

Goals of Care in Long-Term Care: Lessons Learned



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PRESENTER DISCLOSURE



Presenter: Alena Hung

Relationships with financial sponsors:

 **Any direct financial relationships, including receipt of honoraria:**

None

 **Membership on advisory boards or speakers' bureaus:**

N/A

 **Patents for drugs or devices :**

None

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 **Any direct financial relationships, including receipt of honoraria:**

Regional Geriatric Program of Toronto, University of Toronto Continuing Education, Queen's University

 **Membership on advisory boards or speakers' bureaus:**

Advisory Board for Azrie li Foundation for Brain Medicine Program

 **Patents for drugs or devices :**

None

 **Other :**

Grants from Sunnybrook Hub for Applied Research in Education, Sunnybrook Practice-Based Research & Innovation, Quality and Patient Safety (QPS), and the Centre for Quality Improvement and Patient Safety (CQuiPS)

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Presenter: Robyn Moxley

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None

Membership on advisory boards or speakers' bureaus:

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None

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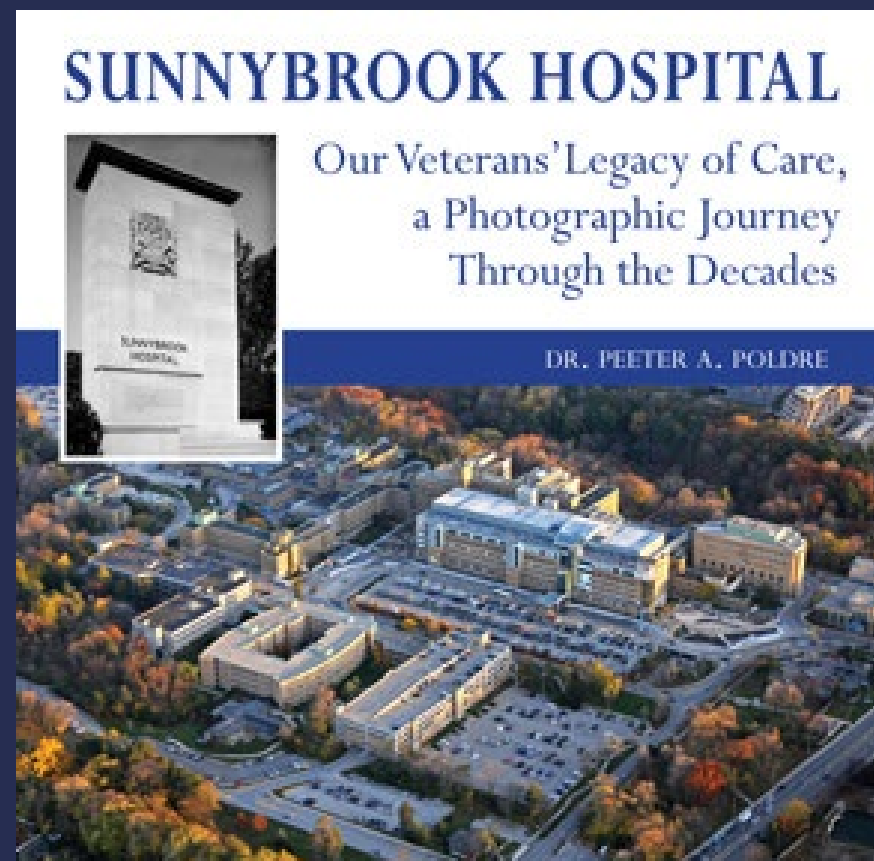
Agenda

Content	Time
Introduction, Goals of Care Overview	10 Minutes
Simulation	30 Minutes
Debrief/ Conclusion	20 Minutes

Objectives

At the conclusion of this activity, participants will be able to:

1. Describe an evidence-based approach to common goals of care scenarios in long-term care
2. Name 3 tools to support goals of care conversations in long-term care
3. Appreciate the potential role of a team-based approach to these conversations



E3PTF4



Ask the Audience

Goals of Care in Long -Term Care

- Most residents in long-term care live with multiple, chronic, progressive, and life limiting illnesses.
- Goals of care conversations are an iterative communication process between residents, their families, and health care providers to explore hopes, wishes, and values for health care in a current context to guide decisions about the use or limitation of specific interventions (Secunda et al., 2019).
- These conversations should happen early, often, and be focused on how to enable ourselves to provide value concordant care.

The Conversations

What does the evidence say?

WHO: Resident, SDM, whoever the resident or family define as important to decision making process, Relevant team members (most important to have someone present with good rapport with resident/family)

WHAT: Have a clear plan and objective for the conversation.

WHERE: Quiet, comfortable private space.

WHEN: Early and often.

