COVID-19 Advance Care Planning and Serious Illness Conversations

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Connections Palliative Care, Oregon Region
Providence Health and Services, Home and Community Care
OUTPATIENT and LONG TERM CARE
Step 1: Are Values Known?  

- **Known Values**: (Epic GOC Note, POLST etc.)
  - COMFORT DNR/DNI
  - TIME TRIAL DNR/DNI
  - FULL CODE OR LIMITED DNR/Intubate OK
  - Consider Hospice Confirm POLST done (GUIDE)⁴
  - Time Trial, no ICU Confirm POLST done (GUIDE)⁴

- **Unknown or Changing Values**: ¹
  - Time Trial (SICG)³
  - Full Code* (ACP)³

Step 2: Prognostication³

- HIGHEST RISK
- MODERATE RISK
- LOWEST RISK

Consider Palliative Care Consult if Available

AG: Anticipatory Guidance
IA: Informed Assent
REMAP/GUIDE: See Conversation Maps
INPATIENT and
EMERGENCY DEPARTMENT
Patient Presents

Step 1: Are Values Known\(^1\)?

**Known Values\(^1\)** (Epic GOC Note, POLST etc.)

- **Comfort Care** (GUIDE\(^4\))
- **TIME TRIAL**
- **DNR/DNI**

**TIME TRIAL**

- **DNR/DNI**
- **Time Trial, no ICU** (GUIDE\(^4\))

**FULL CODE**

- **OR**
- **TIME TRIAL**
- **DNR/Intubate OK**

Step 2: Is Patient Stable\(^2\)?

**STABLE**

- **Step 3: Prognostication\(^3\)**
  - **HIGHEST RISK**
  - **MODERATE RISK**
  - **LOWEST RISK**

- **Time Trial vs. Comfort Care** (REMAP\(^4\))

- **Time Trial** (REMAP\(^4\))

- **Full Treatment** (GUIDE\(^4\))

**UNSTABLE**

- **Step 3: Prognostication\(^3\)**
  - **HIGHEST RISK**
  - **MODERATE RISK**
  - **LOWEST RISK**

- **Time Trial vs. Comfort Care** (REMAP-IA\(^4\))

- **Time Trial** (REMAP-IA\(^4\))

- **Full Treatment** (GUIDE\(^4\))

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Consider Palliative Care Consult if Available

IA: Informed Assent

REMAP/GUIDE: See Conversation Guides
Step 1: Are Values Known?

Known Values
(Epic GOC Note, POLST etc.)

Step 2: Rapid Prognostication

Crisis-REMAP

Step 3: Resource Allocation
Per State Protocol
(Prognosis and Resource Dependent)

Unknown or Changing Values

Step 4: Reassess Values
Prognosis and Resources

Patient Presents

COMFORT
DNR/DNI

TIME TRIAL
DNR/DNI

FULL CODE
OR
LIMITED
DNR/Intubate OK

YELLOW
Lowest Benefit

ORANGE
Intermed Benefit

RED
Highest Benefit

Consider Palliative Care Consult if Available

Crisis REMAP/GUIDE: See Conversation Guides

Consider Palliative Care only AFTER triage decision made

Comfort Care
(GUIDE)

Time Trial, no ICU
(GUIDE)

Time Trial Vs. Comfort Care
(Crisis-GUIDE)

Time Trial
(Crisis-GUIDE)

Full Treatment*
(Crisis-GUIDE)

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Home and Community Care
Draft 4.4.20 caroline.hurd@providence.org
Conversation by Crisis Stage
## Conversation by Location and Crisis Stage

<table>
<thead>
<tr>
<th>PROGNOSIS</th>
<th>CLINICIAN</th>
<th>STAGE 1: CONVENTIONAL</th>
<th>STAGE 2: CONTINGENCY</th>
<th>STAGE 3: CRISIS</th>
<th>DOCUMENTATION</th>
</tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OUTPATIENT/LONG TERM CARE</td>
</tr>
<tr>
<td>Lowest Risk</td>
<td>PCP/Specialist</td>
<td>ACP</td>
<td>ACP</td>
<td>ACP</td>
<td>Advance Directive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>PCP/Specialist</td>
<td>SICG</td>
<td>SICG</td>
<td>SICG</td>
<td>Advance Directive GOC Note</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Risk</td>
<td>PCP/Specialist +/- Pal Care</td>
<td>REMAP-OUTPATIENT</td>
<td>REMAP-OUTPATIENT</td>
<td>REMAP-IA</td>
<td>Advance Directive GOC Note +/- POLST (if DNR)</td>
</tr>
</tbody>
</table>

|                |                            |                        |                      |                | INPATIENT/EMERGENCY ROOM       |
| Lowest Risk    | Primary Teams              | GUIDE                 | GUIDE                | Crisis-REMAP  | GOC Note Code Status           |
|                |                            |                        |                      | Crisis GUIDE  |                               |
| Moderate Risk  | Primary Teams +/- Pal Care | REMAP-INPATIENT       | REMAP-INPATIENT      | Crisis-REMAP  | GOC Note Code Status           |
|                |                            |                        |                      | Crisis-GUIDE  |                               |
| Highest Risk   | Primary Teams +/- Pal Care | REMAP-IA              | REMAP-IA             | Crisis-REMAP  | GOC Note Code Status           |
|                |                            |                        |                      | Crisis-GUIDE  |                               |

PCP: Primary Care Provider  
ACP: Advance Care Planning  
SICG: Serious Illness Conversation Guide  
POLST: Portable Orders for Life Sustaining Treatment  
GOC: Goals of Care  
IA: Informed Assent  
GUIDE: Get ready, Understanding, Inform, Demonstrate empathy, Equip  
REMAP: Reframe, Empathize, Map Values, Align, Plan
Prognostication
## PROGNOSTICATION

Note: One tool cannot provide enough answer to determine prognosis, these tools should be used together to create your best estimate.

