Person-Centered Decision Making in Advancing Illness: 
*Essential Knowledge and Critical Skills*

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We have nothing to disclose
Objectives

• Describe the evidence supporting person-centered decision making and advance care planning in the context of advancing illness

• Understand the decisional and communication challenges in working with patients and families in this context

• Describe and use communication skills and strategies responsive to these challenges
communication in the context of advancing illness
National Academy of Medicine’s Dying in America (September 2014):

The bottom line is the health care system is poorly designed to meet the needs of patients near the end of life.

The current system is geared towards doing more, more, more …

… and that system by definition is not necessarily consistent with what patients want and is also more costly.
I am in a profession that has succeeded because of its ability to fix. If your problem is fixable, we know just what to do.

But if it’s not? The fact that we have had no adequate answers to this question is troubling and has caused callousness, inhumanity, and extraordinary suffering.

*This experiment of making mortality a medical experience is just decades old.*

It is young.

*And the evidence is it is failing.*

pp 8-9
concepts & evidence

decisional & communication challenges

communication skills & strategies
EDMUND D. PELLEGRINO, MD

A Tribute at 100
“Illness forces a change in existential states. It thrusts man into contact with the reality of the via dolorosa that all eventually must traverse. It is only in part defined medically as a concrete organic or psychosocial aberration. It is the perception of the change in existential states that forms the central experience of illness—the perception of impairment and the need to be made whole again—to be cured, healed, or cared for. That perception is personal and unique because each person has a different meaning for health and illness.”
“We feel healthy when we are in a state of equilibrium between our already experienced shortcomings and our aspirations so that we have adjusted our goals to the gap between them. Health is a state of accommodation, defined in different terms by each person.”

“Illness rudely upsets that equilibrium. It is an undesired, unsought, capricious irruption demanding a new equilibrium—one that may drastically different. It mean the loss of personal image, identity, or existence itself. The ill person becomes homo patiens—a patient—a person bearing a burden of distress, pain or anxiety—a person set apart, a person wounded in specific ways.”
“Homo patiens is therefore man in an altered state: wounded, vulnerable, needing help, and afflicted with a special anguish that must be adequately ameliorated in a bona fide healing relationship with other human beings. It is this fact that defines the healing relationship—between homo patiens and those who profess to make him whole again. Genuine healing must be based on an authentic perception of the experience of illness in this person. It must aim at a repair of the particular assaults that illness makes on the humanity of the one who is ill.”
“To heal is ‘to make whole again’ and that entails confronting and ameliorating the ways illness wounds the humanity of the one who is ill.”

“This is precisely what is promised when the professed healer presents himself before the ailing person. He promises that he has authentic knowledge and skill, competence; that he will put them at the service of the patient and will act in the patient’s best interest. This is the true meaning of the act of profession—a promise made to man as homo patiens. This voluntary act on the part of the healer signifies willingness to make the promise authentic.”
Medicine is a special moral enterprise because it is grounded in a special personal relationship—between one who is ill and another who professes to heal.

*Pellegrino, Being Ill & Being Healed, 1979*

Recognizes that “All illness, care, and healing processes occur in relationship” and that “the nature and the quality of relationships are central.” Prioritizes personhood, affect & emotion, reciprocal influence, and relationships are morally valuable.

*Beach & Inui, RCC: A Constructive Reframing, 2006*
The originators of patient centered health care were well aware of the moral implications of their work, which was based on deep respect for patients as unique living beings, and the obligation to care for them on their own terms.

Thus patients are known as persons in the context of their own social worlds, listened to, informed, respected and involved in their care—and their wishes are honored but not mindlessly enacted during their health care journey.

mindful, empathic communication

patient- & person-centered care

shared, informed decision making

advance care planning

What matters most—patient priorities in the context of advancing illness

What matters most—patient priorities in the context of advancing illness
Safe Care  
Safe Effective  
Beneficial  
Patient-and Family-Centered Care  
Enid & Michael Balint
Illness-orientated medicine

Seeks to identify a fault either in the body or in one of the parts or functions of the body in order thus to diagnose it as an illness and then treat it.

vs.

patient-centered medicine

... a patient-centered medicine examines the whole person in order to form an overall diagnosis, including everything that the doctor knows and understands about the patient ...

