Clinical Practice Guideline (CPG)

GOALS OF CARE

SCOPE:

☐ Family Care ☒ PACE ☒ Partnership

AUDIENCE:

Interdisciplinary Team Staff (IDTS), Clinicians, Providers

PURPOSE:

To provide best practice approach to Community Care Inc. Interdisciplinary Team Staff, Physicians and other providers who care for our members.

Community care Clinical Practice Guidelines (CPG) are recommendations intended to guide an overall approach to care. (Please see references for an in-depth review of the condition/disease.)

Individual member factors, comorbidities, member preferences and member "Goals of Care" should be considered when making recommendations for an individual member.

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CONTENTS:

1) Overview of "Goals of Care"

Community Care, in conjunction with the National PACE Association, uses a "Goals of Care" Model. This model was adapted specifically for our participants in both the PACE and Partnership programs from evidence-based published guidelines, using the collective review of experienced Community Care Clinicians, Community Care Medical Management Department, PACE,® Medical Directors, and Contracted Primary Care Physicians and is offered with the belief that shared decision-making between individual PCPs and participants/legal decision makers is optimal.

PACE® and Partnership participants are a heterogeneous group with differing health profiles, prognoses, preferences and goals of care. Life expectancy and quality of life issues require an individualized context within which to apply Clinical Practice Guidelines (CPG) that may have been developed from and for a population of non-frail adults. We recommend that whether a clinician follows any of the summary recommendations of a CPG for an individual participant, it will depend upon factors specific to that participant, including the participant's values, preferences, prognosis and life expectancy, comorbid conditions, functional status, and most importantly, the participant's "Goals of Care."

This model assumes that the "Goals of Care" for participants can be divided into three broad categories: 1) promoting longevity, (2) optimizing function and 3) palliative care. Medical

decision-making is best done in the context of overall goals of care. The clinician will need to determine which recommendations are appropriate for each individual participant, considering the participant's goals of care, preferences, life expectancy, and the expected benefit versus burdens of specific interventions.

Patients with serious, life-threatening illnesses often face challenging treatment choices and high-quality discussions about what is important to them to promote good decision-making and patient centred care. Understanding the patient's care goals, in the context of a serious illness, allows the clinician to align the care provided with what is most important to the patient. **"Goals of Care" conversations help patients with serious illness clarify what they value most and what they hope to see happens with their medical care**

2) Best Practice Standards

- The "Goals of Care" are member/LDM identified goals for healthcare based on the member/LDM's values, preferences and desires.

- The "Goals of Care" are established in discussion with the members and LDMs. These goals are reviewed with the member/LDM at least annually, with a change in condition and following a hospitalization.

- "Goals of Care" conversations are more successful if they begin with gaining a shared understanding of the member's medical conditions and possible outcomes. (See the section on Preventive Care, Management of Acute and Chronic Medical Conditions.)

  - Goals of Care:

    - Longevity: (Cure of disease; Prolongation of life)

      Member expresses a preference for life-prolonging treatment. A member with a goal of longevity typically desires unrestricted use of medically indicated treatments including CPR, invasive procedures and life-sustaining treatments (ACLS, surgery, ventilator support, dialysis, IV fluids and tube feedings).

    - Functional: (Maintenance or improvement in function; Maintenance of control; Optimized quality of life)

      Participant's main goal is to maintain function. Participant makes individualized choices to limit some invasive procedures that are not consistent with that goal. Limited procedures may include CPR, mechanical ventilation, other life-sustaining treatments and speciality consultations.

    - Comfort (Palliative): (Relief of suffering; Support for families and loved ones; Good death)

Member desires treatments aimed at providing comfort only. Treatment choices focus on relieving pain and other symptoms and limiting invasive, life-sustaining treatments such as CPR, mechanical ventilation, dialysis and surgery.

3) Preventive Care, Management of Acute and Chronic Medical Conditions

➢ Patient Defined Goals

- Exploring goals of longevity, functional or comfort in advance of treatment decisions, whether for preventive care or management of acute and chronic medical conditions, helps clinicians understand patient motivations for or against particular treatment.
- Discussions about the member/LDM personal goals or the overarching goals of treatment such as prolonging life, optimizing quality of life or focusing on comfort. Examples include being able to recover enough to engage in meaningful conversation, being comfortable or living to a specific event.

