PLANNING THE GOALS OF CARE CONVERSATION

- **Arrange an appointment**: 15-30 min.
- **Any platform works**: In person, Telehealth, or Virtual Care.
- The conversation can be part of **outreach, monitoring and care of high-risk patients, or CDM.**

- **Suggested patients**
  - **>70 yo and comorbidities**: HT, DM, COPD, cancer, IHD, CHF, CKD, Neurodegen, Dementia, etc
    OR
  - **Other patients** that you know to be appropriate
    OR
  - Consider the '**Surprise question'** - would you be surprised if this person died in the next year?

- Use **MOST Form** (Medical Orders for Scope of Treatment) to document the plan.
  - First spend a moment to become familiar with the form:)
  - You can also use the simple DNR form.
- After the conversation, **fax MOST and/or DNR to LGH Health Records**, if patient agrees.
  - **604.984.5718**
- **Billing options**
  - 13037, 13038 (Telehealth/VC encounter)
  - 14033, 14063 ,14075 (Complex Care)
  - 14050, 14051 etc (Chronic Care Incentives)
  - Other as appropriate
  - Remote billing changes

- **Helpful Resources** (there are many great websites and links. Here are a few of them).
  - PHYSICIAN
    - ADVANCE DIRECTIVE
    - DNR
    - EDITH (Expected death in the home)
    - MOST FORM
    - PATHWAYS
    - RESOURCES ON RESUSCITATION
    - UBC PALL CARE COVID-19 APPROACH

  - PT/FAMILY
    - ABOUT CPR
    - ADVANCE CARE PLANNING RESOURCE
    - CARING CONVERSATIONS
    - MY VOICE: 56 PAGE ACP WORKBOOK
    - UNDERSTANDING DNR