PaCT
Patients Collaborating with Teams

Innovation Hubs
Test Box #3

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Timely Access and Continuity

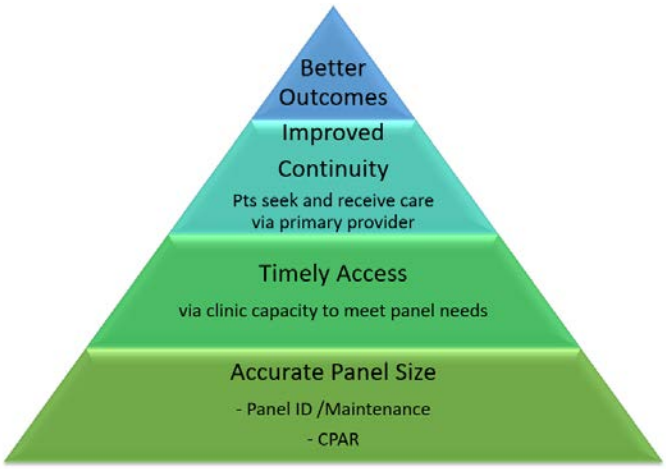
What?

To provide optimal care, and to improve and maintain continuity, patients must consistently be able to see their own provider and the team he or she works with. When clinic teams and individual physicians ensure they have the capacity to meet the needs of their paneled patients this results in timely access for appointments.

Why?

You can encourage, ask and coach patients to seek care at your clinic first, but if there are no appointments available in a timely manner, they may continue to seek care elsewhere - no matter how much they desire to make your clinic their medical home.

By ensuring you have the capacity to provide timely access, continuity will improve over time, and with it the health outcomes for the patients you serve. Supporting patients in care planning involving follow up can be difficult when access is a barrier.



Understanding Your Access

Understanding your delay for appointments is foundational to improving access and continuity of care. Knowledge around panel size is a critical variable and used in conjunction with the other measurements to provide an overall understanding of clinic access and potential improvement opportunities. Teams can measure and monitor their access and continuity using the following sources for data and measures:

Time to Third Next Available Appointment (TNA)

TNA is the gold standard measure, evidenced in international literature, of access to services from a patient perspective. It is broadly used as the foremost measure of patient access by healthcare organizations internationally and is supported by the Institute of Healthcare Improvement (IHI)[1] for access improvement work and by Alberta AIM[2].

