Fraser Northwest Division of Family Practice
A GPSC Initiative

Fraser Northwest Division of Family Practice

Identifying a Substitute Decision Maker

Transitions in Care Project Summary Report

January 2, 2018

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On behalf of the Fraser Northwest Division Project Team

SharedCare Partners for Patients

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Executive Summary

Between December 2015 and October 2017, a Fraser Northwest Division physician-led team embarked on a ***Shared Care – Transitions in Care (TiC)*** project as one of ***three pillars*** of the Division's ***Advance Care Planning*** initiative. The first two pillars, completed over 2014-2016 were designed, respectively, to: (i) engage the general population in advance care planning (community engagement); and (ii) to support healthcare providers to do ACP with patients[1]. As the third pillar, the ***Identifying a Substitute Decision Maker TiC*** project aimed to improve the communication of patients' ACP wishes between acute and community care.

Using a ***Quality Improvement (QI)*** framework, the TiC project team, co-led by Dr. Martha Koehn (Royal Columbian Hospital Emergency Physician) and Dr. Michael Paletta (RCH Hospitalist), decided to focus on:

- a ***Primary Aim*** of having 10% of RCH Hospitalist patients with a statement about the patient's preferred substitute decision maker identified on their medical record by the time of discharge (this primary aim was subsequently increased to 25%);
- a ***Secondary Aim*** of having 10% of RCH Hospitalist patients have a completed 'identification of SDM' form on their medical record by the time of discharge (i.e. on the discharge summary to their community GP).

Over the course of the project, the team directed phased activities and outputs toward achieving these aims, using *Plan-Do-Study-Act* cycles to monitor, review and adjust. Highlights included:

- Wide-ranging consultations with Hospitalists, health care providers, GPs and Fraser Health staff and Executives
- Environmental scan to determine what is happening with ACP and SDM identification at RCH and regionally
- Baseline, mid-project and post-project data collection from chart reviews
- Revision of the RCH ***Notice of Admission to Hospital*** form to ask GPs for patients' ACP information and to simplify the form to increase its usage
- Work with Fraser Health Risk-Legal and department to adapt an ***Identification of Substitute Decision Maker*** form for use in acute care
- Stakeholder meetings to develop support and ownership of the SDM identification process
- Encouraging Hospitalists to ask one question of patients: *If you became unable to make decisions for yourself, who would you want to make decisions on your behalf? (i.e. the patient's preferred Substitute Decision Maker)* and to chart the results, including any follow-up needed.

Results and Conclusions

Data collected through a sampling of charts (n=59 for baseline, n=31 for mid-project, n=55 for post project) indicated the following:

[1] The Community Engagement and Health Care Providers Engagement work was funded through *Shared Care – Partners in Care.*

- The completion rate for the ***MOST form*** (used regionally by Fraser Health and considered to be one piece in the continuum of ACP and SDM identification) increased from 64% at baseline to 97% post-project.
- The ***Notice of Admission (NOA)*** form was completed on 58% of charts at baseline and 90% mid-project after the form was revised and simplified.
- At least one Hospitalist reported receiving patients' ACP information from several GPs after receipt of the NOA
- The proportion of RCH Hospitalist patient charts having a Substitute Decision Maker identified at baseline was 0% at baseline, 20% mid-project and 50% post-project, exceeding the *secondary aim* target of 10%.
- The proportion of discharge summaries to GPs including the name of the SDM increased from 0% at baseline to 12% post-project. This exceeded the original *primary aim* target of 10% but fell short of the revised aim of 25%, which proved too ambitious; the 12% completion rate aligns with the "early adoption" stage of ***Everett Rogers' Innovation Adoption Lifecycle.***
- The new *Identification of Substitute Decision Maker* form for acute care form was not present on any of the 55 charts reviewed post-project, but several Hospitalists confirm they have used it. However, the project team learned that that form has very limited application as it is applicable only when the person a patient wishes to name as their SDM falls outside the legal "default hierarchy" for substitute decision makers

Fraser Northwest Division is still in the early stages of achieving the overall vision where ***"Advance Care Planning is understood, desired and normalized".*** However, the combined evidence suggests that the "Three Pillar" approach, including the *Identifying a Substitute Decision Maker* project, has leveraged a tipping point of culture change in our area – a change that our physician, health care provider, and community ACP champions are sustaining and augmenting. The Division's innovations and learnings have spread to other communities (e.g. Delta and Kamloops), and the BC Centre for Palliative Care has adapted our experiences and tools for their province-wide efforts. In New Westminster, a new hospice is being established - the founders directly credit FNW's April 2015 *Advance Care Planning Fair* with germinating the hospice society.

1.0 Purpose of Report

This report summarizes the activities, outcomes and key learnings from a ***Shared Care -Transitions in Care (TiC***) project undertaken by the ***Fraser Northwest Division of Family Practice (FNW)*** between December 2015 and October 2017. As described below, "*Identifying a Substitute Decision Maker (SDM)"* was the second of two projects under the Division's *Transitions in Care – Discharge Planning* initiative.[2]

The report provides a record of accountability for the project to the FNW Board and membership, Shared Care and Fraser Health Authority. What is more, it narrates the story of how local physician champions are leading a culture shift in attitudes, understanding and adoption of advance care planning within the healthcare provider community – a shift that that stands to benefits patients, families and providers in Fraser Northwest and beyond.

[2] The original 2012 FNW Project Charter under the Transitions in Care program was titled "Discharge Planning". The Charter was based on member priorities identified at an engagement soon after FNW's incorporation.

2.0 Origin of the Project

The objective of the original (2012), overall *FNW Division Transitions in Care (Discharge Planning)* initiative was *"continuity of care as patients are admitted into the hospital and then discharged back into the community".* The focus was the communication stream from community GP to hospitalist and back to community GP. The first project, *Fax Notification to GP of Patient Admission to Hospital,* ran between March 2013 and March 2014. An external evaluator's report[3] concluded this project met all its goals (see *Section 4.0* for data indicating that the Fax Notification process has not only been sustained, but enhanced).