WHY: To ensure value concordant care

(Rosemond et al., 2017, You et Al., 2015; Cooper et al., 2016, Makoul & Clayman, 2006; Elwyn et al., 2013, Bernacki & Block, 2015, Myers et al., 2018; Vermunt et al., 2017; Austin et al., 2015; Bernacki & Block, 2014; NICE Clinical Guidelines on End of Life Care, 2019).

Shared Decision Making



Shared Decision Making (SDM) is a collaborative process between clinicians and patients whereby health care decisions are discussed in reference to the best available evidence, but also rooted in the patient's values, wishes, and preferences

(Makoul & Clayman, 2006; Elwyn et al., 2013).

Tools to Support Conversations

- Respecting Choices
- Go Wish
- Life Sustaining Treatment Initiative
- REMAP
- Serious Illness Conversation Guide

Input

- National LST Advisory Board
- Subject matter experts internal to VA
- Dedicated national LSTDI program to support implementation
- Field staff (clinical duty)
- VA Information Technology (IT) Process
- Budget
- Contracting
- Internal and external collaboration partnerships

Table 1. Example

REMAP

Reframe

Emotion

Map

Align

Propose a Plan

Assumptive LSTDI entails a conversation within 18 months over several years

<https://www.cfp.ca/content/66/7/533>

Figure 1. Serious illness conversation guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. Set up the conversation <ul style="list-style-type: none"> - Introduce purpose - Prepare for future decisions - Ask permission 	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?"
2. Assess understanding and preferences	"What is your understanding now of where you are with your illness?" "How much information about what is likely to be ahead with your illness would you like from me?"
3. Share prognosis <ul style="list-style-type: none"> - Share prognosis - Frame as a "wish...worry", "hope...worry" statement - Allow silence, explore emotion 	"I want to share with you my understanding of where things are with your illness..." Uncertain: "It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I'm worried that you could get sick quickly and I think it is important to prepare for that possibility." OR Time: "I wish we were not in this situation, but I am worried that time may be as short as ____ (express as a range, e.g. days to weeks, weeks to months, months to a year)." OR Function: "I hope that this is not the case, but I'm worried that this may be as strong as you will feel, and things are likely to get more difficult."
4. Explore key topics <ul style="list-style-type: none"> - Goals - Fears and worries - Sources of strength - Critical abilities - Tradeoffs - Family 	"What are your most important goals if your health situation worsens?" "What are your biggest fears and worries about the future with your health?" "What gives you strength as you think about the future with your illness?" "What abilities are so critical to your life that you can't imagine living without them?" "If you become sicker, how much are you willing to go through for the possibility of gaining more time?" "How much does your family know about your priorities and wishes?"
5. Close the conversation <ul style="list-style-type: none"> - Summarize - Make a recommendation - Check in with patient - Affirm commitment 	"You heard you say that ____ is really important to you. Keeping that in mind, and what we know about your illness, I recommend that we _____. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. Document your conversation	
7. Communicate with key clinicians	

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Time for Simulation



Overview of Simulation

- The rules of simulation include:
 - Psychological safety: our **basic assumption** is that all participants are capable, want to do their best, and are looking to improve
 - Confidentiality: please do not discuss the contents of this simulation outside of this setting
 - Mistakes happen: we expect this
 - If in doubt, you can call a “time out”!
 - Have fun and learn.

Overview of Simulation Continued

- Take the first 5 – 10 minutes to read about your scenarios and **prepare** to role play.
- **Role play** for ~ 10 minutes
 - Remember: “Time Outs” are permitted
- Group will reconvene for a **debrief** (~ 10 minutes).

Scenarios

Please break into groups of 3:

- One person will play the role of the patient/family member
- One person will play the role of the healthcare professional (your role)
- One person will observe the interaction (focusing on verbal and non-verbal communication).

Choose your own adventure....

Please choose one card from each of the following categories to build a patient story:

- For the person playing the role of the healthcare professional, please choose one card from each of the following categories:
 - Patient
 - Clinical History
- For the person playing the role of the patient/family member, please choose the cards from the “Patient/Family Member” box that matches the number/letter that your “healthcare provider” has selected.
- Once you have had a chance to read the role play stems, please begin your role play. You may supplement information and/or change the scenario as you see fit.

Debrief

Plus (What Went Well)	Delta (What Would You Change)

Top 5 Tips for Goals of Care Conversations

inLTC

TOP 5 TIPS FOR GOC CONVERSATIONS IN LTC



THANK YOU!



PLEASE FILL OUT YOUR SESSION EVALUATION NOW

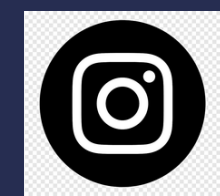
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