



# My Wishes, My Care

Community-led  
Advance Care Planning  
sessions for the public

Program  
Overview



## Acknowledgement

Thank you to everyone who contributed to the development and revision of this program. Without their contributions this undertaking would not have been possible. The development and review process, and the people involved are outlined in [Appendix A](#) in the Program History section.

Particular thanks to the Comox Valley Hospice Society and the Community Engagement Advisory Network (CEAN) of Vancouver Coastal Health Authority for sharing their experience and wisdom on public education in Advance Care Planning.

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## Introduction

### Program Materials

This Program Overview forms one piece of the toolkit for the *Community-led Advance Care Planning sessions for the public* program.

This guide shares important background information on Advance Care Planning, history of the community-led model, and an overview of the program. This guide is intended for everyone involved in the program to review, including organizers and facilitators.

Other components of the toolkit include:

- **Community Partner Guide** - important information and instructions for organizers on promotion, planning and evaluation.
- **Facilitator Guide** - important information about the Advance Care Planning sessions for facilitators.
- **Public-facing materials for public participants** - presentation slides, handouts, example Advance Care Plans etc.

Alongside this toolkit, the BC Centre for Palliative Care (BCCPC) provides facilitator training, and coaching and mentoring.

## Advance Care Planning

### Evolution of Advance Care Planning Concept

The definition of Advance Care Planning has evolved over time. An updated definition was developed by a group of Advance Care Planning experts and published in early 2017:

“ **Advance Care Planning** is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

*The goal of Advance Care Planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.<sup>1</sup>*

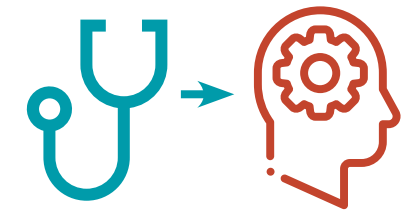
## Advance Care Planning has changed

The focus of Advance Care Planning has evolved over time. These changes have expanded the benefits and relevance of Advance Care Planning. Research has led to a number of changes in our approach:

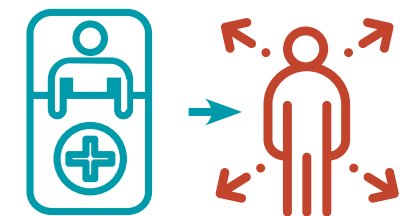


**Past emphasis: document completion → Current emphasis: conversation.** Advance Care Planning practice previously targeted document completion. However, it has been shown that document completion alone does not improve patient/health-care provider communication<sup>2</sup>, or the accuracy of substitute decision making.<sup>3,4</sup>

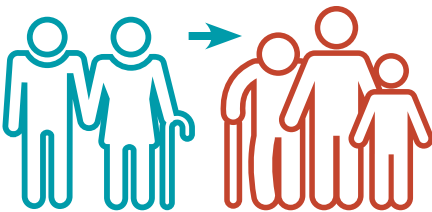
The emphasis has therefore shifted from the document to the care planning process,<sup>5</sup> where the conversation is recognized as a valuable component and an outcome in and of itself.<sup>6,7</sup>



**Past focus: treatment preferences → Current focus: outcomes, values and beliefs.** Early documents focused on outlining specific treatment preferences. However, applying these ‘black and white’ preferences to the nuanced circumstances that actually arise is difficult,<sup>5,7-9</sup> and people in good health are generally unable to predict what they would want in stages of poor health.<sup>10</sup> This has led to the development of documents that are more focused on outcomes, values and beliefs, and can be applied to whatever circumstances arise.<sup>7,8</sup>



**Past benefits: incapacity planning → Current benefits: future decisions, with or without capacity.** Initially, the cited benefits of Advance Care Planning were restricted to times when a person cannot make or communicate a decision about health-care treatment (times of incapacity). However, research has demonstrated additional benefits to Advance Care Planning, such as increased satisfaction with care, increased quality of life, and decreased depression.<sup>11-14</sup>



