Goals of Care Conversations

Mark Beiter, DO, FACP

WA ACP meeting

Nov 4, 2023

Virginia Mason Franciscan Health™

Disclosures

Facilitator & Principle (Train the Trainer) for:

- Vital Talk
- Ariadne Labs: Serious Illness Conversation Guide Training
- WSHA Honoring Choices Serious Illness Guide Training program

Virginia Mason Franciscan Health™

VITAL talk

ARIADNE LABS

Honoring Choices® PACIFIC NORTHWEST

Objectives

What do you mean: *goals of care*?

Why should I care?

OK, how do I do it?

Virginia Mason
Franciscan Health™

Question

How confident are you with having goals of care discussions with patients living with a serious illness:

- Not confident, I don’t do this often
- Confident, but I don’t have enough time to do this.
- Fairly confident and I try to do this as much as I can with my patients.

Virginia Mason Franciscan Health™

goal *noun*

The end toward which effort is directed: AIM

Miriam Webster Dictionary

Virginia Mason Franciscan Health™

Who needs a goals of care discussion?

- Surprise Question:
  - *Would you be surprised if this patient died in the next year?*
  - “Next year” in specialist setting [advanced cancer, dialysis, etc]
  - “Next 2 years” in Primary Care setting
    - Population so much more heterogeneous & mortality is quite low as a whole.

Virginia Mason Franciscan Health™

Lakin et al. *J GEN INTERN MED* **34,** 1467–1474 (2019). Moss et al. CJASN Sep 2008, 3 (5) 1379-1384

Did Janice receive the highest quality healthcare?

Virginia Mason Franciscan Health™

We don’t know

Understanding the quality of care for patients with serious illness necessitates understanding and respecting patients’ values, goals, and care preferences.

Virginia Mason Franciscan Health™

Goal Concordant Care

The goals of the treatment team reflect & support the goals and values of the patient.

Shared decision making.

Virginia Mason Franciscan Health™

Other Social Services (e.g., Education, Employment)

