

# Community organization perspectives on barriers and facilitators to Advance Care Planning in British Columbia

Presenter: Ellie Siden

Co-investigators: Rachel Carter, Doris Barwich, Eman Hassan

We thank our study participants for their contributions.  
Thank you to Melody Jobse and Kathy Kennedy for their feedback on survey questions.

Funding: This research received a Student Summer Research Program grant from the University of British Columbia.  
*Ethics approval was obtained from the University of British Columbia Behavioral Research Ethics Board. (H16-00044).*



# Advance Care Planning and Community Organizations

- Advance Care Planning (ACP) is a process that supports adults to think about and share their values, goals and preferences as they relate to their future health care.<sup>1</sup>
- Community-based organizations are well placed for providing ACP services in their communities – and already are!



1. Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of Pain and Symptom Management*. 2017;53(5):821-832.e1. doi:10.1016/j.jpainsymman.2016.12.331

# BC Centre for Palliative Care Support for Community Organisations

Downloadable ACP resources for community organisations



Thousands of downloads every year

ACP facilitator training workshops



In 2019-2020, **221 community organisation volunteers and staff** were trained to deliver ACP workshops

Conversation game events



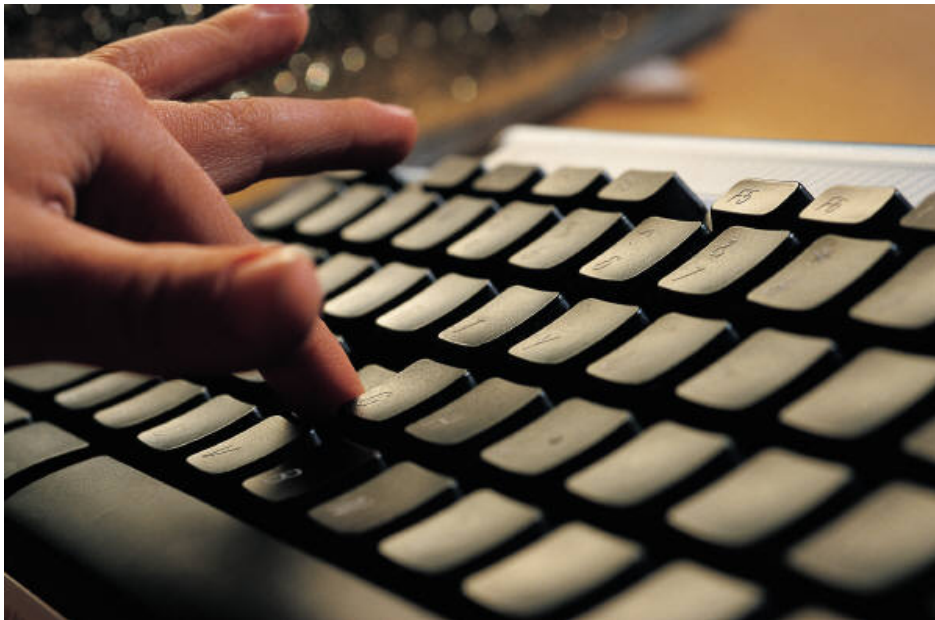
Over 2000 game booklets ordered to support over 100 game events in BC and across Canada

# Research Questions

From a BC community-based organization perspective:

- 1) What are the most important barriers to ACP engagement?
- 2) What are the most important actions to take (facilitators) for ACP engagement?

