Advance Care Planning in Outpatient Practice

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Disclosures

No conflicts of interest.

Past member of the Colorado ACP Stakeholder Workgroup

Developer, Colorado Care Planning: www.Coloradocareplanning.org

Research Funding

National Institute on Aging; Alzheimer's Association; PCORI

- Use of PREPARE (www.prepareforyourcare.org) in an NIH funded Advance Care Planning Group Visit Study

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Objectives

- **Describe communication strategies for advance care planning (ACP) and goals of care conversations**
- Identify appropriate use of the Medical Orders for Scope of Treatment (MOST) form
- Outline adaptations for persons living with dementia
- Identify strategies for integrating ACP into outpatient care

Advance care planning is a process

- Supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

- Aims to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness

Sudore et al. Defining Advance Care Planning for Adults… J Pain Symptom Management 2017. PMID: 28062339

Clinical Summary: Features of advance care planning & serious illness communication

Key features:

- Emphasize the person's values and prognostic awareness
- Discussions include the individual and surrogate decision maker
- Engage in discussions over time - as health, prognostic awareness, and preferences change
- Use understandable documents that are available

Sudore et al. JPSM 2017.
Jackson et al. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69.

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Case: Communicating about Serious Illness and End of Life

89 yo man with chronic lymphocytic leukemia, low-grade sarcoma, hx of prostate cancer, cardiac amyloidosis, cochlear implant, SCC s/p MOHS.

2025: Recurrent pleural effusions causing two-week hospitalization (and dx of sarcoma), resolved

Lives at home with wife, takes 10 meds, brings a list of questions.

<u>ACP documents on file:</u>
-MDPOA form names dtr (wife is primary caregiver)
-Five Wishes from 2018
-No MOST form
-Full code in prior hospitalizations

He is frail, losing weight, referred to palliative care by his oncologist; prefers to f/u with his PCP. How do we approach this conversation?

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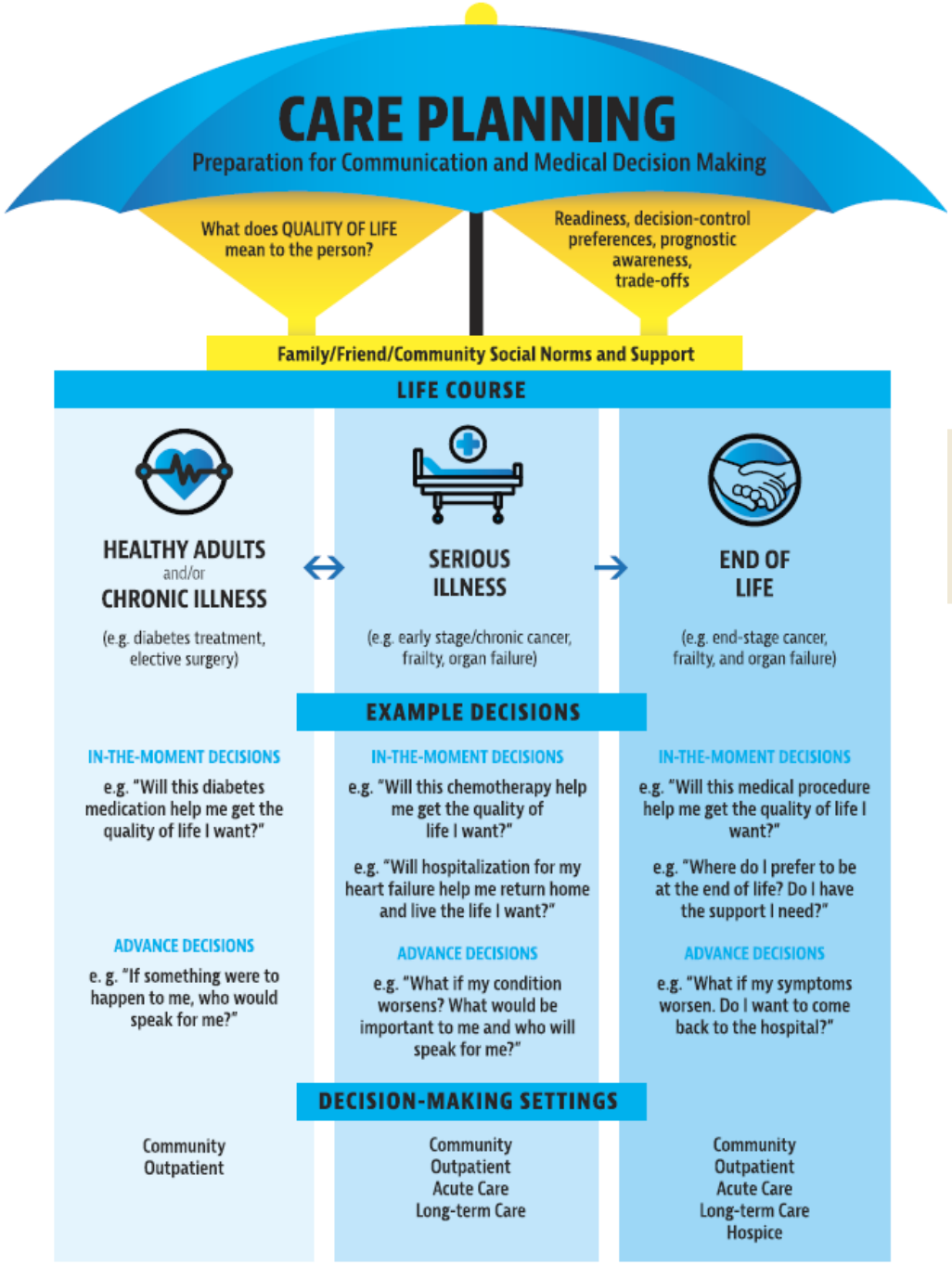
ACP Documents alone are not enough

Rigorous trials of advance care planning interventions have shown that simply having an advance care planning document **does not** result in improved patient outcomes.

Jackson, VA, Emanuel, L. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69

Conversations over time: Care Planning Umbrella

- Planning involves ongoing communication and tailored decision making over the life span
- Involves individuals, trusted surrogate decision makers, medical and legal professionals



Hickman et al. The care planning umbrella: The evolution of advance care planning. J American Geriatrics Society, 2023

If you read one article: Read this one!