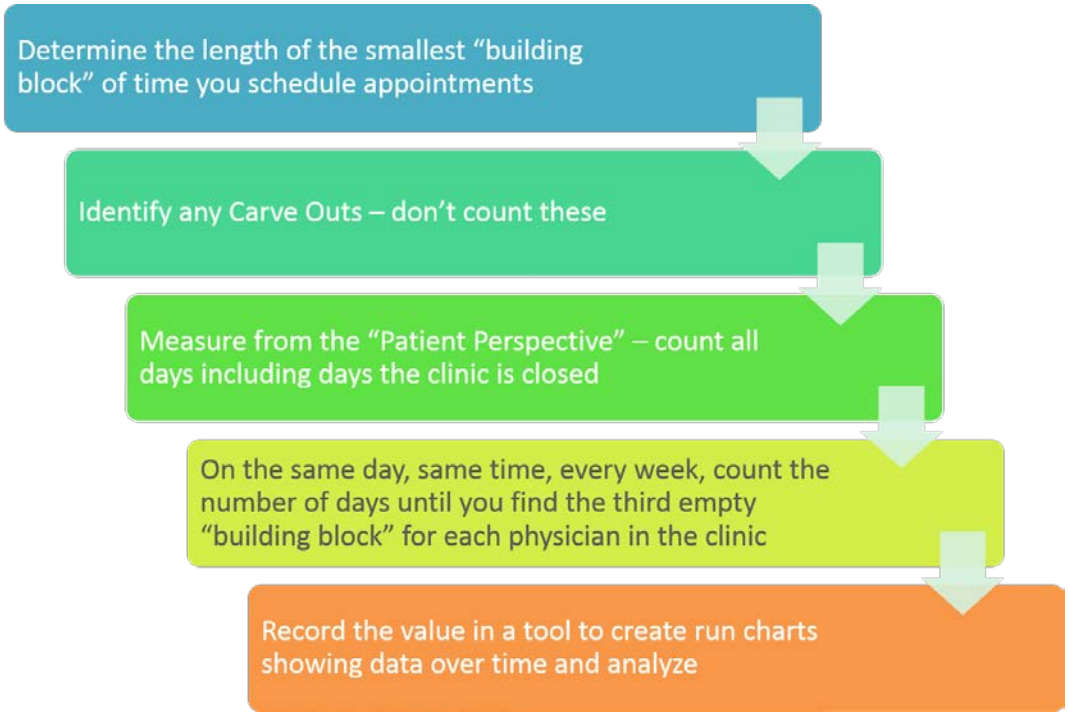
Measuring TNA

TNA is the **number of days** from when a patient makes a request for an appointment with his/her physician or provider, and the **third open appointment** in the schedule for a routine appointment, physical or return visit.

[1] http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx
[2] http://aimalberta.ca/index.php/self-serve-resources/measurement/

A toolkit for measuring TNA was released by Alberta Health to provide guidance to Primary Care Networks. It is recommended that teams seeking guidance on TNA measurement refer to Appendix A in this toolkit: Time to Third Next Available Appointment (TNA) Indicator – May 2016

Standardized Steps to Measuring TNA



1. ***Determine appointment lengths using building blocks of time***
   Determine the length of the shortest appointment slot offered (e.g. 10 minutes). Longer appointments are comprised of multiples of these building blocks. For example an annual physical examination may be booked for 30 minutes which would be 3 – 10 minute blocks equaling a total of 30 minutes. When counting TNA, simply look to see when the third next available empty building block is for a provider.

2. ***Identify any carve outs – don't count these***
   Carve outs are appointments held for specific kinds of patients or clinical needs. These time slots should not be included when counting TNA as they are in essence being held for special circumstances and can only be filled for the identified specific need. When calculating the TNA for each provider, **skip** any carve outs or held slots (e.g. appointments held for walk-in or 'urgents').

3. ***Measure from the 'patient perspective'***
   When calculating TNA, include weekends, days off, holidays, conferences, etc. Any day that the patient can't book an appointment with their physician/provider is considered 'delay'.
   *(NOTE: If **locums** see the paneled patients as scheduled, they are considered to be a substitute and no adjustment to the TNA calculation is required.)*

4. ***Measure at the same time/same day each week***
   TNA should be collected for all physicians in the clinic on the same day of the week and at approximately the same time.

   Tips:
   - PCNs may have adopted a standardized timeframe for all physicians within their group to collect TNA and it is important to follow the PCN's recommendations.
   - If timing of collection is left to the clinic to decide, consider avoiding Mondays and Fridays as holidays usually fall on these days.
   - The current day counts as '0'
   - Designate a particular person to be responsible for calculating and recording TNA
   - Make sure at least one other person is cross-trained to collect TNA

5. ***Record the value in a tool to create run charts showing data over time***
   Many PCNs have a specific tool for capturing TNA, or you may consider using the AIM Online Measurement Tool.

Test

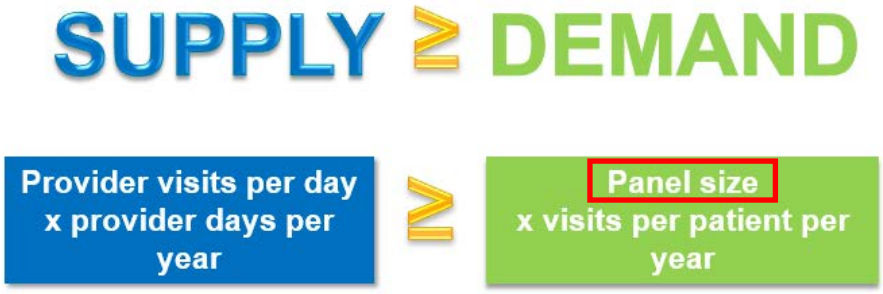
If you choose this item from the test box, then as a team discuss:

- Do we regularly measure our access from the patient's perspective (Third Next Available)?
- Does everyone on the team have a common understanding about:
  - why measuring TNA is important?
  - how TNA is measured?
  - how TNA data is collected and tracked?
  - what our TNA data is telling us about our access and our ability to provide appointments to our patients when they need them?