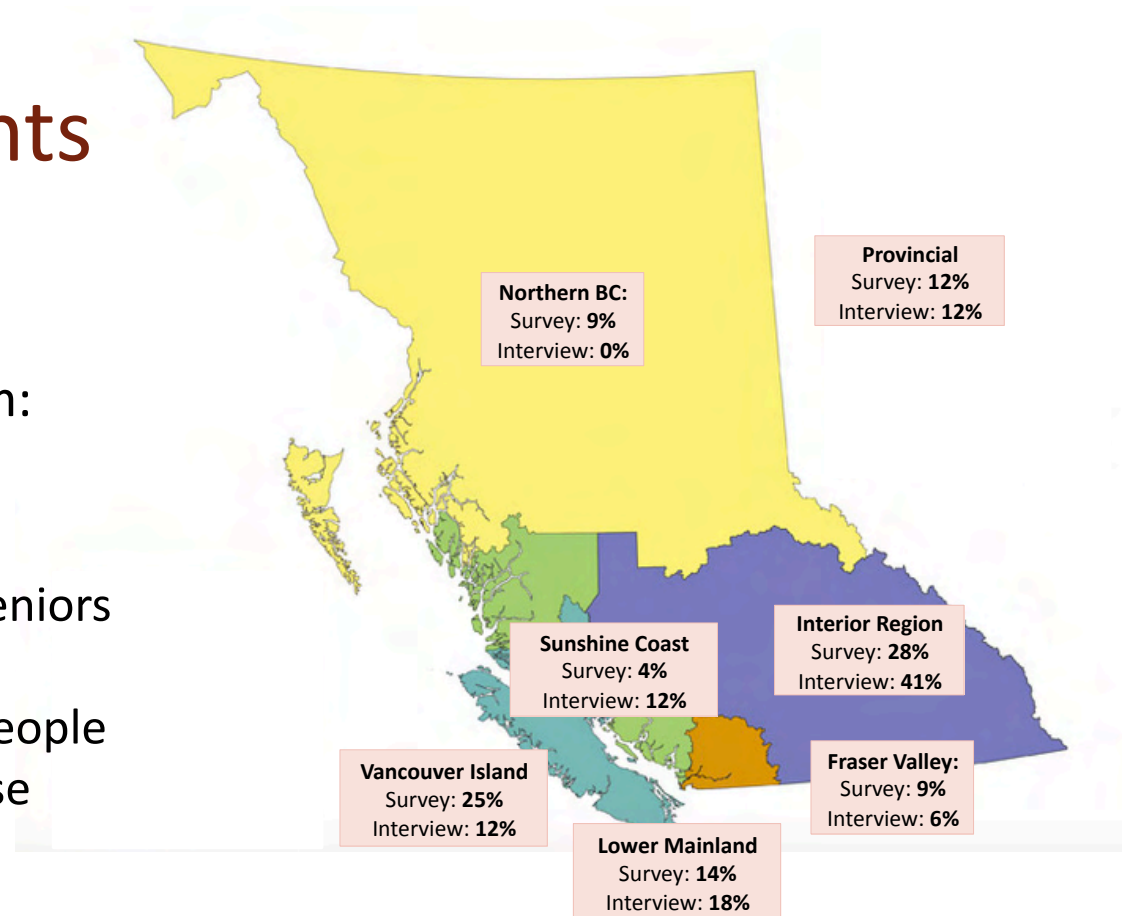
# Methods: Overview, Design and Analysis



June and July of 2020

# Results: Participants

- 57 survey responses
- 17 interviews
- Responses were mostly from:
  - Hospice Societies  
*(Survey 44%, Interviews 53%)*
  - Organizations supporting seniors  
*(Survey 33%, Interviews 12%)*
  - Organizations supporting people affected by a specific disease  
*(Survey 9%, Interviews 18%)*



# Important Barriers to Advance Care Planning

1. Lack of public awareness of ACP
  2. Emotional difficulty of the conversation
  3. Confusing terminology and complicated process
  4. Belief that ACP is a one-time conversation to specify medical orders
- **ACP is a challenge to present in different cultural contexts\***
  - **Siloed approach to public ACP education\***

*\*Emerged in qualitative analysis*

## ACP is a challenge to present in different cultural contexts

“ I don't actually know if there are cultural nuances that I should be aware of if I am speaking with someone from [the local First Nation] about their ACP.”

“ A lot of places, it's a cultural decision.... it's a family decision, how you move forwards in terms of treatment.”



## Siloed approach to public ACP education

*“ [The Health Authority doesn’t] think that other agencies can provide [ACP education]. ”*

*“ From a community perspective, we have more flexibility and can do things faster.”*

# Important Facilitators to Advance Care Planning

1. Develop clear, simple messages
  2. Improve ACP literacy
  - 3. Reframe ACP as part of life planning**
  4. Simplify the documenting and transferring of ACP conversations
  5. Integrate ACP conversations into the scope of practice for all health-care providers
- **Better collaboration between the health system and non-profits\***

*\*Emerged in qualitative analysis*

## Reframe ACP as part of life planning

*“ If [end-of-life & death] are part of our daily conversation, they become normal...*