The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

Navigating and Communicating about Serious Illness and End of Life

Authors: Vicki A. Jackson, M.D., M.P.H., and Linda Emanuel, M.D., Ph.D. Author Info & Affiliations

Published December 20, 2023 | N Engl J Med 2024;390:63-69 | DOI: 10.1056/NEJMcp2304436
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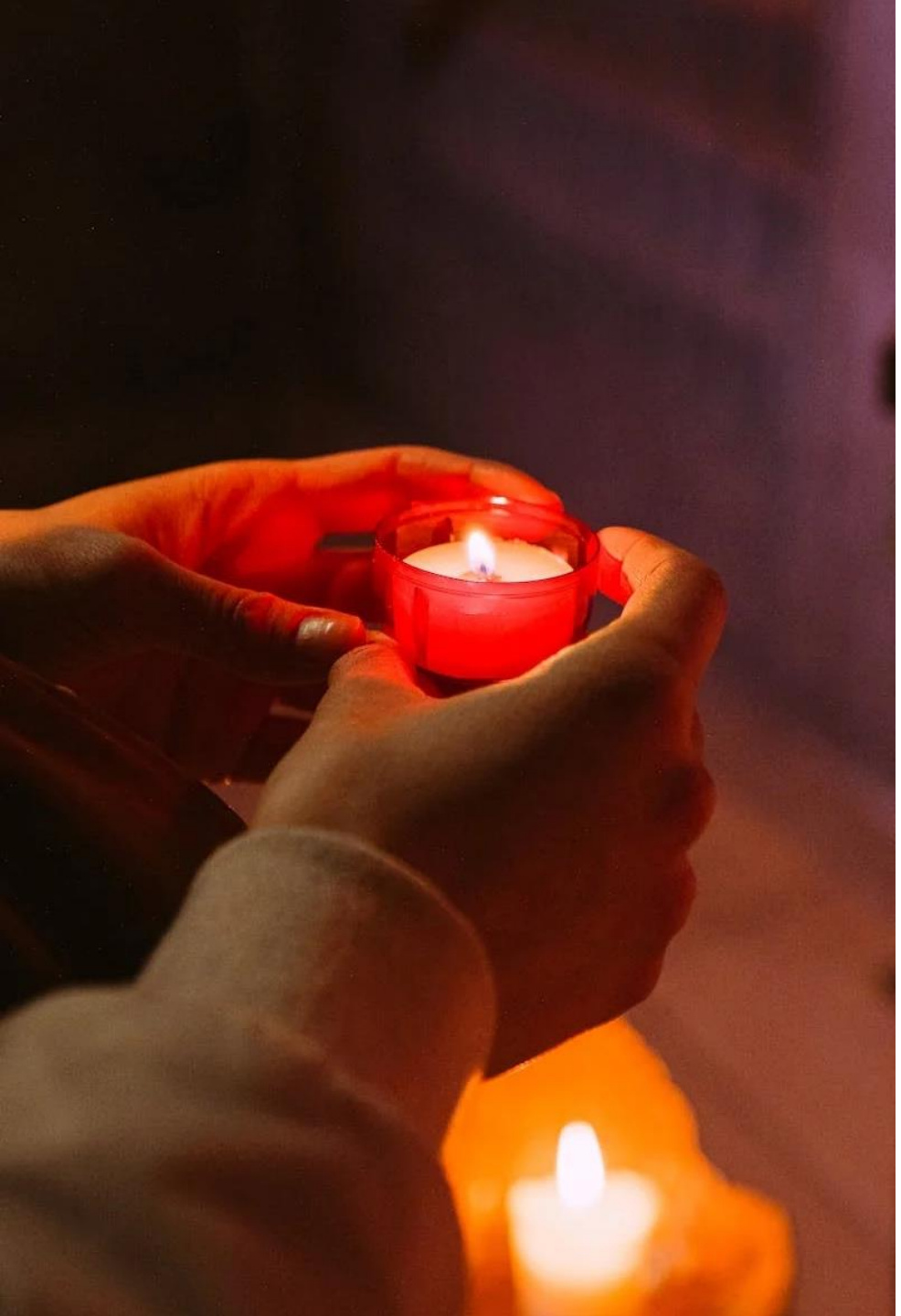
DOI: 10.1056/NEJMcp2304436



The Challenge => Our Goal

- Assess the patient's awareness and coping process, including discerning the patient's priorities for the last part of life
- Help patients translate their diagnosis and prognosis into decisions that align with their goals and priorities
- Balance that patients may want honest prognostic information, and also want their providers to be optimistic

Jackson, VA, Emanuel, L. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69.
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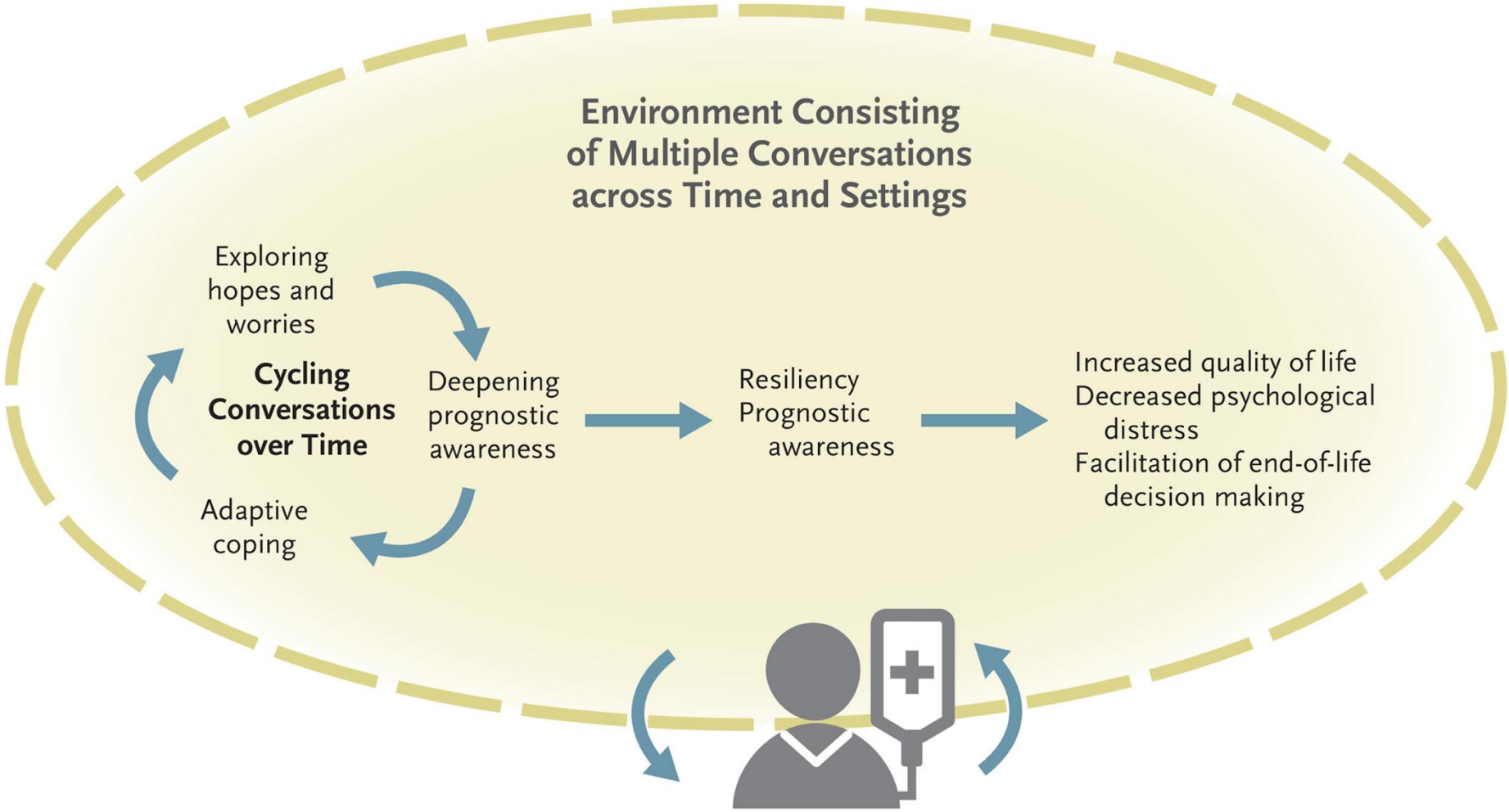
Prognostic Awareness



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Clinical Pearls for Serious Illness Conversations

1. Partner with patients by 1) effectively communicating prognostic information and 2) responding to the emotions
2. Engage in **multiple conversations over time**, as patients integrate prognostic information cognitively and emotionally.
3. Normalize that patients oscillate between hopefulness and more realistic aspirations.
4. Facilitate patient **exploration of their hopes and worries** - this allows them to grieve, understand their priorities, and **build coping skills for living with a serious illness.**
5. As they are ready, **discuss what is most important** given the likely illness trajectory, and incorporate these goals and values into **a recommendation about medical care, including care at the end of life.**

Jackson, V.A.; Emanuel, L. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69. **DOI: 10.1056/NEJMcp2304436**

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Poll question:

When are you most likely to discuss ACP with your patient?

