ADVANCE CARE PLANNING: Applying the House of Healing Model of Communication

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Learning Objectives

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- Define an advance care planning session and its components.
- List the building blocks of the House of Healing and the order of construction.
- List 3 tools for communication to be used in an advance care planning session.

Advance Care Planning

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- Making decisions about future health care based on your personal values, preferences and discussion with your loved ones.
- Can be done with the person/patient or surrogate decision maker.

Advance Care Planning

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- An essential component of care for persons with serious chronic illness
- Respects autonomy
- Reduces cost of care
- Enhances patient/family satisfaction

Advance Care Planning

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When we fail to provide care
that matches patient's preferences
we commit a medical error,
no less urgent than any other harmful error.

Sanders, Curtis, Tulsky. Journal of Palliative Medicine, Vol 21, No S2, 2018
Achieving Goal-Concordant Care:
A conceptual Model and approach to measuring serious illness communication and its impact.

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Tools for Communication

Tools for Communication

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- Ask BEFORE you Tell
- Respond to Emotion
- Align Intentions
- Make a Balanced Medical Recommendation
- Let Go of the Outcome
- When you are going to recommend limiting an intervention always say first what you WILL do

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Curing vs. Healing

Curing vs. Healing

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Curing	Healing
Elimination of disease	Management of chronic disease
Back to normal	The "new normal"
Focused treatment	Disease modifying
Medications	Whole person care
Surgery	Symptom focused
Focused interventions	Family & support systems important
Clinical team has the power	Patient has the power

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Building a House of Healing

Building a House of Healing

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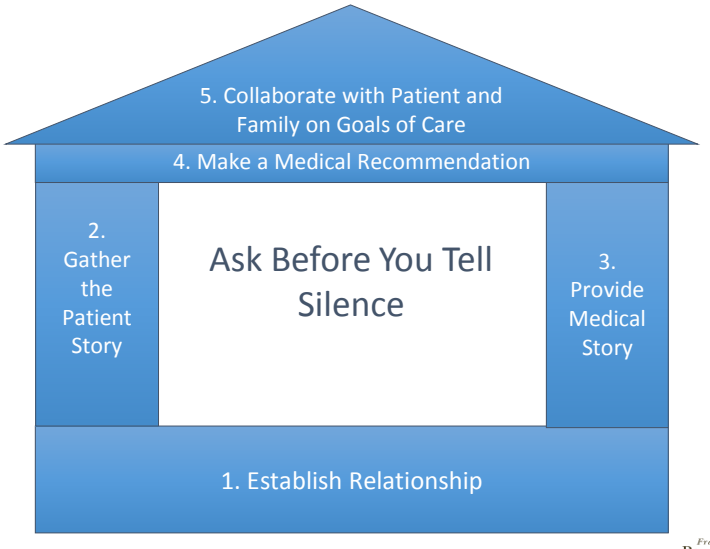

Franciscan Palliative Care Academy

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Ways and Words That Work

Relationship

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Ways

Quiet Space

Elicit their agenda first

Words

Ask permission

Are you comfortable enough to talk?

Patient Story

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Ways

Match the pace of the patient

Don't interrupt

Words

Please tell me in your own words what you have heard about your medical condition?

Where do you find strength and support.

How is this illness affecting your life?

Medical Story

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Ways

Deliver information in headlines

Avoid medical jargon

Words

Ask permission

Deliver headline and be silent

Medical Recommendation

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Ways

Make a medical recommendation that aligns patient priorities and reflects what is possible

Words

This is what I hear is important to you

Ask permission

Collaborative Decision Making

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Ways

Continue to partner 'dance'

Protect quality of the process

Words

Affirm their decision

Use teach-back

Applying the House Model

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- Is time-efficient
- Improves clinician professional job satisfaction

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Documentation

Documentation

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- Describe the GOC conversation
- Use direct quotes when possible
- Translate to written document if appropriate, i.e. POLST

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Billing for Advance Care Planning

Billing for Advance Care Planning

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AMA's CPT manual defines the service:

99497 and 99498 are used to report the face-to-face service between a physician or other qualified healthcare professional (QHCP) and **patient, family member or surrogate** in counseling and discussing advance directives, with or without completing relevant legal forms.