<table>
<thead>
<tr>
<th>Component</th>
<th>Tool/Question</th>
<th>Lowest Risk</th>
<th>Moderate Risk</th>
<th>Highest Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Illness</strong></td>
<td>SOFA score(^3)</td>
<td>≤ 7 (Low potential for death)</td>
<td>8-11 (Intermediate potential for death)</td>
<td>≥ 12 (High potential for death)</td>
</tr>
<tr>
<td><strong>Functional Status</strong></td>
<td>Frailty Scale(^2)</td>
<td>0 Criteria</td>
<td>1-2 Criteria</td>
<td>3+ Criteria</td>
</tr>
<tr>
<td><strong>Functional Trajectory</strong></td>
<td>Has the patient had any unplanned hospital admissions in the last 6 months?(^3)</td>
<td>No</td>
<td>Yes, and age is 65-85</td>
<td>Yes, and age is ≥ 86y</td>
</tr>
<tr>
<td></td>
<td>2 yr “Surprise Question” “Would I be surprised if this patient died in the next 2 years?”(^4)</td>
<td>Yes, I would be surprised</td>
<td>No, I would not be surprised</td>
<td>No, I would not be surprised</td>
</tr>
<tr>
<td><strong>Disease Specific</strong></td>
<td>Does the patient have any of the following and what is the severity?(^5)</td>
<td>None</td>
<td>Major Comorbidities (associated with significantly decreased long term survival)</td>
<td>Severe Comorbidities (associated with &gt;1 year survival)</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td>OR</td>
<td>• Moderate dementia</td>
<td>• Severe dementia</td>
</tr>
<tr>
<td></td>
<td>Malignancy</td>
<td>Minor, well controlled, or earlier stage comorbidities</td>
<td>• Malignancy with a &lt; 10 year expected survival</td>
<td>• Cancer being treated with only palliative interventions</td>
</tr>
<tr>
<td></td>
<td>Heart Failure/CAD</td>
<td></td>
<td>• NYHA Class III heart failure</td>
<td>• NYHA Class IV heart failure plus evidence of frailty</td>
</tr>
<tr>
<td></td>
<td>Pulmonary Disease</td>
<td></td>
<td>• Severe multi-vessel CAD</td>
<td>• Severe chronic lung disease plus evidence of frailty</td>
</tr>
<tr>
<td></td>
<td>ESRD</td>
<td></td>
<td>• Moderately severe chronic lung disease (e.g., COPD, IPF)</td>
<td>• ESRD ≥ 75y</td>
</tr>
<tr>
<td></td>
<td>Cirrhosis</td>
<td></td>
<td>• ESRD in patients &lt;75y</td>
<td>• Cirrhosis with MELD score ≥20, ineligible for transplant</td>
</tr>
<tr>
<td></td>
<td>Progressive Neurologic Conditions (ALS etc.)</td>
<td></td>
<td>• Cirrhosis with history of decompensation</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Moderate dementia
\(^2\) Frailty Scale
\(^3\) Has the patient had any unplanned hospital admissions in the last 6 months?
\(^4\) 2 yr “Surprise Question” “Would I be surprised if this patient died in the next 2 years?”
\(^5\) Does the patient have any of the following and what is the severity?
### SOFA Score

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Score = 0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory</strong></td>
<td>&gt; 400</td>
<td>&lt; 400</td>
<td>&lt; 300</td>
<td>&lt; 200 with resp. support</td>
<td>&lt; 100 with resp. support</td>
</tr>
<tr>
<td>PaO2/FiO2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hematologic</strong></td>
<td>&gt; 150</td>
<td>&lt; 150</td>
<td>&lt; 100</td>
<td>&lt; 50</td>
<td>&lt; 20</td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatic</strong></td>
<td>&lt; 1.2</td>
<td>1.2 – 1.9</td>
<td>2.0 – 5.9</td>
<td>6 – 11.9</td>
<td>&gt; 12</td>
</tr>
<tr>
<td>Bilirubin (mg/dl)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>None</td>
<td>Mean Arterial Pressure &lt;70mmHg</td>
<td>Dopamine &lt; 5 or any Dobutamine</td>
<td>Dopamine &gt; 5 or Epi &lt; 0.1 or Nor-Epi &lt; 0.1</td>
<td>Dopamine &gt; 15 or Epi &gt; 0.1 or Nor-Epi &gt; 0.1</td>
</tr>
<tr>
<td>Hypotension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CNS</strong></td>
<td>15</td>
<td>13 - 14</td>
<td>10 - 12</td>
<td>6 - 9</td>
<td>&lt;6</td>
</tr>
<tr>
<td>Glasgow Coma Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Renal</strong></td>
<td>&lt;1.2</td>
<td>1.2 - 1.9</td>
<td>2.0 - 3.4</td>
<td>3.5 - 4.9</td>
<td>&gt;5.0</td>
</tr>
<tr>
<td>Creatinine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# FRAILTY SCALE

<table>
<thead>
<tr>
<th>FRAIL</th>
<th>SCORE = 0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatigue</strong></td>
<td><strong>“Are you fatigued throughout the day?” (yes=1pt)</strong></td>
</tr>
<tr>
<td><strong>Resistance</strong></td>
<td><strong>“Can you walk up a flight of stairs?” (no=1pt)</strong></td>
</tr>
<tr>
<td><strong>Ambulation</strong></td>
<td><strong>“Can you walk a block?” (no=1pt)</strong></td>
</tr>
<tr>
<td><strong>Illness</strong></td>
<td>Does the patient have &gt; 5 of the following: HTN, DM, cancer (other than skin cancer), chronic lung disease, h/o MI/CAD/stent, CHF, angina, asthma, arthritis, h/o stroke/TIA, CKD? (yes=1pt)</td>
</tr>
<tr>
<td><strong>Loss of weight</strong></td>
<td><strong>“Have you lost weight unexpectedly in the past 6 months?”</strong>&lt;br&gt;<strong>OR:</strong> If weights are in Epic, have they lost more than 5% body weight (yes=1pt)</td>
</tr>
</tbody>
</table>

**SCORE:** 0 criteria = Robust | 1 or 2 criteria = pre-frail | 3+ criteria = frail

Adapted from: Brigham and Women’s Geriatric Resource for Front Line Clinicians Guide and Ref: Morley et. al. www.ncbi.nlm.nih.gov/pmc/articles/PMC4515112/
Role of Palliative Care
Palliative Care in Stage 1 and 2 (Conventional and Contingency)

