Long-Term Care Community of Practice Series

Advance Care Planning

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Host: Jeffrey B. Moat, CM

Presenters: Sharon Kaasalainen & Karine Diedrich

Date: April 14th, 2022

Territorial Honouring

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

Stay connected: www.echopalliative.com

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Project ECHO Palliative Care - Canada BY Pallium Canada

LEAP Long-Term Care

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach, with case studies contextualized to the long-term care setting.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) working in long-term care and nursing homes.
- Promotes teamwork and collaboration among different health care professionals who work in a variety of settings.

Pallium Canada

LEAP
LONG-TERM CARE

- Accredited by CFPC for **27.5 Mainpro+ credits** (online version) and **26.5 Mainpro+ credits** (in-person version).
- Learn more about the course and topics covered www.pallium.ca/course/leap-long-term-care

Introductions

Host

Jeffrey Moat, CM
CEO, Pallium Canada

Presenters

Sharon Kaasalainen, RN PhD
Professor & Gladys Sharpe Chair in Nursing
McMaster University

Karine Diedrich
Director, Operations and Engagement
Canadian Hospice Palliative Care Association

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

Host/ Presenters

- Jeffrey Moat, CM: CEO, Pallium Canada
- Sharon Kaasalainen: I have no potential conflicts or biases to declare
- Karine Diedrich: *CHPCA – Preparing Canadians for their future Health and Personal Care: A Capacity Building Project* has received financial support from Health Canada in the form of a contribution program

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Introductory Session	Dec. 9, 2021 from 12-1pm ET
Session 2	The Palliative Approach as Part of the Continuum of Care	Jan. 13, 2022 from 12-1pm ET
Session 3	The Palliative Approach as an Inter-Professional, Team-Based Approach	Feb. 10, 2022 from 12-1pm ET
Session 4	Individuals and their Families as Members of the Team	Mar. 10, 2022 from 12-1pm ET
Session 5	Advance Care Planning	Apr. 14, 2022 from 12:30-1:30pm ET
Session 6	Resources for LTC: Pre and Post Pandemic	May 12, 2022 from 12:30-1:30pm ET
Session 7	Spiritual and Religious Care as Part of the Holistic Approach	Jun. 9, 2022 from 12-1pm ET
Session 8	Supporting New Team Members	Jul. 14, 2022 from 12-1pm ET
Session 9	Honouring Personhood in Dementia Care	Aug. 11, 2022 from 12-1pm ET
Session 10	Diversity and Inclusion in the Long-Term Care Setting	Sep. 8, 2022 from 12-1pm ET
Session 11	Meaningful Measurement to Support Health System Improvements in LTC	Oct. 13, 2022 from 12-1pm ET
Session 12	Mental Health and Resilience During the COVID Pandemic: Part 1	Nov 10, 2022 from 12-1pm ET
Session 13	Mental Health and Resilience During the COVID Pandemic: Part 2	Dec 8, 2022 from 12-1pm ET

Welcome and Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from and what your role is in the Long-Term Care setting
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties, but also please also feel free to raise your hand!
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **12 Mainpro+** credits.

Advance Care Planning

Objectives of this Session

Upon completing the session, participants will be able to:

- Explain advance care planning
- Undertake advance care planning
- Refer oneself- colleagues, residents and families to useful ACP resources
- Navigate challenging ACP situations.

Welcome

- The Canadian Hospice and Palliative Care Association (CHPCA) acknowledges that our office is located on un-ceded territory of the Algonquin Anishinaabeg People, who have lived on this territory for millennia.

- Their culture and presence have nurtured and continue to nurture this land. We are grateful to have the opportunity to be present in this territory.

