



The Rocky Road of Goals of Care:

Not “One and Done” Conversations



About Us



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Disclosure Statement

No Financial Conflicts to Disclose



Objectives

By the end of this session, participants will be able to:

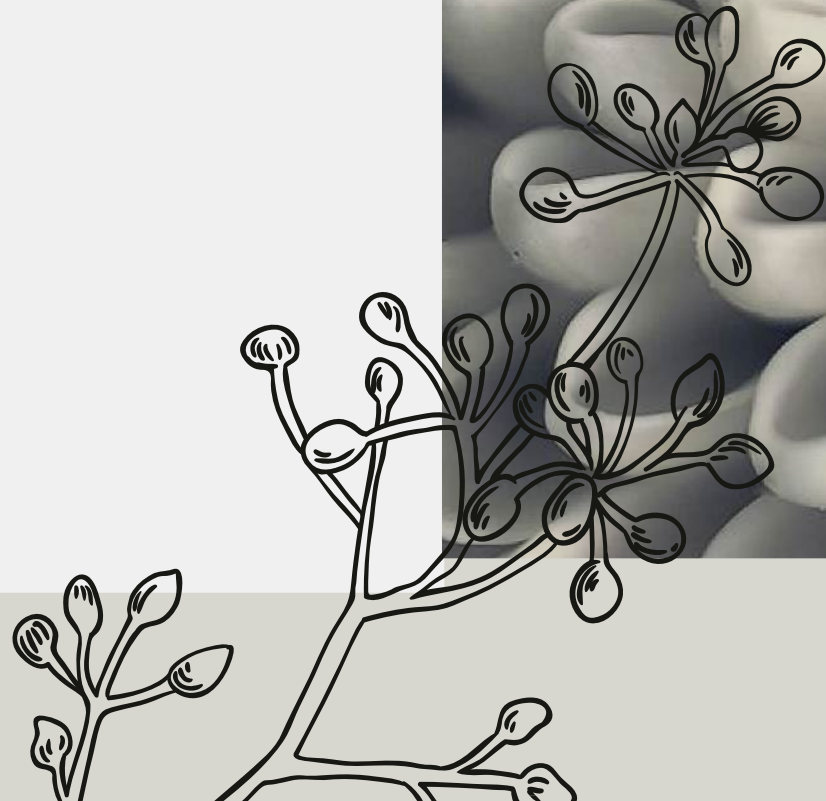
Identify at least three components of a goals of care conversation

Recognize common barriers to communication about patient goals and values

Refine skills for effective communication to maximize benefit of goals of care discussions and care team meetings

Case Study 1

Susie



Case Study 1

73-year-old female with complicated past medical history of COPD on 3 L oxygen, pneumonia, severe asthma, acute on chronic respiratory failure, CHF, Afib on Xarelto, pulmonary hypertension, OSA on CPAP, right lower lobe pneumothorax, non-alcoholic fatty liver disease, depression, perforated diverticulitis- status post colostomy, percutaneous chole drain, with frequent hospitalizations and worsening of her functional status.

Currently listed as Full Code on Chart.

Stating that she wants to remain at home through end of life and be independent as she is now. Despite many attempts, not willing to discuss goals of care. Palliative care consulted.



GOC Communication

Her goals of care: We discussed resuscitation, and she confirms she wishes for do not resuscitate and do not intubate.

Recommended that we complete a COLST form for her refrigerator, which she was agreeable to. Confirmed that she does want to return to the hospital for now, for reversible illnesses. Does not want artificial nutrition, hydration or antibiotics at the end of life.

She does not want her family to be notified of serious illness or death. She chooses a friend as her healthcare agent.

Not willing to discuss higher level of care in future- She wants to "cross that bridge when she comes to it".

COLST sent to PCP and Hospital



Outcome

Patient went to the hospital in acute respiratory distress by EMS about 2 weeks later. Upon Arrival- COLST reviewed with patient by ER provider. She was made comfortable and passed peacefully while inpatient.