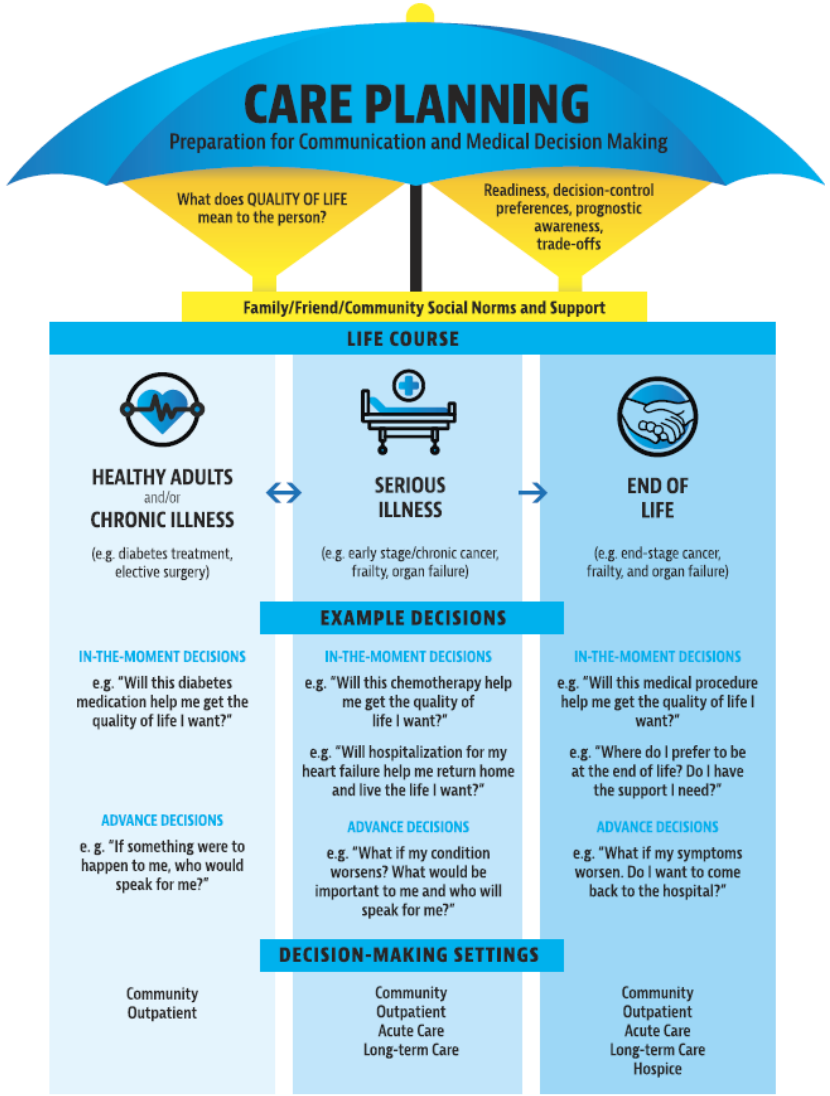
1) During an annual wellness visit
2) When asked by patient or family
3) After a hospitalization or care transition
4) After a serious illness diagnosis
5) Honestly, I miss a lot of opportunities

Care Planning Conversations Over Time

<u>Practical examples in Primary Care:</u>

1. Reaching a new **Decade** in age.
2. Experience the **Death** of a loved one.
3. **Divorce** or change in relationships.
4. New **Diagnosis** of a significant medical condition.
5. **Decline** in condition or functioning.

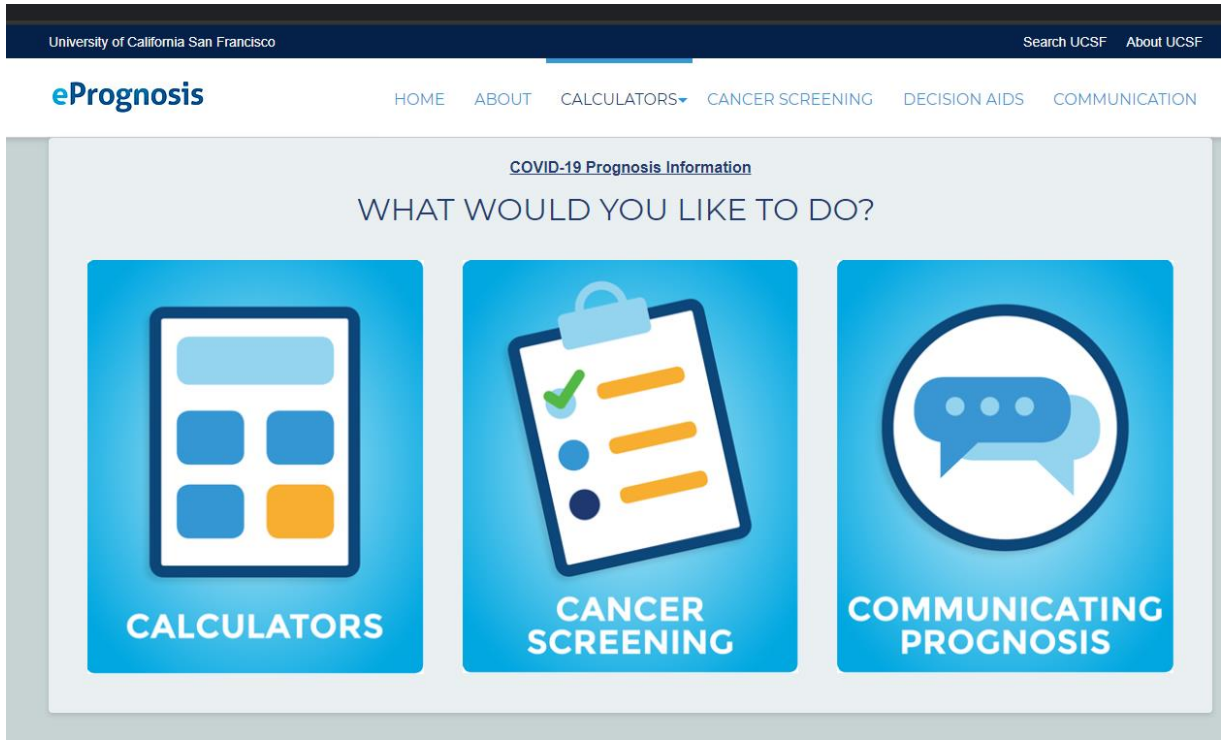
Also, Annual Wellness Visits



Hickman et al. The care planning umbrella: The evolution of advance care planning. J American Geriatrics Society, 2023