Advance Care Planning (ACP) in Canada

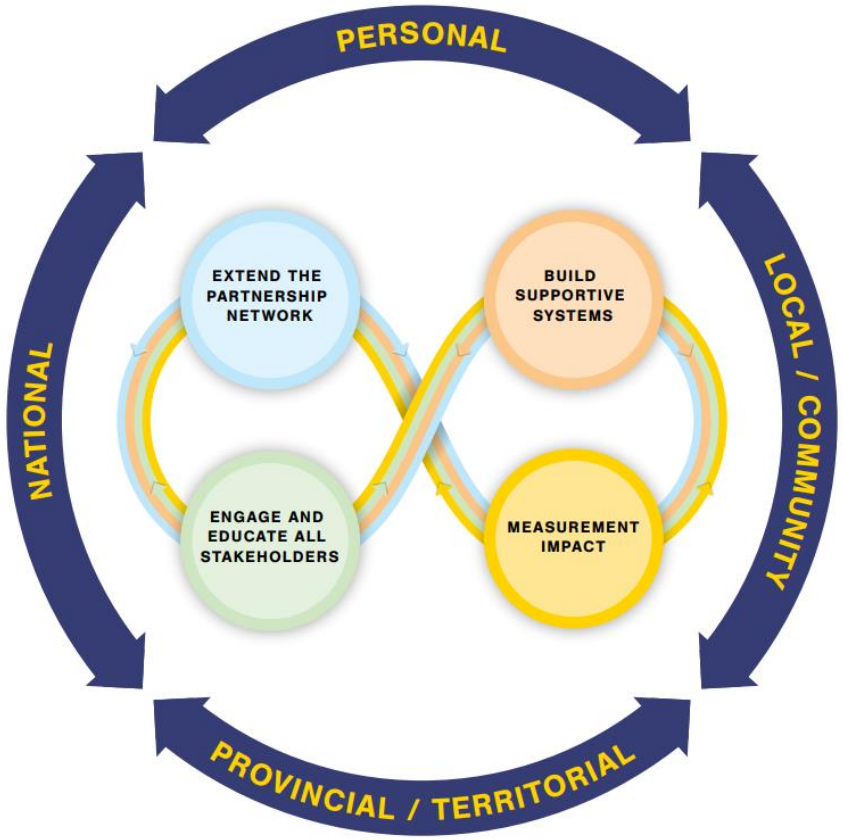
- CHPCA has run the Advance Care Planning (ACP) in Canada initiative since 2008, developing a National Framework for advance care planning in collaboration with several sectors and professional groups

- The updated Framework sets out a new strategy to help people move from thinking that Advance Care Planning is a good idea to having those important conversations

- To do that, we must make Advance Care Planning a normal part of the life journey and give all people in Canada regular opportunities throughout their lives to express their wishes for their future care

Advance Care Planning CANADA

ACP Canada Framework - Model



EXTEND THE PARTNERSHIP NETWORK

Key Priorities

- Identify potential partners with a shared purpose
- Integrate efforts to promote ACP

BUILD SUPPORTIVE SYSTEMS

Key Priorities

- Remove legal barriers to ACP engagement
- Identify ways to improve ACP processes within systems
- Invest in ACP
- Increase accountability for ACP

