

Community-Based Primary Palliative Care Community of Practice Series 3

Communication: Part 2



Facilitator: Dr. Nadine Gebara
Guest Speaker: Dr. Justin Sanders
Date: November 29, 2023

Territorial Honouring

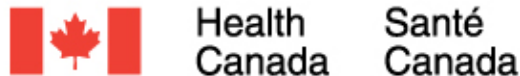


The Palliative Care ECHO Project

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.

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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.



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.



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	Communication: Part 1	Oct 25, 2023 from 12:30-1:30pm ET
Session 2	Communication: Part 2	Nov 29, 2023 from 12:30-1:30pm ET
Session 3	Managing the last hours of life	Dec.20, 2020 from 12:30-1:30pm ET
Session 4	Palliative care for the structurally vulnerable	Jan 24, 2024 from 12:30-1:30pm ET
Session 5	Procedural management of complex pain: Nerve blocks, vertebral augmentation, radiotherapy	Feb 21, 2024 from 12:30-1:30pm ET
Session 6	Terminal Delirium and Palliative Sedation	Mar 27, 2024 from 12:30-1:30pm ET
Session 7	Creative art therapy in palliative care	Apr 24, 2024 from 12:30-1:30pm ET
Session 8	What in store for Palliative Care in Canada: policy, advocacy and implementation	May 29, 2024 from 12:30-1:30pm ET
Session 9	Grief and Bereavement: Beyond the Basics	June 26, 2024 from 12:30-1:30pm 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 **9 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

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

Jill Tom, BSN CHPCN ©

Nurse Clinician for palliative Home Care

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
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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

Guest Speaker:

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

Communication: 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

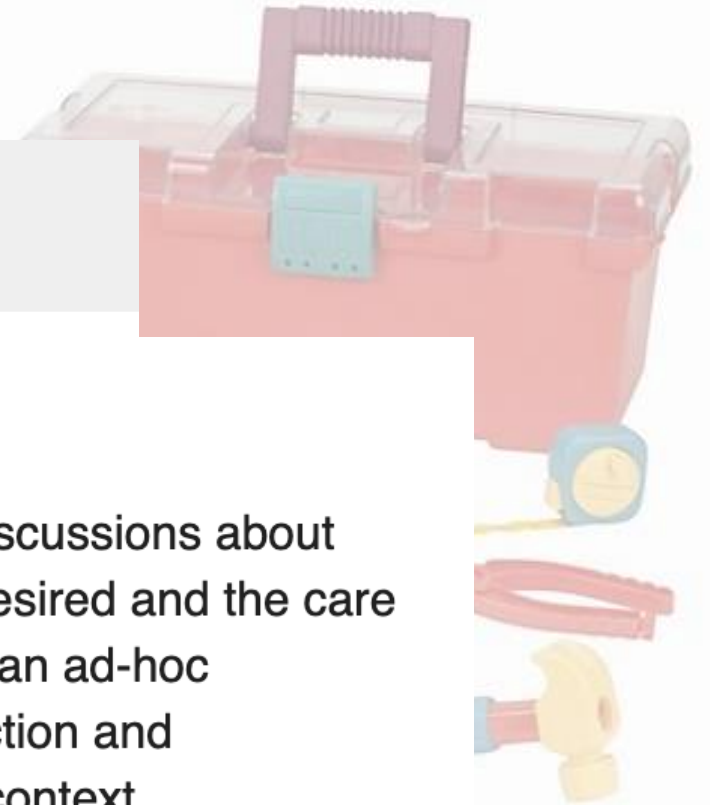
- A range of terms and activities that use similar skills: ACP, Early Goals of Care, Late Goals of Care, Code Status Discussions, Serious illness Conversations
- Overlapping concepts and skills
- “Goals of care” conversations happen when things are going wrong

Serious Illness Communication: ...and tools

PLOS ONE

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 would like to **talk together** about what’s happening with your health and **what matters to you. Would this be ok?**”
- ASSESS** “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?”
- 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.”
- Pause: Allow silence. Validate and explore emotions.**
- EXPLORE** “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?”
- CLOSE** “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.**”

A Serious Illness Conversation Guide

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**

EXPLORE

“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?”

