Ontario Long-Term Care Quality Improvement Community of Practice

Advancing Meaningful Conversations: Advance Care Planning and Goals of Care

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Host: Holly Finn, PMP

Presenter: Tara Cohen, MSW

Panelists: Rachel Ozer, PhD; Amit Arya, MD, CCFP (PC), FCFP

Date: April 22nd, 2025

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.

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.

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LEAP Long-Term Care

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- 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.
- Accredited by CFPC for **27.5 Mainpro+ credits** (online) and **26.5 Mainpro+ credits** (in-person).

Pallium Canada

LEAP
LONG-TERM CARE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-long-term-care

Introductions

Host:

Holly Finn, PMP
Senior Manager, Program Delivery

Presenter

Tara Cohen, MSW
Program Manager
Champlain Hospice Palliative Care Program

Panelists:

Amit Arya, MD CCFP(PC), FCFP
Palliative Care Physician, Ontario
Medical Lead, North York Congregate Access and Support Team
Palliative Care Physician, Freeman Centre for the advancement of Palliative Care
Medical Director, Specialist Palliative Care in Long-Term Care Outreach Program, Kensington Health
Lecturer, Department of Family & Community Medicine, University of Toronto
Assistant Clinical Professor, Division of Palliative Care, Faculty of Health Sciences,
McMaster University

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Senior Knowledge Broker
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Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Pallium is a registered charity
- Funded by Health Canada

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

Disclosure

Host/ Presenters/ Panelists:

- Holly Finn: Senior Manager, Program Delivery at Pallium Canada.
- Tara Cohen: Nothing to disclose

Mitigating Potential Biases:

The scientific planning committee had complete independent control over the development of program content.

Welcome and Reminders

- Please introduce yourself in the chat! Let us know your role is in the Long-Term Care setting.
- Your microphones are currently muted. There will be time throughout this session for questions and discussion, including breakout rooms
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties
- This session is NOT being recorded.
- Take comfort in knowing this is a safe space to share your thoughts and stories.
- Remember not to disclose any Personal Health Information (PHI) during the session

Overall Learning Objectives of this COP

Upon participating in this COP, members should be able to:

- Describe how quality improvement methodologies can support successful integration of a palliative care approach in long-term care homes
- Describe relevant metrics, change ideas and lessons learned from quality improvement initiatives implemented by peers
- Recall case discussions that demonstrate strategies to address challenges to a palliative approach to care
- Recall how to access resources to support QI work

Overview of Sessions

Session #	Date/ Time
Base Camp: Building a Foundation in Palliative Care Quality Improvement for your Home	January 29, 2025 from 12 to 1pm ET
Advancing Meaningful Conversations: Advance Care Planning and Goals of Care	April 22, 2025 from 12 to 1pm ET
From Recognition to Relief: Enhancing Pain Management in Dementia through Quality Improvement	June 4, 2025 from 12 to 1pm ET
PPS and other Palliative Assessment tools	October 1, 2025 from 12 to 1pm ET
Diversity, equity and inclusion considerations	November 26, 2025 from 12 to 1pm ET

Advancing Meaningful Conversations: Advance Care Planning and Goals of Care

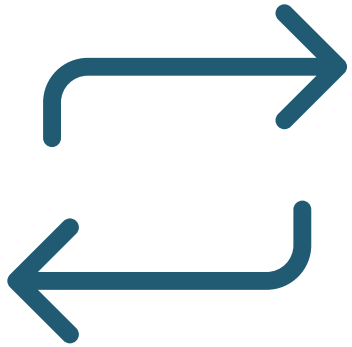
Agenda for today's session

- Overview of terms related to health and personal care decision-making
- Presentation of Preparing vs Deciding Framework
- Breakout Groups

