Goals of Care Discussions

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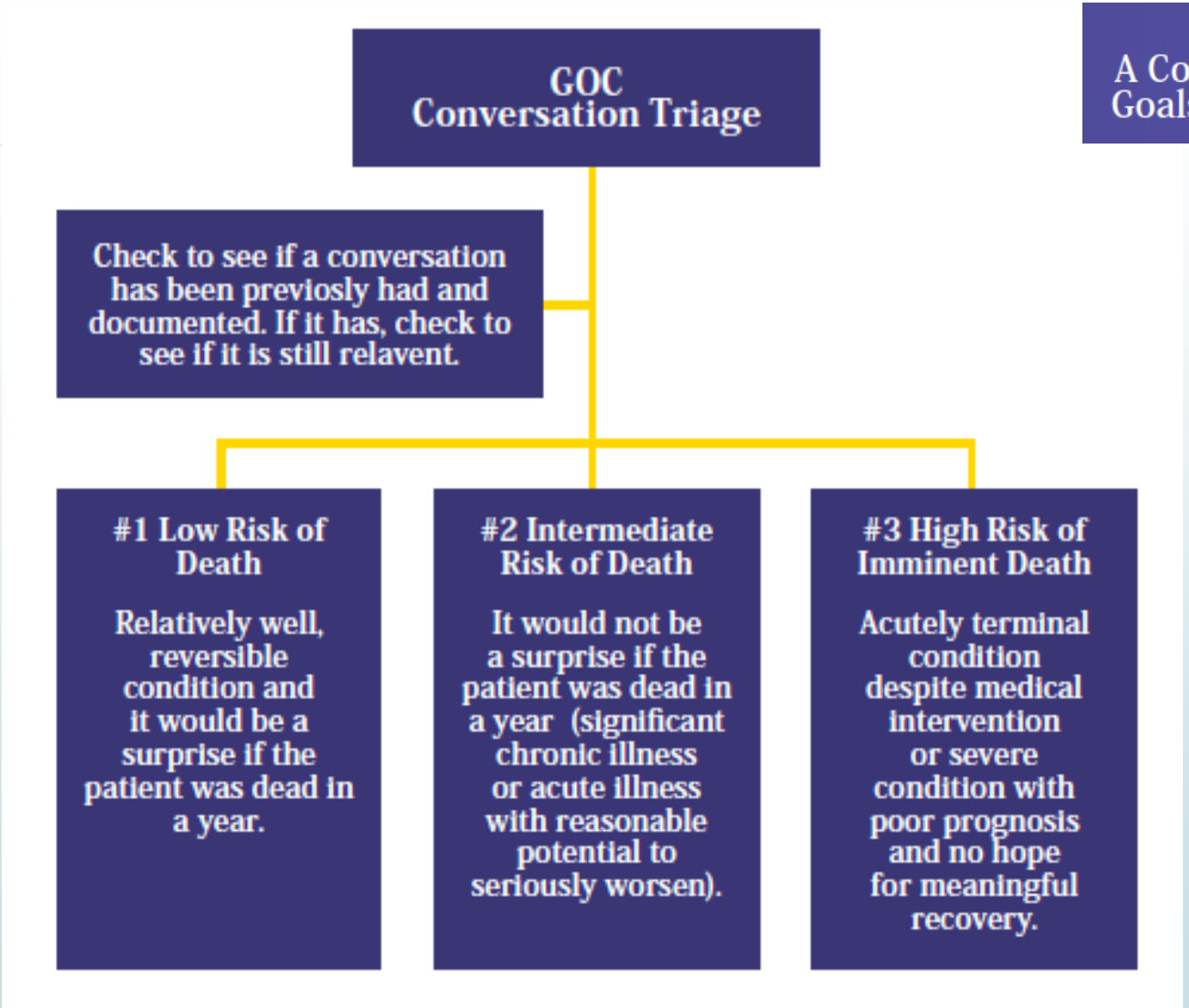
Advance Care Planning

- Advance care planning is a process by which patients consider options for future health care decisions and identify their wishes.
  - ***Not*** *about making specific medical decisions*
  - Preparing patient and SDM(s) for future decisions
    - Plan for making personal and health care decisions in the event that a person become unable to do so him/herself in the future
    - Identifying SDM(s) and deciding on a POA may be part of process

Goals of Care Discussion

- A conversation that incorporates a patient's prior discussed wishes and preferences into the current clinical context
  - Should consider values and preferences
  - Includes prognostic disclosure (where appropriate)
  - Results in a plan of care
  - Is *not* just about code status, but may include a discussion of code status
  - Is dynamic; may change as a patient's clinical status changes

JUST ASK:
A Conversation Guide for Goals of Care Discussions



"Hope does not lie in a way out but in a way through."

– Robert Frost

Approaches to Goals of Care Discussions

- Just Ask – A Conversation Guide for Goals of Care Discussions
  - https://www.thecarenet.ca/docs/ACP%20Just%20Ask%20Booklet-rev-May8_FINAL-web.pdf
- Serious Illness Care Program
  - https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
- VitalTalk
  - https://www.vitaltalk.org/

- All 3 resources recommend similar content in the discussions

Serious Illness Conversation Guide

1. Set-up Conversation
2. Assess Understanding and Preferences
3. Share Prognosis
4. Explore Key Topics
5. Close the Conversation
6. Document Your Conversation
7. Communicate with Key Clinicians

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Table 1. Examples of Clinician Statements to Guide Conversations Regarding Goals of Care

REMAP	Physician Statement
Reframe	"You've worked very hard with all the treatments over the years, and I hear that now you're feeling more tired and it's harder for you to do the things you enjoy. I'm seeing that you're in a different place now. Further treatments may be too hard on you."
Emotion	"What worries you most about this?" "It's understandable that you would feel sad when thinking about these things." "This is hard to talk about." "Is it OK to talk about what this all means for the future?"
Map	"Tell me about some of the things you enjoy doing." "What's most important to you given that time is limited?"
Align	"From what I'm hearing from you, the most important thing for you is to have time at home, sitting on the porch with your family. You feel like at this point you've spent too much time in the hospital, and you wouldn't want to come back if it could only extend your life a few days or weeks."
Propose a Plan	"Given what you've told me, I'd propose that we do everything to help you spend time at home with your family. I don't think more cancer treatment is likely to help with that. I think getting hospice involved would help you do what you want to do with the time you have. What do you think?"