**Past relevance: people at end of life → Current relevance: all adults at any age or stage of health.** While some aspects of Advance Care Planning are more appropriate for people with serious illness or nearing the end of their life, other aspects are relevant for everybody, such as choice of a Substitute Decision Maker and any known wishes relating to sudden catastrophic events. Depending on a person's stage of life and/or their illness, different Advance Care Planning conversations and activities are recommended to help ensure their health care is consistent with their values, goals and preferences.<sup>15</sup>

## Advance Care Planning Definition in Plain Language

BC Centre for Palliative Care (BCCPC) uses the following description to explain to the public the meaning of the term “Advance Care Planning”:

“ **Advance Care Planning is a process of:**

- *thinking about your values, beliefs, and wishes for future health and personal care, and*
- *sharing them with the people you trust.*

*It can include choosing who would make care decisions for you if you cannot. Advance Care Planning can help you get the care that's right for you, even in you're unable to speak for yourself.*

## Pan-Canadian Framework for Advance Care Planning

In 2019, a Pan-Canadian framework on Advance Care Planning was released.<sup>16</sup> The framework envisions a Canada where:

- Advance Care Planning is a normal part of the life journey;
- Advance Care Planning is part of life planning. Like financial and estate planning, care planning is an equally important life-long process (see Figure 1);
- All people in Canada have regular opportunities to express their wishes for their future care;
- The care they receive reflects their wishes; and,

If they can't speak for themselves, their Substitute Decision Makers are ready to speak confidently on their behalf.

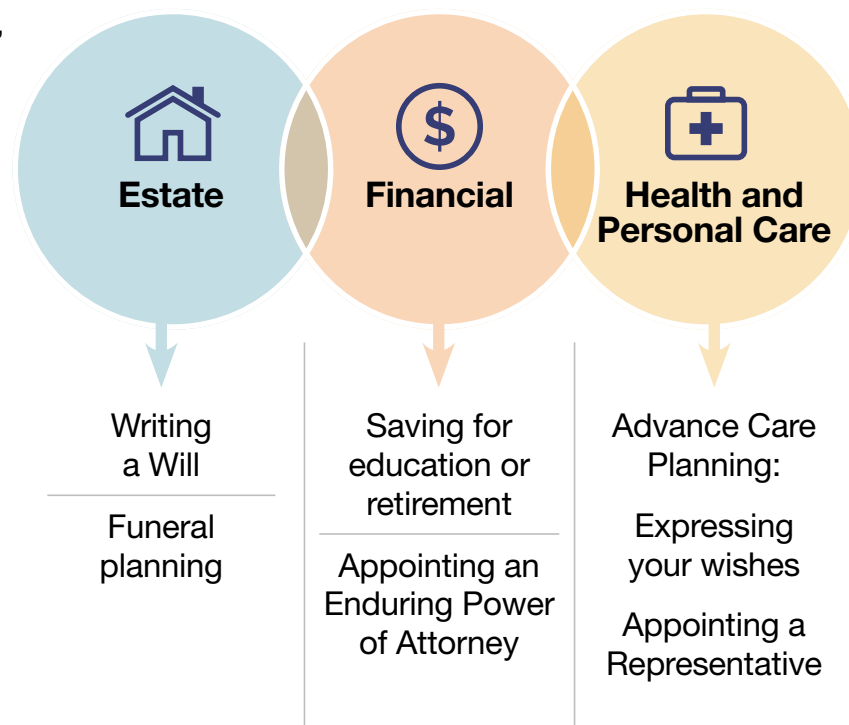


Figure 1: Advance Care Planning as part of life planning<sup>16</sup>

An integral part of the framework is respect for diversity. Culture plays a strong role in how people view health-care decisions, particularly those made near the end of life. Advance Care Planning is open to, respects, and supports the cultural, ethnic, sexual, gender, religious, socio-economic, geographic, and ability diversity of Canada, including the wide range of beliefs and practices related to life, health and well-being, individual and collective decision making, and death and dying.<sup>16</sup>

Care planning may be a new concept for many people, especially for newcomers and recent immigrants who may find that Canadian healthcare system operates quite differently than they are used to. Advance Care Planning is an effective process that opens up lines of communication with health care professionals to ensure that patients get the care that is best for them and that respects their traditional culture and values.

