Helping our patients' Values and Wishes for End of Life Care to be:

- Public Awareness and Education
- Community Engagement
- Clinician Training to have ACP conversations

- Standardized documentation of ACP conversations and MOST that is accessible
- Clinician training to enter MOST
- Information-sharing between Care Providers and Health Record Systems

- Operational Procedures to seek Advance Care planning information, use it to inform decisions and ensure care provided is congruent to patient wishes

It’s finally here!

The Advance Care Planning/MOST tab in Results Review

All the historical info available in one place to make decisions/run a family meeting

Results Review | Full screen | Print | 0 minutes a

Safety Risk

Last 48 Hours | Lab - Recent | Lab - Extended | Microbiology | Diagnostics | Vitals - Recent | Vitals - Extended | Clinical Information | Documents | **MOST/ACP** | Medicine Summary

Flowsheet: Provider Advance Directive Informa ... Level: Provider Advance Directive Informa ◉ Table ○ Group ○ List

Last 100 Results in the Past 3 Years

Navigator
- ☑ Resuscitation Status Details
- ☑ Goals of Care

Showing results from (08-Jul-2017 - 07-Oct-2019) Show more results

Provider Advance Directive Information	07-Oct-2019 22:42 PDT	12-Aug-2019 18:13 PDT	12-Aug-2019 15:38 PDT	01-Jul-2019 21:56 PDT	14-Jun-2019 22:21 PDT	20-May-2019 17:39 PDT	22-Jul-2017 22:32 PDT	08-Jul-2017 14:38 PDT
Resuscitation Status Details								
Intervention Level			M3 – treatme	C2 – ICU/Intu	C2 – ICU/Intu	C2 – ICU		
Following Conversation With			Temporary Su	Representativ	Capable Patie	Capabl		
Names of People Interviewed				Spouse				
Conversation Documented In								
Supporting Documentation Reviewed								
Other Supporting Documentation Reviewed								
Additional Directions								
Special Instructions			common law					
MOST Ordered By			Takeda DR, S	Chen DR, Dal	Culp DR, Gre	[illegible]		
Documentation Site								
Goals of Care								
Goals of Care Narrative	Goals of Care	Goals of Care						

The MOST is the cherry on top, but the Goals of Care Documentation is where the “good stuff” is

To read previous notes on Goals of Care discussions, Double click on the "Goals of Care Narrative" cell and it opens the document for that date.

Document Viewer - Demo, Rachel ACP - 23684814

Result type: Goals of Care Narrative
Result date: Sunday, June 09, 2019 17:42 PDT
Result status: Auth (Verified)
Result title: Goals of Care Narrative
Performed by: Carson DR, Rachel Colleen on Sunday, June 09, 2019 17:42 PDT
Verified by: Carson DR, Rachel Colleen on Sunday, June 09, 2019 17:42 PDT
Encounter info: 92021355401, NRG, Day Care, 24-May-2019 - 24-May-2019

*** Final Report ***

Goals of Care Narrative

I took this opportunity to have a conversation about goals of care. I used the Harvard/Ariadne labs "Serious Illness Conversation Guide" template. Summary of the conversation is as follows:

What do you understand about your illness? He understands that his health has deteriorated in the last several months. He was taken aback when palliative care was brought up but then in talking with various staff he is more understanding of the palliative care philosophy and understands that it is not just for the last days to weeks of life. He understands that he will never be a transplant candidate.

What **prognostic info was given to pt?** I told him that I did not think he would survive multiple years and that his life expectancy was more likely months to perhaps a year.

