Welcome!
We will begin our session momentarily

# Community-Based Primary Palliative Care Community of Practice Series

Beyond the Essential Communications Skills- Part 2

Facilitator: Dr. Haley Draper

Presenter: Dr. Justin Sanders

Case Presenters: Dr. Roger Ghoche & Jill Yu Tom (RN)

Date: April 13th, 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.

**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.

# 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/ Presenters:**

- Dr. Haley Draper: Nothing to declare
- Dr. Justin Sanders: Nothing to declare
- Jill Yu Tom, RN: Nothing to declare
- Dr. Roger Ghoche: Nothing to declare

# Disclosure

**Mitigating Potential Biases:**

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

# 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 for questions and discussion.
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties, but also please also feel free to raise your hand!
- 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.

# How ECHO Works

**General Format:**

- Introduction
- Presentation + Q&A
- Interactive, Case-Based Discussion
- Session Wrap Up

**Be a case presenter!**

- If you would like to submit a case for one of our upcoming sessions, you can:
    - Let us know in the chat
    - Send us an e-mail us at echo@pallium.ca
    - Let us know in your feedback survey after today's session

# Overview of Sessions

| Session # | Session Title | Date/ Time |
|---|---|---|
| Session 1 | Symptom Management | Feb. 16, 2022 from 1-2pm ET |
| Session 2 | Managing Complex Pain | Mar. 2, 2022 from 1-2pm ET |
| Session 3 | Managing the Last Hours of Life in the Home | Mar 16, 2022 from 1-2pm ET |
| Session 4 | Beyond the Essential Communication Skills- Part 1 | Mar 30, 2022 from 1-2pm ET |
| Session 5 | Beyond the Essential Communication Skills- Part 2 | Apr 13, 2022 from 1-2pm ET |
| Session 6 | Beyond the Essential Communication Skills- Part 3 | Apr 27, 2022 from 1-2pm ET |
| Session 7 | Grief and Bereavement: Identifying and Managing Complex Grief | May 11, 2022 from 1-2pm ET |
| Session 8 | Teamwork in Primary Palliative Care | May 25, 2022 from 1-2pm ET |
| Session 9 | Grief in Children | Jun 8, 2022 from 1-2pm ET |
| Session 10 | Community Palliative Resources | Jun 22, 2022 from 1-2pm ET |
| Session 11 | Organizing Practices to Provide Primary Palliative Care | Jul 6, 2022 from 1-2pm ET |

# Introductions

**Facilitator:**

**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

**Panelists:**

**Amanda Tinning, MN NP**
Nurse Practitioner for the home Transitional Heart Failure Clinic
Division of General Internal Medicine
QEII Health Sciences Centre
Halifax, NS

**Dr. Roger Ghoche, MDCM CCFP-PC, MTS (and one of our case presenters today!)**

Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital- Montreal

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

# 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

**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

## Support Team

**Gemma Kabeya**
Education Research Officer, Pallium Canada

**Holly Finn, PMP**
National Lead, Palliative Care ECHO Project, Pallium Canada

# Introductions

## Case Presenter

**Jill Yu Tom, RN**

Home care clinician nurse, specializing in palliative care in the homecare program at Mount Sinai Hospital