Clarifying Confusing Terminology

Not aligned well with Ontario law

- Advance Care Plan
- Advance Directives
- Living Will
- Personal Directive



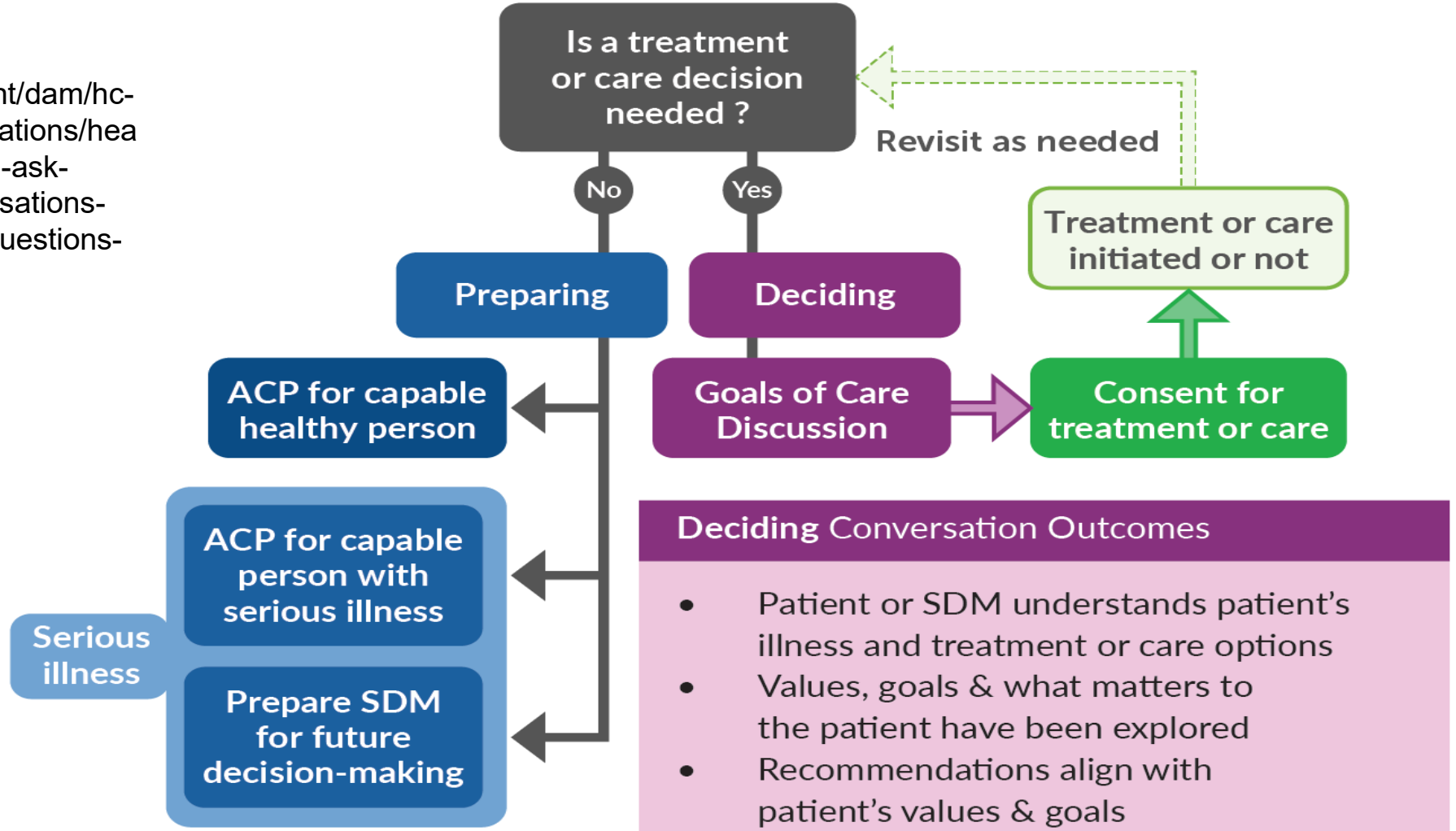
Well aligned with Ontario law

- Advance Care Planning
- Health Care Consent
- Power of Attorney
- Substitute Decision Maker
- Goals of Care

Is a treatment or care decision needed?

- **No** → **Preparing**
- **Yes** → **Deciding**

https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/questions-ask-yourself-make-difficult-conversations-about-serious-illness-easier/questions-ask-en.pdf



Deciding Conversation Outcomes

- Patient or SDM understands patient's illness and treatment or care options
- Values, goals & what matters to the patient have been explored
- Recommendations align with patient's values & goals

Preparing Conversation Outcomes

- Patient & SDM understand SDM's role
- Patient & SDM understand patient's illness
- Values, goals & what matters to the patient have been explored

ACP: Advance care planning
SDM: Substitute decision maker(s)