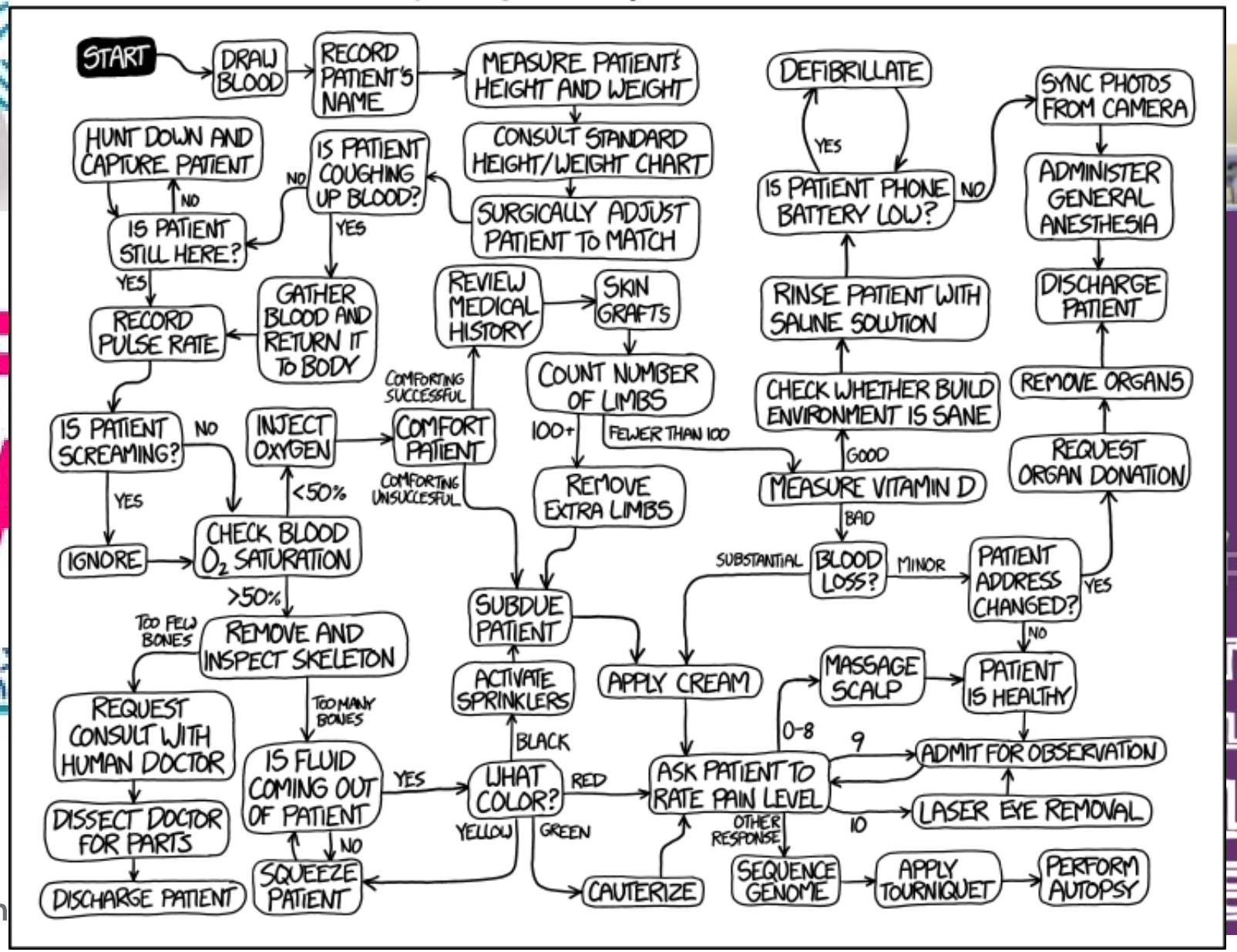
Transportation

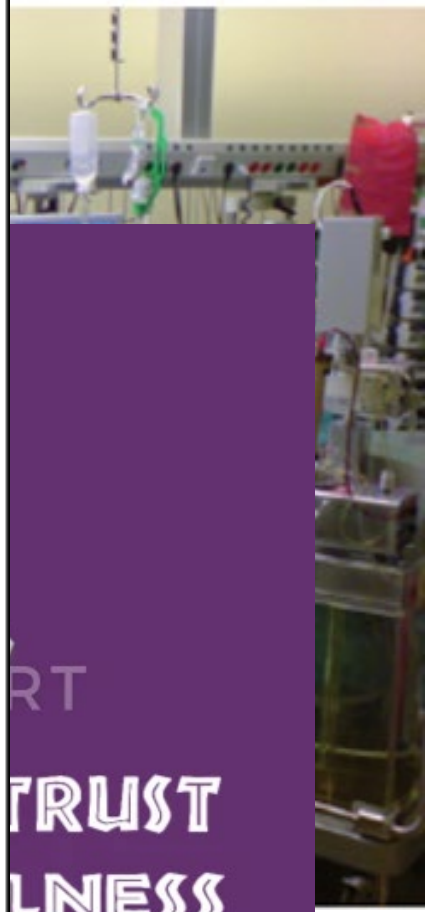
Criminal Justice & Legal Services

Food Access & Nutrition

Housing

A GUIDE TO THE MEDICAL DIAGNOSTIC AND TREATMENT ALGORITHM USED BY IBM'S WATSON COMPUTER SYSTEM





TRUST
LNESS
LGIA
ESS

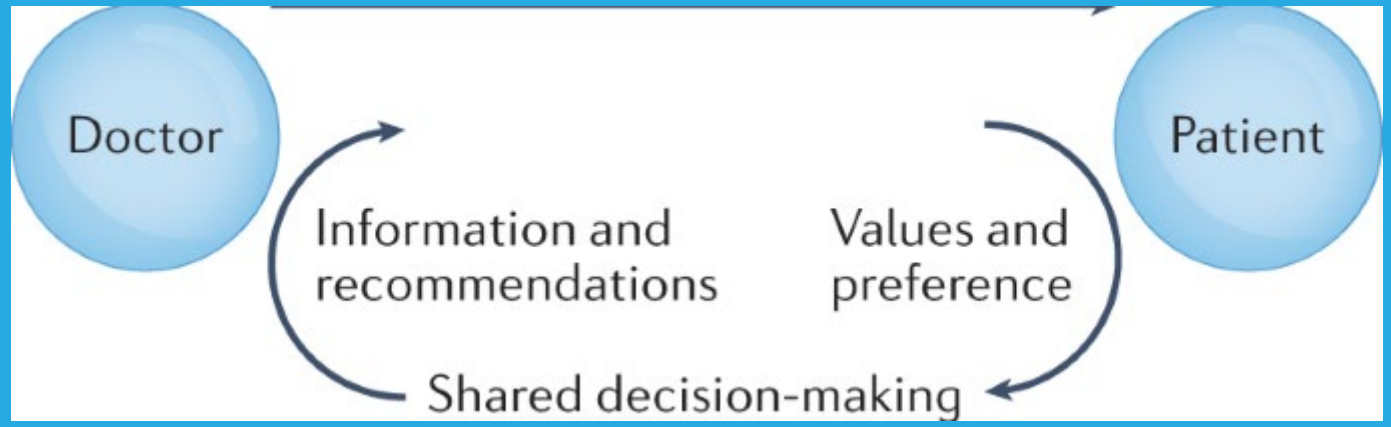
Virginia Mason Franciscan Health