## Community-led Advance Care Planning Model

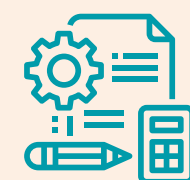
The community-led Advance Care Planning model represents the culmination of many years of work undertaken by both the BC Centre for Palliative Care and a large network of community partners who have participated in the development, adoption, and evaluation of the model's curriculum and toolkit.

**The model is designed to** empower community-based organizations to stimulate Advance Care Planning conversations in the community and support British Columbians to have their wishes for health and personal care known to their circle of family and friends and health care providers.

**The goal is** to help British Columbians get the care that's right for them and is aligned with their values, beliefs, and wishes.

### Did you know...

76% of British Columbians agree that it's important to talk about what matters most for their future health care with those close to them and their health-care providers, but:



**Only 33%** have heard of Advance Care Planning



**Only 48%** have had a conversation with family



**Only 14%** have had a conversation with a health-care provider



**Only 28%** have documented or recorded their health-care wishes

Source: B.C. public opinion poll commissioned by the BCCPC and conducted by Mustel Research Group: Advance Care Planning, 2020.

## Model Components



## Program History

The original version of the community-led Advance Care Planning information sessions program for the public was developed in 2016. This version includes updates based on learnings from:

- Experiences facilitating community-led Advance Care Planning sessions for the public.
- Adaptations made to better meet the specific needs of the Chinese and South Asian communities. Key materials have also been translated into Simplified and Traditional Chinese and Punjabi.
- Adaptations made to better meet the needs of people living with early stages of dementia and their family and friends.

Further information about the program history is included in [Appendix A](#).

## Nationally Recognized Model

The BCCPC's community-led Advance Care Planning education model for the public received national recognition by both the Canadian Foundation for Health Improvement (2017)<sup>18</sup> and the Canadian Frailty Network (2018)<sup>19</sup> as an innovation that should be spread nationally.

## Program Benefits

The program aims to:

- **Empower the public** to advocate for care that is aligned with their wishes and helps them get the care that is right for them.
- **Offer community organizations** the opportunity to relate to the needs of their communities and engage with the public in a proactive, health-oriented way.
- **Offer volunteers** who have a passion to give back to their community the opportunity to develop their knowledge and skills and equip them with the necessary tools that support them in the Advance Care Planning facilitator role.

## *The program helps communities at large become Compassionate Communities.*

**A Compassionate Community** is a community of people who are passionate and committed to improving the experiences of those living with a serious illness, caregiving, dying, or grieving. A Compassionate Community takes an active role in caring for people affected by these experiences, connects people to supports, raises awareness about end-of-life issues, and builds supportive networks.

## Partners in Program Delivery

1. **BC Centre for Palliative Care** - provincial program coordinator
2. **Community organizations** - organizers of Advance Care Planning public sessions
3. **Volunteers or staff affiliated with community organizations** - facilitators of Advance Care Planning public sessions.

## Partner Roles and Responsibilities

### BC Centre for Palliative Care

As the organization coordinating the provincial program, BCCPC has the responsibility to provide the following support and tools:

#### For community organizations:

- Planning resources that outline the necessary components for hosting sessions.
- Resources to support the organization in developing its own Advance Care Planning education program.
- Tools to support the ongoing evaluation of the sessions.
- Marketing tips and examples.

#### For trained facilitators:

- Training in the form of an online training module about Advance Care Planning, background reading materials, and an in-person or online workshop.
- Resources to support session delivery online and in person. These resources are available in Simplified and Traditional Chinese and Punjabi where applicable.
- List of additional online resources to support the facilitator's knowledge of Advance Care Planning and facilitation skills.
- Information tools that can be given to participants to take home after the session. These tools are available in English, Simplified and Traditional Chinese and Punjabi.

### Community Organizations

The role of community organizations is to support the facilitators in their role, and to ensure the sessions are current and accurate in content and can be sustained.

