Using The Serious Illness Conversation Guide

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Objectives

• Attitudes
  – Reflect on the impact of communication on patient care

• Knowledge
  – Describe the benefits of serious illness conversations for patients, families, and clinicians
  – Identify the elements of the Serious Illness Conversation Guide

• Skills
  – Practice using the Serious Illness Conversation Guide
Reflection
Why the Serious Illness Conversation Guide (SICG)?
Atul Gawande

Bestselling Author of

The Checklist Manifesto

How to Get Things Right

Atul Gawande

Being Mortal

Medicine and What Matters in the End
Gap between what patients want and what they get

Patients with serious illness have priorities besides living longer.

– Symptom management and quality of life
– Sense of control and completion
– Strengthening relationships

Singer JAMA 1999; Steinhauser JAMA 2000; Heyland Palliative Medicine 2015
Gap between what patients want and what they get

Most people want to be at home and prefer comfort-focused care at the end of life, but that is often not the reality.

- 86% Medicare beneficiaries want to spend final days at home  
  Barnato 2007
- 25-39% die in an acute care hospital  
  Teno JAMA 2013; Silveira NEJM 2010
- 70% are hospitalized in the last 90 days  
  Teno JM JAMA 2013
- 29% receive intensive care in the last 30 days  
  Teno JM JAMA 2013
- Many experience care transitions and very short hospice stays  
  Teno JM JAMA 2013
What patients *get* often harms them and their families

**Aggressive care for patients with advanced illness is often harmful:**

- **For patients:**
  - Lower quality of life
  - Greater physical and psychological distress
  
  Wright, AA JAMA 2008; Mack JCO 2010

- **For caregivers:**
  - More major depression
  - Lower satisfaction
  
  Wright, AA JAMA 2008; Teno JM JAMA 2004
Conversations are too little, too late, and not great

• Multiple studies show patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life  
  Wright 2008, Dow 2010, Halpern 2011

• Many conversations fail to address key elements of quality discussions, especially prognosis
Clinicians and the medical system are important barriers to conversations and care planning

- Clinicians lack communication competencies, training and confidence [Baile Cancer 1999; Sullivan JGIM 2003; Buss Cancer 2011]

- Culture of medicine does not value key elements of effective care:
  - Accepts late or non-existent conversations
    - Low priority
    - No accountability
  - Tolerates poor end-of-life care
  - Focuses on avoidance of emotions; these are inherently emotionally-intense discussions

- Clinicians feel they do not have enough time

Bottom line: Multiple factors make good conversations difficult.
How to bridge the gap between what patients \textit{want} and what they \textit{get}?

Ask patients about their values and priorities.
Conversations are a key component of the effectiveness of palliative care interventions

Earlier conversations about patient goals and priorities for living with serious illness are associated with:

- Enhanced goal-concordant care  Mack JCO 2010
- Improved quality of life
- Reduced suffering
- Better patient and family coping
- Higher patient satisfaction  Detering BMJ 2010
- Less non-beneficial care and costs  Wright 2008, Zhang 2009
How do we do this?
These are hard conversations to have!
Tools that help

- **NAME:** “This can be a little scary to talk about.”
- **UNDERSTAND:** “It’s normal to feel this way.”
- **RESPECT:** “You have worked hard to deal with your illness.”
- **SUPPORT:** “You are not alone.”
- **EXPLORE:** “Help me understand what you mean when you say...”

- “Tell me more...”
- “I’m hearing that you are hoping for...”
- “I hope....and I worry that...”
- Ask permission as you move through the conversation
- Avoid rabbit holes
- Drop the rope!
- Talk less than 50% of the time
- Make suggestions!
Talking about prognosis

• Never predict with certainty!

• The past predicts the future

• Think about your triggers
  – The Surprise question

• Be prepared for uncertainty

• “For today’s purpose, can we assume that your time is short?”

Christakis, BMJ 2000
Summing it up: the know-do gap for serious illness conversations

• Patients with serious illness have priorities besides living longer.

• To deliver the kind of care patients want during this critical time, we first have to ask about their values and priorities.

• Earlier clinical conversations about values and goals can lead to improved quality of life, reduced suffering, better patient and family coping, and less non-beneficial care and costs.

• But these conversations happen too little, too late, and they’re not great.
Why the Serious Illness Conversation Guide?

- “...emotionally intense conversations”
- Checklists work!
- Is it all there?
- You can get paid now!
CMS reimbursement for Advance Care Planning

• Two new codes
  – 99497 ACP 30 minutes  $85.99
  – 99498 ACP additional 30 minutes  $74.88

• Documentation
  – ?
  – Time spent on the conversation
  – No outcomes

• Who can do this?
  – MD, APC, qualified auxiliary provider under direct supervision of a provider
Implementing a change: Atul’s checklist

1. Learn how to have the conversation
2. Identify patients at risk—what will your triggers be?
3. Start talking to patients and families
4. Use a checklist or conversation guide
5. Document critical information in the EMR
6. Measure your performance
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<th>CONVERSATION FLOW</th>
<th>PATIENT-TESTED LANGUAGE</th>
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<tr>
<td>1. Set up the conversation</td>
<td>“I’m hoping we can talk about where things are with your illness and where they might be going — is this okay?”</td>
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<td>Introduce the idea and benefits</td>
<td>“What is your understanding now of where you are with your illness?”</td>
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<tr>
<td>Ask permission</td>
<td>“How much information about what is likely to be ahead with your illness would you like from me?”</td>
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| 2. Assess illness understanding and information preferences | **Prognosis:** “I’m worried that time may be short.”  
**or** “This may be as strong as you feel.” |
| 3. Share prognosis | “What are your most important goals if your health situation worsens?” |
| Tailor information to patient preference | “What are your biggest fears and worries about the future with your health?” |
| Allow silence, explore emotion | “What gives you strength as you think about the future with your illness?” |
| 4. Explore key topics | “What abilities are so critical to your life that you can’t imagine living without them?” |
| Goals | “If you become sicker, how much are you willing to go through for the possibility of gaining more time?” |
| Fears and worries | “How much does your family know about your priorities and wishes?” |
| Sources of strength | “It sounds like _______ is very important to you.” |
| Critical abilities | “Given your goals and priorities and what we know about your illness at this stage, I recommend...” |
| Tradeoffs | “We’re in this together.” |
| Family | |
### Serious Illness Care Program

#### Materials

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<th><strong>Patient</strong></th>
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The Serious Illness Guide in Action