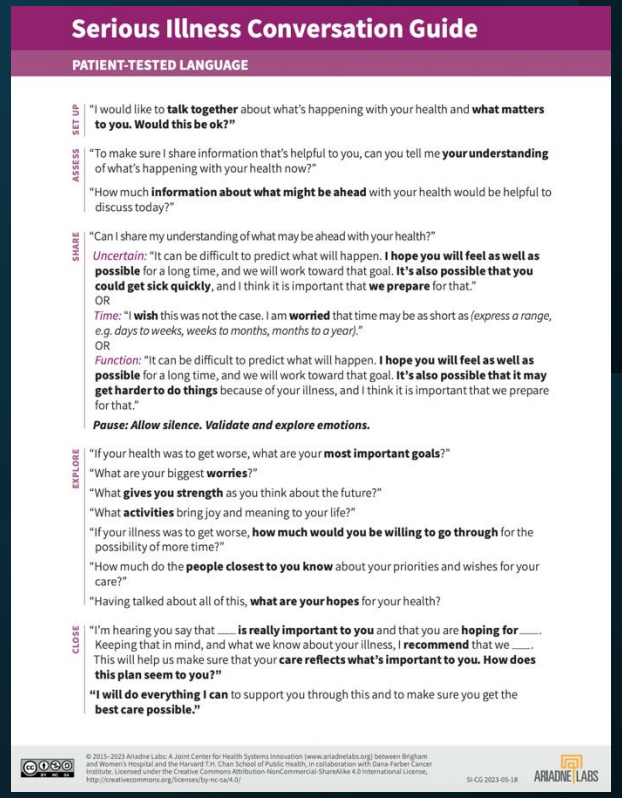
Preparing for Conversations

- Identify who should be there
- Locate any existing advance directives
- Clarify diagnoses
- Estimate prognosis to cultivate prognostic understanding



Evidence-based resource: https://eprognosis.ucsf.edu/

Serious Illness Conversation Guide



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."**

SI-CG 2023-05-18

ARIADNE LABS

Having Conversations

1. **Set up** the conversation
2. **Assess** the person's knowledge and information preferences
3. **Share** information about the person's illness and prognosis
4. **Explore** what matters to the person
   - Most important goals
   - Worries
   - Joys/strength/hopes
5. **Close** the conversations

Evidence-based resource:
www.Ariadnelabs.org

Set-up: How to start the conversation

"I would like to talk together about what's happening with your health and what matters to you. Would this be ok?"

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Assess the patient's knowledge and information preferences

- "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?"

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Poll question: Prognostic Awareness

Among patients with metastatic colorectal cancer receiving chemotherapy (which is not curative), what percent of patients expected that chemotherapy might be curative?

1) ~20%
2) ~40%
3) ~60%
4) ~80%

Share information about the person's illness and prognosis

"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 what matters

- “If your health was to get worse, what are your **most important goals**?”
- “What are your biggest **worries**?”
- “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?

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Table 1. Key Concepts and Examples of Communication Strategies.

Concept	Communication
Assess the patient's prognostic awareness while eliciting and exploring hopes and worries.	"What is your understanding of your illness? When you think about what lies ahead, what are you hoping for? What are you most worried about?"
Respond to prognostic questions with your best understanding, even if there is uncertainty.	"I hope your health will steadily improve, and I am worried that you may have a continued decline in your health."
Respond to emotions.	"This is so sad." "I can only imagine how hard this is."
Include loved ones in conversations exploring illness understanding.	"Who else might be helpful to include in our conversation?"
Help patients discern what matters most to them.	"If your health does worsen, what is most important to you?"
Recommend clinical care that is based on what matters most to the patient.	"It sounds like _____ is most important to you. Given this priority, I'd recommend _____."

Jackson, V.A.; Emanuel, L. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69. **DOI: 10.1056/NEJMcp2304436**

Close the conversations

- “I’m hearing you say that (value) **is really important to you** and that you are **hoping for**…
- Keeping that in mind, and what we know about your illness, I **recommend…**
- 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**.”

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Table 2. Key Elements to Document in the Medical Record.
Prognostic awareness
Illness understanding
Patient's hopes and worries
Prognostic information that was shared (e.g., curable or not curable); continued decline in patient's condition; a time-based prognosis of days to weeks, weeks to months, or months to years
Assessment of how the patient is coping, including strategies used by the patient and family
What is most important to the patient and family, including relationships, disability, suffering, and invasiveness of treatment
Recommendations made to the patient and family

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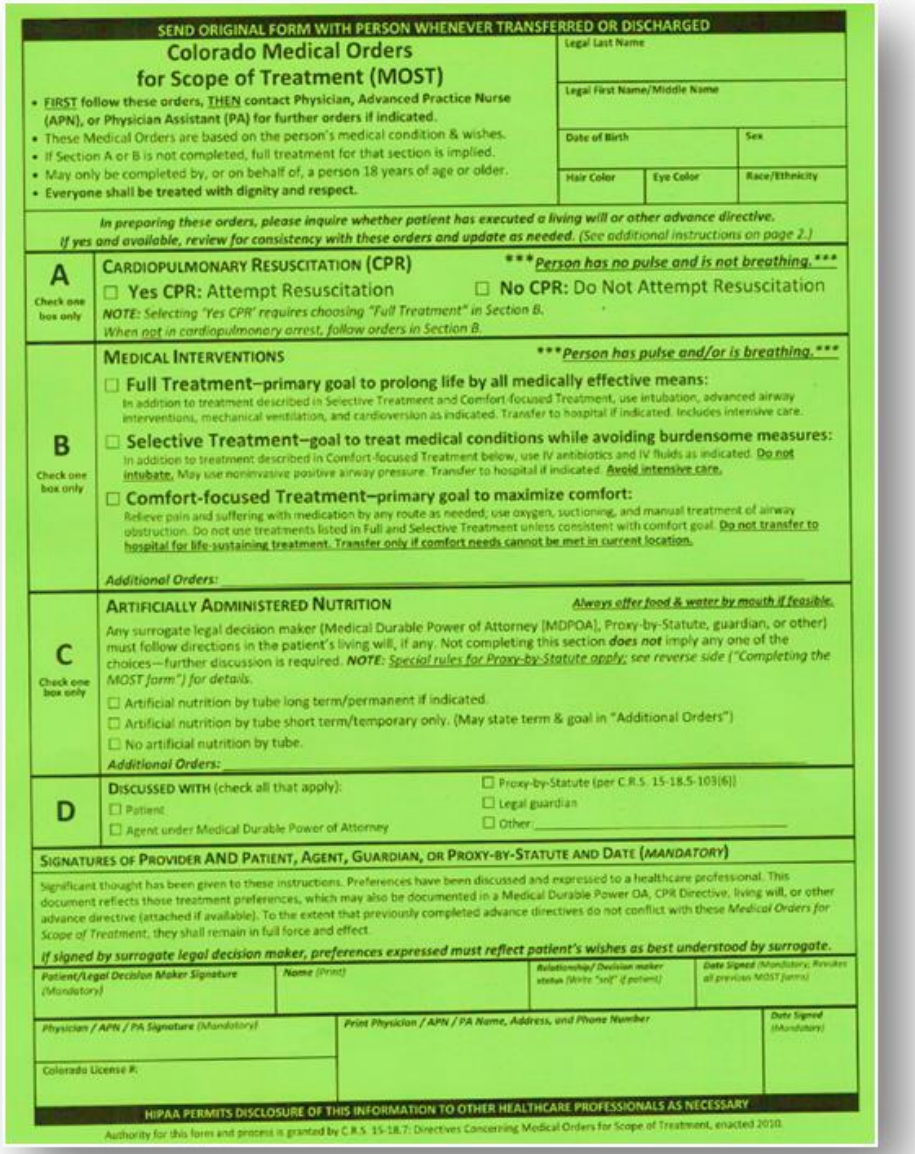
- **Identify appropriate use of the Medical Orders for Scope of Treatment (MOST) form**
- Outline adaptations for persons living with dementia
- Identify strategies for integrating ACP into outpatient care

