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Honoring Veterans' Wishes: Efficacy of an Evidence-Based Shared Decision-Making Tool in VA ICU Goals-of-Care Discussions

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Honoring Veterans' Wishes: Efficacy of an Evidence-Based Shared Decision-Making Tool
in VA ICU Goals-of-Care Discussions

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
Beyster Institute for Nursing Research

DOCTOR OF NURSING PRACTICE PORTFOLIO

By
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A portfolio presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree

DOCTOR OF NURSING PRACTICE

May 2024

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List of Abbreviations

Abbreviation	Definition
ACP-SE	Advance Care Planning Self-Efficacy scale
DNP	Doctor of Nursing Practice
EBP	Evidence-Based Practice
EBST	Evidence-Based Standardized Tool
HER	Electronic Health Record
GOCD	Goals of Care Discussion(s)
ICU	Intensive Care Unit
LST	Life-Sustaining Treatment
PGYMD	Post-Graduate Year Medical Doctor
QI	Quality Improvement
RCT	Randomized Control/Clinical Trial
REMAP	Reframe, Expect emotion, Map out patient goals, Align with goals, and Propose a plan
SICP	Serious Illness Care Program
UCSD	University of California San Diego
VASD	Veterans' Health Administration Medical Center in San Diego

Acknowledgements

First, my capstone project would not have been possible without the guidance and endorsement of Dr. Venkatesh Ramnath and Dr. Anna Astashchanka. Dr. Ramnath recognized the need for improved shared decision-making at our site, provided the educational template, and facilitated the necessary approvals for this project. Dr. Astashchanka was instrumental in creating educational materials, coordinating schedules, and delivering the educational intervention to participants.

Second, I received valuable editing assistance from Dr. Autumn Roque, DNP, PMHNP-BC, and Dr. Sarah Henry, PhD. Dr. Roque guided the development of my original work into a doctoral-level product. Dr. Henry and the Heartful Editor team significantly enhanced my academic writing skills, a service I highly recommend to my colleagues.

Third, I am grateful to all my clinical mentors, including Del Antonio, PMHNP-BC, and Dr. Troy Kurz. Del imparted true wisdom, believed in my potential, and bolstered my self-confidence as a future clinician. Dr. Kurz held me accountable and sharpened my critical thinking, aiding my growth as a provider. Although I have completed this program, my education is just beginning. I will carry forward the lessons from all my mentors into my future clinical practice.

Lastly, I could not have completed this program without the love and support of my family and friends. My partner, Madison, and my uncle Dan provided unwavering patience and encouragement. Their financial and emotional backing enabled me to complete this program in three years with profound dedication. I am forever grateful to these beautiful souls who have supported me on this journey.

Manuscript

**Honoring Veterans' Wishes:
Efficacy of an Evidence-Based Shared Decision-Making Tool
in VA ICU Goals-of-Care Discussions**

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Abstract

Introduction: This Doctor of Nursing Practice project aimed to enhance the knowledge and confidence of the San Diego Veterans Health Administration's (VASD) Intensive Care Unit (ICU) medical providers in goals-of-care discussions (GOCD). Additionally, this project aimed to improve the documentation of these discussions.

Background: Delays in GOCD can lead to futile medical and surgical interventions, inappropriate antibiotic use, and higher rates of mental health conditions in patients and their loved ones. Earlier GOCD are associated with lower ventilation and resuscitation rates, earlier hospice enrollment, reduced ICU admissions, lower financial costs, and better patient and caregiver quality of life. However, medical providers caring for patients in VASD and other hospital settings are often underprepared or hesitant to facilitate GOCD. As a result, these discussions are frequently delayed and documented inconsistently.

Methods: This project implemented three education sessions on an evidence-based standardized tool for facilitating GOCD to 14 physicians within their first five postgraduate years. Participants were then instructed to use the tool with every admitted patient and document GOCD in a life-sustaining treatment (LST) note. Pre- and post-implementation surveys containing the Advanced Care Planning Self-Efficacy scale (ACP-SE) were administered. The frequency of LST was recorded for the three months before and during training.

Results: Pre-survey data showed an average ACP-SE score of 3.23 out of 5, with 5 indicating the highest provider GOCD self-efficacy rating. Half of those surveyed reported having received no prior training in GOCD. The post-survey ACP-SE average was 4.54; however, four out of the 14 participants completed the post-survey. LST note documentation in the ICU began at 16.9% of total admissions and increased by 1% during the project.

Evaluation: New medical providers at the VASD ICU may benefit from additional education and practice in GOCD. Moreover, on-site peer champions, financial incentives, and supervisory involvement may optimize post-survey data collection and LST documentation. Provider self-efficacy with and documentation of GOCD at the VASD ICU may benefit from further quality improvement projects, documentation policy updates, and evidence-based education interventions.

Keywords: advance care planning, education, goals of care, self-efficacy, life-sustaining treatment, intensive care unit

Honoring Veterans' Wishes: Efficacy of an Evidence-Based Shared Decision-Making Tool in VA ICU Goals-of-Care Discussions

Modern technology has gifted the healthcare industry with astounding innovations. Medical and surgical interventions can now enhance or replace organ function and extend life expectancy. However, quality of life and extension of life are not always synonymous, and these interventions can potentially extend suffering for those with severe medical illnesses. To illustrate, clinicians in critical care settings frequently treat patients living with preexisting, life-limiting conditions using interventions like mechanical intubation, artificial nutrition, and renal dialysis. These interventions are painful and can exhaust valuable resources for negligible improvements in health outcomes for the chronically critically ill (Damps et al., 2022; Jones & McCullough, 2014).

The significance of early goals of care discussions (GOCD) extends beyond improving patient and family satisfaction with care. Delays in these discussions can lead to unnecessary and expensive medical and surgical interventions, inappropriate antibiotic use, and higher rates of mental health conditions in patients and their loved ones (Choudhuri et al., 2020; Wright et al., 2008). Conversely, earlier GOCD are associated with lower ventilation and resuscitation rates, earlier hospice enrollment, reduced critical care (i.e., ICU) admissions, reduced healthcare costs, and better patient and caregiver quality of life (Jones & McCullough, 2014; Wright et al., 2008).

Triggers and Opportunities

Desired outcomes of medical interventions for the chronically critically ill are now targeting the health and well-being of the whole person rather than life-sustaining organ support (Sutherland, 2019). To this end, the shared decision-making process is integral to patients' well-

being and that of their loved ones (Welsch & Gottschling, 2021). However, This process can be challenging for both clinicians and patients for several reasons.

Knowledge-Focused Triggers

For example, one multicenter study of 13 hospitals by You et al. (2015) sheds light on some of the challenges to GOCD. This study identified patient and family-member-related factors (You et al., 2015,) as barriers to medical decision-making and found that patients and their loved ones need more information on life-sustaining treatment limitations and support with accepting a poor prognosis. The authors advocated for better GOCD communication strategies for clinicians (You et al., 2015).

A cross-sectional cohort study by Chiarchiro et al. attempted to predict surrogates' understanding and expectation of their prognoses by their ratings of the quality of their physician's communication (2016). The authors found ratings of communication quality did not predict a reasonable expectation about prognosis, and ratings sometimes dropped when their understanding of a poor prognosis became clearer. They argued physicians should not depend on subjectivity ratings to measure communication effectiveness, should use the teach-back method as often as possible when providing prognostic information, and should become comfortable with initiating the shared decision-making process (Chiarchiaro et al., 2016).

Bernacki et al. published a best practice synthesis in 2014 indicating clinicians may cause more barriers to GOCD than patients. While patient-related barriers include illness anxiety, denial about prognosis, and differences in preferences, they still expect their physicians to initiate prognostic conversations. Physicians often respond to these barriers with avoidance or "titrating" discussions for palatability, suspending patients' and surrogates' opportunity to accept their illness and its implications (Bernacki et al., 2014, p. 2).

Patients and their loved ones often wish they knew prognostic information as early as their diagnoses (Welsch & Gottschling, 2021). Research articles published by the National Institute for Health and Care Excellence (NICE), the *Yale Journal of Biology and Medicine*, and the *Journal of Surgical Research* indicated physicians frequently hesitate to prognosticate or give patients clear, specific information about terminal illness (Knutzen et al., 2021; National Guideline Centre UK, 2019; Sutherland, 2019; Taylor et al., 2018). As a result, GOCD are frequently delayed. While it may be onerous, physician competence and self-confidence in initiating these conversations is essential to good medical practice (Bernacki et al., 2014; Brighton & Bristowe, 2016).

Current literature emphasizes the importance of educating clinical staff on how to best facilitate GOCD with patients and their caregivers (Knutzen et al. 2021; National Guideline Centre UK, 2019; Parikh et al., 2017; Sutherland, 2019; Welsch & Gottschling, 2021, You et al., 2015). The need for more effective, standardized, in-depth physician training is clear (Levin et al., 2010; Sutherland, 2019; Parikh et al., 2017).

