



## Honor Individual Goals and Hopes (HIGHway) Curriculum

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**Facilitator Guide**

*Version 7/27/23*

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Disclaimer: The statements presented in this work are solely the responsibility of the authors and do not necessarily represent the views of PCORI.

# Introduction

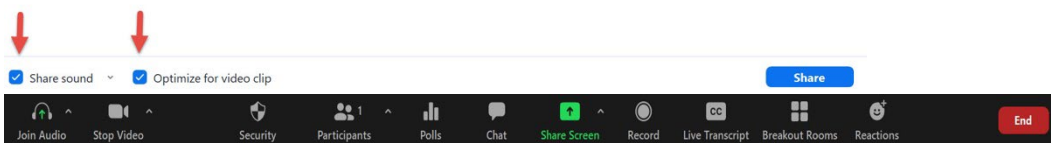
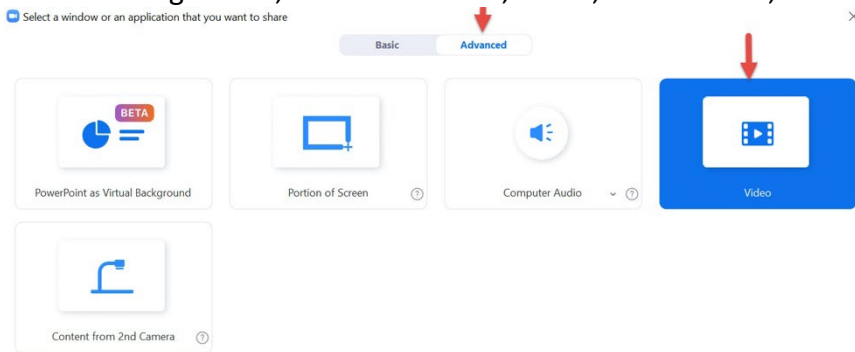
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## About this Training

The HIGHway Curriculum consists of three blended learning sessions intended to prepare social workers to facilitate and conduct Advanced Care Planning (ACP) conversations with dialysis patients. Each session includes 120 minutes of planned content and interactions. Each module also includes one or more video presentations to supplement the live sessions. These may be distributed before and/or after the live sessions.

## Preparation Checklist

- Gather photos and brief bios from participants. Create webpage, document or slide(s) of participants to share during Session 1, prior to Introductions.
- Familiarize yourself with Zoom’s sharing features. See: [Sharing Your Screen or Desktop in Zoom](#)
- When sharing videos, select Advanced, Video, Share sound, and Optimize for video clip.



- Review modules to identify polling questions and set up polls in advance. Refer to instructions from the polling platform vendor to learn how to set up polls (e.g., [Zoom Help Center: Polling for Meetings](#))

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## Session 1: Advance Care Planning Conversations

### Agenda

Time	Topic	Minutes
00:00 – 00:20	Introduction	20
00:20 – 00:30	Understanding Terms	10
00:30 – 00:40	Poor Demonstration of Advanced Care Planning	10
00:40 – 00:50	HIGHway Roadmap	10
00:50 – 00:60	Motivational Interviewing	10
00:60 – 01:30	Motivational Interviewing Role Play	30
01:30 – 01:40	Giving Control Back to the Patient	10
01:40 – 01:50	Closing	10

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### Learning Objectives:




- Describe the goals of the PCORI HIGHway grant
- Describe shared decision-making, advance care planning, motivational interviewing and empathy, culture humility, religion and spirituality and how they are constituents of goals of care conversations
- Recognize the trajectory of chronic kidney disease and how the process of advance care planning fits into it
- Apply motivational interviewing techniques to conduct empathetic advance care planning (ACP) conversations to learn what a dialysis patient wants for their future care
- Adapt ACP conversation to the stage of change of the participant


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### Supplemental Materials:

- [HIGHWay Project: Implementing Advanced Care Planning for Dialysis Patients](#) Recorded presentation (1:32)
- [Advanced Care Planning Conversations: Basic Terms & Concepts](#) Recorded presentation (13:33)
- [Motivational Interviewing](#) Recorded presentation (29:31)
- Motivational Interviewing Handout (see Appendix A)
- Motivational Interviewing Counts Worksheet (see Appendix B)
- [Giving Control Back to the Patient](#) video (3:23)
- [Spiritual Dimensions in Advance Care Planning](#) Recorded presentation (17:33)
- [Empowering Patients in the ACP Process](#) video (1:21)
- [Ensuring Equal Access](#) video (2:27)

**Introduction (20 minutes)**


Slide	Facilitator Notes
 <p><b>HIGHway</b> Honor Individual Goals &amp; Hopes</p> <p>Advance Care Planning Conversations</p> <p>GW Nursing</p> <p>Center for Alternative Care &amp; Quality Patient</p>	<ul style="list-style-type: none"> <li>• Welcome <ul style="list-style-type: none"> <li>○ Welcome participants</li> <li>○ Introduce instructors</li> <li>○ Introduce other team members</li> </ul> </li> </ul>
<p>When you are a learner, which animal do you most identify with?</p> 	<ul style="list-style-type: none"> <li>• Ask participants to share their answers in the chat</li> </ul>
<p>When you have an ACP conversation, which animal mascot do you want to accompany you?</p> 	<ul style="list-style-type: none"> <li>• Ask participants to share their answers in the chat</li> </ul>


<ul style="list-style-type: none"> <li>• Where you are geographically located</li> <li>• How many years as a social worker</li> <li>• How many years at your dialysis organization</li> </ul>	<ul style="list-style-type: none"> <li>• Ask participants to share their answers in the chat</li> </ul>
<h2 style="text-align: center;">Baseline Survey</h2>	<ul style="list-style-type: none"> <li>• Invite participants to complete <a href="#">a survey like this one</a>.</li> <li>• Explain that this survey is designed to measure your current comfort level with advance care planning in the dialysis setting</li> <li>• Note: Survey results are shared in Session 3.</li> </ul>
<h2 style="text-align: center;">QR Code CME</h2>	<ul style="list-style-type: none"> <li>•</li> </ul>
 <p><b>HIGHWAY ROADMAP</b> <b>HIGHway</b> Home Individual Goals &amp; Hopes</p> <p>• Listen, reflect and offer empathy throughout "Empathy is the gas that fuels the conversation"</p> <p>1. WELCOMING BEGINNING 2. VALUES DISCUSSION 3. EXPLORING THE HEALTHCARE AGENT 4. REVIEWING THE ADVANCE DIRECTIVE 5. EXPANDING THE CONVERSATION 6. PLANNING FOR MAKING Wishes ACTIONABLE</p>	<ul style="list-style-type: none"> <li>• Introduce the HIGHway project <ul style="list-style-type: none"> <li>○ The purpose/why</li> <li>○ The schedule</li> <li>○ The to do's</li> <li>○ What happens at each step</li> </ul> </li> <li>• Play or refer participants to the <a href="#">HIGHWay Project: Implementing Advanced Care Planning for Dialysis Patients video</a> (1:32)</li> </ul>



- On-line etiquette
  - Write out your name
  - Mute
  - Camera on
- Ground-rules
  - A safe place for sharing professionally challenging situations
  - Respect confidentiality
- Respect diversity of views

**Understanding Terms (10 minutes)**

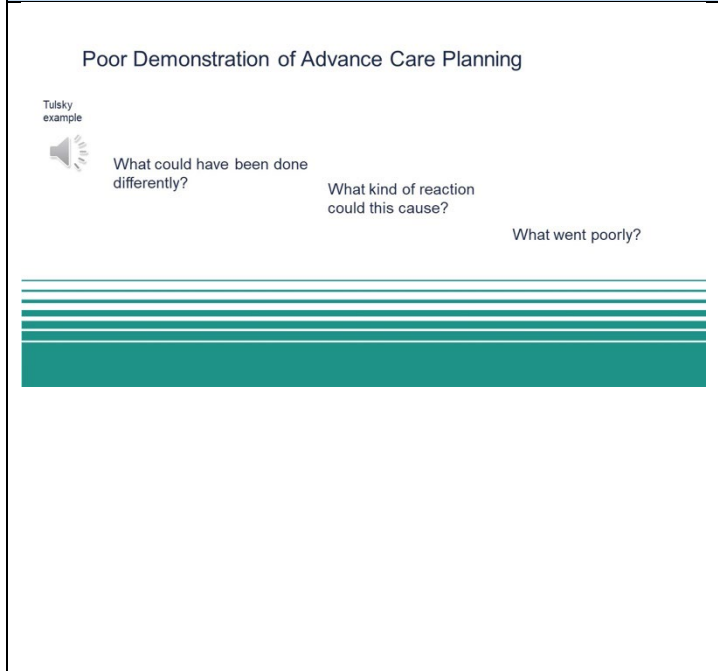
Slide	Facilitator Notes				
<p style="text-align: center;"><b>Understanding Terms</b></p> <p style="text-align: center;">Advance Care Planning vs. Shared Decision-Making vs. Goals of Care Conversations</p> 	<ul style="list-style-type: none"> <li>• On the right is shared decision-making: working with a person or their proxy who is participating in the decision</li> <li>• On the left is advanced care planning: enabling people to have their goals and preferences be known and guide their care if they are not able to make decisions for themselves.</li> <li>• Invite participants to ask questions or share thoughts</li> <li>• Refer participants to <a href="#">Advanced Care Planning Conversations: Basic Terms &amp; Concepts</a> recorded presentation to learn more.</li> </ul>				
<p style="text-align: center;"><b>Religion vs. Spirituality</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #00a68a; color: white; text-align: center; padding: 5px;">Religion</td> <td style="background-color: #76b82a; color: white; text-align: center; padding: 5px;">Spirituality</td> </tr> <tr> <td style="padding: 5px;"> <ul style="list-style-type: none"> <li>• Organized, shared beliefs by a community of like-minded</li> </ul> </td> <td style="padding: 5px;"> <ul style="list-style-type: none"> <li>• Individualized practice with focus on one's purpose in life or connection to something greater</li> </ul> </td> </tr> </table> <p style="font-size: small; margin-top: 10px;">Altilio, M. Otis-Green, S. &amp; Cagle, J. (Eds.). (2022). Oxford textbook of palliative social work. 2nd Ed. Oxford University Press. New York.</p>	Religion	Spirituality	<ul style="list-style-type: none"> <li>• Organized, shared beliefs by a community of like-minded</li> </ul>	<ul style="list-style-type: none"> <li>• Individualized practice with focus on one's purpose in life or connection to something greater</li> </ul>	<ul style="list-style-type: none"> <li>• Conflating these 2 can cause problems- assumptions about community support</li> <li>• Provider discomfort here</li> <li>• Refer participants to the <a href="#">Spiritual Dimensions in Advance Care Planning</a> recorded presentation to learn more.</li> </ul>
Religion	Spirituality				
<ul style="list-style-type: none"> <li>• Organized, shared beliefs by a community of like-minded</li> </ul>	<ul style="list-style-type: none"> <li>• Individualized practice with focus on one's purpose in life or connection to something greater</li> </ul>				

<p><b>Cultural Humility</b></p> <p>Develop understanding of historical, cultural and personal significance of diagnosis</p>		<ul style="list-style-type: none"> <li>•</li> </ul>
<p><b>ABCDE Model for Cultural Assessment</b></p>	<ul style="list-style-type: none"> <li>Attitudes of patients and families</li> <li>Beliefs</li> <li>Context</li> <li>Decision-making style</li> <li>Environment</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>

Alttilio, M. Otis-Green, S. & Cagle, J. (Eds.). (2022). Oxford textbook of palliative social work. 2nd Ed. Oxford University Press. New York.


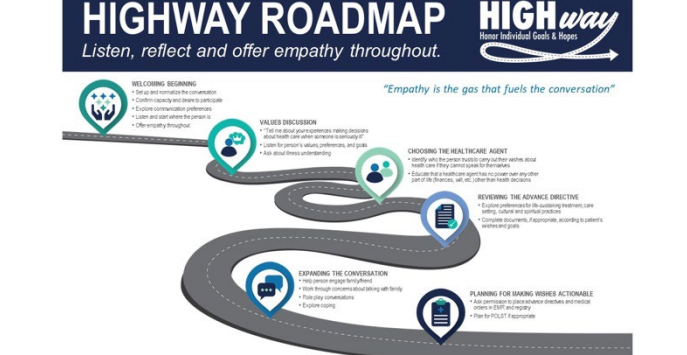
Alttilio, M. Otis-Green, S. & Cagle, J. (Eds.). (2022). Oxford textbook of palliative social work. 2nd Ed. Oxford University Press. New York.