Need more help? Contact the Access Improvement Measurement (AIM) team at https://aimalberta.ca/ for support.

Panel Size and Access

Providing timely access at its most basic comes down to simple math and basic principles around demand and supply balance. You must have enough supply of worker time to meet the demand of work generated by your panel in order to maintain balance, and thereby, timely access. Panel size is a critical variable in this equation.



Panel size effects demand for appointments in 2 ways:

- Generally speaking the larger the panel size the more demand for appointments it will generate.
- Demand for appointments may be less or more depending on demographics and clinical conditions (e.g. –healthy young adults will generate less demand for appointments than older patients with complex health needs or children under the age of 6)

TNA or your measure of delay for access can provide a strong indication of whether your demand and supply are balanced or not.

HQCA Panel Report Data

In Test Box #2, you were introduced to the HQCA panel report, which has important information to help you examine access and continuity in your practice. Specifically, information that can be used to:

- stimulate self-reflection about your practice and how you manage your patients
- identify opportunities for improvement
- establish baseline performance for future improvement
- gauge your performance compared to peers within your PCN and zone.

HQCA has recently released a short video that can help you interpret your access and continuity data in the panel report. Specifically, it provides a way to approximate your supply of appointments and the demand of your patient panel (NOTE: If you don't already have your report, you can request one at HQCA Panel Report.)

Test

- Consider the following from your HQCA Physician Panel Report:
    - What percentage of your patients had **High** continuity (>80% of all visits were to us)**, Medium** continuity (50-80% of all visits were to us) and **Low** continuity (<50 of all visits were to us) on **Page 6** of HQCA 2018 Physician Panel Report. How does this correlate to your TNA results?
    - Over the last 3 years of data, how has your continuity changed (**Page 14** of HQCA Panel Report)?
    - How has continuity to the clinic changed over the last three years (**Page 15** of HQCA Panel Report)?
    - When are your patients primarily accessing the Emergency Department for those conditions that would be best served by the team (**Page 47** of HQCA Panel Report)? How does this correlate to your TNA results?
- Take 5 minutes as a team to review the video - HQCA Panel Reports, Access and Continuity

  TIP: Have your HQCA Panel Report handy when you review the video.
    - What is your provider activity for the last year of data?

      This can be found on **Page 8** of HQCA Panel Report under "total number of visits". This will include patients that are yours as well as those of other primary care providers that came to see you for care. This number is considered a proxy for your capacity or **SUPPLY.**
    - What was the total number of visits your panel of patients made to primary care physicians in the last year of data?

      This can be found on **Page 42** of HQCA Panel Report under "total visits". This will include visits to you and all other family physicians. This number is considered a proxy for **DEMAND** of your patient panel.
    - How do these two numbers compare? In an ideal situation, supply will be greater than or equal to demand. Did your patients have to seek care elsewhere because there was more demand than supply? How does this correlate to your TNA results?
    - How does your average physician continutiy compare to your average clinic continuity? (See **Page 14 & 15** of HQCA Panel Report)
- Now that you have completed some preliminary, high level analysis of your access and continuity, do you have room to improve or want to understand more? Contact the Access Improvement Measurement (AIM) team at https://aimalberta.ca/ for support.

Resources:

- Institute for Healthcare Improvement (IHI) Resources
- AIM Alberta - TNA Basics Workshop
- Toolkit for Time to Third Next Available Appointment (TNA) Indicator – May 2016
- AIM Online Measurement Tool
- Alberta AIM Self-Serve Resources
- HQCA's video - HQCA Panel Report, Access and Continuity

Engaging Patients in Care Planning

What?

