

Ontario Long-Term Care Quality Improvement Community of Practice

Advancing Meaningful Conversations: Advance Care Planning and Goals of Care



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).



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

Rachel Ozer, PhD, MHA

Senior Knowledge Broker

Ontario Centre for Learning, Research and Innovation in Long Term Care at Bruyère Health

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

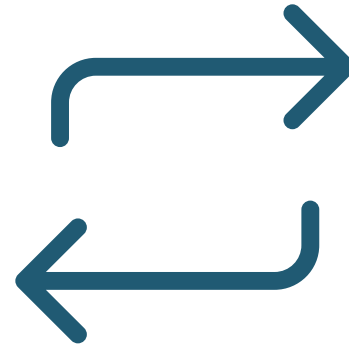
Agenda for today's session

- 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

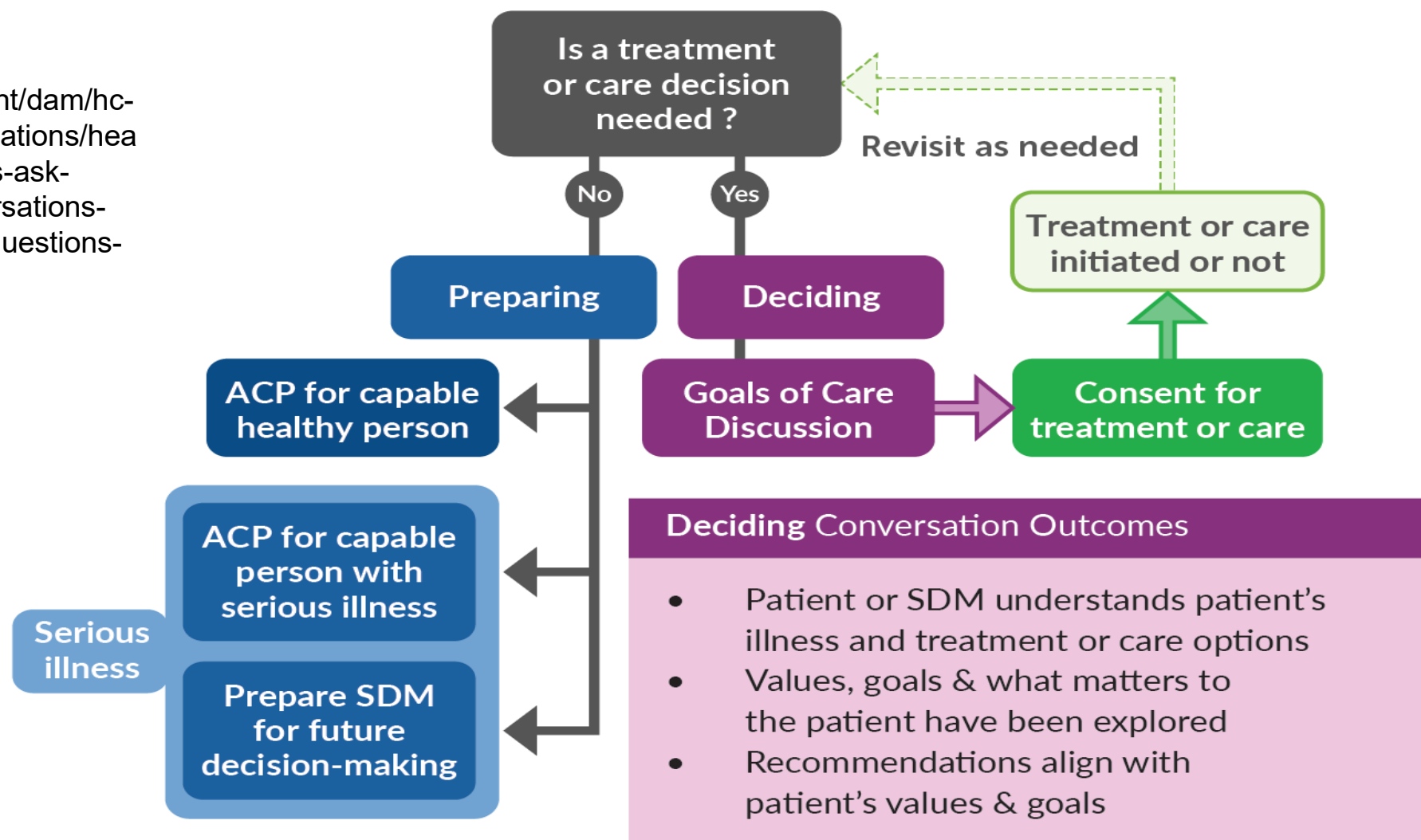


Preparing

Yes



Deciding



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

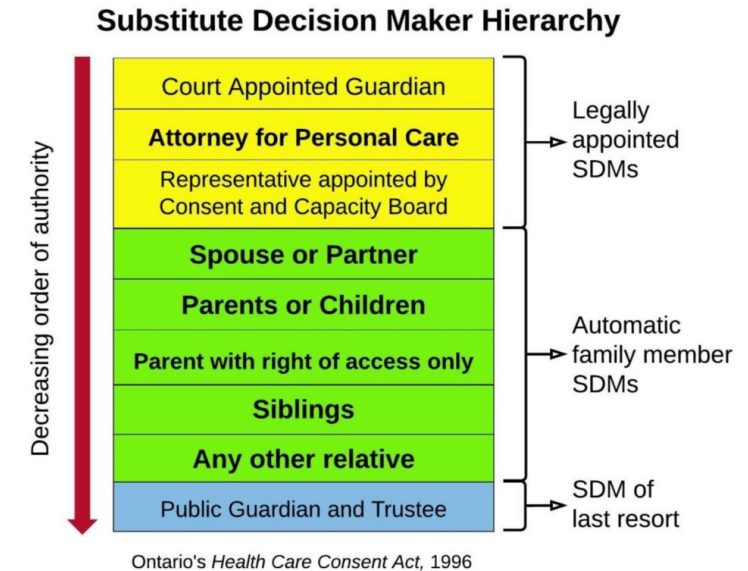
ACP: Advance care planning
SDM: Substitute decision maker(s)

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?)



Person-Centred Decision-Making: Documenting Goals of Care Discussions

Goals of Care (GoC) discussions occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient's goals and values. If there are no current decisions, please see Advance Care Planning resources on the back of this document.

1. Reason for the GoC Discussion?	2. Any concerns about patient's ability to participate in the discussion? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Treatment or care decisions to make <input type="checkbox"/> Admission/Transfer to a new facility <input type="checkbox"/> Code status discussion <input type="checkbox"/> Follow up from previous GoC discussions <input type="checkbox"/> Information sharing Other: _____	If Yes: • Document concerns if patient is mentally incapable to make decision o Engage SDM (patient may still be involved in discussion) o For specific treatments, obtain consent from capable patient or SDM o See below for SDM Hierarchy and resources • Address language or communication barriers