MOST: Medical Orders for Scope of Treatment

- **<u>Medical orders</u> are intended for:**
  - People at risk for a life-threatening clinical event because they have a **serious life-limiting medical condition**
  - Chronically ill or medically frail
  - People with frequent hospitalization and/or care transitions



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- Everyone shall be treated with dignity and respect.

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

A (Check one box only) — CARDIOPULMONARY RESUSCITATION (CPR) ***Person has no pulse and is not breathing.***

☐ Yes CPR: Attempt Resuscitation ☐ No CPR: Do Not Attempt Resuscitation

NOTE: Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B. When not in cardiopulmonary arrest, follow orders in Section B.

B (Check one box only) — MEDICAL INTERVENTIONS ***Person has pulse and/or is breathing.***

☐ Full Treatment–primary goal to prolong life by all medically effective means: In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ Selective Treatment–goal to treat medical conditions while avoiding burdensome measures: In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ Comfort-focused Treatment–primary goal to maximize comfort: Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders:

C (Check one box only) — ARTIFICIALLY ADMINISTERED NUTRITION *Always offer food & water by mouth if feasible.*

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA]; Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section *does not* imply any one of the choices—further discussion is required. *NOTE: Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders:

D — DISCUSSED WITH (check all that apply):

☐ Patient ☐ Agent under Medical Durable Power of Attorney ☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6)) ☐ Legal guardian ☐ Other:

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (MANDATORY)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature (Mandatory) | *Name (Print)* | *Relationship/ Decision maker status (Write "Self" if patient)* | *Date Signed (Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature (Mandatory) | *Print Physician / APN / PA Name, Address, and Phone Number* | *Date Signed (Mandatory)*

Colorado License #:

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

Colorado MOST form available at: https://www.civhc.org/wp-content/uploads/2018/10/MOST-Form-2018.pdf;
University of Colorado Center for Bioethics and Humanities hosts the Colorado MOST Program;
Chelsea.patten@cuanschutz.edu

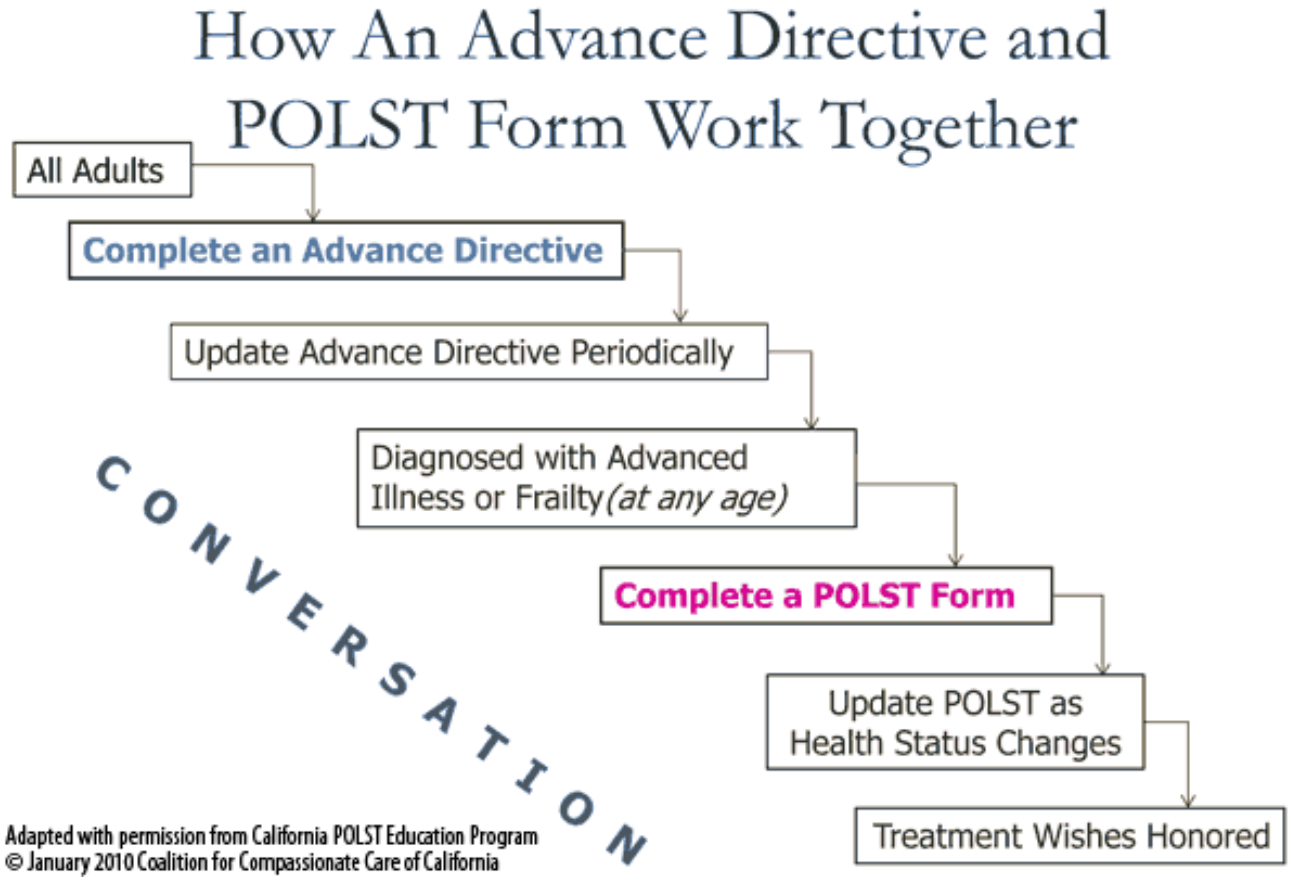
Poll question: MOST form

Can the MOST form be required by a care facility?
(i.e., skilled nursing facility or assisted living facility)

1) Yes
2) No
3) Unsure

Colorado MOST form supports Care Planning Conversations

- Specific values-based conversations about diagnosis, prognosis, and aligned treatment options
- Signed by patient/surrogate and physician, NP, PA
- **Medical orders are immediately effective**
- **MOST form should align with advance directives** (but can also override them)