Serious Illness Communication is challenging

- Complex decision making
- Heightened anxiety for patients and families
- Treatment decisions involve risk of hastened mortality or prolonged dying

Virginia Mason Franciscan Health™

Sanders et al, JPM. Mar 2018. S-17-S-27.



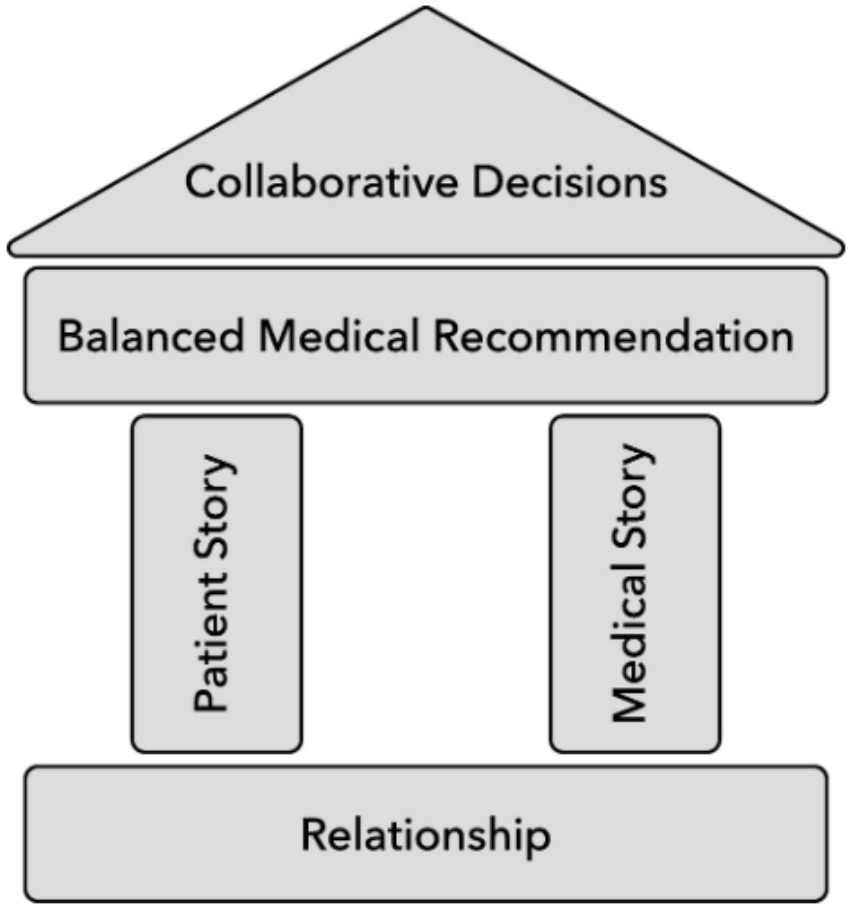
So how do we help our patients achieve goal concordant care?