ENGAGE AND EDUCATE ALL STAKEHOLDERS

Key Priorities

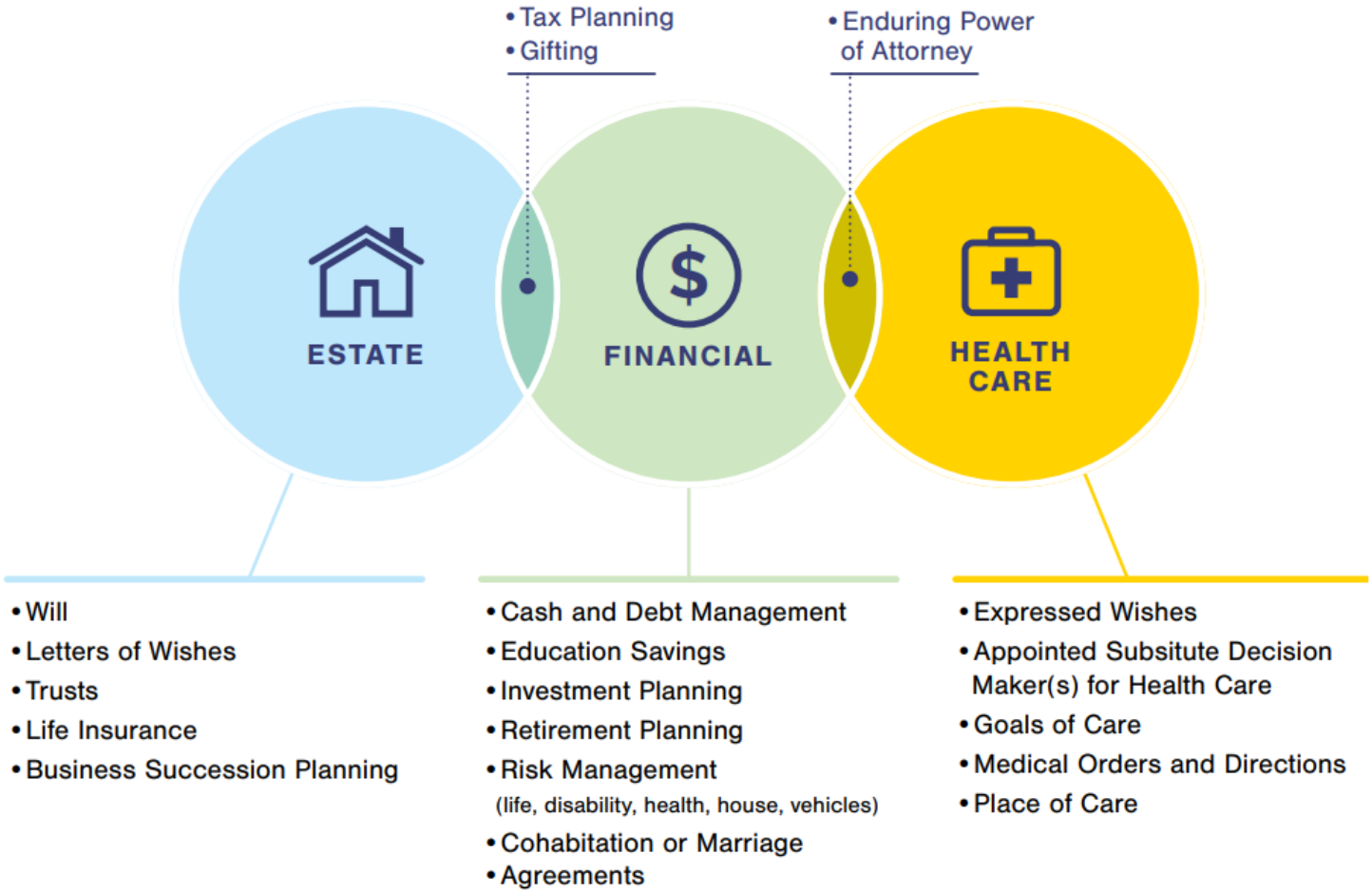
- Normalize ACP conversations
- Reach out to underserved communities
- Support service providers and champions

MEASUREMENT IMPACT

Key Priorities

- Establish targets and key performance indicators
- Use data to drive change

The Life Planning Model



Advance Care Planning

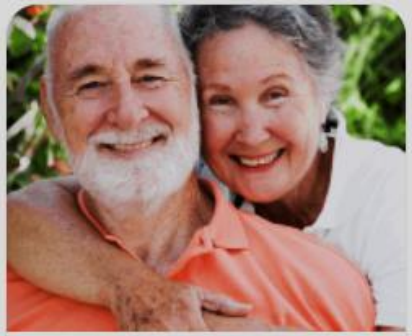
- A process of reflection and communication in which people express their wishes for their future health and/or personal care if they could not speak for themselves

- ACP helps people and their loved ones prepare for situations where difficult decisions need to be made

Why is Advance Care Planning Important?

- Reinforces the importance of tailoring care to each person's needs and wishes
- Reduces some of the distress, anxiety and uncertainty that individuals, their loved ones, and their health care providers may experience during a serious health issue or crisis
- Can lead to better communication and preparation when making health care decisions
- Supports health system priorities of patient safety, quality improvement, and people-centered care

5 Steps of Advance Care Planning



Think

about what is most important to you – your values, wishes and beliefs.

Learn

about your overall health. This may include current conditions you want to better understand.

Decide

on your Substitute Decision Maker(s), one or more people who are willing and able to speak, for you if you cannot speak for yourself.

Talk

about your values, beliefs and wishes with your Substitute Decision Maker(s), family, friends and health care providers.

Record

your values, wishes and beliefs in your Advance Care Planning Guide, in a letter, poem, video or audio recording.