For optimal care to occur, both patients and clinicians need to be involved[1]. Patients and their families bring personal knowledge on their life circumstances and preferences, while clinicians offer guidance and advice on treatment and intervention options. Patient-centred care requires clinicians to meaningfully engage patients in a way that builds trust, motivation and confidence.

The structure, incentives and culture of the system in which we work is often poorly aligned to support health care team efforts to respond to patients' needs as their core priority[1]. Clinicians report that patient-centred practices often feel foreign and even disruptive, indicating that more work is needed to embed potentially better practices into daily clinic processes so that they become more fluid and natural[2].

PaCT Fact

Studies have found that patient-centered primary care visits correlate with fewer diagnostic tests and referrals[3,4].

Why?

When patients, their families, other caregivers, and communities become active participants in care, patient experience, health, quality of life and economic outcomes significantly improve[1]. Patient-centred care correlates with a patient's ability to self-manage their health and adhere to complex treatment plans. Patient engagement takes on increased importance as a means of ensuring that patients are involved in decision making and find the right care to match their needs, preferences, and circumstances[1].

Consider:

A well-designed care planning template or tool is a key supportive structure for teams to translate patient-centred care into practice. What you say, how you say it and the order in which you say it matters. The PaCT Care Plan template was thoughtfully designed by patients and clinicians to incorporate evidence informed care planning practices. The layout of the sections, the inclusion of prompts and examples, and specific wording of questions all aim to promote informational and relational continuity. Consider adopting this tool or adapting your current tool to enhance patient care planning visits.

To align with the theme of this test box, we will highlight key components of the first section of the care plan template, which aims to:

- Build trust and rapport
- Strengthen health literacy
- Assess readiness

Click here to access a video *"Designing a Care Plan with the Patient in Mind"* for a brief overview of the key components – what they are and why they are important.

Build Trust and Rapport

As discussed in previous test boxes, it is important to establish trust early and create a safe place for patients to engage in the conversation and ask questions. Notice how components of set the scene from test box 1 and practice principles from test box 2 are incorporated into the care plan template structure and questions. Both of these contribute to the building of trust and rapport.

Strengthen Health Literacy

People with low health literacy have poorer health[5]. "They are more likely to misuse medication, misunderstand health information and medical directions, and increase the burden on the health care system by requiring more time, money and emergency care". Many Albertans are overwhelmed with the technical details and complex names of drugs and conditions. Health care providers play a critical role in identifying and addressing health literacy issues.

One simple rule is to remember the two essential ingredients for promoting health literacy - **the what and the why**. Patients not only need to understand *what* their health conditions are and *what* can be done to manage them, but also understand *why* taking specific actions will help improve their health and their ability to do the things that are personally important to them.

Check out this resource ***"A Focus on Health Literacy: The What and the Why"*** for more information. Pay close attention to the sequencing of what and why questions and the use of the first ask, then offer principle. The prompting questions included on the PaCT care plan template reflect this desired sequence and use of the first ask, then offer principle.

Assess Readiness

When doing care planning with our patients we need to be skillful in determining what is going on for them in their lives so we can best support them in improving, or maintaining their health as well as helping them achieve their health goals. A principle called RICk® can help us quickly and efficiently determine where our patients are at in their health journey as well as what matters to them in their lives. RICk stands for Readiness, Importance, Confidence and knowledge. These four components together can help providers determine whether a patient will take action or not on recommended lifestyle or treatment options.

Check out the resource "*Ask RICk*" for more information.

Case Example – Ask RICk

Below is a patient case example that shows how the RICk® principle is used conversationally.

Patient Case:

Mr. Singh is a 65 year old gentleman with Type II diabetes, uncontrolled hypertension, obesity and dyslipidemia. He lives with his wife in a condo and works as an accountant for a firm in downtown Calgary. You are his primary care provider and he is coming to see you about his hypertension as he is experiencing dizziness and headaches.