As the organizer of the Advance Care Planning sessions, community organizations have the following areas of responsibility:

- **Recruitment of volunteers or staff for the facilitator role as per BCCPC's criteria** (see section The right facilitator, [page 17](#))
- **Ensure staff and volunteers complete BCCPC's training requirements** (see training plan in [Appendix B](#))

- **Ongoing support for facilitators, including:**

- Encourage facilitators to be reflective of their work.
- Support the collection of feedback from session participants, including collection and analysis of session evaluation data, and sharing the results.
- Provide facilitators with opportunities to debrief and receive constructive feedback.
- Provide an avenue for facilitators to express concerns related to their roles and responsibilities.

- **Administrative support, including:**

- Logistical support to organize the sessions, including matters such as venue, advertising, and provision of session supplies such as participant handouts (see *Community Partner Guide* for program planning information).
- Secure necessary funds for the session through:
  - o the organization's resources,
  - o a minimal fee to recover costs (*the sessions are not-for-profit, but may require funds 'by donation' or a nominal charge to recover costs*), or
  - o partnership/sponsorship with other community groups (*in accordance with the organization's guidelines to avoid potential conflicts of interest*).

- **Oversight**

- Ensure evaluation is conducted on an ongoing basis, including number of sessions, number of participants, collating feedback from evaluation forms and other relevant information (see *Community Partner Guide* for evaluation forms).
- Consider the need for risk management policies and practices related to the sessions; for example, how any complaints about the sessions will be resolved or how facilitators will be supported following a particularly challenging session.

## Facilitators

The role of the facilitator is to effectively lead the Advance Care Planning session and guide interactive conversations in an engaging, safe and respectful manner.

The facilitators are provided with tools to support the content of the session.

Responsibilities of the facilitator include:

- Create a comfortable and safe space for participants to talk about Advance Care Planning.
- Ensure the sessions cover the key information as outlined in the Facilitator Guide.
- Balance conversations and participant engagement with covering the key topics, to meet the desired outcomes of the session.
- Present the information in a neutral manner. Share information, not opinions.
- Refer questions not covered in the Advance Care Planning facilitator training or materials to other resources.
- Share examples, stories, and videos that illustrate the importance of Advance Care Planning and the process of Advance Care Planning.
- Provide participants with tools and resources that can help them engage in Advance Care Planning after the session.
- Aim to model comfort in having conversations about:
  - values and beliefs (what matters most to people) related to future health-care decision making.
  - Advance Care Planning, including comfort discussing death and dying.
- To not provide direction or advice on individual situations.
- To not cover any out of scope topics.

More detailed information and tips for facilitators can be found in the *Facilitator Guide*.

## About the Sessions

This section provides fundamental information about the goal and structure of the Advance Care Planning public sessions.

### Goal

To help adults (those 19 and older) engage in their health-care decision making.

### Objectives

To stimulate and support thinking, talking, and planning related to Advance Care Planning by:

- providing information about Advance Care Planning so participants are aware of their options
- increasing the comfort level of participants in discussing Advance Care Planning with family and their health-care providers
- increasing awareness of resources to support participants in their Advance Care Planning

### Expected Benefits for Public Participants

- Increased participant knowledge of Advance Care Planning and its importance and benefits
- Increased participant readiness to engage in Advance Care Planning
- Motivate participants to engage in Advance Care Planning conversations

### Out-of-scope topics

- Discussions around personal planning related to legal and financial affairs
- Assistance with completion of a written Advance Care Plan or the accompanying legal forms
- Advice about a participant's personal situation
- Detailed information about capability and consent for health care
- Discussions about the needs of individuals with limited capability to participate in their own health-care decision making

### Operations

The Advance Care Planning sessions can be delivered in person or via an online platform. The session can be delivered as one or two sessions. More information is provided in the *Community Partner Guide* and *Facilitator Guide*.

To allow for an interactive session, the optimal number of participants for a session is eight to twelve participants with one facilitator. Sessions with between twelve and twenty participants should have two facilitators. For any groups over twenty participants, please add one facilitator for every ten additional participants. This will enable meaningful discussions to take place in small groups.



