MI-CCSI
Center for Clinical Systems Improvement

Serious Illness Conversations

Today's Presenter

Mary Beth Billie, DNP, RN-BC, CCM

MI-CCSI
Center for Clinical Systems Improvement

Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Objectives

At the conclusion of this presentation the participant will be able to:

1. Define a serious illness conversation.
2. Describe the difference between a Serious Illness Conversation and an Advanced Directive.
3. Name two Serious Illness Conversation trigger criteria.
4. Identify two communication skills that can enhance a Serious Illness Conversation.
5. Utilize role playing to practice using the Serious Illness Conversation guide.

Acknowledgements

- Veteran's Administration Life Sustaining Treatment Decision Initiative (LSTDI)
- Serious Illness Conversation Program (SICP) Ariadne Labs
- The Conversation Project- Institute for Healthcare Improvement

VA

U.S. Department of Veterans Affairs
Veterans Health Administration
National Center for Ethics in Health Care

ARIADNE LABS
BRIGHAM AND WOMEN'S HOSPITAL
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

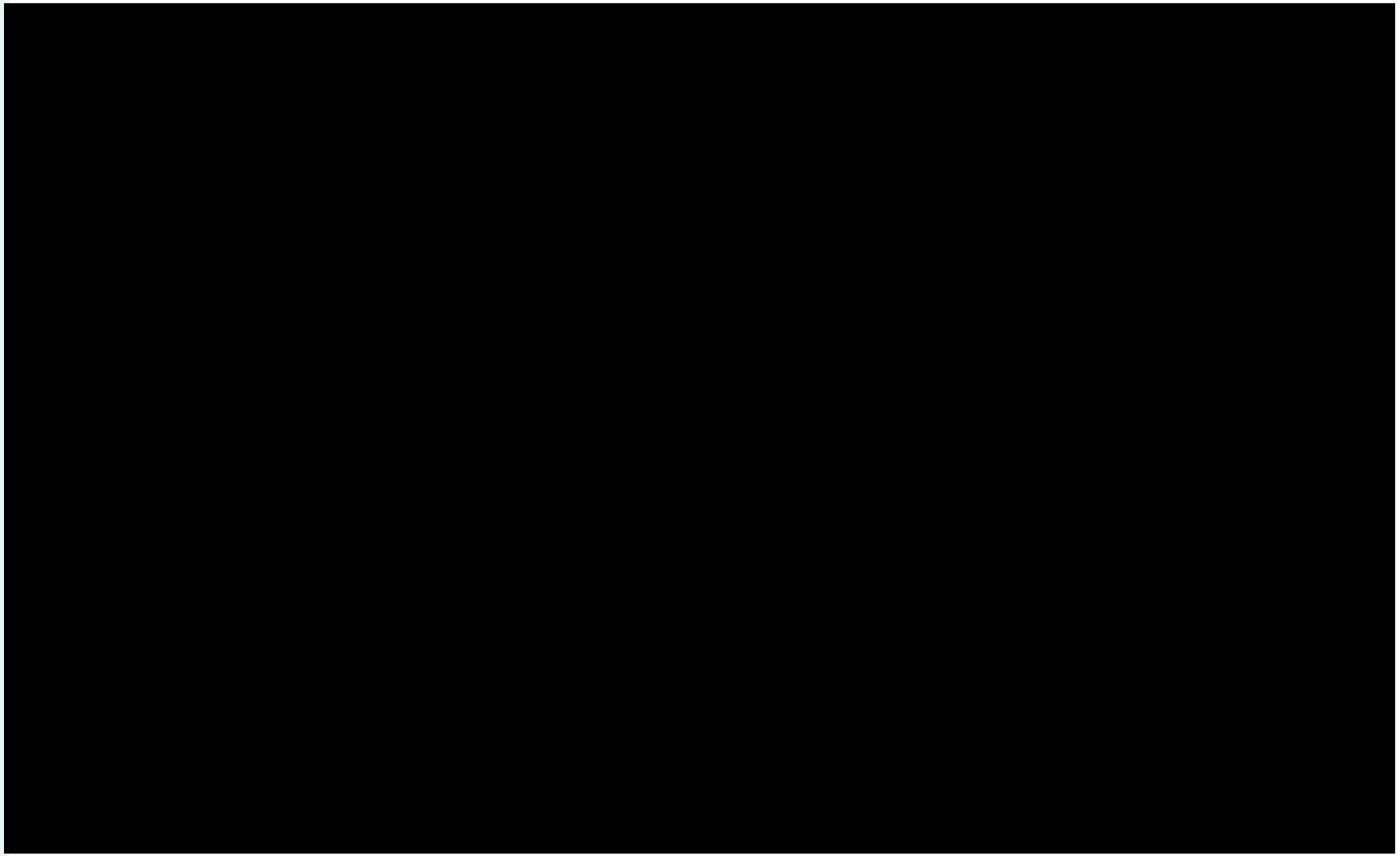
the conversation project

Institute for Healthcare Improvement

Let’s Begin

“In some respects, this century’s scientific and medical advances have made living easier and dying harder.”

Report from the field: Approaching Death: Improving Care at the End of Life-A Report of the Institute of Medicine (IOM, 1997)



https://www.pbs.org/video/frontline-facing-death-excerpt-one-mount-sinai-icu/

MI-CCSI
Center for Clinical Systems Improvement

Conversations are Infrequent, Late and Limited

Infrequent

- Fewer than 1/3 of patients with end-stage diagnoses reported end-of-life (EOL) discussion with clinicians

Late

- First EOL discussion 33 days before death in patients with advanced cancer
- 55% of initial discussions occurred in hospitals