1. **Palliative Care Screening** for COVID19/PUI inpatients (ER or hospital) with serious chronic comorbidities and/or ≥ 65y with:
   - Chart review to identify previously documented GOC/ACP (POLST registry, GOC Epic notes, advance directives etc.)
   - Call PCP/physician of trust as time allows
   - Proceed with palliative care intervention as indicated-ranging from assisting primary clinicians to palliative care specialty team intervention like formal patient care conference.
   - Rounding/Check-in with hospitalist and ICU teams to assess for unmet palliative care needs

2. **Advice and Coaching for Staff, Primary and Other Specialty Teams:**
   - **Prognosis:** Initial prognosis assessment
   - **Communication:**
     - How to deliver serious news and how to convey what beneficial/appropriate treatments are available for patients.
     - Giving anticipatory guidance and basic goals of care conversations (code status, POLST, SICG, REMAP)
   - **Whole Person Symptom management**
     - For patients at any level of care/intervention.
     - For patients on comfort care, including use of comfort care orders and managing end of life trajectory, symptoms to ensure comfort in dying, and support patient and family.
   - **Clinician Moral Distress**

3. **Specialty Consultation**
   - **Prognosis assessment** in patients with serious chronic illness that considers patient’s entire health status (acute illness(es), chronic illness(es), and frailty). Assessment includes disease trajectory with estimated life expectancy/survival, functional status, and the likelihood of available treatments achieving an acceptable health state.
   - **Communication:** Goals of care conference with patient/family when communication is difficult, there are discordant values, family dynamics are challenging, or when there are other barriers to establishing a care plan moving forward.
   - **Whole Person Symptoms:** Complex or refractory symptom management or psychosocial/spiritual distress
Palliative Care in Stage 3 (Crisis, Resource Allocation)

- The Palliative Care Team will continue to provide the same services that are provided in Stages 1 and 2, as staffing and conditions allow*

- The Palliative Care Team will NOT be involved in Triage Decisions about Resource Allocation. This will be done by the Triage Officer and the Triage Team

The following additional services will be offered in Stage 3 as staffing allows:

1. **Palliative Care Screening**:
   - Assist primary teams in rapid assessment of prior documented goals of care in Epic in high risk patients
   - Assist primary teams in rapid assessment of prognostication in high risk patients
   - Proceed to full palliative care consultation as indicated based on communication, whole person symptom management needs and staff availability

2. **Palliative Care Communication**
   - Although resource allocation will be determined by the Triage Team/Triage Officer, Palliative Care can be consulted, **AFTER a triage decision is delivered, to support the patient/family**. For particularly challenging communication situations, Palliative Care can be consulted to coach the Triage Officer and/or Primary Team Attending Physician in person-centered communication and conflict management.

3. **Palliative Care Whole Person Symptom Management**
   - Assist with end of life symptom management, psychosocial/spiritual distress related to pandemic

*Formal Palliative Care specialty team interventions may be dependent on patient acuity (stable vs unstable) and staffing availability, making coaching and support of primary clinicians in primary palliative skills crucial.
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- **Advance Care Planning (Low Risk)**
- **SICG: Serious Illness Conversation Guide (Moderate Risk)**
- **REMAP (High Risk)**
# COVID-19: NURSE(S) RESPONDING TO EMOTIONS

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<th>STEP</th>
<th>WHAT YOU SAY OR DO</th>
<th>TIPS/SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>“You sound concerned.”</td>
<td>Acknowledges the emotion. Be careful to suggest only, most people don’t want to be told how they feel but appreciate the acknowledgement. In general, turn down the intensity (e.g. scared→concerned).</td>
</tr>
<tr>
<td>UNDERSTAND</td>
<td>“I can imagine this is difficult news to hear.”</td>
<td>Normalizes the emotion or situation. Avoid suggesting you understand their experience, because we often can’t.</td>
</tr>
<tr>
<td>UNDERSTAND</td>
<td>“Many people in your situation might feel...”</td>
<td></td>
</tr>
<tr>
<td>RESPECT</td>
<td>“I can see you really care about your mother.”</td>
<td>Expression of praise or gratitude about the things they are doing. This can be especially helpful when there is conflict.</td>
</tr>
<tr>
<td>SUPPORT</td>
<td>“We will do everything we can to support you during this illness.”</td>
<td>Expression of what you can do for them and a good way to express non-abandonment. Making this kind of commitment can be a powerful statement.</td>
</tr>
<tr>
<td>EXPLORE</td>
<td>“Can you tell me more about...”</td>
<td>Emotion cues can be expressions of underlying concerns or meaning. Combining this with another NURSE(S) skills can be very effective and help you understand their reasoning or actions. Make sure to avoid judgment and come from a place of curiosity.</td>
</tr>
<tr>
<td>SILENCE</td>
<td>Can be used in many situations, but often effective after delivering serious news</td>
<td>It is often more therapeutic for family members to provide emotional support to each other. Using silence allows room for this opportunity. Silence can also make space for the person to share more. Use silence intentionally, too much can leave people feeling uncomfortable.</td>
</tr>
<tr>
<td>BONUS: “I wish” statements</td>
<td>“I wish we had better treatments... [more testing ability...that we were in a different situation...that your father wasn’t so sick... etc.]”</td>
<td>I wish statements allow you to affirm your commitment even when don’t have the ability to provide something that is desired.</td>
</tr>
</tbody>
</table>
COVID-19: ADVANCE CARE PLANNING

Outpatient: Low Risk Patients

1. **INTRODUCE** the idea

   [Set Agenda, Normalize] “We want you to have control over your medical care so that you get the best care possible. Because of the coronavirus, we are talking to all our patients about what is important to them if something unexpected happens and they became very sick.”

   [Ask Permission] “Would it be okay if we talk about that today?”

   **YES**: Go to Step 2  
   **NO**: [Explore Concerns] Address concerns first, if concerns cannot be addressed, offer written material and revisit at another encounter.

2. **ELICIT** questions

   [Set Agenda] “Are there things you want to make sure we cover today?”

   **YES**: Elicit/address quick questions, bracket longer questions, then go to Step 3.  
   **NO**: Go to Step 3

3. **EXPLORE** prior plans

   [Assess] “Many people already have plans, or a legal document that outlines their wishes, called an advance directive. What about you?”