## Key concepts

The structure of the community-led Advance Care Planning public sessions is based on three key elements: the right content, the right facilitator, and the right approach.

### 1. The right content

The information provided to the public through the Advance Care Planning sessions was selected to serve the program’s goals and outcomes. The session emphasizes the importance of **thinking**, **talking** and **planning** about Advance Care Planning (see Figure 2), especially the importance of conversations related to Advance Care Planning.

The session content includes the following information:

- What is Advance Care Planning
- Why is Advance Care Planning important
- Who should do Advance Care Planning
- When to do Advance Care Planning
- How to do Advance Care Planning (Think/Talk/Plan/Review)
- Resources to support the participant’s on-going engagement in Advance Care Planning

A more detailed description of content can be found in the *Facilitator Guide*.

Figure 2: Advance Care Planning is an on-going cycle of thinking, talking and planning



### 2. The right facilitator(s)

A facilitator could be a volunteer or a staff member at community organizations interested in establishing an Advance Care Planning education program for the public. The organization selects the right individuals for this role using BCCPC’s criteria for facilitators for Advance Care Planning sessions:

- Has experience with group facilitation (i.e., *the ability to provide information, present options, encourage conversation, but not direct people’s choices*)
- Has interest/passion to educate others about Advance Care Planning
- Solid understanding of key components of Advance Care Planning and the associated legal documents (training provided; content covered in the *Facilitator Guide*).
- Agrees to complete the training provided by BCCPC (see [Appendix B](#) for the training plan)
- Agrees to follow and adhere to the general content outlined in the *Facilitator Guide* and key messages for Advance Care Planning ([see page 18](#))

### 3. The right facilitation approach

To help the public engage in the conversation and enjoy the experience of attending the Advance Care Planning session, the facilitators need to use effective engagement and facilitation techniques. This is further described above in the Facilitator Roles and Responsibilities section ([page 14](#)) and in the *Facilitator Guide*.

## Key messaging

Public information sessions funded by BCCPC **MUST** use the updated plain language definition of Advance Care Planning ([see page 7](#)), and emphasize and promote the following key messages based on the updated definition:

- Advance Care Planning is a process of thinking, talking and planning (Think, Talk, Plan) that involves understanding and sharing your values, beliefs and wishes regarding health and personal care. It may also include choosing who would make these decisions for you if you cannot do so.
- Advance Care Planning is an integral part of personal planning that every adult should do; it is part of being a healthy individual.
- The sooner you start the process of Advance Care Planning, the better.
- Advance Care Planning helps you and your family prepare to make decisions about your health and personal care.
- As long you are able to understand and communicate, you will make your own health-care decisions.
- Advance Care Planning provides peace of mind to you and your family:
  - It provides reassurance to your family that they know what you would want;
  - it provides reassurance to you that your health-care wishes are known.
- Conversations about Advance Care Planning get easier the more you have them.
- Advance Care Planning is not just a one-time event, it is a process that you should revisit throughout your life.
- You can change your Advance Care Plan at any time.
- You have options for how you want to express and record your wishes. Legal documentation in an Advance Care Plan is helpful but not essential.

For more information about the Advance Care Planning process, please refer to the *Facilitator Guide*.

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## Appendix A: Program History

### Recognizing the Need

In 2016, a B.C. public survey commissioned by BCCPC demonstrated relatively low levels of awareness and engagement in Advance Care Planning among British Columbians. Differences exist between age groups, education levels, and gender. Older, highly educated adults and women are more likely to engage in Advance Care Planning.

The data highlighted the need for provincially coordinated efforts in B.C. to further enhance public awareness of Advance Care Planning, and to empower adults to initiate Advance Care Planning conversations with family or with their health-care providers.

To address these gaps, BCCPC launched a provincial initiative, funded by a grant from the Ministry of Health, to promote and improve conversations and documentation related to Advance Care Planning. The goal of the initiative was to help British Columbians receive the care that is right for them and consistent with their values, beliefs and wishes.