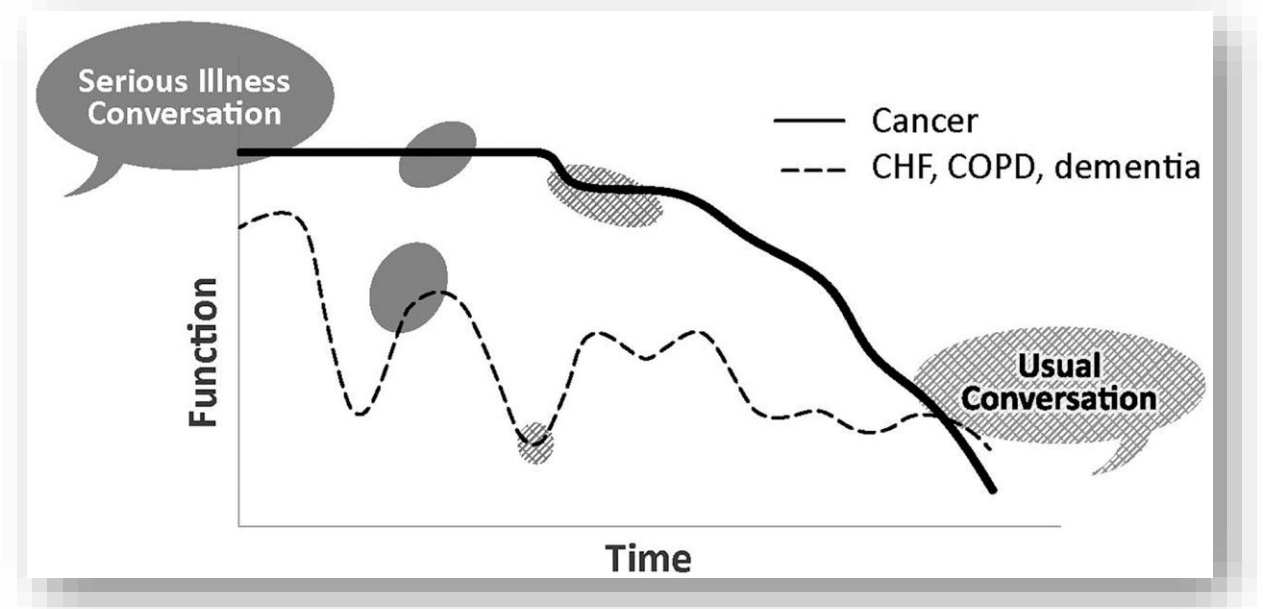
Limited

- Conversations often fail to address key elements of quality discussions
- When conversations take place, outcomes of discussions are often not documented/difficult to retrieve or not captured accurately.

Heyland et al., 2009; Mack, et al., 2012 ;Wright et al., 2008

Early conversations about patient values and goals linked to better serious illness care

- Increased goal-concordant care
- Improved quality of life / patient well-being
- Fewer hospitalizations
- More and earlier hospice care
- Better patient and family coping



Mack, 2010; Wright, 2008; Chiarchiaro, 2015; Detering, 2010; Zhang, 2009

MI-CCSI
Center for Clinical Systems Improvement

Failure to recognize and honor patient's values and goals associated with harm

- Poor quality of life and unnecessary physical and emotional suffering for patients
- Increased family distress
- Poor alignment of medical care with patient wishes
- Prolonged, undesired hospitalizations and ICU stays
- Distress among clinical staff
- Harm of not getting benefits of conversations
- Harm of getting unwanted care

Wright et al., 2008; Wright et al., 2010, Teno et al., 2007, Teno et al., 2004, Wright et al., 2016

Multifactorial

If we know earlier conversations have better outcomes why aren't we having them?

- Curriculum deficits regarding End of Life care
- Lack of clinician communication skills training
- Lack of interprofessional collaboration
- Variance in chronic disease trajectories (i.e., CHF, COPD, ESRD)
  - Life expectancy increased 10 years since 1960 (69 to 79)
  - 69% will develop disabilities before they die and 35% will eventually enter a nursing home
  - 90% will live with one or more serious illnesses in the final year of their life.
- Major advances in technology and treatment options
- US healthcare system default is more care (medical model)

Institute of Medicine, 1997, 2005

Lunney et al., 2002; Lynn & Adamson, 2003

Shift to Serious Illness Care Terminology

Serious Illness (SI)- *"disease(s) that carry a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains the caregiver." (Kelley & Bollens-Lund, 2018)*

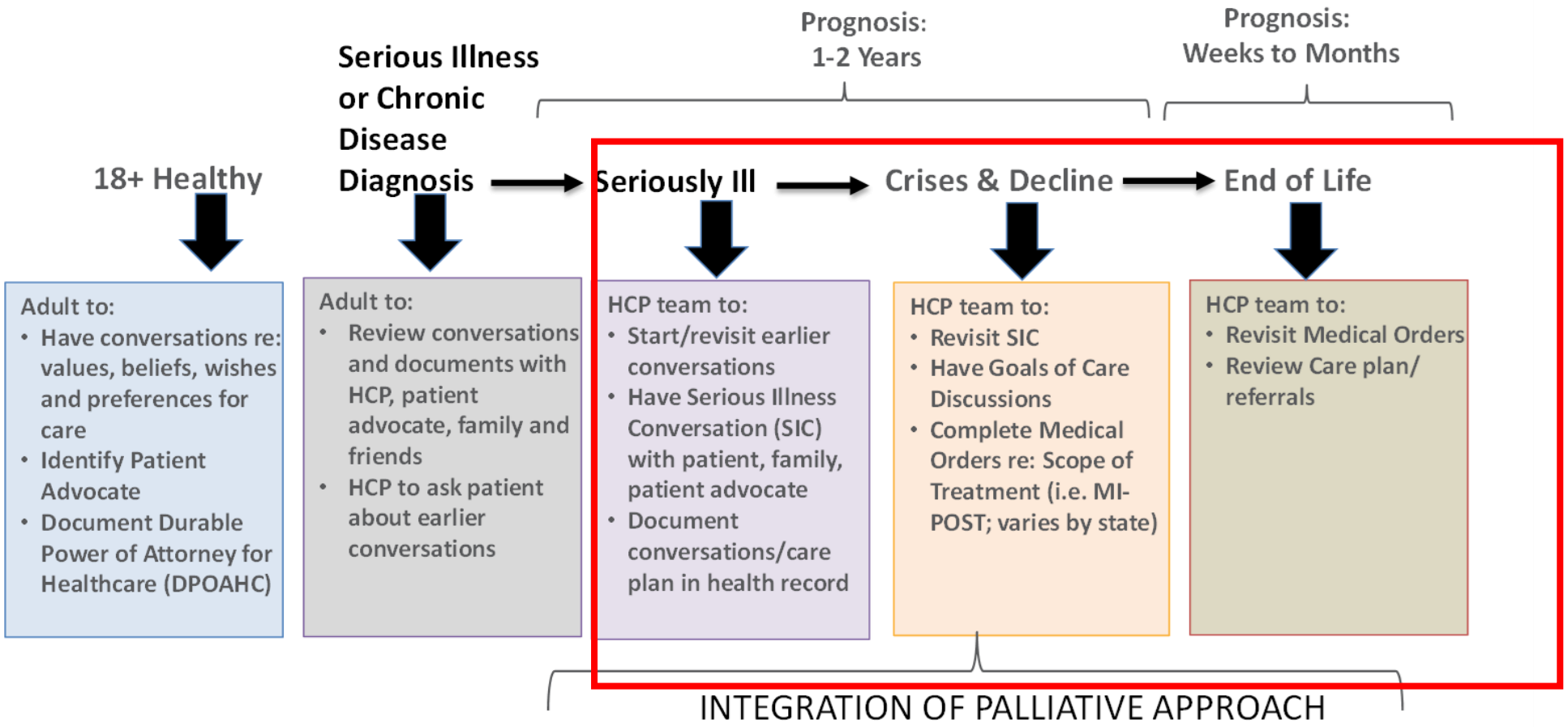
Serious Illness Conversation- *A clinician facilitated conversation with individuals with a serious illness to determine goals, values and preferences that then inform the serious illness plan of care.*

