Let's Talk Informatics

Goals of Care: More Than a Form

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Let’s Talk Informatics

Goals of Care: More Than a Form

Presenters:
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Acknowledgement

We acknowledge we are gathered today
in Mi’kma’ki (*Mig-***_maw_**-gee), the traditional ancestral
unceded territory of the Mi’kmaq (*Mig-**maw**) people.

Informatics

Informatics utilizes health information and health care technology to enable patients to receive best treatment and best outcome possible.

Let’s Talk Informatics Objectives

This series is designed to enable participants to:

- Identify knowledge and skills healthcare providers need in order to use information now, and in the future.
- Prepare health care providers through an introduction to concepts and experiences in Informatics.
- Acquire knowledge to remain current by becoming familiar with new trends, terminology, studies, data and news.
- Collaborate with a network of colleagues to establishing connections with leaders who can provide advice on business issues, best-practice and knowledge sharing.

Conflict of Interest Declaration

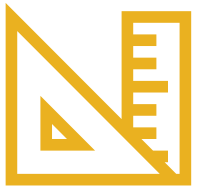
We do not have an affiliation (financial or otherwise) with a pharmaceutical , medical device, health care informatics organization, or other for-profit funder of this program.

Session Specific Objectives

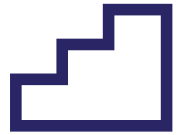
At the conclusion of this activity, you will be able to better understand the:

Project Background and Approach

Level of Integration and Collaboration Involved



Process Improvements Made



Next Steps Related to Implementation

What do we mean by “Goals of Care”?

A person’s goals of care are their overall priorities and expectations for health care based on their personal values, perception of quality of life, and what is meaningful and important to them.

“People have goals in their lives beyond living longer”

Atul Gawande

“I want to be able to go outside and get fresh air”

“I don’t want to spend my final days in the hospital”

“Do everything possible to save my life”

What do we mean by “Level of Intervention”?

Level of Intervention	The scope of medical interventions that ensure alignment with goals of care should the person’s health decline gradually or suddenly. This is more than code status and is determined only after a high-quality discussion.

Patient Story – Jane

- Living with COPD for the past 7 years
- Increasingly frail and needing more oxygen support.
- Several recent ED visits and one recent hospital admission
- Established a personal directive saying “No CPR”
- Admitted to hospital in respiratory failure
- Her family is told she needs to be intubated to save her life
- She is now on a mechanical ventilator in the ICU showing no signs of improvement.
- The family knows she didn’t want CPR, but they don’t want to “give up on her”

What would Jane have wanted?

Project Background

2015	2017	Fall 2020	Winter 2021
EHS Special Patient Program	**Goals of Care Form version 1**	**OPOR: Clinical Standardization**	**HSMR: Documentation**
Mostly used for palliative care in community, to communicate goals of care so paramedics can provide palliative symptom management in the home	Developed by team at QEII as a result of a quality review, "Piloted" for medicine admissions and expanded use during pandemic (EZ, NZ)	OPOR team identified need to develop/define Goals of Care and Levels of Intervention for essential data set EHS TRIC project to upload EHS SPP codes into STAR and Meditech so ED staff could see goals of care upon admission	Recommendation from Quality Review to "Develop and implement a standard process for documentation for Goals of Care"

Documentation is more than a Form

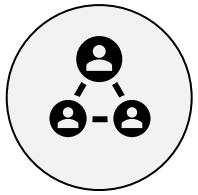
Let’s not forget about Jane’s story!