At the successful conclusion of the Fax Notification of Admission project, on April 17, 2014, the *FNW Discharge Planning Committee*[4] recommended that the next Transitions in Care project focus on *"communication of patients' Advance Care Planning (ACP) preferences (including the MOST*[5] *form) from GP office to hospital and from hospital to GP office".* This focus dovetailed with ACP activities already underway through the Division's ***Shared Care – Partners in Care (PiC)*** funding *(see below).* The Division's Shared Care Advisory Committee and Board subsequently endorsed the recommendation in May 2014.

2.1 A Strategic Approach to Advance Care Planning: Three Interrelated Pillars

FNW's *Partners in Care Advance Care Planning (ACP)* initiative launched in 2013 under the leadership of Dr. Joelle Bradley, Royal Columbian Hospitalist and advance care planning champion. Through a strategic planning process, FNW member GPs, Specialists from multiple specialties, health care providers and community representatives developed a vision and mission, and identified the need for three interrelated pillars to support ACP. Figure 1 shows the overall organization and reporting structure for the program. Figure 2 on page 5 illustrates how the three pillars interconnect and support the vision.

[3] *Evaluation of Fraser Northwest Shared Care Transitions in Care Project.* Reichert & Associates Program Evaluation & Research, March 2014.

[4] The Discharge Planning Committee was comprised of: Dr. Jennifer Yun, Physician Lead; Dr. Diana Stancu, RCH Hospitalist; Dr. Brent Gall, ERH Hospitalist; Mary Miller, then-FNW Executive Director; Leslie Rodgers, FNW Shared Care Lead; Dave Harrhy, then-TiC Initiatives Lead

[5] Medical Orders for Scope of Treatment, implemented at all acute care sites in Fraser Health and increasingly being adopted by Community GPs

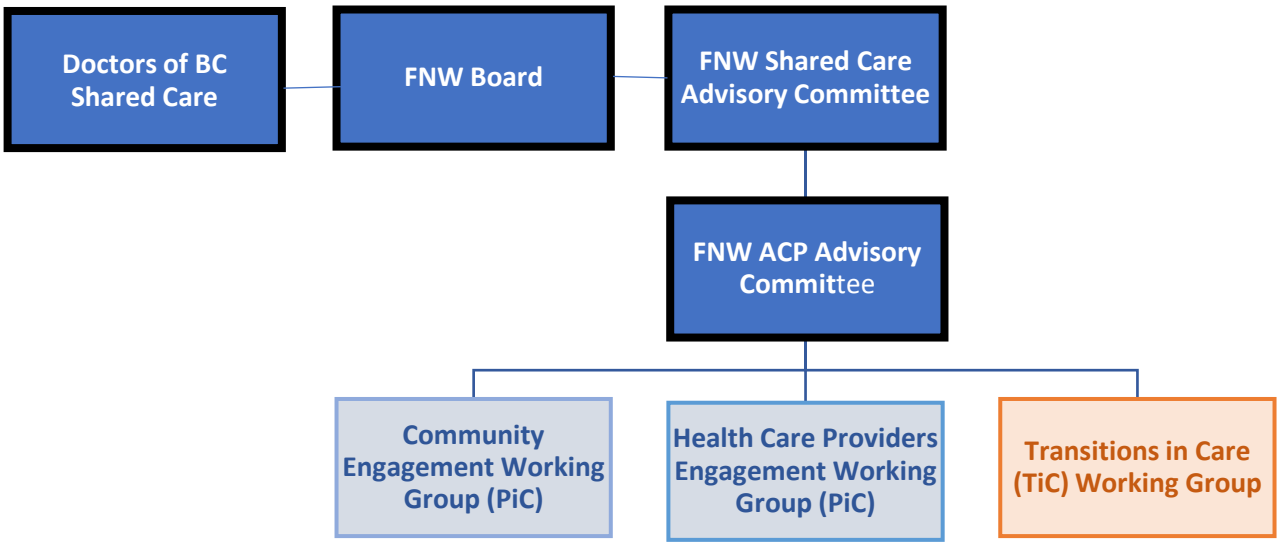


Figure 1. Reporting Structure for the FNW Advance Care Planning Initiative [6]

The key activity under the ***Community Engagement*** pillar was the April 11, 2015 *Advance Care Planning Fair*[7] in New Westminster. And under the ***Health Care Providers Engagement*** pillar, a *Substitute Decision Maker (SDM) Fair*[8] at Royal Columbian Hospital (April 12, 2016). However, Dr. Bradley and her colleagues carried out many other activities under the ACP initiative *(see Appendix 1 for a listing*).

It is interesting to note that the BC Centre for Palliative Care developed a similar three-pillar approach for its provincial advance care planning strategy. Over the course of FNW's ACP work, the Division and the BCCPC forged a close alliance. BCCPC incorporated, built upon and sustained several of our ACP products and processes, and several FNW GPs continue to participate in BCCPC working groups.

[6] Community Engagement and Health Care Providers Engagement was funded under *Partners in Care (PiC)*
[7] See the following reports for details on outcomes and impacts of the ACP Fair: *May 2015 Shared Care Report to FNW Board* and *Summary of FNW Costs for April 2015 ACP Fair*.
[8] See *May 2016 Shared Care Board Report* for a summary of the RCH SDM Fair