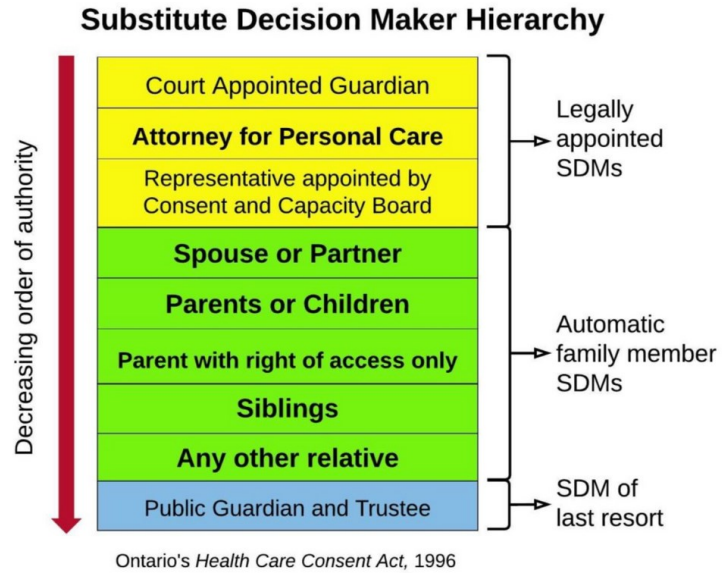
Advancing Meaningful Conversations

Preparing

Residents, SDM(s) and families:

- Ask about ACP (when and how; team confidence)
- Identification of best SDM(s) and their role
- Illness understanding

- Conversations:
  sharing what makes you uniquely you (strengths, fears, worries)
  discussing tradeoff



Advancing Meaningful Conversations

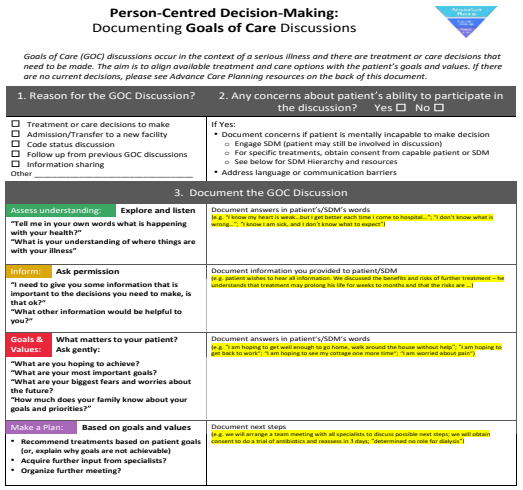
Deciding

LTC Home Team:

- Explore frameworks/programs to support ‘Deciding’ conversations.
- Who will receive which education?

Residents, SDM(s) and families:

- Explain purpose of GoC conversations.
- Discuss illness trajectory and align decisions with goals (who? how often?)



Best Interest Standard

Deciding

Applied when there are no known prior wishes

1. What are the person's known values and beliefs?
2. Will treatment improve the condition, prevent deterioration, or reduce the extent/rate of deterioration from the condition?
3. Would the person's condition improve, stay the same, or worsen if the treatment was not administered?
4. Do the benefits outweigh the risks?
5. Is there a less intrusive/invasive treatment that provides the same benefit?

Once these have been fairly considered, an SDM can be confident that they are acting in the best interest of the person.

Breakout Rooms

Two Rooms – Preparing and Deciding

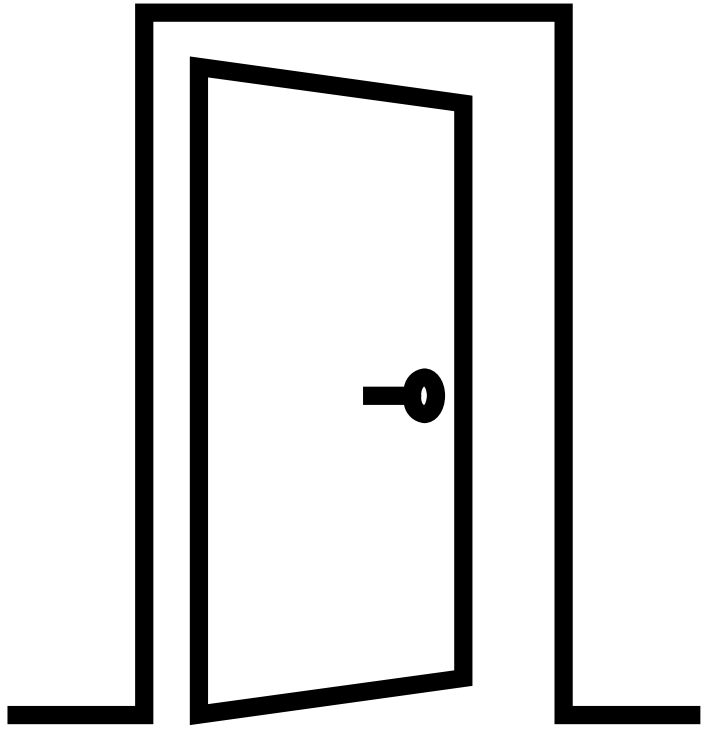
Where are you/is your home now with respect to meaningful conversations?