Billing for Advance Care Planning

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- 99497—first 30 minutes
- 99398—each additional 30 minutes (List separately in addition to code for primary procedure)

House of Healing Pocket Card

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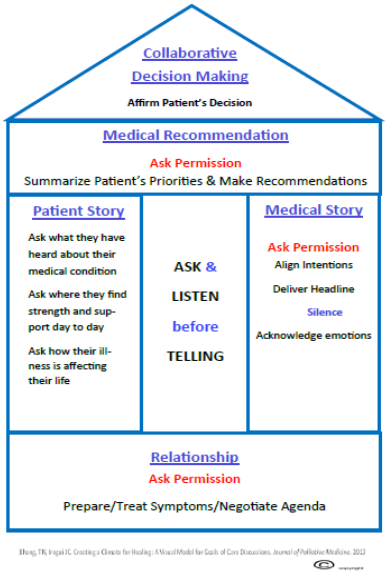

Hoang, TK, Ingold JC. Creating a Climate for Healing: A Mixed Model for Goals of Care Discussions. *Journal of Palliative Medicine*. 2012

WAYS AND WORDS THAT WORK

	WAYS	WORDS
Relationship	• Quiet space, silence phones and pager, request permission to enter, sit down, eye contact • Assess symptoms first • Elicit their agenda first • Review medical records, talk to rest of the team	• ***Ask permission*** *"Is this a good time to talk?"* • Are you comfortable enough to talk now? • What are your expectations for our conversation today? • We want to provide you the ***Best Care Possible from your perspective***. Can we talk about that?
Patient Story	• Match the pace of the patient • Listen carefully • Don't interrupt • Anticipate emotions	***Obtain Patient Story:*** "can you tell me, *in your own words*, what you have heard about your medical condition? Are you able to do the things you enjoy? Where do you get strength and support? What is your body telling you?
Medical Story	• If they do not want to talk, don't proceed • Offer only realistic hope • Deliver information in "Headlines" (15 words or less) • Avoid medical jargon	• ***Ask permission:*** Would it be okay if I share medical information now? • ***Deliver headline*** & **BE SILENT (let them break silence!)** "I am worried that what we are hoping for may not happen" "The cancer has come back" • ***Name Emotion/Empathetic Statement/Align Hope*** "This is hard" "I cannot imagine" "I wish I could make this into good news, but I can't" "This is upsetting" ***Align hope/intention:*** *My hope is that you/your loved one will get better. I also want us to have a plan if what we are hoping for doesn't happen.* "Given your medical situation, what is most important to you?"
Recommendation	• Make a medical recommendation that aligns patient priorities **AND** reflects what is medically possible • When you recommend limiting interventions, make sure you first offer what you WILL do	***Before Making a Recommendation:*** • This is what I hear is important to you: (list them) • Is this correct? (confirm that the list is correct) • Would it be okay if I make a recommendation? **(ASK PERMISSION)** **When making a recommendation:** "Based on what is important to you, I recommend the following" Make recommendations that match their goals. **After making a recommendation:** What do you think about this as a plan? (Obtain their opinion about your recommendations)
Collaborative	• Continue to partner with them • Consider a time limited trial w/specific goal • Protect the quality of the process rather than judging the quality of their decision	• ***Affirm their decision:*** Let me summarize what I have heard from you: *"It sounds like it is really important to you that we place a PEG/treat with Abx/ intubate / perform CPR"* • **Establish a *functional* End-Point for Time-Trial:** **Going forward, how will we know that this plan is working/not working?** (e.g. patient- "more awake/participate in PT/come off Respirator") • **Finish with Teach-Back:** "To make sure I have done a good job communicating, can you share with me what we talked about?

Thank you & Questions

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Thank You

Questions?

Contact:
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