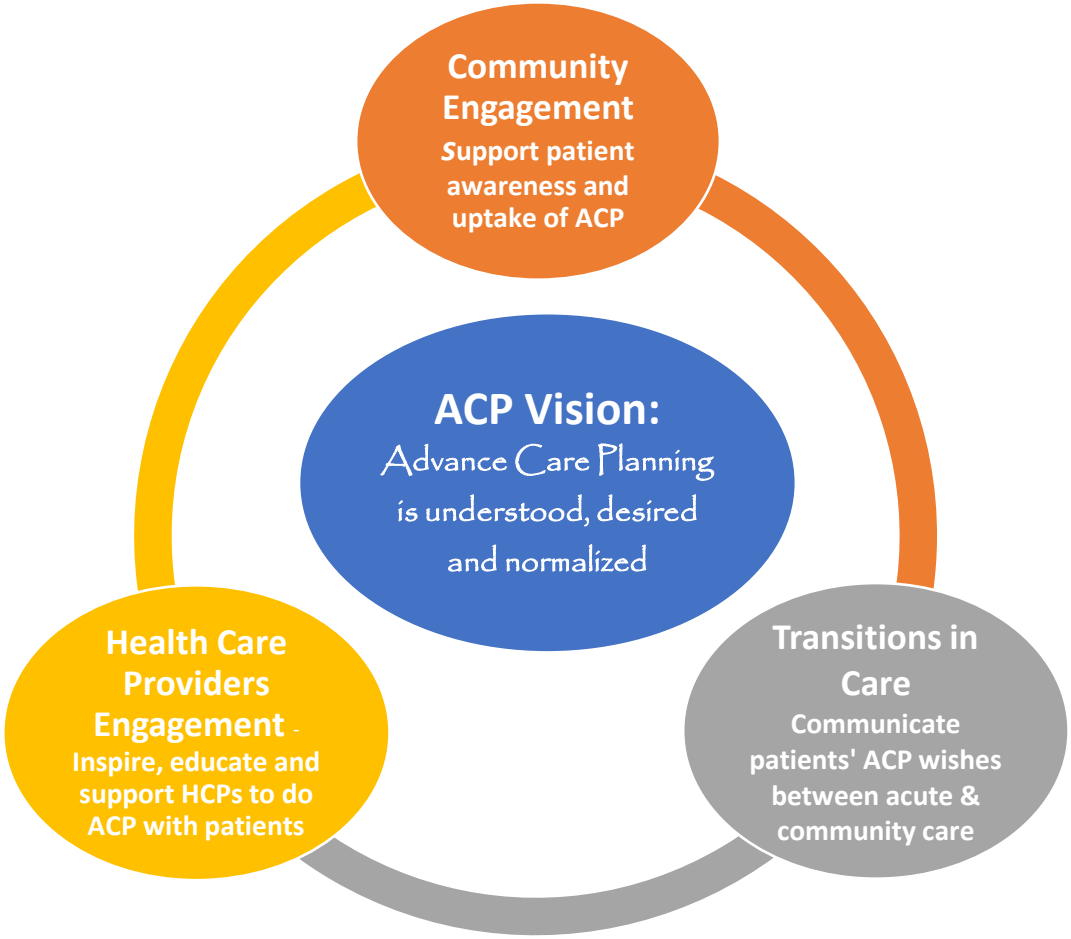


Figure 2. A Strategic Approach: Interdependence of the Three Pillars for achieving the overall Fraser Northwest ACP vision

2.2 Transitions in Care

Work began on the Transitions in Care pillar at the December 2015 start-up meeting of the newly formed TiC project team. The team spanned acute and community care and all members had previous involvement in FNW ACP-related initiatives. The participating physicians are champions for ACP in their respective circles.

The TiC Project Team
Dr. Martha Koehn, RCH Emergency Physician (Co-Lead)
Dr. Michael Paletta, RCH Hospitalist (Co-Lead)
Dr. Joelle Bradly, RCH Hospitalist
Dr. Charlie Chen, FHA Medical Lead, Palliative Care
Dr. Paula Flynn, GP with Tri-Cities Mental Health
Dr. Kathy Jones, Community GP
Dr. Anson Li, RCH Geriatrician
Dr. John Yap, Community GP
Dr. Steve Ligertwood, RCH Hospitalist (QI Advisor)
Leslie Rodgers, FNW Shared Care Lead

Determining a Focus

The team's first task was to develop a feasible, meaningful, and measurable grassroots project within the broad mandate of *"communication of patients' Advance Care Planning (ACP) preferences (including the MOST form) from GP office to hospital and from hospital to GP office"*. This was a challenge, given:

- the variability in understanding and practice of ACP in our area
- the ambitiousness of the ACP vision (i.e. where do we begin?)
- the small scale of the project ($43,800)
- the significant communication gaps between and within acute and community care.

The team thus welcomed RCH Hospitalist Dr. Steve Ligertwood's offer of training and guidance on using a *Quality Improvement* framework to focus the efforts.

> *A key challenge in QI is managing distractions to stay on a clear, specific target.*

3.0 Activities and Outputs

Figure 3 is a schematic of the project team's two-year journey from the December 2015 start-up meeting through final report completion in December 2017.