What are your **goals** if your health worsens? Regarding his goals, he would like to spend as much time as possible with his 1-year-old granddaughter. He spent some time describing how much he enjoys every minute with her and how he very much hopes to live long enough that she knows him and ultimately might remember him when she is older. He would like to spend as much time with his family as possible. Now that his vision is better, He has been hoping he could get his driver's license back and has ensured his car for the last 18 months just in case. He would like to be able to go on outings locally to see

Immunizations
Interactive View and I&O
Patient Information
MAR

Paper MOST Location/Comments — scanned in at Dr Gray's offic
Goals of Care
Goals of Care Narrative — Goals of C
Potential TSDMs - Unranked
Potential TSDM A Name — Daffy Duck — Daffy Duc

Doctors/NPs can document a GOC conversation by creating a new ACP form from the "AdHoc" menu:

It's 3 clicks to open it

The most recent note is visible underneath for reference, with cues for the components of the "Serious Illness Conversation" template underneath that. Sign it by clicking the checkmark (*NOT the floppy disc! If you click the floppy disc your work gets hidden*)

1

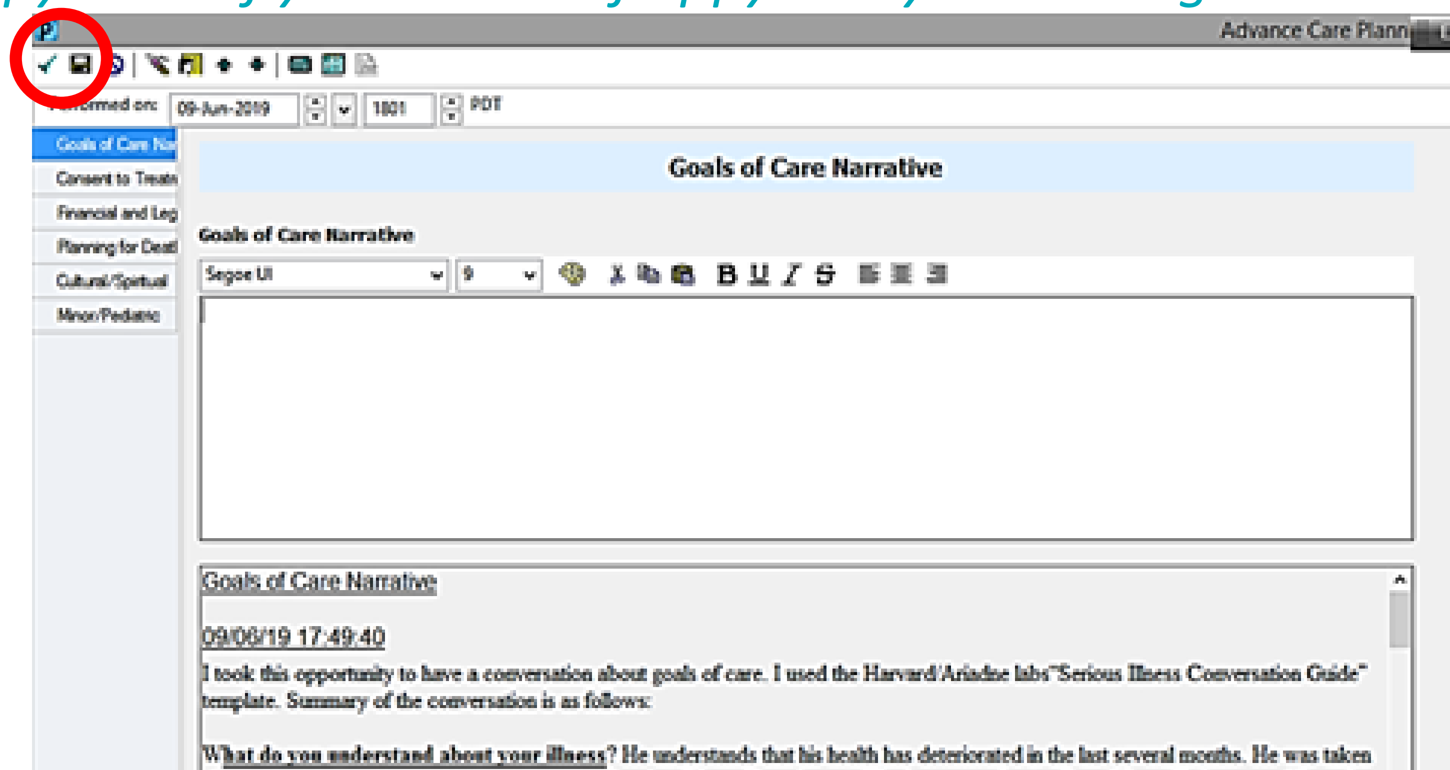
2

3

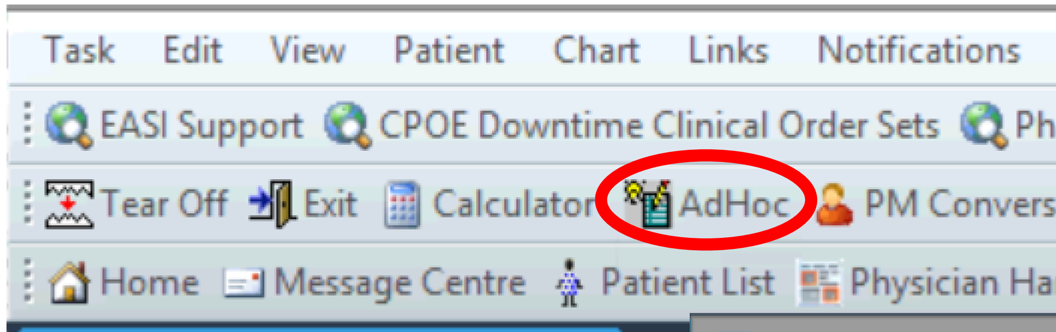
This is what it looks like for physicians. If you can't find it, please call or email me rachel.carson@viha.ca

ANYONE (nurse, social worker, MD, NP, dietitian, PT etc) can use this form to enter information about a Goals of Care conversation they have with the patient, because **Advance Care Planning is a team sport**!

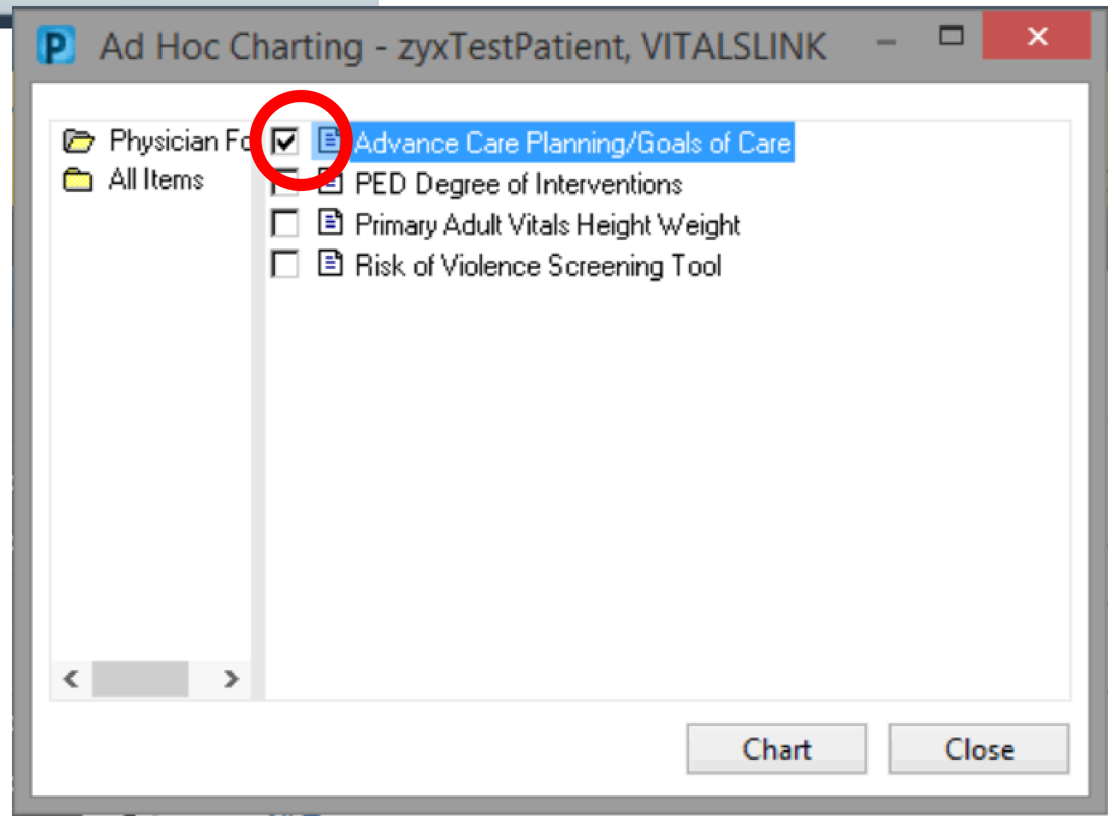
The most recent note is visible underneath for reference, with cues for the components of the "Serious Illness Conversation" template underneath that. Sign it by clicking the checkmark (*NOT the floppy disc! If you click the floppy disc your work gets hidden*)