Case Study 2

Paul



Case Study 2

Paul is a 84 y/o man who resides in a nursing home

Medical hx: severe Alzheimer's dementia, stage IV
CKD,CHF with EF of 25%, Type II DM, OA, HTN,
GERD, frequent UTIs

Functional status: Non-ambulatory- up in wheelchair
during the day, double incontinence, feeds self with
set-up and guidance, usually recognizes his daughter
but not other family members

Advance Care Planning: Daughter is health care agent
but no other documents in place covering tx wishes.
He is a Full Code.



GOC Conversation Context

Pt has had 3 urinary tract infections in the last 6 months

Hospital admission for sepsis last week – complicated by acute worsening of mental status and agitation that has persisted

Staff noticing episodes of coughing during and after mealtimes

Daughter is “prickly” with staff

Scheduled care planning meeting after recent hospitalization



Outcome Part 1

Code status changed to DNR/DNI

Goals of care now prioritizing comfort and minimizing hospital transfers

DNR/COLST completed

Hospice evaluation but Paul did not meet eligibility criteria



Outcome Part 2

Became febrile and unresponsive in the middle of the night on a holiday weekend. Sent to hospital and admitted with sepsis due to UTI and aspiration PNA


COLST was not on file at the hospital

Sent to ICU for IV fluids and Abx before daughter was notified

Daughter opted to complete treatment but requested another hospice evaluation

Discharged back to ECF with hospice services





Common Pitfalls
(not One and Done)

Common Pitfalls of GOC

- ❖ Providing information and starting conversations without confirming patient/family readiness
- ❖ Assuming what the patient or family understands
- ❖ Starting from your own agenda
- ❖ Asking for decisions about treatments or other interventions without establishing context and confirming good understanding
- ❖ Relying on documents (AD/COLST) without further conversations
- ❖ Not reviewing values/priorities when the situation changes
- ❖ Not including family/agent/significant people

A stylized, monochromatic illustration of a plant branch with several large, elongated leaves. The leaves are rendered with fine, parallel lines to indicate texture and shading. The entire illustration is set against a dark gray background.

Components of Good Goals of Care Conversations

Components of Good GOC Conversations

- ❖ Get permission to talk about current situation
- ❖ Establish pt/family level of understanding – educate and reflect as needed to get shared understanding
- ❖ Get permission to discuss the future
- ❖ Elicit patient's priorities (hopes, worries, things to avoid)
"Tell me more about that." "And what else...?"
- ❖ Restate to confirm shared understanding

Components of Good GOC Conversations

- ❖ Ask permission to make recommendations
- ❖ Frame recommendations or tx plan in the context of patient priorities/values AND what is medically feasible
- ❖ If not already done, establish way to include family and/or proxy
- ❖ Confirm plan and next steps
- ❖ At every step, allow time for patient to express self, and respond to emotion with empathy.



Documenting

(also not “One and Done”)

- ❖ Clear explanation of patient understanding, goals, and plan
- ❖ Advance Directive – for future guidance, not necessarily for present
- ❖ At least Appointment of Agent if not ready to make decisions about limitations or future treatment wishes
- ❖ COLST – only for present limitations (No COLST for Full Code)
- ❖ Ensure that AD and COLST are filed in all the appropriate places: PCP, local hospital, Registry (AD only)



Resources

Clinician Resources

Vital Talk Courses

vitaltalk.org for courses and app

CAPC Courses via Membership

Communication in Serious Illness Tool

Ariadnelabs.org/serious-illness-care/

Conversation Project

The background of the slide features a dark, high-contrast image of a leaf's vein structure on the left side. On the right side, there is a light-colored illustration of a branch with several small, rounded buds or flowers.

