



Epic & Advance Care Planning

Concurrent Session

Kat Thomas, BSN, RN - Epic



Concurrent Session Abstract

- This presentation will provide a high-level general overview of standard Epic tools and workflows for Advance Care Planning, including those within the MyChart patient portal. This session is intended for those who work for organizations already using or currently installing Epic. Attendees will have an opportunity to learn about new enhancements in Epic and discover workflows to enhance sharing of patient-centered data across disciplines and locations. The presentation will focus on tools that are currently available in the most recent version of Epic software. Following the presentation, all information shared will also be accessible from Epic's UserWeb to facilitate follow-up with the appropriate teams at each organization.

Agenda

- Guiding Principles
- Workflows in Hyperspace
- Workflows in MyChart
- Staying Involved & Next Steps

Agenda

- **Guiding Principles**
- Workflows in Hyperspace
- Workflows in MyChart
- Staying Involved & Next Steps

Guiding Principles: Advance Care Planning in Epic

1. ACP information should be collected before it is needed.
2. It should be easy to update and maintain as a source of truth.
3. It should be apparent and available to appropriate users when it is needed.

Advance Care Planning in Epic

- Tools available
 - Healthcare Agents
 - Patient Capacity
 - Code Status
 - ACP Documents
 - *Optional:* Patient Wishes, POLST
 - Patient Entered Questionnaires
 - ACP Notes
 - MyChart

Licensing

- Built off of existing EpicCare framework
- Not a separate license
- Same activity across Inpatient and Outpatient
- Additional functionality in MyChart

Agenda

- Guiding Principles
- **Workflows in Hyperspace**
- Workflows in MyChart
- Staying Involved & Next Steps

Advance Care Planning Activity

Georgine Coleman
Female, 85 y.o., 3/19/1933
MRN: 35227
Bed: 1004
Code: FULL (with Adv Directives)
HCA: Not Active

ADMITTED: 7/4/2018 (DAY 99)
5/P total knee replacement (+4)
Jennifer Johnson, M.D., Attending

TREATMENT PLANS
! No active plans

BP: 120/70
HR: 78
RR: 14
SpO2: 92%
T: 98.3 °F
Last Wt: 162 lb

MOST RECENT MDS
None in date range

NO THERAPY LEVEL
No therapy projected

Advance Care Planning

Health Care Agents

Active?	Name	Relationship	Health Care Agent Relationship	Legal Guardian?	Primary	
	Trish Unger	Sister	Health Care Agent			414-749-3922 (Mobile) Advance Directives
	Coleman, James	Son	First Alternate Health Care Agent	No		608-777-1111 (Home) Attach Document

Capacity to Make Own Care Decisions

This section is currently read-only. You do not have the security to edit this section.

Full capacity
Continue to monitor memory loss.
Jennifer Johnson, M.D.
7/10/2018
Last updated by Jennifer Johnson, M.D. at 7/10/2018 10:25 AM.

Code Status

Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
6/12/2014 1517	Full Code	1419391		Jennifer Johnson, M.D.	Inpatient

Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comments	User	Context
6/10/2014 1424	6/11/2014 1732	Full Code	1419473		Patt Cooper, M.D.	Inpatient
12/20/2013 1501	6/10/2014 1424	Full Code	1419443		Jamie Smith, M.D.	Inpatient
3/24/2007 1358	3/24/2007 1358		None		Marty Seeger, M.D.	Demographics

Documents

Advance Care Planning Documents

Inpatient ~ nursing admission workflow

Navigators
Admission Transfer Discharge

Healthcare Directives - Healthcare Directives

Time taken: 1035 1/5/2018

Show: ☐ Row Info ☐ Last Filed ☐ Details ☐ All Choices

Values By [Create Note](#)

Advance Directives (For Healthcare)

Have you reviewed your Advance Directive and is it valid for this stay?