The silent 6th step - Review

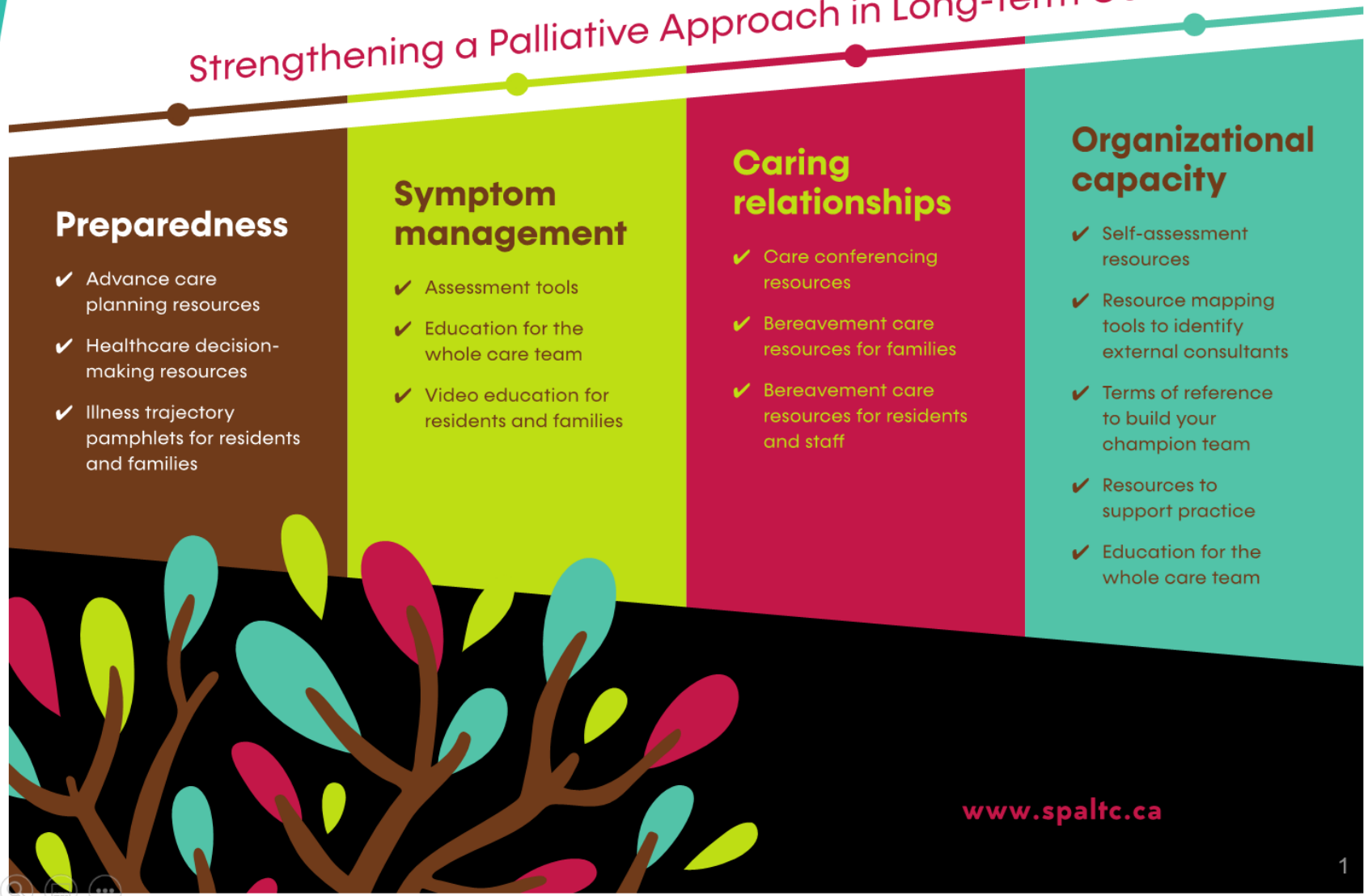
- **Why?** Patient and caregiver understanding of health and treatment options can change over time, as can their values and goals
- **When?** Whenever life, health or circumstances change
- **How?** Use the same five-step process. If anything changes, ensure others are aware of the changes (e.g., substitute decision maker)

A Palliative Approach to Care

- Focuses on meeting a person's and family's full range of needs — physical, psychosocial and spiritual – at all stages of frailty or chronic illness, not just at the end of life

