Online Data Supplement

Effect of Palliative Care Curriculum on Serious Illness Conversation Preparedness

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Palliative Care Curriculum Outline

Resources:

- Centers to Advance Palliative Care (CAPC) https://www.capc.org/

Framework:

I. Faculty Led Didactic Lectures:
   a. Introduction to the Serious Illness Conversation guide framework from Ariadne Labs and how to access prior advanced care planning documentation in our electronic health record.
   b. Case discussion: Physician Orders for Life Sustaining Treatments (POLST) forms. When to fill them out, why and how.
   c. Case discussion: Health Care Proxy forms and challenges that can arise, especially when the patient has no one to name, fears giving up control, or lacks capacity to appoint a health care proxy.

II. Role Playing Sessions:
   a. Serious illness conversations (two sessions): Residents were placed into pairs where one resident played the role of a patient with serious illness and the other was the physician. Residents were given 10 minutes to act out a goals of care discussion using the Ariadne Labs Serious Illness Conversation guide. Faculty sat in during role play scenarios and gave feedback immediately following the scenario. Each resident was allowed to play the role of physician and patient at least once.
      i. Scenario 1: Discussing goals of care during admission in the emergency department
      ii. Scenario 2: Re-exploring goals of care upon ICU transfer
   b. Responding to emotion: Faculty modeled how to respond to emotions during conversations with patients. Subsequently residents were paired and practiced responding to the emotions portrayed by their peers, who had been instructed to portray an upset or saddened patient.
   c. Family meeting (1 session): Residents practiced a family meeting.

III. CAPC Modules:
   a. Clarifying goals of care
   b. Advanced care planning conversations
   c. Delivering serious news
   d. Discussing prognosis
   e. Conducting a family meeting

Serious Illness Conversation Guide, ARIADNE Labs

Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. *Assess understanding and preferences*	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* · Share prognosis · Frame as a "wish…worry", "hope…worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness…" *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year).*" OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. *Explore key topics* · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. *Document your conversation*	
7. *Communicate with key clinicians*	

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Patient Baseline Demographics

	Prior Academic Year n=453	Pre-Intervention n=245	3 months Post-Intervention n=424	6 months Post-Intervention n=494	p-value*
Age (mean, SD)	68.84, 18.01	68.51, 16.65	67.04, 18.77	68.96, 17.61	0.36
Male (n, %)	234, 52%	129, 53%	220, 52%	225, 46%	
Female (n, %)	219, 48%	116, 47%	204, 48%	269, 54%	0.14
Log_{10} length of stay in days (mean, SD)	1.82, 0.34	1.81, 0.35	1.78, 0.35	1.73, 0.33	<0.01
Comorbidities					
Cancer (n, %)	130, 29%	72, 29%	105, 25%	125, 25%	0.37
NYHA class II-IV CHF (n, %)	142, 31%	80, 33%	115, 27%	132, 27%	0.19
Obstructive Lung Disease (n, %)	140, 31%	51, 21%	153, 36%	176, 36%	<0.01
≥CKD IV (n, %)	103, 23%	30, 12%	84, 20%	89, 18%	0.01
Chronic liver disease (n, %)	52, 11%	17, 7%	36, 8.5%	29, 6%	0.02

***Values obtained by logistical regression**