**Poor Demonstration of Advanced Care Planning (10 minutes)**

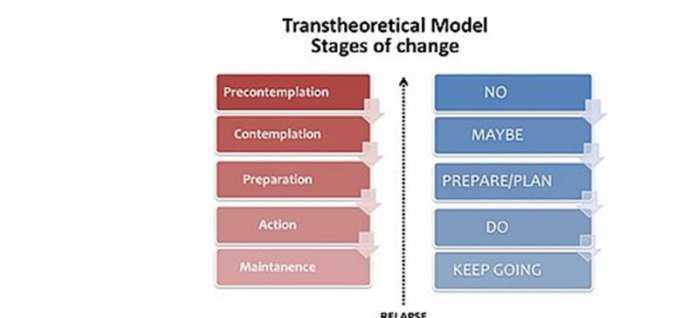
Slide	Facilitator Notes
<p>Poor Demonstration of Advance Care Planning</p> <p>Tulsky example</p> 	<ul style="list-style-type: none"> <li>• Play audio clip, then have participants respond to the following questions via audio or chat: <ul style="list-style-type: none"> <li>○ What could have been done differently</li> <li>○ What kind of reaction could this cause</li> </ul> </li> <li>• What went poorly Sometimes the conversation is uncomfortable because we don't have a crystal ball</li> <li>• Ask: What would have happened if it were a patient who did want heroic measures?</li> <li>• Take home message – be neutral. Any decision is fine as long as people have the opportunity to understand, think through and make their wishes known.</li> </ul>



## HIGHWay Roadmap (10 minutes)

Slide	Facilitator Notes
 <p><b>HIGHWAY ROADMAP</b> Honor Individual Goals &amp; Hopes Listen, reflect and offer empathy throughout "Empathy is the gas that fuels the conversation"</p> <p>WELCOMING BEGINNING • Set up and minimize the time needed</p> <p>VALUES DISCUSSION • Set up and minimize the time needed</p> <p>CHOOSING THE HEALTHCARE AGENT • Family with the person needs to meet with them before their health care</p> <p>REVIEWING THE ADVANCE DIRECTIVE • Help person engage throughout</p> <p>EXPANDING THE CONVERSATION • Help person engage throughout</p> <p>PLANNING FOR MAKING WISHES ACTIONABLE • Help person engage throughout</p>	<ul style="list-style-type: none"> <li>Review roadmap as a framework for future sessions</li> <li>Emphasize importance of adapting with principles of cultural humility and incorporating spirituality</li> </ul>
 <p><b>HIGHWAY ROADMAP</b> Listen, reflect and offer empathy throughout. "Empathy is the gas that fuels the conversation"</p> <p>WELCOMING BEGINNING • Set up and minimize the time needed • Listen, reflect and offer empathy throughout • Offer empathy throughout</p> <p>VALUES DISCUSSION • Set up and minimize the time needed • Listen to person's values, preferences, and goals • Ask about their understanding</p> <p>CHOOSING THE HEALTHCARE AGENT • Family with the person needs to meet with them before their health care • Family with the person needs to meet with them before their health care</p> <p>REVIEWING THE ADVANCE DIRECTIVE • Help person engage throughout • Review understanding of the document • Complete document, if appropriate, according to patient's preferences/goals</p> <p>EXPANDING THE CONVERSATION • Help person engage throughout • Share through conversation/understanding with family • Provide information • Acknowledging</p> <p>PLANNING FOR MAKING WISHES ACTIONABLE • Help person engage throughout • Set up and minimize the time needed • Plan for POLST appointment</p>	<ul style="list-style-type: none"> <li>It is a windy road that goes off in different directions.</li> </ul>

## Motivational Interviewing Overview (10 minutes)

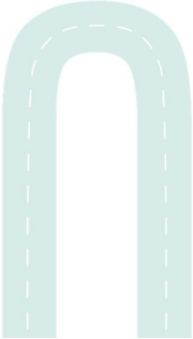
Slide	Facilitator Notes
 <p><b>Transtheoretical Model Stages of change</b></p> <p>Precontemplation Contemplation Preparation Action Maintenance</p> <p>NO MAYBE PREPARE/PLAN DO KEEP GOING</p> <p>RELAPSE</p> <p>Source: <a href="https://en.wikipedia.org/wiki/Transtheoretical_model">https://en.wikipedia.org/wiki/Transtheoretical_model</a></p>	<ul style="list-style-type: none"> <li>We can use this model for all kinds of things (e.g., quit smoking)</li> <li>Precontemplation: No, I'm not doing this, haven't thought about it (e.g., I love my cigarettes, don't even think about taking them from me)</li> <li>Contemplation: Ambiguousness, dropping hints, thinking about what are the things that might be positive about this change.</li> <li>Preparation: Actively planning to do something (e.g., on Tuesday, I'm going to throw my cigarettes away; on call to family about advanced directive, they say they've heard about it, they are on the cusp of doing something about it)</li> </ul>



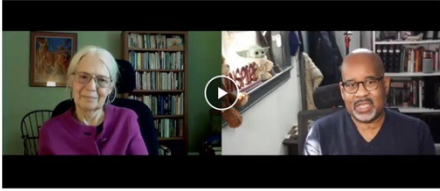
	<ul style="list-style-type: none"> <li>• Action: Actively changing. (e.g., I filled out the form, need to get it to my Dr.)</li> <li>• Maintenance: I've made this change, but I may change my mind (e.g., used to want aggressive treatment, now I don't want it).</li> <li>• Relapse: With any behavior change, relapse is a normal part of the process. We don't see relapse as a failure, but as new information that will help us next time.</li> </ul>
<p>Which best describes the majority of your patients?</p> <ul style="list-style-type: none"> <li>a. Pre contemplative – I've heard of advanced care planning, but it's not for me.</li> <li>b. Contemplative – I've heard of advanced care planning, and would like to know more.</li> <li>c. Preparation – I am ready to work on an advanced care plan.</li> <li>d. Action – I am having conversations with my family and Dr. right now!</li> <li>d. Maintenance – I've done advanced care planning and I'm willing to revisit it.</li> </ul>	<ul style="list-style-type: none"> <li>• Use polling feature or ask participants to post their answer in the chat.</li> </ul>
<h2>Motivational Interviewing</h2> <ul style="list-style-type: none"> <li>• Open Ended Questions</li> <li>• Listen/Empathy</li> <li>• Inform Sparingly</li> <li>• Resist the Righting Reflex</li> <li>• Roll with Resistance</li> </ul>	<ul style="list-style-type: none"> <li>• Review MI concepts</li> <li>• Invite participants to ask questions or share thoughts</li> <li>• Refer participants to <a href="#">Motivational Interviewing</a> recorded presentation (29:31) and Motivational Interviewing Handout (Appendix A) to learn more about motivational interviewing.</li> </ul>

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**Motivational Interviewing Role Play (30 minutes)**

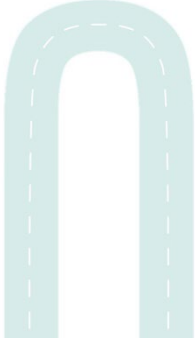


Slide	Facilitator Notes
<p style="text-align: center;"><b>Slide</b></p> <p><b>Motivational Interviewing Counts Worksheet Role Play</b></p> <p>Record (tic marks) how often the Social Worker does the following:</p> <p><u>Asking</u></p> <ul style="list-style-type: none"> <li>○ Open ended</li> <li>○ Closed ended</li> </ul> <p><u>Listening/Reflective Statement</u></p> <p><u>Empathetic Statement</u></p> <p><u>Informing</u></p> <ul style="list-style-type: none"> <li>○ With permission</li> <li>○ Without permission</li> </ul> <ol style="list-style-type: none"> <li>1. Examples of <u>flexibility</u></li> <li>2. Examples of <u>Resist the Righting Reflex</u></li> <li>3. Examples of <u>Rolling with Resistance</u></li> <li>4. Examples of allowing/elevating awareness of <u>Ambiguity</u></li> </ol> 	<ul style="list-style-type: none"> <li>● Refer participants to the Motivational Interviewing Counts Worksheet (Appendix B).</li> <li>● Review and explain the worksheet. <ul style="list-style-type: none"> <li>○ Participants should use it to make note of open/closed questions, listening/reflective statements, empathetic statements, informing with and without permission demonstrated in the role play.</li> <li>○ Note examples of flexibility, resisting the righting reflex, rolling with resistance and allowing/elevating awareness of ambiguity</li> </ul> </li> </ul>
<div style="background-color: #008080; color: white; padding: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <h2 style="margin: 0;">Role Play Scenario</h2> <p style="font-size: small; margin-top: 10px;">Are you going to try to start talking to me about dying? I've heard this conversation before and I want no part of this!"</p> </div> <div style="width: 50%; padding-left: 20px;"> <p>Female with ESRD, diabetes and high blood pressure.</p> <p>6 months on dialysis-relatively well controlled.</p> <p>Married 50 years</p> <p>First meeting with SW</p> </div> </div> </div>	<ul style="list-style-type: none"> <li>● Tell participants you will role-play a conversation based on the scenario.</li> <li>● Facilitators role-play conversation. <ul style="list-style-type: none"> <li>○ The social worker starts by asking if she was to get really sick and couldn't speak for herself, who would she want to speak for her. Janet responds with responds with... "Are you going to try to start talking to me about dying? I've heard this conversation before and I want no part of this!"</li> </ul> </li> <li>● Revisit role-play, switching roles.</li> <li>● Model getting stuck and working through.</li> <li>● Debrief scenario by asking participants to share their observations.</li> <li>● Model debriefing: <ul style="list-style-type: none"> <li>○ Were you able to use the motivational interviewing skills? Were they helpful?</li> <li>○ What would you do differently?</li> <li>○ What would you do next?</li> <li>○ Ask the patient how it felt.</li> </ul> </li> </ul>

**Giving Control Back to the Patient (10 minutes)**

Slide	Facilitator Notes
<p style="text-align: center;"><b>Giving Control Back to the Patient</b></p>  <p style="font-size: small;">Video-taped interview with John as a part of a teaching tool for helping patients and family members cope with the impacts of COVID-19. January 2021.  <a href="https://qwu.box.com/s/trzcnfayb39ew4pxruqstq74o33stb9m">https://qwu.box.com/s/trzcnfayb39ew4pxruqstq74o33stb9m</a></p>	<ul style="list-style-type: none"> <li>• Play video: John discusses the importance of providers taking the time to give control back to the patient/fully listening to the patient; what it means to be a patient and having to be assertive</li> <li>• We thought this was a good example of what we've discussed today.</li> <li>• Invite participants to share thoughts and reflections.</li> </ul>

**Closing (10 minutes)**

Slide	Facilitator Notes
 <p style="text-align: center;"><b>Rejuvenation</b></p> <p style="text-align: center;">The 5 senses</p> <p style="text-align: center;"><b>Grounding Technique: Resting attention in the senses</b></p> <p style="font-size: x-small;">"I learned about a quick technique that helps people when they are feeling anxious or panicked. Would you like to hear about it (or do it with me)?"</p> <p style="font-size: x-small;">Relaxation Techniques Video:  <a href="https://www.youtube.com/watch?v=RHpTR2wRc8c">https://www.youtube.com/watch?v=RHpTR2wRc8c</a></p> <p style="font-size: x-small;">Allow your eyes to softly scan your surroundings. Gently notice 5 things you see that give you pleasure. Now close your eyes. Notice          4 sounds          3 smells          2 sensations on your skin          1 taste.          Take in a breath.          Open your eyes.</p> <p style="font-size: x-small;">This technique can also be used by staff to ground and calm before a difficult patient encounter.</p>	<p>This technique works by bringing the attention to the sensory experience of this moment. Grounding in present sensory experience – the lived reality of this moment – helps the mind let go of incessant redoing of the past or worry about the future. This technique can also be used by staff to ground and calm before a difficult patient encounter.</p> <p><a href="#">Relaxation Techniques Video</a></p> <p><b>Facilitator Script</b>          I learned about a quick technique that helps people when they are feeling anxious or panicked. Would you like to hear about it (or do it with me)?          Allow your eyes to softly scan your surroundings.          Gently notice 5 things you see that give you pleasure. Now close your eyes.          Notice 4 sounds          3 smells          2 sensations on your skin          1 taste.          Take in a breath.</p>

	<p>Open your eyes.</p>
<h2>Next Steps</h2> <p>Homework: Consider how this might work in your dialysis center:</p> <ul style="list-style-type: none"> <li>• Who are your allies?</li> <li>• What are the barriers?</li> <li>• Can you identify one or two things you'd like to try?</li> </ul> <p>Supplemental materials:</p> <ul style="list-style-type: none"> <li>• <a href="#">Advanced Care Planning Conversations: Basic Terms &amp; Concepts</a></li> <li>• <a href="#">Motivational Interviewing</a></li> <li>• <a href="#">Spiritual Dimensions in Advance Care Planning</a></li> <li>• <a href="#">Principles to Guide the Conversation</a></li> </ul> 	<ul style="list-style-type: none"> <li>• Review homework</li> <li>• Distribute the following question by email or survey to gather examples to weave throughout the training: <ul style="list-style-type: none"> <li>○ Without using any PHI, describe a challenging or difficult situation you have had in doing advance care planning. It can be with a patient, family member, team member, organization, etc.</li> </ul> </li> <li>• Refer to supplemental materials</li> <li>• Preview of next session: <ul style="list-style-type: none"> <li>○ More on using empathy as “the gas” to move the conversation</li> <li>○ Differing patient perspectives on why ACP is useful – or not</li> </ul> </li> </ul>
 <h2>CE and CME Evaluation Link:</h2> 	<ul style="list-style-type: none"> <li>• Add CE or CME evaluation survey here if appropriate</li> </ul>

