# Community-Based Primary Palliative Care Community of Practice Series 2

## Communication: Part 2

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Nadine Gebara
Guest Speaker: Dr. Justin Sanders
Date: December 7th 2022

# Territorial Honouring

# The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

**Stay connected: www.echopalliative.com**

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

# LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

# Objectives of this Series

**After participating in this series, participants will be able to:**

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

# Overview of Sessions

| Session # | Session Title | Date/ Time |
|---|---|---|
| Session 1 | Pain: Beyond the Basics | Nov 9, 2022 from 1-2pm ET |
| Session 2 | Communication: Part 1 | Nov 23, 2022 from 1-2pm ET |
| Session 3 | Communication: Part 2 | Dec.7, 2022 from 1-2pm ET |
| Session 4 | Palliative Care and Substance Use Disorders | Jan 18, 2023 from 1-2pm ET |
| Session 5 | GI Symptoms in Palliative Care | Feb 1, 2023 from 1-2pm ET |
| Session 6 | Delirium | Feb 15, 2023 from 1-2pm ET |
| Session 7 | Spiritual Care and Rituals around Death and Dying | Mar 1, 2023 from 1-2pm ET |
| Session 8 | Palliative Sedation | Mar 15, 2023 from 1-2pm ET |
| Session 9 | What's in store for Palliative Care in Canada: Policy, Advocacy and Implementation | Mar 29, 2023 from 1-2pm ET |
| Session 10 | Grief and Bereavement: Beyond the Basics | Apr 12, 2023 from 1-2pm ET |
| Session 11 | Practical Tips: Lessons from the Front Line | Apr 26, 2023 from 1-2pm ET |

# Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function to ask questions and add comments throughout the session
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **11 Mainpro+** credits.

# Disclosure

Relationship with Financial Sponsors:

**Pallium Canada**

- Not-for-profit
- Funded by Health Canada

# Disclosure

**This program has received financial support from:**

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

**Facilitator/ Presenter:**

- Dr. Nadine Gebara: Nothing to disclose
- Dr. Justin Sanders: Nothing to disclose
- Dr. Haley Draper: Nothing to disclose

# Disclosure

**Mitigating Potential Biases:**

- The scientific planning committee had complete independent control over the development of course content

# Introductions

**Facilitator:**

**Dr. Nadine Gebara, MD CCFP- PC**
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

**Panelists:**

**Dr. Haley Draper, MD CCFP- PC**
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

**Dr. Roger Ghoche, MDCM CCFP-PC, MTS**
Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital - Montreal

# Introductions

## Panelists (continued):

**Elisabeth Antifeau, RN, MScN, CHPCN(C), GNC(C)**
Regional Clinical Nurse Specialist (CNS-C), Palliative End of Life Care
IH Regional Palliative End of Life Care Program
Pallium Canada Master Facilitator & Coach, Scientific Consultant

**Thandi Briggs, RSW MSW**
Care Coordinator, Integrated Palliative Care Program
Home and Community Care Support Services Toronto Central

**Claudia Brown, RN BSN**
Care Coordinator, Integrated Palliative Care Program
Home and Community Care Support Services Toronto Central

**Rev. Jennifer Holtslander, SCP-Associate, MRE, BTh**
Spiritual Care Provider

## Support Team

**Aliya Mamdeen**
Program Delivery Officer, Pallium Canada

**Diana Vincze**
Palliative Care ECHO Project Manager, Pallium Canada

# Introductions

**Presenter:**

**Dr. Justin Sanders, MD, MSC**

Kappy and Eric M. Flanders Chair of Palliative Care
Director, Palliative Care McGill
Associate Professor, Department of Family Medicine, McGill University

# Beyond the Essential Communication Skills- Part 2

# Session Learning Objectives

**Upon completing the session, participants will be able to:**

- Describe the potential impact of an evidence-based communication tool to help navigate goals of care and serious illness conversations.
- Integrate strategies to eliciting values and aligning them with a recommendation regarding future care options.
- Reflect on the primary motivation for applying communication skills in the setting of serious illness.

