Goals of Care Conversations for Individuals with Serious Illness

Goals of care conversations for individuals with serious illness are an integral component to person-centered care.

This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: https://www.honoringchoicespnw.org/polst-toolkit/.

Overview

To differentiate from other advance care planning, we are using the term "goals of care conversation" to refer to conversation intended for individuals with serious or chronic, progressive illness, or advanced frailty. These conversations lead to individuals receiving care that is aligned with their goals and values. High-quality goals of care conversations use a framework of intentional questioning, respectful sharing of information, and importantly, skillful listening for what is important and meaningful to the individual. Additionally, these conversations build trust between the individual and the health care provider by empowering the individual to have an active role in their own care planning.

Characteristics of a high-quality goals of care conversation include:

- Ask permission.
- Express intention to provide individual with care options that align with their stated values and goals.
- Assess the individual's understanding of their condition.
- Explore key topics.
- Respond to emotion when sharing information and mapping values.
- Summarize and determine next steps.

Health Care Team Approach

Many members of the clinical team can support goals of care conversations. Typically, prognostication is reserved for health care providers (MD, DO, ARNP, PA-C). Clinical chaplains, case managers, nurses, social workers, and therapy professionals (PT, OT, ST), are important members of the multidisciplinary team that can support and initiate many elements of the goals of care conversation within their scope of practice.

Documentation

All members of the health care team have a responsibility to document any, or all, parts of the goals of care conversation. This will promote continuity of care centered around the individual's

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preferences for their care and foster a team approach to care planning. Electronic health records now offer the opportunity to document goals of care discussions. Ideally, this will be a unique template or separate document. The note's contents should efficiently describe and reflect the individual's stated values, goals, and preferences, as well as the general content of the goals of care discussion.[i]

POLST

It is important that the health care provider and other health care professionals on the team have a process for knowing when an individual might benefit from a having a POLST.

POLST should be offered if the individual:

- Has a serious life-limiting medical condition or advanced frailty.
- Has a condition which would put them at risk of harm from aggressive invasive measures.
- The goals of care conversation reveals an individual's desire to limit care in an emergency.

Remember, you may offer POLST, but like all advance care planning, it is voluntary for the individual.

Example case:, Alex Person, now 66 y.o. diagnosed with Stage 4 Breast Cancer
Situation: A year after completing her health care directive and durable power of attorney for health care, Alex was diagnosed with Stage 4 breast cancer. She has had three rounds of chemotherapy, but the degree of metastasis is not responding to these efforts; recent findings of metastasis to brain are worrisome. Her primary oncologist initiates a goals of care conversation.
Goals of Care Discussion: Alex expresses the following goals:

- She understands her disease is not curable and might shorten her life to a few years.
- She reiterates the importance of being with family; that they bring her joy and give her strength.
- She treasures the ability to communicate with her family and to "know my own mind". She fears not being able to control her thinking or speech, she does not want to end up on machines without the ability to know her family or speak to them.
- She is willing to have short-term measures, like intubation, to prolong life but just long enough to see if she will recover close to her current level of function or long enough to give her family a chance to gather. She also states she does not want "heroic" measures.
- She wants to attend her son's wedding next summer.
- She would like her family to know her wishes and be able to support her at home, if possible, at the end of life.

Plan: She is referred to an ACP facilitator to amend her health care directive. Her oncologist invites her to return for a second appointment to discuss POLST, inviting her to bring her husband and other family. They include a note in her chart outlining the key topic areas above and make a plan to address POLST at her next appointment.

Training

Honoring Choices PNW, in collaboration with Ariadne Labs, provides skills-based trainings to use the Serious Illness Conversation Guide. To register for this free training, visit https://www.honoringchoicespnw.org/events/list/ and search for "Serious Illness Conversation Guide Training." This activity has been approved for *AMA PRA Category 1 Credit*™.

[i] Wilson, E, Bernacki R, Alexander C, Jackson V, Jacobsen J. Rapid Adoption of a Serious Illness Conversation Electronic Medical Record Template: Lessons Learned and Future Directions. J Palliat Med. 2020; 23(2):159.