## Session 2: Advance Care Planning Conversations

### Agenda

Time	Topic	Minutes
00:00 – 00:13	Opening/Sharing Experiences	13
00:13 – 00:18	Intersecting Concepts: HIGHway Roadmap & Readiness to Change	5
00:18 – 00:30	ACP Barriers & Facilitators	12
00:30 – 00:35	Tools for Moving the Conversation Forward	5
00:35 – 00:45	Emotion Words	10
00:45 – 00:55	Role Play: Putting Empathy into Words	10
05:55 – 01:00	Additional Practice: Naming Emotions	5
01:00 – 01:05	Break	5
01:05 – 01:10	The Beginning: How Do You Start the Conversation?	5
01:10 – 01:15	The Middle of the Journey	5
01:15 – 01:40	Role Play: Challenging Scenarios	25
01:40 – 01:50	The End of the Journey: Documenting, Communicating to Others	10
01:50 – 02:00	Closing	10

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### Learning Objectives:


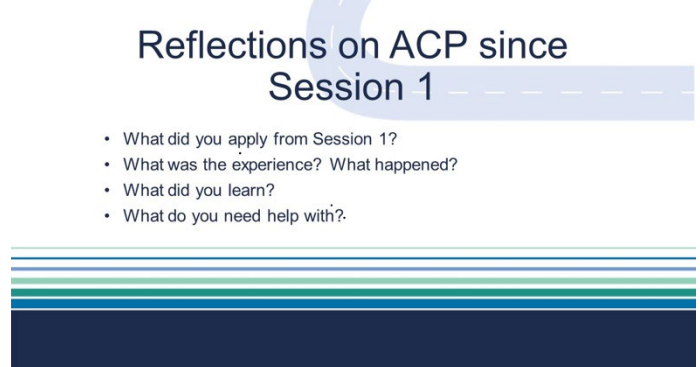
- Apply motivational interviewing techniques to conduct empathetic advance care planning (ACP) conversations to learn what a dialysis patient wants for their future care
- Adapt ACP conversation to the stage of change of the participant
- Reflect on barriers and facilitators experienced while conducting ACP conversations
- Facilitate advance care planning for a patient with chronic kidney disease using the HIGHWay Roadmap framework
- Describe documents used to make patient wishes actionable
- Assist in completion of goals of care, advanced directives and medical orders

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### Supplemental Materials:

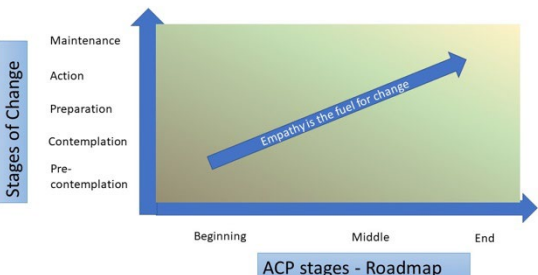
- [Principles to Guide the Conversation](#) Recorded presentation (24:41)
- Empathy Word Worksheet (Appendix C)
- [Effective Empathetic Communication](#) video (3:23)

**Opening/Sharing Experiences (13 minutes)**

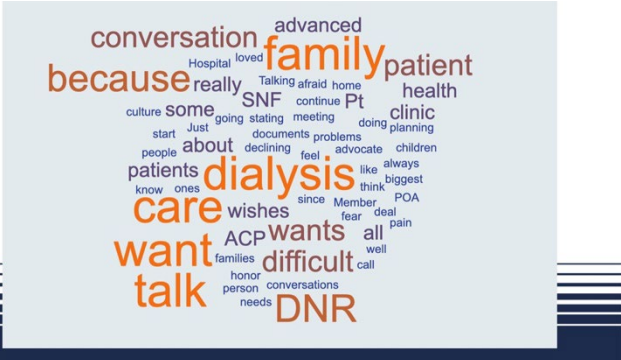


Slide	Facilitator Notes
 <p><b>Advance Care Planning Conversations</b></p>	<ul style="list-style-type: none"> <li>Review session agenda               <ul style="list-style-type: none"> <li>Further empathy skill-building</li> <li>Conversations at beginning, middle, end of roadmap</li> </ul> </li> </ul>
 <p><b>Reflections on ACP since Session 1</b></p> <ul style="list-style-type: none"> <li>What did you apply from Session 1?</li> <li>What was the experience? What happened?</li> <li>What did you learn?</li> <li>What do you need help with?</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate group discussion related to slide questions.</li> </ul>

**Intersecting Concepts: HIGHway Roadmap & Readiness to Change (5 minutes)**

Slide	Facilitator Notes
 <p><b>HIGHWAY ROADMAP</b>  <i>Listen, reflect and offer empathy throughout.</i></p> <p><i>"Empathy is the gas that fuels the conversation"</i></p> <p><b>WELCOMING BEGINNING</b></p> <ul style="list-style-type: none"> <li>Set up and normalize the conversation</li> <li>Define capacity and where to articulate</li> <li>Explore communication preferences</li> <li>Listen and start where the person is</li> <li>Offer empathy throughout</li> </ul> <p><b>VALUES DISCUSSION</b></p> <ul style="list-style-type: none"> <li>Talk first about your experiences, feelings, decisions about health care when someone is seriously ill</li> <li>Listen for person's values, preferences, and goals</li> <li>Ask about stress understanding</li> </ul> <p><b>CHOOSING THE HEALTHCARE AGENT</b></p> <ul style="list-style-type: none"> <li>Identify who the person trusts to care for them when about health care if they cannot speak for themselves</li> <li>Evaluate the healthcare agent like to choose them and other staff of the healthcare setting to make their health decisions</li> </ul> <p><b>REVISING THE ADVANCE DIRECTIVE</b></p> <ul style="list-style-type: none"> <li>Evaluate preferences for life-sustaining treatment, care setting, comfort and artificial nutrition</li> <li>Complete documents, if appropriate, according to capacity, wishes and goals</li> </ul> <p><b>EXPANDING THE CONVERSATION</b></p> <ul style="list-style-type: none"> <li>Help person engage family/friends</li> <li>Work through concerns about talking with family</li> <li>Explore coping</li> </ul> <p><b>PLANNING FOR MAKING THINGS ACTIONABLE</b></p> <ul style="list-style-type: none"> <li>Ask permission to share advance directives and medical orders in EHR and registry</li> <li>How to FOLLOW if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Review HIGHway Roadmap               <ul style="list-style-type: none"> <li>Beginning, middle and end of ACP are different skills</li> <li>At each stage, patient may have different level of readiness to engage</li> <li>Empathy helps move from one stage to the next</li> </ul> </li> </ul>

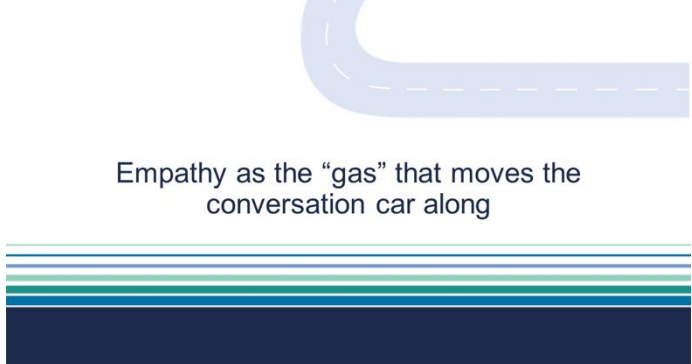
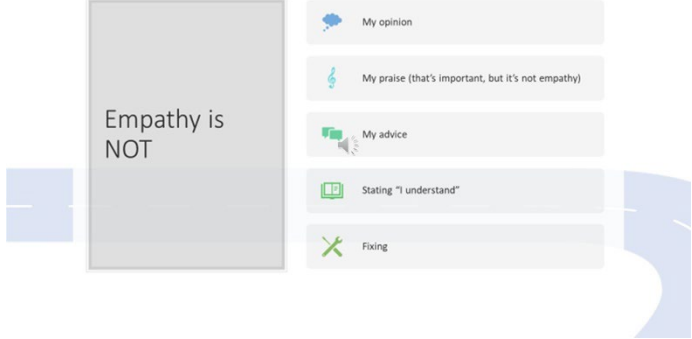
<p>Two intersecting concepts</p> 	<ul style="list-style-type: none"> <li>• Applying readiness to change to ACP</li> <li>• Lead discussion of where different patients fit in the space – upper or lower quadrants. E.g. Consider patient who may be ready to discuss a decision-maker, but not ready to fill our advance directive forms – where do they fit on this diagram? They may be high motivation in “middle” roadmap tasks but low motivation for “end” tasks.</li> </ul>
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**ACP Barriers & Facilitators (12 minutes)**


Slide	Facilitator Notes
	<ul style="list-style-type: none"> <li>• Facilitate sharing of challenges and strategies <ul style="list-style-type: none"> <li>○ You are not alone in facing challenges</li> </ul> </li> </ul>
<p>Breakout Groups: Discuss FMC Context from Homework (Allies/Barriers)</p>   <ul style="list-style-type: none"> <li>• Who are your allies?</li> <li>• What are your barriers?</li> <li>• Is the challenge at the beginning, middle or end of the roadmap?</li> <li>• Are patients looking ahead to what may come next?</li> <li>• Get the name and phone number of someone in your group you can call for help.</li> </ul>	<ul style="list-style-type: none"> <li>• Homework from session 1 was to think about allies and barriers.</li> <li>• Facilitate discussion in breakout groups</li> </ul>



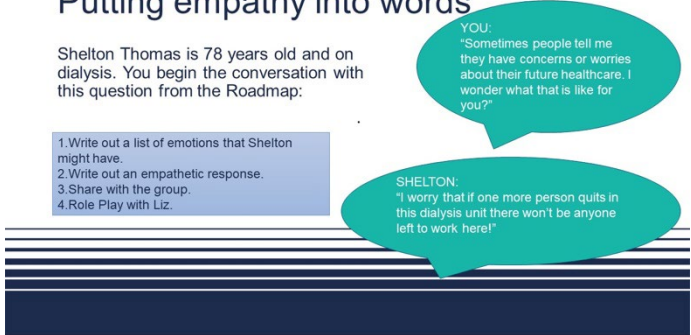
## Tools for Moving the Conversation Forward (5 minutes)

Slide	Facilitator Notes
 <p>Empathy as the “gas” that moves the conversation car along</p>	<ul style="list-style-type: none"> <li>Refer participants to <a href="#">Principles to Guide the Conversation</a> recorded presentation (24:41) to learn more about integrating empathy into ACP conversations.</li> </ul>
 <p>Empathy is NOT</p> <ul style="list-style-type: none"> <li>My opinion</li> <li>My praise (that's important, but it's not empathy)</li> <li>My advice</li> <li>Stating “I understand”</li> <li>Fixing</li> </ul>	<ul style="list-style-type: none"> <li>Part of skill building related to conversation skills is being able to accurately identify and label what is coming out of our mouth.</li> <li>What is empathy and what is it not? (These are not all bad things, but they are not empathy)</li> <li>Empathy is the ability to accurately identify where someone is emotionally.</li> <li>It is not my opinion. My opinion might be important, but it is not empathy (e.g., Dale, this advanced directive looks great!)</li> <li>Praise is important, but it is a different skill than empathy (e.g., Dale, I’m really proud of you for XYZ).</li> <li>Advice may be helpful, but not empathy.</li> <li>Remove the language of “I understand” – need to be able to articulate what it is you understand.</li> <li>Fixing – similar to advice – e.g., struggling with my son – hey, why don’t I have a phone call with both of you?</li> <li>Empathy is the ability to resonate and articulate the emotions of someone.</li> </ul>

## Emotion Words (10 minutes)

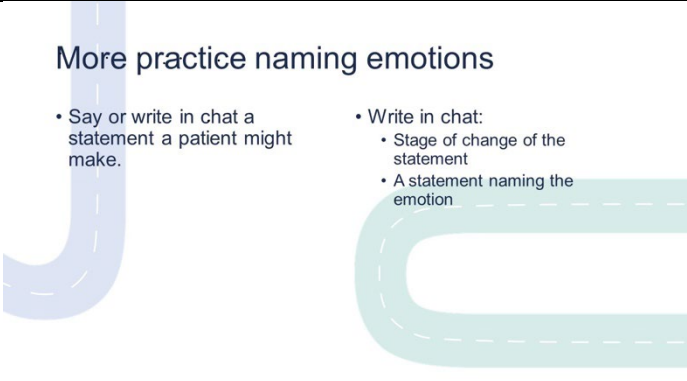
Slide	Facilitator Notes
<p data-bbox="306 432 805 499">Emotion words Refer to “Emotion Word Worksheet”</p>  <ul data-bbox="526 527 789 722" style="list-style-type: none"> <li>• It's <b>frightening</b> to think about how much turnover has happened in the dialysis unit.</li> <li>• You are <b>concerned</b> that your healthcare will be impacted by staffing issues.</li> <li>• You <b>worry</b> that without staff you won't get the dialysis you need.</li> </ul>	<ul data-bbox="880 432 1455 789" style="list-style-type: none"> <li>• Refer participants to Emotion Words Reference (Appendix C)</li> <li>• Ask participants to share a scenario appropriate for practicing using emotion words. If participants have nothing to share, refer to scenario in Appendix D.</li> <li>• Elicit participants suggestions for emotion words in response to the scenario</li> </ul>