Problem-Focused Triggers

The Jennifer Moreno VA Medical Center (VASD) needs clearer directives in documentation, training for clinicians, and responsibility assignments regarding GOCD. The medical center currently has no postadmission timeframe requirements for GOCD documentation. There is no standardized process for deciding who should have a GOCD. The primary related documentation is the LST note, which is only required when a patient's code status changes. Therefore, many patients' electronic health records (EHRs) at VASD do not contain GOCD documentation during their hospital stay. Training on GOCD in medical school and residency is variable, and these clinicians often rely on supervisory instruction, in-vivo

exposure, and self-study with hospital resources to gain competence in GOCD (Sutherland, 2018). Similarly, medical providers at VASD do not receive consistent, standardized training on facilitating GOCD.

VASD providers are most frequently exposed to the shared decision-making process in the ICU. The medical and palliative care team conducts weekly goals-of-care rounds, during which each case is discussed. ICU medical providers, many of whom are residents and interns, often delegate responsibility for GOCD to the palliative care team. However, the palliative care team relies on the ICU medical team for GOCD, as they consistently follow a case after receiving a consult request. With a shortage of palliative care providers, other medical providers and clinical staff at VASD are equally responsible for facilitating shared decision-making and GOCD. Therefore, all providers at VASD should ideally feel comfortable with and receive adequate training in the shared decision-making process, especially in the ICU.

Evidence-Based Practice Model

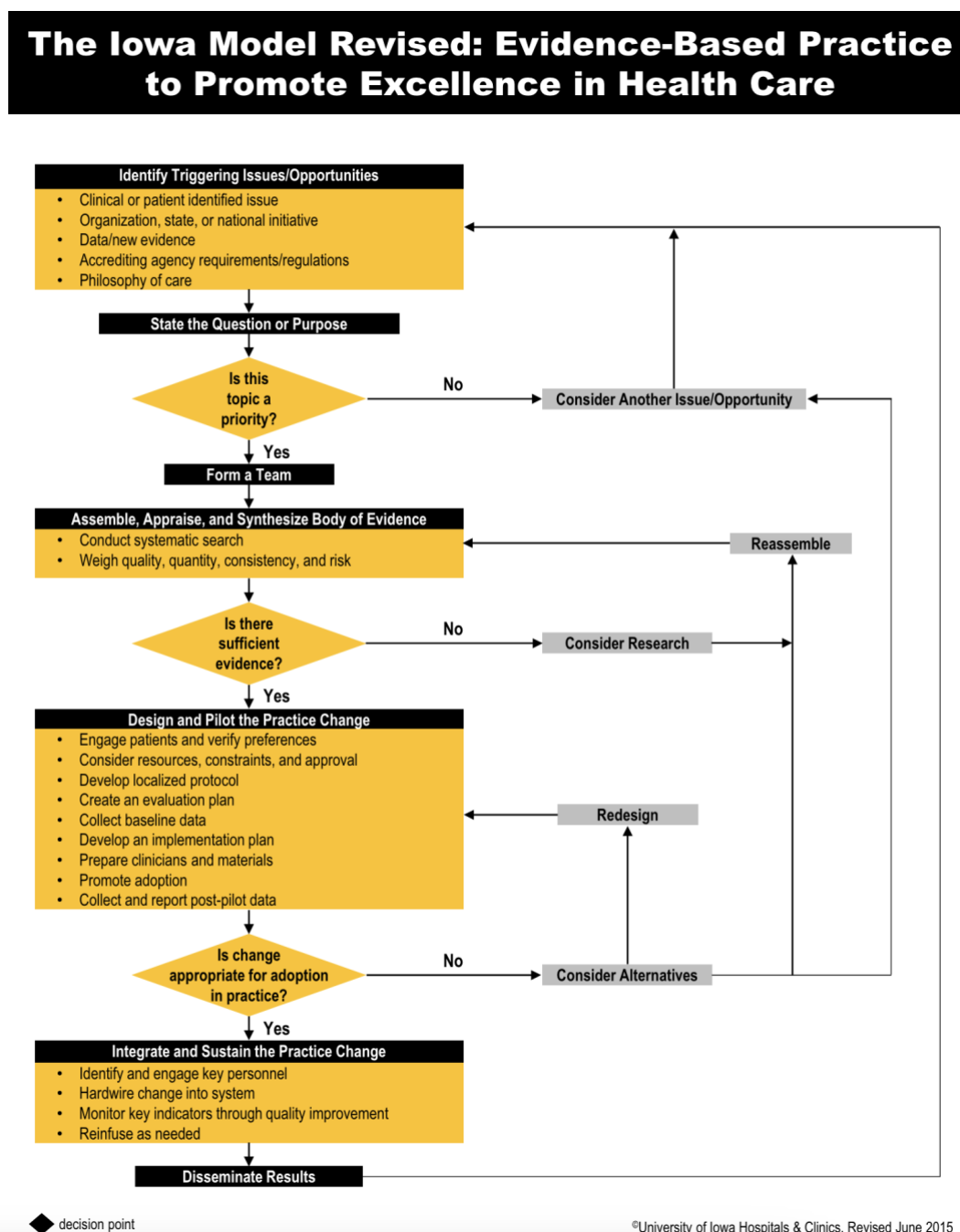
The Iowa model (see Figure 1) was selected as a guiding framework for this evidence-based practice (EBP) project due to its practical, multistep process and clinical utility in hospital settings (Iowa Model Collaborative, 2017). Knowledge-focused triggers from the literature review and problem-focused triggers from current practice at VASD highlighted an opportunity for growth in GOCD training and documentation. The ICU director, V. Ramnath, MD, a palliative care MD Fellow, A. Astashchanka, MD (“Fellow” capitalized in future reference), and the DNP student formed the core team members.

Literature Review

These knowledge and problem-focused triggers inspired the DNP project’s PICO question for evidence review:

Figure 1

The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care



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Population: For physicians and advanced practice clinicians in critical care

Intervention: Does standardized training for providers in facilitating goals-of-care discussions

Comparison: Compared to current practice

Outcome: Improve clinicians' subjective and objective competency in facilitating and documenting goals-of-care discussions

Search Terms

A literature search with this PICO question was conducted on *PubMed* and *GoogleScholar* databases. Relevant research was limited to publications within the last 6 years and adults aged 18 and older. Keywords included *advance care planning, education, goals of care, self-efficacy, life-sustaining treatment, and intensive care unit*. After finalizing the search, eight articles related to the PICOT question were selected for the evidence review. Additional searches were conducted to appraise evidence-based education interventions and measures for provider self-efficacy.

Synthesis of Evidence

Four randomized clinical trials (RCTs) in this evidence review were designed with intervention groups who received varied educational interventions (Curtis et al., 2023; Curtis et al., 2018; Manz et al. 2020; Paladino et al., 2019). These interventions included a single page “jumpstart guide” as a “priming tool” for GOC conversations (Curtis et al., 2023, p. 5), training programs with integrated machine learning for mortality predictions (Manz et al. 2020), instruction in a “communication quality-improvement intervention” (Paladino et al., 2019, p. 3), and a “bilateral, preconversation, communication-priming intervention” (Curtis et al., 2018, p.

4). These studies were large enough to produce statistically significant results, demonstrating that educating providers on GOCD can improve the quality and frequency of GOCD documentation.

Other non-RCT studies have demonstrated similar findings. For instance, Ma et al. (2020) completed a retrospective chart review after a hospital-wide “serious illness care program [SICP]” (p. 2). Clinician training in this program included a two-and-a-half-hour interactive workshop on GOCD and a palliative approach earlier in the patient’s stay. The retrospective quality of documented GOCD was then assessed using a “validated codebook,” which showed the intervention group had higher quality documentation from providers who completed training (Ma et al., 2020, p. 2). A 2022 commentary applauded the SICP program as an “excellent intervention to improve the care of patients with advanced cancer” (Karim et al., 2022, p. 8) and provided recommendations on overcoming challenges to its implementation in clinical settings. Earlier studies also demonstrated the effectiveness of the SICP program but were excluded by publication date from this review.

EBP and quality improvement (QI) pilot projects have demonstrated similar outcomes. Nagpal et al. (2021) delivered a 3-hour simulation training with a live exercise to 84 residents, with pre- and post-training surveys to measure their subjective confidence with GOCD. Seventy percent of these residents demonstrated significant improvements in GOCD communication skills, and 90% reported more confidence in GOCD and familiarity with discussing prognoses (Nagpal et al., 2021). Similarly, Childers & Arnold (2018) gave half to full-day training courses, which included lectures, interactive practice, and simulations, to about 500 clinicians in their QI project. Post-survey self-reports revealed improved GOCD facilitation skills, and EHR records displayed that trained clinicians were more likely to document GOCD (Childers & Arnold, 2018).

All healthcare facilities in Quebec, Canada underwent a QI project, which was published in the *Journal of Social Work in End-of-life & Palliative Care* in 2021. A unified format for documenting patient preferences and an interprofessional training program was provided to all healthcare team members. While limitations may have been visible on a local site level, most healthcare facilities using the unified format improved documentation, interdisciplinary collaboration, and patient advocacy in GOCD after implementation (Fortin & Dumont, 2021). This project demonstrated that comparable projects can be effective on a multi-facility scale. Compellingly, evidence review has shown that educating physicians and providers can improve provider readiness for and documentation of GOCD.