- *Often a series of conversations*
- *Often involves patients and families*

A Serious Illness Conversation is NOT:

- ***Discussion of medical treatments***
- ***Completing Advanced Directives Forms such as HCPOA and POLST forms***
  - ***CPR and DNR discussions***
- ***Referrals to Palliative Care or hospice (can be an outcome of SI conversation)***

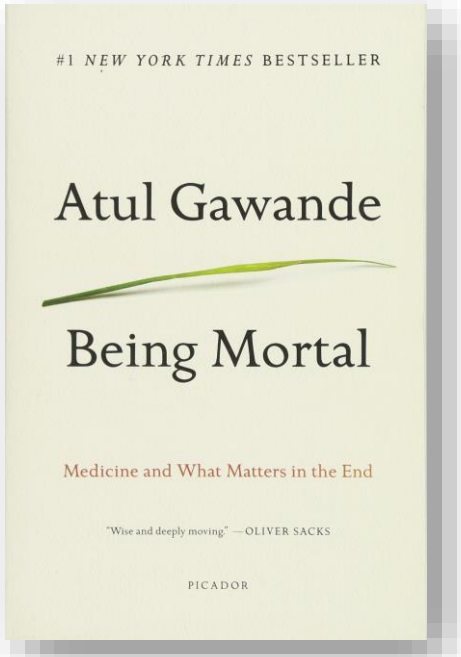
Advance Care Planning Continuum



Advance Care Planning - Planning in Advance of Serious Illness
Serious Illness Care Conversation - Planning in the context of progression of serious illness
Goals of Care Discussion- Decision making in context of clinical progression/crisis/poor prognosis

BC Centre for Palliative Care Draft, 2017, Adapted from Ariande Labs

Serious Illness Conversations

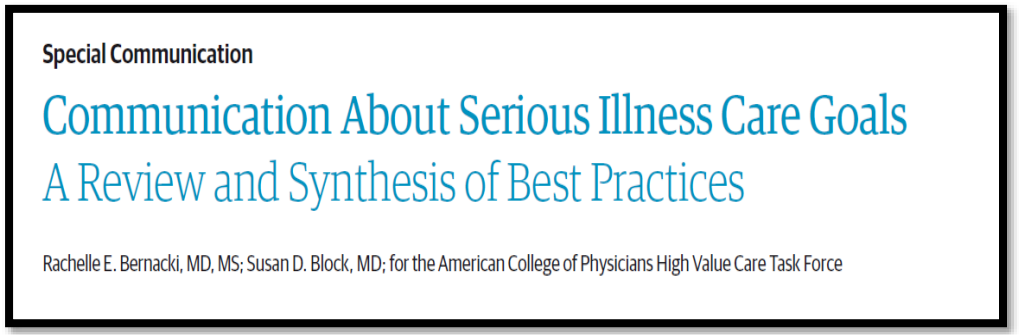


https://www.youtube.com/watch?time_continue=11&v=45b2QZxDd_o

Evidence Based Intervention

Written for and Endorsed by the American College of Physician High Value Care Task Force **:**

A System Approach to Serious Illness Communication


Special Communication

Communication About Serious Illness Care Goals

A Review and Synthesis of Best Practices

Rachelle E. Bernacki, MD, MS; Susan D. Block, MD; for the American College of Physicians High Value Care Task Force

1. Mechanisms to **identify patients** who would benefit from a SI conversation
2. Prompts to **remind clinicians** to engage in SI conversations at the right time
3. Use of **structured communication guide**
4. Serious Illness (SI) **communication training**
5. Patient and family **education**
6. A system for **documenting personalized patient goals and priorities** in the electronic health record

Bernacki & Block, 2014

Identification - The Denominator Challenge

- Diagnosis
  - Dartmouth Atlas of Healthcare **9 serious chronic conditions accounts for 90% of death**
    - Modified above criteria to find most severely ill
- Utilization
  - Inpatient
- Measures of Need Domains: **high need if 2 or more** of following are positive
  - Functional dependence
  - Nutritional decline
  - Cognitive impairment
  - Pain limiting symptoms
  - Caregiver strain

Kelley & Bollens-Lund, 2018

1 Serious Medical Condition[a] (18% of total FFS population)

↓

Hospitalization in past 6 months (7% of total FFS pop)

↓

Outcomes in 1 year			% of group that is:		
Total Medicare Costs, mean	Hospital Stay	Death	Top 10% costs	2+ needs screen	ADL Impairment
$30,489	53%	25%	37%	82%	67%

Adjusted C- statistic adjusted death within 1 year .78 (Bollens & Kelley Lund, 2018)

1 Serious Medical Condition[a] (18% of total FFS population)

↓

Hospitalization in past 6 months (7% of total FFS pop)

↓

Dependent for 1 or more Activities of Daily Living (4% of total FFS pop)

↓

Outcomes in 1 year			% of group that is:		
Total Medicare Costs, mean	Hospital Stay	Death	Top 10% costs	2+ needs screen	ADL Impairment
$34,425	58%	30%	42%	95%	100%

Adjusted C- statistic adjusted death within 1 year .77 (Bollens & Kelley Lund, 2018)

Serious Illness Criteria

Consider SI conversation if patient meets ANY of the following criteria:

Disease Based Criteria

Inpatient admission in last 6 months & one of the following:

- Cancer with poor prognosis, metastatic or hematologic
- Chronic obstructive pulmonary disease or interstitial lung disease, only if using home oxygen or hospitalized for the condition
- End stage renal failure
- Congestive heart failure, only if hospitalized for the condition
- Advanced liver disease or cirrhosis
- Diabetes with severe complications (ischemic heart disease, peripheral vascular disease and renal disease)
- Advancing dementia

Serious Illness Criteria

Additional Criteria Categories

Utilization/ Functional Status Criteria

- Two or more unplanned hospital admissions within past 6 months
- Resides in long term care facility
- Significant and rapid decline in ability to complete ADL's

Why Use a Structured Guide

Dr. Susan D. Block is a Professor of Psychiatry, Chief of Psychosocial Oncology and Palliative Care at the Dana-Farber Cancer Institute and the Co-Director of the Harvard Medical School Center for Palliative Care.

https://www.youtube.com/watch?v=mByh7f7F7a8

Why use a structured communication tool?