Traditional Conversation:

Hi, Mr. Singh. I understand that you're having increased dizziness and headaches. Is that true? (Mr. Singh nods). Well, I did note that your lab results are also showing signs of increased hypertension. Based on what I'm seeing, I think it would be good to get you started on a hypertension medication to address this. How does that sound to you?

His Response:

Sure, I'm not super fond of taking medication but if you think that will help me, I can try it.

Ask RICk® Conversation:

knowledge question:
Mr. Singh, what's your understanding of what is causing your dizziness and headaches?
His Response: I remember my pharmacist telling me that if my blood pressure goes up I may experience dizziness. I think my blood pressure might be up a bit lately as I have had a lot of dizziness. I have been walking every day, decreasing my salt and eating more vegetables but it's not helping!

Importance question:
It sounds like you're doing a lot of the right things. You're right - dizziness is one sign of increasing blood pressure. Based on your lab results, your blood pressure reading and your symptoms, I think it would be valuable to explore options for decreasing your blood pressure and hopefully treating the dizziness and headaches. Would you say this is a priority for you right now?
His Response: Yes! These headaches and the constant dizziness is just too much for me! It's impacting my ability to do my work.

Readiness question:
It sounds like work is very important to you. (Mr. Singh nods with agreement). We've talked about taking medication to help manage your blood pressure in the past, but at the time you shared that you didn't want to take medication. With your symptoms increasing and your elevated lab values which we discussed earlier, I feel that starting a blood pressure medication would be beneficial given that your work is being impacted. Given everything else going on for you right now, Mr. Singh, how do you see it? Do you feel that now is right timing for you to begin a blood pressure medication?
His Response: I do have a lot happening with work. I often work late at the firm and don't get home until 8. Is medication the only option?

Confidence question:
Yes, taking medication is one option and as you shared at the start of our appointment, things like increasing activity and nutrition can also be beneficial. My understanding is that you are already working on these things? (Mr. Singh nods his head). That's great. It would be valuable to keep doing those things as they can help but I do think based on your symptoms that medication will have the most benefit at this time. If I could offer medication options that you would only take in the morning would you be open to discussing that for the reminder of the appointment today, knowing we can come back and review the other lifestyle changes at your next appointment?
His Response: Yes, if I could take one pill in the morning and not worry about taking one at work, I feel I could do that.

Reflection questions

- Do you think in the traditional conversation would have resulted in Mr. Singh taking the medication? Why or why not?
- How long did the "Ask RICk" conversation take vs the traditional conversation?
- Was the additional time valuable? Why or why not?
- How was the provider able to use the information from the RICk questions to build the patient's motivation and influence his readiness to start taking a blood pressure medication?

Test

Adopt a new or adapt a current care plan template

- As a team, review the current care plan template used by the clinic. Identify and discuss what aspects help to build trust and rapport, strengthen health literacy and assess readiness. Are there changes your team would want to consider?
- Compare your current care plan template to the PaCT Care Planning template. Are there components that the team would like to test using? How will the team know if the test is successful?
- Consider asking a few patients what they think of the template your team is testing or using. What aspects do they find valuable? Are there any changes they'd suggest?

Resources:

Designing a Care Plan with the Patient in Mind (video)

A Focus on Health Literacy: The What and the Why (info sheet)

Ask RICk (info sheet)

References:

[1]Institute of Medicine. (2013). *Best care at lower cost: The path to continuously learning health care in America*. Washington, DC: The National Academies Press. https://doi.org/10.17226/13444.

[2]*Berwick, D.M. (2009). What "patient-centered" should mean: Confessions of an extremist. Health Affairs (Millwood), 4(28), 555-565. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.4.w555*

[3]*Epstein, R.M., Franks, P., Shields, C.G., Meldrum, S.C., Miller, K.N., Campbell, T.L., Fiscella, K. (2005). Patient-centered communication and diagnostic testing. Annals of Family Medicine, 5(3), 415–421.*

[4]*Stewart M., Brown J.B., Donner A., McWhinney I.R., Oates J., Weston W.W., Jordan J. (2000). The impact of patient-centered care on outcomes. Journal of Family Practice, 9(49), 796–804. Retrieved from https://www.researchgate.net/publication/12292586_The_Impact_of_Patient-Centered_Care_on_Outcomes*

[5] *ABC Life Literacy Canada. (2016). The case for health literacy in Canada. Retrieved from https://abclifeliteracy.ca/case-health-literacy-canada*

Team Roles & Responsibilities

What?