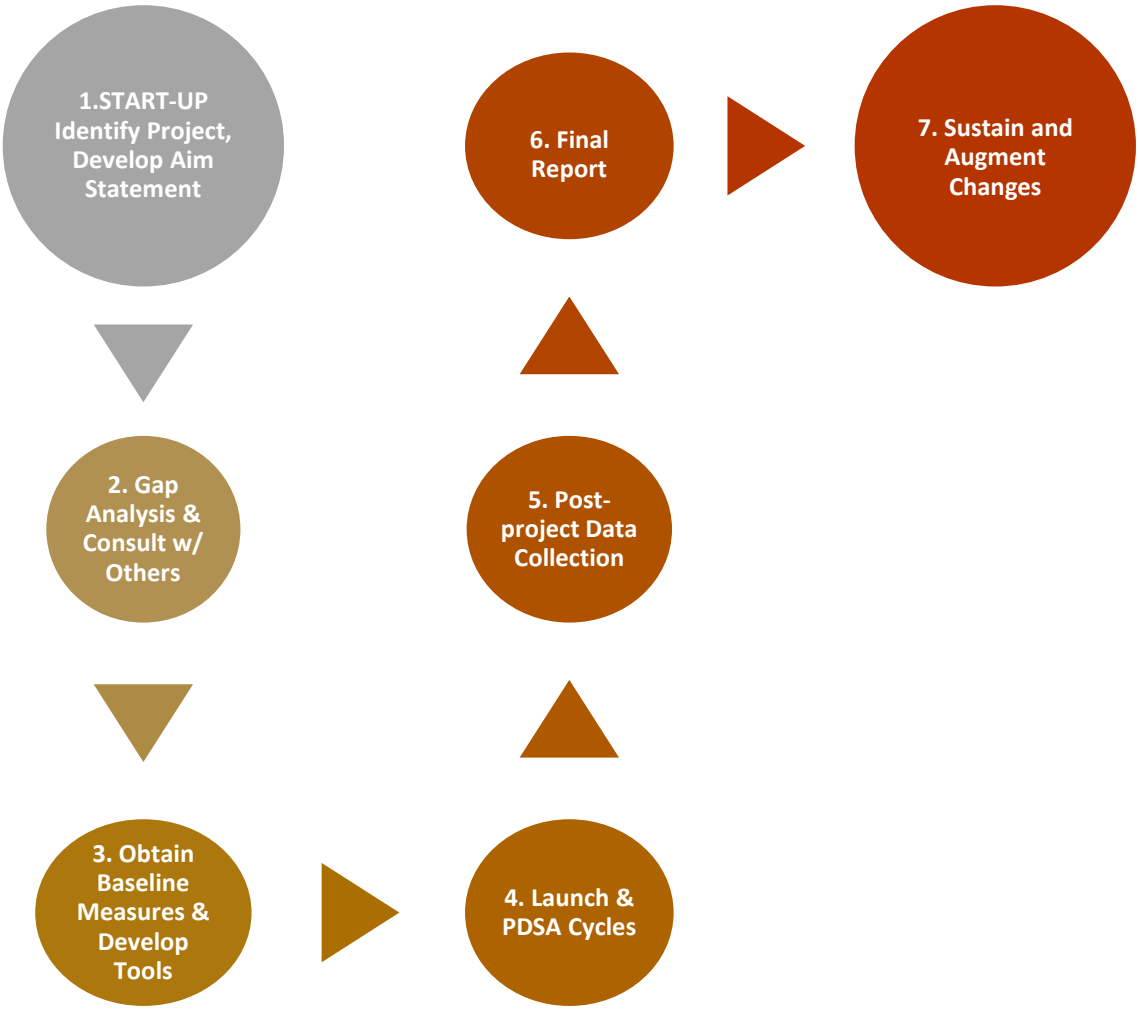


Figure 3. Process Flow for Transitions in Care *Identifying a Substitute Decision Maker* Project

1. Start-up – Consultations and Research to Develop Aim Statement

Activities:

- Multiple project team meetings
- Discussions with colleagues to widen scope of input
- Quality Improvement training
- Integrate Transitions in Care mandate with QI Aim
- Identify who needs to be consulted/involved

What was learned:

- ACP is happening piecemeal (i.e. in an uncoordinated manner) across the region
- ACP crosses multiple health care provider disciplines
- Advance Care Planning (ACP) is wide-ranging and complex – achieving the vision requires multiple efforts and continuous improvement

Key Outputs:

- Google Drive link set up for project documents
- Project Charter: QI Aim Statement and Driver Diagram developed

After considerable deliberation and consultation with colleagues and Fraser Health staff, the team created the following *QI Aim Statement and Driver Diagram*[9].

PRIMARY AIM: *To have 10% of RCH Hospitalist patients with a statement about the patient's preferred substitute decision maker identified on their medical record by the time of discharge.*

SECONDARY AIM: *To have 10% of RCH Hospitalist patients have a completed 'identification of SDM' form on their medical record by the time of discharge.*

Primary outcome measure*:*

- The percent of Hospitalist patients at RCH that have a documented statement regarding the patient's preferred choice of substitute decision maker in their discharge summary

Secondary outcome measures:

- The percent of Hospitalist patients at RCH that have a completed 'identification of SDM' form on their medical record by the time of discharge

- The percent of RCH Hospitalist patients who have a GP notification sent on admission

- The percent of Hospitalist patients that have the request for SDM addressed by GP

[9] The Aim Statement was subsequently revised as part of the *PDSA (Plan-Do-Study-Act)* Cycle. Specifically, the *Primary Aim* was increased to 25% and the secondary outcome measure *"the percent of Hospitalist patients that have the request for SDM addressed by GP"* was removed as it proved impractical to collect this data (see *Results* section for a detailed explanation).

2, Gap Analysis and Consultations

Activities

- Discussions with colleagues about if, how and when they ask patients their preferred SDM and the ways in which the information is/is not being documented
- Determination of gaps and barriers to ACP/SDM identification
- Consultations with RCH Hospitalist group, Emergency Department, FHA Medical Records and Risk/Legal departments to assess options for documenting a patient's Substitute Decision Maker
- Identify an Executive champion for the project

What barriers prevent physicians from speaking with patients about advance care planning? Barriers such as unfamiliarity or discomfort with the subject; belief that ACP is someone else's responsibility; uncertainty about how to introduce it; insufficient time. The TiC project aimed to reduce those barriers by providing tools and a straightforward, time-efficient question health care provider could ask patients:

If you became unable to make decisions for yourself, who would you want to make decisions on your behalf?
(i.e. the patient's preferred Substitute Decision Maker)

What was learned:

- Health care providers in Fraser Health have no uniform way of capturing and charting patients' ACP or SDM preferences; if such information is recorded, it is typically buried somewhere in the patient chart, such as in social workers' notes that physicians are unlikely to see
- Fraser Health has focused on use of the Medical Orders for Scope of Treatment (MOST) form as a standard of care; however, MOST is not specifically designed to gather a full range of ACP or SDM information
- Fraser Health has two ACP/SDM tools available to Hospitalists in Meditech: (i) the *Advance Care Planning Record* and (ii) the *Confirmation of Substitute Decision Maker Form,* (for use when an adult patient is incapable of giving or refusing consent to health care); however, virtually none of the Hospitalists know where to locate these forms in Meditech and they are rarely, if ever used. Moreover, there is no form available for to record a patient's preferred SDM when they *can communicate for themselves.*
- Residential Care has an *Identification of Substitute Decision Maker* form that might feasibly be adapted for use in acute care
- To meet Risk/Legal requirements, the existing SDM forms are complex and detailed; this complexity deters health care providers from using it
- If any ACP or SDM information *is* captured, in either a GP's office or in acute care, there is no mechanism for transferring the information between the two
- The Hospitalist "Purple Sheet" is likely the most effective mechanism for charting ACP/SDM information as this is what Hospitalists reference for in-hospital transfer and discharge summaries
- Eagle Ridge and Peace Arch Hospital's *Notification of Admission* form is much simpler than the one used at RCH: simplifying the RCH form is an opportunity to both increase its use and

to add a specific request for the GP to fax back any ACP or SDM information they have for the patient