- Structure increases Confidence
- Assures adherence to key processes
- Achieve higher level of baseline performance
- Ensures completion of necessary tasks during a complex, stressful situation

Roles and Responsibilities

RNs/SWs/Chaplains/MDs/APRNs/PAs	MDs/APRNs/PAs ONLY
• Introduce the goals of care conversations • Discuss role of the surrogate • Elicit understanding of diagnosis and prognosis • Elicit patient's values, goals • Provide basic information about LSTs & services • Document the conversation	• Deliver news about diagnosis and prognosis • Establish a Life Sustaining Treatment plan with patient (or surrogate) • Complete Life Sustaining Treatment ST Progress Note and Orders

https://www.ethics.va.gov/GoCC.asp

Keys to a Successful Conversation

MI-CCSI
Center for Clinical Systems Improvement

Principles

- Patients have goals and priorities besides living longer; learning about them empowers you to provide better care
- You will not harm your patient by talking about end-of-life issues
- Managing your own and the patients' anxiety are key tasks in this conversation.
- Patients want the truth about prognosis
- Giving patients an opportunity to express fears and worries is therapeutic

Practices

- Follow the guide while you are learning it
- Talk less than half the time
- Allow silence
- Acknowledge and explore emotions
- Focus on the patient's quality of life, fears, and concerns

Prepare for Conversation

To optimize your Serious Illness Conversation with the patient provide the “What Matters to Me” workbook in advance of your conversation.

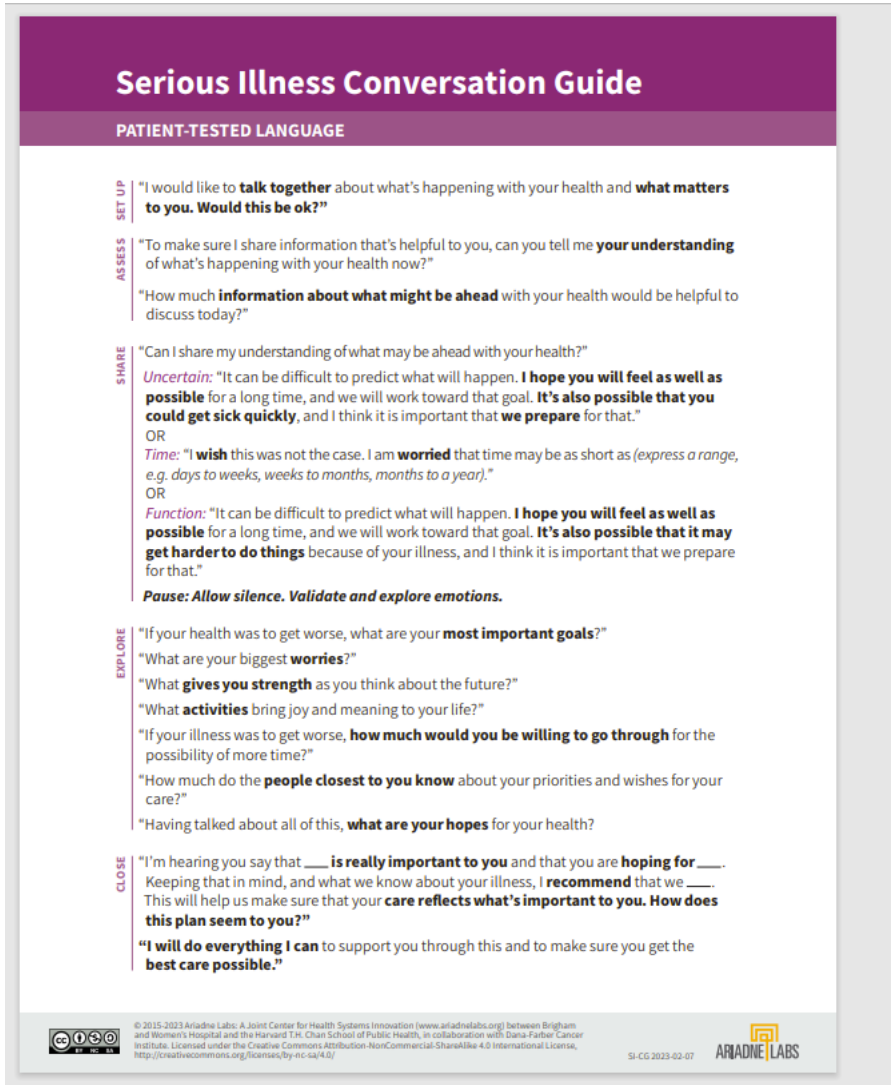
The workbook is designed to help people with a serious illness get ready to talk to their health care team (doctor, nurse, social worker, etc.) about what is most important to them.

Discuss

- What is challenging about having a serious illness conversation with your patients?

Components of the Structured Guide

1. **Introduce** conversation and obtain permission
2. **Assess** understanding of health status and desire for information
3. **Share** prognosis within scope of practice
4. **Explore** values and goals for care
5. **Summarize** and **Close**



Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I would like to **talk together** about what's happening with your health and **what matters to you. Would this be ok?"**

ASSESS

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

SHARE

"Can I share my understanding of what may be ahead with your health?"

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that you could get sick quickly**, and I think it is important that **we prepare** for that."

OR

Time: "I **wish** this was not the case. I am **worried** that time may be as short as *(express a range, e.g. days to weeks, weeks to months, months to a year).*"

OR

Function: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence. Validate and explore emotions.

EXPLORE

"If your health was to get worse, what are your **most important goals**?"

"What are your biggest **worries**?"

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

"What **activities** bring joy and meaning to your life?"

"If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"

"How much do the **people closest to you know** about your priorities and wishes for your care?"

"Having talked about all of this, **what are your hopes** for your health?

CLOSE

"I'm hearing you say that ___ **is really important to you** and that you are **hoping for** ___. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your **care reflects what's important to you. How does this plan seem to you?"**

"I will do everything I can to support you through this and to make sure you get the **best care possible."**

MI-CCSI
Center for Clinical Systems Improvement

Introduce Conversation

Provide purpose of the conversation and obtain patient's agreement to engage.

