HOW TO LEAD A FAMILY MEETING
A Serious Illness Communication Resource Guide for Palliative Care Teams

~ 2018 ~

PC NOW
Introduction

This guide is designed to assist clinicians lead family meetings and includes the following tools:

A. A link to a voiced over PowerPoint presentation by Dr. Sean Marks of the Medical College of Wisconsin discussing How to Lead a Family Meeting.

B. Links to Fast Facts 222-227 which details various components of a Family Meeting as highlighted in the presentation. Authored by David E Weissman MD, Timothy E Quill MD, and Robert M Arnold MD.

C. A summary of the 9 steps of leading a family meeting.

D. A Serious Illness Evaluation Tool for use in assessing learners.
A. How to Lead a Goals of Care Conference. Dr. Sean Marks.
   Dr. Marks Presentation-20181101 1407-1

   Recorded Thursday November 1, 2018.

   (N.B. You may need to download the WebEx chrome add on)

B. Fast Facts for the Family Meeting

1. FAST FACTS AND CONCEPTS #222 - PREPARING FOR THE FAMILY MEETING.

2. FAST FACTS AND CONCEPTS #223 - THE FAMILY MEETING: Starting the conversation.

3. FAST FACTS AND CONCEPTS #224 - RESPONDING TO EMOTION IN FAMILY MEETINGS.


5. FAST FACTS AND CONCEPTS #226 - Helping Surrogates Make decisions.

6. FAST FACTS AND CONCEPTS #227 - The Family Meeting: Goal Setting and Future planning.
C. THE FAMILY GOAL SETTING CONFERENCE

1. Preparation
   - Review chart—know all medical issues: treatment course, prognosis, treatment options
     - Coordinate medical opinions among consultant physicians
     - Decide what tests/treatments are medically appropriate
   - Review Advance Care Planning documents
   - Review/obtain family psychosocial information
   - Clarify your goals for the meeting—what decisions are you hoping to achieve
   - Decide who you want to be present from the medical team
   - Check your own emotions

2. Establish proper setting
   - Private, comfortable; Everyone seated in a circle

3. Introductions/Goals/Relationship
   - Allow everyone to state name and relationship to patient
   - Identify if there is legal decision-maker (POA, Guardian)
   - State your meeting goals; ask family to state their goals
   - Build relationship: ask non-medical question about patient: Can you tell me something about your father?

4. Family understanding of condition
   - What have you heard from the doctors about your medical condition?
   - Encourage all present to respond
   - For patients with a chronic illness, ask for a description of changes in function over past weeks/months (activity, eating, sleep, mood) How have things been going the past 3 months

5. Medical review/summary
   - Summarize “big picture” in 2-3 sentences—use “dying” if appropriate.
   - Avoid organ-by-organ medical review or day-by-day diary of hospitalization.
   - Avoid jargon

6. Silence/reactions
   - Respond to emotional reactions and questions
   - Prepare for common reactions: acceptance, conflict/denial, grief/despair; respond empathically to conflict/denial (see below)

7. Present Broad Care Options/Set Goals
   - Provide prognostic data using a range; respond to emotion
   - Present goal-oriented options (e.g. prolong life, improve function, return home, dignified death)
   - Stress priority of comfort, no matter the goal
   - Make a recommendation based on knowledge/experience
   - Ask: What is important in the time you have left?
C. THE FAMILY GOAL SETTING CONFERENCE (cont.)

8. **Translate goals into care plan**
   - Review current and planned interventions—make recommendations to continue or stop based on goals
   - Discuss DNR, Hospice/Home Care, Artificial Nutrition/Hydration, future hospitalizations
   - Summarize all decisions made

9. **Document and discuss**
   - Write a note: who was present, what decisions were made, follow-up plan
   - Discuss with team members (consultants, nurse, etc.)
   - Check your emotions; Team debriefing

**Managing Conflict**
- Listen and make empathic statements *This must be very hard*
- Determine source of conflict: guilt, grief, culture, family dysfunction, trust in med team, etc.
- Clarify misconceptions; Explore values behind decisions
- Set time-limited goals with specific benchmarks (e.g. improved cognition, oxygenation, mobility)

©2014 MCW Research Foundation, Inc.
D. Communication Skills
Leading Goals of Care Conversations in Serious Illness Evaluation Tool
MCW Hospice and Palliative Medicine Fellowship

Brief Instructions:
1. The evaluator should directly observe the clinician having a serious illness conversation with a patient and/or family (i.e. delivering bad news or discussing goals of care) and complete the survey.
2. The evaluator will give face-to-face feedback to the trainee after the encounter as soon as possible.
3. Please turn completed forms to the Fellowship PD (Sean Marks) or PC (Brooke Lessmiller).

Observed Clinician Name: _________________________
Evaluator Name: __________________________________
Evaluator Background (circle one):
 a) Resident/fellow 
 b) Attending physician 
 c) Advance practice provider 
 d) Psychologist 
 e) Social worker 
 f) Chaplain 
 g) Other: ________

Based on my observations and expectations of a palliative care physician, this clinician may take part in a family meeting (Please circle appropriate rating on entrustment scale):
1. Only after remediation (critical deficiencies)
2. 
3. Under ongoing, full supervision (e.g. participate in a family meeting facilitated by another).
4. 
5. Under reactive supervision (e.g. lead some or all of a family meeting with supervisor present and anticipating need to intervene).
6. 
7. Independently (e.g. effectively facilitates most family meetings without a supervisor present).
8. 
9. Aspirational (e.g. effectively facilitates complicated meetings in an independent manner that would be instructive to other attendees).

Comments – Strengths

Comments -- Recommendations
Introduction
• Facilitates introductions and roles
  YES  NO
• Uses non-verbal signs of engagement (seated, appropriate eye-contact, etc)
  YES  NO
• Establishes purpose of meeting with patient/family
  YES  NO

Comments:

Elicits Patient’s or Family’s Perspective
• Assesses patient/families concerns or worries
  YES  NO
• Uses open-ended questions to assess the patient/family’s understanding
  YES  NO

Comments:

Delivery of Information
• Presents small amount of information at a time
  YES  NO
• Checks periodically for patient comprehension
  YES  NO
• Avoids jargon
  YES  NO
• Provides a clear, concise and accurate medical summary even if prognosis is grim (e.g. uses word dying if appropriate)
  YES  NO

Comments:

Emotional Engagement
• Allows patient/family adequate time/space to react to news and express emotions
  YES  NO
• Effectively responds to emotions
  YES  NO

Comments:

Follow Up
• Elicits, listens and responds to patient/family’s questions
  YES  NO
• Discusses next step
  YES  NO

Comments
About Palliative Care Network of Wisconsin

Mission Statement
To support the growth of palliative care services in Wisconsin through education, systems change, and advocacy.

PCNOW Goals
- Advance the care of Wisconsin patients and families through the growth of generalist and specialist palliative care services in all health care settings.
- Advance the knowledge and skills of all health professionals providing care for seriously ill patients.
- Advocate for improved palliative care services through changes in health care policy, regulations and legislation.

• For additional resources, including more Fast Facts, Advocacy Alerts, Quality Tools, and links to Mentors, visit: https://www.mypcnow.org

• Want to receive regular updates and get access to all of the PCNOW tools and resources? Join! (It’s free...) https://www.mypcnow.org/join

• Love what we are doing and want to donate? You can find our donate page here https://www.mypcnow.org/donate

Have a question, suggestion, or want to volunteer? Email us!
wiscpallcare@gmail.com