Outputs:

- A Modified QI Aim (the *Primary Aim* was increased from 10% to 25% of RCH Hospitalist patients having a preferred SDM identified in their discharge summary)
- Action plan developed
- Darlene Mackinnon, RCH Executive Director, identified as executive champion for the project

3. Obtain Baseline Measures and Develop Tools

Activities

- Review of patient charts to collect baseline data on completion of MOST form and Notification of Admission, and on identification of SDM in discharge summaries (see p. x for results)
- Work with Fraser Health to relocate the existing *Confirmation of SDM* form, *ACP Record* and *MOST* under a more accessible menu in Meditech
- Work with Fraser Health to adapt the *Identification of SDM – Residential Services* - for use in acute care
- Collaborate with RCH Hospitalist Group and a sampling of GPs to improve the Notification of Admission (NOA) form (specifically, to make it easier for Hospitalist to use and for GPs to read quickly, and for the NOA to request ACP/SDM information from patient's GP)
- Facilitate a letter of appreciation from the Fraser Northwest Board, on behalf of GPs, to RCH and ERH Hospitalists for the NOAs being sent to GPs
- Confirm RCH Hospitalist Fax # so there is a consistent mechanism for receiving ACP/SDM and other patient information from GPs

What was learned:

See baseline data results on page 12

Outputs

- Baseline data
- MOST, SDM Form and ACP Record relocation in Meditech
- Letter of appreciation from FNW Board
- Revised NOA Form *(see Appendix 2 for previous and revised forms)*
- New (adapted) SDM Form

4. Launch and PDSA Cycles

Activities:

- June 2017 meeting with a range of RCH healthcare providers to promote SDM identification and availability of new form, elicit feedback, and forge interdisciplinary coordination re: SDM identification
- Meeting with Darlene Mackinnon to secure Executive support
- Frequent feedback sought from Hospitalists and other RCH health care providers

- Multiple team meetings to review and respond to feedback and adjust
- Liaison with FHA Advance Care Planning Coordinator re: launch of Fraser Health's central fax line for MOST Form and ACP Records launched in October 2016

What was learned:

See Section 5.0 Conclusions

5. Post-Project Data Collection

Activities

- Review of 55 patient charts to compare with baseline and PDSA Cycle 1 data (see results on p. x)
- Informal survey of RCH Hospitalists
- Informal survey of GPs on project team
- In-depth interviews with Drs. Koehn, Paletta and Bradley

What was learned

- *See Section 4.0, Results*

6. Summary Report

Activities:

- Data comparison and analysis
- Physician Co-Lead review and editing of draft report

Outputs:

- Draft and final reports

7. Sustain and Augment Changes

- Champion changes post-project

4.0 Results

4.1 Quantitative Results

An RCH security-cleared contractor was engaged to collect the *baseline* and *PDSA Cycle 1* data at Royal Columbian Hospital. The baseline data were collected in March 2016 and involved a review of 59 randomly-selected patient charts from three medical units. PDSA Cycle 1 data were collected one year later in March 2017 from 31 patient charts. Finally, Dr. Michael Paletta collected post-project data through a review of 55 patient charts in November 2017. The reviews encompassed:

- Presence of completed and faxed *Notice of Admission* forms (collected for both baseline and PDSA Cycle 1)[10]
- Presence of completed Medical Orders for Scope of Treatment (MOST) forms
- Presence of completed new *Identification of SDM form* (PDSA Cycle 1 for baseline measure plus post-project chart review)[11]
- SDM identified in Hospital Transfer Summary
- SDM identified in Hospitalist Discharge Summary

Table 1 shows the results of the three chart reviews.

Timing of Chart Review	MOST completed on Chart	NOA Completed & Faxed	SDM Form Completed	SDM Identified in Hospitalist "Purple Sheet"	SDM Identified in Discharge Summary to GP
Baseline (n=59)	64%	58%	N/A	Not collected	0%
PDSA Cycle 1 (n=31)	100%	90%	0%	20%	Not collected
Post-Project (n=55)	97%	*Not collected*	0%	50%	12%

Table 1. Results from three chart reviews

Project Team Observations and Analysis

1. *MOST Form Completion* - The completion rate for the MOST form was 64% at the March 2016 baseline, 100% one year later (PDSA Cycle 1), and 97% in November 2017 (post-project). The increase in the rate of MOST completion is noteworthy and encouraging, and may mirror the *Innovation Adoption Lifecycle* shown in Figure 4. Discussions with the Hospitalist group as part of the *SDM Identification project* may also have stimulated MOST form completion.

> ***ACP champions maintain that the MOST form does not equate with ACP because MOST gives instructions for medical care at the time of a medical crisis. It does not deal with future care goals and how they may evolve over time. However, used with other tools and processes, it contributes to the continuum of ACP and SDM identification. Thus, general adoption of MOST is a step in the right direction.***

2. *Notice of Admission (NOA) Completion* – By March 2017, the NOA completion/fax rate (58%[12] at the March 2016 baseline, using the original RCH NOA form) had increased significantly to 90%. This was after

[10] The original NOA was in use at the time of the baseline review, the revised NOA at the time of the PDSA Cycle 1 review.