# Agenda

- Serious illness communication: contexts, concepts, and tools
- The Serious Illness Conversation Guide: a framework and some words to try
- Strategies to make the SICG most useful
- Reflection on the value of serious illness communication

# Serious Illness Communication: Contexts and Concepts

- A range of terms and activities that use similar skills: ACP, Early Goals of Care, Late Goals of Care, Code Status Discussions, Serious illness Conversations
- Overlapping concepts and skills
- “Goals of care” conversations happen when things are going wrong

# Serious Illness Communication: …and tools

PLOS ONE

OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

## Communication Tools for End-of-Life Decision-Making in Ambulatory Care Settings: A Systematic Review and Meta-Analysis

Simon J. Oczkowski, Han-Oh Chung, Louise Hanvey, Lawrence Mbuagbaw, John J. You

Published: April 27, 2016 • https://doi.org/10.1371/journal.pone.0150671

# Serious Illness Communication: …and tools

PLOS ONE

**Conclusions**

The use of structured communication tools may increase the frequency of discussions about and completion of advance directives, and concordance between the care desired and the care received by patients. The use of structured communication tools rather than an ad-hoc approach to end-of-life decision-making should be considered, and the selection and implementation of such tools should be tailored to address local needs and context.

# A Serious Illness Conversation Guide

## Some history…

- Started with a conversation between Atul Gawande and Susan Block
- Developed at Ariadne Labs
- Part of a systems-level approach
- In use in health systems around the world

## Serious Illness Conversation Guide

**PATIENT-TESTED LANGUAGE**

**SET UP**

"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?**"

**ASSESS**

"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?"

**SHARE**

"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."

**EXPLORE**

"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?"

**CLOSE**

"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."

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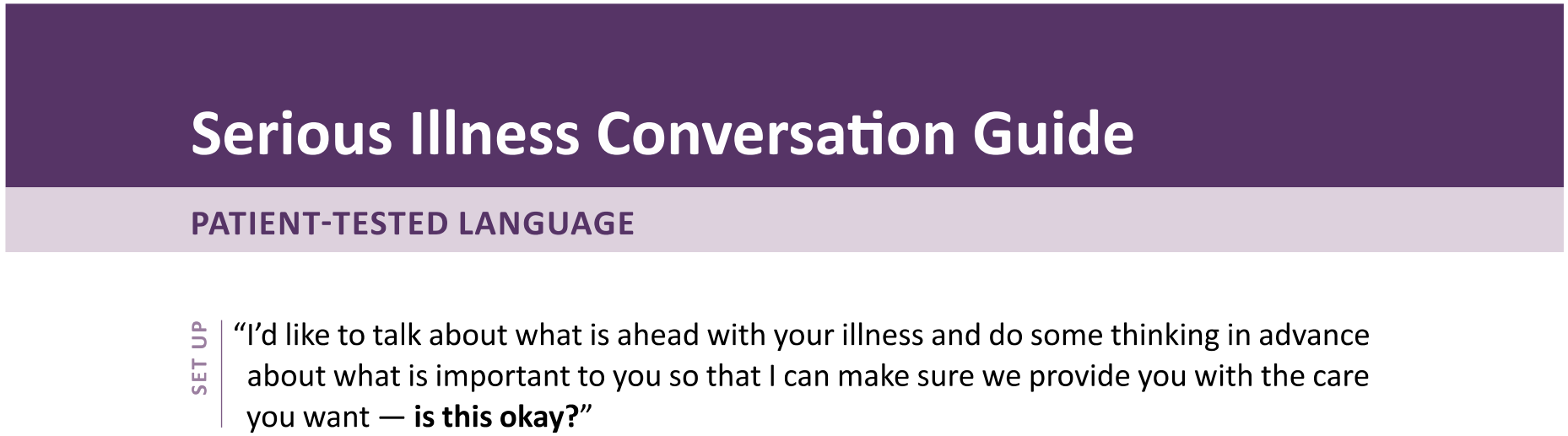
SI-CG 2017-04-18

# A Serious Illness Conversation Guide



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"How does this plan seem to you?"

