SP PACKET

SERIOUS ILLNESS

VERSION: JUNE 2025

Date

MI-CCSI
Center for Clinical Systems Improvement

CONTENTS

Palliative Care: Serious Illness Training

Optimizing Serious Illness Conversations, Conducting a Comprehensive Assessment and Care Coordination

TRAINING AGENDA INCLUDING SIMULATIONS		
10:30	**11:30**	**PDCM Billing and Care Coordination** ***Mode of Learning**: Didactic presentation and practical application participation* ***Presenters**: Sue Vos, BSN, RN, CCM & Lynn Klima, DNP* ***Objective**: Review key considerations and available codes for billing of services related to serious illness.*
11:30	**12:00**	**Lunch**
12:00	**1:00**	**Psychosocial/Behavioral Assessment** ***Mode of Learning**: Didactic presentation and practical application participation* ***Presenter**: Ellen Fink-Samnick, DBH, MSW, LCSW, ACSW, CCM, CCTP, CRP, FCM* ***Objective**: Identify key components of a psychosocial assessment for patients living with serious illness (SI) (e.g., social determinants of health, cultural aspects of diversity and inclusion)*
1:00	**2:00**	**Biomedical/Physical Assessment** ***Mode of Learning**: Didactic presentation and practical application participation* ***Presenter**: Carol Robinson DNP, RN, CHPN* ***Objective**: Review of the comprehensive assessment to include areas sensitive to Serious Illness, end-stage conditions*
2:00	**2:10**	**Break**
2:10	**4:30**	**SERIOUS ILLNESS SIMULATIONS: (Includes simulation & feedback)** ***Objective:** Practice conducting the serious illness conversation with a trained standard patient to build skill and confidence.* *Review feedback of the simulation with the instructor/evaluator to identify strengths and opportunities.* Group 1 – 2:10 - 2:40 pm

Group 2 – 2:40 – 3:10 pm

Group 3 – 3:10 - 3:40 pm

Group 4 – 3:40 pm – 4:10 pm

Simulation times will be assigned. Total simulation will depend on the number of attendees.

EACH ROUND IS 30 MINUTES

Course Evaluation (following each simulation)

Additional information

STANDARD PATIENT CASE: SERIOUS ILLNESS CONVERSATION – COPD CASE

OVERVIEW

Logistics: You (the patient) were discharged from the hospital one month ago and are scheduled to have a virtual visit today.

Emotional state: You (the patient) experienced more hospital admissions and are *scared* you are getting worse. You know things are not likely to get better and are *worried* about this.

PATIENT HEALTH HISTORY

- 68-year-old retired salesperson
- Patient has
    - Severe Chronic Obstructive Pulmonary Disease (COPD)
        - On steroids and home oxygen
    - Chronic kidney disease
    - Diabetes
    - Chronic hip pain
- This year the patient has had three hospitalizations (COPD exacerbations) and two ED visits (falls)
- Worsening shortness of breath, muscle weakness, fatigue, declining functional status at home, despite short stays in rehab after each hospitalization
- Spouse very involved and 28-year-old daughter lives nearby

PATIENT BACKGROUND

You were discharged from the hospital one month ago. Upon discharge, you were told your physician wants you to use your oxygen all the time (24/7) at home (previously you only used it during the day as needed). Your physician didn't explicitly say anything to you about your prognosis, and you were afraid to ask.

You know your condition is likely getting worse and are feeling alone and scared. You don't want to worry your spouse or your children, so you try and put on a brave face, but it is getting more difficult. You have been working with the case manager from your doctor's office

At the end of your call last week with the care manager / attendee, the care manager / attendee sent you some information to share with your spouse and help you prepare for today's discussion. This visit is not about that information sent to you– we do not expect the care manager / attendee to reference the information. It is about having the conversation to understand your values and wishes.

CARE MANAGER / ATTENDEE ROLE

The goal of the discussion today for the care manager / attendee is to use a Serious Illness Conversation Guide (standard communication tool), to explore your (the patient's) values, goals, and priorities for care in the setting of illness progression. The tool the care manager / attendee should be using is the Serious Illness Conversation Guide.

This guide is not shared with the patient. The guide serves as a reminder to the care manager/attendee of what to discuss with the patient. As the care manager/attendee prepares to speak with the patient, they are instructed to consider the following:

The patient has Chronic Obstructive Pulmonary Disease (COPD), a disease of the lungs that is not curable, and other chronic diseases (co-morbidities) to include: diabetes, kidney disease, chronic hip pain.

Given the hospitalizations and declining functional status (ability to independently care for him/herself), the case manager/attendee is outreaching today to address the concern of the patient's challenges of managing at home and prepare for the future, as the condition places the patient at risk for something serious happening quickly. This is why the care manager / attendee are meeting today, to begin a conversation to address what the patient understands and what they would like to happen if the condition worsens. They will use the "Serious Illness Conversation Guide."