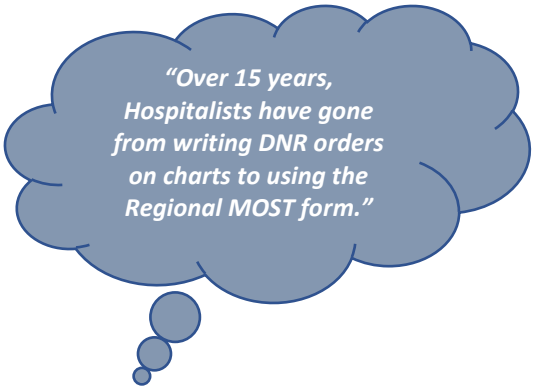
[12] The 58% NOA completion rate seen at the March 2016 baseline measurements slightly exceeded the original 2013 project goal of 50% completion at RCH, and indicates the process was sustained.

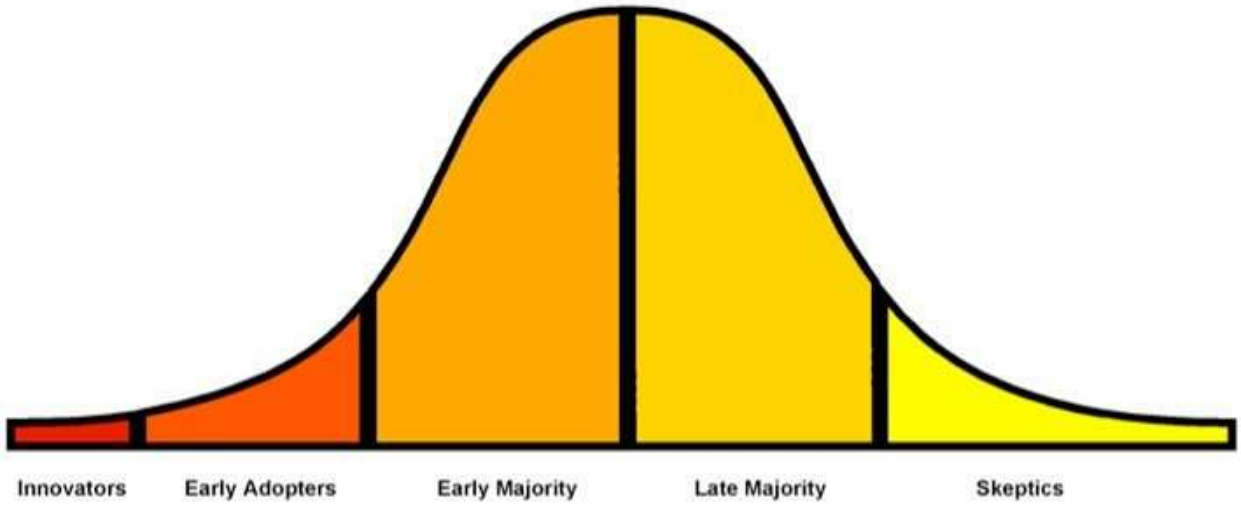
introduction of the collaboratively redesigned form. The increase is important as it indicates improved Hospitalist-GP communication, the overarching goal of the Division's Transitions in Care (Discharge Planning) initiative. Moreover, for the *SDM Identification* project, it means expanded opportunities for communication of patients' ACP/SDM preferences from community GPs to RCH Hospitalists.

3. *SDM Form Completion* - Presence of the new *Identification of SDM Acute Care* form began from a baseline of zero in March 2017. Since then, several Hospitalists confirm they have used and charted the form on occasion. However, these did not show up in the sample of patient charts reviewed in November 2017. It turns out the new form has very limited application as most patients desire the "default hierarchy" for their SDM *(see Appendix 3).* The *Identification of SDM* form is applicable only when a patient wishes to name someone in an order different from the hierarchy (when this happens a *Representation Agreement* is required and access to this is typically facilitated by a hospital social worker).

4. *SDM Identified in Hospitalist "Purple Sheet" –* The proportion of purple sheets documenting a patient's SDM increased from 20% in March 2017 (PDSA Cycle 1 – the first time this data was collected) to 50% in November 2017 (post-project). The project team believes the increase is an outcome of the project. More physicians are asking patients who they would want to make decisions on their behalf if they were no longer able to do so, and the information is being documented and transferred to the next phase of the patient's acute care journey.

5. *SDM Identified in Discharge Summary to GP* – Prior to the project, only a handful of Hospitalists routinely asked a patient for their preferred SDM, and only rarely, if ever, was the SDM's name included in the patient's discharge summary. It simply wasn't on Hospitalists' radar. As a result, the project team at first set a modest, but achievable target of having 10% of Hospitalist discharge summaries include the patient's preferred SDM. The November 2017 chart review determined this target was slightly exceeded (12%), but the revised target of 25% was not met. Thoughts on this:
    - The original 10% target was more realistic than the revised 25% target
    - According to the *Innovation Adoptions Lifecycle* (Fig. 4), the 12% adoption suggests SDM identification and charting is in the "early adoption" stage
    - With reiteration and reinforcement (see Section 6.0 for what is planned), SDM identification and charting may move through the complete *Lifecycle* to majority adoption, which is what occurred over time with the MOST form





The Innovation Adoption Lifecycle (Adapted from the Original)

The Innovation Adoption Lifecycle, first developed by Everett Rogers, models how a group or organization typically responds to change over time. *Innovators* (2.5%) initiate and drive the change, and *Early Adopters* (13.5%) are first out of the gate. The *Early* and *Late Majority* together comprise 68% of the organization, while *Skeptics* (16%) may or may not ever adopt the change.

