**Implementation Worksheet**

**Identifying High-Risk Patients / Candidates for Goals of Care Conversations**

How will high-risk patients be identified?

* + - CAN Scores
    - Multiple Hospitalizations
    - Loss of functioning/independence
    - Metastatic/Stage 4 Disease
    - Specific Diagnoses (CHF, Dementia, ALS, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who will be responsible for managing this process?

How will the team track and communicate about candidates for GOCCs?

**Preparing Patients for Goals of Care Conversations**

Who will be responsible for preparing patients and/or surrogates?

Will this occur during other appointments or by telephone?

What will be said?

**Patient Education Materials**

Which patient education materials will be used?

Who will prepares/order/copy the materials?

Are they provided to patients in advance?

If so, who does this?

**Leading Goals of Care Conversations**

Who will lead goals of care conversations?

Who will finalize the life-sustaining treatment plan with the patient (or surrogate)?

**Making Appointments**

Do you need to set up a new clinic or adjust existing clinics?

If so, who will do this?

Who will make patient appointment?

How will the scheduler be notified?

**Documenting Goals of Care Conversations**

What note is used in your facility to document goals of care conversations conducted by nurses, social workers, psychologists, and chaplains?

Who is authorized to write addenda on existing LST Progress Notes?

**Arranging Follow-Up**

How will pertinent information be communicated with the practitioner(s)?

Will follow-up with the practitioner be conducted in person or over the telephone?

How will follow-up with the practitioner, if needed, be arranged?

Who will be responsible for helping the patient with advance directives?

Who will be responsible for helping with state-authorized portable orders?

**Monitoring and Improving Quality**

What goals of care-related quality indicators will your clinic monitor and improve?

* Goals of care conversations occur with high-risk patients in your clinic
* Follow-up with the practitioner occurs to finalize LST plans
* Patients are satisfied with the process
* Documentation is complete and consistent (progress notes, orders, advance directives, state-authorized portable orders)
* Follow-up occurs after hospitalization to assess for changes to goals, decisions
* Patient’s goals and decisions are honored near the end of life
* Other

How will quality indicators be tracked?

Who will track quality indicators?

When will the team discuss quality indicators?

**Team Goals**

Who will do what by when; specific, measurable, attainable, relevant, timely

Examples:

* The HBPC team will discuss high-risk patients who may be candidates for goals of care conversations in each team meeting
* The Blue PACT team will identify and initiate goals of care conversations with five high-risk patients (CAN scores = 98 or 99) by June30

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| **Anticipated Barrier** | **Potential Solution(s)** |
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