"I would like to **talk together** about what's happening with your health and **what matters to you Would this be okay?"**

Helpful Tips

- *Normalize the conversation …"this is an approach that is use for all patients with serious illness".*
- *Emphasize you prefer to do this when things are stable, so that there is more time to consider the issues.*
- *Frame the conversation as allowing the patient to be in control and relieve the burden of decision making for their loved ones.*
- *No need to make decisions today.*

MI-CCSI
Center for Clinical Systems Improvement

Assess Understanding

Purpose-assess the extent of alignment of patient expectations and medical realities.

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

Potential probes

- *Tell me what you understand about your COPD, etc.*
- *What changes have you noticed over the past few months?*
- *Tell me more….. Can you expand on that?*

Share Prognosis
(within scope of practice)

Purpose- help patient prepare for what may be ahead.

"Can I share my understanding of what may be ahead with your health?" (***Choose EITHER Uncertain, Time OR Function statement below."***

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time and we will work towards that goal. **It's also possible that you could get sick quickly,** and I think it is important that **we prepare** for that."

OR Time: "I **wish** this were not the case, I am **worried** that time may be as short as (express a range, e.g. days to weeks. Weeks to months, months to a year.)."

OR Function "It can be difficult to predict what will happened**. I hope you will feel as well as possible** for a long time, and will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence, validate and explore emotions.

Physician: What if I Don't Know the Prognosis?

https://www.youtube.com/watch?v=GC-FZ-h6qmQ

Nurse: Sharing a Functional Prognosis

https://www.youtube.com/watch?v=CEUo6TzxLBE&t=11s

MI-CCSI
Center for Clinical Systems Improvement

Explore Values and Goals

Purpose- elicit values and goals to inform the current/future serious illness plan of care.

- "If your health was to get worse, what are your **most important goals?"**
- "What are your biggest **worries?**"
- "What **gives you strength** as you think about the future?"
- "What **activities** bring joy and meaning to your life?"
- "If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"
- "How much do the **people closest to you know** about your priorities and wishes for your care?"
- "Having talked about all of this **what are your hopes** for your health?

MI-CCSI
Center for Clinical Systems Improvement

Summarize and Close

Purpose-ensure understanding of patient goals and recommend next steps for the plan.

"I'm hearing you say that _____ **is really important to you** and you are **hoping for** _____. Keeping that in mind, and what we know about your illness, I **recommend** that we _____. This will help us make sure that your **care reflects what's important to you."**

"How does this plan seem to you?"

"I will do everything I can to support you through this and to make sure that you get the best care possible."

Document Conversation

- **Discussion Date: MM/DD/YYYY**
  - Patient completed a(n) in-person/telephone interaction. (Chose one)
  - The patient spoke with the nurse/ social worker to discuss goals of care and advance care planning. *(Choose one)*

- **Patient stated understanding of Health Condition: (use "quotes" as much as possible):**

  i.e. I am getting sicker, I have been in the hospital more this last year, my doctors hasn't really said anything specific but I think I am getting worse

- **The following topics were discussed (*use "quotes" as much as possible)*:**
  - Values/important goals if patient were to get sicker: *(from Care Goals worksheet for example, maximize function, not suffer, don't let family be present)*
  - Biggest concerns/worries: *(i.e., suffocating from COPD, being in high levels of pain, moving into a SNF)*

- **Optional if discussed**: End of life preferences were also discussed with the patient and s/he expressed the following

Key Communication Skills

1. Open Ended Questions
2. Reflective listening
3. Exploring
4. Affirmations
5. “I wish” statements

Ambivalence

Ambivalence is having two conflicting desires

- “I don’t want to live like this. The treatment leaves me with no quality of life. ”
- “ My husband is not ready to let me go so I can’t stop treatment.”

Watch for questions that are expressions of emotion

- “Isn’t there something else they can do for the cancer?”
- “Why is this happening to me?”

- Respond to the **emotion with empathy** rather than responding to the **question with facts**
  - “It must be so hard to be going through this.”

https://www.ethics.va.gov/GoCC.asp

Open-Ended Questions

- Elicit the patient's own knowledge, language, understanding and/or feelings
- Elicit details rather than one-word answers
  - "How has your health affected your day-to-day life?"
  - "You mentioned you have heart failure; what is your understanding of that disease?"

https://youtu.be/fj5uUoNAtZU

https://www.ethics.va.gov/GoCC.asp

Reflective Listening

The skill of listening carefully to another person and repeating back to the speaker the heard message to correct any inaccuracies or misunderstandings

Examples of Reflective Listening

- "It sounds like ….."
- "It seems as if …."
- "What I hear you saying …."
- I get a sense that ….
- "It feels as though…."
- "Help me to understand. On the one hand…. On the other hand….

PATIENT: "My breathing is bad – I can't walk as far as I used to, and I have to wear oxygen all the time now."

SIMPLE REFLECTION: "Your breathing has really been giving you a hard time."

PATIENT: "My doctors keep telling me there is no way to know if my cancer treatments are working. They won't know anything until my next scan. Why do we have to wait so long?"

Complex Refection CLINICIAN: "It sounds like it's really hard to live with the uncertainty."

https://www.ethics.va.gov/goalsofcaretraining/team.asp. Updated January 24, 2018.

Are you listening or problem solving?

https://www.google.com/search?q=communication+the+nail&oq=communication+the+nail&aqs=chrome..69i57j0.3423j1j7&sourceid=chrome&ie=UTF-8

Exploring

Seeks more information

- Clarifies meaning
- Builds deeper understanding

"Tell me more…"

"What else?"

"What do you mean when you say live independently?"

https://www.ethics.va.gov/goalsofcaretraining/team.asp.

Affirmations

- Recognize strengths & acknowledge positive behavior
- Build rapport & patient's confidence

PATIENT:

"I'm a fighter, I know I can beat this thing."

CLINICIAN:

"You've been so strong through so much."

CLINICIAN:

"You're saying this is difficult to talk about, and yet you came to today's appointment anyway."