☐ Yes ☐ No ☐ Not applicable

Advance Directives Reviewed: 1/4 1006 - 1/5 1035; Advance Directives Reviewed: 1/4 1006 - 1/5 1035

Advance Directive

☐ Patient has advance directive, copy in chart ☐ Patient has advance directive, copy not in chart

☐ Patient does not have advance directive ☐ Patient would like information

☐ Patient would not like information ☐ Not applicable

Advance Directives Assessment: 1/4 1006 - 1/5 1035; Advance Directives Assessment: 1/4 1006 - 1/5 1035

Information Provided on Healthcare Directives

☐ Yes ☐ No ☐ Other (Comment)

Advance Directives Assessment: 1/4 1006 - 1/5 1035; Advance Directives Assessment: 1/4 1006 - 1/5 1035

Pre-existing DNR/DNI Order

☐ Yes, notify physician for order ☐ No ☐ Other (Comment)

Advance Directives Assessment: 1/4 1006 - 1/5 1035; Advance Directives Assessment: 1/4 1006 - 1/5 1035

Patient Requests Assistance

☐ Yes, advice to complete post dischar... ☐ Yes, referral made to case manager ☐ Yes, referral made to chaplain

Advance Directives Assessment: 1/4 1006 - 1/5 1035; Advance Directives Assessment: 1/4 1006 - 1/5 1035

[Restore](#) [Close](#) [Cancel](#) [Previous](#) [Next](#)

Inpatient – nursing admission workflow

Health Care Agents

Active?	Name	Relationship	Health Care Agent Relationship	Legal Guardian?	Primary	Home	Work	Mobile
	Bell, John	Spouse	Health Care Agent	No	608-555-4455 (Home)	608-555-4455		
	Bell, Joseph	Son	First Alternate Health Care Agent		920-555-8855 (Home)	920-555-8855		

[Edit Contacts](#) [Close](#) [Previous](#) [Next](#)

[Implants](#) [New Implant](#)

Show: ☒ Explained [Refresh](#) [Print](#)

Advance Care Planning Activity

Advance Care Planning

Health Care Agents

Active?	Name	Relationship	Health Care Agent Relationship	Legal Guardian?	Primary
	Trish Unger	Sister	Health Care Agent		414-749-3922 (Mobile) Advance Directives
	Coleman, James	Son	First Alternate Health Care Agent	No	608-777-1111 (Home) Attach Document

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7/10/2018
Last updated by Jennifer Johnson, M.D. at 7/10/2018 10:25 AM.

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12/20/2013 1501	6/10/2014 1424	Full Code	1419443		Jamie Smith, M.D.	Inpatient
3/24/2007 1358	3/24/2007 1358	None			Marty Seeger, M.D.	Demographics

Documents

Advance Care Planning Documents

Health Care Agents

Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

Health Care Agents

Activation History

Trish Unger

Sister

Health Care Agent

414-749-3922 (Mobile)

Advance Directives

Coleman, James

Son

First Alternate Health Care Agent

No

608-777-1111 (Home)

Attach Document

Edit Contacts

Close

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Health Care Agents

Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

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Advance Directives

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Edit Contacts

Close

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Full capacity
Continue to monitor memory loss.
Jennifer Johnson, M.D.
7/10/2019
Last updated by Jennifer Johnson, M.D.

Code Status

Current Code Status

Date Active

Coleman, Georgine (DOB: 3/19/1933)

120%

Health Care Advance Directive
Part I
Appointment of Health Care Agent

1. HEALTH CARE AGENT
I, Cynthia M. Johnson, hereby appoint Christopher Johnson as my agent to make health and personal care decisions for me as authorized in this document.

2. ALTERNATE AGENTS
I name the following (each to act alone and successively, in the order named) as alternates to my Agent, IF
- I revoke my Agent's authority, or

Patient Capacity – with edit security

Capacity to Make Own Care Decisions

Full capacity Incapacitated Needs review

Continue to monitor as dementia progresses.

Last updated by Rachel Garza, MD at 1/18/2018 7:57 PM.

✓ Close

Code Status & History

Advance Care Planning

HEALTH CARE AGENTS
AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE
PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

ADVANCE CARE
PLANNING NOTES

ACP Notes

Code Status

Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
10/10/2018 0716	Partial Code	1456642		Jim Anderson, RN	Inpatient

Questions for Current Code Status

Question	Answer	Comment
Code Limitations:	No Internal/External Pacemaker	
Code Limitations:	No Mechanical Ventilation with Intubation	

Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comments	User	Context
6/12/2014 1517	10/10/2018 0716	Full Code	1419391		Jennifer Johnson, M.D.	Inpatient
6/10/2014 1424	6/11/2014 1732	Full Code	1419473		Pat Cooper, M.D.	Inpatient
12/20/2013 1501	6/10/2014 1424	Full Code	1419443		Jamie Smith, M.D.	Inpatient
3/24/2007 1358	3/24/2007 1358	None			Marty Seeger, M.D.	Demographics