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

# A Serious Illness Conversation Guide Some evidence

## More, Earlier, and Better Serious Illness Conversations

- 96% vs. 79% documented conversations (p<.001)
- 144 vs. 71 days, conversation documented prior to death (p<0.001)
- 90% vs 45% documentation of prognosis disclosure (p<0.001)
- 89% vs 44% documentation of goals and values (p<0.001)

Paladino J. JAMA IM 2019

# Serious Illness Conversations improve patient well-being and outcomes

- 50% reduction in rates of moderate to severe anxiety and depression
- Better illness understanding

*"When I talk to my family, I tell them what [the doctor] said. It's not a death sentence, but [the doctor] has to tell us. Now we're treasuring every day we have together."*

- Improved relationships with clinicians

*"I felt more valued as a patient, like we got a little bit closer."*

- Increased focus on practical planning

*"I came home and had this conversation with my daughter…and have been working on a living will and who's in charge of making my medical decisions if I cannot so my wife and kids know my final wishes."*



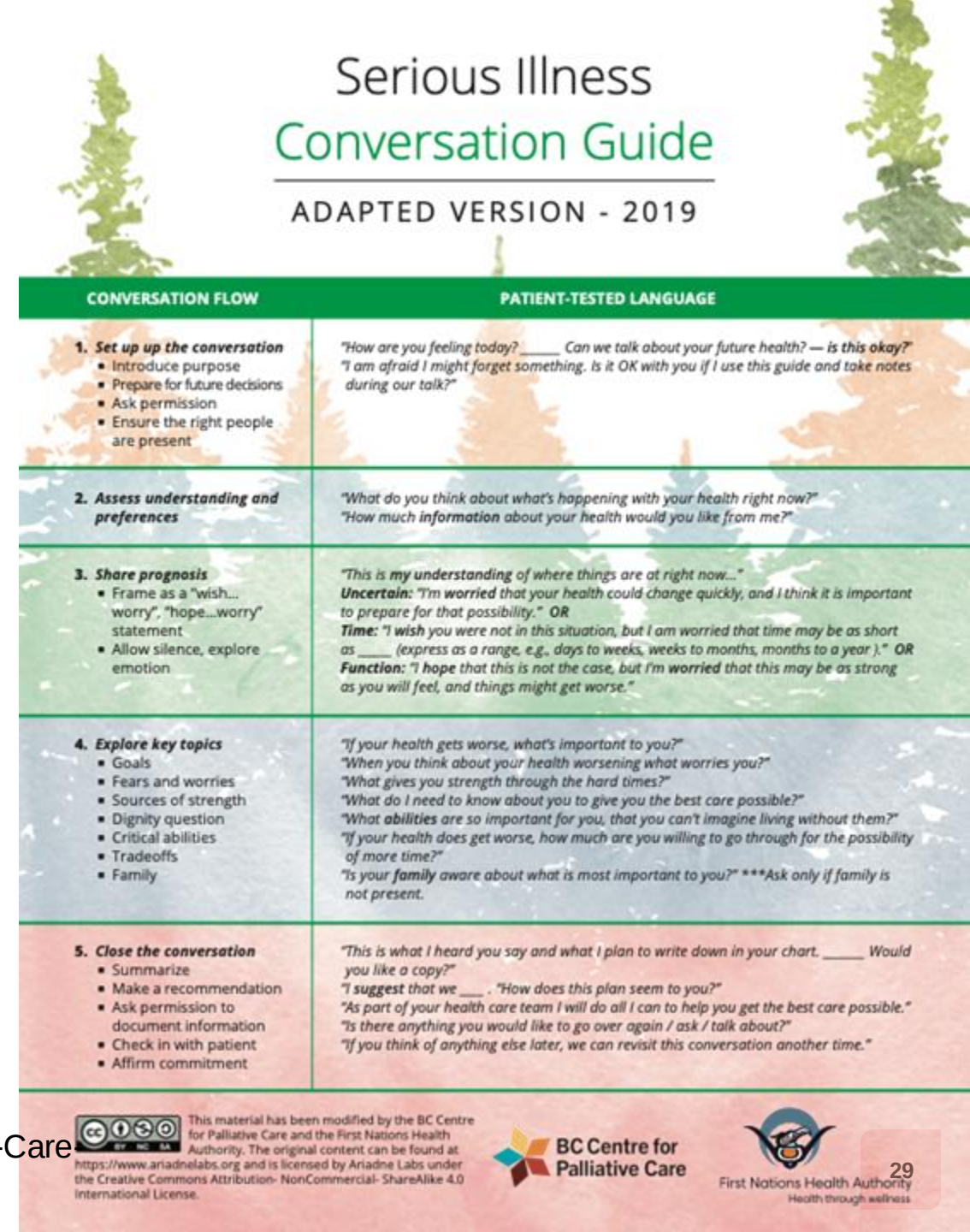
Bernacki R. JAMA Onc 2019; Paladino J. JAMA IM 2019; Kumar P. JCO. 2020; Paladino J. JPM. 2020