Resources

Patient and Family Resources

VT Ethics Network

Conversation Starter Kit

Patient Values Questionnaire

Medical Situation and Tx Worksheet

Patient and Family Resources

Vermont Ethics Network

Conversation tools found under the Medical Decision-Making tab:

- Conversation Starter Kit
- Patient Values Questionnaire
- Medical Situation and Tx Worksheet

Forms:

- Appointment of Agent
- “Short” form etc
- DNR/COLST



Patient and Family Resources

Speak Sooner

- [Speaksooner.org](https://speaksooner.org)
- Online or print journal-type tool for communicating about serious illness with providers and family

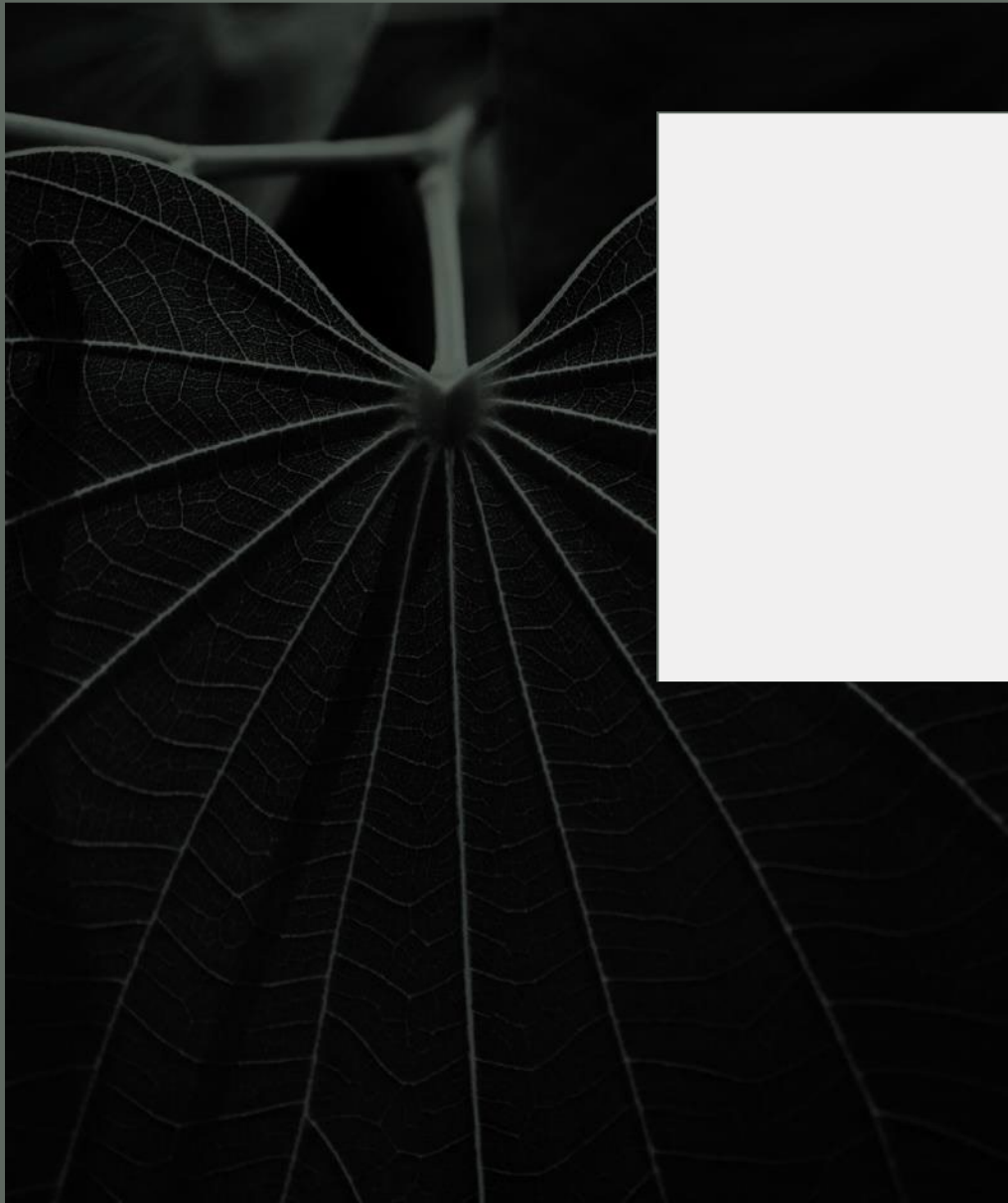


ONCE



- [ONCEapp.org](https://onceapp.org)
- Questionnaire-based app for end-of-life planning
- Clarify preference for medical care, legal issues, finances, and personal wishes





Q&A



Thank you

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