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Family Meeting Planning Tool

I. FAMILY MEETING GOALS

Potential goals for a FM meeting include:

- Sharing information about patient's diagnosis, clinical status, treatment options
- Make a medical/clinical decision
- Create a disposition plan

Keep in mind:

- Goals often have to be reformulated during the meeting.
- Because goals cannot always be accomplished in one meeting, think of a family meeting as a 2 or 3 part series of interactions.

II. FAMILY MEETING PARTICIPANTS

Representing the Patient:

Question	*Consider*	*We recommend*
Who is the decision maker?	Patient vs. HCP vs. Surrogate? (Refer to ACP Tab in Epic)	Complete documentation for HCP/Surrogate in the chart
	Is the patient a ward of the state, or is OPWDD involved (Office for People with Developmental Disabilities), or should they be involved?	**If YES,** this FM protocol does not apply until palliative care SW gives go ahead to proceed.
Additional supportive participants?	Does the patient/family wish to include additional people in the meeting?	Explore with patient/family member about additional participants.
	If **YES**, which other family members or friends should be present?	If a key supportive person can't be present in person, offer to include them by phone.
Is an interpreter necessary?	If command of English is not sufficient for discussion of complex medical issues, encourage interpreter from patient services	Patient Services # dial 66 from any house phone. In-person interpreter may require 24 hour advance notice

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Representing the Clinical Services:

Clinical service	*We recommend*
Primary team	♦ Attending and/or intern/resident ♦ Must be someone familiar with the patient's care
Unit staff	♦ Unit social worker ♦ Unit chaplain
Specialists / consultants	♦ If their input/contribution relates to prognosis, include relevant specialist(s) ♦ Consider including PCP if available
Palliative care team	♦ At least 2 disciplines should be present for IDT approach and perspective; ♦ Options include MD(s) or NP AND SW and/or chaplain. ♦ Additional PC team member(s) who may know patient/family: e.g. LMT, Yoga therapist, Art Therapist

III. BEFORE THE FAMILY MEETING: INFORMATION GATHERING

Question	*Consider*
What are the options for care at this point?	♦ May require input from disease specialist or PCP
What result do you expect from each option?	♦ How will/will not a treatment or intervention change clinical course? ♦ Is there agreement among providers on the plan and/or recommendations? ♦ If providers are offering differing viewpoints, create a plan for how information can be relayed --or refocus the agenda for the meeting.
Do clinicians have a sense of prognosis?	♦ Time frame ? (hours/days; days/weeks; weeks/months)
What might the clinical path look like?	♦ Will depend on disease trajectory, e.g. chronic critical illness, frailty, end stage organ disease ♦ Pt /family may want to know estimates of cognitive status, physical function, possibility of living independently/or at home
What settings are possible options for this patient?	♦ Home/Independent, Home/Dependent, Institutional setting (nursing home versus SAR)

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IV. FAMILY MEETING: PRE-MEETING

Topic	*We recommend*
Discuss clinical picture	♦ Review all relevant information as a group (*See Section III above: Information Gathering)*
Discuss meeting outcomes	♦ Explore options for possible recommendations ♦ Teams may consider different recommendations depending on patient/family responses to information shared
Role assignment	♦ Identify who will lead the meeting ♦ Assign information sharing roles ♦ Coach residents/fellows on how to share medical information, taking into account patient/family emotion and medical literacy.
Educational issues	♦ Identify the learning goals for trainees on the team: ▪ Medical students: what skills should they watch for? ▪ Fellows: what skill(s) do they want to practice? ▪ Resident rotators: depends on level of training

V. DURING THE FAMILY MEETING: FAMILY MEETING ASSESSMENT TOOL

- This topic is discussed in greater depth in other resources, including Geri-talk and other communication courses.
- Family Meeting Communication Assessment Tool (FaMCAT) available on the Geri-Pal app: https://geripal.careteamapp.com/uploads/FaMCAT-Tool_Final.pdf

VI. AFTER THE FAMILY MEETING: DEBRIEF AND DOCUMENT

Debriefing:

Primary team clinicians	♦ Are there emotions to identify, explore? ♦ What is the plan moving forward?
For the Palliative Care team	♦ Are there emotions to identify, explore? ♦ What is the plan moving forward (if need for more nuance/detail)
For learners on the Palliative Care team	♦ Are there emotions to identify, explore ? ♦ Plan moving forward (if there is need for more nuance/detail)

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Documenting:

Topic	*What to document*
Who was there?	♦ List the key participants (names and roles)
What was said?	♦ Include specific examples/statements, with quotes. ♦ How did patient/family react or respond to the information? ♦ Did patient/family share information that might changes treatment plans; did they inform teams of their specific needs?
What is patient/family's prognostic awareness?	♦ What is their understanding of the illness? *Possible options include*: ▪ *Not discussed* ▪ *Not Serious* ▪ *Serious, but reversible* ▪ *Serious and progressive* ▪ *Life threatening, but pursuing/requesting ongoing life prolonging care* ▪ *Terminal with plan for comfort focused care and comfort care order written*
Decision-making	♦ What did the patient/family decide? ♦ If decision was made, what are the next steps? ♦ If patient/family needed more time to make decisions, is there a plan to regroup? And when will that be?
Assessment/Plan	♦ Are there changes in medical plans as result of this meeting?
Total time for meeting	♦ Record start and end time of meeting* *The ACP code requires documentation of at least 16 minutes time spent by the responsible clinician (Attending/NP)

MemorialCare™
Long Beach Medical Center

A TEAM Approach to Preparing for Family Meetings

Katy Hyman, 2019

Take the time

Establish a goal/purpose

Anticipate challenges

Make a plan

Take the time

- Seems obvious, but you have to DO IT
- Should take 3-5 minutes at most
- Best done immediately before meeting but can be done earlier

Establish a goal/purpose

- Should have 1 goal per meeting, 2 at most
- What's the goal/purpose of this meeting?
    - Assess understanding
    - Deliver serious news
    - Educate about diagnosis, prognosis, treatment
    - Build rapport
    - Elicit patient values
    - Make a decision

Anticipate challenges

- Based on the goal/purpose, what are the major anticipated challenges?
    - Serious news to communicate
    - Complex family dynamics
    - Low medical literacy
    - Unclear patient wishes
    - Time pressure for a decision

Make a plan

- Given the goal and the challenges, who is best-suited to facilitate this meeting?
    - Facilitate: Begin and conclude the meeting, keep the meeting on track, etc
- What is the facilitator's plan/outline for the structure of the meeting?