- What are the challenges?
- What possibilities are exciting?

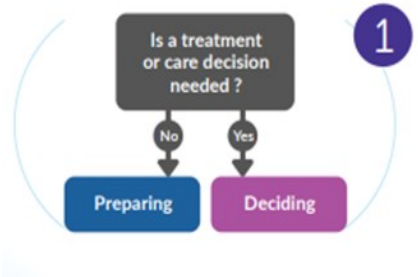
Why do you think meaningful conversations are the way they are?

Given what has been shared today what changes can be made?

- What is one thing that you/your home could implement?



Handout – Introducing a Palliative Approach Guide

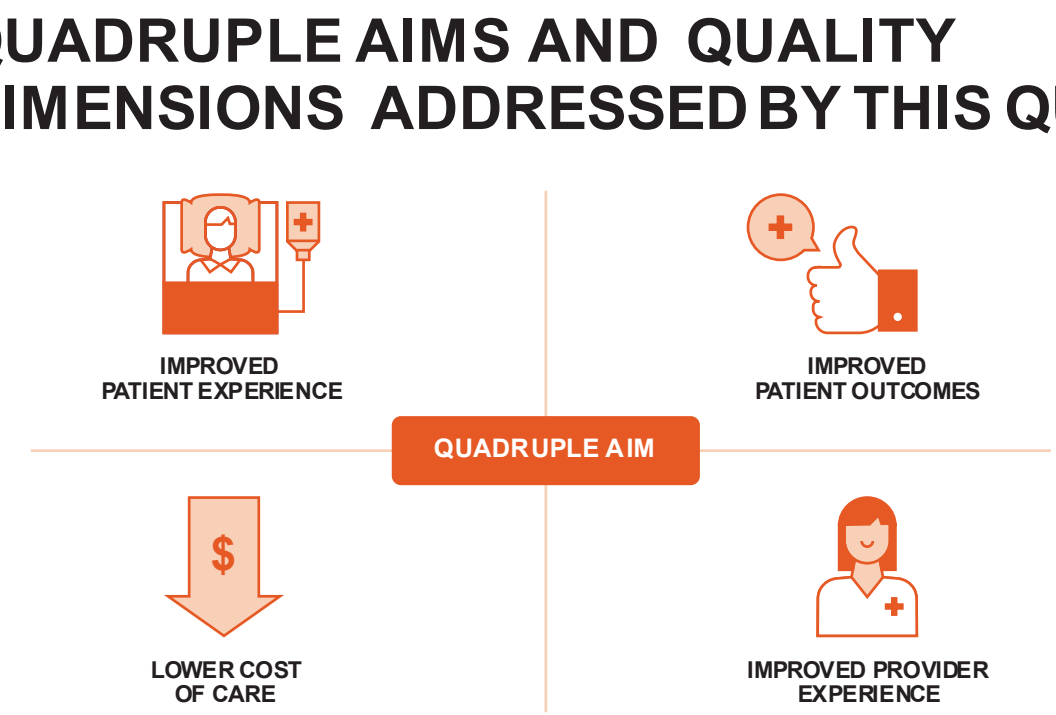


Explain the purpose of the conversation and its importance.

Assess illness understanding.

What matters to the person?

Quality Improvement Toolkit: Essential Conversations in LTC



This toolkit supports those working in long-term care facilities to improve essential conversations with residents and their substitute decision makers.

Session Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat.
- Join us four our Second Session that will be held on **June 04, 2025 from 12 to 1pm ET**
- A copy of these slides will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You

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