CLOSE

“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.**”

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

A Serious Illness Conversation Guide - First Nations Adapted

Serious Illness Conversation Guide

ADAPTED VERSION - 2019

	CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
	<p>1. Set up the conversation</p> <ul style="list-style-type: none"> Introduce purpose Prepare for future decisions Ask permission Ensure the right people are present 	<p>"How are you feeling today? ____ Can we talk about your future health? — is this okay?" "I am afraid I might forget something. Is it OK with you if I use this guide and take notes during our talk?"</p>
<p>4. Explore key topics</p> <ul style="list-style-type: none"> Goals Fears and worries Sources of strength Dignity question Critical abilities Tradeoffs Family 	<p>2. Assess understanding and preferences</p> <p>"If your health gets worse, what's important to you?" "When you think about your health worsening what worries you?" "What gives you strength through the hard times?"</p> <p>3. Share prognosis</p> <p>"What do I need to know about you to give you the best care possible?" "What abilities are so important for you, that you can't imagine living without them?" "If your health does get worse, how much are you willing to go through for the possibility of more time?" "Is your family aware about what is most important to you?" ***Ask only if family is not present.</p>	<p>"What do you think about what's happening with your health right now?" "How much information about your health would you like from me?"</p> <p>"This is my understanding of where things are at right now..." Uncertain: "I'm worried that your health could change quickly, and I think it is important to prepare for that possibility." OR "I wish you were not in this situation, but I am worried that time may be as short as _____. I 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 might get worse."</p>
<p>5. Close the conversation</p> <ul style="list-style-type: none"> Summarize Make a recommendation Ask permission to document information Check in with patient Affirm commitment 	<p>"This is what I heard you say and what I plan to write down in your chart. ____ Would you like a copy?" "I suggest that we ____ . "How does this plan seem to you?" "As part of your health care team I will do all I can to help you get the best care possible." "Is there anything you would like to go over again / ask / talk about?" "If you think of anything else later, we can revisit this conversation another time."</p> <p>5. Close the conversation</p> <ul style="list-style-type: none"> Make a recommendation Ask permission to document information Check in with patient Affirm commitment 	<p>"If your health gets worse, what's important to you?" "When you think about your health worsening what worries you?" "What gives you strength through the hard times?" "What do I need to know about you to give you the best care possible?" "What abilities are so important for you, that you can't imagine living without them?" "If your health does get worse, how much are you willing to go through for the possibility of more time?" "Is your family aware about what is most important to you?" ***Ask only if family is not present.</p> <p>"This is what I heard you say and what I plan to write down in your chart. ____ Would you like a copy?" "I suggest that we ____ . "How does this plan seem to you?" "As part of your health care team I will do all I can to help you get the best care possible." "Is there anything you would like to go over again / ask / talk about?" "If you think of anything else later, we can revisit this conversation another time."</p>