SPA-LTC

Strengthening a Palliative Approach in Long-Term Care



Strengthening a Palliative Approach in Long-Term Care
SPA LTC

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Our Strategy

- Informed by Participatory Action Research (PAR)
- Balances action (change) with research (understanding)

Illness Trajectory Pamphlets

- Provide information on chronic progressive life-limiting illnesses
- Encourage residents and families/friends to engage in ACP in LTC
- Resources have been implemented and evaluated in LTC

Our Results

- Residents and family reported the pamphlets:
  - encouraged reflection (84%)
  - helped to clarify what to ask (70%)
  - increased comfort talking about EOL (63%)

JAMDA

journal homepage: www.jamda.com

Original Study

Condition-Specific Pamphlets to Improve End-of-life Communication in Long-term Care: Staff Perceptions on Usability and Use

Tamara Sussman PhD [a,*], Sharon Kaasalainen PhD [b], Eunyoung Lee MSW [a], Noori Akhtar-Danesh PhD [b], Patricia H. Strachan PhD [b], Kevin Brazil PhD [c], Robin Bonifas PhD [d], Valérie Bourgeois-Guérin PhD [e], Patrick Durivage MSc [f], Alexandra Papaioannou MD [g], Laurel Young PhD [h]

Article

"Now I Don't Have to Guess": Using Pamphlets to Encourage Residents and Families/Friends to Engage in Advance Care Planning in Long-Term Care

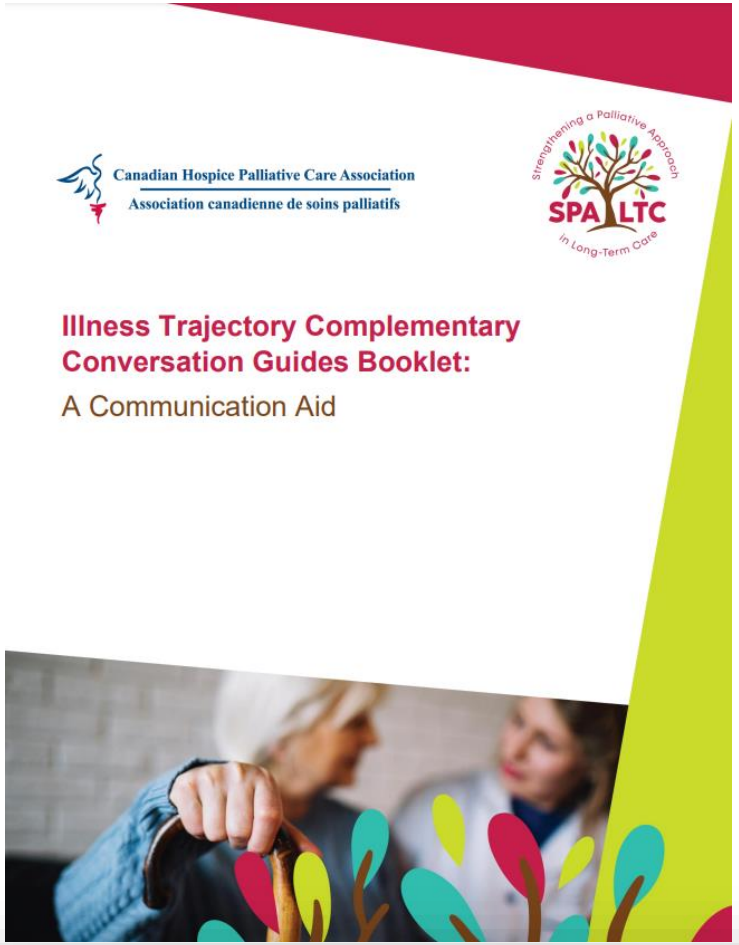
Tamara Sussman, MSW, PhD[1], Sharon Kaasalainen, RN, PhD[2], Matthew Bui, RN, BScN, BScKin, MSc[2], Noori Akhtar-Danesh, MSc, PhD[2], Susan Mintzberg, MSW[1], and Patricia Strachan, RN, PhD[2]

Conversation Guide – Overview Video

ILLNESS TRAJECTORY COMPLEMENTARY CONVERSATION GUIDES: AN INTRODUCTION

Conversation Guide

- Designed to assist Health Care Providers (HCP) in facilitating conversations with families
- Offers guidance on how to respond to questions within a palliative approach to care
- Designed to accompany any of the corresponding Illness Trajectory Pamphlets but may be used independently