3. Document the GoC Discussion	
Assess understanding: Explore and listen "Tell me in your own words what is happening with your health?" "What is your understanding of where things are with your illness?"	Document answers in patient's/SDM's words e.g. "I know I am sick, and I don't know what to expect." "I don't know what to expect." "I know I am sick, and I don't know what to expect."
Inform: Ask permission "I need to give you some information that is important to the decisions you need to make, is that ok?" "What other information would be helpful to you?"	Document information you provided to patient/SDM e.g. "I am going to tell you about the benefits and risks of further treatment. The information that treatment may prolong life for weeks to months and that the risks are..."
Goals & Values: What matters to your patient? Ask gently: "What are you hoping to achieve?" "What are your most important goals?" "What are your biggest fears and worries about the future?" "How much does your family know about your goals and priorities?"	Document answers in patient's/SDM's words e.g. "I am hoping to get well enough to go home." "I want to be able to walk." "I am worried about the possibility of being in a hospital." "I am worried about..."
Based on goals and values • Recommend treatments based on patient goals (or, explain why goals are not achievable) • Acquire further input from specialists? • Organize further meeting?	Document next steps e.g. "We will arrange a team meeting with all specialists to discuss possible next steps. We will update patients to do a final of treatments and resources in 3 days." "Deferred no care for steps."