"You have shown so much support for your dad."

https://www.ethics.va.gov/GoCC.asp

“I Wish” Statements

- Recognize patient’s hope
- Align with the patient
  - “I wish you didn’t have to deal with these lung problems.”
  - “I wish we had more effective treatments.”
  - “I hope for a miracle, too.”

https://youtu.be/gcJE2pK4Uyg

https://www.ethics.va.gov/GoCC.asp

KEY SKILLS AND SAMPLE STATEMENTS				
	Reflection			
Affirmation Acknowledging patient's strengths and abilities	**Simple** Restate or rephrase what patient says	**Complex** Interpretation such as naming feelings	**Exploring** Encouraging patient exploration	**"I wish"** Aligning with the patient's experience
You are such a (strong, committed, caring) person.	*This is really important to you.*	*You can't imagine discussing this with your son, but at the same time you're worried about how this could affect him later.*	*What do you mean when you say I don't want to give up (be a vegetable/ a burden/ on life support)?*	*I, too, hope that _____ happens.*
You (or your dad, mom, child, spouse) are such a strong person, and have been through so much.	*You just aren't ready to discuss this yet.*	*One of the hardest things for you is all the uncertainty. On one hand,____, and on the other,____.*	*What else?*	*I wish things weren't so stressful for your family.*
This is very difficult to think about, and yet you are still willing to talk to me about it.	*So _____ has been the most difficult symptom for you to deal with.*	*This sounds frustrating (scary, overwhelming, difficult, challenging, hard).*	*Tell me more…*	*I wish the situation were different.*
You have done so much to try to manage your illness (help your loved one with their illness).	*Dealing with this illness has been such a big part of your life and has taken so much energy.*	*Other people in your situation have told me this feels very (name emotion).*	*Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you.*	*I hope for a miracle, too.*

https://www.ethics.va.gov/GoCC.asp

SAMPLE RESPONSES TO CHALLENGING STATEMENTS/QUESTIONS

These statements are examples of empathic continuers. Patients may not immediately respond to your first empathic statement. It often takes multiple successive empathic responses to help patients work through strong emotion.

God's going to bring me a miracle.

- I too hope that a miracle happens. (**Remember no buts**!) **("I wish")**
- You have such a strong faith. (**affirmation**)
- Having faith is very important to you. (**reflection**)
- Can you share with me what a miracle might look like for you? (**exploring**)

My dad is a fighter!

- He is. He is such a strong person and he has been through so much. (**affirmation**)
- You care about your dad so much. (**affirmation**)
- It must be so (**name emotion**) to see him so sick. (**reflection**)
- Tell me more about your dad and what matters most to him. (**exploring**)

Do you know something I don't know?

- Tell me more about what you are asking. (**exploring**)
- You seem worried. **(reflection)**
- You are wondering if there is something your doctors haven't told you. **(reflection)**
- What is your understanding of where things are at with your health? **(open ended)**
- This situation must be very **(name emotion). (reflection)**

Why are we talking about this now?

- You seem worried/overwhelmed/ scared. **(reflection)**
- Maybe you aren't ready to discuss this right now. **(reflection)**
- That's ok if you don't want to discuss this right now. **(affirmation)**
- You don't think this is a good time to discuss this. Tell me more about what the right time would look like. (**exploring**)

Are you giving up on me?

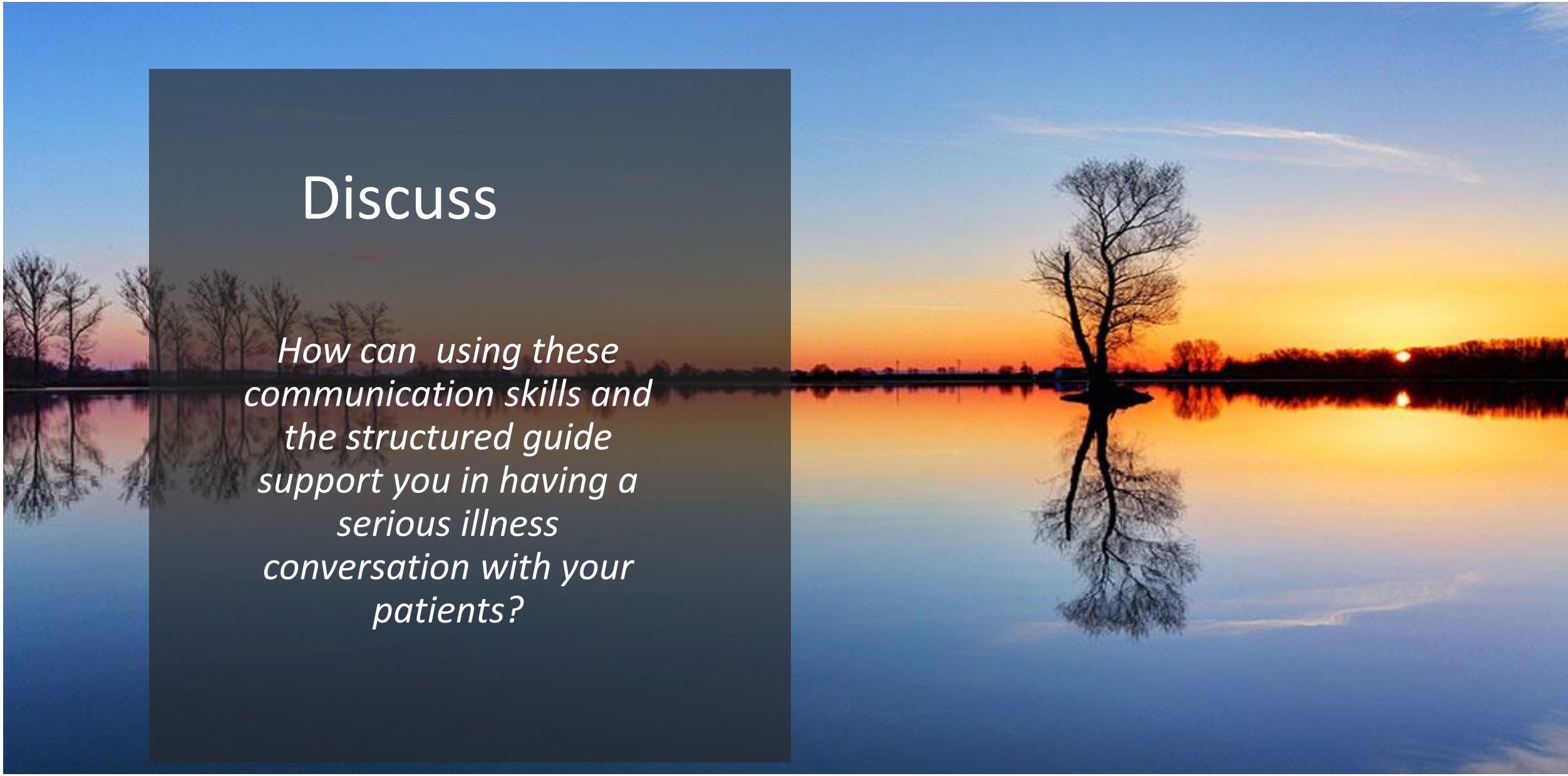
- It sounds like you might be feeling…. (**name emotion)**
  - Alone
  - Scared
  - Etc.
- We will go through this together. (**affirmation**)
- No – I want to make sure we get you the best care possible to take care of what's going on for you now.