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A framework for Structured CPR Conversations - GUIDE

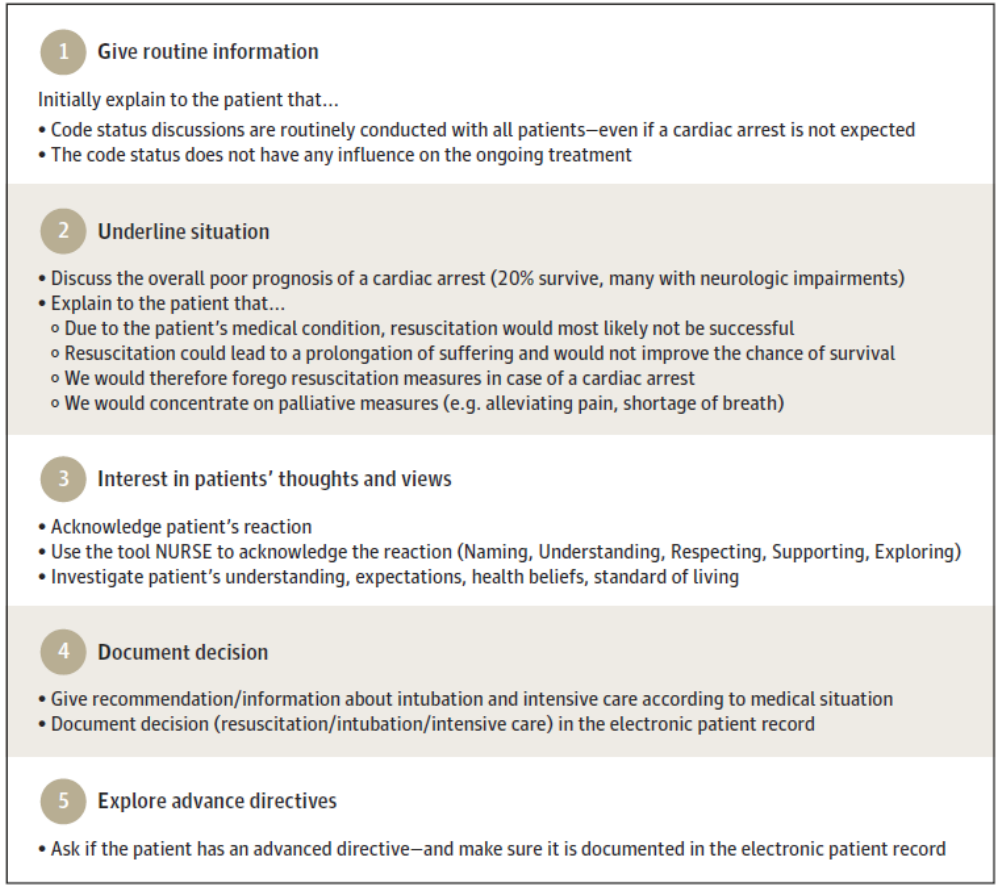
1) Give routine information

"I talk with all patients about code status"

2) **Underline** the situation

- Discuss the overall poor prognosis of a cardiac arrest (20% survive, many with neurologic impairments)
- Due to your medical conditions, resuscitation would most likely not be successful
- Resuscitation could lead to neurologic injury and would not improve the chance of survival
- I recommend allowing a natural death instead of CPR, if you have a cardiac arrest
- We would concentrate on comfort (e.g. alleviating pain, shortage of breath)

Figure 1. GUIDE: Checklist for Code Status Discussion in Patients With Cardiopulmonary Resuscitation (CPR) Futility



Arpagaus et al. Check-list Guided Code Status Discussions… *JAMA Network Open. 2025;8(9):e2533638. doi:10.1001/jamanetworkopen.2025.33638*

A framework for Structured CPR Conversations - GUIDE

3) Interest in patient's thoughts and views

- Honor emotions, ask about understanding, expectations, values

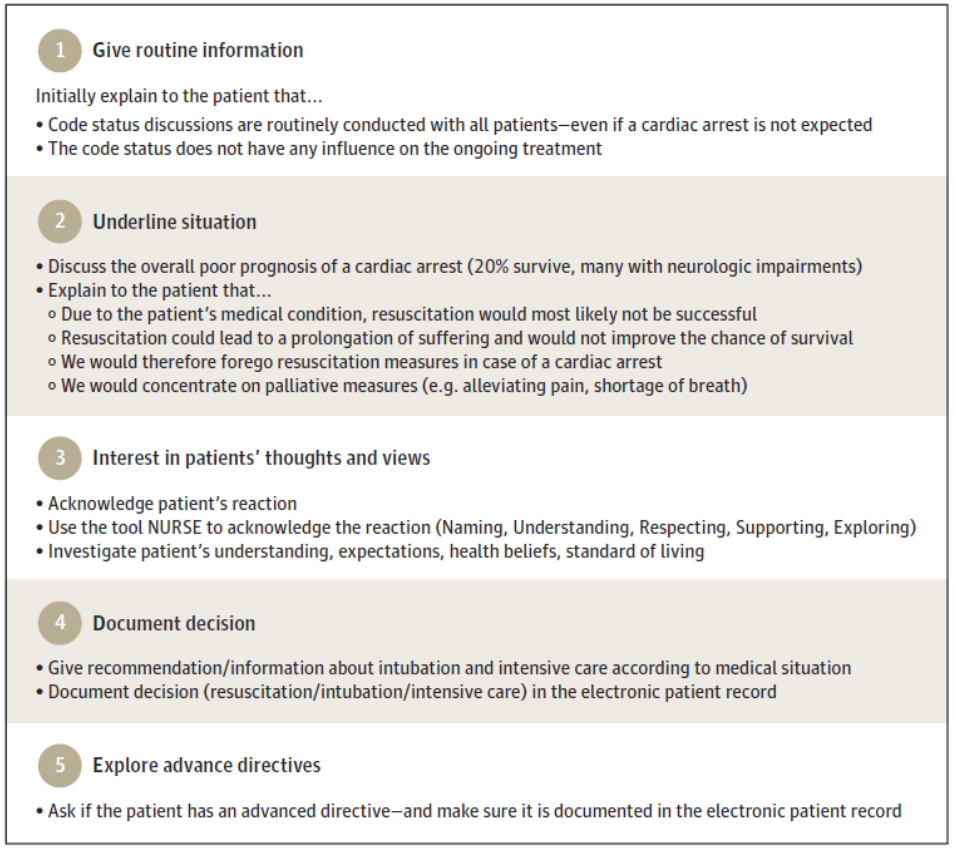
4) **Document** decision

- Give recommendation/information about intubation and intensive care, according to medical situation
- Document decision in the record (complete MOST form)

5) **Explore** advance directives

- Ask / review/ document advanced directive information

Figure 1. GUIDE: Checklist for Code Status Discussion in Patients With Cardiopulmonary Resuscitation (CPR) Futility



1 Give routine information

Initially explain to the patient that...