Best Interest Standard

Deciding

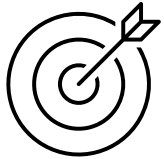
Applied when there are no known prior wishes

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.

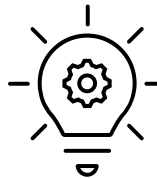
Breakout Rooms

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?

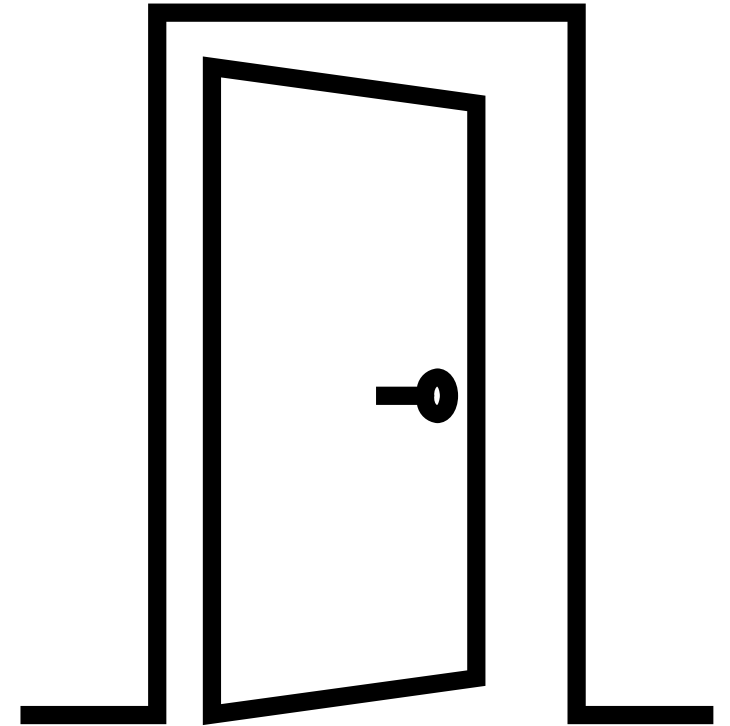


Why do you think meaningful conversations are the way they are?



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.



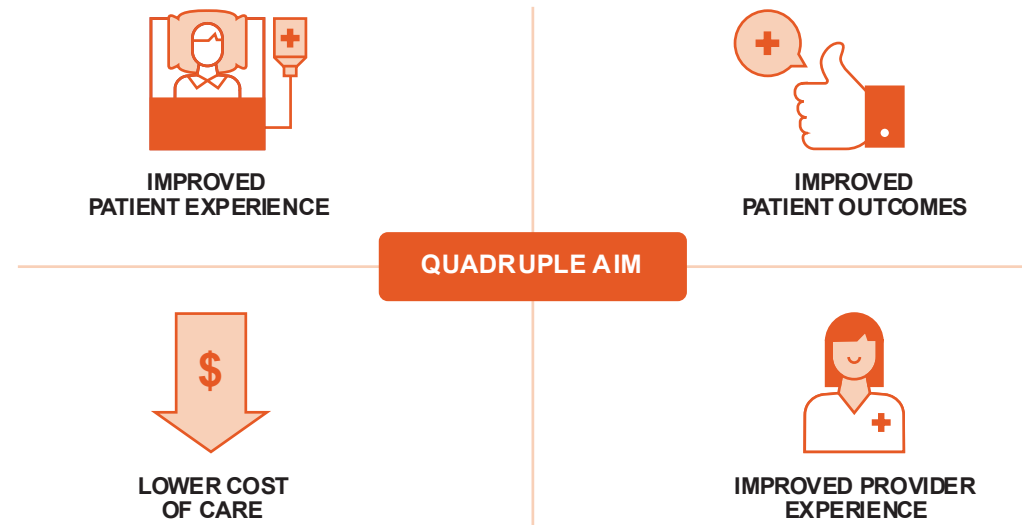
Assess illness understanding.



What matters to the person?

Quality Improvement Toolkit: Essential Conversations in LTC

QUADRUPLE AIMS AND QUALITY DIMENSIONS ADDRESSED BY THIS QUIC



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 for 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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