Effective teamwork requires that the workload is defined and then distributed amongst team members. Doing this successfully involves:

- Determining what needs to happen – defining the steps required (process map)
- Exploring who could do the steps (skills & scope) + who has experience and/or interest
- Balancing the distribution of work so no one is overloaded
- Planning for back-up (cross-training)
- Strategically introducing patients to the concept of having care provided by team members ('warm handoff' or 'passing the halo')

Why?

When team members distribute the workload in a family practice, good things happen:

- Patients experience better access to care when they need it
- Team members typically work to full scope of practice, which is more challenging and rewarding
- Physicians have time to see the more complex patients
- Less burnout for clinical providers
- Higher patient and provider satisfaction

Test

Consider using the **Roles & Responsibilities: Care Planning Tool**

1. Review your process map for care planning. Are you satisfied with the process as it is? Are there any missing steps?
2. Analyze the process map to identify who is responsible for each step.
3. Consider available team members – does anyone have previous experience related to care planning? Does anyone have an interest in learning to do care planning or aspects of it? Whose scope does care planning fall within – who technically could be doing each step?
4. Would there be value in learning each other's roles? How could cross-training be planned and supported?

Through Patient's Eyes

"The trust that a patient has in his/her doctor is not automatically extended to the rest of the team so the patient needs to know that this has been initiated directly by their doctor. If the team member does not explain why he or she is stepping in, the patient may be upset with having someone new and unknown be privy to his/her medical condition."

~ Diane
PaCT Patient Advisor

FOR PHYSICIANS:

Introducing Team Members with Intention – the "Warm Handoff"

For some clinics, the concept of the patient seeing someone other than the physician for clinical care may be new. Patients may be concerned about this change of process, and feel that they're not getting the 'best' care.

For this reason, it's critical to be strategic when introducing patients to team members for shared care. Some tips include:

- If possible, make the introduction in person
- Highlight the knowledge and skill level of the team member
- Indicate that you trust the team member implicitly
- Reassure the patient that you will still be their primary provider and be available when they need you
- Explain that the team member will be keeping you up to date on the patient's situation and progress
- As appropriate, highlight that the team member actually knows more about the topic than you do, and can offer a lot more to help or guide the patient (e.g., dietitian)
- Be patient! Some patients need time to adjust to a new process

Example

'Traditional Handoff':

Physician: *Mrs. Cardinal, to learn more about managing your medications, I'd like to refer you to our PCN clinical pharmacist.*

'Warm Handoff':

Physician: *Mrs. Cardinal, to learn more about managing your medications, I'd like you to meet with Sue. She's here today - we can stop by and I'll introduce you on the way out. She's a fantastic pharmacist who works with us and knows all about the medications you're taking, and how to take them safely so that they work as well as possible. Our patients say that they find the extra support from Sue really helpful. She'll keep me up to date on what you talk about, and I'll still see you whenever you need to. How does that sound?*

- Although it's good to offer to continue seeing the patient as often as they would like to see you, most physicians who switch to a team approach report that patients typically start to book with them less frequently, as many of their needs are met by the team. This allows for physicians to focus on the delivering the care that only they can.

Discussion:

- From the patient perspective, is there any risk with the more traditional handoff?
- Is the warm handoff worth the time? Why or why not?