# Serious Illness Conversations improves clinician confidence and satisfaction

- SICG effective & efficient (90%)
- Increased satisfaction in their role (70%)
- Reduced anxiety in having serious illness conversations (~2/3)
- Improved patient-centered communication skills ($p<0.0001$)

*"I feel more comfortable and empowered to have these conversations with my patients."*

# A Serious Illness Conversation Guide - First Nations Adapted



Serious Illness
Conversation Guide
ADAPTED VERSION - 2019

| CONVERSATION FLOW | PATIENT-TESTED LANGUAGE |
|---|---|
| **1. *Set up up the conversation***<br>• Introduce purpose<br>• Prepare for future decisions<br>• Ask permission<br>• Ensure the right people are present | *"How are you feeling today? _____ Can we talk about your future health? — **is this okay?**"*<br>*"I am afraid I might forget something. Is it OK with you if I use this guide and take notes during our talk?"* |
| **2. *Assess understanding and preferences*** | *"What do you think about what's happening with your health right now?"*<br>*"How much **information** about your health would you like from me?"* |
| **3. *Share prognosis***<br>• Frame as a "wish... worry", "hope...worry" statement<br>• Allow silence, explore emotion | *"This is **my understanding** of where things are at right now..."*<br>***Uncertain:** "I'm **worried** that your health could change quickly, and I think it is important to prepare for that possibility." **OR***<br>***Time:** "I **wish** you 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***<br>***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 might get worse."* |
| **4. *Explore key topics***<br>• Goals<br>• Fears and worries<br>• Sources of strength<br>• Dignity question<br>• Critical abilities<br>• Tradeoffs<br>• Family | *"If your health gets worse, what's important to you?"*<br>*"When you think about your health worsening what worries you?"*<br>*"What gives you strength through the hard times?"*<br>*"What do I need to know about you to give you the best care possible?"*<br>*"What **abilities** are so important for you, that you can't imagine living without them?"*<br>*"If your health does get worse, how much are you willing to go through for the possibility of more time?"*<br>*"Is your **family** aware about what is most important to you?" ***Ask only if family is not present.* |
| **5. *Close the conversation***<br>• Summarize<br>• Make a recommendation<br>• Ask permission to document information<br>• Check in with patient<br>• Affirm commitment | *"This is what I heard you say and what I plan to write down in your chart. _____ Would you like a copy?"*<br>*"I **suggest** that we ___ . "How does this plan seem to you?"*<br>*"As part of your health care team I will do all I can to help you get the best care possible."*<br>*"Is there anything you would like to go over again / ask / talk about?"*<br>*"If you think of anything else later, we can revisit this conversation another time."* |

This material has been modified by the BC Centre for Palliative Care and the First Nations Health Authority. The original content can be found at https://www.ariadnelabs.org and is licensed by Ariadne Labs under the Creative Commons Attribution- NonCommercial- ShareAlike 4.0 International License.

BC Centre for Palliative Care

First Nations Health Authority
Health through wellness

https://www.fnha.ca/Documents/FNHA-BC-Centre-for-Palliative-Care-Preparing-for-a-Serious-Illness-Conversation-Guide.pdf