- Code status discussions are routinely conducted with all patients—even if a cardiac arrest is not expected
- The code status does not have any influence on the ongoing treatment

2 Underline situation

- Discuss the overall poor prognosis of a cardiac arrest (20% survive, many with neurologic impairments)
- Explain to the patient that...
  - Due to the patient's medical condition, resuscitation would most likely not be successful
  - Resuscitation could lead to a prolongation of suffering and would not improve the chance of survival
  - We would therefore forego resuscitation measures in case of a cardiac arrest
  - We would concentrate on palliative measures (e.g. alleviating pain, shortage of breath)

3 Interest in patients' thoughts and views

- Acknowledge patient's reaction
- Use the tool NURSE to acknowledge the reaction (Naming, Understanding, Respecting, Supporting, Exploring)
- Investigate patient's understanding, expectations, health beliefs, standard of living

4 Document decision

- Give recommendation/information about intubation and intensive care according to medical situation
- Document decision (resuscitation/intubation/intensive care) in the electronic patient record

5 Explore advance directives

- Ask if the patient has an advanced directive—and make sure it is documented in the electronic patient record

Arpagaus et al. Check-list Guided Code Status Discussions… *JAMA Network Open. 2025;8(9):e2533638. doi:10.1001/jamanetworkopen.2025.33638*

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Considerations for ACP in Dementia

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Special article

Optimizing Advance Care Planning in Dementia: Recommendations From a 33-Country Delphi Study

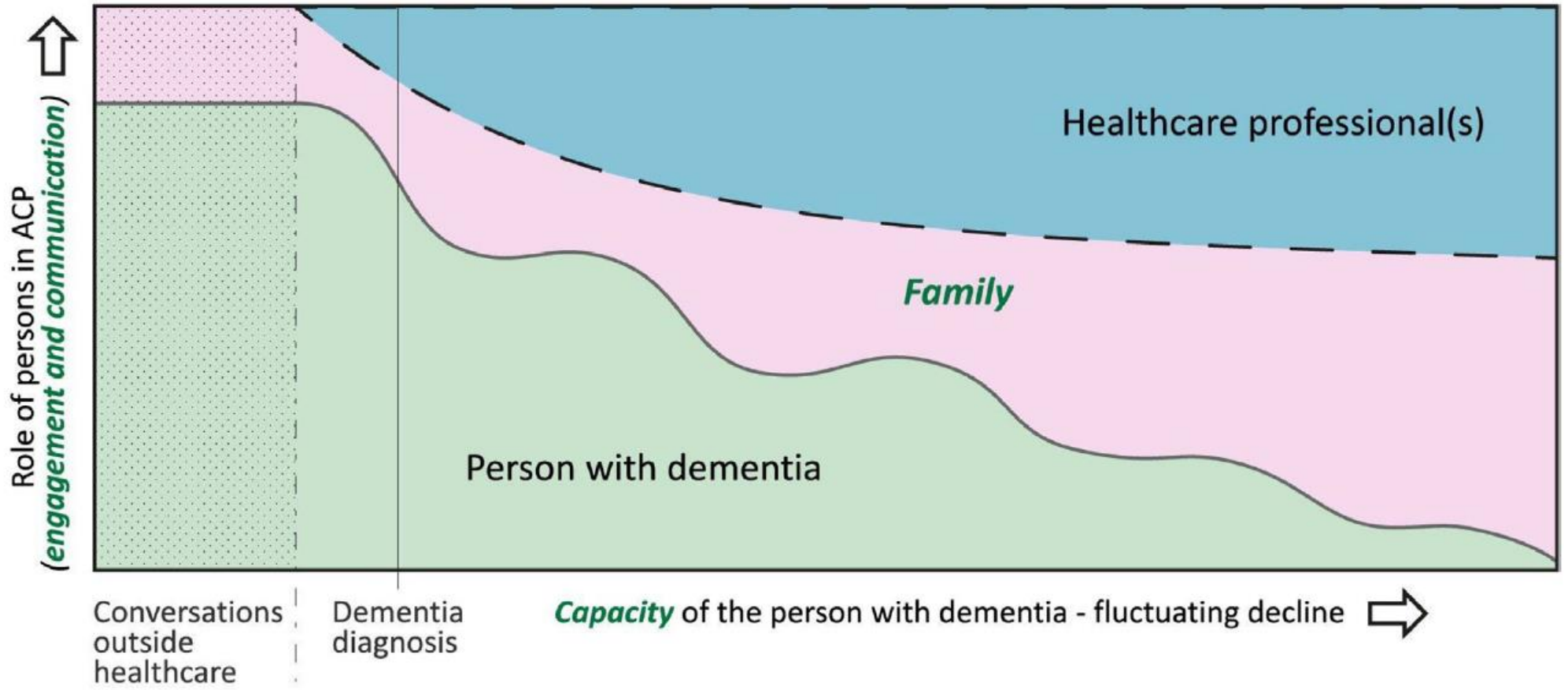
Jenny T. van der Steen, MSc, PhD, FGSA, Lieve Van den Block, PhD, Miharu Nakanishi, RN, PhD, Karen Harrison Dening, RN, RNM, RNLD, MA, PhD, Deborah Parker, RN, PhD, Philip Larkin, PhD, MSc, RN, RCN, RNT, Paola Di Giulio, RN, MSc, Jürgen in der Schmitten, MD, MPH, Rebecca L. Sudore, MD, Ninoslav Mimica, MD, MSc, PhD, IFAPA, Iva Holmerova, MD, PhD, Sandra Martins Pereira, RN, MSc, PhD, and Ida J. Korfage, PhD, on behalf of the European Association for Palliative Care (EAPC)

<u>Recommendations from an international Delphi panel:</u>

- Assume capacity as a principle,
- Explore fluctuation in capacity
- Encourage engaging and playing active roles,
- Establish connection and inform and prepare family
- Offer ACP around time of dementia diagnosis
- Assess dementia stage and palliative care needs of the person living with dementia
- Discuss end of life issues over time
- Focus on values and preferences, rather than concrete life-sustaining interventions

Van der Steen et al. Optimizing Advance Care Planning in Dementia: Recommendations From a 33-Country Delphi Study. JPSM 2025.

Relating ACP Conversations, Engagement, Capacity, and Family in Dementia over time



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Does this person have decision making capacity?

Patients must be able to:

(1) demonstrate understanding of the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment);

(2) demonstrate appreciation of those benefits, risks, and alternatives;

(3) show reasoning in making a decision; and

(4) communicate their choice.

Surrogate decision making: Who decides?

