Peterborough FAMILY HEALTH TEAM

An EMR Advance Care Planning (ACP) Tool for Talking with Patients About End of Life

Background

A palliative care physician in our community noticed that many patients he came in contact with had not had a conversation around ACP. As these conversations most appropriately begin at the primary care level, he wanted to offer support to primary care providers in starting the conversation. The palliative care physician, QIDSS and a clinical nurse educator in cancer care from our local hospital collaborated to design an EMR tool to help facilitate these conversations.

ACP is important and everyone should have conversations about their wishes. These conversations become even more important when someone has a serious illness or chronic condition. Research has shown that if patients engage in ACP they are more likely to have their end of life wishes known and followed, family members will have less stress and anxiety because they know their loved one's wishes, patients and families are more satisfied with care and patients have a better quality of life and death.[1]

Approach/Process

The tool was developed for two EMRs (PS Suite and Accuro®) and utilizes various resource materials created by Speak Up Ontario. The tool was designed as a means to get started and therefore, it is intentionally short and simple.

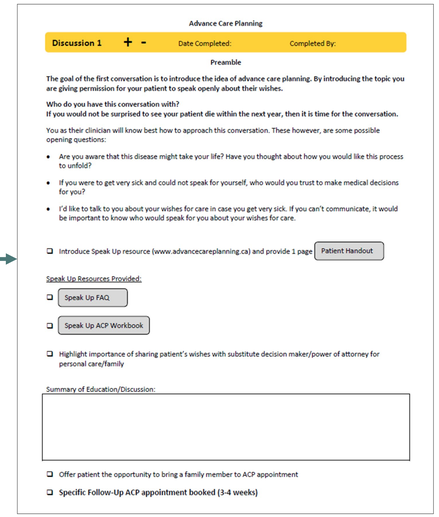
The tool is organized into three parts:

Part 1: As an addition to an existing patient visit. The idea is to introduce the topic of ACP and provide relevant resource materials to prepare the patient to have conversations around ACP.

Part 2: As a scheduled visit specific to ACP. This is where the primary care provider will have a dedicated conversation about ACP with their patient.

Part 3: As an addition to a subsequent visit that the patient is already having with their primary care provider. This final part is meant to document SDM/POA information and ensure any relevant documents are scanned into the patient's EMR.

The tool was deployed to all EMRs across the FHT and was presented by the palliative care physician and clinical nurse educator at each of our five FHO meetings. The tool was also presented at our annual FHT continuing medical education day.



Advance Care Planning

Discussion 1 + - Date Completed: Completed By:

Preamble

The goal of the first conversation is to introduce the idea of advance care planning. By introducing the topic you are giving permission for your patient to speak openly about their wishes.

Who do you have this conversation with?
If you would not be surprised to see your patient die within the next year, then it is time for the conversation.

You as their clinician will know best how to approach this conversation. These however, are some possible opening questions:

- Are you aware that this disease might take your life? Have you thought about how you would like this process to unfold?
- If you were to get very sick and could not speak for yourself, who would you trust to make medical decisions for you?
- I'd like to talk to you about your wishes for care in case you get very sick. If you can't communicate, it would be important to know who would speak for you about your wishes for care.

❑ Introduce Speak Up resource (www.advancecareplanning.ca) and provide 1 page [Patient Handout]

Speak Up Resources Provided:

❑ [Speak Up FAQ]

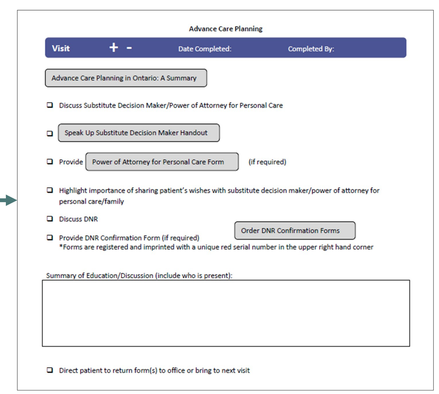
❑ [Speak Up ACP Workbook]

❑ Highlight importance of sharing patient's wishes with substitute decision maker/power of attorney for personal care/family

Summary of Education/Discussion:

❑ Offer patient the opportunity to bring a family member to ACP appointment

❑ Specific Follow-Up ACP appointment booked (3-4 weeks)



Advance Care Planning

Visit + - Date Completed: Completed By:

[Advance Care Planning in Ontario: A Summary]

❑ Discuss Substitute Decision Maker/Power of Attorney for Personal Care

❑ [Speak Up Substitute Decision Maker Handout]

❑ Provide [Power of Attorney for Personal Care Form] (if required)