ACP Documents

Documents

Advance Care Planning Documents

Document Type	Status	Effective Date	Expiration Date	Received On	Description
Power of Attorney	Received	04/23/18	04/25/23	04/24/18	Power of Attorney UPDATED.pdf
Advance Directives and Living Will	Received	02/13/17	04/30/23	04/24/18	AD and Living Will
Advance Directives and Living Will (expired)	Received	09/08/16	09/11/18	09/18/18	Advance Directives

Denied Advance Care Planning Documents

[Jump to Document List to update filed documents](#)

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ACP Documents

Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

ADVANCE CARE PLANNING NOTES

ACP Notes

Documents

Advance Care Planning Documents

Document Type	Status	Effective Date	Expiration Date	Received On	Description
Advance Directives and Living Will	Received			09/13/13	Advance Directives
Power of Attorney	Not Received				

[Jump to Document List to update filed documents](#)

Coleman, Georgine (DOB: 3/19/1933)

Patient-Entered Wishes

120%

Health Care Advance Directive

Part I

Appointment of Health Care Agent

1. HEALTH CARE AGENT

I, Cynthia M. Johnson, hereby appoint Christopher Johnson as my agent to make health and personal care decisions for me as authorized in this document.

2. ALTERNATE AGENTS

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Patient-Entered Wishes



The screenshot shows a digital form titled "Patient-Entered Wishes" with a teal header bar containing a person icon and the title. The form is divided into two main sections. The first section, "Patient-Entered End-of-Life Planning", includes a disclaimer: "This documentation does not take the place of any legal documents regarding advance care planning." Below this is a question: "What experiences has the patient had with serious illness or death and how has that influenced their wishes and values?". A text box contains the answer: "My grandfather passed away a few years ago, after a brief illness and while in the ICU. This has caused me to think about my own wishes sooner than I probably would have otherwise." The second section asks: "What fears or worries does the patient have regarding end-of-life?". A text box contains the answer: "I am worried that my family will have unnecessary stress because they don't know what I would want, or they don't want to make a wrong choice on my behalf." The form has a light gray background with a white border. A teal bar at the bottom of the form contains the text "Patient-Entered Wishes" and a small icon of a person.

Patient-Entered Wishes

Patient-Entered End-of-Life Planning

This documentation does not take the place of any legal documents regarding advance care planning.

What experiences has the patient had with serious illness or death and how has that influenced their wishes and values?

My grandfather passed away a few years ago, after a brief illness and while in the ICU. This has caused me to think about my own wishes sooner than I probably would have otherwise.

What fears or worries does the patient have regarding end-of-life?

I am worried that my family will have unnecessary stress because they don't know what I would want, or they don't want to make a wrong choice on my behalf.

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Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

ADVANCE CARE PLANNING NOTES

ACP Notes

Patient Wishes

General Authority of the Health Care Agent

I DO NOT want my health care agent to be able to do the following:

Mark the check box for anything listed below that you DO NOT want your health care agent to do.

☐ DO NOT: Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, DO NOT decide whether to keep it going or have it stopped based on my stated instructions or my best interests.
 ☐ DO NOT: Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
 ☐ DO NOT: Review and release my medical records and personal files for my medical care.
 ☐ DO NOT: Arrange for my medical care and treatment in my home state or any other state, as my health care agent thinks is appropriate.
 ☐ DO NOT: Determine which health care professionals and organizations provide my medical treatment.
 ☐ DO NOT: Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

Limitations on Mental Health Treatment

Pursuant to state statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

To complete the next 3 sections: Indicate one statement in each section. If you do not mark any box in a section, your choice is "no." This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

1. Admission to a Nursing Home or Community-Based Residential Facility

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

☐ Yes, my health care agent has this authority, subject to any limits I set in this document.
 ☐ No, my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

Orders for Life~Sustaining Treatment

Orders for Life-Sustaining Treatment

This navigator section is missing SmartForm configuration. Please contact an administrator.