## Role Play: Putting Empathy Into Words (10 minutes)

Slide	Facilitator Notes
<p data-bbox="224 1024 634 1062">Putting empathy into words</p> <p data-bbox="224 1083 529 1142">Shelton Thomas is 78 years old and on dialysis. You begin the conversation with this question from the Roadmap:</p>  <ol data-bbox="224 1171 461 1255" style="list-style-type: none"> <li>1. Write out a list of emotions that Shelton might have.</li> <li>2. Write out an empathetic response.</li> <li>3. Share with the group.</li> <li>4. Role Play with Liz.</li> </ol> <p data-bbox="623 1062 797 1157"><b>YOU:</b> "Sometimes people tell me they have concerns or worries about their future healthcare. I wonder what that is like for you?"</p> <p data-bbox="558 1213 786 1276"><b>SHELTON:</b> "I worry that if one more person quits in this dialysis unit there won't be anyone left to work here!"</p>	<ul data-bbox="880 1003 1455 1890" style="list-style-type: none"> <li>• Review slide with scenario &amp; prompts: <ul data-bbox="928 1041 1430 1188" style="list-style-type: none"> <li>○ Write out a list of emotions that Shelton might have.</li> <li>○ Write out an empathetic response.</li> <li>○ Share with the group</li> </ul> </li> <li>• Role play scenario</li> <li>• Invite participants to share their perspectives</li> <li>• Examples: <ul data-bbox="928 1356 1446 1661" style="list-style-type: none"> <li>○ It's frightening to think about how much turnover has happened in the dialysis unit.</li> <li>○ You are concerned that your healthcare will be impacted by staffing issues.</li> <li>○ You worry that without staff you won't get the dialysis you need.</li> </ul> </li> <li>• Explore these statements with the audience. For example, if you respond with "you worry that without the staff you won't get the dialysis you need." How might Shelton respond? How could you refocus to advance care planning?</li> </ul>

	<ul style="list-style-type: none"> <li>• Take-Aways: <ul style="list-style-type: none"> <li>○ Hold off on “fixing” at this point.</li> <li>○ Hold space for person to express values. People often give us cues about what they value.</li> </ul> </li> </ul>
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**Additional Practice: Naming Emotions (5 minutes)**

Slide	Facilitator Notes
<p>More practice naming emotions</p> <ul style="list-style-type: none"> <li>• Say or write in chat a statement a patient might make.</li> <li>• Write in chat: <ul style="list-style-type: none"> <li>• Stage of change of the statement</li> <li>• A statement naming the emotion</li> </ul> </li> </ul> 	<ul style="list-style-type: none"> <li>• Ask participants for patient statements that stump them</li> <li>• Participants write out “name the emotion” statements and put in chat</li> </ul>

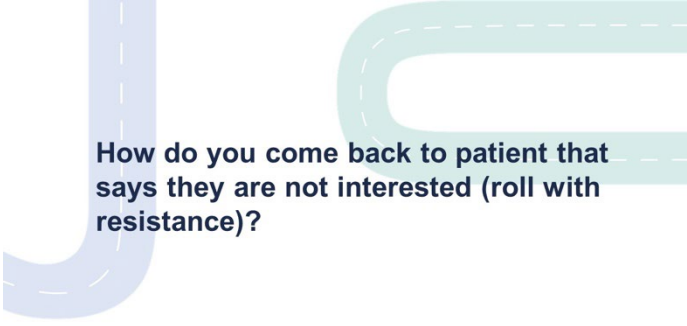
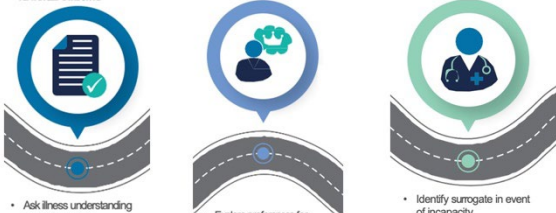

**Break (5 minutes)**

Slide	Facilitator Notes
	

## The Beginning: How Do you Start the Conversation? (5 minutes)

Slide	Facilitator Notes
<div data-bbox="224 401 792 751"> <p><b>HIGHWAY ROADMAP</b> Honor Individual Goals &amp; Hopes</p> <p><i>"Empathy is the gas that fuels the conversation"</i></p> <ul style="list-style-type: none"> <li>• Listen, reflect and offer empathy throughout.</li> </ul> <p><b>WELCOMING BEGINNING</b></p> <ul style="list-style-type: none"> <li>• Set up and normalize the conversation</li> <li>• Confirm capacity and desire to participate</li> <li>• Explore communication preferences</li> <li>• Listen and start where the person is</li> <li>• Offer empathy throughout</li> </ul> <p><b>VALUES DISCUSSION</b></p> <ul style="list-style-type: none"> <li>• "Tell me about your experiences, feelings, decisions about health care when someone is seriously ill"</li> <li>• Listen for person's values, preferences, and goals</li> <li>• Ask about stress understanding</li> </ul> <p><b>CHOOSING THE HEALTHCARE AGENT</b></p> <ul style="list-style-type: none"> <li>• Identify who the person wants to care for their wishes about health care if they cannot make their own decisions</li> <li>• Evaluate the healthcare agent like to provide care and other staff of the healthcare, ask about their health decisions</li> </ul> <p><b>REVISING THE ADVANCE DIRECTIVE</b></p> <ul style="list-style-type: none"> <li>• Explore preferences for life-sustaining treatment, care setting, cultural and spiritual practices</li> <li>• Complete documents, if appropriate, according to capacity, wishes and goals</li> </ul> <p><b>EXPANDING THE CONVERSATION</b></p> <ul style="list-style-type: none"> <li>• Help person engage family/friends</li> <li>• Work through concerns about talking with family</li> <li>• Talk about conversations</li> <li>• Explore coping</li> </ul> <p><b>PLANNING FOR MAKING THINGS ACTIONABLE</b></p> <ul style="list-style-type: none"> <li>• Ask permission to place advance directives and medical orders in EHR and registry</li> <li>• Plan to FOLLOW if appropriate</li> </ul> </div>	<ul style="list-style-type: none"> <li>• Remind participants about Roadmap sections – emphasizing beginning, middle, end</li> <li>• Relate the barriers and facilitators shared in prior discussion with stops on the roadmap.</li> <li>• Relate any specific examples shared of challenging patient situations to where they are on the roadmap</li> </ul>
<p data-bbox="212 785 709 852">What are the important principles to follow at the beginning of ACP?</p> <ul style="list-style-type: none"> <li>• Speak up or chat in</li> </ul>	<ul style="list-style-type: none"> <li>• Ask participants to share their answers via video/voice or chat.</li> </ul>
<div data-bbox="168 1163 852 1514"> <p><b>How do you start the conversation?</b></p> <p><b>WELCOMING BEGINNING</b></p> <ul style="list-style-type: none"> <li>• Set up and normalize the conversation</li> <li>• Confirm capacity and desire to participate</li> <li>• Explore communication preferences</li> <li>• Listen and start where the person is</li> <li>• Offer empathy throughout</li> </ul> <p>• Steps to include:</p> <p>#1: Values, concerns, preferences – ASK. Listen, Empathy.</p> <p>Assessing information preferences – ASK</p> <p>Assessing illness understanding – ASK</p> </div>	<ul style="list-style-type: none"> <li>• There will be circling back – you will be with patients for years and their goals may change.</li> <li>• Asking is a good place to start: about their wishes; their understanding of their illness; what their preferences are (e.g., Do they like to talk about everything? Do they like family members to handle it?)</li> <li>• Roll with resistance</li> </ul>


**The Middle of the Journey (5 minutes)**

Slide	Facilitator Notes
<p><b>How do you come back to patient that says they are not interested (roll with resistance)?</b></p> 	<ul style="list-style-type: none"> <li>• Listen for motivations</li> </ul>
<p><b>The middle of the journey</b></p>  <ul style="list-style-type: none"> <li>• Ask illness understanding and information preferences</li> <li>• Assess decision-making capacity</li> <li>• Explore preferences for life-sustaining treatment</li> <li>• Complete documents, if appropriate, according to patient's wishes and goals</li> <li>• Identify surrogate in event of incapacity</li> </ul>	<ul style="list-style-type: none"> <li>• Review these portions of the roadmap related to the middle of the journey</li> <li>• Ask/Discuss:             <ul style="list-style-type: none"> <li>○ When you go in to ask people about their health, what do you hear from patients?</li> <li>○ Do they seem to have a good sense of disease trajectory?</li> <li>○ Are they realistic, unrealistic?</li> </ul> </li> </ul>
<p><b>The middle of the roadmap</b></p> <ul style="list-style-type: none"> <li>• Tools for moving the conversation forward             <ul style="list-style-type: none"> <li>• MI tools</li> <li>• "Empathy is the gasoline to move the car"</li> </ul> </li> </ul> 	<ul style="list-style-type: none"> <li>• History has taught us that asking people about advance directives in a cold/clinical way contributes to resistance</li> </ul>

**Role Play: Challenging Scenarios (25 minutes)**

Slide	Facilitator Notes
<p><b>Role Play: Challenging Scenarios</b></p> <ul style="list-style-type: none"> <li>• Conflict between family &amp; patient</li> <li>• Participant is afraid to talk to loved ones about ACP</li> <li>• Addressing “I want to leave this in God’s hands”</li> </ul> <div style="background-color: #00a68a; color: white; padding: 10px; margin: 10px 0;"> <ul style="list-style-type: none"> <li>• How would you use motivational interviewing in this situation?</li> <li>• Where on the roadmap would you address this challenge?</li> </ul> </div>	<ul style="list-style-type: none"> <li>• Present challenge(s)</li> <li>• Give participants 5 minutes to address the questions on the slides.</li> <li>• Invite participant(s) to share ideas verbally or in the chat</li> </ul>
<p><b>Role Play instructions</b></p> <p>Breakout – groups of 4 2 people role play a challenging situation of your choice Other 2 people take notes</p> <p>Count</p> <ul style="list-style-type: none"> <li>- open ended questions</li> <li>- close ended questions (yes/no questions)</li> <li>- emotion naming statements (empathy)</li> <li>- other statements (not empathy)</li> </ul> <p>Discuss</p> <p>Switch to allow 2 more people to role play Take notes, discuss</p>	

**The End of the Journey: Documenting, Communicating to Others (25 minutes)**

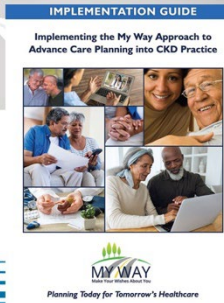
Slide	Facilitator Notes
<p>The end of the journey: Forms, medical orders, discussions with providers and family</p>  <p><b>REVIEWING THE ADVANCE DIRECTIVE</b></p> <ul style="list-style-type: none"> <li>• Explore preferences for life-sustaining treatment, care setting, cultural and spiritual practices</li> <li>• Complete documents, if appropriate, according to patient’s wishes and goals</li> </ul> <p><b>PLANNING FOR MAKING WISHES ACTIONABLE</b></p> <ul style="list-style-type: none"> <li>• Ask permission to place advance directives and medical orders in EMR and registry</li> <li>• Plan for POLST if appropriate</li> </ul> <p><b>EXPANDING THE CONVERSATION</b></p> <ul style="list-style-type: none"> <li>• Help person engage family/friend</li> <li>• Work through concerns about talking with family</li> <li>• Role play conversations</li> <li>• Explain coping</li> </ul>	<ul style="list-style-type: none"> <li>• This has tended to be the starting place for discussions in many dialysis facilities: “do you have an advance directive”? While that is fine as an assessment question, if patient says “no” it’s hard to know where to go from there.</li> <li>• Having completion of forms flow from the earlier steps on the roadmap is usually more successful approach. Builds on patient values, makes it easier for patient to articulate what they want and document it in forms.</li> </ul>

## Recommended Resources

- MY WAY coach and patient guides
- <https://go.gwu.edu/mywayguides>



- Coach guide
- Patient guide
- Implementation guide



- Describe and refer participants to resources
- Three recommended sets of resources:
  - My Way – develop specifically for patients with kidney disease. Based on motivational interviewing. Patient guide and guide for “coach” freely available
  - PREPARE for your care
    - Source for patient friendly forms for every state, multiple languages. Also has patient website that guides patients through filling out forms.
  - National POLST website – has separate information for patients and professionals

## IMPLEMENTATION GUIDE

- Motivate** staff to embrace Advance Care Planning
- Your** charting & billing systems are standardized
- Workflows** implemented & optimized
- Advance** Care Planning forms available
- Yearly** updates are included

- My Way summary of steps for implementing more advance care planning

## Recommended Resources

- Links to PREPARE and POLST
- Emphasize that participants should become familiar with PREPARE resources and POLST resources. PREPARE form in particular is much more patient friendly than many state forms.