   **YES**: Review prior preferences (use rest of map if needed) and obtain documents.  
   **NO**: Go to Step 4

4. **CHOOSE** a healthcare representative

   [Context, Normalize] “A good first step can be choosing someone who could make medical decisions for you if you were too sick to communicate your own wishes. Not everyone has someone they could trust to make medical decisions for them, and others already have someone in mind. How about you?”

   **YES**: Ask who, and if they have a legal form designating this person. If they have form, ask for a copy, if they don’t, offer to complete one at the end.  
   **NO**: [Affirm] “That’s okay, many people don’t have someone who could speak for them. In this situation it is even more important that we know your wishes and preferences before a crisis happens and we can’t communicate with you.”

5. **ASK** what matters

   [Elicit Values] “The next step is to think about key things that matter most to you in your life. Everyone defines quality of life differently, what does a ‘good day’ look like for you? [pause and listen]...“What activities or experiences are most important to you?”

   [Reflect Back Values] “It sounds like [value] is most important....”

   [Respect Contributions] “Thank you for sharing, it really helps me understand better.”

Adapted by Caroline.Hurd@providence.org using work from VitalTalk, Ariadne Labs, Elizabeth Lindenberger, Lindsay Dow, Amy Kelley, Diane Meier, Elke Lowenkopf and Rachelle Bernacki version 4.4.20
6. **ASK** about serious illness

**[Context]** “Now that I have a better understanding of what is most important in your life now, it can be helpful to think about what would be important to you if you unexpectedly got very sick.”

**[Past Experiences]** “Have you seen or experienced a serious medical illness or accident? [‘‘Has anyone you know had the coronavirus?’’]

“What did you take away from that experience? What went well? What did not go well? Why?”

“If you were in these situations, what would be important to you?”

**[Respect Contributions]** “Thank you, that is really helpful.”

7. **ASK** about tradeoffs

**[What if]** “Something else, that can be hard to think about is, if you got the coronavirus, or another serious illness, and became so critically ill that the doctors thought you were unlikely to survive, what would be important to you?”

**[Values Triad]**
- “Some people would want to try all life support treatments to **live as long** as possible, even if this meant living on machines for the rest of their life or not being aware of their surroundings.”
- “Other people would want a **trial** of life support treatments, but if they weren’t working and were only causing suffering they would want them stopped.”
- “Other people would not want artificial life support treatments and would want to focus on **comfort and a natural death**.”

“How about you?”

8. **DOCUMENT** preferences

**[Align and Plan]** “We’ve had a really important talk today and I want you to know that if you get sick, our team will do everything we can to help you recover. I will document our conversation in the medical record, so everyone knows your wishes. You can also complete an advance directive, which is a legal document that can assign a health care representative and can provide written instructions.”

**[Ask Permission]** “Would it be okay if we complete one today?”

**YES:** Complete [State] advance directive and make **recommendations** based on your conversation and thank them for the discussion.

**NO:** “Let us know if you change your mind. Thank you for talking with me about this today.”

9. **SHARE** preferences

If they have someone they trust to make medical decisions:

“I encourage you to talk with your healthcare representative about your wishes. It can really help people when they are in stressful situations and have to make medical decisions for someone else. If you want help talking with them, let us know.”

Adapted by Caroline.Hurd@providence.org using work from VitalTalk, Ariadne Labs, Elizabeth Lindenberger, Lindsay Dow, Amy Kelley, Diane Meier, Elke Lowenkopf and Rachelle Bernacki version 4.4.20
COVID-19: Serious Illness Conversation Guide

Outpatient: Moderate Risk Patients

1. INTRODUCE the idea

[Set Agenda, Normalize] “Given the situation with the coronavirus, I am asking all my patients about what matters most and what they might expect for their situation. This way, we can prepare for the future, so you get the best care possible.

[Ask Permission] “Would it be okay if we talk about that today?”

YES: Go to Step 2
NO: [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, offer to revisit at another encounter.

“I am going to use this guide, so I don’t miss anything…”

2. ELICIT agenda

[Elicit Agenda] “Are there things you want to make sure we cover today?”

YES: Elicit/address quick questions, bracket longer questions, then go to Step 3.
NO: Go to Step 3

3. DISCUSS prognosis

[Assess What they Know] “So I know where to begin, what have you heard so far about the coronavirus and how it could affect your situation?”

[Assess Information Preferences] “How much information, about what to expect in the future, would be helpful?”

[Ask Permission] “Would it be okay if I share what I know?”

[Headline] “Based on your medical conditions, you are at increased risk for serious complications from coronavirus” [Then pick ONE of the following strategies]

Uncertainty: “While it can be difficult to predict, some people with similar medical conditions get the coronavirus and do very well with mild symptoms and other people get very sick quickly, and even die.” [Can also use best/worst/most likely case]

Time: “I wish we were not in this situation. I’m worried that if you got coronavirus and became very sick, even with medical support, time could be as short as [days to weeks, weeks to mths]….”

Function: “I hope you do well for a long time, I worry if you got the coronavirus, you would not be able to [function]…”

4. EXPECT EMOTION

[Use the NURSE(S) tool to explicitly empathize before giving more information]

Name: “You seem worried.”
I wish: “I wish I had better news…”
[see NURSE(S) tool for more responses]
In order to provide you with the best care if you were to get sick, it helps me to know what are some things that matter most to you now? ... If you got the coronavirus and your health situation worsened, then what would matter most?

When you think about the future with your health, what are your biggest worries or concerns?

What gives you strength as you think about the future?

What abilities are so critical that you can’t imagine living without them?

Has anyone you know been seriously ill? How does this experience impact your own decisions? Do you have any spiritual or cultural beliefs that impact how you think about these decisions?

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

Some people would want to try all life support treatments to live as long as possible, even if this meant living on machines for the rest of their life or not being aware of their surroundings.

Other people would want a trial of life support treatments, but if they weren’t working and were only causing suffering they would want them stopped.

Other people would not want artificial life support treatments and would want to focus on comfort and a natural death.

Thank you for sharing this with me. As I listen, it sounds like what matters most is...[summarize values]. Did I miss anything?

Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team will do everything we can to help you through this.

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic), if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.
1. **INTRODUCE** the idea

   [Set Agenda, Normalize] “Given the situation with the coronavirus, I am asking all my patients about what matters most and what they might expect for their situation. This way, we can prepare for the future, so you get the best care possible.”