Restore

Close

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- POLST Clinical Program
 - Describes the build and implementation strategy for creating similar tools and a supporting workflow in your system.
 - Download it from Galaxy: [Documenting Patients' Preferences for Life-Sustaining Treatment](#)

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Advance Care Planning Notes

Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

ADVANCE CARE PLANNING NOTES

ACP Notes

Notes

Advance Care Planning Notes

Create ACP Note

Date of Service		Author	Author Type	Status	Note Type
07/10/18 1030	Addend	Jennifer Johnson, M.D.	Physician	Signed	ACP (Advance Care Planning)
04/18/18 0652	Addend	Jennifer Johnson, M.D.	Physician	Signed	ACP (Advance Care Planning)
10/25/17 2259	Addend	Drew Walker, M.D.	Physician	Signed	ACP (Advance Care Planning)
06/14/17 1020	Addend	Jennifer Johnson, M.D.	Physician	Signed	ACP (Advance Care Planning)

Advance Care Planning Notes

Advance Care Planning

HEALTH CARE AGENTS AND PATIENT CAPACITY

Health Care Agents

Patient Capacity

CODE STATUS

Code Status

ADVANCE CARE PLANNING DOCUMENTS

ACP Documents

Patient-Entered...

Patient Wishes

Orders for Life-Su...

ADVANCE CARE PLANNING NOTES

ACP Notes

Notes

Advance Care Planning Notes

Create ACP Note

Date of Service		Author	Author Type	Status	Note Type
07/10/18 1030	Addend	Jennifer Johnson, M.D.	Physician	Signed	ACP (Advance Care Planning)
04/18/18 0652	Addend	Jennifer Johnson, M.D.	Physician	Signed	ACP (Advance Care Planning)
10/25/17 2259					ACP (Advance Care Planning)
06/14/17 1020					ACP (Advance Care Planning)

Report Viewer

ACP (Advance Care Planning) by Jennifer Johnson, M.D. at 4/18/2018 6:52 AM

Author: Jennifer Johnson, M.D.

Service: Geriatrics

Author Type: Physician

Filed: 7/10/2018 10:30 AM

Date of Service: 4/18/2018 6:52 AM

Status: Signed

Editor: Jennifer Johnson, M.D. (Physician)

Georgine Coleman is an 85 yo female with mild memory loss, osteoarthritis and increasing weakness. She discussed Advance Care Planning a couple of years ago with her primary care physician, but hasn't thought much about it since. She recently saw a TV documentary about end of life planning and has some questions to discuss.

We reviewed goals of care at this time. She wishes to remain in her home as long as is reasonable, and her greatest joy comes from spending time with family, especially her great grandchildren. Any future treatments or decisions should consider these goals.

Referral to ACP team for follow-up discussion.

Jennifer Johnson, M.D.
04/18/2018

Hide copied text

Hover for details

ACP documentation in any note type

The screenshot displays the 'Advance Care Planning' section of a medical software interface. The top navigation bar includes tabs for 'Chart Review', 'Care Everywhere', 'Rooming', 'Plan', 'Wrap-Up', 'Sign', 'FYI', and 'Advance Care Planning'. The left sidebar lists various categories: 'HEALTH CARE AGENTS AND PATIENT CAPACITY', 'Health Care Agents', 'Patient Capacity', 'CODE STATUS', 'Code Status', 'ADVANCE CARE PLANNING DOCUMENTS', 'ACP Documents', 'Patient Wishes', 'Orders for Life-Su...', 'ADVANCE CARE PLANNING NOTES', and 'ACP Notes'. The main content area is titled 'Advance Care Planning Notes' and includes a 'Create ACP Note' button. Below this, a table lists notes with columns for 'This Encounter?', 'Date of Service', 'Author', 'Author Type', 'Status', and 'Note Type'. A table with one row is visible, showing a note from 'Gary Eddy' on '09/18/17' with a status of 'Sign at close' and a note type of 'Progress Notes'. A 'Progress Notes' window is open, showing details for a note by 'Gary Eddy Johnson, MD' on '9/19/2017 11:36 AM'. The note text describes a patient's wishes regarding medical intervention. The window also includes a 'Show:' section with checkboxes for 'Manual', 'Template', and 'Copied', and an 'Added by:' section with a checkbox for 'Gary Eddy Johnson, MD'. A 'Full Note Text' link is at the bottom of the note content.