<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



ACKNOWLEDGE EMOTIONS



REFLECTION STATEMENT

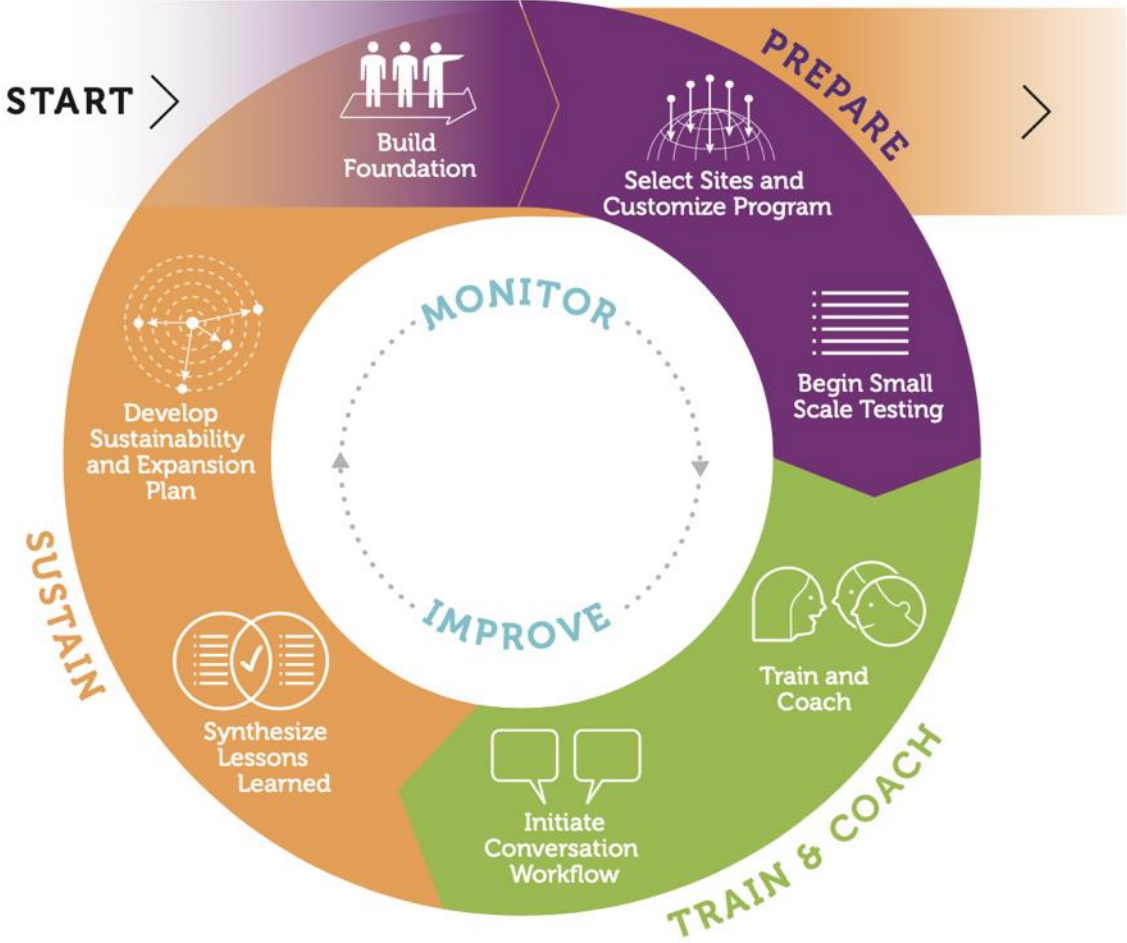


GRATITUDE

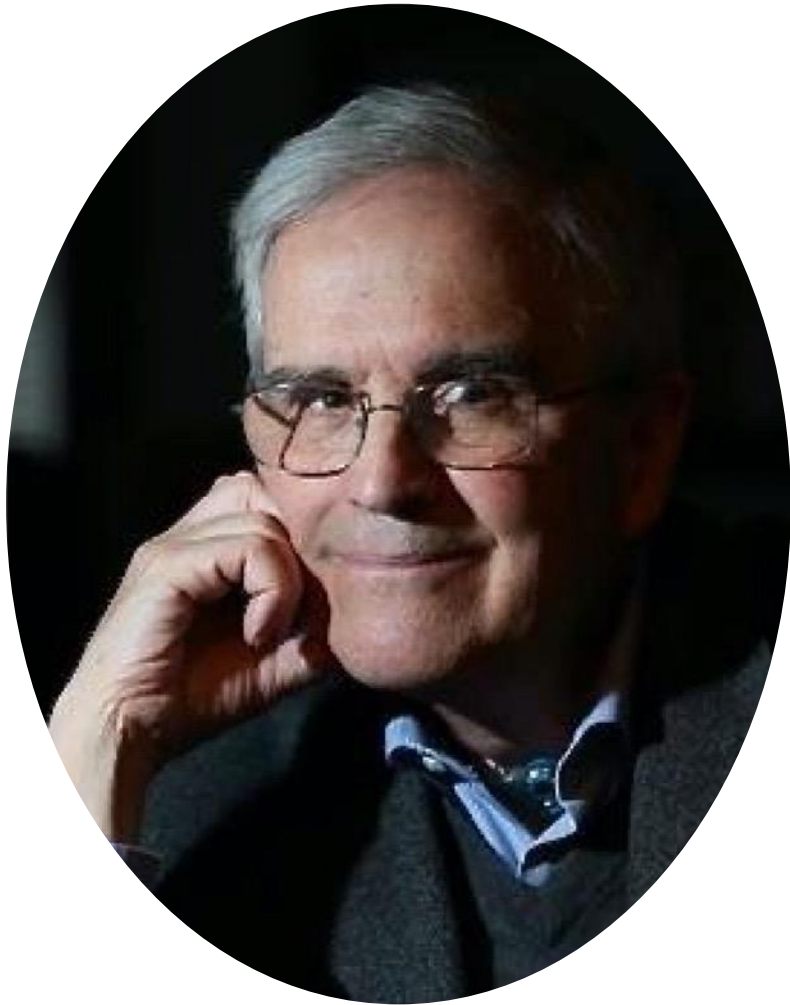


BOOKMARK

Strategies to make SICG most useful



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

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.
- We hope to see you again at our next session taking place **December 20th, 2023 from 12:30-1:30pm ET** on the topic of **Managing the last hours of life.**
- Thank you for your participation!

Thank You



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