Patient with capacity to make decisions

Guardian – legally appointed

Agent with medical durable power of attorney

- Assigned by patient with decision making capacity

Proxy – chosen by people who care about patient

- No hierarchy in Colorado

Physician-proxy of last resort

(for an admission)

HB16-1101. Medical Decisions For Unrepresented Patients, enacted May 2016

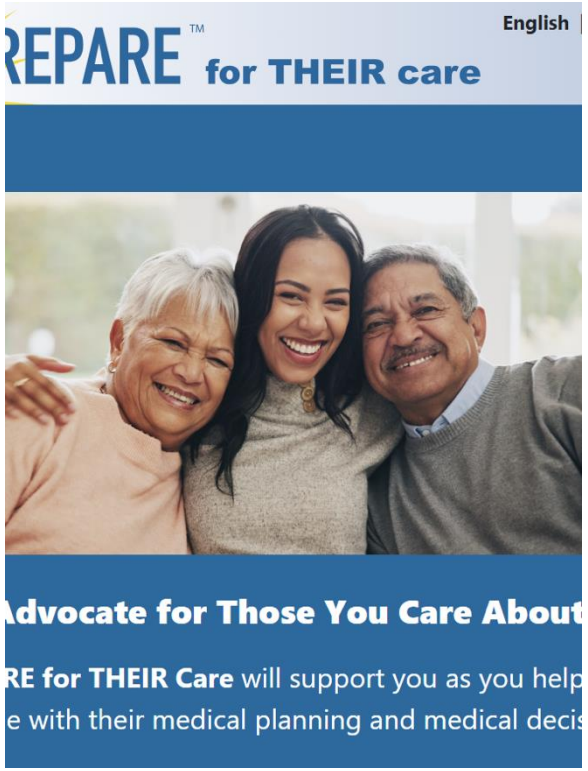
Resources for Surrogates

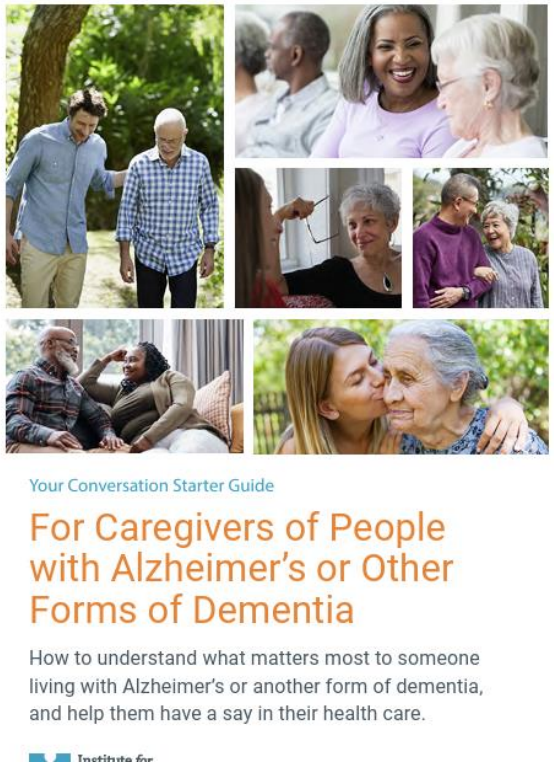
- **PREPARE for THEIR care:**

https://prepareforyourcare.org/en/prepare-for-their-care/welcome

- **The Conversation Project – Cognitive Impairment:**

https://theconversationproject.org/alzheimers-additional-resources/





Practical tips to consider

- In your clinical context, how do you:
  - Support conversations that highlight the need for supported decision making?
  - Assess capacity and document it?
  - Engage an MDPOA in their role as surrogate decision maker for future planning and current decision making?
  - Use team-based approaches to support the decision maker?

Objectives

- Describe communication strategies for advance care planning (ACP) and goals of care conversations
- Identify appropriate use of the Medical Orders for Scope of Treatment (MOST) form
- Outline adaptations for persons living with dementia
- **Identify strategies for integrating ACP into outpatient care**

Leveraging the Annual Wellness Visit

- ACP
  - Is there a decision maker? Are documents on file?
  - As you think about future care planning or navigating a serious illness, what is important for me to know about you? (Dignity question)
  - Plan for ongoing conversations; provide resources; refer to social work and/or specialty palliative care
  - Consider discussing the MOST form, only if appropriate (serious illness)

Billing for ACP - 99497

- Face-to-face time between patient and family member or surrogate in counseling and discussion of advance directive with or without completing relevant forms
- Do not need a specific diagnosis but appropriate to include condition for which you are counseling on
- **99497** (first 30 minutes, minimum 15 min)
- 99498 (each additional 30 minutes, minimum of 45 min total time)
- **Can bill alone** (without accompanying E&M visit) **or along with** initial, subsequent visit codes

Resources for Patients

- **Colorado Care Planning**
  www.ColoradoCarePlanning.org
- **Easy to Read Advance Directive:**
  www.prepareforyourcare.org
- **The Conversation Starter Kit**
  https://theconversationproject.org/starter-kits/
- **The Conversation Project – Cognitive Impairment:**
  https://theconversationproject.org/alzheimers-additional-resources/
- 1-page Medical Durable Power of Attorney
  https://www.coloradoadvancedirectives.com/wp-content/uploads/2014/07/MDPOA_form.pdf

Your Conversation Starter Guide

For Caregivers of People with Alzheimer's or Other Forms of Dementia

How to understand what matters most to someone living with Alzheimer's or another form of dementia, and help them have a say in their health care.

Institute for Healthcare Improvement

the conversation project

Resources for Clinical Teams

- **The Serious Illness Toolkit:** https://www.seriousillnessmessaging.org/quick-guides/acp/
- **5 wishes (combines living will and MDPOA) https://fivewishes.org/shop/order/product/five-wishes**
- **E-Prognosis:** www.Eprognosis.ucsf.edu
- **Colorado Care Planning**

  www.ColoradoCarePlanning.org

Colorado MOST Program, https://medschool.cuanschutz.edu/coloradocareplanning/resources/colorado-most-program

What if there is no decision maker?

- Think deeply and broadly about individuals who could be involved
  - It's never too late to establish a new and meaningful connection

- Consider hiring a care manager, attorney, or other qualified person to serve as a surrogate decision maker.

- Consider and complete form(s) that convey values and preferences (advance directives), including a MOST form, if appropriate.

Returning to our case…

- Asking about perspectives from oncologist and other specalists (assess understanding/perspective)
- Invite perspectives of patient, wife and daughter
- Ask about patient's overall preferences, raise questions of value of hospitalization to understand if he is interested in placing limits on interventions
- Revisit advance directives; work toward completing a MOST form (recommendation against CPR)

Why Care Planning Conversations matter:

- Helps to ensure that the care provided reflects patient goals
- Improves quality of patient-provider communication
- Reduces unwanted admissions
- Increases use of palliative care
- **Improves patient quality of life**

Bernacki et al. Effect of the Serious Illness Care Program in Outpatient Oncology… JAMA Intern Med 2019
Paladino et al. Evaluating an Intervention to Improve Communication Between Oncology Clinicians and Patients with Life-Limiting Cancer. JAMA Oncol 2019.

Clinical Pearls for Serious Illness Conversations

1. Partner with patients by 1) effectively communicating prognostic information and 2) responding to the emotions
2. Engage in **multiple conversations over time**, as patients integrate prognostic information cognitively and emotionally.
3. Normalize that patients oscillate between hopefulness and more realistic aspirations.
4. Facilitate patient **exploration of their hopes and worries** - this allows them to grieve, understand their priorities, and **build coping skills for living with a serious illness.**
5. As they are ready, **discuss what is most important** given the likely illness trajectory, and incorporate these goals and values into **a recommendation about medical care, including care at the end of life.**

Jackson, V.A.; Emanuel, L. Navigating and Communicating about Serious Illness and End of Life. *N. Engl. J. Med.* **2024**, *390*, 63–69. **DOI: 10.1056/NEJMcp2304436**

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Q&A

Thank you!