   [Ask Permission] “Would it be okay if we talk about this today?”

   **YES:** Go to Step 2  
   **NO:** [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, offer to revisit at another encounter.

2. **ELICIT** questions

   [Elicit Agenda] “Are there things you want to make sure we cover today?”

   **YES:** [Bracket Questions] “Great, thank you, I will make sure I address those by the end of our conversation.” Then go to Step 3.  
   **NO:** Go to Step 3

3. **REFRAME** we are in a different place

   [Assess What they Know] “So I know where to begin, what have you heard so far about the coronavirus and how it could affect your situation?”

   [Ask Permission] “Thank you, that’s helpful. You’ve heard some important information. Would it be okay if I share what I know?”

   [Deliver Headline = Information + Meaning]  
   **Info:** “Because of your other medical conditions [and your age], you are in the highest risk group for serious complications if the coronavirus makes you very sick.”

   **Meaning:** “This means that if you got the coronavirus and became so sick that you needed intensive care, I worry that you would not survive, even with maximal medical support.”

   STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

4. **EXPECT EMOTION**

   [Use the NURSE(S) tool to explicitly empathize before giving more information]

   **Name:** “This must be hard news to hear.”
   **I wish:** “I wish I had better news...”
   [see NURSE(S) tool for more responses]

5. **MAP** out values

   [Context, Ask Permission] “Given this situation, I’d like to step back and talk about what would be most important to you if you got the coronavirus and your health situation worsened. Is that okay?” [If yes, proceed, if not, explore emotions first]

   **[Hopes]** “What are you hoping for in the coming days, weeks, mths...? What/who else is important to you?...What does a ‘good day’ look like?...Anything else that is important that we should know?...”

   **[Concerns]** “When you think about the future with your health, what are your biggest concerns or worries?”
MAP out values (cont.)

**VALUES TRIAD**

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

- Some people would want to try all life support treatments to live as long as possible, even if this meant living on machines for the rest of their life, or not being aware of their surroundings, they would even want CPR if their heart stops and they die.

- Other people would want a trial of medical treatments, but if they weren't working, and they weren't going to get back to doing important things, they would want them stopped. They would not want to be on a ventilator that breathes for them and they would not want CPR.

- Other people, if they got the coronavirus and got very sick, would want to avoid the hospital all together, focus on comfort and have a natural death. They would want to start hospice to manage their symptoms and try to stay at home.

**How about you?**

For Surrogates-Empty Chair

If your father could understand the situation and talk to us, what would he say?

6. Align

Respect and Reflect Values

Thank you for sharing this with me. As I listen, it sounds like what matters most is... [summarize values]. Did I miss anything?

7. Plan

Recommend

Given what I know about your medical situation and what you said is most important, would it be okay if I made a recommendation about next steps?

Response 1-Value Longevity:

If you were to get the coronavirus, or some other serious illness and you needed to go to the hospital. I would recommend all available medical treatments to help you live as long possible. [Affirm] I want you to know that, if this happens, we will do everything we can to help you recover.” [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Provide Anticipatory Guidance] “I also want you to be prepared that even with this plan, there may come a time when you are so sick that you would die even with these treatments. If this happens, your doctors might not even recommend a ventilator machine to breathe for you, or CPR, because these treatments would not help.

Response 2-Value Function/Time Trial:

If you were to get the coronavirus, or some other serious illness and you needed to go to the hospital. I would recommend all available medical treatments that would help you get back to doing things that are important to you. If you get sicker, despite these treatments, I don’t think we should put you on a machine that breathes for you, or do CPR, but instead shift our focus to your comfort at the end of life and allow a natural death. [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Affirm] I want you to know that, if this happens, we will do everything that we think will help you recover.

Response 3-Comfort:

If you were to become seriously ill with the coronavirus, or another serious illness. I would recommend avoiding the hospital and not using breathing machines or CPR. We could arrange hospice care to help manage your symptoms at home, focus on your comfort, and allow a natural and peaceful death. [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Affirm] I want you to know that, if this happens, we will do everything we can to keep you comfortable.

Close

Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team will do everything we can to help you through this.

8. Document your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic), if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.
Emergency Department and Inpatient COVID-19 Talking Maps

Connections Palliative Care, Oregon Region
Home and Community Care
Providence St. Joseph Health
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## COVID-19: NURSE(S) RESPONDING TO EMOTIONS

<table>
<thead>
<tr>
<th>Step</th>
<th>What You Say or Do</th>
<th>Tips/Skills</th>
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<tbody>
<tr>
<td><strong>NAME</strong></td>
<td>“You sound concerned.”</td>
<td>Acknowledges the emotion. Be careful to suggest only, most people don’t want to be told how they feel but appreciate the acknowledgement. In general, turn down the intensity (e.g. scared → concerned).</td>
</tr>
<tr>
<td><strong>UNDERSTAND</strong></td>
<td>“I can imagine this is difficult news to hear.”</td>
<td>Normalizes the emotion or situation. Avoid suggesting you understand their experience, because we often can’t.</td>
</tr>
<tr>
<td></td>
<td>“Many people in your situation might feel…”</td>
<td></td>
</tr>
<tr>
<td><strong>RESPECT</strong></td>
<td>“I can see you really care about your mother.”</td>
<td>Expression of praise or gratitude about the things they are doing. This can be especially helpful when there is conflict.</td>
</tr>
<tr>
<td><strong>SUPPORT</strong></td>
<td>“We will do everything we can to support you during this illness.”</td>
<td>Expression of what you can do for them and a good way to express non-abandonment. Making this kind of commitment can be a powerful statement.</td>
</tr>
<tr>
<td><strong>EXPLORE</strong></td>
<td>“Can you tell me more about…”</td>
<td>Emotion cues can be expressions of underlying concerns or meaning. Combining this with another NURSE(S) skills can be very effective and help you understand their reasoning or actions. Make sure to avoid judgment and come from a place of curiosity.</td>
</tr>
<tr>
<td><strong>SILENCE</strong></td>
<td>Can be used in many situations, but often effective after delivering serious news</td>
<td>It is often more therapeutic for family members to provide emotional support to each other. Using silence allows room for this opportunity. Silence can also make space for the person to share more. Use silence intentionally, too much can leave people feeling uncomfortable.</td>
</tr>
<tr>
<td><strong>BONUS:</strong></td>
<td>“I wish we had better treatments… [more testing ability….that we were in a different situation…that your father wasn’t so sick… etc.]”</td>
<td>I wish statements allow you to affirm your commitment even when don’t have the ability to provide something that is desired.</td>
</tr>
</tbody>
</table>

Adapted by Caroline.Hurd@providence.org using work from VitalTalk, Ariadne Labs, Elizabeth Lindenberger, Lindsay Dow, Amy Kelley, Diane Meier, Elke Lowenkopf and Rachelle Bernacki version 4.4.20

Example: Patients with KNOWN values that are DNR/DNI

Before You Start: This talking map is for patients who have clear goals of care. If a patient has DNR/DNI preferences documented in the chart (POLST, GOC note etc.) Confirm their preferences first before having the conversation below. If this information is incorrect, or they want to change their preferences, use the REMAP talking map instead.

