2.1 ACP in Older Populations

O25

A Randomized Trial of a 'Goals of Care' Decision Support Intervention (PlanWell™) in Primary Care in Alberta, Canada

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Background: We aimed to determine the efficacy of a recently developed decision support intervention, PlanWell™, which was designed to improve the quality of Goals of Care Determinations (GCD) in primary care settings.
Methods: We conducted a multicenter randomized trial of patients considered by the primary care doctor to require establishment or review of GCD. Enrolled patients were randomized to receive the study intervention by a trained facilitator or usual care. Outcomes included preferences for life-sustaining treatments, a modified decisional conflict score (DCS), and the proportion of patients who with completed GCD form 8-12 weeks post intervention. Physician ratings of DCS and amount of time spent with patient obtaining GCD were also compared.
Preliminary Results: 123 were consented and randomized, 115 completed the trial. Of enrolled patients, 52% were male and the average age was 74 years. Post intervention, fewer intervention patients preferred CPR and ICU care (15 % vs. 30%, $p=0.25$). Patients in the intervention group were better informed ($p=0.03$) and feeling more support from the physician ($p=0.03$). The completion rate of GCD forms was similar in both groups (96.7% intervention vs. 94.0% usual care, $p=0.71$). Physicians considered intervention patients to be better informed ($p=0.07$) and to have a clear sense of their values ($p=0.04$) and spent less time with them (9.7 vs 13.0 mins, $p<0.001$) compared to usual care patients.
Conclusions: The PlanWell™ intervention seems to help clarify values, better inform patients and may reduce preference for resuscitation, while reducing the physician's time to accomplish GCD decisions.

O26

Effects of a Late Life Supportive Care Innovation that Focuses on What Matters Most

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Background: Whole person care is a new paradigm for serious illness beyond disease specific practice guidelines and lacks robust evaluation. The purpose of this presentation is to describe the effects of LifeCourse(LC), a person-centered program for patients living with serious illness, utilization of healthcare, care experience and quality of life.
Methods: This quasi-experimental intervention study with a Usual Care (UC) comparison group was conducted between 2012-2017. Enrolled patients (N=903) were estimated to be within 3 years of end of life and diagnosed with 1+ serious illness. Community health workers (CHWs) delivered standardized monthly 1-hour home visits based on palliative care guidelines to assist patients in identifying self-defined goals, support ongoing person-centered advance care planning, and promote physical, psychosocial and financial wellbeing. Primary outcomes included healthcare utilization measured by electronic health records and patient and caregiver-reported experience and quality of life measured every 3 months.
Results: Patients were elderly (LC 74, UC 78 years) and primarily non-Hispanic, white, living at home, and had a cardiovascular primary diagnosis (LC 69%, UC 57%). A higher proportion of LC patients completed advance directives during the study (N=173, 38%) than did UC patients (N=66, 15%; $p<0.001$). LC patients who died spent more days in hospice (88±191 days) compared to UC patients (44±71 days; $p=0.018$). LC patients reported greater improvements than UC in communication as part of the care experience ($p=0.016$).
Conclusions: The implementation of person-centered programs delivered by CHWs is feasible. Inexpensive upstream expansion of palliative care models can yield benefits for patients and caregivers.

O27

Implementation of the Serious Illness Care Program in the hospital setting: emerging results of a multi-site quality improvement collaborative.

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Background: Seriously ill, hospitalized patients often receive treatment that is not aligned with their values and goals. The Serious Illness Care Program (SICP) is a multi-faceted health system intervention aimed at enabling more person-centered conversations about goals-of-care (GoC) with patients who have serious, life-limiting illness.
Methods: We conducted a multi-site quality improvement study to adapt and implement the SICP on the medical wards of 3 Canadian hospitals. Our primary outcome measure was the change in patient or family member responses to the validated question: "Over the past 2 days, how much have you felt heard and understood?" (1=not at all; 5=completely) before versus after a conversation about GoC with a clinician trained in the use of the Serious Illness Conversation Guide (SICG). At one site, we also examined health resource use before and after implementation.
Results: With phased implementation across sites, we trained 57 clinicians in use of the SICG, delivered conversations using the SICG to 205 patients (mean age 76 years), or their family members. Of these conversations, 139 were documented in the electronic medical record. After these guided conversations, participants felt more

heard and understood (increase of 0.4 ± 1.1 points; P=0.005). Compared to historical controls, conversations using the SICG were associated with a reduction in length of stay as an acute care patient (5 vs. 19 days, P=0.001).
Conclusion: The SICP was associated with improvement in patients' and family members' perception of being heard and understood by their healthcare team and a reduction in health resource use.

O28

How do Dutch primary care providers overcome barriers to advance care planning with older people? A qualitative study

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Background: Few older people benefit from advance care planning (ACP), due to several barriers related to primary care professionals, such as insufficient knowledge, negative beliefs and a lack of time. Information on overcoming these barriers is limited. We assumed primary care professionals experienced in ACP with older patients are likely to have learned how to overcome these barriers. Therefore we investigated how primary care professionals, experienced in ACP with older patients, overcome these barriers.
Methods: A qualitative study, based on semi-structured interviews, among a purposive sample of 14 Dutch primary care professionals experienced in ACP with older people. Transcripts were thematically analysed.
Results: We interviewed eight general practitioners (GPs), three nurses and three elderly care physicians, experienced in ACP with older people. Respondents overcame their own insufficient knowledge and skills, as well as their negative attitudes and beliefs by gaining experience through practicing ACP in their daily practices, exchanging and reflecting on those experiences with peers, pursuing continuing education, teaching and participating in research. To overcome patients' and families' lack of initiative and openness to ACP, respondents prepared them for further steps in ACP. To overcome a lack of time, respondents used tools and information communication technology, delegated parts of ACP to other primary care professionals, acquired financing and systematized documentation of ACP.
Conclusions: Primary care professionals can overcome barriers to ACP with older patients by practicing, reflecting on experiences and pursuing continuing education, by preparing patients and involving family and by investing in support to approach ACP more efficiently.

O29

'While my thinking is clear': Outcomes from a feasibility pilot of a multidisciplinary, step-wise pathway for ACP in Family Medicine

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Background: Advance care planning (ACP) and goals of care (GCD) discussions with patients align with the tenets of patient-centred shared decision-making central to family medicine (FM). We sought to determine whether a multidisciplinary pathway is feasible in family medicine to enable effective ACP conversations. This pathway reorders Ariadne Lab's Serious Illness Conversation Guide (SICG) with a values clarification tool in a step-wise approach to ACP.
Methods: Mixed-methods feasibility pilot study of pathway implementation in an urban FM clinic in Alberta, Canada. We recruited community-dwelling patients age 60 or older with indications of frailty (multi-morbidity, unplanned hospitalizations), and their surrogate decision-maker (SDM). An allied health professional initiated the ACP pathway, which preceded an appointment with the family physician (FP) to complete the SICG discussion. We conducted a survey of patients and SDMs, and a focus group with clinicians to evaluate feasibility, acceptability and perceived impact.
Results: Nine patients, seven SDMs, and four clinicians participated in the pilot. All patients and SDMs rated the process as "very good" or "excellent". Eight patients and two SDMs reflected that discussing and documenting their preferences helped them feel more prepared for future illness, and that involving SDMs was essential. Clinicians found the pathway and SICG improved their skills and empowered them to facilitate these conversations more effectively.
Conclusions: This pathway that adapts use of the SICG was acceptable and effective for all participants. The pathway fits well into FM as the trusting relationship between the patient and FP provides the foundation for these meaningful conversations.