### Initial Development

As part of the provincial Advance Care Planning initiative, in 2016 BCCPC partnered with two community organizations to develop a program that delivers community-led Advance Care Planning sessions for the public. The two organizations, Comox Valley Hospice Society and VCH Community Engagement Advisory Network (CEAN), are pioneers in Advance Care Planning public education in B.C.

Program development was led by Terry Webber, with essential support from working group members, and advice from an advisory group of Advance Care Planning experts in health authorities and members of the public.

#### Working Group members:

- Barbara Colwell, Comox Valley Hospice Society
- Barb Warren, Comox Valley Hospice Society
- Joyce Kuhn, Comox Valley Hospice Society
- Karen Sanderson, CEAN
- Pat Porterfield, CEAN
- Terry Webber, BCCPC
- Sue Grant, BCCPC
- Rachel Carter, BCCPC
- Laura Spencer, BCCPC

## Research Project and Seed Grant Program Evaluation

Between 2016 and 2019, BCCPC supported the development and delivery of public Advance Care Planning sessions delivered by trained facilitators who volunteer within 68 community-based organizations (the initial adopters of the program). In addition to training, access to the toolkit, and coaching, the initial adopters of the program received seed funding from BCCPC.

In 2017 a research project of the initial implementation, funded by the Canadian Frailty Network, demonstrated it to be an effective and sustainable way to increase Advance Care Planning engagement. Findings include:

- Organizations experienced more partnerships, a positive image and improved connectivity with community;
- Facilitators' knowledge, skills and confidence to facilitate public Advance Care Planning sessions were improved; and
- Public participants' engagement in Advance Care Planning increased.

Further training was provided in the Lower Mainland, Northern and Interior regions in 2019 to support further spread and sustainability. Program evaluation of this spread has continued to support the positive outcomes demonstrated by the research project.

#### Research project investigators:

- Doris Barwich, Division of Palliative Care, University of British Columbia
- Jennifer Kryworuchko, Department of Nursing, University of British Columbia
- Arminee Kazanjian, School of Population and Public Health, University of British Columbia
- Eman Hassan, Director Public Health Initiatives, BCCPC
- Shima Soheilipour, School of Population and Public Health, University of British Columbia
- Jessica Simon, Division of Palliative Medicine, The University of Calgary
- Richard Sawatzky, School of Nursing, Trinity Western University
- Kelli Stajduhar, School of Nursing, University of Victoria
- Pippa Hawley, Division of Palliative Care, University of British Columbia

#### Research project sites:

- Comox Valley Hospice Society
- CEAN
- Cowichan Valley Hospice Society
- Kamloops Hospice Society
- Nanaimo Hospice Society
- Pacific Rim Hospice Society
- Seniors 411 Centre
- Sunshine Coast Hospice Society
- Terrace Hospice Society

#### Research team:

- Rachel Carter, Project Manager
- Amber Husband, Research Assistant
- Larry Mroz, Research Coordinator

#### Seed grant spread and evaluation:

- Eman Hassan, Director Public Health Initiatives, BCCPC
- Kathy Kennedy, Community Development Specialist, BCCPC
- Melody Jobse, Community Engagement Specialist, BCCPC

## Cultural Adaptation and Translation

Despite further spread of public Advance Care Planning sessions, they were largely attended by older, well-educated Caucasians. Feedback from our partners, stakeholders and session participants has identified that the model did not address the specific needs of various cultural, religious or language groups. Given our multicultural society, this is a substantial gap.

- Supported by funding from Health Canada’s Health Care Policy Contribution Program, in 2019/2020 the program has been reviewed and updated to consider cultural adaptations for the Chinese and South Asian communities. Key materials have been translated into Simplified and Traditional Chinese and Punjabi. This work was completed by working groups comprising individuals who serve and support these communities, with advice from an Advisory Committee, and with input from end-users throughout the process.