Review of Education Interventions

While the educational methods employed in these studies were varied, current best evidence supports using standardized frameworks for GOCD. Recommended frameworks in the literature shared a similar structure. The Reframe, Expect emotion, Map out patient goals, Align with goals, and Propose a plan (REMAP) framework is an evidence-based method for conducting GOCD, and it has been tested in various clinical settings (Childers et al., 2017). Essential components of this process include assessing patients' understanding of their condition, empathizing with emotion, providing reflective statements, aligning with the patient's values, and giving honest recommendations (Childers et al.). Other frameworks, such as the six-step "SPIKES" protocol, is also evidence-based and shares essential elements (Finlay & Casarett, 2009, p 1).

Bernacki et al. described best practices for serious illness conversations and provided recommendations for healthcare professionals and systems in a 2014 review and synthesis (2014). Their recommendations for high-quality GOCD include eight components:

1. Explore the patient's understanding of their illness and prognosis
2. Understand the patient's preferences on how much decision-making information they want access to
3. Inform patients of their general prognosis and what to expect from their illness
4. Tailor advice to the patient's specific goals to give them a sense of control and purpose
5. Allow time for patients to express fears and concerns
6. Explore patient values to ascertain their individually acceptable level of function
7. Explore trade-offs between time in hospital enduring procedures vs. at home with potentially better overall quality
8. Understand patient preferences on family involvement and develop a plan to engage with family members based on those preferences (Bernacki et al., 2014).

These recommended components GOCD delivery were integrated into this project's education interventions.

Laying the Groundwork

This DNP project had two primary objectives. The first objective was to improve medical providers' knowledge and self-confidence in facilitating GOCD at the VASD ICU. The second objective was to increase the frequency of documented GOCD in the LST note. Positive project outcomes would then be disseminated throughout the medical center and to other VA sites. Following is a discussion of the project's stakeholders, ethical considerations, , and cost-benefit analysis involved in pursuing these two objectives.

Stakeholders

Interdisciplinary stakeholders included ICU medicine leadership and residents, the VASD IRB representative, ethics committee representatives, the data analytics team, and the palliative care team. ICU medicine leadership approved resident training for this project. The IRB representative directed the DNP student through the nonresearch criteria approval process. The data analytics team acquired relevant ICU LST and admission data. Ethics and palliative care committee representatives were consulted for all GOCD training materials.

Ethical Considerations

This project met Department of Veterans Affairs IRB criteria for the category “non-research/not-human subjects research” (see Appendix A). The University of California San Diego (UCSD) and VASD ethics and palliative care committee representatives approved the program design and training materials. Permission to use the Advanced Care Planning-Self Efficacy (ACP-SE) scale (see Appendix B) and Iowa model (see Figure 1) was obtained from Dr. Baughman and the University of Iowa Hospitals and Clinics, respectively.

Cost-Benefit Analysis

Delayed GOCD and aggressive end-of-life care are costly. A 2019 systematic review from the *Journal of Hospice and Palliative Care* reported significant cost avoidance from GOCD within 30 days of end-of-life (Starr et al., 2019). Through lower “high-cost care” utilization, reduced “heroic measures” nearing the end of life, and reduced length of stay, the cost avoidance cited was \$22,432 (Starr et al., 2019, p. 11). Nonfinancial benefits include improved patient quality of life, improved patient and surrogate satisfaction with care, reduction in provider and nurse burnout, and improved GOCD communication (Choudhuri et al., 2020; Wright et al., 2008, Starr et al., Wang et al., 2019; Molero et al., 2021).

The Fellow and DNP student delivered the educational intervention. Training time was approved by the supervising medical team and integrated into their workflow, and no additional salary compensation was needed for the trainees. Costs of material development were approximately \$1000 for 10 hours of the Fellow's time and \$10 for printing materials. Therefore, the total financial cost of this project was approximately \$1010. Additionally, adjusting provider workflow to accommodate for GOCD and documentation may have incurred other nonfinancial costs. This cost-benefit analysis equates to a potential \$22.21 savings for every dollar spent and a 2,121% return on investment (see Figure 2 for calculation).

Figure 2

Cost-benefit Analysis and Return on Investment Calculation

Cost-benefit analysis:	$\frac{\text{Program benefits}}{\text{Program costs}} = \frac{22432}{1010} = \mathbf{\$22.21}$
Return on investment:	$\frac{\text{Program benefits} - \text{program costs}}{\text{Program costs}} \times 100 =$ $\frac{22432 - 1010}{1010} = 21.21 \times 100 = \mathbf{2,121\%}$

Methods

Seven of the eight literature review articles' primary outcomes demonstrated improved GOCD documentation (Childers & Arnold, 2018; Curtis et al., 2023; Curtis et al., 2018; Fortin & Dumont, 2021; Ma et al., 2020; Manz et al., 2020, Paladino et al., 2019). Two of these studies developed unique quantitative measures to assess provider confidence (Fortin & Dumont, 2021;

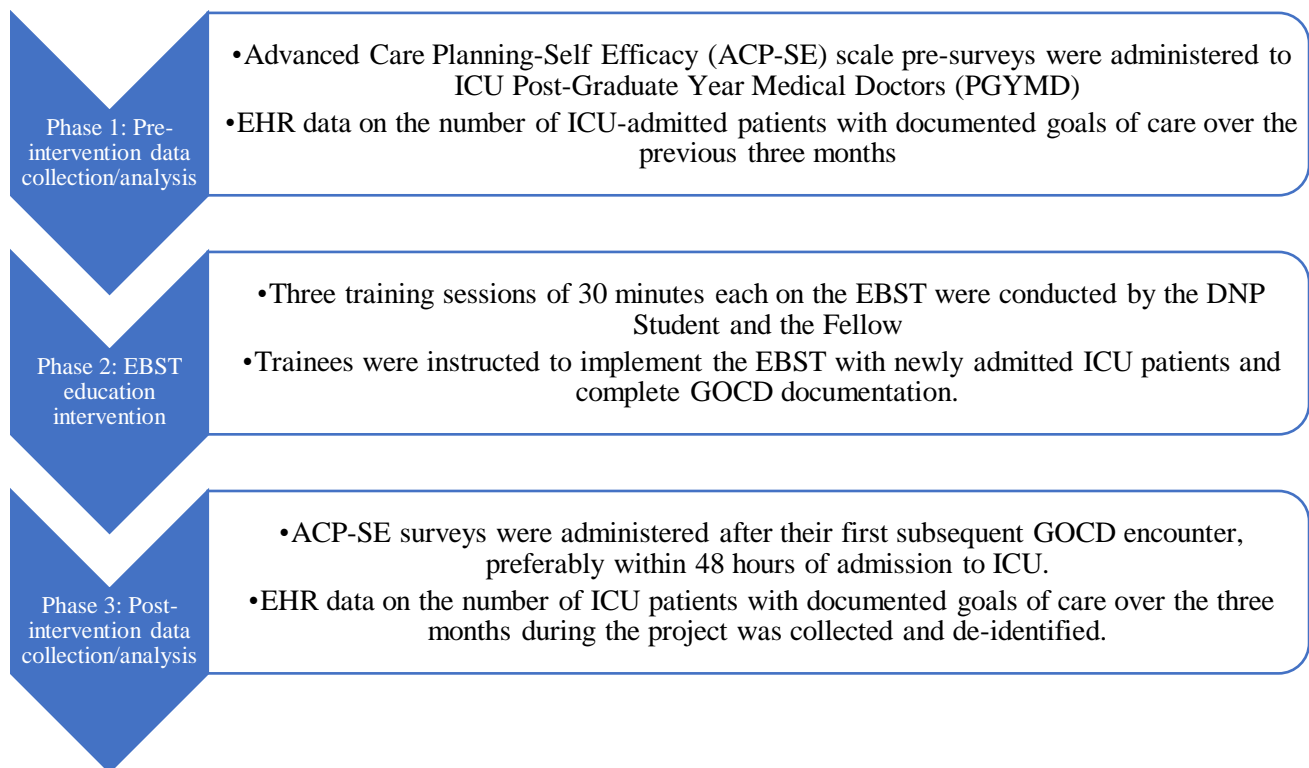
Nagpal et al., 2021). For this project, a validated instrument to assess provider readiness, self-efficacy, and confidence with GOCD was preferable. The ACP-SE scale has demonstrated validity and reliability in psychometric testing and was selected for quantitative measurement of provider knowledge and confidence with GOCD (Baughman et al., 2017; Lasmarias et al.; Zhou et al., 2024).

Educational Materials

An evidence-based standardized tool (EBST) for shared decision-making was used for training (see Appendix C). The EBST was developed for use at UCSD and VASD critical care units by the ICU director based on *Journal of the American Medical Association* recommendations (Bernacki et al., 2014), the REMAP program (Childers et al., 2017), and the “Jumpstart Guide” by Curtis et al. (2023). Other training material was developed by the UCSD palliative care education department, the Fellow, and the DNP Student. An EBST infographic (see Appendix D) was posted in the ICU resident break room in a high-traffic area. All educational and supplemental materials were submitted to the ethics, palliative care, and medical education committee representatives for review and approval before implementation in the VA ICU.

Project Outline

The DNP project consisted of three phases (see Figure 3). Phase 1 consisted of preintervention data collection and analysis. Phase 2 consisted of the EBST education intervention. Phase 3 consisted of postintervention data collection and analysis.

