Tips for Using this Guide

- Review the guide before a conversation with a patient and pick 1-2 things/phrases you want to try.
  - Silence is golden - you do not have to fill the space; allow the patient time and space to think.
- Try to talk less than 50% of the time.

Patients who would benefit from a serious-illness conversation

- If you answer "no" to the surprise question, e.g., would you be surprised if this patient died in the next year?
- Frequent ED or inpatient admissions
- Metastatic cancer
- Advanced organ disease (HFrEF, COPD, ESLD, etc.)
- Consideration of PEG tube
- Code status concerns
- Unclear goals of care
- Advanced dementia

Seriously ill patients who have conversations with their clinicians about their goals and wishes are more likely to have better outcomes, fewer non-beneficial medical interventions and better quality of life. Yet less than one third of patients with end-stage medical diagnoses report discussing their care goals and preferences with their clinicians. This pamphlet was created to provide tools to help guide the clinical in these critical discussions.

Helpful Resources

Palliative Care
(520) 324-3771

Hours: Monday-Friday 8 a.m. to 5 p.m.
"Consult to Palliative Care" in Epic

Our inpatient palliative care team consists of physicians, advance practice providers, social workers and nurses who work with patients and families to provide expert symptom management and support. Serving patients of any age and any stage of serious illness, the team helps people live with and manage a wide range of diseases and challenging treatments. Examples of serious illness include, but are not limited to, cancer, heart disease (including heart failure), kidney disease, lung disease (such as COPD), and neurologic problems (including stroke or dementia).

Palliative Care is different from hospice care, which provides compassionate end-of-life care for patients and their families. For hospice consults order "referral to hospice" in Epic and contact Case Management.

The Palliative Care team also provides education to clinicians on a variety of topics including Communication Strategies for Seriously Ill Patients.

Ethics Committee
(520) 327-5461 or press "0" from a house phone and ask for the Ethics Committee member on call.

For ethical consideration that arise during patient care, you can reach out to the Ethics Committee. A member is available 24/7.

Arizona End of Life Care Partnership
(520) 903-3937

www.azendoflifecare.org

This partnership of community organizations, anchored at United Way of Tucson and Southern Arizona, provides a starting point for people seeking resources on end-of-life care. Website includes free advance directive forms.

TMC GOAL-CONCORDANT CARE

Arizona END OF LIFE CARE PARTNERSHIP
Anchored at United Way of Tucson and Southern Arizona

The Arizona End of Life Care Partnership is supported by The David and Lura Lovell Foundation and the Community Foundation for Southern Arizona.

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A CLINICIAN'S GUIDE

Communication Strategies

for seriously ill patients

Would you be surprised if your patient died in the next year? If you answer "no," consider using these strategies.

Grant Funding for the Goal Concordant Care Initiative provided by the David and Lura Lovell Foundation and TMC Foundation

Steps

Setup | Assess | Prognosticate | Explore | Reframe/Summarize/Close

Make sure important family/friends are there, if needed

Setup

"I would like to discuss your *(state illness)* with you on what to expect and find out what's important to you in advance so I can ensure we provide medical care you agree with. **Is that OK with you?**"

Assess

"What have your doctors explained to you about your *(state illness)* so far?"

"Would you like to discuss possibilities on what to expect with your *(state illness)* moving forward?"

"To what depth would you like to discuss your illness?"

Prognosticate – base comments on prognosis:

Uncertain: "It can be difficult to predict exactly what will happen with your *(state illness)*. I hope you continue on for a long time, but I'm worried you will become sicker and things may change rapidly. I think it's important we prepare for that possibility."

OR

Time: "I wish this were not the case but I'm worried your time may be limited to *(express a range, e.g. days-weeks, weeks-months-months-year).*"

OR

Function: "I hope you get stronger but I'm worried this may be as strong as you will feel given the circumstances, and things are likely to become more difficult as time goes on."

Explore (goals, fears, worries)

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

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

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

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

"Does your loved ones know about your priorities and wishes (goals, fears, worries)?"

Reframe – Wish, Worry, Wonder

When a patient seems to have an unrealistic goal:

"I **wish** that for you too, but I **worry** that _____, and I **wonder** if we should make a back-up plan."

Summarize/Close

"I've heard you say that _____ is really important to you."

"Keeping this in mind, and what we know about your illness, I recommend we _____. This will help us make sure that your treatment plan reflects what is important to you."

"How does this plan seem to you?"

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

NURSE

Respond to emotions using the **NURSE** mnemonic

Name
"It looks to me like you are concerned or maybe worried?"
Even a guess is OK! They will correct you.

Understand
"Given what has happened, I can understand your concern."

Respect
"I can see how hard you've worked to learn about your illness."
OR ***"I can see how much you are concerned about your loved one."***

Support
"I'd like to make this situation better, so I and our team are here to help."

Explore
"Tell me more."

Advance Care Planning (ACP) in the Electronic Medical Record

- **Hover to uncover** – On the Epic banner, find advance care planning documents and previous code status by hovering over ACP docs in the far left corner of every chart.
- Always view patient's **previous code status** upon **admission** and **before placing code orders**.
- Use **.ACPNOTE** to document advance care planning discussions

Advance Care Planning (ACP) billing codes*

99497 (16 minutes) | 99498 (>30 minutes)
*ACP cannot be reported with critical care services, 99291

Document Handoff Communication

I spoke with the patient about _____ and I learned _____. I think they would benefit from_____.