# A Serious Illness Conversation Guide - First Nations Adapted

| | |
|---|---|
| **4. *Explore key topics***<br>▪ Goals<br>▪ Fears and worries<br>▪ Sources of strength<br>▪ Dignity question<br>▪ Critical abilities<br>▪ Tradeoffs<br>▪ Family | *"If your health gets worse, what's important to you?"*<br>*"When you think about your health worsening what worries you?"*<br>*"What gives you strength through the hard times?"*<br>*"What do I need to know about you to give you the best care possible?"*<br>*"What **abilities** are so important for you, that you can't imagine living without them?"*<br>*"If your health does get worse, how much are you willing to go through for the possibility of more time?"*<br>*"Is your **family** aware about what is most important to you?" ***Ask only if family is not present.* |
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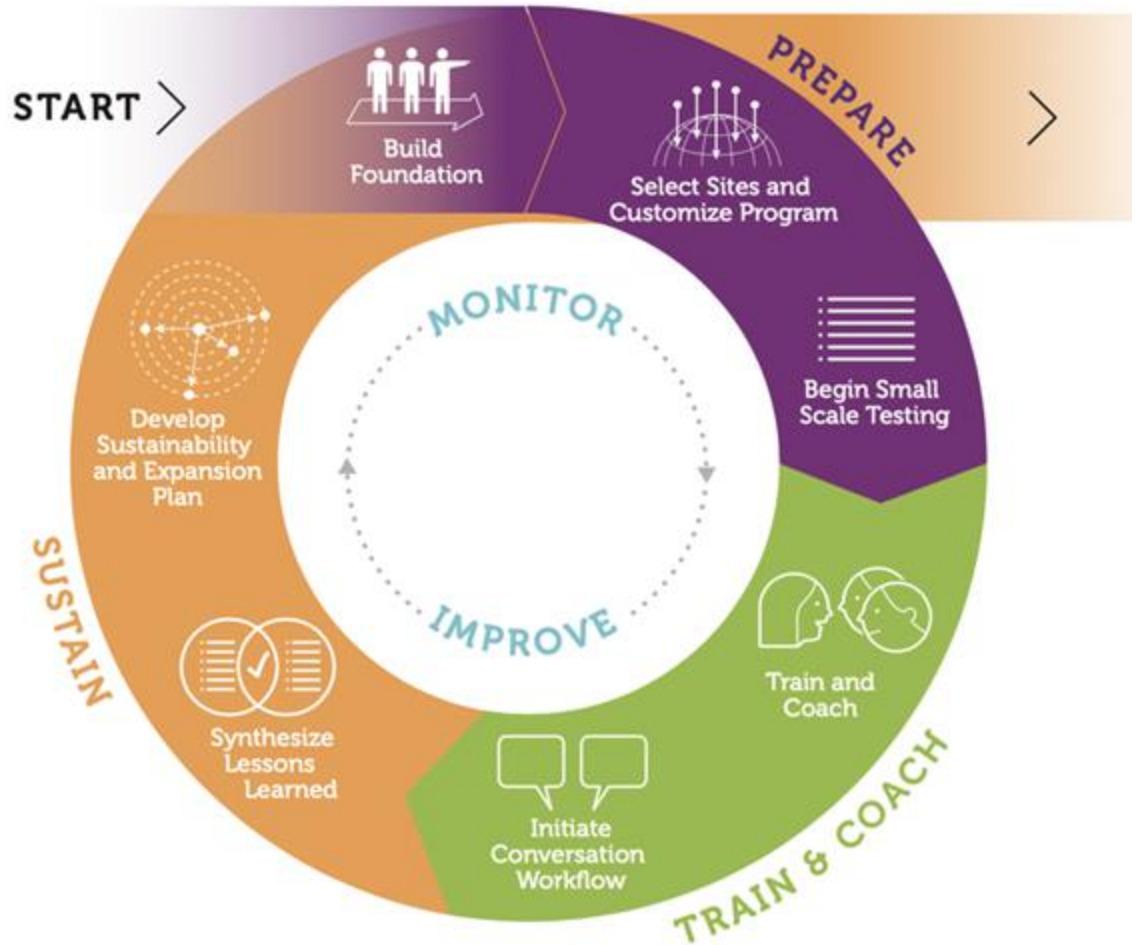
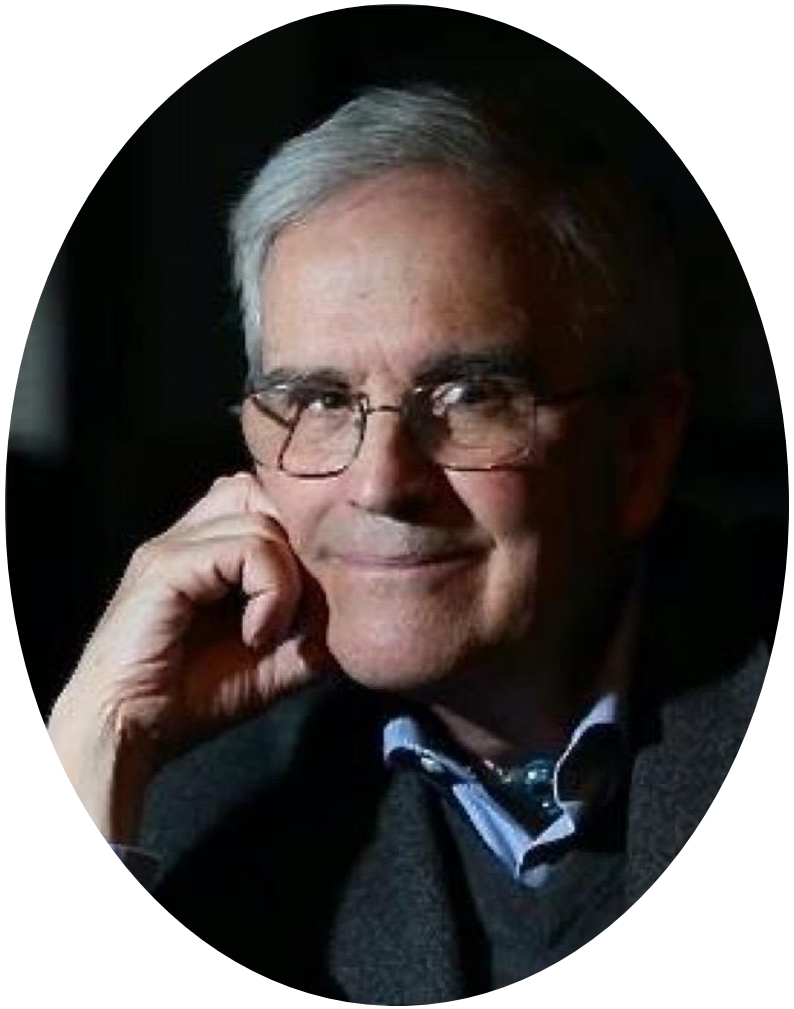
https://www.fnha.ca/Documents/FNHA-BC-Centre-for-Palliative-Care-Preparing-for-a-Serious-Illness-Conversation-Guide.pdf