Figure 3*Project Outline*

In Phase 2, three 30-minute training sessions on the EBST were provided to Post-Graduate Year Medical Doctors (PGYMDs) on shared decision-making and GOCD during shift downtime. Training materials consisted of a PowerPoint presentation and live demonstration of appropriate GOCD documentation in the EHR (see Appendix E for training materials developed by the Fellow and the DNP student). Each session was completed in a different month; new PGYMDs rotate out of the ICU service monthly, and this pilot was focused on implementation in the ICU. After the education intervention, trained PGYMDs were tasked to use the EBST in a GOCD and document it in the LST note with at least one patient newly admitted to the ICU.

In Phase 3, post ACP-SE reminders were sent to participants through email, Microsoft Teams, and text message throughout the weeks following training. Data on the quantity of ICU LST notes and the total number of ICU direct admissions were collected for the 3 months before

and during the PGYMD ICU rotations (July 17, 2023–January 17, 2024). LST note documentation after the January date was not requested, as trainees would have transferred to other hospital services.

Results

During their ICU rotation, a total of 14 PGYMDs completed the three training sessions on October 17, November 28, and December 19, 2023. At the beginning of each training session, a brief survey including the ACP-SE scale was administered to these trainees through their mobile devices. Survey demographics and baseline characteristics are displayed in Table 1, and pre- and post-ACP-SE scores are displayed in Tables 2 and 3. Seven of the 14 PGYMDs reported no prior formalized GOCD training.

Pre-survey ACP-SE score average was 3.23 out of 5, with 5 denoting the highest self-efficacy rating. Four out of the 14 participants completed a post-training ACP-SE survey. For those who completed the post-survey, the average score was 4.54. Fourteen LST notes were documented out of 83 direct admissions before the training (16.9%), and 14 were completed out of 78 admissions during the training period (17.9%). In summary, the number of LST notes did not change, and the percentage of admissions with a documented LST note increased by 1%.

Limitations

This DNP project was applied to a small subset of trainees for a specific unit in the hospital. The Fellow and the DNP student steered the project with the ICU director's guidance and approval from leadership teams, and leadership involvement was otherwise minimal. Several factors limited this project's results and affected the number of participants, postsurvey data collection, and LST documentation data.

Table 1*Demographics and Baseline Experience of Participants*

Baseline characteristic	Sample	
	<i>n</i>	%
Gender		
Female	9	64.3
Male	4	28.6
Post-Graduate Year		
1	4	28.6
2	5	35.7
3	2	14.3
5	1	7.1
Ethnicity ^a		
Asian	4	28.6
Caucasian/White	5	35.7
Hispanic	1	7.1
Indian	2	14.3
Middle Eastern	1	7.1
Language spoken ^b		
English	10	71.4
Spanish	2	14.3
Mandarin	2	14.3
Korean	1	7.1
Tamil	1	7.1
Number of GOCD experiences ^b		
0	1	7.1
1–10	6	42.9
10–20	2	14.3
> 50	1	7.1
Received GOCD training in medical school or residency		
Yes or similar answer ^c	5	35.7
No	7	50

Note. *N* = 14. Average age of respondents was 29.2. Incomplete percentage totals indicate that some survey fields were left unanswered by participants. GOCD: Goals of Care Discussions

^a: self-described.

^b: multiple responses allowed

^c: similar answers included: “online modules”, “lectures in residency”

Table 2*Pre-Intervention ACP-SE Scores*

Participant	Score
1	2.00
2	3.05
3	3.47
4	3.35
5	4.53
6	2.76
7	3.18
8	4.65
9	2.35
10	2.59
11	3.70
12	2.94
13	3.41
14	3.29
Average	3.23

Note. $N = 14$. Average age of participants was 29.2

Table 3*Post-Intervention ACP-SE Scores*

Participant	Score
1	3.82
2	4.82
3	5
4	4.53
Average	4.54

Note. Participant numbers in Table 2 do not correlate with those in this table.

First, training dates were selected based on the availability of the Fellow, DNP student, and the PGYMDs ICU rotation. Since each PGYMD level started their month-long ICU service rotation during different weeks, training dates were limited to the intersection of these rotations. Additionally, the DNP Student and the Fellow also had full-time employment and academic obligations, and training dates were further limited by their schedule availability. Consequently, it was only feasible to complete three training sessions.

Second, the education intervention was given during downtime, a time usually set aside for PGYMD documentation and lunch breaks. Supervising attendings were given advance notice for the designated dates and some took responsibility for answering pagers during the 30 minutes. However, the training sessions were given to the PGYMDs who were available at those times; last-minute assignments or pages could not be accounted for. For these reasons, the participant sample size was limited to 14.

Third, standardized tools with completed psychometric testing are generally preferred for EBP interventions. The EBST used in this project was developed based on best practice recommendations, has been utilized at other local medical centers, and was tailored to the ICU. However, no psychometric testing has been done on the EBST to measure validity and reliability.

Fourth, GOCD documentation data collection did not consider note quality or sources outside of LST notes. The data query for this project was limited to LST note frequency, and no data was captured related to health factors within the LST notes. With this additional information, there may have been discernable change in LST note quality. Furthermore, narrative entries in other progress notes may have contained documentation of goals of care discussions, which could not have been accounted for in an LST data request.

Lastly, the DNP Student and the Fellow collected pre- and post-survey responses, which presented some challenges. Pre-surveys were distributed in person and immediately before the training, therefore all PGYMDs who received the education intervention completed a presurvey. However, postsurveys were independently assigned to the PGYMD to complete after their first post-training GOCD and LST documentation. The DNP student presented in person 2 business days after each training session to remind participants of the postsurvey. However, the surveys were anonymous, and the DNP student's presence coinciding with the PGYMDs schedule was not possible to coordinate in advance. Therefore, the evaluation of posteducation ACP-SE scores was limited to those who completed the postsurvey.

Recommendations for Practice

The challenges described in the Limitations section can provide insights for future evidence-based education interventions for medical units with rotating PGYMDs. The following recommendations can mitigate the aforementioned limitations:

1. While it may present additional costs for employee compensation, allocating time for the education interventions, as opposed to during downtime, may result in greater participation and reduce knowledge disparities between providers. Additionally, the use of psychometrically tested standardized tools in education interventions is preferable.
2. The DNP student received two of the four postsurveys after the in-person visit, suggesting that physical presence may enhance survey participation. Postsurvey data collection may also be aided by a peer "champion" to provide in-person reminders. Furthermore, survey reminders from immediate supervisors and financial incentives may also enhance postsurvey participation.

3. It may be ideal for project leaders and facilitators to work for the same organization and to be allocated time and compensation for project initiatives. Compensated time for scheduling and planning would improve coordination of service delivery and training participation.
4. Capturing GOCD documentation quality may be achievable by analysis of health factors embedded in each note and by expanding data queries to include other progress notes.
5. VASD may require a policy change, leadership involvement, buy-in from clinicians, and more educational interventions for providers in all services to improve GOCD documentation.

Conclusions

In this DNP project, the team implemented an EBST educational intervention, aiming to improve provider knowledge and confidence with GOCD and its documentation at the VASD ICU. Due to several limitations, this project did not result in significant changes to either outcome. However, lessons learned from this project's limitations can be applied to future initiatives.

Overall, earlier, more frequent, clearly documented GOCD remains an area of potential growth at VASD. Additionally, there is an evident need for additional GOCD education interventions for medical providers. Further education interventions on standardized, practical, and evidence-based approaches to shared decision-making can be applied to all medical units. With more leadership involvement, allocated training time, provider participation, and documentation policy changes, VASD can bridge the current practice gap to honor veterans' values and end-of-life wishes.

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Appendix A

IRB Approval

Department of Veterans Affairs

Date: 08/02/2023
From: VA Electronic Determination Aid (VAEDA) Portal
Subject: Preliminary determination for Honoring Veterans' Wishes: Efficacy of an Evidence-Based Shared Decision-Making Tool in VA ICU Goals-of-Care Discussions
Percent Effort: 80.00
Project Duration: 08/02/2023 - 04/30/2024
To: Alexander, Stephanie

1. Thank you for completing the VAEDA tool. Based on your answers the project you describe does not meet the regulatory definition of research in accordance with 38 CFR 16.102(l).
2. Your project may require a privacy review and you should seek guidance from your privacy officer.
3. You have selected that you are conducting a quality improvement/performance improvement/quality assurance project for an issue specific to your institution without the intent to validate the results for applicability beyond your institution.
4. You have selected that you are conducting an evidence-based practice project that does not include a research component. There are no restrictions to publishing the results of EBP projects, but you must not use the term research in your abstract, presentation, or publication.
5. You have selected that your activity is either not a systematic investigation or that you are not designing the project so that the knowledge gained from it can be brought into general use or applied to a wider or different range of circumstances or populations.
6. You have selected that you are conducting a program evaluation with the intention to improve a specific program titled, Honoring Veterans' Wishes: Efficacy of an Evidence-Based Shared Decision-Making Tool in VA ICU Goals-of-Care Discussions. There are no restrictions to publishing the results of program evaluation projects, but you must not use the term research in your abstract, presentation, or publication.
7. This is a single institution project.
8. If your project changes in intent, plans, or methods you must amend the final determination to ensure the regulatory category of your project has not changed.
9. You must check with your institution as to what permissions you need to start such a project. The Joint Commission requires that PI/QA/QI projects are tracked within each healthcare facility. There are no restrictions to publishing the results of QI/QA/PI projects, but you must not use the term research in your abstract, presentation, or publication.
10. Best of luck with your research.
11. You must check with your institution as to who can give you permission to start your project.

