91 DISEASE SPECIFIC ADVANCE CARE PLANNING IN A LARGE HEALTH SYSTEM

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Current advance care planning practices focus on completion of a health care directive which usually lack clarity in treatment preferences, provide little assistance for patients, health care agents, care team to reliably honour goals and wishes and generally focus on end of life decisions. Individuals and their health care agents living with chronic illness are unprepared to respond to the medical decision making expected when an individual has an expected complication which results in an unexpected "bad outcome." Individuals and health care agents who participate in Disease Specific Advance Care Planning (DS-ACP) discussions have excellent satisfaction ratings; are more confident in knowing individual treatment preferences; have increase prevalence of advance care plan documents in the medical record (94.3% vs. 24.9%, $p<0.001$); are more likely to receive care according to documented wishes; and receive end of life care prior to death (56% vs. 37%, $p=0.002$). As a result of the positive outcomes from DS-ACP, it is cultural accepted as standard in for all patients living with chronic progressive illness. DS-ACP facilitator certification is now a required competency for staff caring for the complex chronically ill.

Key learning from the DS-ACP pilot identified the importance of the following strategies for successful adoption:

1. Leadership/stakeholders engagement.
2. Electronic referral and documentation process.
3. Patient, family, care team engagement.
4. DS-ACP included in system care improvement strategies.
5. Standard ACP education/training

Leadership to support process improvement and change management.