



Care Planning Meeting Policy

New York–Reducing
Avoidable Hospitalizations

Purpose

This policy defines a protocol to ensure that palliative care is integrated into the care planning process.

Responsibility: Physician, NP or PA, social worker, nurse, and pastoral care representative.

Scope

Care Planning Meetings are regularly scheduled meetings (within 14 days of admission and quarterly thereafter unless triggered by a significant change, transfer, or discharge) whose purpose is to discuss resident status, clinical condition, and goals of care. The care plan is developed through the input of patient, family, caregivers, and involved healthcare providers. The care planning meeting is an ideal time to discuss Palliative Care.

The care plan process includes structured assessment and documentation to include:

- Physical and psychological assessment, which addresses the current disease status, treatment options, functional status, expected prognosis, symptom burden and psychological coping.
- Social and spiritual assessment, which addresses the social, practical, religious, spiritual, existential concerns, and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability and stress, access to medicines and equipment.
- Cultural assessment, including, but not limited to, locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for complementary and alternative medicine,

Attendees of care planning meetings include nursing, social work and representatives from the medical team (MD or NP). A speech pathologist and/or dietician may attend if the resident shows signs and symptoms of dysphagia and/or significant weight loss. In addition, it is recommended that the resident and/or family members/significant others be present during the meeting. Care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex, competing and shifting priorities in goals of care.

The MD, NP, or PA ***must*** be represented at care planning meetings where advance directives will be addressed. Unless otherwise agreed by the facility, information regarding the resident's medical condition and diagnostic and treatment options is to be provided to the resident and/or family by an MD or NP. Information should be provided in plain, clear, empathetic, non-medical terminology.

Palliative care interventions such as completion of MOLST and health care proxies ***cannot*** proceed without initial counseling on diagnosis and treatment options. For those residents in whom DNR/DNI/DNH orders are completed at an initial care planning meeting, attendance by the MD or NP at subsequent meetings is not required but may be requested if a significant change in status has occurred.

Family contact information should be provided for SNF staff present at the meeting so that the social worker can contact the family within one day of the care planning meeting to ask if they have any further/follow up questions and/or additional concerns that may have arisen from the meeting.

Protocol

1. All members present should introduce themselves including their name, title and role
2. The goal of the meeting should be clearly stated, covering the resident's medical issues, treatment options and preferences for care that may need to be updated. Palliative care and MOLST discussion(s) also takes place at the care planning meeting. Information is to be offered, not forced, on residents and families.
 - a. The following is a suggested way that clinical information be presented: "Would it be helpful to you if we explain in clear and straightforward terms what illness you have, what your options are for treatment, and how the illness is likely to progress over time?"
3. Inquire as to prior living arrangements and functional status and any issues felt relevant by resident and/or family;
4. Discuss goals of care (e.g., rehab and discharge, ongoing custodial residency, return home with services, etc.);
5. Elicit resident and/or family preferences;
6. Discuss specific symptom management needs (e.g., pain, constipation, etc.) as well as spiritual support needs;
7. Present medical issues and treatment options, and likely illness trajectory (e.g., weight loss in dementia, etc.);
8. Discussion and completion of Palliative Care and MOLST
 - a. NOTE: if MOLST is not completed at the initial planning meeting, a clear schedule for follow-up should be established, whether by phone or by follow up meeting;
9. Make sure a box of tissues is available!

References: National Quality Forum / Center to Advance Palliative Care Crosswalk http://www.capc.org/capc-resources/capc_publications/nqf-crosswalk.pdf.