## Question about POLST procedures – what if colored original not available?

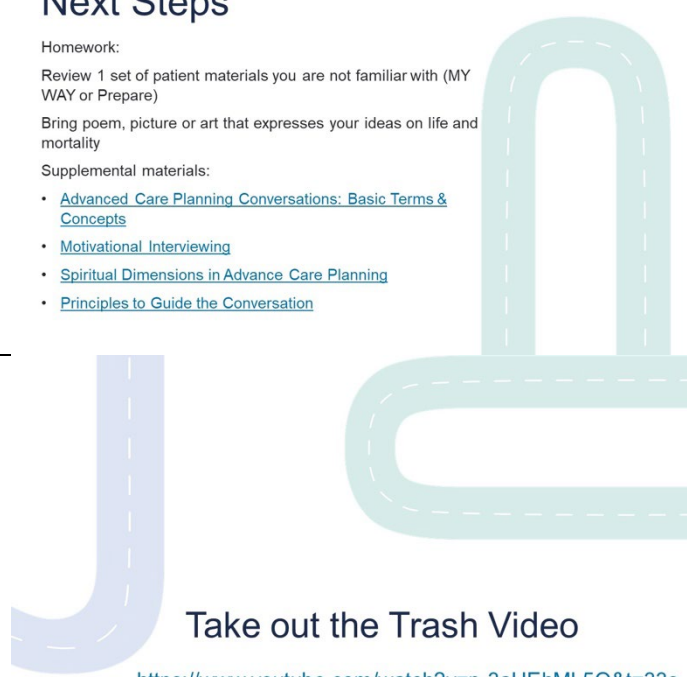
### • Answers from National POLST Organization State by State summary

<https://polst.org/wp-content/uploads/2021/04/2021.04.05-POLST-State-Laws-and-Regulations-Grid.pdf>

Topic	New Jersey	New York	Pennsylvania
Original vs. Copies/faxes?	Original recommended; copies also valid (in NJ Guidelines for Implementation) [see form]	Pink original is preferred. Copies, fax and electronic representation are legal and valid orders.	Print on pulsar pink card stock recommended. Copies valid [see form]
Terminology	Practitioner Orders for Life-Sustaining Treatment (POLST)	Medical Orders for Life-Sustaining Treatment (MOLST)	Pennsylvania Orders for Life-Sustaining Treatment (POLST)
Web page for additional resources	<a href="http://www.njha.com/qualitypatient-safety/advancecare-planning/polst">www.njha.com/qualitypatient-safety/advancecare-planning/polst</a> and <a href="http://www.qualitycare.org/jo-ist-form">www.qualitycare.org/jo-ist-form</a>	NYSDOH MOLST page: <a href="http://www.nyhealth.gov/professionals/patient/patient_rights/index">www.nyhealth.gov/professionals/patient/patient_rights/index</a> MOLST.org: <a href="https://molst.org/">https://molst.org/</a>	Jewish Healthcare Foundation <a href="https://www.jahf.org/">https://www.jahf.org/</a> The Aging Institute at UPAC <a href="https://www.upac.com/Services/aginginstitute/aj/partnerships-andcollaborations/polst">https://www.upac.com/Services/aginginstitute/aj/partnerships-andcollaborations/polst</a>
Regulations	None. Guidance publication provided by the NJ Hospital Association at <a href="http://www.njha.com/qualitypatient-safety/advancecare-planning/polst">www.njha.com/qualitypatient-safety/advancecare-planning/polst</a>	Form approved by Dept. of Health and EMS practice changed to allow EMS to follow DNS, DNI, and MOLST orders, effective 7/8/08. <a href="http://www.nyhealth.gov/professionals/patient/patient_rights/molst">www.nyhealth.gov/professionals/patient/patient_rights/molst</a>	Secretary of Health approved a standard form called Pennsylvania Order for Life-Sustaining Treatment for use in Pennsylvania. October 24, 2010

- Discuss whether POLST or equivalent forms used in dialysis center. Discuss questions participants have about using such forms. Example question on slide – along with sample answers on POLST website,
- If participants hand POLST to patients directly, emphasize that POLST/MOLST aren't patient friendly forms and should be used in conjunction with patient friendly forms such as PREPARE or My Way patient guide.

## Closing (10 minutes)

Slide	Facilitator Notes
<p><b>Next Steps</b></p> <p>Homework:</p> <p>Review 1 set of patient materials you are not familiar with (MY WAY or Prepare)</p> <p>Bring poem, picture or art that expresses your ideas on life and mortality</p> <p>Supplemental materials:</p> <ul style="list-style-type: none"> <li>• <a href="#">Advanced Care Planning Conversations: Basic Terms &amp; Concepts</a></li> <li>• <a href="#">Motivational Interviewing</a></li> <li>• <a href="#">Spiritual Dimensions in Advance Care Planning</a></li> <li>• <a href="#">Principles to Guide the Conversation</a></li> </ul>	<ul style="list-style-type: none"> <li>• Review homework</li> <li>• Refer participants to supplemental materials</li> <li>• See Appendix X for additional guidance regarding art gallery to be shared at the next session.</li> </ul>
 <p><b>Take out the Trash Video</b></p> <p><a href="https://www.youtube.com/watch?v=p-3aHEhML5Q&amp;t=33s">https://www.youtube.com/watch?v=p-3aHEhML5Q&amp;t=33s</a></p>	<ul style="list-style-type: none"> <li>• Play video</li> </ul>
	<ul style="list-style-type: none"> <li>• CE or CME evaluation as appropriate</li> </ul>

## Guided relaxation exercises

"I would like to offer you a tool that many people who are experiencing a difficult illness/treatment find helpful. Would you feel comfortable closing your eyes and taking a few breaths? Focus on your breathing. Rest in the feeling of breath coming in and going out, like ocean waves. Now let your worries and thoughts pass by like clouds moving in the sky."

"Close your eyes. Starting with your feet, tighten all the muscles, and then let go suddenly with a big sigh. Move up to your whole leg. Tighten it, hold, and let go quickly with another sigh. Keep moving up your body, tightening and releasing each area. Finish by making a face like you are eating something very sour. Tighten your mouth, your eyes, and let go with a big sigh. Now starting at your head, imagine that warm chocolate is washing over you, letting every muscle relax and rest."

- Guided meditation for 1 minute
  - Use short guided meditation of facilitator's choice to help participants transition back to work duties
  - See appendix X for scripts

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## Session 3: Deepening the conversation, including family

Time	Topic	Minutes
00:00 – 00:10	Opening	10
00:10 – 00:20	Baseline Survey Results	10
00:20 – 00:30	Review Homework	10
00:30 – 00:40	AD Forms & POLST	10
00:40 – 00:50	What motivates people to engage in ACP?	10
00:50 – 01:00	Name the Motivation	10
01:00 – 01:05	Break	5
01:05 – 01:15	Family Involvement	10
01:15 – 01:25	Role Play: Family Involvement	10
01:25 – 01:40	Breakout Groups: Practice Family Involvement	15
01:40 – 01:50	Caregiver Assessment Questions	10
01:50 – 01:55	Art Gallery	5
01:55 – 02:00	Closing	5

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### Learning Objectives:



- Describe the range of patient perspectives related to ACP
- Describe the social worker’s role in leading the care coordination and hand-off process for goals of care conversations for a patient with chronic kidney disease
- Describe strategies to engage family members and resolve conflicts in ACP
- Integrate ACP into the social worker’s ongoing workflow
- Describe strategies for leadership and communication of ACP within an interdisciplinary care team

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### Supplemental Materials:

- [Key Concepts in ACP: The Patient’s Perspective](#) Recorded presentation (17:19)
- [Leading ACP in Teams](#) Recorded presentation (5:06)
- [Family Involvement in Advanced Directives](#) Recorded presentation (10:31)
- [Having the Conversation](#) video (4:00)

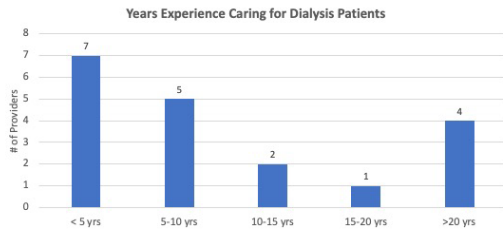
**Opening (10 minutes)**

Slide	Facilitator Notes
<p><b>Session 3 agenda</b></p> <hr/> <p>Share experiences with applying HIGHway to date</p> <hr/> <p>Discuss results of baseline survey – the “improvable middle”</p> <hr/> <p>Homework – resources for forms, patient education</p> <hr/> <p>What motivates people to engage in ACP?</p> <hr/> <p>Involving family in the process</p> <hr/> <p>Art gallery sharing</p> <hr/> <p>Next steps</p>	<ul style="list-style-type: none"> <li>• Review session agenda</li> </ul>
 <p>ACP experiences since last session</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p><b>GW</b> Nursing </p>	<ul style="list-style-type: none"> <li>• Share experiences since last session</li> </ul>

**Baseline Survey Results (10 minutes)**

Slide	Facilitator Notes
 <p><b>Baseline Survey Results</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p><b>GW</b> Nursing </p>	<ul style="list-style-type: none"> <li>• Share results from baseline survey of HIGHway participants in test             <ul style="list-style-type: none"> <li>○ ACP activities that are most, least doable.</li> <li>○ ACP activities that are the “improvable middle”</li> </ul> </li> </ul>

19/23 providers in Cohort B completed baseline survey:  
 12 nurses  
 7 social workers



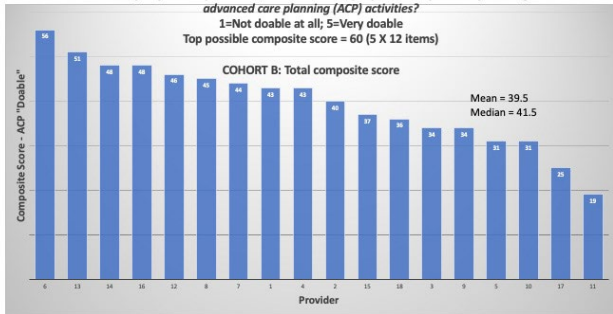
Currently at your dialysis center, how doable is it for you to carry out the following advanced care planning (ACP) activities?

- Q1. Introduce ACP to patients
- Q2. Have a private, quiet place for goals of care conversations with patients at dialysis center
- Q3. Have a private, quiet place for goals of care conversations with patients at dialysis center
- Q4. Document patient goals of care in the medical record
- Q5. Help patients complete advance directive forms
- Q6. Get completed advance directive (AD) forms into the dialysis center medical records
- Q7. Help patients enter their advance directives into an available registry or medical record
- Q8. Prepare POLST/MOLST forms with patients for further review and signature with their physician
- Q9. Know the time to revisit/revise advance care plan and associated documents
- Q10. Track where patients are in process of ACP and what is next step
- Q11. Work closely and have support of other team members for making ACP a regular part of care
- Q12. Use an app or algorithm to help your ACP process

- This slide to be replaced with summary of entire HIGHway project

These questions ask how “doable” each step of ACP process is

Currently at your dialysis center, how doable is it for you to carry out the following advanced care planning (ACP) activities?  
 1=Not doable at all; 5=Very doable  
 Top possible composite score = 60 (5 X 12 Items)



- This slide to be replaced with summary of entire HIGHway project

### Most and least “doable” ACP activities

**Hardest: scored <3 on “doable”**

- Help patients complete advance directive forms: mean = 2.8
- Help patients enter their advance directives into an available registry or medical record: mean =2.6
- Prepare POLST/MOLST forms with patients for further review and signature with their physician: mean =2.0

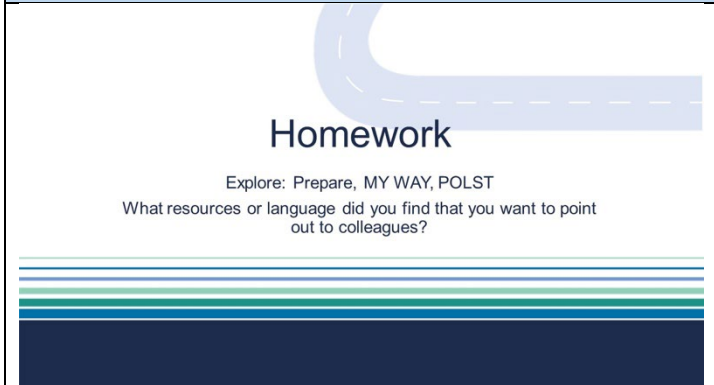
**Most doable: >3.5 on doable**

- Introduce ACP to patients: mean= 4.1
- Work closely and have support of other team members for making ACP a regular part of care: mean=3.8
- Document patient goals of care in the medical record: mean = 3.8
- Have a private, quiet place for goals of care conversations with patients at dialysis center: mean=3.7

- This slide to be replaced with summary of entire HIGHway project

<p>The improvable middle of “doable” ACP activities</p> <p>Middle scores: 3 to 3.5</p> <ul style="list-style-type: none"> <li>• Hold goals of care (GOC) conversations via telehealth: mean = 3.5</li> <li>• Get completed advance directive (AD) forms into the dialysis center medical records: mean =3.4</li> <li>• Track where patients are in process of ACP and what is next step: mean =3.4</li> <li>• Know the time to revisit/revise advance care plan and associated documents: mean=3.2</li> <li>• Use an app or algorithm to help your ACP process: mean =3.2</li> </ul>	<ul style="list-style-type: none"> <li>• This slide to be replaced with summary of entire HIGHway project</li> <li>• These are places to concentrate improvement activities – since they have room for improvement, but aren’t extremely difficult. This is the “low hanging fruit” for change</li> </ul>
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**Review Homework (10 minutes)**

Slide	Facilitator Notes
	<ul style="list-style-type: none"> <li>• Share homework – what did participants find useful in PREPARE, MY WAY, or POLST?</li> <li>• Note if VYNCA or other advance care planning programs in use, discuss how to help patients engage with those programs</li> </ul>