FOR TEAM MEMBERS:
Introducing Your Role with Intention

If a patient doesn't know you, or you haven't worked directly with them in the past, taking time to introduce your role in their care is important to building trust. A patient may not be familiar with your title or what you can offer. Consider taking a few minutes to explain your role in layman's terms – what you'll do and what you won't do. Reassure the patient that you're seeing them at the physician's request and that you work closely with him or her. Let the patient know that you will be communicating with the physician and discussing their situation. Patients who are unfamiliar with a team approach sometimes worry that they've been 'passed off' to someone else. (For more information on introducing your role, consider reviewing Setting a Strong Foundation: Patient Centred Interactions from test box 1.)

Example

Introduction 1:
Hi Mr. Jones – I'm Paula the CDM-RN from the PCN. Dr. Chan asked me to see you about managing your diabetes.

Introduction 2:
Hi Mr. Jones – I'm Paula. I'm a nurse with special training in chronic diseases like diabetes. I work with several patients here at the clinic to help them better understand their conditions and what they can do to be as healthy as possible. Dr. Chan thought that you and I could work together on managing your diabetes. If you're interested in working with me, I'll make sure that Dr. Chan is kept up to date on what we discuss, and you can see him whenever you need to – just like always. My role isn't to tell you what to do. Instead, together we can find options and strategies that will work for you in your unique situation. Does that sound alright?

Discussion:

- From the patient perspective, what are some potential issues with introduction #1?
- Is the second example worth the time? Why or why not?

Resources:
Roles & Responsibilities: Care Planning Tool

Standardizing Data Entry for Team-based Care

What?

If the title of this section sounds familiar, that's because it is! We are revisiting this important activity of standardizing your data entry – where and how data is entered into the EMR to optimize team based care for care planning. In this test-box we are looking at a few specific fields that map in the care planning template. These fields can also be used to create useful searches and triggers/rules/reminders in the EMR.

Why?

There are many benefits to standardizing the entry of your data into the EMR.

- When there is one standard way to enter the information, all members of your team know where to look for it – this saves time
- It reduces duplication
    - you may duplicate care if you cannot see that it was already completed
    - you decrease duplication of entry if the field can map directly to the care planning template
- All team members can see the information if they know where to look for it; you don't have to ask the patient extra questions – making it more patient-centred
- Information is searchable and your searches provide accurate information

Test

In this test-box, there are 3 sections on the care plan template that we will look at standardizing data in the EMR so we can map these fields to auto-populate the template.

1. Health Targets

The 'Health Targets section' of the care plan template includes 2 targets that, if entered into the EMR in a standardized way, will map and populate the document.

Target in the care plan template: Blood Pressure

Target in the care plan template: BMI *(Note: this requires weight and height)*

These 2 targets require the standardized entry of 3 fields: **blood pressure**, **weight** and **height**. If your clinic has worked on some of the ASaP (Alberta Screening & Prevention) maneuvers, then you may have already completed this work.

If you need a refresher, take a look at the TOP EMR Guides which have additional information on where to enter these data fields and how to search them.

Test:

For this test of change, use the ASaP principles and consider discussing as a team:

- Who takes blood pressure, height and weight?
- Where does it get entered in the EMR?
- Who enters it into the EMR?
- How do you know if a patient is due?
- Do you have reminders set in your EMR?
- Are you tracking your screening rates for these 3 (i.e., blood pressure, height, weight) maneuvers to see how you are doing?

Meeting as a team to discuss these questions will help you to form a plan to increase the likelihood that the data will be in the EMR when you need it, and how you need it.

2. Problem Lists

EMRs have at least one designated area to enter confirmed diagnoses and, in most EMRs, this is called the 'problem list'. Problem lists facilitate continuity of patient care by providing a comprehensive and accessible list of patient problems in one place. Agreeing as a team to have consistent entry into one area in a consistent manner is critical to enable team-based care of patients with chronic conditions.

Common challenges with use and upkeep of the problem list include:

- Some clinics do not use their problem list, or use it sporadically
- Many problem lists are not coded using the ICD-9 codes, thus not entered consistently
- It can take a few clicks to enter information in the problem list in a standard way
- In most systems, only the physician or licensed health care provider can add to or alter the problem list – in most clinics this is 'doctor work'
- It takes time to go back and clean up problem lists that have not been kept up

PaCT Fact

Problem lists used within EMRs typically include illnesses, injuries, and other factors that affect the health of an individual patient, usually indicating the time of occurrence or identification, and resolution.