4.2 Qualitative Indicators

The data provided above provide quantitative evidence of ACP/SDM culture change underway at Royal Columbian, and by extension, Eagle Ridge Hospital[13]. The project team leads also collected the following anecdotal evidence from their colleagues:

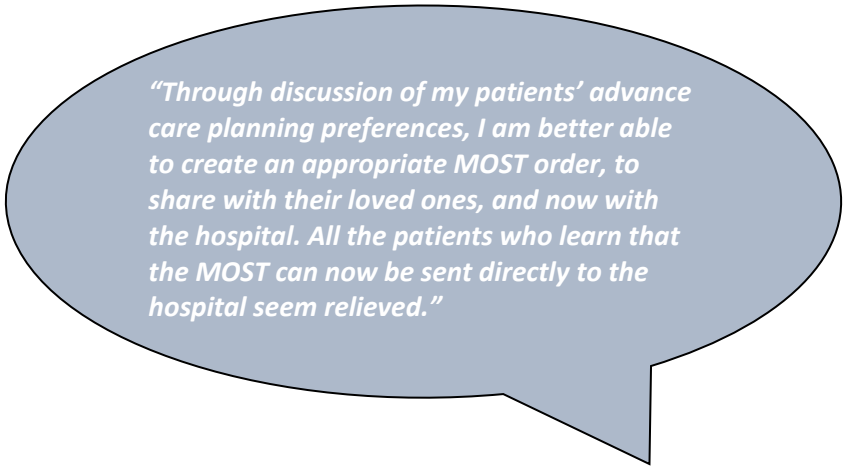
- Informal discussions with Hospitalists and Emergency Department Physicians revealed that they find "the SDM question" to be the most comfortable, effective and efficient way to introduce the topic of advance care planning to patients. It is less daunting for patients and providers than starting with questions about preferred medical procedures[14] or a person's general values[15]. The SDM question can provide a segue for more in-depth discussions at an appropriate time. "Early adopters" are seeking out the "innovators" (Drs. Bradley, Paletta and Koehn) to share how they have asked a patient's SDM and/or initiated advance care planning

"Asking a patient for their preferred substitute decision maker is the easiest way to start the conversation."

- A Hospitalist colleague reported receiving phone calls from several GPs who, after receiving the new Notice of Admission from RCH, wanted to discuss their patient's ACP wishes

[13] Although RCH was the focus of the project, its impacts have spread to Eagle Ridge Hospital as many Hospitalists work in both locations.
[14] E.g. resuscitate/do not resuscitate, feeding tube, dialysis
[15] E.g. What do you value in life? What is most important to you?

- It is now much easier for ER Physicians and Hospitalists to find relevant forms (MOST, SDM, ACP Record) in Meditech; knowing how to access the forms increases the chance physicians will complete the forms (this is especially so for MOST)
- The launch of Fraser Health's *central fax line for MOST and ACP Record forms*[16] is contributing to improved communication of patients' ACP/SDM wishes from community GP to acute care. One GP project team member is writing and faxing MOST orders to communicate with acute care after in-depth discussion of a patient's ACP wishes.



[16] Explain

5.0 Conclusions – What has changed? Is it sustainable?

The *SDM Identification* project journey was a winding road through a hitherto unknown landscape. Nevertheless, the project team, working collaboratively with many stakeholders and supporters, made considerable progress toward achieving stated goals. Data support the conclusion that discussion and documentation of patients' substitute decision maker at RCH is growing, and that "early adopter" Hospitalists are naming the SDM in their discharge summaries to community GPs. The revised *Notification of Admission* form is being faxed to GPs 95% or more of the time and the request for the GP to fax (or call) back any ACP information they have on their patients is yielding responses. Moreover, Fraser Health's *Central Fax Line for MOST and ACP Records* is helping to bridge the communication gap between community and acute care.

We are in early stages in achieving the overall vision where *"Advance Care Planning is understood, desired and normalized".* However, the combined evidence suggests that the "Three Pillar" approach has leveraged a tipping point of culture change in the Fraser Northwest Division – a change that will not only be sustained, but augmented going forward. Like stones thrown into a pond, the Division's work has sown ripple effects that are stimulating ACP work within our community and beyond. Some highlights:

- Formation of the ***New Westminster Hospice Society,*** which has already fundraised thousands of dollars, galvanized support from all levels of government, and is on the cusp of securing a building for a hospice in the community; the founding Directors have publicly attributed the genesis of the Society to FNW's 2015 Advance Care Planning Fair in New Westminster
- Sustainment and spread of our work through the ***BC Centre for Palliative Care***; the Centre has adapted our experiences and tools as part of their province-wide ACP work, taken up the role from our team for liaising with the 650-strong Century House seniors network (New West and Burnaby) regarding ACP, and continues drawing on FNW GPs' ACP expertise in working groups
- Spread of our tools and experiences to other ***Divisions of Family Practice*** (e.g. Delta) and communities (e.g. Kamloops Hospice Society), who are using our materials and experiences in their own Advance care Planning initiatives
- Establishment of an informal network of over ***70 Health Care Providers*** in Fraser Northwest who have been involved in FNW ACP initiatives and are now the champions leading change in their circles of influence. This includes the physician leads for the *SDM Identification* project, Dr. Martha Koehn, Dr. Michael Paletta and Dr. Joelle Bradley, who continue to champion adoption of SDM identification and documentation amongst their peers.

Appendix A1: Examples of Fraser Northwest Advance Care Planning Activities 2013-2017