GET READY
[Key Information] Make sure you have the key information (COVID-19 test results, prognosis, POLST etc.)

[Key People] Make sure you have the key people (patient, family, surrogate and interprofessional clinicians etc.)

[Key Space] If possible, find a private, quiet space and allow adequate time

UNDERSTAND what they know
[Warning Statement] “I have some serious news to talk about today.”

[Assess Prior Knowledge] “So I know where to begin, it’s helpful to know what you’ve already been told. What do you already know about [your test results for the coronavirus, how coronavirus affects your lungs...what to expect with a coronavirus infection... etc.]”

[Always assess] what the patient or family knows before giving information, this allows you to tailor your response.

INFORM using a headline
[Ask Permission] “Thank you, that’s helpful. You’ve heard some important information already. Would it be okay if I share what I know?” [If yes, proceed, if no explore concerns]

[Headline = Information + Meaning]
Information (1-2 sentences of key information):
Example 1: “The test results show that you have the coronavirus.”
Example 2: “The CT scan shows that the coronavirus has caused serious damage to your lungs...”

Meaning:
Known Values for DNR/DNI Time Trial: “This means that while we hope you will recover quickly, some people with your other medical conditions get sick quickly and do not survive.”

Known Values for DNR/DNI Comfort Care: “This means that while we hope you will improve; we are worried you may get sicker quickly and not survive.”

STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.
DEMONSTRATE EMPATHY

[Use the NURSE(S) tool to explicitly empathize before giving more information]

Name: “This must be hard news to hear.”
Understand: “I can only imagine how difficult this is to think about.”
Respect: “I really appreciate you having this difficult conversation with me.”
Support: “Our teams are here to support you through this.”
Explore: “Tell me more about what you are thinking…”
I wish: “I wish I had better news…”

EQUIP for next steps

[Align First] “I want you to know that our team will do everything we can to support you.”

[Anticipatory Guidance] [Provide a spectrum of potential outcomes and signpost potential challenges]
“I also want you to be prepared for what’s to come. Our plan right now is…”

Option 1: Known DNR/DNI Time Trial  “…admit you to the hospital for a trial of medications and treatments to help you get better. We will monitor you closely on our acute care floor. We hope you improve quickly and we can get you home as soon as possible. Sometimes people’s condition worsens, despite our best efforts. Given your prior wishes, and their unlikely benefit in people with serious underlying medical conditions, if you became critically ill and were dying, we would not do CPR or put a tube into your lungs and connect you to a ventilator machine that breathes for you. Instead we would shift our focus to comfort during the dying process.”
[Remember you will likely need to respond to emotions again after this recommendation]

Option 2: Known DNR/DNI Comfort Care  “…admit you to the hospital and start medications and treatments to help you feel better. Because of the severity of this illness, your other medical conditions, and your previously expressed wishes, we will focus our care on treating symptoms to ensure your comfort. We will not do treatments that don’t provide comfort like CPR, ventilator breathing machines that require a tube into the lungs, or transfer you to the intensive care unit. Some patients, even when we focus on comfort, will recover from this illness. However, even if you worsen, we will pay close attention to shortness of breath, or any other signs of discomfort, and we will give medications and other treatments that will help you feel more comfortable during the dying process.”
[Remember you will likely need to respond to emotions again after this recommendation]

[Check-in] “That is a lot to process, what questions do you have?”

[Affirm and Close] “Thank you for talking with me about this today. I will write our discussion down in your chart, so everyone on our healthcare teams knows the plan. We are committed to making sure you get the best care possible.”

DOCUMENT your conversation

In addition to documenting your conversation in the EHR [Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete/recommend as appropriate.
COVID-19: REMAP For Goals of Care

Example: Stable Moderate Risk Patients who are FULL code or DNR/Intubate Okay (Acute Care Focus)

1. **INTRODUCE** the idea
   
   [Set Agenda, Normalize] “Things can change quickly when people have the coronavirus. Because of this, I am asking *all my patients* about what matters most and what they might expect for their situation. This way, we can be prepared during your hospital stay and makes sure you get the kind of medical care you want.”

   [Ask Permission] “Would it be okay if we talk about this today?”

   **YES:** Go to Step 2
   **NO:** [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, offer to revisit at another encounter.

2. **ELICIT** questions
   
   [Elicit Agenda] “Are there things you want to make sure we talk about during our conversation?”

   **YES:** [Bracket Questions] “Great, thank you, I will make sure I address those by the end of our conversation.” Then go to Step 3.
   **NO:** Go to Step 3

3. **REFRAME** we are in a different place
   
   [Assess What They Know] “So I know where to begin, what have you heard so far about the coronavirus and how it could affect your particular situation?”

   [Ask Permission] “Thank you, that’s helpful. You’ve heard some important information. Would it be okay if I share what I know?”

   [Headline = Information + Meaning]
   **Information:** “Because of your other medical conditions, you are at risk for serious complications if the coronavirus makes you very sick.”

   **Meaning:** “This means that if you became so sick that you needed intensive care, I worry that you may not survive, even with maximal medical support.”

   STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

4. **EXPECT EMOTION**
   
   [Use the NURSE(S) tool to explicitly empathize before giving more information]
   
   Name: “You seem worried…”
   I wish: “I wish I had better news…”
   [see NURSE(S) tool for more responses]

5. **MAP** out values
   
   [Context, Ask Permission] “Given this situation, I’d like to step back and talk about what would be most important to you if your health situation worsened. Is that okay?” [If yes, proceed, if no, explore emotions first]

   [Hopes] “What are you hoping for in the coming days?...What/who else is important to you?...What does a ‘good day’ look like?”