Test:

Who can enter into and maintain the problem list?

- Who is authorized to add to, update, and resolve problems in the problem list?
- Who is responsible for this work and when?
- Consider the value of involving the patient in the maintenance of the problem list. Is it beneficial and/or efficient for it to be updated in conversation with the patient?

What problems are entered into the problem list?

- Consider developing a list of common problems where it would be of benefit to have the problems coded. The TOP EMR Guides have sample lists from Alberta clinics to assist you with this.

How will you go back and tidy up your problem list?

- If you find your problem list isn't at the standard that you have agreed on, you may need to retrospectively do some work on individual patient's problem lists. There are different approaches that have been shared with us on how clinics have approached this:
    - **Patient by patient:** The provider (or designate) will update the list when a patient is in for a comprehensive health visit (e.g. care planning, physical) along with the patient in the room
    - **Problem by problem:** The EMR search engine can be used to create lists of patients who have a certain problem.
        - If you have multiple ways to enter a certain problem into your problem list, you may be able to search these various ways to create a list to update. For instance, diabetes you could search for "DM"; "NIDDM"; Diabetes Type II, etc.
        - If you think you have not captured all patients you should have with a certain problem you can run lists with proxy indicators such as a billing code, a lab, or a medication. Using diabetes as an example again, you may search for "250" billing or for a medication such as metformin which may indicate the patient has diabetes.

          The TOP EMR Guides have more information on these types of searches.

Document your new processes.

3. Advance Care Planning

Advance care planning is a section on the PaCT Care Plan Template that includes 3 elements:

- I have a personal care directive (Y/N)
- I have a Power of Attorney (Y/N)
- Do you have your goals of care documented?

There are 3 common scenarios for clinics:

- The personal care directive and/or the goals of care designation documents have been completed with patient at the clinic and you have them on file
- The patient has completed the documents elsewhere (as with the Enduring Power of Attorney)
- The documents have not been completed for a patient

The personal care directive and goals of care documents may be completed at the clinic with the provider or a team member. A copy is always provided to the patient with a copy also kept by the clinic. One or both of these documents may also be completed by another provider in another part of the health system. Enduring Power of Attorney documents are not created/completed at the clinic.

PaCT Fact

Advance care planning is a way to help patients think about, talk about, and document wishes for their healthcare. It's a process that can help to make healthcare decisions now and for the future.

If the documents are in existence, it is best practice that a copy is on file in the patient's medical record in the medical home.

Clinics will want to create *standardized* processes for filing these documents so they can search for them, create rules for them, and/or be able to map them to other documents. In the event that the clinic does not have a copy but the patient lets their clinic know they exist, teams may also want to capture this in a standardized way.

As TOP has not collected best practices for advance directives to date, we have done an initial environmental scan and have compiled approaches to test for each of the 4 EMRs represented in the PaCT innovation hubs to test.

Wolf EMR – Advance Directives EMR Tips

Accuro EMR – Advance Directives EMR Tips

Med Access EMR – Advance Directives EMR Tips

Healthquest EMR – Advance Directives EMR Tips (coming soon)

How to file and search for care plan documents

Once you have created a care plan document for a patient, you want to be able to easily find the most recent copy of the document. Depending on your EMR, you may need to create a new version every time you make a change, or you may be able to update a version several times before creating a new one. In either case, you always want the most recent version accessible to all team members, with no confusion as to which is the most recent version.

Keys to success for this practice include:

- Create a **standard naming convention** for your care plan documents.
    - If you were care planning before PaCT, you may want to distinguish between your "PaCT" care plan documents and your previous ones.
- Depending on how your EMR files documents, determine a **dating convention** to attach to the name of the document.

Searching for your documents will be like your searches for other documents in your EMR. If you put a constraint on your search, this will limit how much show up in your results.