### Chinese Working Group Members:

- Katherine Tam, Volunteer Facilitator, CEAN
- Marisa Ku, Volunteer Facilitator, CEAN
- Bonnie Leung, Palliative Care Nurse
- Betty Chan, Public Partner

### Project Team:

- Eman Hassan, Project Director
- Rachel Carter, Project Manager
- Vicki Lee, Curriculum Development Specialist
- Thomas Shajan, Project Officer; South Asian Project Coordinator
- Jing Xu, Chinese Project Coordinator; Translator
- Gagan Kurrha, South Asian Project Coordinator; Translator
- Cynthia Ng, Chinese Community Liaison
- Nitin Kumar, South Asian Community Liaison
- Pam Martin, Evaluation Consultant
- Chibuzo Ottih, Performance Measurement Specialist
- David Jung, Graphic Designer
- Pam Warkentin, Communications Consultant
- Leslie Ste. Marie, Writer/Editor

### South Asian Working Group Members:

- Jas Cheema, Surrey Hospice Society
- Joti Gill, Advance Care Planning Facilitator, Patient Pathways
- Tara Shushtarian, Public Partner
- Pat Porterfield, Volunteer Facilitator, CEAN

### Advisory Committee:

- Cheema, Surrey Hospice Society
- Saori Yamamoto, CEAN
- Khairun Jivani, Canadian Cancer Society
- Janine Sam, VCH, Richmond (co-chair)
- Arun Garg, Canada India Network Society / South Asian Health Institute
- Rani Mangat (for Yvonne Chiu), Multicultural Health Brokers Cooperative
- Gloria Gutman, Department of Gerontology, Simon Fraser University
- Cari Hoffmann, Fraser Health
- Wallace Robinson, Providence Healthcare
- Pat Porterfield, BCCPC public awareness and education committee, co-chair
- Margaret Young, Public Partner
- Saroj Ludhera, Public Partner
- Kathy Kennedy, Community Development Specialist, BCCPC

## Program Adaptation and Development for People Living with Early Stages of Dementia

Supported by funding from Public Health Agency of Canada’s Dementia Community Investment and in-kind contributions from project partners, the model was adapted to meet the specific needs of people living with early stages of dementia and family and friends of people living with dementia. A guided conversation event was developed to complement the ACP information session. This work was completed in collaboration with a Task Group of Experts, with advice from an Advisory Committee, and with input from end-users throughout the process.

### Project Partners

- Alzheimer Society of B.C.
- Diversity Access Team for iCAN-ACP research study
- Family Caregivers of B.C.
- Hospice Palliative Care Ontario
- United Way of the Lower Mainland - Healthy Aging

### Task Group of Experts

- Carol Anderson, Public Partner, Instructor, UBC Health
- Marissa Stalman (Co-Chair), Dementia-Friendly Community Task Group Member, Maple Ridge Seniors Network
- Myrna Norman, Public Partner, Executive Member, Dementia Advocacy Canada
- Pat Porterfield, ACP facilitator, CEAN (Community Engagement Advisory Network), Vancouver Coastal Health
- Stephen Holliday, Instructor, North Shore Elder College Society

**Advisory Committee**

- Angela Brooks, Program and Operations Coordinator – Population Health, United Way of the Lower Mainland
- Anthony Kupferschmidt, Executive Director, West End Seniors’ Network
- Avery Milne, Provincial Coordinator- Knowledge Mobilization, Alzheimer Society of B.C.
- Barbara Lindsay, Director - Advocacy & Education, Alzheimer Society of B.C.
- Barbara MacLean, Executive Director, Family Caregivers of B.C.
- Carol Anderson, Public Partner, Instructor, UBC Health
- Cathy Almost, Engagement Leader – Patient & Public Engagement, BC Patient Safety & Quality Council
- Gloria Gutman, Principal Investigator, iCAN-Advance Care Planning, Simon Fraser University
- Heather Cook, Seniors Services Advisor, Ministry of Health
- Julie Darney, Director - Education & Strategic Partnerships, Hospice Palliative Care Ontario
- Laurel Gillespie, Director – Advance Care Planning in Canada Initiative, Canadian Hospice Palliative Care Association
- Marissa Stalman (Co-Chair), Dementia-Friendly Community Task Group Member, Maple Ridge Seniors Network
- Myrna Norman, Public Partner, Executive Member, Dementia Advocacy Canada
- Pat Porterfield, Advance Care Planning facilitator, CEAN (Community Engagement Advisory Network), Vancouver Coastal Health
- Rachel Carter, Research Manager, Cultural Adaptations Project Manager, BCCPC
- Stephen Holliday, Instructor, North Shore Elder College