- **Ongoing:** FNW GP representation on BC Centre for Palliative Care working groups
- **June 2017**: Presentation and tool sharing with BC Centre for Palliative Care
- **May 2017:** Presentation to BC Hospice Palliative Care Annual Forum
- **April 2017:** Dr. Joelle Bradley, Dr. John Yap and Leslie Rodgers interviewed by London School of Economics researcher re: our ACP work
- **April 2016:** Substitute Decision Maker Day at Royal Columbian Hospital (250 acute care workers)
- **Jan 2016:** Health Care Providers "selfies" project (wearing ACP button with a patient) to build collegial momentum
- **Dec 2015:** Transitions in Care (Identifying an SDM) project launched
- **Sept 2015:** Health Care Providers working group established – planning process begins
- **April 2015:** ACP Fair in New Westminster, 221 participants; City of New Westminster declares the date "ACP Day in New Westminster
- **Nov 2014:** Dr. Charlie Chen Conversations about Advance Care Planning Workshop for Health Care Providers
- **April 2014:** (National ACP Day) seniors and physicians as co-learners ACP workshop
- **April 2014:** Canadian Geriatrics conference, "MD's and own ACP" abstract poster
- **June 2014:** Advocis (Financial Advisors Association of Canada) meeting
- **June 2014:** ACP Community Engagement Working Group launched
- **June 2014:** New Grads UBC conference, "ACP Pecha Kucha"
- **June 2014:** FHA and Interdivisional Council ACP update
- **May 2014:** BC Hospice Palliative Care Association Forum
- **May 2014:** Presentation to Doctors of BC
- **Oct – Dec 13:** ACP Advisory Committee Established, Three Pillar Strategic Approach developed
- **Dec 2013:** Guest blog www.advancecareplanning.ca
- **Nov 2013:** Dangerous Soapbox win, "Could ACP be like art?"
- **Nov 2013:** Victoria Hospice Heart Failure and Palliative Care conference, "Maintaining preferences for care at end of life in heart failure"
- **Sept 2013:** Canadian Hospitalist conference, "MD's and own ACP" abstract poster
- **Sept 2013:** Canadian Hospitalist conference, "MD's and own ACP" abstract poster
- **May 2013:** Workshops with 26 GPs, Hospitalists and Specialists to develop an ACP Vision and Mission
- **Apr 2013:** Conversations about ACP at Royal Columbian Hospital – Dr. Joelle Bradley talked with 137 physicians and health care providers

Appendix A2: Former and Revised RCH Notification of Hospital Admission Forms

17/02/2016 16:03

fraserhealth

HOSPITALIST PROGRAM
ADMISSION NOTIFICATION

DRDR103264A Rev: Feb. 17/04 Page: 1 of 1

☐ **Burnaby Hospital**
3935 Kincaid Street, Burnaby, BC V5G 2X6
T: 604-434-4211 F: 604-412-6185

☐ **Delta Hospital**
5800 Mountain View Blvd., Delta, BC V4K 3V6
T: 604-946-1121 F: 604-946-3086

☐ **Eagle Ridge Hospital**
475 Guildford Way, Port Moody, BC V3H 3W9
T: 604-469-5129 F: 604-469-5159

☐ **Ridge Meadows Hospital**
11666 Laity Street, Maple Ridge, BC V2X 7G5
T: 604-871-3120 Pgr: 604-463-1888

☐ **Surrey Memorial Hospital**
13750 96th Avenue, Surrey, BC V3V 1Z2
T: 604-581-2211 F: 604-588-3377

☐ **Royal Columbian Hospital** ☐ **Queen's Park Care Centre**
c/o 330 E. Columbia Street, New Westminster, BC V3W 3W7
T: 604-520-4001 F: 604-520-4069

DATE: _____

TO: Doctor _____ Fax: ( ) _____ Phone: ( ) _____

RE: Patient _____

Your patient has been admitted under the care of the Hospitalist Team.

The presenting problem is: _____

IMPORTANT: Please fax pertinent information regarding this patient's medical history to the respective site. Please see list below for specific area(s) about which more information is needed. Also, if available, please indicate **DNR status** (level of intervention) including faxed copy of ***current*** Advance Directive/Living Will.

☐ Cardiac	☐ Respiratory	☐ GI/Liver	☐ Endocrine	☐ Blood	☐ Other
☐ Mental/ Cognitive	☐ ENT	☐ Ortho	☐ Neuro	☐ Current medications /recent changes	☐ ADLs

If you require further information, fax your request to the respective site. If your knowledge of this patient's medical condition includes information of a time-urgent or critical nature please page the hospitalist immediately. (604 - 450 -7234)

You will receive a Discharge & Return to Care form soon after your patient is discharged. In addition, a copy of the Discharge summary will be forwarded to you.

Sincerely,

_____
Hospitalist

CONFIDENTIAL: If received in error, please contact sender.

REVISED NOA FORM

RCH Hospitalist Program
Notice of Admission
Tel: 604-520-4001
Fax: 604-520-4069

Date: _____

Dear Dr: _____

Fax: _____
Phone: _____

Re: _____
DOB: _____

Your patient has been admitted to the RCH Hospitalist Service.

Admitting Dx: _____

The Hospitalist team requests info on from you regarding:

- Medical Issues

_____

_____

_____

- Advance Care Planning

_____

Please Fax FHA approved forms such as MOST to **604-587-3748.**

Thank you for your assistance is managing this patient.

CONFIDENTIAL: If you have received this fax in error, please contact sender

Appendix A3: Default Hierarchy for Substitute Decision Maker

Temporary Substitute Decision Maker (TSDM) in British Columbia

If you have not legally named a representative (SDM) to make health care decisions for you when you are incapable of making them yourself, **a health care provider will choose the nearest qualified person to be your temporary substitute decision maker (TSDM) as outlined below:**

The doctor or healthcare provider will contact your TSDM from a predefined list. **The order of the people on the list is determined by B.C. law.** To be able to act as a TSDM, the person must be 19 or older, be capable, have no dispute with you, and have been in contact with you in the past year.

1. Your spouse (married, common-law, same sex - length of time living together doesn't matter)
2. A son or daughter (19 or older, birth order doesn't matter)
3. A parent (either, may be adoptive)
4. A brother or sister (birth order doesn't matter)
5. A grandparent
6. A grandchild (birth order doesn't matter)
7. Anyone else related to you by birth or adoption
8. A close friend
9. A person immediately related to you by marriage (in-laws, step-parents, step-children, etc.)

You may not change the order of the list. A person lower down on the list may only be chosen as your TSDM by your health care provider if all the people above them do not qualify or are not available.

However if you know that you want someone lower on the list, or not on the list, to make your health care decisions, then you should name that person legally as your represenative using a **representation agreement form.**

Your TSDM is legally required to make decisions that respect your wishes. If you have had discussions about advance care planning and have written down your beliefs, values and wishes, your TSDM will be best prepared to speak to your wishes when asked to make health care treatment decisions for you.