*They wouldn't be scary anymore, and we could talk over the things that we're worried about.”*

*“ You could work it into education practices, in terms of parent teacher associations.”*

## Better collaboration between the health system and non-profits

*“ Local family health teams [could] collaborate with...local community organizations.*

*Where [the] community organization is doing [an] ACP planning workshop once a week, and [the] physician is referring their patient to this workshop.”*

*“ We’re encouraging the physicians to refer people to us.”*

# Significance of our study

## Approach:

- The **community-based organization perspective** on ACP barriers and facilitators has not been specifically explored

## Results:

- Community-based organizations feel that there is a **siloed approach to ACP education in BC**
- There is **frustration with current provincial ACP materials** is frequent, with a wish for clearer, simpler messages that are **adapted for different cultures and languages**
- Reframing ACP as part of life planning may be a **solution to the discomfort associated with end-of-life discussions, and non-profits are suited to support this**

# What can I do to help?

Use culturally and linguistically appropriate ACP resources

Reframe ACP as part of life planning

Reach out to local community organisations to partner with them

**预先安排医护计划**

预先安排医护计划是人生计划的重要组成部分，正如遗产计划和理财计划一样。

**思考：什么对你来说最重要？**  
符合你的价值和信念的医疗决定。例如，你可以活的尽可能长久，不欠代价，另可能不能接受某些其他可能没有帮助的其他医疗措施。随着你生活和健康状况，对你而言最重要的事情可能会随之变化。

**可以引导你思考：**  
你来说最重要？  
你生病和不能沟通的时候，什么对你来说最重要？  
哪些医疗护理和个人护理是你想要的？  
家的健康状况，你有什么顾虑？  
的健康计划，你会怎样决定？有什么参与？  
人意愿对你最重要？  
你在哪里最舒服？什么对你来说是灵性（精神）或文化习俗？

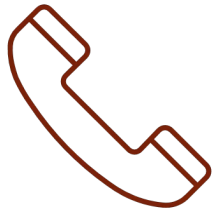
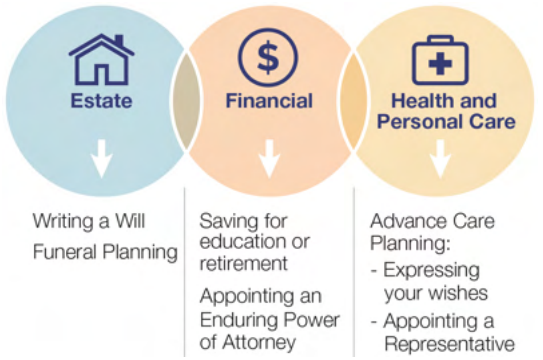
**在你不能为自己做决定的时候 谁可以替你做决定**  
解释你所面临的医疗护理措施，并清楚地表达自己的意愿。根据你的知识，你的所有决定都会尊重。知情同意你了解其目的、收益及风险的情况受的相关医疗措施。  
具备所需能力，那么你需要一名代理这个人可以根据你的意愿，代替你为保护你。  
自己最佳人选，可以指定他/她为代理人。如果你没有指定任何人，医生会根据名单程序，指定一位临时代理或者由法院指定一位监护人。

**你可以引导你思考：**  
你来说最重要？  
你生病和不能沟通的时候，什么对你来说最重要？  
哪些医疗护理和个人护理是你想要的？  
家的健康状况，你有什么顾虑？  
的健康计划，你会怎样决定？有什么参与？  
人意愿对你最重要？  
你在哪里最舒服？什么对你来说是灵性（精神）或文化习俗？

**在你不能为自己做决定的时候 谁可以替你做决定**  
解释你所面临的医疗护理措施，并清楚地表达自己的意愿。根据你的知识，你的所有决定都会尊重。知情同意你了解其目的、收益及风险的情况受的相关医疗措施。  
具备所需能力，那么你需要一名代理这个人可以根据你的意愿，代替你为保护你。  
自己最佳人选，可以指定他/她为代理人。如果你没有指定任何人，医生会根据名单程序，指定一位临时代理或者由法院指定一位监护人。

**你可以引导你思考：**  
你来说最重要？  
你生病和不能沟通的时候，什么对你来说最重要？  
哪些医疗护理和个人护理是你想要的？  
家的健康状况，你有什么顾虑？  
的健康计划，你会怎样决定？有什么参与？  
人意愿对你最重要？  
你在哪里最舒服？什么对你来说是灵性（精神）或文化习俗？