Appendix B

Advance Care Planning Self-Efficacy (ACP-SE) Scale

On a scale from 1 to 5 where 1 equals not at all confident and 5 equals very confident, how confident are you that you can do the following for patients?

	Not at all confident			Very confident	
	1	2	3	4	5
A. Find the time to discuss the patient's prognosis, preferences and care plan with the patient					
B. Determine how much the patient wants to know about the prognosis	1	2	3	4	5
C. Determine the level of involvement the patient wants in decision-making	1	2	3	4	5
D. Determine who else (e.g., family members) the patient would like to be involved in decision-making	1	2	3	4	5
E. Provide the desired level of information and guidance needed to help the patient in decision-making	1	2	3	4	5
F. Describe the pros and cons of different life-sustaining treatments	1	2	3	4	5
G. Determine the patient's specific wishes for types of medical treatment	1	2	3	4	5
H. Discuss and negotiate individualized treatment goals and plans with patient	1	2	3	4	5
I. Ensure that patient's treatment preferences will be honored at your facility	1	2	3	4	5
J. Ensure that patient's treatment preferences will be honored at a hospital if patient is hospitalized	1	2	3	4	5
K. Discuss how to complete a living will with the patient	1	2	3	4	5
L. Determine when there should be a shift in care goals	1	2	3	4	5
M. Reassess the patient's wishes when a shift in care goals is needed	1	2	3	4	5
N. Openly discuss uncertainty with patient when it exists	1	2	3	4	5
O. Educate patient and clarify any misperceptions about the disease or prognosis	1	2	3	4	5
P. Respond empathetically to patient's and family's concerns	1	2	3	4	5
Q. Communicate "bad news" to patients and their families	1	2	3	4	5
R. Engage patients in advance care planning conversations	1	2	3	4	5

Note that the last item, R, is a general item that includes all advance care planning and not part of the scale. It can be used for comparison to the scale.

The scale is scored by adding the first 17 items (A. through Q.) and then dividing by 17 to get an average item score.

Citation: Baughman KR, Ludwick R, Fischbein R, McCormick K, Meeker J, Hewit M, Drost J, Kropp D. Development of a scale to assess physician advance care planning self-efficacy. American Journal of Hospice and Palliative Medicine®. 2017 Jun;34(5):435-41.

Appendix C

Evidence-Based Standardized Tool

Approach to Shared Decision-Based ICU Family Meetings

Venktesh Ramnath, MD

June 11, 2023

Given the general lack of public awareness of what “critical care” means and how it relates to how medical teams make decisions around aligning what is medically possible with what a specific individual would find meaningful, developing skills around shared decision-making is essential for critical care providers. Like with most complex tasks, having a structured foundation is useful, upon which practitioners can then apply nuances tailored to each unique situation. Below are some tips in these regards:

Before the meeting:

1. Be aware of yourself and where you are from emotional standpoint. Are you having a tough or rushed day, such that you might have difficulty with committing to a discussion? Any countertransference/visceral bias issues to be aware of? A calm, soft, neutral, professional manner and tone is essential.
2. Be aware of your audience: are they ready for constructive discussion? Are they angry, sad, detached, or other? Do you need others with you from the medical team side (i.e. nurse, social worker, etc.)?
3. Make an honest assessment of the prognosis. This requires a detailed review of past and current records and intellectual honesty. Don't get stuck on the numbers that can be fixed. What is your holistic assessment? Would you be surprised if the patient died within the next year, month, week, day, or hour? Be aware of feelings that may come up in the process.
4. Remember family meetings are a journey, not an endpoint. A successful family meeting opens dialogue and provides clarity and structure to generate trust and empowerment to patients and decision makers about how to align medical therapies with values in life. They are joint ventures between providers and decision makers as equal partners (hence the term “shared decision making”). It is uncommonly successful in one setting only.
5. Be conscious about prior goals of care discussions (especially during the current hospital course) and be careful about readdressing decisions already made that do not warrant re-exploration. Doing so may inadvertently raise doubt about the motives of the medical team and cause unintended friction. Significant changes in clinical condition (e.g. cardiac arrest, intubation, new shock) are typical landmarks that can warrant a new or updated discussion.
6. Be aware of time. Most effective family meetings should not be hours-long affairs. In general, plan to conclude the meeting within 30 minutes, to minimize risk of co-dependency. Remember your objective is to facilitate empowerment of decision makers, not have them dependent on you to make decisions.
7. Leading an effective family meeting is a learnable skill and “art.” Practice makes perfect.

Step 1: Frame the conversation (<5 min)

1. Ask attendees if now is a good time to have the meeting. If it is not, immediately reschedule.
2. Introduce yourself and all the members on the medical team who are participating (i.e. physician, nurse, social work, etc.) and ask them to introduce themselves individually.

3. Confirm that all the decision makers who want to be involved have been invited and that reasonable attempts to have them participate have been made. If some cannot attend in-person, offer conference calls on speakerphone or Zoom meetings. Try to be as inclusive as reasonably possible as it will minimize feelings of alienation by certain family members.
4. Determine the current knowledge of the medical issues by the decision makers. What is their understanding of "what is going on medically" with the patient? Does everyone know that the patient is suffering from COVID-19 ARDS or do people think it's cancer? Their descriptions will give you a starting point from which to build your explanations.
5. Remember that people respond to familiar, concrete language in a time of crisis rather than general, vague descriptions. Placing these details into a "timeline of illness" is often effective to connect events together that they previously viewed as unconnected.
6. Align people in the room by acknowledging that everyone, including the medical team, wants the same thing: the best for the patient. Acknowledge how much they love the patient and are doing their best to advocate for them. So are we.

Step 2: Obtain background (<5 min)

1. Learn about who the patient was before they were admitted. Ask open-ended questions about personal details of the patient to build trust and gain crucial information, such as:
 - a. The patient's personality ("Tell me about your mom? What is she like? What activities does she like to do? How does she spend her time? What things are important to her?")
 - b. Recent life events in the last 6-12 months. ("Did she move to the area to be near her kids?")
 - c. Segue to the medical side of patient's outpatient life. "What has been the medical condition over the last 6-12 months prior to current hospitalization e.g. how many times hospitalized? How has the recovery been? How did the patient feel about his recovery? How interested is patient in attending appointments and follow all directions?"
 - d. Assess baseline level of functioning e.g. ADLs, communicativeness, etc.
2. Be attentive for clues. "My dad was active and independent, driving his car until this hospitalization"; "things have been increasingly hard in last few months"; "my mom is sleeping all the time and doesn't want to go to the doctor," "my sister is getting worse and worse," etc.
3. Paraphrase what you have heard to show them that you are listening carefully. ("Let me make sure I got this right: your mom is a very religious, independent woman who doesn't want anyone telling her what to do." "What I am hearing is that..."). This is very instrumental to clarify key attributes of patient in your own mind while simultaneously building an empathic bond with decision makers.
4. End this section by saying that what you have learned is "very helpful to know where things have been before talking about what is happening now, and what options he/she has looking forward." I gesture my hands to indicate the before, the now, and the future to make it visually clear as well.

Objectives:

- Present yourself as a neutral professional who is interested in the patient as a person and as a patient
- Build trust with the decision makers
- Identify clues that can help you process information as you move to presenting care plan options

- Create an arc of medical condition based on clearly differentiated stages of 1) pre-hospital condition, 2) intra-hospital condition, and 3) projected future condition
- Align with the family/surrogate as much as possible

Step 3: Explain the current medical situation in concrete, layman terms (<5 min)

1. Choose the 3 most important organ systems that are causing current critical illness and describe how they have “failed” in layman terminology
 - a. The organs are often lungs (respiratory failure), brain (encephalopathy), heart (shock), and kidneys (AKI), but would tailor according to actual illnesses (e.g. cancer, GI bleed, etc.)
 - b. Use basic physiology descriptions if possible. For example: “The lung is a pump, to get the good air (‘oxygen’) in and the waste air (‘carbon dioxide’) out. Your father’s lungs have failed since they cannot get enough waste air out so it builds up in his body, causing a high amount of acid in the blood.”
2. Explain how being “critically ill” is inherently “tough” because helping the failed organs that rely upon each other can become complicated, leading sometimes to a Catch-22. (“Giving patient fluids makes the kidney very happy but makes the lung upset, but taking fluid away makes the lung happy but the kidneys upset.”). Tailor to the individual situation of the patient in question.
3. Do not be afraid in using the words “death” and “dying.” Using euphemisms can distract from what we think is really happening.
4. Segue to the goals of care discussion: “Whenever things get this complex, as I have described, it’s helpful to take a step back and think about what options he has, because *everyone* has options.”