Quality Concerns

Process Issues	No standardized documentation	No consistent approach to conducting these discussions	Lack of integrated process for sharing information across settings of care
Current Impacts	Patients may receive care that does not align with their priorities or hinders their quality of life	Increased distress when decisions need to be made in a crisis situation	Patients and families may be asked repeatedly to confirm “code status”, which only addresses CPR

Quality improvement initiative

Improve the documentation of the discussion and make it easily accessible in the health record



Improve communication across settings of care with a consistent approach and terminology

Improve the quality of the discussion, building in important cues and understanding of patient priorities

Shared decision–making

Patient/Family	**Shared Decision-making**	Health care provider/s
Unique views about what quality of life means Personal experiences with death and dying Cultural and spiritual needs Risk tolerance Beliefs about end-of-life care	Together, this can result in decision-making that is based on the best available medical information but is driven by the person's priorities and what quality of life means to them.	Medical assessments Information about an illness and how it may progress Knowledge of evidence-based treatment options and how they could impact a person's function Professional experience

Benefits

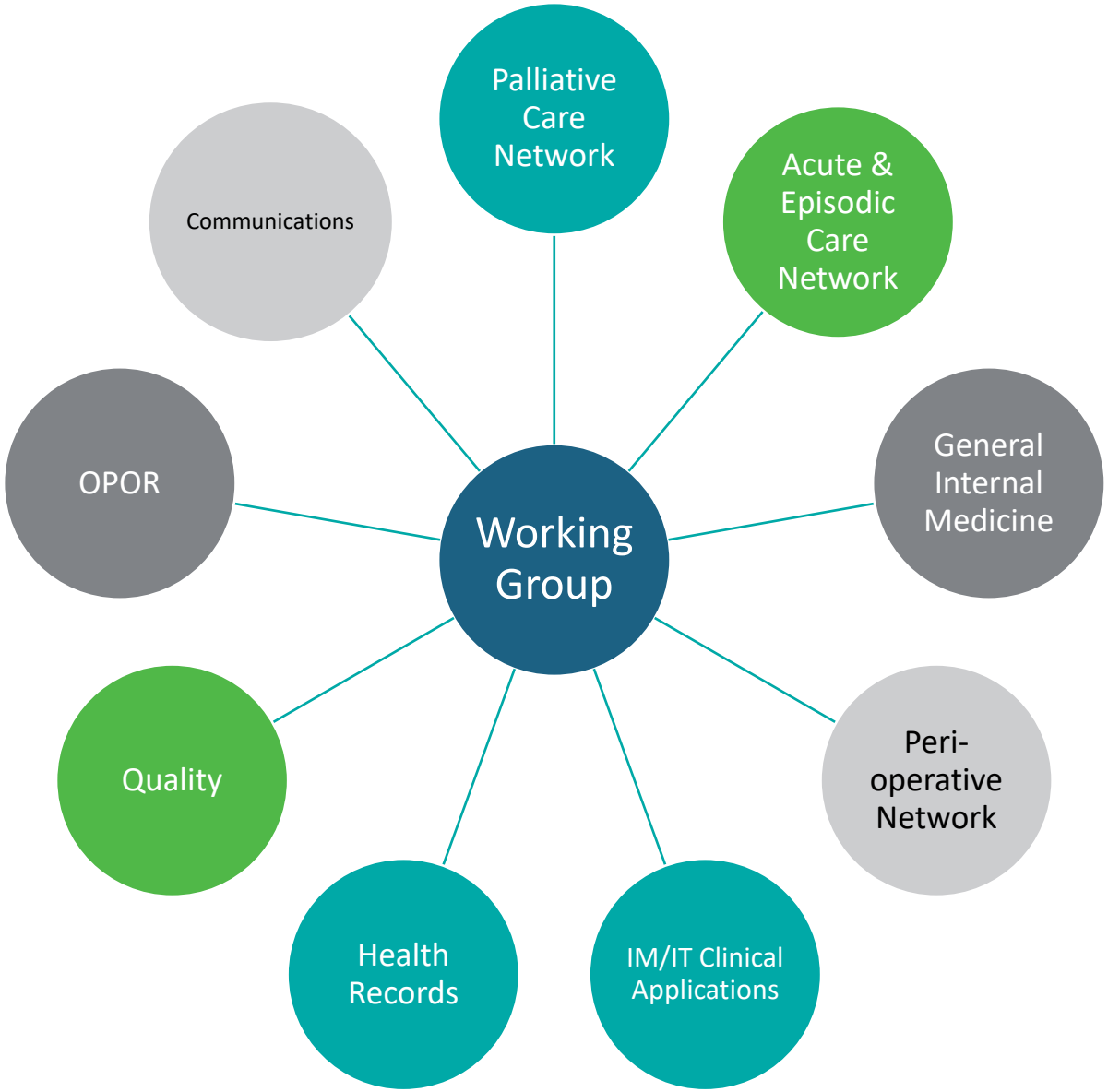
For patients and families:

- More likely to be satisfied with their care
- Require fewer aggressive interventions at the end of life
- Reduced distress for caregivers
- More likely to take advantage of hospice resources or die at home

For health care providers:

- Reduces moral distress
- Reduces conflict
- Avoids unnecessary treatment
- Promotes discussion about various options for care
- Promotes/increases awareness and understanding of resources and support, before a crisis
- Promotes a shared understanding within the care team

Working Group



- Clinicians
- Interprofessional Practice
- Library Services
- Frailty Network
- EHS
- Patient Family Advisory Council

Project Priorities

Improve documentation of the discussion and make it easily accessible in the health record

- Environmental scan
- Review of evidence & key themes
- Inventory of current forms
- Stakeholder engagement
- Form design
- Location in health record
- Policy development

Project Priorities

Improve communication across settings of care with a consistent approach & terminology

Phase 1 Implementation - Target Acute Care

Outreach to guide implementation approach

Link to EHS Special Patient Program (SPP):
- Comfort Care (C1, C2)
- Selective Care (S1, S2)
- Full Code (F)

Develop Critical Care Indicator (CCI) codes

Green Sleeve

Phase 2 Implementation - Target community-based providers

Project Priorities

Improve the quality of the discussion, building in important cues & understanding of patient priorities

Building Capacity

Link Advance Care Planning, Goals of Care & Levels of Intervention

Developing additional education support for healthcare providers

Leveraging technology to support this initiative

1. Building readiness for future clinical information systems
2. Implementing standardized CCI codes & flags to support continuity of care
3. Encouraging healthcare providers to seek documentation in health record
4. Adding a QR code to the form to direct healthcare providers to relevant tools & resources

How will Jane's experience be different?

- GOC discussion will occur
- Healthcare providers, Jane, caregivers and family will have a mutual understanding and agreement of Jane's GOC & LOI
- Goals of Care discussion will be documented on a standardized form and uploaded to patient's health record
- Jane and family will have a copy in a Green Sleeve
- CCI flag will be printed on next admission
- Healthcare team will have access to documentation of previous discussions
- Based on her current status, healthcare team will review & recommend treatment based on Jane's priorities
- Family will feel supported & reassured that care is in alignment with Jane's priorities

Next Steps

- Continue to finalize materials for implementation through education and practice support
- Finalize policy to support Goals of Care implementation
- Implement communication plan
- Engage with site leads/champions
- Confirm rollout plan for non-acute care settings/providers
- Confirm evaluation plan

Project Team:

Cheryl Tschupruk, Dr. Nabha Shetty, Kate Melvin, Dr. Paige Moorhouse, Aafreen Valiya Manathal, Melissa Buckler, Linda Plummer, Charmaine Chisholm, Mary Eileen MacPhail, Jon Hilder, Terry Thorne, Dr. Jordan Thorne, Debbie Lelievre…. And many other partners

Let’s Talk Informatics Certifications

- **Digital Health Canada** - participants can claim 1CE hour for each presentation attended.
- **College of Family Physicians of Canada and Nova Scotia Chapter** - participants can earn one Mainpro+ credit by providing proof of content aimed at improving computer skills applied to learning and access to information.
- **Canadian College of Health Information Management** **-** approves 1 CPE credit per hour for this series for professional members of Canada’s Health Information Management Association (CHIMA).

Thank you

Need More Info?

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