Doctors/NPs can document a GOC conversation by creating a new ACP form from the "AdHoc" menu:



This is what it looks like for some physicians – 3 clicks to open



Doctors/NPs may also want to put the Goals of Care Discussion as part of their main consult / progress note then copy (CTRL-C) and paste it into the ACP/Goals of Care form box

Why? Because the ACP/Goals of Care form can't be copied to someone outside of iHealth (e.g. to family physician office office) the way a physician consult can.

Only an MD/NP document (not a form) can be sent out electronically to physician offices, so if you want to send a summary of the discussion to the GP, the MD/NP has to put it in a note, and copy that to GP then cut and paste it into the ACP form

Nursing or allied health documentation can only be sent out to physician offices by printing and faxing

Who are you going to call?

Emergency Contacts in Cerner are:

- Different from substitute decision makers (neighbour vs relative in Toronto)
- unreliable (“ghost contacts”… spooooooky)
- encounter-specific (not patient-level like the allergy record)
- not editable by clinical staff (only NUAs/patient-placement staff have access)

Record <u>potential</u> temporary substitute decision makers (TSDMs) and their contact info in the ACP form (Consent to Treatment section)

Advance Care Planning/Goals of Care - zyxTestPatient, VITALSLINK

Consent to Treatment

Enter it Here

Potential Temporary Substitute Decision Makers

	Name	Relationship	Eligible?	Reason Ineligible	Additional Doc Location and Date/Time	Phone Number(s)
Potential TSDM A	Jake Peralta	son	Eligible			250-555-2222
Potential TSDM B	Roger Peralta	ex husband	Possibly eligible, verify	estranged		250-222-4444

Results Review

Find it here

Potential TSDMs - Unranked	24-Oct-2019 17:30 PDT
Potential TSDM A Name	Jake Peralta
Potential TSDM A Relationship	son
Potential TSDM A Eligible?	Eligible
Potential TSDM A Phone Number	250-555-2222
Potential TSDM B Name	Roger Peralta
Potential TSDM B Relationship	ex husband
Potential TSDM B Eligible?	Possibly eligible, verify
Potential TSDM B Reason Ineligible	estranged
Potential TSDM B Phone Number	250-222-4444
Potential TSDM C Name	Amy Santiago
Potential TSDM C Relationship	daughter in law
Potential TSDM C Eligible?	Eligible
Potential TSDM C Phone Number	250-111-1111
Potential TSDM D Name	Raymond Holt
Potential TSDM D Relationship	friend
Potential TSDM D Eligible?	Eligible
Potential TSDM D Phone Number	250-888-7777