Objectives:

- Explain critical illness in terms of concrete, specific organ failure
- Keep attention focused on no more than 3 organs to avoid overwhelming decision makers
- Use lay language and avoid medical jargon or euphemisms whenever possible
- REMAP: as appropriate, indicate your concern that patient may not survive the illness

Step 4: Framing the options (<5 min)

1. Provide a brief recap: “So far we have discussed where things have been before this hospitalization, where things are today, with the three organ failures we discussed, and now we would like to talk about what options the patient has looking forward.” I usually gesture with my hands to reinforce the before, current, and future.
2. Share your thoughts on the prognosis.
3. Reiterate that every patient has options. Avoid the phrase “there is nothing more we can do” and reiterate that we are always caring for the patient, it’s just a matter of *how* we care for him/her.
4. Based on the REMAP, use this time to propose the option that incorporates the values/emotions that have been shared, of the following available 3 categories:
 - a. Option 1 is to be “aggressive.”
 - i. Clarify it is an attempt and not a guarantee of success, to “try to push the body through what is happening now.” “Try” means making a commitment to try, without any guarantee of success, to ‘get better’ in the way the patient finds

meaningful. "Push" means that this is going to be hard work that may be uncomfortable, maybe even painful at times, and would involve any tubes, drains, lines, procedures, surgeries in order to *try* to get better."

- ii. Mention that being aggressive usually is more relevant when there are reversible illnesses than irreversible or "unfixable" ones. Refer back to the 3 organ failures – are they improving, and by how much? Can we return the patient to his/her baseline, that you learned in the Background (Step 2)? Complement your prognosis into the context. For example, a respiratory illness in an older patient who has been declining for months without improvement on the ventilator for the last 12 days may be less reversible than the consequences of a small subdural hematoma in a patient who tripped and fell that is now smaller on imaging.
 - iii. Give a concrete example or analogy from your own experience that details sacrifice towards a longer-range goal. "The analogy is signing up to run a marathon or climb a mountain. When you sign up for a marathon, you pay for the marathon, give up what you want to eat, sacrifice other activities to train every day, and it will be tough and even painful at times, and at the end of the day you may not even make it half way through the marathon. Being "aggressive" means you are making a commitment to *try to push*."
 - iv. Mention that the patient has received aggressive care until this point.
- b. Option 2
- i. Indicate that not everyone agrees with aggressive care. "Other people say 'I *could* choose option 1 (to be aggressive), but on the other hand, at this stage in my life, at my age, with the medical problems I have, and my course before this illness (refer to any clues from the Background (Step 2)), I don't want to sign up for more support from tubes, drains, procedures, surgeries that may not get me to where I want to be and are more than I want to take on. Instead, I'd like to be taken care of, but focus on being peaceful, comfortable, dignified, and allow a natural process to occur that is taking place already, which may not allow me to live as long on the clock but I would not have to be hooked up to tubes, drains and receive procedures and surgeries during this process that doesn't look good for me anyway."
 - ii. Explain the relationship to hospice, as many may be familiar with this. "Hospice is a service for physical, emotional, and spiritual support to patients and families when the body is near the end of life." (Note: use of "body" is intentional)
 - iii. Frame this option as a positive liberation from discomfort: "it's about feeling good as the body is shutting down." "It's about allowing the body to relax."
 - iv. Share that this is a way for people to get care at home, especially for those who are tired of going to clinic visits, hospitals, ERs, etc. non-stop. Again, it's about being able to "rest," or "relax."
- c. Option 3: Time and/or therapy-limited trials of aggressive care (Chang et al. JAMA 2021; 10.1001/jamainternmed.2021.1000)
- i. Indicate that this is potentially the most confusing option. "I leave this option for last because it is often the most confusing, since it's designed for people who are not ready for either option 1 or option 2 but want something potentially in the middle."

- ii. Clarify therapy-based limitations: "Some people might say that certain therapies are ok, but others are not. For example, someone might say that medications and fluids and oxygen in the nose are ok, but a breathing tube or dialysis or surgery is not ok." Often aggressiveness of specific therapies can be incorporated into this explanation.
- iii. Clarify time-based limitations: "Some people might say that they would be willing to do this for a certain amount of time, like a week, 6 months, a few days, or a year." (I intentionally change the time frames haphazardly to minimize any possible anchoring bias)
- iv. Rephrase in a layman way: "Another way to explain this option is to say that as long as someone is doing better, we would continue to support him/her, but if he/she do not getting better, or is getting worse, then we would consider shifting gears and consider option 2 (comfort care). Option 3 is a decision to allow, but not exceed, current aggressiveness of care."
- v. Determine a specified time point at which a joint reassessment should take place, keeping certain discrete markers in mind to track progress.

Objectives:

- Present clear categories of options
- Give analogies and concepts others can relate to

Step 5: Getting to a workable answer (<5 min)

1. Remind the decision maker about where we are and your thoughts about prognosis. "So at this point, we have seen where your father has been before this hospitalization, where things are now, and looking to the future, we have talked about the options in front of him."
2. Describe your role as impartial agent conveying information. "I am not here to judge whatever choice he would make – just to give all of you information about what is happening."
3. Indicate your clear commitment for the benefit of the patient as #1 priority, regardless of which option is chosen. "No matter which option is chosen, we care for your father 100%, no matter what. The only difference between the options is how he wants us to take care of him, because we want to take care of him in the way he wants to be taken care of, for example not doing things he does not want us to do."
4. Highlight the role of decision maker as the surrogate of the patient. "We always wish the patient could sit here with us in the room and understand all the positives and negatives of all the options presented, but unfortunately he cannot, for which we need you to have his thoughts expressed with your voices, *even if you and I disagree with what he/she would say.*"
5. Point out that the decision applies to *today* and not in the past. "Please understand that we all make different choices at different times of our lives, such that something we choose when we were younger or even more recently may change..."
6. Ask first, but propose the option that best aligns the prognosis with what you have learned in Steps 1-3. "Based on what you shared with me about where things were, and where things are now, I think what may be most meaningful for your mother at this point is..."
7. Finally, ask for their input. "Given what we have talked about, which of the options do you think your father would find most valuable today looking forward?"

Objectives:

- Reinforce the context of current conversation in the overall arc of his life and medical problems
- Underscore your commitment to patient's values and benefit, regardless of choices made
- Differentiate the surrogate's own wishes from the patient's wishes
- Ground the goals of care decisions based on today's context and not past decisions made

Addressing Code Status

At the end of the goals of care discussions, code status should be addressed as a separate intervention, rather than a state of being.

- Consider addressing code status as a "separate but related matter" in cases where Option 2 (comfort care) is not clearly agreed upon. In this case (Option 2), assuming the surrogate decision maker truly understands what is involved, it may not be necessary to be completely deliberate about the details. Would determine this on a case-by-case basis.
- Address as a medical treatment that is entirely different from goals of care, to avoid pitfalls of "DNR = DNT (do not treat)" by providers and decision makers. "In spite of the aggressive care goals that are continuing (for example, if she gets a pneumonia we will treat it, or if she has a blood clot we will give a medicine for it)..."
- Phrase it as an unexpected, catastrophic event. "If for some reason your mother's heart suddenly stopped or lungs failed and she died..." (most lay people consider cessation of heart and lung function as equivalent to death)
- Indicate that resuscitation is an *attempt* to restart the heart with multiple modalities at the same time, with probable complications and with low likelihood of success to discharge alive and with neurologic intact state (the latter point should be tailored to underlying age, comorbidities of individual patients). "Would she want us to make an attempt to resuscitate, with chest compressions, shocking, breathing tube in the throat, and medicines to jumpstart the heart, in which we often have to break ribs as we are providing compressions, to bring her back from dead, given the low likelihood to survive to leave the hospital especially with a level of brain function she would find reasonable?"
- Note: In situations where resuscitation efforts would be considered clinically inappropriate (non-beneficial) such as that of a terminally ill patient whose death is expected, many hospitals support informing the surrogate decision maker that resuscitation will not be attempted (i.e. rather than expecting the surrogate to make this choice).

Specific challenges

1. "My mom is a fighter." This is often a sign of perceived threat against the welfare of the patient by a protective surrogate. Best to acknowledge their feeling, gently inquire as to how you may better understand this element of the patient's character. Challenging this feeling directly is often unsuccessful and can detract from trust.
2. "Don't pull the plug." See #3 under Step 5. Reinforce that you are caring for the patient no matter what

3. "I want a second opinion." Acknowledge this need as "normal" and provide options. Consider asking for details about whether there is something they did not understand ("Help me understand if there is something that I did not explain to your satisfaction?") and provide additional explanation as requested. If still desired, facilitate arrangement of a different provider that will satisfy their request within certain limits (i.e. help find a neurologist for neuro- prognostication or a different intensivist if possible within the institution).
4. "I don't know what to believe because I hear different things from different doctors." This is often an expression of overwhelm and hearing unstructured information from bedside nurses and other providers. Validate their concerns about how feeling confused and overwhelmed is entirely normal. Don't try to speculate or denigrate what others might have said.
5. "I believe in miracles." Acknowledge this statement and do not challenge directly as it speaks to deeper emotions surrounding the soul. Consider commenting that, as a chaplain once told me, "miracles happen in spite of us, not because of us" – this redirects the attention to the patient's body (rather than soul), which can then shift the focus of medical therapies to support the body (i.e. not the soul).
6. "I want to have hope." Remember that hope comes in many forms. Create a "hope portfolio" by being curious about all the things the patient and surrogate decision makers are hopeful for (when one is offered, gently ask "What else? What else?"). Hopes focus on particular goals, while "optimism" is a general feeling that positive outcomes will occur. Don't focus on trying to refute unrealistic hopes. *Also, remember that clinicians sometimes contribute to unrealistic hopes by using overly optimistic language.*
7. "My mom doesn't want to be a 'vegetable'" or "My brother has an advance directive that says he does not want prolonged life support if there is no chance for improvement." This is common, since most states have a "terminal condition" requirement for DNR status. It requires more discussion, unless the clinical situation truly involves a terminal condition. This often comes up more during code status discussions.
8. "I can't do this to my father." Try to reinforce the following:
 - a. The surrogate decision maker is not the sole agent (the medical team is helping the patient as well)
 - b. The patient's body is changing and ultimately is "in charge" of the outcome, as medical therapies are largely supportive.
 - c. The surrogate decision maker's role is as the voice of the patient, even if others disagree
 - d. The importance of the surrogate decision maker him/herself. I usually try to empower the surrogate decision maker by stating that the patient is lucky to have him/her speak on his/her behalf, which requires courage because trying to navigate this is challenging, scary, and overwhelming, and many patients we see do not have surrogate decision makers.