## 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

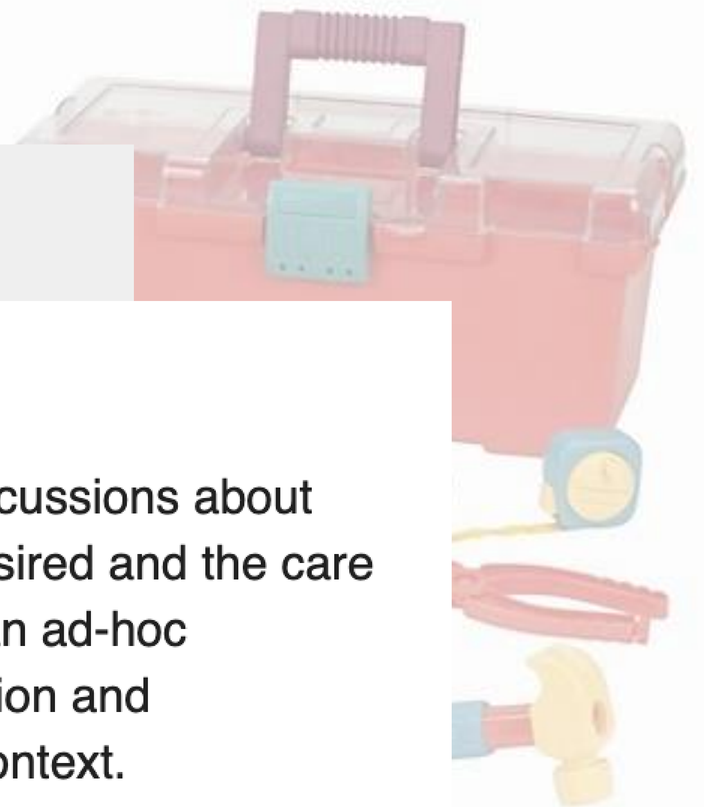
- A range of terms and activies that use similar skills: ACP, Early Goals of Care, Late Goals of Care, Code Status Discussions, Serious illness Conversations
- Overlapping concepts and skills
- “Goals of care” conversations happen when things are going wrong
- Patient and caregiver suffering remains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

# 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

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# A Serious Illness Conversation Guide

## Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

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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

SHARE

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*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)*."

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# A Serious Illness Conversation Guide

EXPLORE

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

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"How much does your **family** know about your priorities and wishes?"

# 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."*

Paladino, J et. al Cancer Medicine. 2020. Paladino J. JPM. 2020

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HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

# 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.* |
| **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."* |

## 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" <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."* |


| | |
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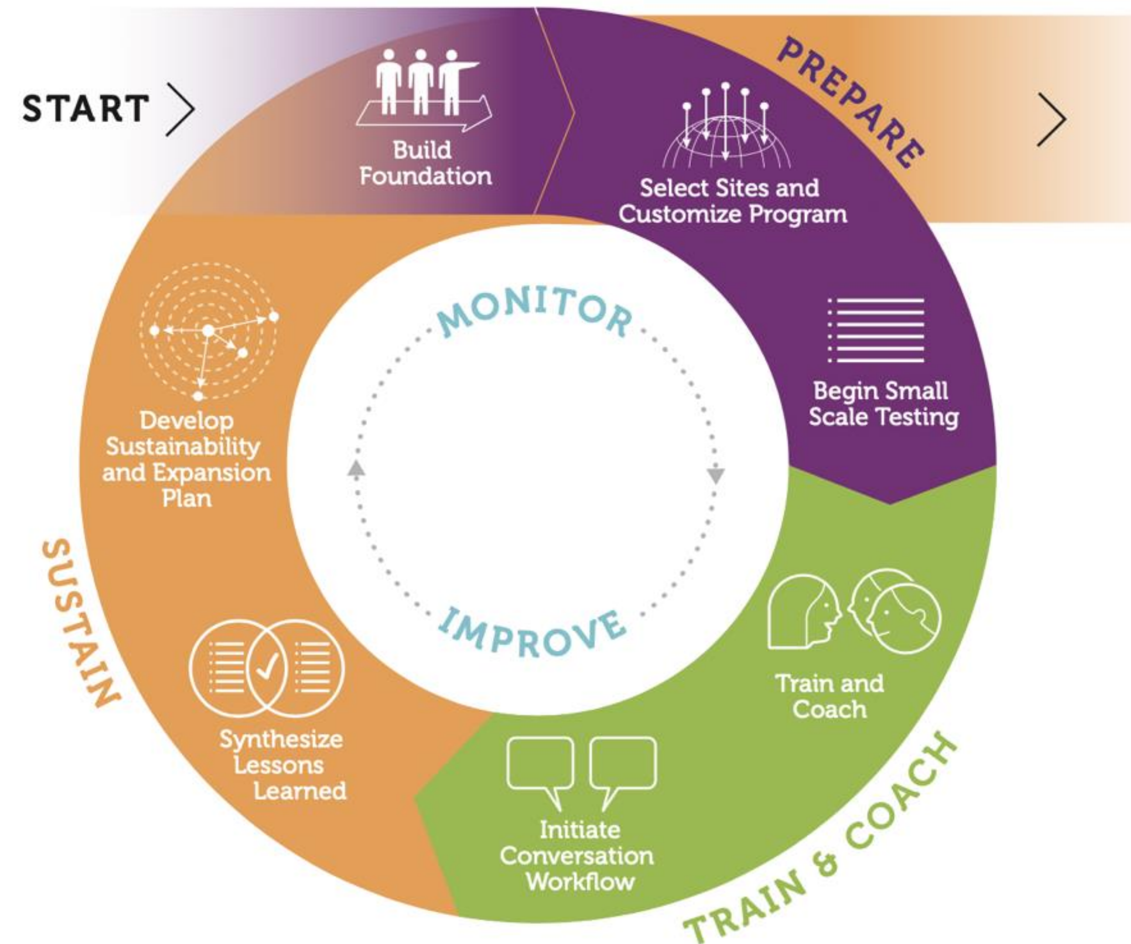
BC Centre for Palliative Care