Virginia Mason Franciscan Health™

REMAP

GOALS OF CARE, LATE IN THE ILLNESS

STEP	WHAT YOU SA
REFRAME why the status quo isn't working.	*"There is someth* *"We're in a different* *"This is a point where* You may have need separate task.
EXPECT EMOTION respond with empathy.	*"It sounds like yo [Name the patie* *"I can see how much* *"You have worked so*
MAP OUT big picture values, what's important.	*"Can we step bac and try to find a* *"Given this situation,* *"Have you ever thou you want?"*
ALIGN yourself & team with the patient's values.	*"It sounds like th [spending time v enjoying your ga* *"By planning ahead, didn't want."* Reflect the patient's
PLAN medical treatments that match the patient's values.	*"Thank you for ta team and come* *"For this situation, h*



Framework for goals of care conversations.

Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET IT UP

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

"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?"

"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.

"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?

"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."**

VITAL talk

© 2015–2023 Ariadne Labs: A Joint Center for Health Systems Innovation (www.ariadnelabs.org) between Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health, in collaboration with Dana-Farber Cancer Institute. Licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License, http://creativecommons.org/licenses/by-nc-sa/4.0/

SI-CG 2023-05-18

ARIADNE LABS

5 steps for goals of care conversations:

1. Set up the conversation
2. Provide context for the conversation
3. Explore goals/values
4. Affirm what you heard was most important
5. Make a values based recommendation

Virginia Mason Franciscan Health™

1. Set up the conversation

Virginia Mason Franciscan Health™

1. Set up the conversation

I'd like to take a few minutes to talk about where we are with your health and do some thinking in advance about what matters most to you so that I can make sure we provide you with the best possible care.

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

From the Serious Illness Conversation Guide

Virginia Mason Franciscan Health™

2. Provide context for the conversation

Virginia Mason Franciscan Health™

2. Provide context for the conversation

New clinical reality.

Virginia Mason Franciscan Health™

2. Provide context for the conversation

1. Assess understanding [Tailor information based on what they already know]
   What have you already heard about your illness?
   From your perspective, how are things going with your health?
2. Ask permission
   Would it be OK if I share what I know?

3. Share information about the new clinical reality

Virginia Mason Franciscan Health™

2. Provide context for the conversation

Headline:

Information + meaning + *compassion*

CITY PRICES

London Herald

LATE EDITION

SATURDAY 11th NOVEMBER 1989

BERLIN WALL TUMBLES

'Beginning of the End' for Communism

Germany Re-unified

Virginia Mason Franciscan Health™

2. Provide context for the conversation

Jamie, your CT scan shows the cancer is worse, and I'm worried this means we are in a different place.

OR

This means that even with more treatments, I'm worried that time may be as short as weeks to short months.

Virginia Mason Franciscan Health™

2. Provide context for the conversation

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."

From the Serious Illness Conversation Guide

Virginia Mason Franciscan Health™

Pause

Acknowledge & validate emotion

Virginia Mason Franciscan Health™

3. Explore goals/values

Virginia Mason Franciscan Health™

3. Explore goals/values

Ask open ended questions:

Given what we know about your illness:

- What is most important to you?
- What are you hoping for?
- What are you worried about?
- What else?