Reminder: At the last visit, the care manager / attendee introduced him / herself and mentioned this meeting to continue the serious illness conversation topic. The care manager / attendee provided you with some reading materials to review with your family. Today's conversation is not to review the materials but to use the Serious Illness Conversation Guide to understand your values and wishes

THE MEETING (SIMULATION)

The case manager/attendee reaches out to talk to you during your scheduled "virtual visit".

We have provided beginning suggested patient responses in each category. The goal is for the care manager / attendee to use key communication skills taught in the morning session, including reflection, exploring, affirmation and "I wish" statements to thoroughly elicit your responses in each category.

Ideally, the care manager/attendee will adhere to the structured communication guide and use key communication skills to elicit more information during the visit. If the care manager / attendee veers too far off track, you may redirect the care manager/attendee using tips from the "troubleshooting suggestions" included in this packet.

For purposes of this simulation, we are limiting the time allotment for the simulated conversation to no longer than 20 minutes which would allow 5 minutes for the evaluator and attendee to complete their evaluations and 5 minutes for the evaluator feedback. The instructor/evaluator will serve as a timekeeper and will provide a 5-minute warning if needed.

STANDARD PATIENT CASE: SERIOUS ILLNESS CONVERSATION – CANCER CASE

OVERVIEW

Logistics: You (the patient) were discharged from the hospital one month ago and are scheduled to have a virtual visit today.

Emotional state: You (the patient) experienced more hospital admissions and are *scared* you are getting worse. You know things are not likely to get better and are *worried* about this.

PATIENT HEALTH HISTORY

- 65 year-old retired police officer
- Background
    - Stage IV colon cancer with metastases to the liver- diagnosed 4 months ago
    - He/she has been receiving palliative chemotherapy for past 2 months
    - Labs and imaging have been stable, but s/he lost about 10 lbs. this past month
- Experiencing loss of appetite, significant fatigue, and declining functional status
- Spouse very involved and 3 adult children live nearby

PATIENT BACKGROUND

You were discharged from the hospital one month ago. You know that your cancer is not curable but have not been given any time specific prognosis, and you were afraid to ask.

You know your condition is likely getting worse and are feeling alone and scared. You don't want to worry your spouse or your children, so you try and put on a brave face, but it is getting more difficult. You have been working with the case manager from your doctor's office

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CLINICIAN SAMPLE SCRIPT-ONCOLOGY	SUGGESTED PATIENT RESPONSES- ONCOLOGY
Introductions	
(Introduction) *Introduce yourself and remind patient this a follow up call from last week.* *Introduce the conversation, i.e. "on our last call I mentioned we would like to spend some time today discussing your goals and preferences so that we can better align your care with your desires. "* *(Agreement to Talk)* *Ask the patient for their approval to continue to discuss goals of care.*	
(Follow-up on last conversation) *Did you have an opportunity to think about what we discussed at the last meeting?*	***Yes, I looked at the materials. Honestly, those are some hard things to think about. I know things have not been going well. It made me really think about what is important to me. It feels kind of scary to talk about this, like it will make it more real.***
Reassures patient that talking about their goals can help align their care with the things that are important to them.	*Allow the case manager to respond to the above comment.*
Encounters some patient resistance to discussing- queries the patient about resistance	*You eventually agree to the conversation.*
Patient Understanding and Needs	
(Patient Understanding) *Assess patient's understanding of health*	*I know I have cancer that has spread to my liver. I was hoping the chemotherapy would help, but I am feeling worse since I started it. I've lost 10 pounds, and I have no appetite. I just feel weaker and can hardly do anything. I mostly just sit in the chair or take naps all day. My doctor didn't really say too much, just said that the chemotherapy might help the cancer from spreading more. With how I feel, I am scared that things are getting worse and I am not sure what to expect. The doctor never said how long I could live with this cancer, but I am feeling worse than I felt two months ago.* *I thought the doctor would tell me if it was bad, but then again, he never seems to have time to talk about those kinds of things. It's always about what medications am on, how am I physically feeling, we never talk about that other stuff.*