   [Concerns] “When you think about the future, what are your biggest concerns or worries?”
MAP out values (cont.)

[Tradeoffs] “If you become sicker, how much would you be willing to go through for the possibility of gaining more time?”

- Longevity: “Some people would want to try all life support treatments to live as long as possible, even if this meant living on machines permanently, or not being aware of their surroundings. They would even want CPR attempted if their heart stopped and they died.”

- Function: “Other people would want a trial of life support treatments, such as a ventilator machine which requires a tube down into the lungs to help you breathe. But if the treatments weren’t working, and they weren’t able to get back to doing important things, they would want them stopped. They would also not want CPR.”

- Comfort: “Other people, if they got very sick from the coronavirus, would only want treatments focused on comfort. They would not want a ventilator or CPR and they would want to have a natural peaceful death, even if they lived a shorter time.”

“How about you?”

6. ALIGN

[Respect and Reflect Values] “Thank you for sharing this with me. As I listen, it sounds like what matters most is…. [summarize values]. Did I miss anything?”

7. PLAN

[Recommend] “Given what I know about your medical situation and what you said is most important, would it be okay if I made a recommendation about next steps?”

[Response 1-Value Longevity]: “For now, I would recommend all available medical treatments to help you live as long possible. [Affirm] I want you to know that, if you get sicker, we will do everything we can to help you recover.” [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Provide Anticipatory Guidance] “I also want you to be prepared that even with this plan, there may come a time when you are so sick that you would die even with these treatments. If this happens, your doctors might not even recommend a ventilator machine to breathe for you, or CPR, because these treatments would not help.”

[Response 2-Value Function/Time Trial]: “For now, I would recommend a trial of all available medical treatments that would help you get back to doing things that are important to you. If you get sicker, and you are dying despite these treatments, I don’t think we should put you on a machine that breathes for you, or do CPR, but instead shift our focus to your comfort during the dying process and allow a natural death. [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Affirm] I want you to know that, if you get sicker, we will do everything that we think will help you recover.”

[Response 3-Comfort]: “I recommend that we focus our care on treating symptoms to ensure your comfort. We call this ‘comfort care.’ This would mean that we don’t do treatments that would cause discomfort, like CPR, breathing machines or moving you to the intensive care unit. But we aggressively treat any symptoms that are causing you to be uncomfortable. Some patients, even when we focus on comfort, will recover from this illness. However, even if you worsen, we will pay close attention to shortness of breath, or any other signs of discomfort, and we will give medications and other treatments that will help you feel more comfortable during the dying process.” [Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?” [Affirm] I want you to know that we will do everything we can to keep you comfortable.”

[Close] “Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what’s important to you. Our team will do everything we can to help you through this.”

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic), if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.
COVID-19: REMAP-Informed Assent For Goals of Care

Example: Unstable High Risk Patients Unlikely to Benefit from CPR or Intubation (ED Focus)

1. **INTRODUCE** the idea

   **[Context]** “I am worried you are very sick and might have the coronavirus. Things can change quickly and we want to make sure you have all the information you need about what to expect for your situation and we also want to know what matters most to you if you became critically ill and you cannot communicate with us.”

   **[Ask Permission]** “Is that okay?”

   **YES:** Go to Step 2

   **NO:** [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, at least try to complete step 2 to identify a health care representative.

2. **ASK** about a Health Care Representative

   **[Normalize]** The first thing I want to know is if there is someone you trust to make medical decisions for you if you become too sick to communicate your own wishes. Not everyone has someone they could trust to make medical decisions for them, and others already have someone in mind. How about you?”

   **YES:** Ask who the person is, and if they’ve legally designating this person. If they have, ask your team to help get the paperwork.

   **NO:** [Affirm] “That’s okay, many people don’t have someone who could speak for them. In this situation it is even more important that we know your wishes and preferences before a crisis happens and we can’t communicate with you.”

3. **REFRAME** we are in a different place + informed assent for DNR/DNI

   **[Context]** The next thing I want to talk about are your wishes if you suddenly become critically ill.

   **[Assess What they Know]** “So I know where to begin, what have you heard so far about the coronavirus and how it could affect your particular situation?” [Actively listen so you can tailor your information to what they already know]

   **[Ask Permission]** “Thank you, that’s helpful. You already have important information. Would it be okay if I share what I know?”

   **[Headline = Information + Meaning]**

   **Information:** “The test results show that it is very likely that you have the coronavirus. I am worried that you have developed a serious complication in which the virus has affected your lungs.”

   **Meaning Part 1**

   "This **means** that if the infection becomes severe, despite our best efforts, **most** people who already have serious medical conditions, don’t survive, even with maximal medical support. [Pause]

   **Meaning Part 2**

   **[Informed Assent]** Therefore we don’t recommend invasive treatments like CPR, or a ventilator breathing machine that requires a tube into your lungs to help you breathe, because these treatments would only cause harm.”

   STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

4. **EXPECT EMOTION**

   **[Use the NURSE(S) tool to explicitly empathize before giving more information]**

   Name: “I can see this is upsetting to hear.”

   I wish: “I wish I had better news…”

   **[see NURSE(S) tool for more responses]**
5. **MAP out values**

[Ask Permission] “**Given this situation,** I want to know how best to care for you. I know this can be hard to think about. Is it okay if we go on?”

[If yes, proceed, if no, explore concerns and emotions.]

Option 1: Time Trial “**Some people hear this news and knowing that CPR and ventilator breathing machines would not be helpful, they want a trial of all other available treatments** that the doctors recommend.

Option 2: Comfort Focused “**Other people hear this news and say that if are this sick, they only want treatments and medications that help with comfort and want to have a natural peaceful death. They also want any treatments that don’t provide comfort stopped.”**

“How about you?”

[Note: If a patient is actively dying and even a time trial would not be effective, skip to making a clear recommendation to transition to comfort focused care now, see Option 2 below.]