**在你不能为自己做决定的时候 谁可以替你做决定**  
解释你所面临的医疗护理措施，并清楚地表达自己的意愿。根据你的知识，你的所有决定都会尊重。知情同意你了解其目的、收益及风险的情况受的相关医疗措施。  
具备所需能力，那么你需要一名代理这个人可以根据你的意愿，代替你为保护你。  
自己最佳人选，可以指定他/她为代理人。如果你没有指定任何人，医生会根据名单程序，指定一位临时代理或者由法院指定一位监护人。



# References

1. Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of Pain and Symptom Management*. 2017;53(5):821-832.e1. doi:10.1016/j.jpainsymman.2016.12.331
2. Wert R van, Wallace E. Impact of Advance Care Planning Interventions on Patient and Family Satisfaction: A Systematic Review and Descriptive Analysis (S777). *Journal of pain and symptom management*. 2018;55(2):698-699. doi:10.1016/j.jpainsymman.2017.12.431
3. Bischoff KE, Sudore R, Miao Y, Boscardin WJ, Smith AK. Advance care planning and the quality of end-of-life care in older adults. *Journal of the American Geriatrics Society*. 2013;61(2):209-214. doi:10.1111/jgs.12105
5. Prince-Paul M, DiFranco E. Upstreaming and Normalizing Advance Care Planning Conversations—A Public Health Approach. *Behavioral Sciences*. 2017;7(4):18. doi:10.3390/bs7020018
6. Candrian C, Lasker Hertz S, Matlock D, et al. Development of a Community Advance Care Planning Guides Program and the RELATE Model of Communication. *American Journal of Hospice and Palliative Medicine*. 2020;37(1):5-11. doi:10.1177/1049909119846116
7. *Advance Care Planning in Canada: A Pan-Canadian Framework.*; 2020. <https://www.advancecareplanning.ca/wp-content/uploads/2020/01/ACP-Framework-EN-Updated.pdf>
8. Banner D, Freeman S, Kandola DK, et al. Community perspectives of end-of-life preparedness. *Death studies*. 2019;43(4):211-223. doi:10.1080/07481187.2018.1446060 [doi]
9. LeBaron VT, Smith PT, Quiñones R, et al. How Community Clergy Provide Spiritual Care: Toward a Conceptual Framework for Clergy End-of-Life Education. *Journal of Pain and Symptom Management*. 2016;51(4):673-681. doi:10.1016/j.jpainsymman.2015.11.016
10. Cortez DM, Harding K, Koutouratsas L, Pietras C, Meyer J. Advance Care Planning for the Homeless: A Community Collaboration. *Narrative inquiry in bioethics*. 2017;7(1):E14-E15. doi:10.1353/nib.2017.0028 22.
11. Shaw M, Hewson J, Hogan DB, Raffin Bouchal S, Simon J. Characterizing Readiness for Advance Care Planning From the Perspective of Residents, Families, and Clinicians: An Interpretive Descriptive Study in Supportive Living. *The Gerontologist*. 2018;58(4):739-748. doi:10.1093/geront/gnx006
12. Biondo PD, King S, Minhas B, Fassbender K, Simon JE, Advance Care Planning Collaborative Research and Innovation Opportunities Program (ACP CRIO). How to increase public participation in advance care planning: findings from a World Café to elicit community group perspectives. *BMC public health*. 2019;19(1):679. doi:10.1186/s12889-019-7034-4
13. Ramsaroop SD, Reid MC, Adelman RD. Completing an advance directive in the primary care setting: What do we need for success? *Journal of the American Geriatrics Society*. 2007;55(2):277-283. doi:10.1111/j.1532-5415.2007.01065.x 24.
14. Sudore, R. L. *et al.* Effect of the PREPARE Website vs an Easy-to-Read Advance Directive on Advance Care Planning Documentation and Engagement Among Veterans. *JAMA Intern. Med.* 94121, 1102 (2017).
15. Fried TR, Bullock K, Iannone L, O'Leary JR. Understanding advance care planning as a process of health behavior change. *Journal of the American Geriatrics Society*. 2009;57(9):1547-1555. doi:10.1111/j.1532-5415.2009.02396.x