... the patient, in fact, must be understood as a unique human being.

8,000 interviews with patients, their families, physicians, and clinical staff:

What do patients want and value? What helps or hinders their ability to manage their health problems? What aspects of care are most important?
high quality health care is patient-centered as well as efficient, safe, equitable, effective, & timely... providing care that is respectful and representative of individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
<table>
<thead>
<tr>
<th>Principle</th>
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<tbody>
<tr>
<td>1. Care is based on continuous healing relationships</td>
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<td>2. Care is customized according to patient needs and values</td>
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<td>3. The patient is the source of control</td>
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<td>4. Knowledge is shared and information flows freely</td>
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<td>5. Decision making is evidence-based</td>
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<td>6. Safety is a system property</td>
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<td>7. Transparency is necessary</td>
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<td>8. Needs are anticipated</td>
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<td>9. Waste is continuously decreased</td>
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<td>10. Cooperation among clinicians is a priority</td>
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Perspective

Shared Decision Making — The Pinnacle of Patient-Centered Care

Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A.
Ethically valid consent is a process of shared decision making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments.

... a universal desire for information, choice, and respectful communication about decisions ... Informed consent must remain flexible, yet the process ... is ethically required of health care practitioners in their relationships with all patients, not a luxury for a few.
Clinician expertise
Diagnosis
Disease etiology
Prognosis
Treatment options
Outcome probabilities

shared, informed decision making

Patient expertise
Experience of illness
Social circumstances
Attitudes toward risk
Values
Preferences
systematic reviews of patient decision-making preferences indicate that majorities prefer to be actively involved in decision making ... the trend for a preference for shared decisions has increased over time.

A process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal ... is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness. For many people, this process may include choosing and preparing another trusted person or persons to make medical decisions in the event the person can no longer make his or her own decisions. (Sudore et al, 2017).
patient goals and priorities
what matters most to patients in the context of advancing illness

- cure
- avoidance of premature death
- maintenance/improvement of function
- prolongation of life
- relief of suffering
- optimized quality of life
- maintenance of control
- a good death
- support for families & loved ones
MORE IS NEEDED!

ACP associated with less aggressive treatment near death & earlier hospice referrals.

Aggressive treatment associated with worse patient QoL and worse bereavement adjustment.

Prospective RCT – 309 patients/154 in intervention (ACP) arm – focus on goals, values & beliefs; future medical preferences; appointment of surrogate; documentation of wishes

Main outcome measure: were patients’ wishes known AND respected? Other measures: patient & family satisfaction; stress, anxiety, & depression in surviving relatives

Key findings: ACP improved EOLC and patient & family satisfaction & reduces distress in NoK

Respecting Choices & Related Models of ACP

- Increase in incidence and prevalence of advance directives and POLST: low level of evidence
- Increase patient-surrogate congruence: high level of evidence
- Change the consistency of treatment with wishes and overall health care utilization at EOL: mixed & inconclusive

ACP: Strategic Timing

Fundamental goal of ACP: to assure that care is congruent with a patient’s informed wishes

Avoiding the problem of “too early” and “too late”: the importance of prognostication in identifying patients who would benefit from ACP

the surprise?: Would you be surprised if this patient died within the next year? (supporting evidence in cancer and ESRD patients)

For older adults with multiple chronic conditions is care that is aligned with their priorities associated with improved patient-reported outcomes and reduced unwanted care?

Non-randomized clinical trial of 366 adults 65 years+ with multiple chronic conditions found that participants receiving patient priority-driven care vs usual care reported a greater reduction in treatment burden and their EHRs reflected, e.g., cessation of medications, diagnostic tests, etc.

