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SUPER: A New Framework for Goals of Care Communication

Niharika Ganta, MD MPH, Laura Dingfield, MD, and Nina R. O'Connor, MD

Dr. Ganta (niharika.ganta@uphs.upenn.edu) is an assistant professor of clinical medicine at the Perelman School of Medicine at the University of Pennsylvania. Dr. Dingfield (laura.dingfield@uphs.upenn.edu) is an assistant professor of clinical medicine at the Perelman School of Medicine at the University of Pennsylvania. Dr. O'Connor (nina.oconnor@ uphs.upenn.edu) is an associate professor of clinical medicine at the Perelman School of Medicine and director of hospice and palliative care for the University of Pennsylvania Health System.

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Communication about goals of care is central to the patient-provider relationship. Clear exchange of perspectives allows patients to express their understanding of their medical care and expectations moving forward. Clear communication also enables providers to share realistic information about prognosis and disease trajectory with the goal of delivering care that is consistent with each patient's unique goals. When this communication is skillfully navigated, patients feel supported and aligned with their medical team. Despite the importance of goals of care communication, very few physicians receive formal training in leading these difficult conversations.[1]

Goals of care communication can occur at any time during a serious illness, and these conversations are associated with increased likelihood of goal-consistent care, improved quality of life for patients, and improved family outcomes.[2] Simple tools are needed to guide goals of care conversations in multiple settings by different members of the healthcare team.

SUPER Framework

The SUPER framework was developed as a patient/family-centered tool that encompasses both communication of medical information and discussion of patient values. SUPER is an acronym that stands for Setup, Understanding, Priorities, Explain, Review & Recommend, and described as follows:

Setup. This first step reminds clinicians to prepare for goals of care communication by reviewing medical records, speaking to other providers, and ensuring that key stakeholders, such as surrogate decision makers, are present. This step also includes finding a quiet and private setting for the conversation, minimizing interruptions, and having adequate seating. The actual conversation begins with introductions of everyone present.

Understanding. The next step is to assess patient/family understanding of the medical situation. By listening to the patient or family's summary, the provider can assess for knowledge gaps. Providers should allow the patient/family to express their view without interrupting. Interruptions may discourage the patient/family from openly sharing, and the provider will have an opportunity to correct discrepancies later in the conversation. This step also allows providers to assess a patient or family's health literacy so that information can be best tailored to the audience at hand.

Priorities. This step allows the provider to build a rapport with patient/family and remain focused on nonmedical goals and values. The patient/family is encouraged to discuss their hopes and fears regarding medical care while the provider engages in active listening. In addition, the patient can discuss any treatments that would not be consistent with their notion of good quality of life. For instance, a patient may express that he/she is willing to receive all treatments but would never agree to living in a nursing home. This step communicates to patients and families that the medical team cares about the patient as a person and that treatment plan must fit within the context of the patient's entire life.

Explain. This step turns the spotlight to the provider. The provider should fill in knowledge gaps and provide prognosis, if known. Providers must avoid medical jargon, speak in simple and short sentences, and pause frequently to allow listeners time to process information. This step is especially effective if the priorities shared in the previous step are woven into the medical information. For instance, "Your heart disease is getting worse. I worry that you may not make it to your granddaughter's graduation, which is very important to you." The provider can share any barriers or threats to achieving the patient's stated goals; for example "Let's think about what needs to happen for you to go home as hoped."

Review and Recommend. The last step is to review the discussion points to ensure that everyone is in agreement. It is important to highlight the key medical issues and patient/family values. At this time, the provider synthesizes the clinical situation with patient/family wishes to make a recommendation about next steps. For instance, if a patient with end stage heart failure values freedom from symptoms, spending time with family, and dying at home, an appropriate recommendation might be home hospice services. Aligning the recommendation for next steps with patient/family values increases the likelihood of patient/family agreement with the proposed plan. If the recommendation is not ac-

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cepted, the provider can respectfully explore questions or hesitations. An acceptable alternative may surface. If not, the provider should establish a plan to reconvene at another time to revisit the patient's condition and patient/family priorities. The conversation should always end in agreement.

Applying SUPER to Clinical Practice
SUPER is designed to create a forum for patients and families to openly discuss their wishes and values for medical care. It is an effective framework for family meetings, but can also be used for shorter screening goals of care conversations. For example, a provider can move through the sequence in 10-15 minutes to screen for knowledge gaps and discrepancies between patient/family goals and current treatments, and a longer discussion can be scheduled with family if needed. SUPER can also be used to guide discussions about code status. A brief discussion about priorities enables the provider to make a recommendation for code status that is

grounded in both the patient's prognosis and the patient's values. An informed recommendation shifts the burden of decision making away from patient or family.

Adapting SUPER for Various Disciplines and Levels of Training
The SUPER framework can be used by clinicians from many disciplines, and at different levels of training. SUPER can be used in its entirety, incorporating all five steps, or components can be used based on the user's comfort and training level. For example, nurses are well positioned to use SUPER to assess patient and family understanding of disease status, as well as hopes and goals as part of informal conversations during routine care. Similarly, the initial steps of SUPER do not require detailed knowledge about prognosis or treatment options, so the tool can be adapted for goals of care conversations by junior providers and trainees. At our institution, we have successfully taught SUPER to experienced physicians, resident and fellow trainees, medical students,

advanced practice providers, registered nurses, and social workers.

Discussion
The SUPER tool is simple to use, encourages patient/family involvement, and empowers providers to synthesize clinical information with patient values to make treatment recommendations. Moreover, SUPER allows providers to conclude goals of care discussions with agreement. Additional work is needed to determine impact on patient outcomes and family satisfaction, but the intuitive nature of this tool merits circulation for widespread use.

References
1. Block SD. Medical education in end-of-life care: the status of reform. *J Palliat Med.* 2002;5: 243-8.
2. Bernacki RE, Block SD. Communication about serious illness care goals: a review and synthesis of best practices. *JAMA Intern Med.* 2014;174(12): 1994-2003.

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