**AD Forms & POLST (10 minutes)**

Slide	Facilitator Notes
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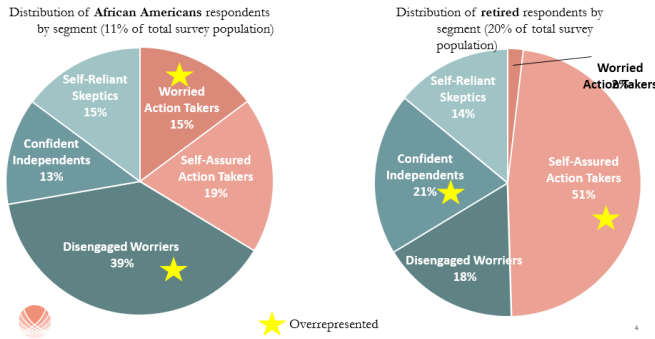
<h3>Recommended Resources</h3> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%; padding: 5px;"> <p><b>PREPARE for your care</b>  <a href="https://prepareforyourcare.org/welcome">https://prepareforyourcare.org/welcome</a>  <a href="https://prepareforyourcare.org/advance-directive">https://prepareforyourcare.org/advance-directive</a></p> </div> <div style="width: 50%; padding: 5px;"> <p><b>POLST patient site</b>  <a href="https://polst.org/startng-polst">https://polst.org/startng-polst</a></p> </div> <div style="width: 50%; padding: 5px;"> <p><b>VYNCA</b>  <a href="https://vynca.health.com/en/serious-illness-care-planning-conversations">https://vynca.health.com/en/serious-illness-care-planning-conversations</a></p> </div> <div style="width: 50%; padding: 5px;"> <p><b>My Way</b>  <a href="https://myway.org/">https://myway.org/</a>  <ul style="list-style-type: none"> <li>• Coach guide</li> <li>• Patient guide</li> <li>• Implementation guide</li> </ul> </p> </div> </div>	<ul style="list-style-type: none"> <li>• Review AD forms and POLST</li> <li>• Websites for PREPARE, MY WAY, POLST, VYNCA</li> </ul>
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### What motivates patients to engage in ACP? (15 minutes)

Slide	Facilitator Notes
<div style="text-align: center;"> <h2>What motivates people to participate in ACP?</h2> <h3>Insights from consumer research</h3> <p>List all the motivations you can think of for why someone participates in ACP and/or completing AD</p>  </div>	<ul style="list-style-type: none"> <li>• Write down list of all the motivations can think of for engaging in ACP and/or AD (they can be different motivations)</li> <li>• Explain findings from consumer research from Massachusetts.</li> <li>• Can't tell by demographics what will motivate an individual</li> <li>• Control and advocacy resonated for most groups – but not all individuals</li> </ul>
<div style="text-align: center;"> <h3>Five Consumer Segments</h3>  <div style="display: flex; justify-content: space-around;"> <div style="width: 45%;"> <p><b>Action Takers</b></p> <p>100% have both a written document naming their health care decision maker and a document that describes their wishes for care; about 90% have also spoken to loved ones about their wishes and many (50-85%) have talked to their doctors, too.</p> </div> <div style="width: 45%;"> <p><b>Non Action Takers</b></p> <p>Very few have completed written documents (4 – 16%); about half have had conversations with loved ones about their wishes; few (~20%) have talked to their doctors.</p> </div> </div> <p><small>Advancing the Language of Advance Care Planning: A Messaging Research Project. Massachusetts Coalition for Serious Illness Care; 2019. Accessed December 17, 2020. <a href="http://maseriouscare.org/uploads/messaging-research-overview-updated-november-2019.pdf">http://maseriouscare.org/uploads/messaging-research-overview-updated-november-2019.pdf</a></small></p> </div>	<ul style="list-style-type: none"> <li>• Introduce study, who/what they did: Comes from market/consumer research – segmentation.</li> <li>• Titles are alternative to “non-compliant” terminology. Gives the power back to the people and acknowledges they may have good reasons for being where they are</li> </ul>



**Examples: where is the African American community? Where is the retired community?**



- Looking descriptions, it is coming from their experience with the healthcare system.
- Trust that people come to skepticism/disengagement for valid reasons.
- Demographics are associated with the categories – but you can't assume based on demographics. Have to ask each person and learn their individual view.

**Five Supporting Messages/“Reasons” Were Tested**

<b>Love/Gift</b> Love means speaking up.	If any of us became seriously ill, those closest to us may have to make important decisions about our care. Asking and sharing what would matter most to each other in that event is an act of love and kindness that can make future decisions easier—a gift we can give to those who matter most.
<b>Peace of mind</b> There's no need to wonder.	The future is full of unknowns. But open conversations can pave the way to clarity, no matter what happens with our health. Having conversations about serious illness and the kind of care that's right for us gives us a shared understanding that fosters peace of mind.
<b>Demand the right care</b> We can have a say in our care.	Getting the health care we need often involves decisions, and we can and should speak up about the kind of care that works for us and ask doctors to understand what matters to us. Asking for what we want from our care also means telling those closest to us what we'd want if we couldn't make decisions for ourselves.
<b>Control (via decision-maker)</b> Conversations clarify.	We can't plan for everything. But we can help manage life's unknowns by talking openly about what matters to us and what we'd want most if we became seriously ill. Conversations about things we can't control can actually help to give us a sense of control.
<b>Honor loved ones' wishes</b> Caring means learning what matters to them.	There may be a time when we have to help the people closest to us—our friends, our spouses, our parents or grandparents—get the care that's right for them. Delivering on the promise means understanding what is most important to them in the face of serious illness.

- This research tested 5 different messages.

**Control and Self-Advocacy “reasons” were preferred by most**

	To gain control Conversations clarify	To demand shared decision-making We can have a say in our care	To help advocate for others Caring means learning about them	To get peace of mind There is no need to wonder	To give a gift to loved ones Love means speaking up
Worried Action Taker	●	●	●	●	●
Self-Assured Action Taker	●	●	●	●	●
Disengaged Worrier	●	●	●	●	●
Defiant Independent	●	●	●	●	●
Self-Reliant Skeptic	●	●	●	●	●

- Different messages resonated differently across the groups. Some people are more interested in doing it for their family; others for themselves
- “Gain control – conversations clarify” resonated for all groups.
- “Peace of mind” not preferred by any group.
- “Give a gift” resonated mostly for “self-reliant skeptics”

**UMBRELLA MESSAGE**

**RESONATES WITH ALL CONSUMER SEGMENTS**

**A good day tomorrow starts with a good talk today.** If you became seriously ill, would the people who matter most really know what matters most to you? Share the kind of care that's right for you, and what your good days look like—no matter what happens tomorrow.

**SUPPORTING MESSAGES/ REASONS WHY**

**Conversations clarify.** We can't plan for everything. But we can help manage life's unknowns by talking openly about what matters to us and what we'd want most if we became seriously ill. Conversations about things we can't control can actually help to give us a sense of control.

**We can have a say in our care.** Getting the health care we need often involves decisions, and we can and should speak up about the kind of care that works for us, and ask doctors to recognize what matters to us. Asking for what we want from our care also means telling those closest to us what we'd want if we couldn't make decisions for ourselves.

**PROOF POINTS**

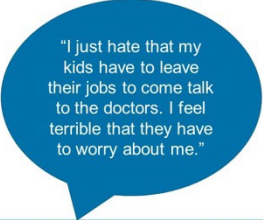

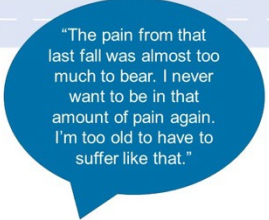
**Information is power.** We can help answer tomorrow's questions today by sharing our values and preferences with the people who matter most. We may not be able to predict every choice we'll have to make, but we can give those we love the guiding principles to confidently make decisions for us.

**If we don't say it, they won't know.** Our caregivers may need to make decisions for us, whether we've told them what we want or not. We can't simply assume they know.

**You know you.** We're not doctors, but we're the experts on what's right for us and our lives. When we share our values, preferences and wishes with our doctors, we're part of the team that helps us get the right care for us.

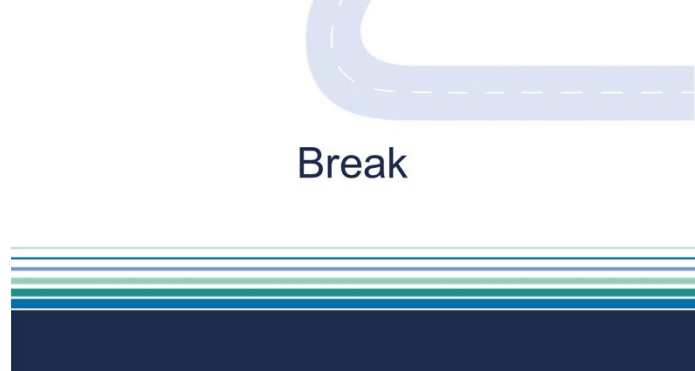
**Having a say means getting the most out of every day.** Serious illness care can involve choices that impact our quality of life. The more we speak up, the better care can be, and the more we'll have the chance to receive the kind of care that works for us.

- The top message relates to everyone.
- The intent is not to memorize a message for each group, but rather to focus on helping them unpack where they are and why.
- Acknowledge and validate that people have their own reasons for feeling the way they do.
- We are all impacted by factors beyond what we are born with. This

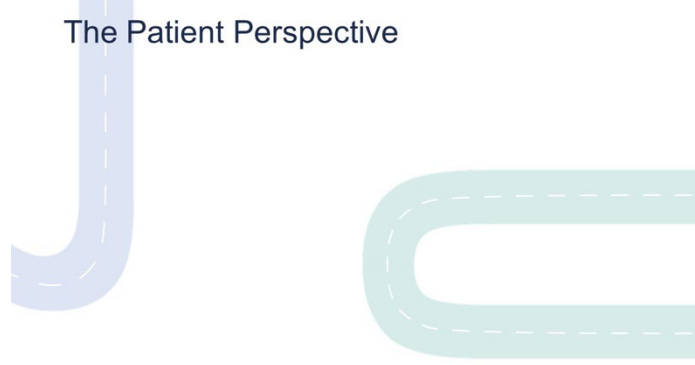

	<p>study confirms that negative experiences impact people, particularly populations that have historically been ignored or discriminated against in the healthcare system, so they may come with skepticism and we can understand why.</p> <ul style="list-style-type: none"> <li>Refer participants to <a href="#">Key Concepts in ACP: The Patient’s Perspective</a> Recorded presentation (17:19) for more information and a link to this study.</li> </ul>
<p><b>What is their motivation?</b></p> <ul style="list-style-type: none"> <li>Client Z is a 52 year old with ESRD/diabetes/CHF.</li> <li>They have 2 children, ages 22 and 24, that have just begun their careers.</li> <li>Client Z is not married, works FT in IT, and has had 2 recent hospitalizations. You’ve stopped by to just check in following the last hospitalization and Client Z says:</li> </ul>  	<ul style="list-style-type: none"> <li>Name the motivation in 2 scenarios</li> <li>Distinguish naming patient’s own motivation from “selling” with a motivation you assume they will relate to</li> <li>Optional if time – role play a patient whose motive is not apparent</li> </ul>
<p><b>What is their motivation?</b></p> <ul style="list-style-type: none"> <li>Client L is an 83 y/o person with ESRD and COPD.</li> <li>Client L just moved to an Assisted Living Facility because it was becoming more difficult for them to get their ADLs done at home.</li> <li>You are checking in to find out about the transition and Client L says:</li> </ul> 	


**Break (5 minutes)**

Slide	Facilitator Notes
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 <p style="text-align: center;">Break</p>	
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**Family Involvement (10 minutes)**

Slide	Facilitator Notes
<p>The Patient Perspective</p> 	<ul style="list-style-type: none"> <li>•</li> </ul>
<p>Family Involvement</p>  <p>EXPANDING THE CONVERSATION</p> <ul style="list-style-type: none"> <li>• Help person engage family/friend</li> <li>• Work through concerns about talking with family</li> <li>• Role play conversations</li> <li>• Explore coping</li> </ul>	<ul style="list-style-type: none"> <li>• Ask: What is it like in your dialysis community to partner with family? How does that go for you? Does anyone have a system that is going well?</li> <li>• Reflect on participants responses to reinforce family involvement concepts.</li> <li>• Ask questions to prompt further discussion of participants' experience</li> </ul>

 <h2 style="text-align: center;">Family Involvement</h2> <ul style="list-style-type: none"> <li>• Process vs content</li> <li>• How would life be different if "problem" was solved?</li> <li>• How has family coped through disagreements in the past?</li> <li>• How has it impacted the family?</li> <li>• How has family impacted the patient?</li> </ul> <div style="border: 1px solid blue; padding: 5px; width: fit-content; margin: 10px auto;"> <ul style="list-style-type: none"> <li>• Quality of life</li> <li>• Depression</li> <li>• Key factor in dialysis decisions</li> </ul> </div> <div style="border: 1px solid green; padding: 5px; width: fit-content; margin: 10px auto;"> <p>Multisystems Family Therapy  Object Relations Family Therapy  Problem solving Family Therapy  Structural Family Therapy  Solution Focused Family Therapy</p> </div>	<ul style="list-style-type: none"> <li>• Family are an underused resource – when we involve family, patients report improved quality of life and less depression. We know that family are key in dialysis decisions. We know it’s important to involve them, and yet with don’t.</li> <li>• They are also overused: carrying all of the weight (transporting, caregiving, etc.); also may have income lost because demands require them to stop working</li> <li>• Refer participants to <a href="#">Family Involvement in Advanced Directives</a> recorded presentation to learn more.</li> </ul>
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### Family Involvement Role Play (10 minutes)