Virginia Mason Franciscan Health™

Virginia Mason
Franciscan Health™

3. Explore goals/values

VALUES TRIAD

Longevity

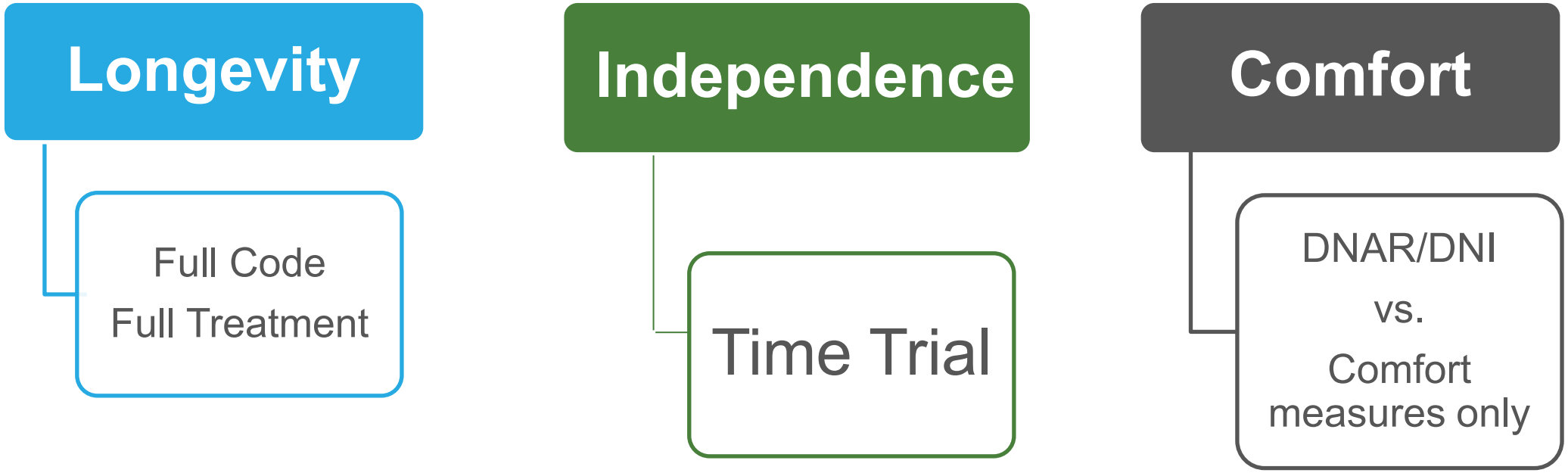
Independence

Comfort

Virginia Mason Franciscan Health™

3. Explore goals/values

VALUES TRIAD



Virginia Mason Franciscan Health™

3. Explore goals/values

FORECASTING . . .

“If you become sicker, what would you be willing to go through for the possibility of gaining more time?"

Virginia Mason Franciscan Health™

3. Explore goals/values

EMPTY CHAIR . . .

When talking with surrogate decision makers,
bring the patient into the room:

If your loved one could talk to us now, what would they say is most important?

Virginia Mason
Franciscan Health™

4. Affirm what you heard was most important

Virginia Mason Franciscan Health™

4. Affirm what you heard was most important

Reflecting back their values explicitly shows you listened.

“What I hear is most important is…”

“I’m also hearing...”

“Did I get that right?”

Virginia Mason Franciscan Health™

4. Affirm what you heard was most important

“What I hear is most important is to remain as comfortable as possible, ideally in your own home, even if it means you may not live as long.”

“I’m also hearing staying out of the hospital and not having invasive treatments like CPR at the end of your life is also important.”

“Did I get that right?”

Virginia Mason Franciscan Health™

4. Affirm what you heard was most important

Affirming ≠ agreeing.