# Strategies to make SICG most useful

- Practice: Whose words are these?
- Respond to Emotion
- Bookmark
- Remember the value of a recommendation
- Engage the system



# On the value of serious illness communication



What we're trying to do in Palliative Care, and **all medical care**, is establish healing connections to be experienced by those who are ill or dying and their families.

# Questions & Discussion

# Interactive, Case-Based Discussion

# Mini Cases

1) What makes this case difficult?
2) What skill or tool can you use to navigate this

# Mini Case #1

- Ms. S is an 87 yo F. She presented with an intracranial hemorrhage, attributed to an unwitnessed fall. She required intubation in the ER for decreased LOC. Her long-time friend is her POA. They met at a pro-life rally in 1969. Ms. S is catholic and very observant. Her POAs son is a priest. The POA is clear that intubation, CPR and artificial feeding are within her goals of care. The intensivist has shared that Ms. S will have no meaningful recovery and that her prognosis is measured in days.

1. **What makes this case difficult?**
2. **What skill or tool can you use to navigate this?**

# Mini Case #2

- Mrs. P is a 76 yo F with end stage heart failure. She is admitted to hospital with a heart failure exacerbation. She is requiring a Lasix infusion and vasopressor support. You are meeting her on day 3 of admission. The Cardiology team has asked you to address her code status as it is currently "full code". They share that the ER physician, intensivist and cardiologist have all attempted to discuss goals of care. Mrs. P and her daughter Janet are frustrated and don't want to talk about code status "All you people care about is letting my mother die!"

1. **What makes this case difficult?**
2. **What skill or tool can you use to navigate this?**

# Mini Case #3

- Mr. T is a long-time family practice patient. He is a 55 yo M with metastatic pancreatic cancer. He was diagnosed 18 months ago. He underwent a Whipple procedure followed by chemotherapy. He recently had progression of his cancer despite chemotherapy. He has had steady decline in his functional status in the last few weeks. His current PPS (Palliative Performance Scale) score 40% (spending most of his time in bed or chair). Yesterday, he met with his oncologist along with his spouse. The oncologist shared that she can no longer offer chemotherapy but can reconsider if he gets stronger. Mr. T is asking if there are any rehabilitation programs that he can be referred to help him get stronger.

1. **What makes this case difficult?**
2. **What skill or tool can you use to navigate this?**

# Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Thank you for your participation during our second series!

# Thank You

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