Are you telling me my dad is dying?

These responses will affirm the question empathically – so do not use them if the patient is not dying

- I wish the situation were different. **("I wish")**
- This must be such a shock for you. (**reflection**)
- I can't even imagine how difficult this must be. (**reflection**)

https://www.ethics.va.gov/GoCC.asp



Discuss

How can using these communication skills and the structured guide support you in having a serious illness conversation with your patients?

Putting It All Together

- Observe: What communication skills did you see the clinician use?

- Share other observations or reflections.

SI demonstration

Instructions: Break Out exercise

- Each group has a previously assigned facilitator
- There is one Serious Illness Conversation Scenario (20 minutes)
- Facilitator role plays the patient and stops at defined points to engage in the group in discussion
- Participants will take turns playing the clinician utilizing their guide. Participants will use a round robin to move through each of the following components
    1. Introduce
    2. Assess understanding of health
    3. Share prognosis (within scope of practice)
    4. Elicit values and goals of care
    5. Make a plan (physician, family)
    6. Summarize & close
- Brief report out back to main group- what worked well? What were the challenges?

Practice Case 1

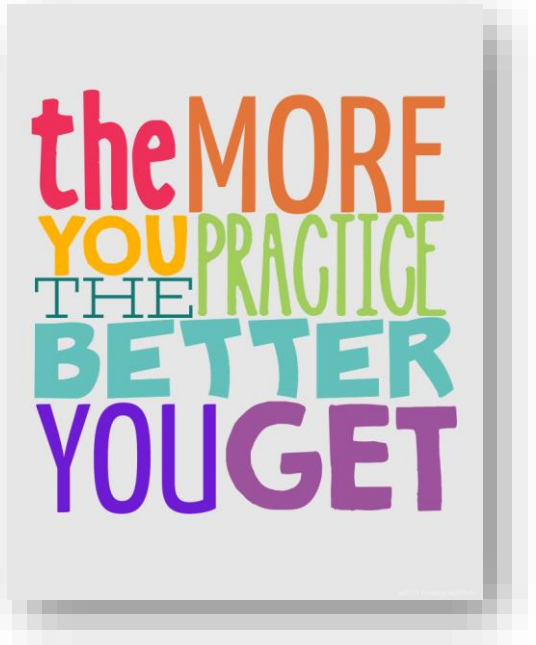
SETTING: Clinic, one month after hospitalization for COPD exacerbation.

- Mr. Smith is a 68-year-old retired salesperson
- Chronic Obstructive Pulmonary Disease (COPD), on steroids and home oxygen; diabetes; chronic kidney disease; chronic hip pain
- Three hospitalizations this year (COPD exacerbations)
- Two ED visits (fall, med refill)
- Worsening shortness of breath, muscle weakness, fatigue
- Declining functional status at home, despite short stays in rehab after each hospitalization
- Spouse very involved, 28-year-old daughter lives locally

https://implementation.aria.ariadnelabs.net/aria2/resources/

Practice Case 1

- The goal of the discussion today is to use the Structured Communication Guide to explore Mr. Smith's values, goals and priorities for care in the setting of illness progression.
- As you prepare to speak with Mr. Smith, you consider the following:
  - Mr. Smith has COPD and multiple co-morbidities (diabetes, kidney disease, chronic hip pain)
  - Given the hospitalizations and declining functional status, you are worried that he will have a harder time managing at home and that something serious could happen quickly, so you want to begin a conversation.



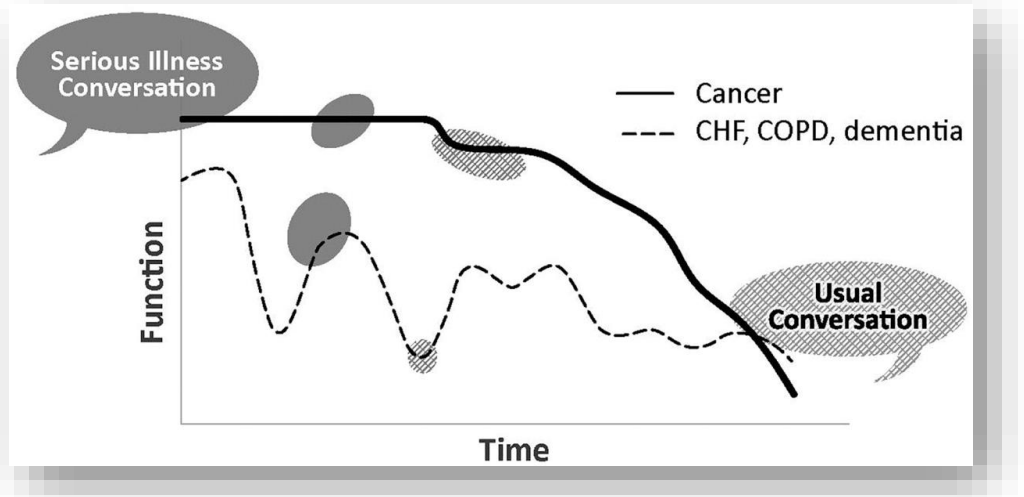
https://implementation.aria.ariadnelabs.net/aria2/resources/

MI-CCSI
Center for Clinical Systems Improvement

Break Out Session

Care Team Positioned to Initiate SI Conversations

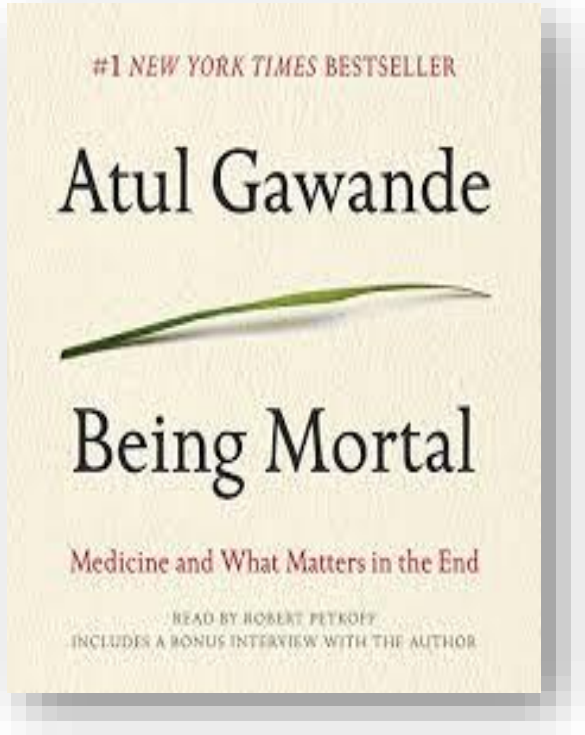
- **Longitudinal relationships** with patients and families
- Ambulatory case managers – **ideal timing** – non urgent situation
- Ability to go **upstream** to help **inform** serious illness plan of care



Closing Reflection

"If to be human is to be limited, then the role of caring professions and institutions—ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that.