CLINICIAN SAMPLE SCRIPT-ONCOLOGY	SUGGESTED PATIENT RESPONSES- ONCOLOGY
The case manager ideally, responds appropriately to your comments. *(i.e. I'm glad we can have the conversation today and I can work with your physician to make sure you and your family have the information you want to have about your health.*	***I guess it would be good to talk more to my doctor about that kind of stuff. I realized as I was reading the materials and giving this more thought, I probably need to have more information about where my health is right now so I can plan.***
(Informational Needs) *How much information about what is likely to be ahead with your illness would you like from the healthcare team?*	*I need to know what is going on so there are no surprises. If something happens to me, my wife will be by herself, and I need to prepare her for that if that is what happens. She knows I have cancer, but we haven't really talked too much about it. She is hoping I will get better, but I don't think that is going to happen.* ***I am not sure my family understands how serious my health situation is, and that is probably not good.***
Patient Perspectives	
(Goals) *If you were to get sicker, what would be most important to you?* *Case manager responds (i.e. let's work on a plan that will help you spend more time with your grandchildren)*	*Well, I have been getting sicker, and I can tell you my priorities are spending more time with my family, especially my kids and grandkids. I have been feeling so sick I haven't been able to see my grandkids. As much as I want to see them, I hate for the kids to see me like this." A good day for me is being able to spend time with the grandkids.*
(Worries) *As you think about the future with your health, what are you most worried about?* *Case manager responds (ideally uses reflective listening and other key communication skills to respond to the patient.*	*I worry about being in pain. I take the pain medicine, but it doesn't really help that much. The doctor said they could give me stronger pain medicine, but I think that will probably just make me sleepier. I don't like the way the medicine makes me feel.* *I also worry about my wife. If something happens to me, she will really have a tough time. We've been married for 40 years, and we are just used to having each other around. I'm not sure how she will be without me.*
(Priorities) *What are the things that are so critical to you that your life would not be worth living without them?*	*Like I said, it's important for me to spend time with my kids and grandkids. If I didn't have enough energy to do that, it would be hard. I also hate not having energy to do the things I like to do, like playing golf and meeting my buddies for coffee.*
(Strengths) *What are the things that give you strength?*	*It's my family and my religion. Those are the most important in my life. I trust God has some type of plan for me, but it is not always easy to see what the plan is. Even so, I have very strong faith and that sustains me during these difficult times. If it is my time to go, that is the way it is.*

CLINICIAN SAMPLE SCRIPT-ONCOLOGY	SUGGESTED PATIENT RESPONSES- ONCOLOGY
(Trade-offs) *If you become sicker, how much are you willing to go through for the possibility of gaining more time?*	*I'm not sure I want to continue to take the chemotherapy because it makes me feel worse. I need to talk to the doctor about that to see if there is something they can do besides the chemo.* *I don't really want to go back to the hospital. I guess I would be willing to try some things if they thought it would help, but I don't want to go through a lot of stuff if it isn't making me feel better. I really hate being in the hospital, so I would try and avoid that if I could. I don't want to be burden to my wife and kids. I know the treatment can't cure the cancer, but at least I was hoping it would make me feel stronger for whatever time I have left.*
Patient Plan	
(Plan) *How much do your loved ones know about your health status and your preferences if your health declines?* *(Communications)* *How much have you shared with your doctor about your goals and preferences?*	*We haven't really talked about it that much. My wife and I have been focused on just taking it day by day. I am not sure I would know what to say to her and my kids. The grandkids are too young to know anything. They just know grandpa hasn't been feeling good.* *Like I said before I really haven't talked to my doctor about what I want done. He is always so busy when I see him. I am not sure how to arrange that. Maybe you could help me talk to my wife and my doctor.*
Summary and Next Steps	
(Summary) *I heard you say it is important to have a meeting with your doctor and family to talk about your goals and plan of care. Keeping that in mind, and what you know about your illness, I recommend that we schedule a meeting to include you and whoever you would like from your family and the doctor and our social worker. That will help us to make sure that your plan of care reflects the things that are most important to you.*	*This was good to talk about. I don't want to leave my wife not knowing what's important to me.*
(Agreement)) *How does this plan seem to you?*	*That sounds like a good plan. Thank you for bringing this up today. I feel a little better knowing we will have a plan that is based on what's important to me.*
(Appreciation) *Thank you for speaking with me today. This can be a difficult topic to discuss. I appreciate you sharing your thoughts with me today. Now let me get started on getting that meeting scheduled.*	*Thank you.*

WORKFLOW

PURPOSE OF THIS SIMULATION ACTIVITY

The overall purpose of this exercise is to encourage the attendees to use and follow the **Serious Illness Conversation Guide** and the four areas outlined in the guideline (see the S/P Case Study for details).

PARTICIPANTS IN THE BREAKOUT SESSION

1. Attendee
2. Standard Patient (SP)
3. Instructor/evaluator

ATTENDEE

To begin the conversation, the attendee provides an introduction of self and the purpose of the visit today.

