability to ensure that their loved one's wishes are heard and respected. This project will be initiated in September, with the goal of interviewing a minimum of 15 family members by December 2016. The initial findings will form the basis for developing a survey to be administered between January 2017 and September 2017 to an additional 20 family caregivers, with a report of findings and recommendations to be submitted to the Council.

43. **Spaulding Hospital Cambridge** has formed a Goals of Care Committee charged with improving the quality of communication between patients, families and clinical staff with the goal of improving care satisfaction for all parties. We are measuring our success through the number of health care proxies (HCP) we have on our patients and the number of MOLSTs. Our goal is to have 100% HCP on file and to have a documented MOLST conversation with any patient who meets our internal criteria of having a serious medical condition. We are working toward this goal through a variety of in-services to all clinical providers as a well as 1:1 tutorials on the patient care units.
44. **Tribute Home Care** commits to supporting the Coalition's goals by providing our clients and employees with health care planning tools and educational materials. We will share information on advance care planning, serious illness care, and health care proxies, and encourage our clients and team members to participate in ongoing health care discussions.
45. **Tufts Health Plan** believes strongly in the Coalition's mission to ensure that health care for everyone in Massachusetts is in accordance with their goals, values and preferences at all stages of life and in all steps of their care. We have taken the following steps in support of the Coalition's overall goals:
    - Schwartz Center Rounds: We were the first local health plan – and the second in the country – to initiate these rounds to allow clinical staff to reflect on their relationships with members. These rounds are ongoing, and support the needs of our clinicians, nurses, social workers and other care managers.
    - The Conversation Project: We began offering The Conversation Project workshops to employees in 2013. In 2016, we trained our care managers to have these important discussions with members and their families/caregivers using The Conversation Project starter kit. We have also begun to spread this work to our provider network.
    - Honoring Choices Massachusetts: We host info tables for our employees to promote the services and resources available through Honoring Choices Massachusetts, which works to ensure a person's health care choices are understood and honored all through their life.
    - Our Employees: Working with Fidelity Investments, we've provided counseling on estate planning that is in accordance with a person's end-of-life goals. We also host lunch and learn sessions and provide information for employees on National Health Care Decisions Day to help them in their planning and decision-making.
    - Our Provider Network: We work closely with our provider partners on this issue, including regular meetings and discussions with oncology and palliative care doctors. We also pay the providers in our network to have these important discussions with their patients.
    - More Services at Home: In 2016, we removed the homebound requirement for palliative care services for many of our members. This means more of our members can receive the care they need in the comfort of their own homes.
46. **UMass Memorial Medical Center** commits to:
    - training all internal medicine residents and hospitalist teaching faculty to conduct effective goal-oriented conversations -- first, with acting patients using simulated scenarios, and next at the bedside to evaluate their skills and promote ongoing practice improvement;
    - developing standardized documentation and storage of advance care planning discussions in outpatient primary care and specialty clinics in our electronic medical record; and

- promoting routine advance care planning for all patients, including an online tool that allows patients to create an advance care plan that is automatically downloaded into their electronic chart.