Slide	Facilitator Notes
<h2 style="text-align: center;">Role Play – Family Phone Call</h2> <ul style="list-style-type: none"> <li>• Exploring divergent patient &amp; family goals.</li> </ul>	<ul style="list-style-type: none"> <li>• Invite a participant volunteer to engage in a phone call role play where the participant’s goals for his/her loved one differ from that of the patient. You are the social worker calling caregiver. You’ve already met the family.</li> <li>• Step 1: Establish common ground <ul style="list-style-type: none"> <li>○ Tell me how things are going</li> <li>○ In honor of transparent conversation, is it OK if I share feedback about what we are seeing here</li> <li>○ I know their quality of life is important to you, how can we work together.</li> </ul> </li> <li>• See Appendix D for an alternative scenario.</li> <li>• Engage participants in a discussion of strategies to engage &amp; assist caregivers.</li> </ul>

	<ul style="list-style-type: none"> <li>○ How would you proceed with this family?</li> <li>○ What natural resources exist and can be drawn upon?</li> <li>○ How can the wishes of the client be recognized?</li> </ul>
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**Breakout Groups: Practice Family Involvement (10 minutes)**


Slide	Facilitator Notes
	<ul style="list-style-type: none"> <li>● Breakout groups to practice involving family member</li> </ul>

**Caregiver Assessment Questions (10 minutes)**

Slide	Facilitator Notes
<p>Caregiver Assessment Questions</p> 	<ul style="list-style-type: none"> <li>● These are some options for opening the conversation</li> <li>● Invite participants to share questions/conversation openers they use</li> </ul>

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**Closing (10 minutes)**

Slide	Facilitator Notes
 <p data-bbox="219 420 365 451">Art gallery</p>	<ul data-bbox="876 388 1437 577" style="list-style-type: none"><li>• Invite participants to share thoughts about what they submitted, what it expresses for them</li><li>• See Appendix X for additional guidance on the art gallery activity.</li></ul>

## Booster Session 1: Leading Interdisciplinary Teams in ACP

Time	Topic	Minutes
00:00 – 00:10	Opening	10

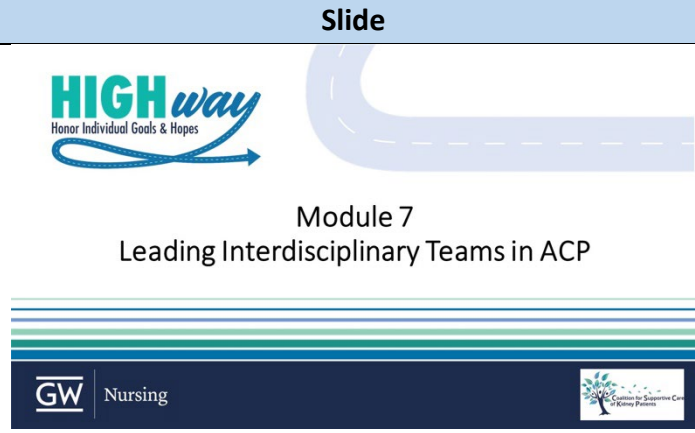
### Learning Objectives:

- Describe the social worker’s role in leading the care coordination and hand-off process for goals of care conversations for a patient with chronic kidney disease
- Integrate ACP into the social worker’s ongoing workflow
- Describe strategies for leadership and communication of ACP within an interdisciplinary care team

### Supplemental Materials:

- [Leading ACP in Teams](#) Recorded presentation (5:06)
- Team Planning Worksheet for Advance Care Planning in the Dialysis Unit

### Leading ACP in Interdisciplinary Teams (??)

Slide	Facilitator Notes
 <p>The slide features the 'HIGHway' logo with the tagline 'Honor Individual Goals &amp; Hopes' and a blue road graphic. Below the graphic, it reads 'Module 7 Leading Interdisciplinary Teams in ACP'. At the bottom, there are logos for 'GW Nursing' and the 'Center for Palliative Care'.</p>	<ul style="list-style-type: none"> <li>• Ask: How do we share with the team the unique value of ACP?</li> <li>• Invite participants to share their approach to leadership in teams when approaching topics such as ACP or other topics.</li> <li>• Refer participants to <a href="#">Leading ACP in Teams</a> recorded presentation (5:06) to learn more.</li> </ul>





How do you define Leadership?

## Differences in Leadership Styles Across Disciplines

There is often a variance of leadership skill sets across disciplines (Klarare et al., 2020) as traditional medical hierarchies can influence interprofessional collaboration negatively (Mertens et al., 2019). This mismatch is both due to training, such as valuing autonomy resulting in a reluctance to delegate authority (Kornacki, 2017) or the opposite of being trained to cede authority to others (Dahlin et al., 2019). Social work leadership describes a client-centered or collective approach (Peters & Hopkins, 2019; Sullivan, 2016) that focuses on the needs of the client and how to improve the conditions, processes, and interventions (Sullivan, 2016)



## Leadership Styles





## Introducing and Supporting ACP in Teams



## Facilitating Team Communication and Warm Hand Off



## Resolving Conflict in Teams

**GW** Nursing



Who are your allies?  
Where are your opportunities to engage team members?

Create a plan



Closing:  
Transitions



## Booster Session 2: Implementation Tools

Time	Topic	Minutes
00:00 – 00:05	Opening	5
00:05 – 00:20	How to Make Things Happen in HIGHway	15
00:20 – 00:35	Cause & Effect Diagram	15
00:35 – 00:50	PDSA & Small Tests of Change	15
00:50 – 00:55	Closing	5


### Learning Objectives:

- Facilitate advance care planning for a patient with chronic kidney disease using the HIGHway Roadmap framework
- Describe documents used to make patient wishes actionable
- Assist in completion of goals of care, advanced directives and medical orders

### Supplemental Materials:

- [Implementation Tools](#) Recorded presentation (16:09)
- Worksheet for Testing Change
- Cause and Effect Handout Progress through Change

### Opening (5 minutes)

Slide	Facilitator Notes
	<ul style="list-style-type: none"> <li>•</li> </ul>

### How to Make Things Happen (15 minutes)

Slide	Facilitator Notes
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<h3>How to make things happen in HIGHway</h3> <ul style="list-style-type: none"> <li> Change the process</li> <li> Cause and effect analysis</li> <li> PDSA – Plan-Do-Study-Act</li> <li> Plan first test of change</li> </ul>	
<h3>Processes</h3> <pre> graph LR   A[All Processes] --&gt; B[Are perfectly designed]   B --&gt; C[To produce the results they are producing]   </pre>	
<h3>CKD and Dialysis Processes to Consider for ACP</h3> <ul style="list-style-type: none"> <li><b>Patient Education</b> <ul style="list-style-type: none"> <li>• CKD</li> <li>• New patient admission</li> </ul> </li> <li><b>Admission to Dialysis</b> <ul style="list-style-type: none"> <li>• Comprehensive Assessment</li> <li>• Plan of care (POC)</li> <li>• Reassessment</li> </ul> </li> <li><b>Change in Status</b> <ul style="list-style-type: none"> <li>• Post hospitalization</li> <li>• Modality change</li> <li>• Change in living situation (Rehab/LTC)</li> <li>• Stable/Unstable for POC</li> </ul> </li> </ul>	

**Cause & Effect Diagram (15 minutes)**

Slide	Facilitator Notes
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## Cause and Effect Diagram



What causes the problem?



Materials, Methods, Equipment, Environment, and People.



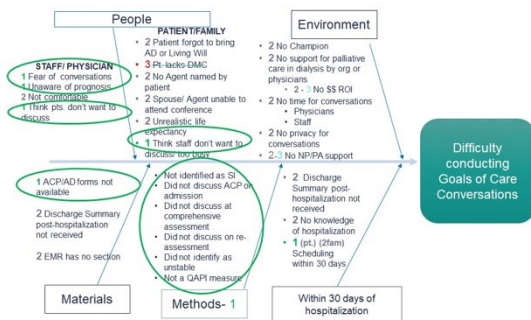
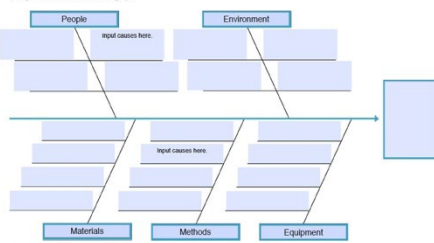
5 Whys- for each cause ask "WHY?" 5 times

### Example Cause and Effect Diagram for lack of ACP

#### Template: Cause and Effect Diagram

Team: \_\_\_\_\_ Project: \_\_\_\_\_

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.



- First brainstorm everything that could go in that section
- Use 5 whys to generate more items - keep asking "why"
- Then rate each cause – 3= can't control, 2= difficult to control 1= changeable by team -

## Follow up with Cause and Effect Diagram

- Review the Cause and Effect Diagram your team made
- Choose two of the "1's (complete control)
  - Brainstorm how to overcome this barrier
  - Plan how to overcome this barrier - handout
  - This is designing a small test of change

Slide	Facilitator Notes
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Plan, Do, Study, Act (PDSA)



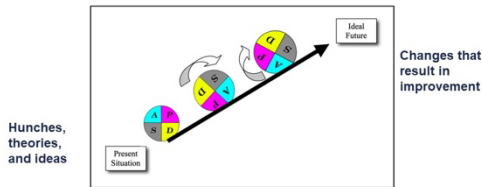
- PLAN**
- How to **test the change**
  - Take into account cultural and organizational characteristics
- DO**
- **Make a change** in standard procedures, **track progress** using quantitative **measures**
- STUDY**
- Results for **insight on how to do better**
- ACT**
- Make the successful **changes permanent** or
  - **Adjust the changes** that need more work.

2003 Institute for Healthcare Improvement

<ul style="list-style-type: none"> <li>•</li> </ul>
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Small Tests of Change

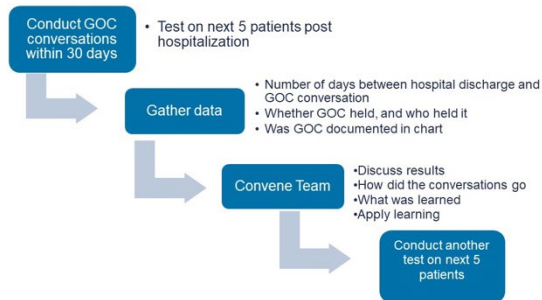
This process continues serially over time and refinement is added with each cycle; these are known as "Plan-Do-Study-Act" (PDSA) cycles of learning.



2003 Institute for Healthcare Improvement

<ul style="list-style-type: none"> <li>•</li> </ul>
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Small test of change



<ul style="list-style-type: none"> <li>•</li> </ul>
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Study Small Test of Change

- Convene Team
- What was learned?
  - Barriers and challenges
  - Workarounds
  - Failures/ what didn't work?
  - Unintended consequences
- Incorporate into process



2003 Institute for Healthcare Improvement

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Worksheet For Testing Change

Aim: (Overall goal you would like to reach)

Your goal will require multiple smaller tests of change.

Describe your first (or next) test of change	Person Responsible	When to be done	Where to be done

**Plan**

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done
1.			
2.			
3.			
4.			
5.			

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1.	1.
2.	2.
3.	3.
4.	4.

**Do**

Describe what actually happened when you ran the test

**Study**

Describe the measured results and how they compared to the predictions

**Act**

Describe what modifications to the plan will be made for the next cycle from what you learned

### Next steps:



Cause and Effect Diagram (with team?)



Plan small test of change (keep it small!)



Test the change on small scale

## Narrated powerpoint on implementation

<https://vimeo.com/gwnursing/highwaygrant/video/690941478>

## Appendix A: Motivational Interviewing Handout

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### Understanding Motivational Interviewing

#### Summary

Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change. However, definitions of MI vary widely, including out of date and inaccurate understandings. This document provides a brief summary of what MI is, what is isn't and where to go next if you are interested in learning more about this approach.

#### What is Motivational Interviewing?

*“MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”* (Miller & Rollnick, 2013, p. 29)

The most current version of MI is described in detail in Miller and Rollnick (2013) *Motivational Interviewing: Helping people to change* (3<sup>rd</sup> edition). Key qualities include:

- MI is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice).
- MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change.
- MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.

It is important to note that MI requires the clinician to engage with the client as an equal partner and refrain from unsolicited advice, confronting, instructing, directing, or warning. It is not a way to “get people to change” or a set of techniques to impose on the conversation. MI takes time, practice and requires self-awareness and discipline from the clinician. (Miller & Rollnick, 2009)

While the principles and skills of MI are useful in a wide range of conversations, MI is particularly useful to help people examine their situation and options when any of the following are present:

- **Ambivalence is high** and people are stuck in mixed feelings about change
- **Confidence is low** and people doubt their abilities to change
- **Desire is low** and people are uncertain about whether they want to make a change

- **Importance is low** and the benefits of change and disadvantages of the current situation are unclear.

## Core elements of Motivational Interviewing

- MI is practiced with an underlying **spirit** or way of being with people:
  - **Partnership.** MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.
  - **Evocation.** People have within themselves resources and skills needed for change. MI draws out the person's priorities, values, and wisdom to explore reasons for change and support success.
  - **Acceptance.** The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices about changing or not changing.
  - **Compassion.** The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.
- MI has **core skills** of OARS, attending to the language of change and the artful exchange of information:
  - **Open questions** draw out and explore the person's experiences, perspectives, and ideas.

Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide- Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.

- **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
  - **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
  - **Summarizing** ensures shared understanding and reinforces key points made by the client.
  - **Attending to the language of change** identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
  - **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two way street and needs to be responsive to what the client is saying.
- MI has four fundamental **processes**. These processes describe the "flow" of the conversation although we may move back and forth among processes as needed:

- **Engaging:** This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.
- **Focusing:** In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.
- **Evoking:** In this process the clinician gently explores and helps the person to build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.
- **Planning:** Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important.

MI is framed as a method of communication rather than an intervention, sometimes used on its own or combined with other treatment approaches. There are a number of benefits of learning MI amongst other approaches to helping conversations:

- MI has been applied across a broad range of settings (e.g. health, corrections, human services, education), populations (e.g. age, ethnicity, religion, sexuality and gender identities), languages, treatment format (e.g. individual, group, telemedicine) and presenting concerns (e.g. health, fitness, nutrition, risky sex, treatment adherence, medication adherence, substance use, mental health, illegal behaviors, gambling, parenting).
- MI compares well to other evidence-based approaches in formal research studies.
- MI is compatible with the values of many disciplines and evidence-based approaches.
- Although the full framework is a complex skill set that require time and practice, the principles of MI have intuitive or "common sense" appeal and core elements of MI can be readily applied in practice as the clinician learns the approach.
- MI has observable practice behaviors that allow clinicians to receive clear and objective feedback from a trainer, consultant or supervisor.

## Further questions

- What are some ways MI could be helpful in your work?
- What are some reasons you might want to learn more about MI?
- What might be a next step or two? If you are interested in learning more about MI, you might

consider reading the next document in the series: Learning Motivational Interviewing or the core text by Miller and Rollnick (2013).

## References

- Miller, W.R. & T.B. Moyers (2017) Motivational Interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology, 85*(8), 757-766
- Miller, W.R. & Rollnick, S. (2013) *Motivational Interviewing: Helping people to change* (3<sup>rd</sup> Edition). Guilford Press.
- Miller & Rollnick (2017) Ten things MI is not Miller, W.R. & Rollnick, S. (2009) Ten things that MI is not. *Behavioural and Cognitive Psychotherapy, 37*, 129-140.

## Appendix B: Motivational Interviewing Counts Worksheet

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**Directions:** Record (tic marks) how often the Social Worker does the following:

Asking

- Open ended
- Closed ended

Listening/Reflective Statement

Empathetic Statement

Informing

- With permission
- Without permission

1. Examples of flexibility
2. Examples of Resist the Righting Reflex
3. Examples of Rolling with Resistance
4. Examples of allowing/elevating awareness of Ambiguity

## Appendix C: Emotion Words Worksheet

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From: Hepworth, D. H., Rooney, R., & Larsen, J. (2000). *Direct social work practice: Theory and skills*. Pacific Grove, CA.: Brooks.

<u>Competence, Strength</u>		<u>Happiness, Satisfaction</u>	
Convinced you can	confident	Elated	superb
Sense of mastery	powerful	Ecstatic	on cloud nine
Potent	courageous	On top of the world	organized
Resolute	determined	Fantastic	splendid
Strong	influential	Exhilarated	jubilant
Brave	impressive	Terrific	euphoric
Forceful	inspired	Delighted	marvelous
Successful	secure	Excited	enthusiastic
In charge	in control	Thrilled	great
Well-equipped	committed	Super	in high spirits
Sense of accomplishment	daring	Joyful	cheerful
Feeling oats	effective	Elevated	happy
Sure	sense of conviction	Lighthearted	wonderful
Trust yourself	self-reliant	Glowing	jolly
Sharp	able	Neat	glad
Adequate	firm	Fine	pleased
Capable	on top of it	Good	contented
Can cope	important	Hopeful	contented
Up to it	ready	Satisfied	gratified
Equal to it	skillful	Fulfilled	tranquil
		Serene	calm
		At ease	



**Caring, Loving**

**Depression, Discouragement**

Adore	loving	Anguished	in despair
Infatuated	enamored	Dreadful	miserable
Cherish	idolize	Dejected	disheartened
Worship	attached to	Rotten	awful
Devoted to	tenderness towards	Horrible	terrible
Affection for	hold dear	Hopeless	gloomy
Prize	caring	Dismal	bleak
Fond of	regard	Depressed	despondent
Respect	admire	Grieved	grim
Concern for	taken with	Brokenhearted	forlorn
Turned on	trust	Distressed	downcast
Close	esteem	Sorrowful	demoralized
Hit it off	value	Pessimistic	tearful
Warm toward	friendly	Weepy	down in the dumps
Like	positive towards	Deflated	blue
Accept		Lost	melancholy
		In the doldrums	lousy
		Kaput	unhappy
		Down	low
		Bad	blah
		Disappointed	sad
		Below par	

**Inadequacy, Helplessness**

**Anxiety, Tension**

Utterly	worthless	Terrified	frightened
Good for nothing	washed up	Intimidated	horrified
Powerless	helpless	Desperate	panicky
Impotent	crippled	Terror-stricken	paralyzed
Inferior	emasculated	Frantic	stunned
Useless	finished	Shocked	threatened
Like a failure	impaired	Afraid	scared
Inadequate	whipped	Stage fright	dread
Defeated	stupid	Vulnerable	fearful
Incompetent	puny	Apprehensive	jumpy
Inept	clumsy	shaky	distrustful
Overwhelmed	ineffective	butterflies	awkward
Like a klutz	lacking	defensive	uptight
Awkward	deficient	tied in knots	rattled
Unable	incapable	tense	fidgety
Small	insignificant	jittery	on edge
Like a wimp	unimportant	nervous	anxious
Over the hill	incomplete	unsure	hesitant
Immobilized	like a puppet	timid	shy
At the mercy of	inhibited	worried	uneasy
Insecure	lacking confidence	bashful	embarrassed
Unsure of self	uncertain	ill at ease	doubtful
Weak	inefficient	uncomfortable	self-conscious
Unfit		insecure	alarmed
		restless	

**Confusion, Troubledness**

Bewildered                      puzzled  
Tormented by                      baffled  
Perplexed                          overwhelmed  
Trapped                              confounded  
In a dilemma                      befuddled  
In a quandry                      at loose ends  
Going around in circles              mixed-up  
Disorganized                      in a fog  
Troubled                              adrift  
Lost                                  disconcerted  
Frustrated                          floored  
Flustered                          in a bind  
Disturbed                          conflicted  
Stumped                              feeling pulled  
    apart  
Mixed feelings about              uncertain  
Unsure                                  bothered  
Uncomfortable                      undecided  
Uneasy

**Rejection, Offensiveness**

Crushed                              destroyed  
Ruined                                  pained  
Wounded                              devastated  
Tortured                              cast off  
Betrayed                              discarded  
Knifed in the back                      hurt  
Belittled                              abused  
Depreciated                              criticized  
Sensured                              discredited  
Disparaged                              laughed at  
Malinged                              mistreated  
Ridiculed                              devalued  
Scorned                                  mocked  
Scoffed at                              used  
Exploited                              debased  
Slammed                                  slandered  
Impugned                              cheapened  
Mistreated                              put down  
Slighted                                  neglected  
Overlooked                              minimized  
Let down                                  disappointed  
Unappreciated                              taken for  
    granted  
Taken lightly                              underestimated  
Degraded                                  discounted  
Shot down  
Could chew nails                              fighting mad

**Anger, Resentment**

Furious                                  enraged  
Livid                                      seething

Burned up                              hateful  
Bitter                                      galled



## Appendix D: Case Study for Emotion Words Activity

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Terrance is the 70 year old caregiver and husband of Mary, a dialysis patient of 3 years in rural Pennsylvania. Terrance requests to meet with the new social worker because he hopes that they can assist in getting better transportation on Weds. During the conversation, the social worker asks him not just how Mary is doing, but how he is holding up. Terrance discloses that in addition to being Mary's only caregiver, waking at 4 AM to get her to dialysis, he has had cancer and he thinks it is re-occurring, but hasn't found a doctor in the community taking new patients. The social worker resists the urge to fix and stays silent, encouraging Terrance to keep talking by nodding her head and avoiding writing or typing. The social worker responds with empathy by stating "You must be exhausted witnessing Mary suffer, and carry the burden of worrying about your own future." Terrance begins to cry and states, "That's not all. Every morning when I wake her up to go to dialysis, she says 'I don't want to go; I'm just going to die anyway. This is just an existence'" The social worker again responds with empathy by leaning in, looking Terrance in the eye, and touching his hand and states, "It's heartbreaking to hear the person you love so much say that." Terrance continues to quietly cry. The social worker asks, "This is so heavy for you to carry. Who do you have to talk to?" Terrance replies, "no one. I have never talked to anyone about this. This is the longest I've ever talked about Mary's dialysis with anyone."

Terrance is the 70 year old caregiver and husband of Mary, a dialysis patient of 3 years in rural Pennsylvania. Terrance requests to meet with the new social worker because he hopes that they can assist in getting better transportation on Weds. During the conversation, the social worker asks him not just how Mary is doing, but how he is holding up. Terrance discloses that in addition to being Mary's only caregiver, waking at 4 AM to get her to dialysis, he has had cancer and he thinks it is re-occurring, but hasn't found a doctor in the community taking new patients. The social worker resists the urge to fix and stays silent, encouraging Terrance to keep talking by nodding her head and avoiding writing or typing. The social worker responds with empathy by stating "You must be exhausted witnessing Mary suffer, and carry the burden of worrying about your own future." Terrance begins to cry and states, "That's not all. Every morning when I wake her up to go to dialysis, she says 'I don't want to go; I'm just going to die anyway. This is just an existence'" The social worker again responds with empathy by leaning in, looking Terrance in the eye, and touching his hand and states, "It's heartbreaking to hear the person you love so much say that." Terrance continues to quietly cry. The social worker asks, "This is so heavy for you to carry. Who do you have to talk to?" Terrance replies, "no one. I have never talked to anyone about this. This is the longest I've ever talked about Mary's dialysis with anyone."

## Appendix E: Case Study for Family Involvement Role Play

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- Ada (73) and Ben (76) Folsom were placed together in a nursing home two months ago. Ada presented as alert and fully oriented. Ben has been diagnosed with severe Alzheimer's disease. Ada has ESRD and is currently on dialysis. Ada states that she 'can't stand' dialysis and that it is 'very painful'. Ada reports that she has a lot of cramping, feels very fatigued on a daily basis, low blood pressure, vomiting, headaches, and has been in and out of the emergency room in the past six months. Ada scored a one on her most recent SPMSQ which indicates normal mental functioning. Both must have assistance with all ADLs. Since being in the nursing home, Ada has told workers multiple times that she will convince Ben to take her out of the nursing home and drive them home, as Ada herself cannot drive. The couple has two children, Chris (45) and Kayla (43). Kayla lives with her husband and two children next door to Ben and Ada's home. Kayla is currently unemployed and her husband is a contractor. Chris is recently divorced, lives a three-hour drive away and is a lawyer. No additional family members have been identified.

During an in-person meeting at the nursing home with Ben and Ada and their two children, Kayla made it very clear that she wants her mother to stay on dialysis. Chris, however, stated that he believes that it is up for his mother to decide, and to 'follow her own [Ada's] wishes'. It was noted that in the past, Ben has also stated that he would like for Ada to stay on dialysis, however, when asked in the current meeting, he stated that he wasn't sure what to think. Ada was tearful in the meeting and told her children she was afraid of being a burden.

- Facilitate a discussion of this case using the following questions:
  - How would you proceed with this family?
  - What natural resources exist and can be drawn upon?
  - How can the wishes of the client be recognized?



## Appendix X: Guided Relaxation Exercises

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### Facilitator Scripts

- “I would like to offer you a tool that many people who are experiencing a difficult illness/treatment find helpful. Would you feel comfortable closing your eyes and taking a few breaths? Focus on your breathing. Rest in the feeling of breath coming in and going out, like ocean waves. Now let your worries and thoughts pass by like clouds moving in the sky.”
- “Close your eyes. Starting with your feet, tighten all the muscles, and then let go suddenly with a big sigh. Move up to your whole leg. Tighten it, hold, and let go quickly with another sigh. Keep moving up your body, tightening and releasing each area. Finish by making a face like you are eating something very sour. Tighten your mouth, your eyes, and let go with a big sigh. Now starting at your head, imagine that warm chocolate is washing over you, letting every muscle relax and rest.”



## Appendix X: Expressing and Cultivating Emotional Understanding of Mortality through Art

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Art/Poetry/Music Gallery – You are the Curator.

Through human history and across civilizations, artists have tried to convey their feelings and philosophy about life, mortality, grief. Often, viewing or participating in these artistic works is cathartic and healing in ways that rational expression does not reach. Invite participants to select one personal favorite poem, painting, photograph, song, or any other artwork that expresses some aspect of the illness, dying, death and bereavement experience that is meaningful to them. It can be a work by a famous or popular artist, or something you created yourself, such as a photo, journal entry, or poem. Share these in a gallery during a break or to close a session. Invite participants to share how the artwork is meaningful to them and what it expresses about mortality, living, and dying.