**Aligning care with patients’ priorities may improve outcomes for patients with multiple chronic conditions.**

high quality care in serious illness:
concordance between patient goals/priorities & treatment

discordant treatment:
a medical error

communication quality & processes
- Info gathering & sharing
- Responding to emotion
- Fostering relationships
- Timing & setting

patient experience
- personhood;
- informed-ness;
- QoL; trust;
- Tx alliance;
- distress

shared decision making
ACP
In the moment decisionmaking

bereaved caregiver experience
- distress
- regret
- trust
- peacefulness

GOAL CONCORDANT CARE

train clinicians

identify at risk patients

use checklist or guides

trigger discussions in the o/p setting before crises

optimize the EHR

measure & report performance

educate patients & families

Decisional and communication challenges

- Time/reimbursement
- Training
- Ideal space
- Getting the "right" people together
- Timing; "too early...until too late"
- Medical complexity
- Family complexity
Decisional and communication challenges

U.S. physicians spent **17-24 minutes** with their patients, according to a survey conducted in 2018.

Decisional and communication challenges

• Training

“It has been observed that communication skills tend to decline as medical students progress through their medical education, and over time doctors in training tend to lose their focus on holistic patient care. Furthermore, the emotional and physical brutality of medical training, particularly during internship and residency, suppresses empathy, substitutes techniques and procedures for talk, and may even result in derision of patients”

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/
Decisional and communication challenges

- Training

“Fewer than one-third (29%) of physicians report having any formal training in communication about goals of care, and nearly half (46%) report that they are unsure about what to say”

https://www.capc.org/strategies/clinical-communication-skills/
Decisional and communication challenges

- Preserving Autonomy
- Advance directives
- Healthcare Representatives
  - spouse and adult child who is not the child of the spouse
  - adult child
  - parent
  - adult sibling
  - adult grandchild
  - close friend

- Who makes the decisions?

- Act 169
  https://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2006&sessInd=0&smthLwInd=0&act=169
Decisional and communication challenges

- Who makes the decisions?
- Emotionally laden topics
- Jargon and forms
- Documentation workflows, fidelity and translation into practice
- Bias
Decisional and communication challenges

- Who makes the decisions?
- Emotionally laden topics
- Jargon and forms
- Documentation workflows, fidelity and translation into practice
- Bias

What is ‘quality of life’?
Communication skills and strategies

• Responding to emotions
• Vital Talk
• ADAPT
• Ariadne Labs
• Respecting Choices: Advance Care Planning and Shared Decision-Making in Serious Illness
CAPC Communication Courses

https://www.capc.org/

5 Courses

- **Delivering Serious News**
  Communicating serious clinical news to patients and families.
  Completed on Nov. 18, 2018
  VIEW

- **Discussing Prognosis**
  How to discuss patient prognosis in a manner that is sensitive, clear, and supportive.
  Completed on Nov. 18, 2018
  VIEW

- **Clarifying Goals of Care**
  Strategies for eliciting patient goals and preferences to inform treatment decisions.
  Completed on Dec. 3, 2018
  VIEW

- **Conducting a Family Meeting**
  Communication techniques for an effective family meeting.
  Completed on Dec. 5, 2018
  VIEW

- **Advance Care Planning Conversations**
  How to initiate and conduct conversations about advance care planning.
  Completed on Nov. 4, 2018
  VIEW
# NURSE the Emotions

<p>| | |</p>
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<tbody>
<tr>
<td><strong>Naming</strong></td>
<td>“It sounds like you are frustrated”</td>
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<tr>
<td></td>
<td>In general, turn down the intensity a notch when you name the emotion</td>
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<tr>
<td><strong>Understanding</strong></td>
<td>“This helps me understand what you are thinking”</td>
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<tr>
<td></td>
<td>Think of this as another kind of acknowledgment but stop short of suggesting you understand everything (you don’t)</td>
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<tr>
<td><strong>Respecting</strong></td>
<td>“I can see you have really been trying to follow our instructions”</td>
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<td></td>
<td>Remember that praise also fits in here eg “I think you have done a great job with this”</td>
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<tr>
<td><strong>Supporting</strong></td>
<td>“I will do my best to make sure you have what you need”</td>
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<tr>
<td></td>
<td>Making this kind of commitment is a powerful statement</td>
</tr>
<tr>
<td><strong>Exploring</strong></td>
<td>“Could you say more about what you mean when you say that…”</td>
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<td></td>
<td>Asking a focused question prevents this from seeming too obvious</td>
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[Image of a nurse and patient]
# Responding to Emotions