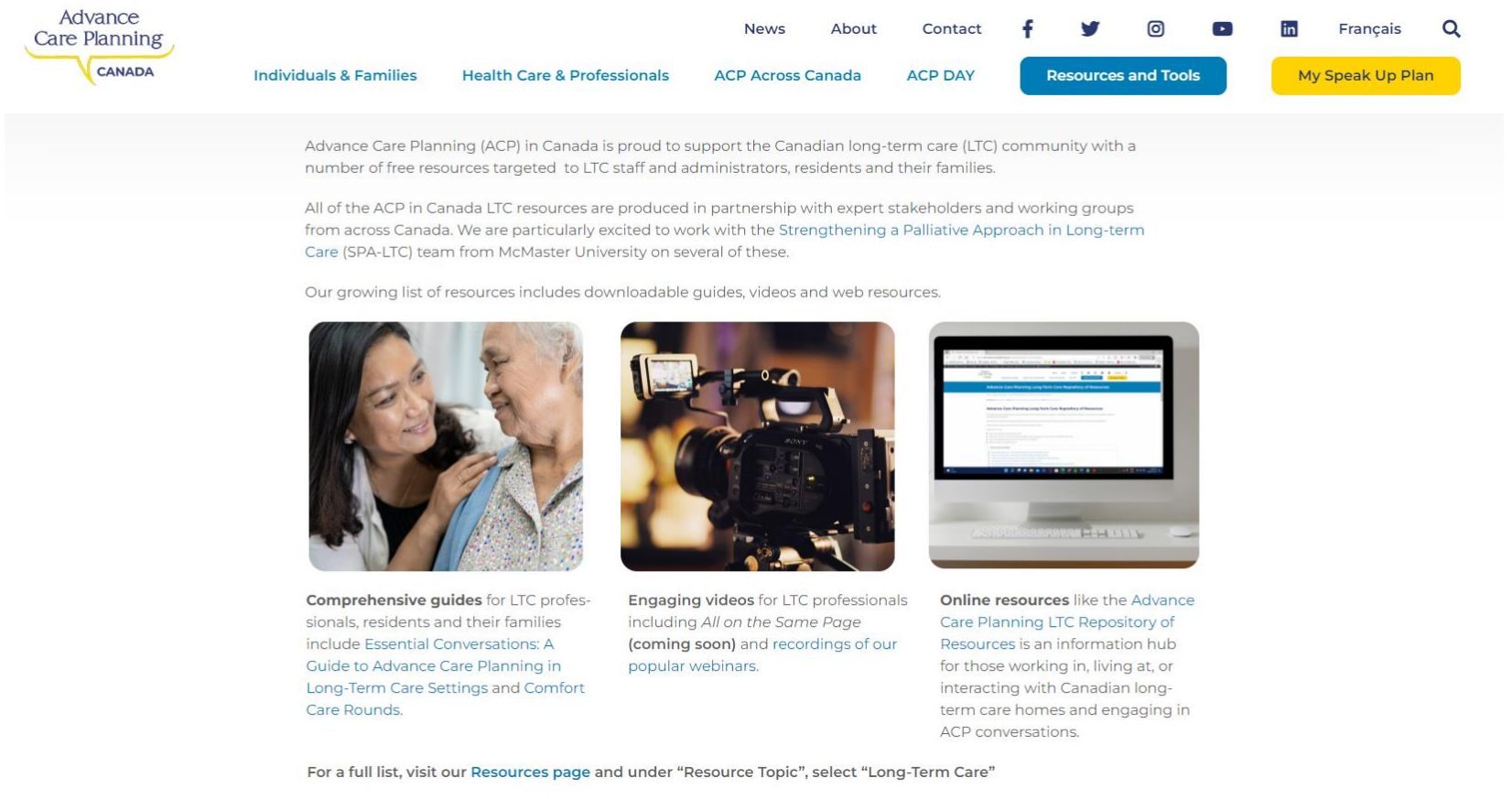


Introductory video

https://vimeo.com/656165692

ACP and LTC Resources

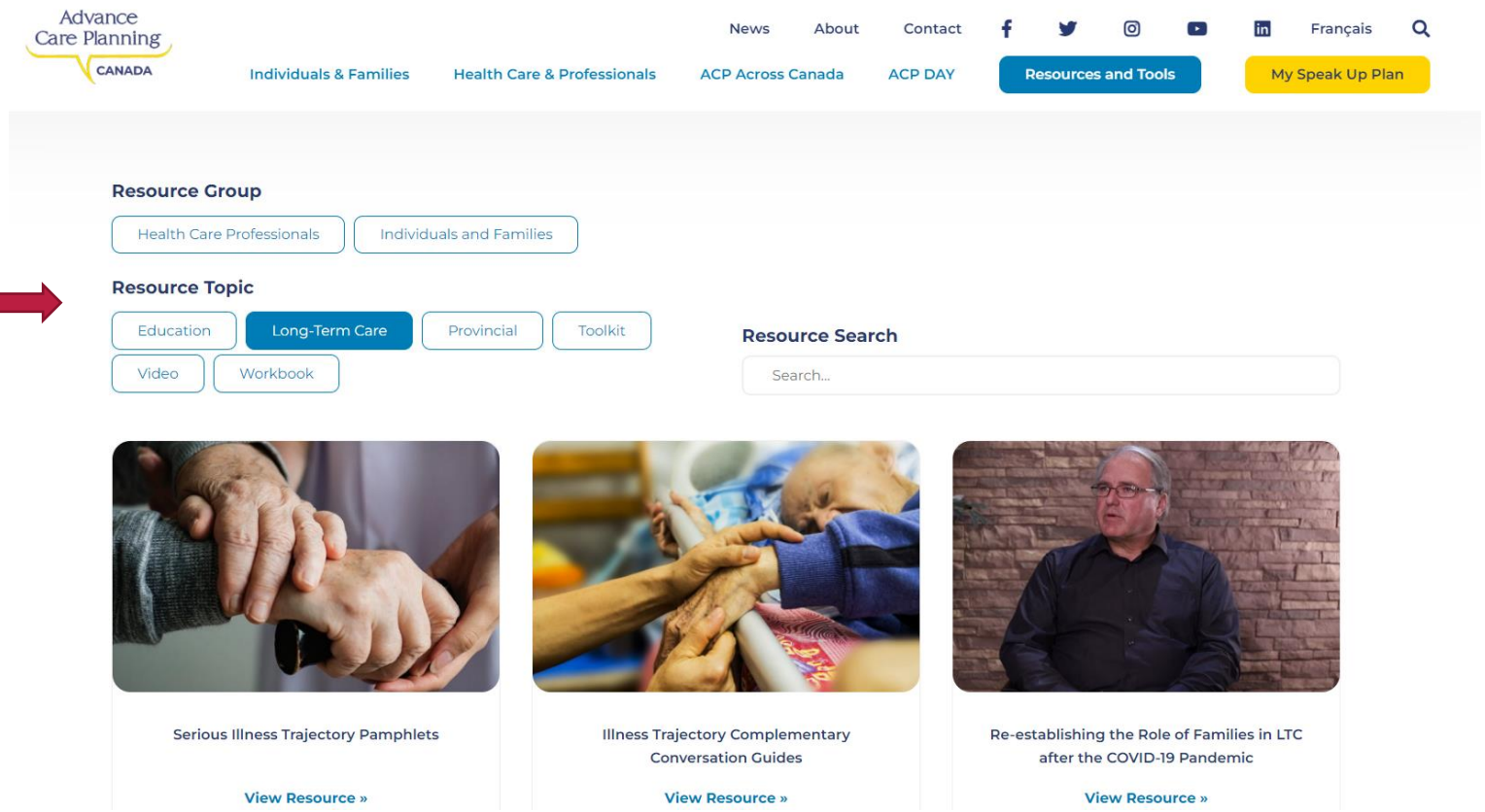
www.advancecareplanning.ca/ltc



ACP and LTC Resources

www.advancecareplanning.ca/resources-and-tools

Under ‘Resource Topic’ select ‘Long-Term Care’



Questions

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Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat
- A recording of this session will be emailed to registrants within the next week
- Please join us for the next Long- Term Care Community of Practice Session!
  - Resources for LTC: Pre and Post Pandemic
  - May 12th, 2022 from 12:30-1:30pm ET

Thank You

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