6. **ALIGN**

[Respect and Reflect Values] “**Thank you for sharing this with me. As I listen, it sounds like what matters most is... [summarize values]. Did I miss anything?”**

7. **PLAN + informed assent for DNR/DNI**

[Recommend] “**Given what I know about your medical situation and what you said is most important, would it be okay if I made a recommendation about next steps?”**

[Option 1-Value Function/Time Trial]: “For now, I would recommend a trial of available medical treatments* that we think will help. We will not do CPR or use a ventilator breathing machine, because these would not help in your situation. [Informed Assent] If you get sicker, and you are dying despite these treatments, we would shift our focus to your comfort during the dying process. We would increase treatments and medications to manage your symptoms and we would stop any treatments that are not helping. [Affirm] I want you to know that our whole team hopes that we help you recover.”

[Option 2-Comfort]: “I **recommend** that we focus our care on treating symptoms to ensure your comfort. We call this ‘comfort care.’ We will pay close attention to shortness of breath, or any other signs of discomfort, and we will give you medications and other treatments that help you feel more comfortable during the dying process. We will also stop or avoid treatments that cause discomfort, like CPR, breathing machines or moving you to the intensive care unit. [Affirm] I want you to know that we will do everything we can to keep you comfortable.”

[Pause and Check-in] “How does this plan seem to you?” “Did I miss anything?”

[Close] Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team is committed to supporting you through this.”

[*BiPAP and HFNC are controversial. Would only offer if these are available, recommended and would potentially offer benefit, they are aerosolizing procedures and require special PPE]*

**DOCUMENT your conversation**

In addition to documenting your conversation in the EHR [Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.
COVID-19: REMAP-Informed Assent  For Goals of Care

Example: Talking to Surrogates When Patients Are Dying Despite Critical Care (ICU Focus)

1. **INTRODUCE** the idea

   [Context and Warning Statement] “I have some serious news to talk about today about how [patient] is doing. Things have changed a lot in the last few [hrs, days etc.] and I want to give you a medical update and then talk about a plan together for next steps.”

   [Ask Permission] “Is that okay?”

   **YES**: Go to Step 2
   **NO**: [Explore Concerns] Emotions are often under these concerns, address these first and try again. If emotions are too high, and the situation is urgent, ask if there is another surrogate to talk to, if the situation is non-urgent arrange another time to talk.

2. **REFRAME** we are in a different place

   [Assess What they Know] “Before I begin, it’s helpful to hear, from your perspective, how you think [patient] is doing, and what you already know about his current condition.” [Actively listen so you can tailor your information and plan to their needs.]

   [Ask Permission] “Thank you, that’s helpful. You already have important information. Would it be okay if I share what I know?”

   [Deliver Headline = Information + Meaning]
   **Information:**
   Option 1: “Despite our best efforts, in the past few [hours/days], [patient] has not improved....”
   Option 2: “Despite our best efforts, in the past few [hours/days], [patient] has become sicker.”

   **Meaning + Informed Assent**
   Option 1: “This means that we are worried that the infection and damage are so severe that [patient] won’t survive and may even die in the next couple of [hrs/days].”
   Option 2: “This means that the infection and damage are so severe that even with maximal medical support, [patient] is dying.”

   STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

3. **EXPECT EMOTION**

   [Use the NURSE(S) tool to explicitly empathize before giving more information]
   Name: “I can see this is unexpected.”
   Understand: “I can only imagine how difficult this is to think about.”
   Respect: “I really appreciate you having this difficult conversation with me.”
   Support: “Our teams are here to support you through this.”
   Explore: “Tell me more about what you are thinking...”
   I wish: “I wish we had better treatments to fight this infection...”
**MAP out values**

| [Ask Permission] | “Given this situation, I want to know how best to care for [patient]. This can be hard, is it okay if we go on?” |
|---------------------------------------------|
| [If yes, proceed, if no, explore concerns and emotions.] |

**Option 1: Time Trial** “Some people hear this news and even though they understand that their loved one is unlikely to survive, they want to continue all recommended medical treatment for another few days to see if there is any improvement.”

**Option 2: Comfort Focused** “Other people hear this news and say that if [patient] is likely to die/is dying no matter what, their loved one would only want treatments and medications that help with comfort. They would want all life support treatments stopped to allow their loved one to have a natural peaceful death. This would include stopping the ventilator and any other treatments that cause discomfort and starting more medications and treatment to improve comfort.”

| [Empty Chair] | “If [patient] could sit with us and understand the situation and talk to us, what would he say?” |

| [Note: If a patient is actively dying and even a time trial would not be effective, skip to making a clear recommendation to transition to comfort focused care now, see Option 2 below.] |

**ALIGN**

| [Respect and Reflect Values] | “Thank you for sharing this with me. As I listen, it sounds like what matters most is...[summarize values]. Did I miss anything?” |

**PLAN (informed assent recommendation for DNR)**

| [Recommend] | “Given what I know about the medical situation and what you said is most important to [patient], would it be okay if I made a recommendation about next steps?” |

| [Option 1-Time Trial]: “For now, I would recommend a trial of [time] using all available medical treatments that we think will help. We will watch closely for signs of improvement, including [list signs]. We will also look for any signs that [patient] is getting worse, including [list signs]. [Informed Assent for DNR] At a minimum I would recommend that if [patient] gets so sick that their heart stops and they die, we should not do CPR because it would only cause harm and not help [patient] survive. If [patient] gets sicker, and they are dying despite these treatments, we will likely recommend that we shift our entire focus during the dying process and stop the ventilator to allow a natural and peaceful death. [Affirm] We want you to know that whatever happens our team will support you through this.” |

| [Option 2-Comfort]: “I recommend that we focus our care on treating symptoms to ensure [patient] comfort. We call this ‘comfort care.’ We will pay close attention to shortness of breath, or any other signs of discomfort, and we will [patient] medications and other treatments to help with comfort during the dying process. When we take people off the ventilator who are this sick, they usually die within minutes to hours, though occasionally it can be days. [Affirm] I want you to know that we will do everything we can to keep [patient] comfortable.” |

| [Pause and Check-in] | “How does this plan seem to you?” “Did I miss anything?” |

| [Close] | Thank you for talking with us about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team is committed to supporting you through this.” |

| [offer supportive/bereavement services from the interprofessional team as appropriate] |

| [Note: you may have to address visitation policies etc.] |

**DOCUMENT your conversation**

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic), if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.