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

# Strategies to make SICG most useful

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

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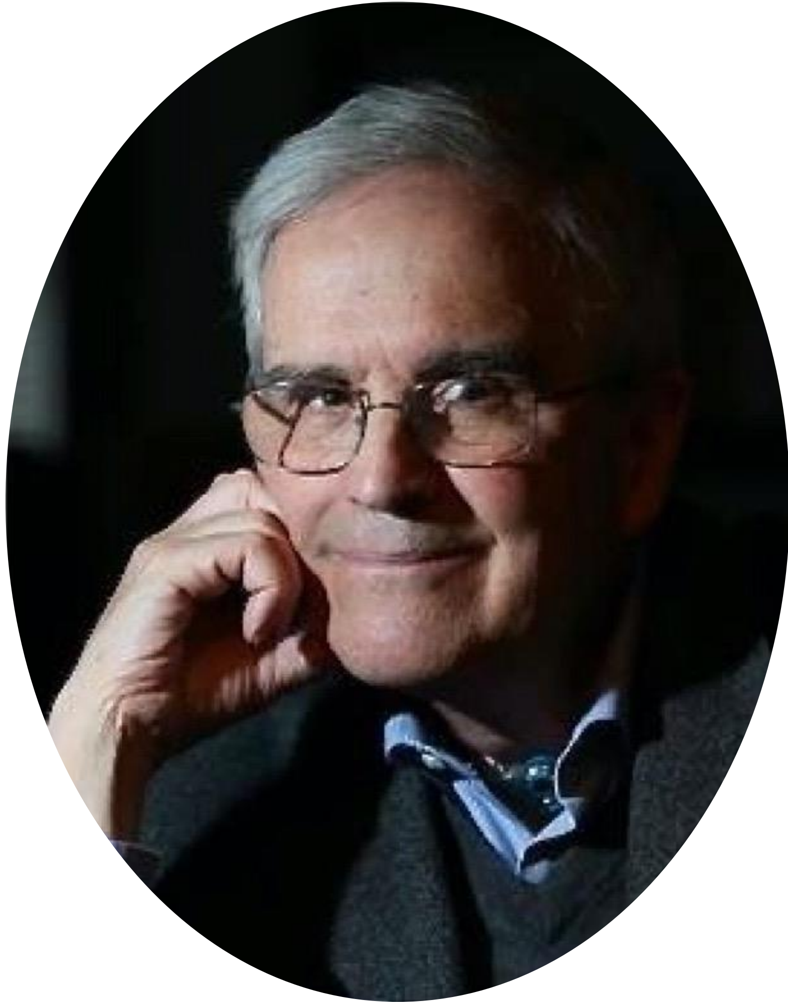
# On the value of serious illness communication



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

# Questions & Discussion

# Interactive, Case-Based Discussion

# Session Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat
- A recording of this session will be emailed to registrants within the next week
- Please join us for the next session in this series:
  - Beyond the Essential Communication Skills- Part 3
  - Presenter: Katie Marchington
  - April 27th, 2022 from 1-2pm ET
- Bring us your cases! There are several ways to initiate this process:
  - Contact our support team at echo@pallium.ca
  - Let us know in the feedback survey

# Thank You

**Stay Connected**
www.echopalliative.com