But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking."



Atul Gawadne Being Mortal: Medicine and What Matters in the End.

Recap Learning Objectives

1. Define a serious illness conversation.
2. Describe the difference between a Serious Illness Conversation and an Advanced Directive.
3. Name two Serious Illness Conversation trigger criteria.
4. Identify two communication skills that can enhance a Serious Illness Conversation.
5. Utilize role playing to practice using the Serious Illness Conversation guide.

Questions?

References

Ariande Labs, (n.d.) Retrieved from https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

Bernacki, R., & Block, S. (2014). Communication about serious illness care goals a review and synthesis of best practices. Special communication for the American College of Physicians high value task force. JAMA Internal Medicine, 174, (12), 1994-2002.

Chiarchiaro, J., Buddadhumaruk, P., Arnold, R. , & Whiie, D. Prior advance care planning Is associated with less decisional conflict among surrogates for critically ill patients. (2015). Annals of American Thoracic Society, 12(10), 1528-33. doi: 10.1513/AnnalsATS.201504-253OC.

Demonstration of a Serious Illness Conversation. (2023). (Video). You tube. https://www.youtube.com/watch?v=jA0l-PoZaaE&t=686s

Detering, K., Hancock, A., Reade, M. & Silvester, W. (2010). The impact of advance care on end of life in elderly patients; randomized controlled trial. BMJ, 340:c1345. doi.org/10.1136/bmj.c1345

Heyland, D., Allan, D., Rocker, G., Dodek, P., Pichora, D. & Gafni, A. (2009). Discussing prognosis with patients and their families near the end of life: impact on satisfaction with end-of-life care. Open Medicine, 3(2):e101-10. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765767/

Institute of Health Care Improvement. (2021) The conversation project. Helping people talk about end of life wishes. Retrieved from http://www.ihi.org/Engage/Initiatives/ConversationProject/Pages/default.aspx

Institute of Medicine. (1997). Approaching Death: Improving Care at the End of Life. Washington, DC: The National Academies Press.

References

Institute of Medicine. (2015). Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academics Press.

Kelley, A. S., & Bollens-Lund, E. (2018). Identifying the population with serious illness: The “Denominator” challenge. Journal of Palliative Medicine, 21(S2), 16. doi:10.1089/jpm.2017.0548

Lunney, J., Lynn, J., & Hogan, C. (2002). Profiles in older Medicare decedents. Journal of the American Geriatric Society, 50(6), 1108-1112.

Lynn, J., & Adamson, D. (2003). Living well at the end of life: Adapting health care to serious chronic illness in old age. Retrieved from https://www.researchgate.net/publication/328083514_Living_Well_at_the_End_of_Life_Adapting_Health_Care_to_Serious_Chronic_Illness_in_Old_Age

Mack, J., Weeks, J., Wright, A., Block, S. & Prigerson, H. (2010). End of life discussions, goal attainment, and distress at the end of life: predicators and outcomes of receipt of care consistent with preferences. Journal Clinical Oncology, 28(7), 1203-1208.

Mack, J., Cronin, A. Keating, N. Taback, N. , Huskamp, H., Malin, J., Earle, C. & Weeks, J. (2012) . Associations between end-of-life discussion characteristics and care received near death: a prospective cohort study. Journal of Clinical Oncology.30(35),4387-95. doi: 10.1200/JCO.2012.43.6055.

Sokol-Hessner L, Zambeaux A, Little K, Macy L, Lally K, McCutcheon Adams K. “Conversation Ready”: A Framework for Improving End-of-Life Care (Second Edition). IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2019.

References

Teno, J., Clarridge, B. , Casey, V., Welch, L., Wetle, T., Shield, R., & Mor, V. (2004) Family perspectives on end-of-life care at the last place of care. Journal of American Medical Association, 291(1),88-93. doi: 10.1001/jama.291.1.88. PMID: 14709580.

Teno, J., Gruneir, A., Schwartz, Z., Nanda, A. & Wetle, T. A. (2007). Association between advance directives and quality of end-of-life care: a national study. Journal American Geriatric Society, 55(2),189-94. doi: 10.1111/j.1532-5415.2007.01045.x. PMID: 17302654.

U.S. Department of Veterans Affairs National Center for Ethics in Health Care. Goals of Care Conversations Training for Physicians, Advance Practice Registered Nurses, and Physician Assistants website. https://www.ethics.va.gov/goalsofcaretraining/practitioner.asp. Updated January 3, 2019. Accessed July 1, 2021

Vital Talk (n.d.). Retrieved from https://www.vitaltalk.org/

Wright, A., Zhang, B., Ray, A., Jack, J., Balboni, T. Mitchell, S., Jackson, V., Block, S., Maciejewski, P. & Prigerson, H. (2008). Associations between end of life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA, (14) 1665-73. doi: 10.1001/jama.300.14.1665

Wright, A., Keating, N., Ayanian, J., Chrischilles, E., Kahn, K., Ritchie, C., Weeks, J., Earle, C., & Landrum, M. (2016). Family perspectives on aggressive cancer care near the End of life. Journal American Medical Association, 315(3):284-92. doi: 10.1001/jama.2015.18604. PMID: 26784776; PMCID: PMC4919118.

Zhang, B., Wright, A. A., Huskamp, H. A., Nilsson, M. E., Maciejewski, M. L., Earle, C. C., Block, S., Maciejewski, P & Prigerson, H. G. (2009). Health care costs in the last week of life: Associations with end-of-life conversations. Archives of Internal Medicine, 169(5), 480-488. doi:10.1001/archinternmed.2008.587