Non-beneficial or "potentially inappropriate" treatment (aka "medical futility") is commonly invoked but difficult to apply because it is fraught with subjectivity. 4 main categories as described by Brody and Halevy¹ are the following:

1. Physiological (quantitative): interventions that fail to achieve intended physiological effect (e.g. chest compressions when heart is ruptured)

2. Imminent demise: interventions that do not improve the imminent lethal condition (e.g. giving epinephrine boluses with escalating frequency to regain ROSC in patient with end-stage heart failure and repeated cardiac arrests)
3. Lethal condition: interventions that do not improve the near imminent lethality of a separate but terminal condition (e.g. intubation in a patient with widely metastatic, refractory, and rapidly progressive cancer with new dyspnea)
4. Qualitative futility: interventions that do not contribute to the "best interest" of the patient. This is problematic since "best interest" concept of beneficence is subject to value judgments of both patient and provider about the actual benefit/burden, proportion, and appropriateness of the medical intervention.

If pursued, follow the method suggested by the multinational Consensus Statement.²

Checklist for Shared Decision Meeting note documentation:

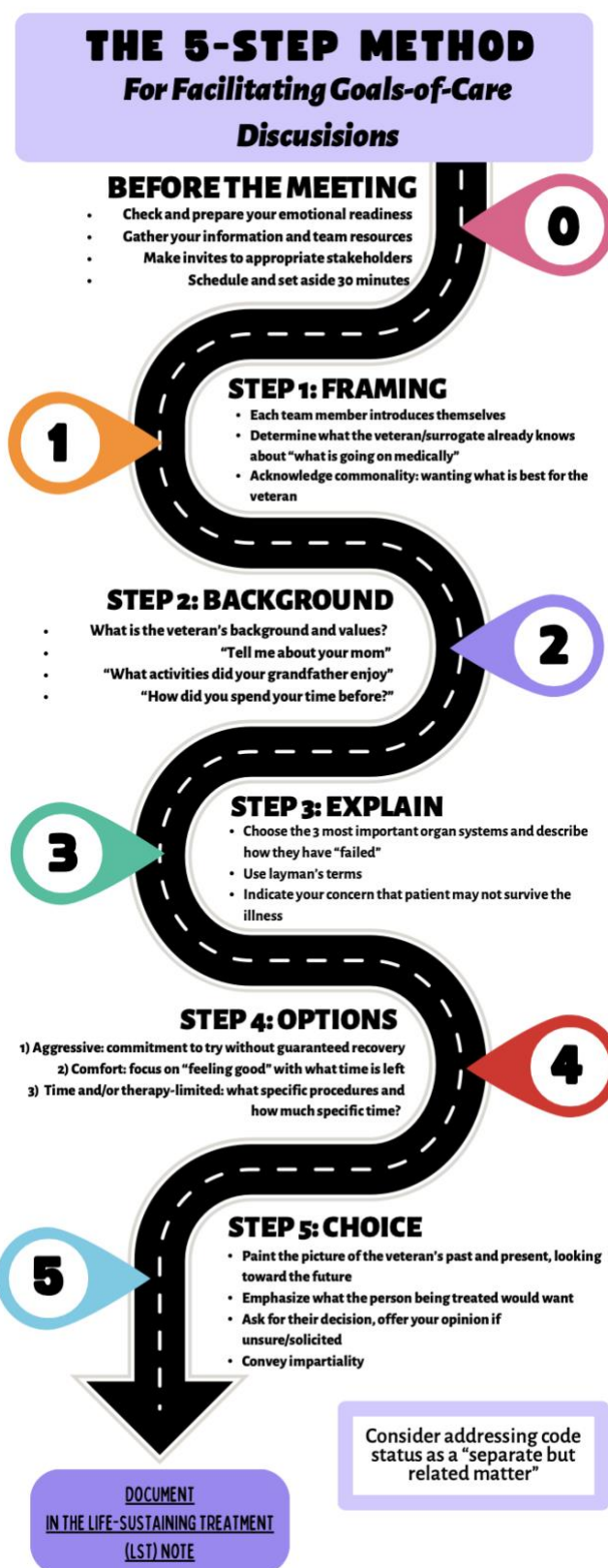
Criterion to be discussed	Answer provided
Who is Surrogate Decision Maker?	
Was past history prior to this hospitalization reviewed that highlighted patient values?	
≤3 main failed organ systems that were discussed in relation to overall prognosis?	
Aggressive care vs. comfort focused care vs. time- and therapy-limited goals of care discussed? Decision made? If not, why not?	
If Aggressive care, is trach and PEG planned? If not, why not?	
If Comfort focused care, when to initiate? Are we waiting for other family members?	
If time- and/or therapy-limitation, what are details for limitations and time-based endpoint? When is define time of joint reassessment?	
Code Status discussed as a package for cardiopulmonary arrest (CPR+meds+shocking)? Is intubation for pure respiratory failure offered as a separate option?	
Does surrogate decision maker want a follow up meeting? When?	
Other (special features)	

References

1. Brody BA, Halevy A. Is futility a futile concept? *J Med Philos.* 1995;20:123-144.
2. Bosslet et al. An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in ICUs.
3. REMAP framework. Vital Talks.

Appendix D

Infographic



Appendix E

Training Material slides

Anna Astashchanka, MD, and Stephanie Alexander, BSN, RN

Shared Decision Making In The ICU



1

Disclaimer

- Some slides have been adapted and modified from 'Goals of Care' and 'Delivering Bad News' by Toluwalase Ajayi MD and Heather Herman, NP at UCSD Palliative Care

2

Objectives

- 1 Discuss importance of advanced care planning
- 2 Address what 'goals of care' are
- 3 Provide a practical approach to advanced care planning
- 4 Assess provider confidence around advanced care planning
- 5 Introduce a pilot project with an aim to optimize advanced care planning in the ICU

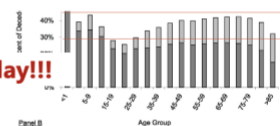
3

Why Does This Matter?

- Mortality in the intensive care unit is >20% **Q: When is the right time to have this discussion?**
- Patients :
 - They do not want it
 - Will not benefit them
 - Carry financial strain

- Early advanced care planning is nonstandard **A: Today!!!**

- Majority of patients with cancer do not undergo their first goals of care discussion until they're in the inpatient setting (55%)
- Within 4 months of their death, only 37% of patients reported having a GOC discussion with their physician



4

It's Always Too Early, Until It's Too Late

It's always too early, until it's too late.

- There are a host of reasons why Americans haven't discussed their own wishes. Top reasons from the survey include: It's not something they need to worry about at this point in life (29%), they aren't sick yet (23%), the subject makes them feel uncomfortable (21%), or they don't want to upset their loved ones (19%).
- Similarly, among those who haven't talked about their loved ones' desires for their final days, two reasons for

More than 9 in 10 Americans think it's important to talk about their loved ones' and their own wishes for end-of-life care

It's too early, until it's too late!

When we do talk, the experience is improved

- More than half of those who have lost someone without ever discussing end-of-life wishes admit that some aspect of the experience could have been improved if they'd had a conversation.
- Those who did have such a conversation had what could be considered a more positive experience in their loved ones' final days—63% say they felt better knowing they were honoring the wishes of their loved ones, while 39% know their loved one was able to die just the way they wanted.

The Conversation Project, 2013

5

What Are The Challenges?

Patient Factors

- Illness Denial**
- Timing**
 - More than 90% said their doctors never brought up advanced care planning
 - In patients >65 years or older, 84% have never been asked what they would want from their medical treatment towards the end of life
- Anxiety
- Complex social dynamics

Clinician Factors

- Minimal formal communication training**
- Discomfort about the topic**
- Time constraints
- Unclear whose 'role' it is in patients with complex medical teams
- Difficulty navigating emotions of patients/family
- Conflating goals of care with code status

6

What are goals of care?

RESTORATIVE OR CURE IMPROVE SURVIVAL RELIEVE SYMPTOMS RETURN TO BASELINE IMPROVE FUNCTION ALLOW NATURAL DEATH

... and how do we help tie these goals into medical reality?