## Three fundamental skills

<table>
<thead>
<tr>
<th>Example</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tell me more</strong></td>
<td><strong>“Tell me more about…”</strong></td>
</tr>
<tr>
<td></td>
<td>Use when you are not sure what someone is talking about (rather than jump to an assumption).</td>
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<tr>
<td><strong>Ask-tell-ask</strong></td>
<td><strong>“What do you think about…”</strong></td>
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<td></td>
<td><strong>“Here’s what the tests show”</strong></td>
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<td></td>
<td><strong>“Does that make sense…?”</strong></td>
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<td></td>
<td>Related to Assess-Knowledge-Respond in SPIKES. Think of this as one unit of information transfer</td>
</tr>
<tr>
<td><strong>“I wish” statements</strong></td>
<td><strong>“I wish I could say that the chemo always works”</strong></td>
</tr>
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<td></td>
<td>Enables you to align with the patient while acknowledging the reality of the situation</td>
</tr>
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</table>
## Discussing Prognosis: ADAPT

<table>
<thead>
<tr>
<th>Step</th>
<th>What you say</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask what the patient knows, what they want to know</td>
<td>What have other doctors told you about what your prognosis, or the future? How much have you been thinking about the future?</td>
</tr>
<tr>
<td>2. Discover what info about the future would be useful for the pt</td>
<td>For some people prognosis is numbers or statistics about how long they will live. For other people, prognosis is about living to a particular date. What would be more helpful for you?</td>
</tr>
<tr>
<td>3. Anticipate ambivalence</td>
<td>Talking about the future can be a little scary. If you’re not sure, maybe you could tell me how you see the pros and cons of discussing this. If clinically deteriorating: From what I know of you, talking about this information might affect decisions you are thinking about.</td>
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<tr>
<td>4. Provide information in the form the patient wants</td>
<td>To provide using statistics: The worst case scenario is [25th percentile], and the best case scenario is [75th percentile]. If I had 100 people with a similar situation, by [median survival], 50 would have died of cancer and 50 would still be alive with cancer. To provide without statistics: From my knowledge of your situation and how your cancer has been changing/responding, I think there is a good/50-50/slim chance that you will be able to be around [on that date/for that event].</td>
</tr>
<tr>
<td>5. Track emotion</td>
<td>I can see this is not what you were hoping for. I wish I had better news. I can only imagine how this information feels to you. I appreciate that you want to know what to expect.</td>
</tr>
</tbody>
</table>
Communication skills and strategies

Serious Illness Conversation Guide

– Ariadne Labs:
  • https://www.ariadnelabs.org/about-us/

– The Guide:

– Video:
  • https://www.ariadnelabs.org/resources/videos/introducing-serious-illness-care-program/
Communication skills and strategies