Agenda

- Guiding Principles
- Workflows in Hyperspace
- **Workflows in MyChart**
- Staying Involved & Next Steps

Advance Care Planning in MyChart

MyChart
Epic Medical Center

Gerard Harrison
Log Out

Health Visits Messaging Billing Resources Profile

End-of-Life Planning

Setting up a plan is one of the best gifts you can give to those you care about.

New to end-of-life planning? Start by watching this short video.

[WATCH VIDEO](#)

Schedule a time to meet with trained staff about end-of-life planning.

[SCHEDULE APPOINTMENT](#)

Ready to start planning?

Setting up a plan is one of the best gifts you can give to those you care about.

trained staff about end-of-life planning.

[SCHEDULE APPOINTMENT](#)

Ready to start planning?

For my doctor
Let your doctors know what your wishes are so they can provide the best care for you.

[UPDATE](#)

For me
Take the time to write down what's most important to you.

[UPDATE](#)

[Health Care Agents](#) ⓘ [Planning Documents](#) ⓘ

Related Links

[Ask a question](#)

Planning Questionnaires
Filling out the End-of-Life Planning questionnaires helps your care team understand your wishes, but it does not replace up-to-date legal documentation of your end-of-life plans.

Helpful Resources
These resources will help you make care decisions and prepare for conversations with your family, friends, and doctors.

[Five Wishes](#)
replace up-to-date legal documentation of your end-of-life plans.

Helpful Resources
These resources will help you make care decisions and prepare for conversations with your family, friends, and doctors.

[Five Wishes](#)
Help others understand what matters most to you.

[Helping With Comfort and Care](#)
Advice to cultivate comfort and happiness towards the end of life.

Advance Care Planning in MyChart

MyChart
Epic Medical Center

Gerard Harrison
Log Out

Health Visits Messaging Billing Resources Profile

End-of-Life Planning to Share With Your Care Team

Having a plan for end-of-life care is important for everyone regardless of age or current life situation. Answer these questions when you're ready. You can always choose to finish any part of the questionnaire later by clicking the Finish Later button below. Your responses will not be shared with your care team until you click Submit. You can also change any of your responses in the future by returning to this questionnaire.

What experiences have you had with serious illness or death and how has that influenced your own wishes and values?

My grandfather passed away a few years ago, after a brief illness and while in the ICU. This has caused me to think about my own wishes sooner than I probably would have otherwise.

What fears or worries do you have regarding end-of-life (for example, being in pain, being a burden on others, cost, not getting the care you need)?

me to think about my own wishes sooner than I probably would have otherwise.

What fears or worries do you have regarding end-of-life (for example, being in pain, being a burden on others, cost, not getting the care you need)?

I am worried that my family will have unnecessary stress because they don't know what I would want, or they don't want to make a wrong choice on my behalf.

Related Links

[Ask a question](#)

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[Helping With Comfort and Care](#)
Advice to cultivate comfort and happiness towards the end of life.

Advance Care Planning in MyChart



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Resources on the UserWeb

- [Advance Care Planning Setup & Support Guide](#)
- [Improve Workflows for Advance Care Planning ~ Clinical Program with Gundersen](#)
- [Advance Care Planning topic on the UserWeb](#)

What others are doing

- [PAC09 Advance Care Planning - Facilitating Conversation Through Efficient Documentation \(MaineHealth\)](#)
- [UGM318 - Code Order Redesign Using POLST to Honor Patient Wishes \(Hawai'i Pacific Health\)](#)
- [UGM 287 - Advance Care Planning Success Story \(Cleveland Clinic\)](#)
- [UGM 321 - Getting Advanced with Advance Care Planning \(PDF\) \(Johns Hopkins\)](#)
- [Making the Most of POLST and Hospital Code Status Orders \(Johns Hopkins\)](#)
- [UGM320 Development of a Native, Electronic POLST Tool \(Providence\)](#)

ACP Forum

- Quarterly WebEx (next is January 2019)
- Variety of topics, with time for feedback and discussion
- Search [“ACP Forum”](#) on the UserWeb for info from past sessions
- Reach out to kat@epic.com to get added to the list

Next Steps

- Attend the workshop on Thursday for a deeper dive
- Review available resources on the UserWeb
- Join our Advance Care Planning forums
- Reach out to Kat (kat@epic.com) with any questions!



Questions?

Kat Thomas – kat@epic.com

Thank You!