Haberle et al, 2011

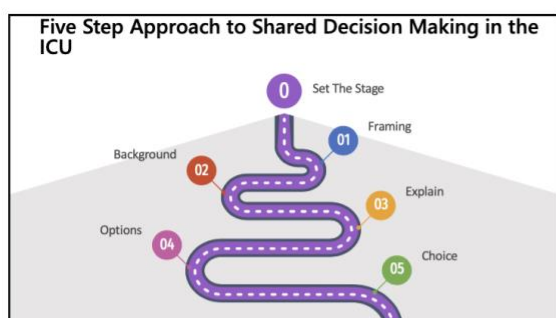
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Introduction to a Five Step Approach to Shared Decision Making in the ICU

- Utilizes evidence-based concepts from literature recommendations tailored to the ICU setting
- Family meetings are a journey, not an endpoint
- Successful family meeting opens dialogue, clarity and structure to generate trust and empowerment to patients
- Leading an effective family meeting is a learnable skill and an 'art.'

Practice makes perfect!

8



9

Setting The Stage **Step 0**

- Ask permission to discuss goals-of-care
- Identify and involve all relevant stakeholders in patient's care
- Find quiet location with seats for everyone involved
 - Determine whether patient can be/wants to be part of conversation
- Let someone else hold your pager/phone to minimize interruptions
 - Whole discussion should be ~30 minutes
- Huddle with other members of your team to ensure everyone is on the same page
- Are you able to make a prognosis?
 - If not, do you need more information?
 - If so, get said information

10

Framing The Conversation (5min) **Step 1**

- Introduce yourself and have your whole team introduce themselves individually
- Determine current knowledge of the medical issues
 - Open ended questions:
 - What have the doctors told you?
 - What is your understanding of what has been happening this hospitalization?
- Note the level of **comprehension** and the specific words they use. Listen for **value** statements and use **reflection** statements:
 - I hear you saying...

11

Obtaining Background (5min) **Step 2**

- Learn who the patient was before they were admitted
- Allows family to really think about their loved one outside the hospital setting
 - "What was your life like before you got sick?"
 - Consider including time-markers (Six months ago? One year ago?)
 - "What is a typical day like for you when you're not in the hospital?"
 - "What brings you joy?"
 - Use **reflection** statements: "It sounds like you are a person who..."
- Paraphrase what you heard
- End this section by saying its helpful to know where things were and how we can move forward

12

Explain Medical Condition (5min) **Step 3**

- Choose **3** most important organ systems that are causing current illness and describe how they have 'failed'
- Look for opportunities to explain how treating one condition may hurt the other as appropriate
- Avoid the word 'prognosis'; rather, introduce how the above can be life-altering, including possible death
 - Answer any questions regarding the 'how'
- At this point, family/patient likely to have emotional response
- Allow them to have time to process before proceeding to goals of care discussion

13

Stop For Emotional Response **STOP**

- People often can't process information after receiving bad news
 - Average acute emotional response lasts <1 minute
- Allow for silence
- Avoid shoving tissues or fidgeting
- Wait for eye contact or deep breath before asking permission to share the next steps
- Potential transitions:
 - 'I can see that this isn't what you were hoping for'
 - 'I wish this was different'
 - 'I want you to be prepared for the next steps. May I explain?'

14

Framing The Options (5min) Step 4

- Provide a brief recap:
 - "So far we have discussed where things have been before this hospitalizations, where things are today, what organs have failed and now we would like to talk about what options we have moving forward."
- Reiterate that *every patient* has options
- Three broad options:
 - Aggressive treatment
 - Comfort-focused treatment
 - Time and/or therapy limited trials of aggressive treatment
- We always take 'care' of the patient, the type of care will depend on the treatments we are using

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Framing The Options (5min) Step 4

Only offer/discuss options that are In line with prognosis/medical reality

- Attempt but not a guaranteed success
 - "Try to push the body through what's happening."
- Makes the most sense when things are reversible
- Sacrifice to range goal
- Reiterate the received aggressive treatment
- Focus on symptom control, 'feeling as good as possible' while allowing for the natural dying process
- May not live as long but focusing on 'quality' for the remaining invasive medications non-essential
- What is too much?
- What is acceptable?
- How long is acceptable?
 - A week? A month? An hour?

16

Workable Answers (5min) Step 5

- 'At this point, we have seen where things are now, looking to the future, and the options in front of us.'
- Describe your role as impartial agent conveying information
 - Emphasize that the decision doesn't solely rest on the decision maker, but is made as a team
- Indicate the benefit of the patient is the number one priority no matter what is chosen
- Ask to share the options that make most sense to you
- Propose an option that aligns with their values with the prognosis as described

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Code Status

- Separate but related matter
- Medical treatment goals are different from code status
- Unexpected, catastrophic event
 - Tell people that 'if they died'
- Indicate the resuscitation is an *attempt* to restart the heart with multiple modalities at the same time
 - Partial code should *never* be offered
- Provide your recommendation (that fits previous discussion)
- If resuscitative effort requested is inappropriate, speak to your attending

18

Specific Challenges

- 'My mom is a fighter'
- 'Don't pull the plug'
- 'I want a second opinion'
- 'I don't know what to believe because I hear different things from different doctors'
- 'I believe in miracles/We're praying for a miracle'
 - 'Miracles happen in spite of us, not because of us'

19

So You've Had the Conversation... Now What?

- Even when goals of care are done, they are frequently not documented or documented in inconsistent, difficult to find locations
- Current recommendation is standardization of both location and contents of these discussions
- We do not have a system like this in place at the VA

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Introduction To Pilot Project: Goals

- To promote the practice of early GOC discussions
- To improve provider knowledge and confidence in facilitating goals-of-care (GOC) discussions
- Reduce administration ineffective or unwanted treatment interventions for veterans in the ICU
- Improve GOC documentation at VAMCSD, beginning in the Intensive Care Unit (ICU).

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Pilot Project Outline

Trainee responsibilities:

1. Complete pre-training surveys
2. Complete this training course
3. Initiate and facilitate GOC discussions for all subsequent cases within 24 hours of admission or consultation to ICU
4. Document these discussions in CPRS
5. Complete post-training surveys after at least 1 patient encounter or by the end of your PGY week and indicate how many encounters

Data Collection:


- Pre-training surveys
- Post-training surveys
- Pre-training GOC documentation in ICU
- Post-training GOC documentation in ICU

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Document in CPRS LST note using template

- Open CPRS
- Find patient
- Open "notes" tab
- Click on "New Note"
- Type in "LIFE"
- Select "Life-Sustaining Treatment Plan" note

Questions about documentation? Contact Steph: (858)353-7793

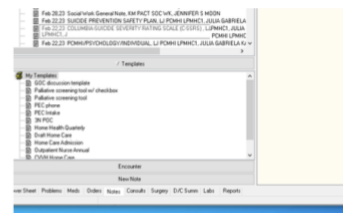


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Document in CPRS LST note

- Click through & finish LST note popout
- Import Goals of Care template into goals of care section
- Make edits to LST note & sign

Questions about documentation? Contact Steph: (858)353-7793



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Additional Questions/Concerns?

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Citations

1. Angus DC, Barnato AE, Linde-Zwirble WT, et al. Use of intensive care at the end of life in the United States: an epidemiologic study. *Crit Care Med*. Mar 2004;32(3):688-93. doi:10.1097/01.ccr.0000114816.62331.08
2. Bernacki RE, Block SD, for the American College of Physicians High Value Care Task F. Communication About Serious Illness Care Goals: A Review and Synthesis of Best Practices. *JAMA Internal Medicine*. 2014;174(12):1994-2003. doi:10.1001/jamainternmed.2014.5271
3. Curtis JR, White DB. Practical Guidance for Evidence-Based ICU Family Conferences. *Chest*. 2008;134(4):835-843. doi:https://doi.org/10.1378/chest.08-0235
4. Haberle TH, Shinkunas LA, Enckson ZD, Keldjian LC. Goals of Care among Hospitalized Patients: A Validation Study. *American Journal of Hospice and Palliative Medicine*. 2011;08(01):280-335-341. doi:10.1177/1049909110388505
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6. Vincent JL, Marshall JC, Hemmings-Silver SA, et al. Assessment of the worldwide burden of critical illness: the intensive care over nations (ICON) audit. *Lancet Respir Med*. May 2014;2(5):380-6. doi:10.1016/j.rlm.2013.2600.1470061-x
7. Walter JK, Schall TE, DeWitt AG, et al. Interprofessional Team Member Communication Patterns, Teamwork, and Collaboration in Pre-family Meeting Huddles in a Pediatric Cardiac Intensive Care Unit. *J Pain Symptom Manage*. Jul 2019;58(1):11-18. doi:10.1016/j.jpainsymman.2019.04.009

26

Values that are important to patient	What is important to you at this time?
Activities that are significant for the patient?	When you think about the future, what are the things you want to do? What are the activities you like to do now?
Living well/tradeoff	What would be an unacceptable way of living for you? If you get sicker, what are you willing to go through for the possibility of more time?
Uncertainties/fears/worries	What fears/worries do you have regarding your health? What concerns do you have regarding your future?
Experience with serious illness?	What experiences have you had with family/friends who have died or been seriously ill? What was your last hospitalization like? What did you learn from these experiences?
Sources of strength/spirituality	What gives you strength to cope in difficult times? Do you have religious or spiritual beliefs that

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