Session 7 Cheat Sheet: Care Planning Strategies with the Patient

	Strategies	Clinic Examples	Benefit to the provider

1. EXPLICITLY MAKE A COMMITMENT TO ONGOING CARE	• **RENEW YOUR VOWS**
	• Concretize your relationship with the patient and family
	• Explain your responsibilities (roles)
	  ○ Whatever happens, good or bad, I'm going to be there for you.
	  ○ We're in this together. I'm going to help you and your family along this entire journey.
	  ○ As your primary care provider, this is what my role in this journey is…
	  ○ You're going to seeing a specialist, but it's important I stay involved.
	  ○ A one-time conversation about this is not enough. Let's make regular appointments. Is this ok?
		• Communicate: Have regular two-way communication between GP and patient and home care providers! and caregivers!
		  ○ Find these patients early makes this easier!
		  ○ Get the patient and family on board
		  ○ Invite them into the ongoing conversation.
		• Identify the SDM and relevant caregiver(s) and get permission to share medical info
		
		Other things to discuss over time:
		• Have an approach to discussing MAID
		• Discuss what happens after patient dies
		• How you will follow family into bereavement
			• Help shape future communication channels
			• Develop shared trust
			• Help elicit care goals
			• Encourage longitudinal conversations

2. SHIFT TO PROACTIVE CARE PRACTICES	• **MAINTAIN CONTACT & TRACK CARE PLANNING**
	• Book appointments regularly (check-ins)
	• Longer appointments, first and last
	• Offer telephone support
	• Explain availability to respond during health fluctuations (e.g. on-call services)
	• Schedule home visits
		• Schedule follow-up/regular check-ins (registry)
		  ○ Plan to make home visits if needed
		  ○ Allow time for patients to express emotions
		• Know the supports available:
		  ○ Caregiver support groups, financial benefits, and options for private/assistance
		• Create action plans for common situations:
		  ○ Expected death in the home, expected complications near EOL
			• Increase in communication
			• Maintain relational commitment
			• Ensure that patient/family agenda is met

3. BROADEN THE HEALTH CARE TEAM	• **ENGAGE -OLOGISTS, FAMILY! & OTHER LOCAL RESOURCES (home care)**
	• Engage interdisciplinary supports within the practice
	• Connect with specialists involved
	• Engage community & home care support
	• Leverage informal caregivers
		• Easily accessible contact info of key resources
		  ○ case coordinator #, home oxygen #,
		  ○ PC specialist resources for consultation
		• Develop rapport with local specialist resources
		  ○ Hospices, specialists, hospitals, etc.
		• Get CME on common meds like opioids
			• Connect with additional supports from community (additional eyes and ears)
			• Connect with specialists to prevent getting lost to vortex
			• Identify 'informal team' and a consistent team
			• Caregivers are part of 'unit of care'