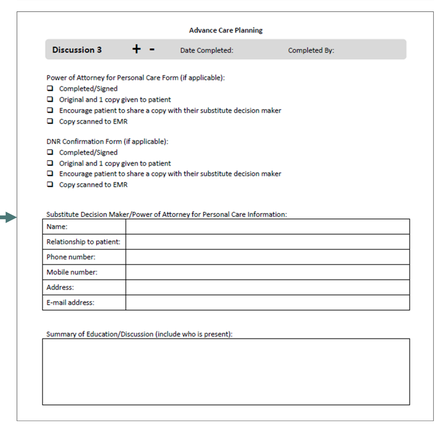
❑ Highlight importance of sharing patient's wishes with substitute decision maker/power of attorney for personal care/family

❑ Discuss DNR

❑ Provide DNR Confirmation Form (if required) [Order DNR Confirmation Forms]
*Forms are registered and imprinted with a unique red serial number in the upper right hand corner

Summary of Education/Discussion (include who is present):

❑ Direct patient to return form(s) to office or bring to next visit



Advance Care Planning

Discussion 3 + - Date Completed: Completed By:

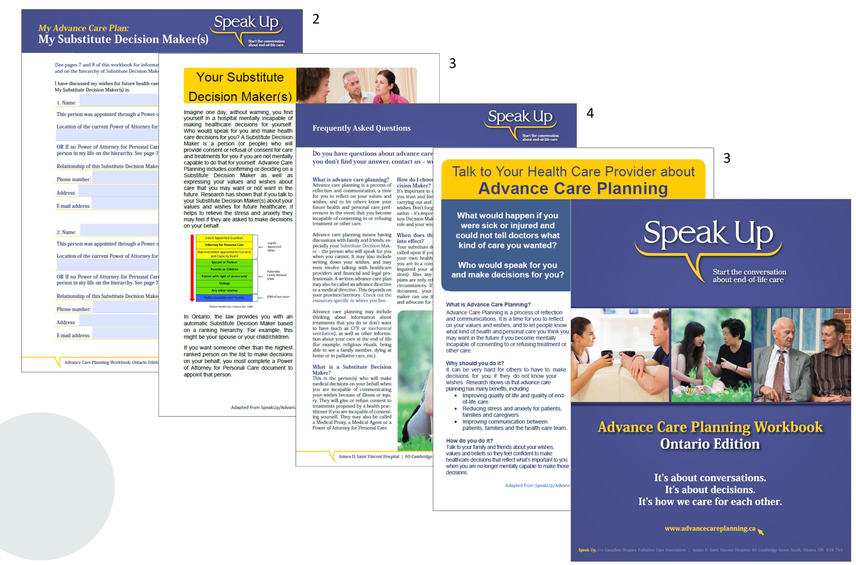
Power of Attorney for Personal Care Form (if applicable):
❑ Completed/Signed
❑ Original and 1 copy given to patient
❑ Encourage patient to share a copy with their substitute decision maker
❑ Copy scanned to EMR

DNR Confirmation Form (if applicable):
❑ Completed/Signed
❑ Original and 1 copy given to patient
❑ Encourage patient to share a copy with their substitute decision maker
❑ Copy scanned to EMR

Substitute Decision Maker/Power of Attorney for Personal Care Information:

Name:	
Relationship to patient:	
Phone number:	
Mobile number:	
Address:	
E-mail address:	

Summary of Education/Discussion (include who is present):



Future Directions

The tool was deployed at the beginning of 2017 and we intend to assess uptake through measuring the number of times the tool is used in the EMR. We have heard of at least one success story whereby the tool had been used to document a conversation and it was shared with our local hospital in the provision of patient care.

We will continue to promote the importance of having these conversations with patients and supporting our primary care providers in doing so.

For more information contact Amanda Hiemstra at: amanda.hiemstra@peterboroughfht.com

Collaborators:

Amanda Hiemstra, CHIM, QIDSS, Peterborough Family Health Team
Dr. John Beamish, Family Physician, Peterborough Family Health Team
Lori Laperle, RN, MScN, Clinical Nurse Educator Cancer Care, Peterborough Regional Health Centre
Lynda Chilibeck, BScPhm, RPh, Former Director of Clinical Programs, Peterborough Family Health Team
Lyne Edington, BScPhm, MBA, Former Director of Allied Health Programs & Services, Peterborough Family Health Team

References:

1. What's your excuse? (2017). Retrieved August 8, 2017, from http://www.advancecareplanning.ca/acp-news/whats-your-excuse/
2. Advance Care Planning Workbooks and Quick Guides. (2015). Retrieved August 08, 2017, from http://www.speakupontario.ca/resource/acp-workbook/
3. Primary Care. (2017). Retrieved August 08, 2017, from http://www.speakupontario.ca/resource/primary-care-toolkit-ontario/
4. Frequently Asked Questions. (2015). Retrieved August 08, 2017, from http://www.advancecareplanning.ca/resource/faqs/