**Project Team:**

- Eman Hassan, Project Director
- Kathy Sheng, Project Manager
- Kathy Kennedy, Project Lead, Community Development Specialist, Master Trainer
- Vicki Lee, Curriculum Development Specialist
- Melody Jobse, Community Engagement
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**Program Update for the Public**

**Project Team:**

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- Rachel Carter, Research Manager, Cultural Adaptations Project Manager
- Kathy Sheng, Project Manager, Adaptations for People Living with Early Stages of Dementia

**Appendix B: Facilitator Training Plan**

	<b>Actions</b>	<b>Resource</b>
<b>1.</b>	<b>Review</b>	<input type="checkbox"/> My Voice – Advance Care Planning Guide (Ministry of Health) - <a href="https://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf">https://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf</a>
<b>2.</b>	<b>Complete</b>	<input type="checkbox"/> Advance Care Planning Online Module (Fraser Health Authority) Access instructions provided on the following page. (submit the Record of Completion to your organization)
<b>3.</b>	<b>Review key toolkit components</b>	<input type="checkbox"/> Program Overview <input type="checkbox"/> Community Partner Guide
<b>4.</b>	<b>Attend BCCPC training sessions )</b>	<input type="checkbox"/> three 2.5-hour online training sessions, <b>or</b> <input type="checkbox"/> one-day in person training session Facilitated by BCCPC, training includes review of the key concepts of Advance Care Planning, demonstration and discussion of ways to facilitate a public session, introduction to the BCCPC toolkit.
<b>5.</b>	<b>Post-training Actions</b>	<input type="checkbox"/> Review and be familiar with the full toolkit <input type="checkbox"/> Rehearse a session with your peers <input type="checkbox"/> Follow up on questions with BCCPC

## How to access the Advance Care Planning Online Module (Fraser Health Authority)

This course, developed by Fraser Health, is a basic introduction to Advance Care Planning: what it is; why it is important; when it should start; and who should be involved in the discussions. The course consists of a series of slides and interactive activities and should take about 30 minutes to 1 hour to complete. There is a final quiz at the end of the course and the quiz result will be automatically recorded into your user history.

### STEP 1: access the Learning Hub website

- From any computer connected to the internet, please go to the following website:  
<https://learninghub.phsa.ca>

### STEP 2: create an account

- Click ‘Sign up for an account’
- Enter your Profile information – Name, email, confirm your email and create a password
- Click ‘Create Account’
- Check the email account that you entered for a system message and click in the message to ‘activate your account’. If you do not receive this message, check your junk mail or click ‘Resend Activation Email’ button on the website.
- Read the Notice and Consent and click ‘Agree’
- Select role - ‘Volunteer’
- Select the Health Authority where you are located.
- *For example, if your community is Abbotsford, select Fraser Health.* If you are not sure which health authority you should select, please consult with your organization's project lead.
- Complete your profile:
  - Name:
  - Volunteer Role: enter “Advance Care Planning Facilitator”
  - Department/Facility : enter “BC Centre for Palliative Care”
- Click “Complete Profile”

### STEP 3: start the course

- If you are signed in to the Learning Hub website, enter course code 10775 or the course title Advance Care Planning (Advance Care Planning) Level 1 (online)
- Otherwise, go to <https://learninghub.phsa.ca/Courses/10775/advance-care-planning-Advance-Care-Planning-level1-online> to take you directly to the Advance Care Planning online course.
  - Sign in using your email address and password.
- As you work through the course there will be questions to answer to show that you have understood the information. We expect that you will retake the module until you have reached 100% correct responses.
- Once the course has been completed you can download or print a Record of Completion.

*Note: to sign out of the Learning Hub, at the top right there will be a symbol with your name beside it– left click on the arrow and select “Logout”.*



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*All British Columbians affected by serious illness  
will have equitable access to compassionate,  
person-centred care and resources.*