## Serious Illness Conversation Guide

<table>
<thead>
<tr>
<th>CONVERSATION FLOW</th>
<th>PATIENT-TESTED LANGUAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Set up the conversation</strong></td>
<td>&quot;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?&quot;</td>
</tr>
<tr>
<td>- Introduce purpose</td>
<td></td>
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<tr>
<td>- Prepare for future decisions</td>
<td></td>
</tr>
<tr>
<td>- Ask permission</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Assess understanding and preferences</strong></td>
<td>&quot;What is your understanding now of where you are with your illness?&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;How much information about what is likely to be ahead with your illness would you like from me?&quot;</td>
</tr>
<tr>
<td>3. <strong>Share prognosis</strong></td>
<td>&quot;I want to share with you my understanding of where things are with your illness...&quot;</td>
</tr>
<tr>
<td>- Share prognosis</td>
<td>Uncertain: &quot;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.&quot;</td>
</tr>
<tr>
<td>- Frame as a &quot;wish...worry&quot;, &quot;hope...worry&quot; statement</td>
<td>OR Time: &quot;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).&quot;</td>
</tr>
<tr>
<td>- Allow silence, explore emotion</td>
<td>OR</td>
</tr>
<tr>
<td>4. <strong>Explore key topics</strong></td>
<td>&quot;What are your most important goals if your health situation worsens?&quot;</td>
</tr>
<tr>
<td>- Goals</td>
<td>&quot;What are your biggest fears and worries about the future with your health?&quot;</td>
</tr>
<tr>
<td>- Fears and worries</td>
<td>&quot;What gives you strength as you think about the future with your illness?&quot;</td>
</tr>
<tr>
<td>- Sources of strength</td>
<td>&quot;What abilities are so critical to your life that you can’t imagine living without them?&quot;</td>
</tr>
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<td>- Critical abilities</td>
<td>&quot;If you become sicker, how much are you willing to go through for the possibility of gaining more time?&quot;</td>
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<td>- Tradeoffs</td>
<td>&quot;How much does your family know about your priorities and wishes?&quot;</td>
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<td>- Family</td>
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</table>
| 5. **Close the conversation**         | "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."
|   - Summarize                           | "How does this plan seem to you?"                                                      |
|   - Make a recommendation             | "I will do everything I can to help you through this."                                   |
|   - Check in with patient              |                                                                                         |
|   - Affirm commitment                  |                                                                                         |
| 6. **Document your conversation**     |                                                                                         |
| 7. **Communicate with key clinicians**|                                                                                         |
Communication skills and strategies

### Serious Illness Conversation Guide

**Conversation Flow**

| 1. Set up the conversation | "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?" |
| 2. Address |  |
| 3. Share |  |
| 4. Explore |  |
| 5. Close the conversation | "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you." |
| 6. Document your conversation |  |
| 7. Communicate with key clinicians |  |

**Patient-Tested Language**

- **Set up the conversation**: Introduce purpose, prepare for future decisions.
- **Address**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
- **Share**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
- **Explore**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
- **Close the conversation**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
- **Document your conversation**:  
- **Communicate with key clinicians**:  

---

**Communication between Doctor and Patient**

- **Doctor**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
- **Patient**: "I want to make sure that we ... This will help us make sure that your treatment plans reflect what's important to you."
Communication skills and strategies

**Serious Illness Conversation Guide**

**CONVERSATION FLOW**

1. **Set up the conversation**
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission

2. **Assess understanding and set stage**
   - "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?"

3. **Advance conversation**
   - "What is your understanding now of where you are with your illness?"
   - "What abilities are so critical to your life that you can't imagine living without them?"
   - "What are you most worried about with your health?"
   - "What are you most worried about with your illness?"
   - "If something is getting worse, what questions would you like me to ask?"

4. **Review and reflect**
   - "How do you feel about what we talked about?"
   - "How would you like me to summarize what we discussed?"

"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?"
Communication skills and strategies

Serious Illness Conversation Guide

1. **Set up the conversation**
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission

2. **Assess understanding and preferences**
   - "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?"

4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family

5. **Close the conversation**
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment

6. **Document your conversation**

7. **Communicate with key clinicians**
Communication skills and strategies

Serious Illness Conversation Guide

CONVERSATION FLOW

PATIENT-TESTED LANGUAGE

“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.”

5. Close the conversation
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment

6. Document your conversation

7. Communicate with key clinicians

I am prepared for the worst, but hope for the best.
Benjamin Disraeli
Communication skills and strategies

Serious Illness Conversation Guide

CONVERSATION FLOW

1. Check in with patient
   - Affirm commitment

2. Document your conversation

3. Communicate with key clinicians

PATIENT-TESTED LANGUAGE

“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?”

“I will do everything I can to help you through this.”
Explore Understanding of Options

• “...how much are you **willing to go through** to possibly gain more time?”
  – Another hospitalization
  – ICU level of care
  – Another course of chemotherapy
  – LVAD placement
  – Dialysis
  – Intubation and mechanical ventilation
  – CPR
Explore Understanding of Options

What do you understand about the possible *benefits and burdens* of:

– Another hospitalization
– ICU level of care
– Another course of chemotherapy
– LVAD placement
– Dialysis
– Intubation and mechanical ventilation
– CPR
Communication skills and strategies

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"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."