Power of affirmation

Virginia Mason Franciscan Health™

5. Make a values based recommendation

Virginia Mason Franciscan Health™

5. Make a values based recommendation

We should…

We might…

And because you said … we shouldn't…

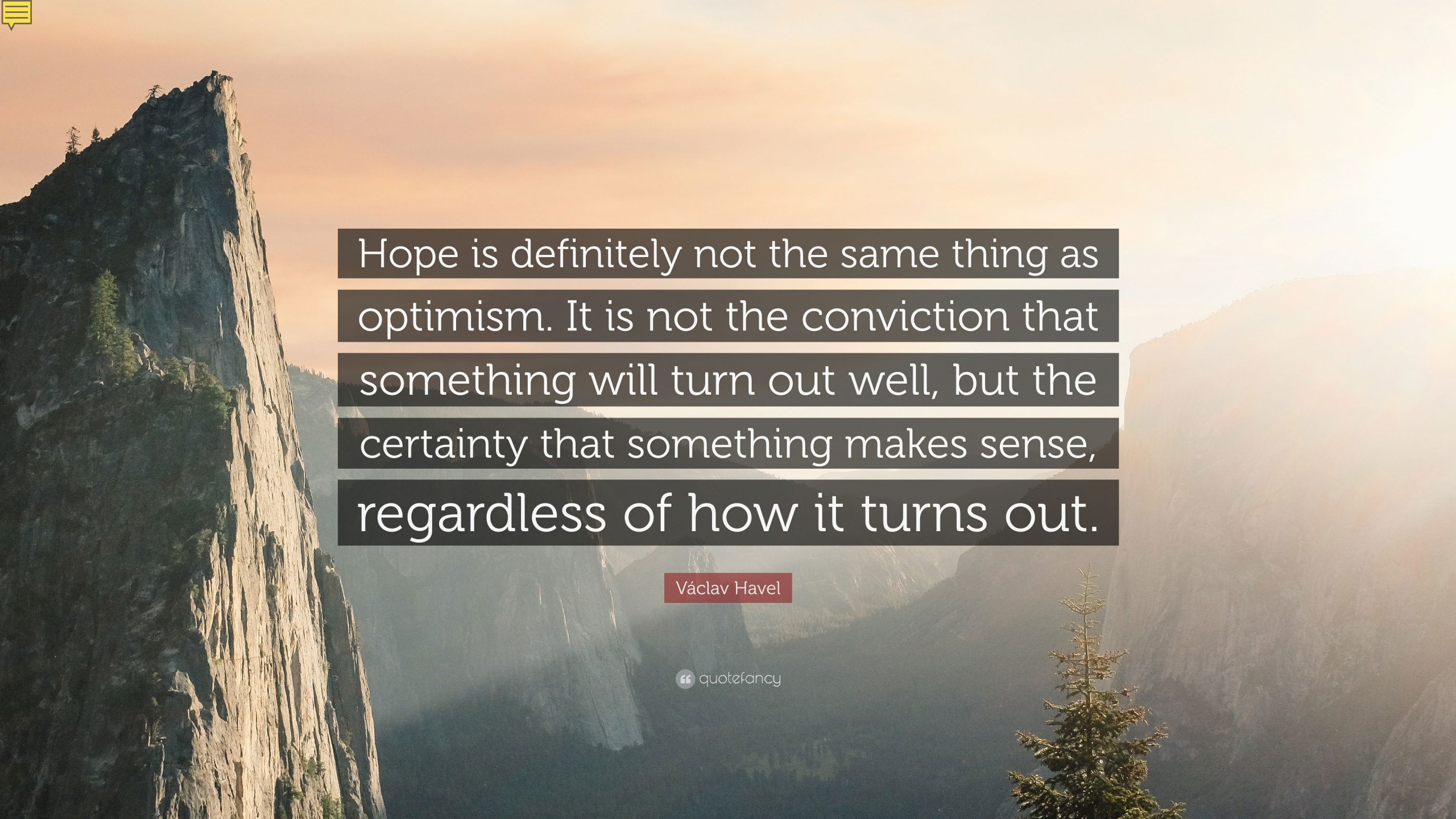
Virginia Mason Franciscan Health™

5. Make a values based recommendation

You may recommend a plan that differs from your own values.

Values Based Plan = Goal Concordant Care

Virginia Mason Franciscan Health™


Hope is definitely not the same thing as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out.
Václav Havel
quotefancy

5 steps for goals of care conversations:

1. Set up the conversation
2. Provide context for the conversation
3. Explore goals/values
4. Affirm what you heard was most important
5. Make a values based recommendation

Virginia Mason Franciscan Health™

ACP codes

CPT Codes	Billing Code Descriptors
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Documentation Requirements

You must document your ACP discussion with a patient, family member, caregiver, or surrogate. In your documentation, include:

- The voluntary nature of the visit
- The explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions

Virginia Mason Franciscan Health™

More information . . .

Name	Access	Description
Respecting Choices	Access to materials is through agreement with Respecting Choices www.respectingchoices.org	Provides training for structured facilitation of advance care planning
Vitaltalk	www.vitaltalk.org	Training for physicians and others leading goals of care conversations
VALUE framework	Publication[29]	Communication strategies to improve decision making
Serious Illness Care	https://www.ariadnelabs.org/areasof-work/serious-illness-care/	A program and guide to improve communication. Includes the serious illness communication guide
Best case/Worst case	Publication[35]	Communication tool for side by side comparison of options, and narrative description of the anticipated course with each option
Patient Priorities Care	Publication[7]	deliberate evaluation of patient values and the development of SMART goals (specific, measurable, actionable, reliable, and time bound) to drive medical decision-making.

Comer A, Fettig L, Torke AM. Identifying Goals of Care. Med Clin North Am. 2020 Sep;104(5):767-775. doi: 10.1016/j.mcna.2020.06.002. PMID: 32773044.

Questions?

Virginia Mason Franciscan Health™