STANDARD PATIENT

1. Join the Zoom breakout room with your ***ASSIGNED PATIENT NAME***.
2. Respond to care manager / attendee based on their questions and information using the scenario outlined in the ***CASE STUDY***.
3. As needed, redirect the attendee to using the ***SERIOUS ILLNESS CONVERSATION GUIDE*** and to discuss your values and wishes.

   Example – if they start discussing medications, use of oxygen, getting sleep, etc. Use statements such as – *"I thought the discussion today was more about what I want done should my condition worsen. It now feels like we're talking about how I am currently managing my health. Should we get back to the conversation on what I want should my health start worsening?"*
4. After the visit
   - Share any thoughts on how you felt the conversation went from the patient perspective.
   - Leave the breakout room and return to the main room. (Click on Leave Breakout to go to the main room).
   - Prepare for the round and repeat starting at 1.

INSTRUCTOR/EVALUATOR WILL CONTINUE FROM HERE (THIS IS INFORMATION ONLY FOR THE SP)

Have the attendee complete their ***SELF-ASSESSMENT*** using the SurveyMonkey link. This will take approximately 5 minutes and should have the link in their instructions. If they do not have the link or instructions, have them spend time and reflect on the visit. Have them think about:

- Did they use the guide and follow it?
- Identify the communication skills they used to engage you.
  - Did they refrain from wanting to talk about medical management?

TROUBLESHOOTING "USING THE SERIOUS ILLNESS GUIDE"

1. **The care manager / attendee will start with the "introduction".**

   IF THE CARE MANAGER / ATTENDEE DOES NOT INTRODUCE HIM/HERSELF USE A STATEMENT TO REMIND THE CARE MANAGER / ATTENDEE OF THIS. SOMETHING LIKE…

   "Oh – are you the person who I met briefly at my last appointment, and gave me some information?" I recall someone doing that and saying they would be calling to follow up on this. Is that why we are meeting today?"

2. **The second step to anticipate from the care manager / attendee is completing the assessment of your understanding of the severity of your condition. The care manager / attendee should use open-ended questions (a question that cannot be answered with a yes or no). Examples of the questions to anticipate from the care manager / attendee:**

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

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

   IF THE CARE MANAGER / ATTENDEE DOES NOT DO THIS, USE A STATEMENT TO GUIDE THEM TO THIS. SOMETHING LIKE…

   "Well, I appreciate this conversation. It seems like before we go any further, it would be good for me and you to know where I am with my health status. Should we start with this before anymore conversation?"

3. **After assessing your understanding of your health condition, the care manager / attendee should next offer to share his/her insight. You should hear comments as those below:**

   "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."

   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)."

   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."

   IF THE CARE MANAGER / ATTENDEE DOES NOT DO THIS, YOU COULD REDIRECT THEM. SOMETHING ALONG THE LINES OF…

   "I've shared with you what my understanding is, why don't you tell me what you know or understand."

4. **Now the care manager / attendee should begin exploring your values and what will be important to you as you become sicker and/or unable to maintain a desired lifestyle. The care manager / attendee should use statements/questions as below:**

"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?

IF THIS DOES NOT OCCUR, REDIRECT THE CARE MANAGER / ATTENDEE TO THIS. YOU CAN USE STATEMENTS SUCH AS…

"This is an interesting conversation. It seems like it would be good for you to know what is important to me. Are you interested in hearing what gives me strength, and what I'm willing to put up with to maintain life? Want to talk about that before we end the visit?"

5. **Planning should now take place. This is to ensure your physician and support system understand your wishes. You should hear the care manager / attendee using questions like these:**

"How much do your loved ones know about your priorities and wishes?"

"How much does your doctor know about your priorities and wishes?"

IF THIS DOES NOT OCCUR, REDIRECT THE CARE MANAGER / ATTENDEE TO THIS. YOU CAN USE STATEMENTS OR QUESTIONS TO DO THIS. EXAMPLES:

"You and I know where I stand. Is it important to have my support know this too? I'm thinking it would be good for my loved ones and doctor to know this. Want to talk about what they do or don't seem to know?"

6. **The final step is to summarize the visit and repeat the next steps. You should hear the care manager / attendee include some of these statements:**

"I've heard you say _____. I will pass that information to the rest of the health care team."

"Keeping that in mind, and what you know about your illness, I recommend that we _____. That will help us make sure that your treatment plans reflect what's important to you?"

"How does this plan seem to you? We will do everything we can to help you through this."

IF THIS DOESN'T OCCUR, YOU CAN REDIRECT THE CARE MANAGER / ATTENDEE TO THIS ACTION. EXAMPLES TO DO THIS…

"Before we end the visit, do you think it would be good to summarize what we discussed?"

"I want to make sure you heard what I said, would you mind summarizing our conversation, to include the next steps?"

7. **The visit should end thanking you for meeting today and discussing the information.**