Serious Illness Conversation Guide - *Principles*

- Patients want the truth about prognosis
- You will not harm your patient by talking about end-of-life issues
- Anxiety is normal for both patient and clinician during these discussions
- Patients have goals and priorities besides living longer; learning about them empowers you to provide better care
- Giving patients and families opportunity to express fears and worries is therapeutic
- Titrate conversation based on patient's responses

Serious Illness Conversation Guide - *Practices*

- **Do:**
  - Give a direct, honest prognosis when desired by patient
  - Present prognostic information as a range
  - Allow silence
  - Acknowledge and explore emotions
  - Focus on the patient's quality of life, fears, and concerns
  - Make a recommendation ("Based on XX medical situation, YY treatment options, and ZZ important goals and values, I recommend...")
  - Document conversation

Serious Illness Conversation Guide - *Practices*

- **Do Not:**
  - Talk more than half the time
  - Fear silence
  - Give premature reassurance
  - Provide factual information in response to strong emotions
  - Focus on medical procedures

Serious Illness Conversation Guide - *Set Up the Conversation*

- Introduce Purpose
- Prepare for Future Discussions
- Ask Permission

SET UP

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

Serious Illness Conversation Guide -
Assess Understanding and Preferences

ASSESS

"What is **your understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

Serious Illness Conversation Guide - *Share Prognosis*

- Share Prognosis
- Frame as a "wish...worry", "hope...worry" statement
- Allow silence, explore emotion

SHARE

"I want to share with you **my understanding** of where things are with your illness..."

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."
OR
Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year).*"
OR
Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

Serious Illness Conversation Guide - *Explore Key Topics*

- Goals
- Fears and worries
- Sources of strength
- Critical Abilities
- Tradeoffs
- Family

Serious Illness Conversation Guide -
Explore Key Topics

EXPLORE

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

Serious Illness Conversation Guide - *Close the Conversation*

- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

CLOSE

"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

Approaches to Goals of Care

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- Vital Talk – REMAP

1. **R**eframe
2. **E**motion
3. **M**ap
4. **A**lign
5. **P**ropose a plan

My Approach to the "Acute" Goals of Care Conversation

- Introduce yourself/Set-up Conversation
- Assess understanding or what they have been told so far
- Explain the current situation clearly and the need for decisions about care
- Explain the options
  - Risk/benefits of each option
    - This should include some discussion quality of life that might be expected is person survives and what they may have to go through (possible physical and emotional suffering)
- Discuss prognosis
  - " Even with admission to ICU including aggressive and invasive care think your loved one is unlikely."
- Elicit preferences and/or pre-expressed wishes
- Try to help people frame decisions in terms of the patients goals

CPSO - PLANNING FOR AND PROVIDING QUALITY END-OF-LIFE CARE

- Physicians **must not** unilaterally make a decision regarding a no-CPR order.Before writing a no-CPR order in the patient's record, physicians **must** inform the patient and/or substitute decision-maker that the order will be written and the reasons why.[13]
- If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians **must** engage in the conflict resolution process as outlined in this policy and **must not** write the no-CPR order while conflict resolution is underway.
- If the patient experiences cardiac or respiratory arrest while conflict resolution is underway regarding the writing of a no-CPR order, physicians **must** provide all resuscitative efforts required by the standard of care, which may include CPR.[14]

COVID Ready Communication Skills

A Playbook of Vital Talk Tips

- https://www.vitaltalk.org/guides/covid-19-communication-skills/

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Deciding When things aren't going well

What they Say	What you Say
I want everything possible. I want to live.	We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? **What do I need to know about you to do a better job taking care of you?**
I don't think my spouse would have wanted this	Well, let's pause and talk about what they would have wanted. Can you tell me what they considered most important in their life? **What meant the most to them, gave their life meaning?**
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. **Can you say more about what you mean?**
I am not sure what my spouse wanted—we never spoke about it.	You know, many people find themselves in the same boat. This is a hard situation. To be honest, given their overall condition now, if we need to put them on a breathing machine or do CPR, they will not make it. The odds are just against us. **My recommendation is that we accept that he will not live much longer and allow him to pass on peacefully.** I suspect that may be hard to hear. What do you think?

What can you do?

- Doctors
  - Have more conversations
  - Document conversations well - consider dictating so they show up in Meditech
- Interprofessional Team
  - Recognize opportunities to initiate discussions within your scope of practice
  - Collaborate with interprofessional team to ensure patients goals are understood by everyone

What can you do?

- Access resources below to improve your approach and skill in having these conversations
  - https://www.vitaltalk.org/guides/covid-ready-communication-skills/
  - https://www.thecarenet.ca/docs/ACP%20Just%20Ask%20Booklet-rev-May8_FINAL-web.pdf
  - https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
  - https://www.vitaltalk.org/
  - https://www.vitaltalk.org/vitaltalk-apps/ (Vital Talks Tips App)

- *Remember you can always ask for help*

"The single biggest problem in communication is the illusion that it has taken place."

– George Bernard Shaw