➢ Treatment Preferences

- Explore with member/LDM how a particular treatment will help the patient attain their goals and if it is concordant with their values.
- Consider treatment decision involving a particular intervention such as a surgery or medication in light of the broader categories of values, goals and general treatment preferences, as well as medical evidence and expert opinion about the value of a particular treatment.
- Older adults are particularly at risk for polypharmacy, ordering of duplicative or unnecessary testing and referrals for potentially unwanted evaluations. The American Geriatrics Society has joined the Choosing Wisely campaign, making a series of recommendations about specific treatments with the goals of reducing burdensome polypharmacy and the ordering of screening tests that are unlikely to benefit older adults.

➢ The Clinical Context

- The “Goals of Care” are also dependent upon the clinical situation and prognosis. Knowing the likely outcomes of the patient’s condition, as well as the range of options, is essential to the decision-making process. Among geriatric patients, clinical features such as frailty and functional status vary widely from patient to patient. Comorbidities also complicate estimates of prognosis for older adults

➢ Treatment Plans

- After the “Goals of Care” conversation, decisions need to be communicated and translated into medical treatments. Appropriately documenting the decisions made, as well as the reasons for the decisions, are important to future decision-making. The

decision may lead to proceeding with a surgery, a hospital admission or other major intervention.

- Treatment planning also involves deciding ahead of time about emergent interventions such as code status, intubation, artificial nutrition, elective intubation, antibiotics, etc. Such decisions should be documented in the member medical record (utilizing the appropriate form in Electronic Medical Records (EMR) e.g., Intergy utilized by Community Care or by DNR orders in the hospital or Do Not Hospitalize orders in the nursing home setting.

➢ Specialty Consultation in Goals of Care

- "Goals of Care" has the potential to raise difficult ethical issues and can lead to conflict between families, patients and clinicians, IDT and even among clinicians. Clinicians may experience moral stress, the feeling that they know the right thing to do but are constrained from carrying it out. Discordance among values, goals and treatments can be an important source of moral distress and ethical conflict. In such cases, palliative care consultations and ethics consultations can help to readdress decision-making. Additionally, when emotional or religious concerns are prominent, social workers and chaplains can play a role in providing support and navigating the decision-making process.

4) Process for Interdisciplinary Team Staff (IDTS)

- Review "Goals of Care" with the member/LDM at initial, or within first six months of enrollment and then at least annually, when there is a change of condition and following a hospitalization.
- Share the member "Goals of Care" with the IDT at care plan meetings, change of condition, etc.
- Re-initiate a "Goals of Care" discussion with the member/LDM utilizing a shared decision-making process when the member "Goals of Care" are not aligned with the member disease burden and life expectancy.
- Consider an Advanced Disease Support consultation, if the member goals are not aligned with member disease burden and life expectancy or if member is on a Palliative/Comfort focused care plan.
- Use "Goals of Care" to guide your ordering of Preventative Health Screens, application of Clinical Practice Guidelines, treatment decisions for acute and chronic medical problems, prescribing medications, authorizing services, etc.
- Use motivational interviewing techniques to assess barriers to recommended preventive and other health care, eliciting decision-making preferences, understanding

fears and goals, exploring views on trade-offs and impaired function and wishes for family involvement.

- PACE PCP or Partnership NP to document "Goal of Care" in member assessment using the appropriate form in the EMR system in Intergy utilized by Community Care.

5) Quality Assurance Monitoring

- Community care monitors quality of care provided to all its members via Internal File Review (IFR), target audits, risk reports, HEDIS data, Acumen data, Electronic Health Record Guideline Reports, Clinical Dashboards and feedback from providers.
- Community care recognizes that Clinical Practice Guidelines are intended to assist in decision-making and may not apply to all members or circumstances, and complete compliance is not expected for all guidelines.

6) References

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