- Critical abilities
- Tradeoffs
- Family

"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?"

5. Close the conversation
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment

"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."

6. Document your conversation
7. Communicate with key clinicians
Communication skills and strategies

Epic ACP Activity
Accessible
Reliable
Actionable
PA POLST

- Medical order
- Signed by patient or HCPOA
- Signed by MD/DO, PA, NP
- Would you be surprised if the patient died in next year? (AUC ~0.80)
- Part A-No pulse/breathing
  - CPR or AND?
- Part B- Compromised state
  - Intubation/MV & hospitalization or comfort care?
- Part C- Antibiotics?
- Part D- tube feeding or not?

ACP Billing

• 2016 MC began reimbursement.
• Physicians and non-physician providers can bill. Other staff when under direct supervision of managing physician.
• Any care setting; office, hospital, facility, home. Special rules for telehealth, hospice, FQHC, PACE.
• What should be included?
  – A conversation that is voluntary, with an opportunity to decline.
  – An in-person, face-to-face conversation with a patient who has the capacity to participate OR an in-person conversation with the designated surrogate, if the patient is unable to participate (e.g., a patient on a ventilator or a patient with advanced dementia).
  – A conversation specific to a patient’s health status and medical condition.
Role Play Exercise

• Introduce person-centered communication skills
• Practice using Ariadne SICG
• Experience from patient and surrogate perspective
• Give and receive feedback
• Acknowledgements:
  – Environmental
  – Personal
  – Time
Role Play Exercise

- **Charlie**: 78 year-old man.
- **PMH**: diabetes mellitus type 2 (controlled); HFpEF (NYHA II; hospitalized 9 months ago; ED twice since); severe dementia (limited ability to contribute to decision-making; responses are 'yes/no' with interjected, random, perseverating statements)
- **Social**: Lives in ranch house with **wife (Nancy)**. Son (John) lives nearby. Has advance directive which is 2 years-old, declaring Nancy as HCPOA and minimalist care choices (DNR/DNI, no transfusion, no mechanical ventilation, no tube feeding)
- **Functional**: Ambulates with walker; mechanical fall 3 months ago with no major injuries. No driving for 2 years. Dependent for all IADLs. Independent for all ADLs but has had a few episodes of urinary incontinence.
Role Play Exercise

Groups of 3 participants, 3 conversations, 10 minutes each, followed by time to debrief.

<table>
<thead>
<tr>
<th></th>
<th>Conversation 1</th>
<th>Conversation 2</th>
<th>Conversation 3</th>
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<tbody>
<tr>
<td>Participant 1</td>
<td>Clinician</td>
<td>Nancy</td>
<td>Charlie</td>
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<tr>
<td>Participant 2</td>
<td>Charlie</td>
<td>Clinician</td>
<td>Nancy</td>
</tr>
<tr>
<td>Participant 3</td>
<td>Nancy</td>
<td>Charlie</td>
<td>Clinician</td>
</tr>
</tbody>
</table>
Role Play Exercise

• Conversation 1: Communicate about Charlie and Nancy's understanding of Charlie’s condition, prognostic awareness, hopes and fears
• Conversation 2: Communicate about critical abilities, what would Charlie be willing to go through to possibly gain more time
• Conversation 3: Shared decision-making regarding CPR (confirming the accuracy of his prior advance directive which could possibly lead to completion of a POLST form)
Role Play Exercise

Debrief:

– Clinician: How did this feel? What went well and not so well? How could you incorporate this into your practice?
– Charlie: How did this feel? Did the clinician and Nancy keep you at the center?
– Nancy: How did this feel? Was the conversation about Charlie's preferences and decisions, or yours?
Wrap-up

• Evidence supports person-centered communication
• Decisional and communication challenges are solvable with evidence-based practice and system design
• Mindful integration of these skills improves patient and family satisfaction, provider and team wellbeing, and reduction in unnecessary costs
• Person-centered, shared-decision making goes beyond ‘code status’ to include all healthcare decisions
• Commit to a SMART plan of integrating these skills into your practice in the next week
Thank you!