

EP01.007 CO-DEVELOPING ADVANCE CARE PLANNING RESOURCES: A PUBLIC ENGAGEMENT APPROACH FOR HINDI SPEAKING COMMUNITIES IN BC

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Background The BC Centre for Palliative Care (BCCPC) evaluated its adapted advance care planning (ACP) resources for Punjabi-speaking members of the South Asian community and found the need for similarly adapted resources in Hindi. To address this need, the ACP Hindi Translation project was initiated in Summer of 2021 to translate ACP resources to Hindi from those previously culturally adapted for South Asian communities.

Methods This project used a public engagement approach which included two (2) professional translators and five (5) working group members from across BC who translated and reviewed the materials for cultural appropriateness, reading level, colloquialisms and terms borrowed from other languages. A focus group of ten (10) community members with no background in ACP or healthcare also reviewed the translated materials for cultural appropriateness and overall readability. The resources were then finalized and prepared for web posting.

Results The use of a public engagement approach facilitated the inclusion of community voices and perspectives on how ACP can best be understood within the community, introduced a common vocabulary on a difficult topic, and ensured ACP resources can be used in a variety of cultural and linguistic contexts. Among the key takeaways from this project are the strong, ongoing need for access to culturally and linguistically diverse resources, and the importance of public engagement in creating health resources that enable difficult conversations with family, friends and health-care providers in a culturally informed manner.

Conclusion The co-development of culturally and linguistically appropriate resources is feasible and creates meaningful results. The public engagement approach used in this project can be applied to other interventions, communities and jurisdictions.

EP01.008 EXPERIENCE FROM ASIA: LESSONS FOR PROMOTING ADVANCE CARE PLANNING IN MAINLAND CHINA

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Background Advance Care Planning (ACP) remains nascent in mainland China since it has yet to be integrated with end-of-life care. While Shenzhen recently became the first city in mainland China to have legalized ACP, the uptake of living wills is rare throughout the country due to institutional and cultural barriers. In this study, we have examined ways in which other Asian countries—with similar values and norms as mainland China—have championed patient-focused end-of-life care practices in a family-centered environment, including culturally adapted ACP. Our findings suggest that the selected countries and territories like Singapore, Taiwan, and Hong Kong, could offer valuable ACP experiences for mainland China, as well as other countries, to consider.

Methods We conducted 10 semi-structured online interviews with palliative care physicians, nurses, and academics with ACP expertise and representation across six Asian countries and territories (Singapore, Vietnam, Taiwan, Hong Kong, South Korea, and Japan). On average, the interviews were 45 minutes long and conducted between January and March 2022.

Results Seven themes emerged from the interviews: Integration of culturally adapted ACP with medical services; system-wide buy-in; death education for the public, for patients and families, and for medical professionals; interdisciplinary teams; and legal changes. Our informants identified examples of how they rolled out ACP and worked to overcome institutional and cultural barriers.

Conclusion These ACP practices could provide lessons for mainland China to consider in embedding more patient-focused end-of-life care in its family-centered system. The examples that were cited by our informants could be tailored to support the roll-out of Shenzhen's legislation, end-of-life care practices in cities that have yet to implement an ACP legislation, and in places beyond China.

EP01.009 INITIATING ADVANCE CARE PLANNING IN PRIMARY CARE: A MODEL FOR SUCCESS

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Background Primary care providers recognize the importance of ACP conversations and their role in having them. PCP's report barriers to having these conversations that include not having adequate training, not knowing what to say, not having enough time and patient-family member conflict.¹ for ACP to succeed, better clinician communication skills are necessary.² Conversations of a Lifetime[®] (COL), a Hospice of Cincinnati program and part of the TriHealth system, combined multiple evidence-based modalities to initiate ACP in 36 TriHealth primary care practices.

Methods

- Respecting Choices Advanced Steps[®] curriculum for RN care managers to identify appropriate patients, facilitate conversations, and serve as a resource in completing advance directives.
- VitalTalk[®] developed a custom coaching curriculum for physicians to feel more confident about initiating ACP conversations.
- Electronic Medical Record (EMR) enhancements:
 - ACP Summary Report
 - ACP Best Practice Alert
- An ACP Nurse Liaison provided technical support to optimize workflows and EMR documentation.

Results ACP conversations initiated and documented increased in 36 primary care practices with a combination of communication coaching, staff training, RN technical support and EMR enhancements (Intervention period: May 2014 – Dec 2016; 7,199 conversations). ACP conversations sustained (Post-Intervention period: Jan-Dec 2017; 7,589 conversations).

Conclusion By combining two complementary, evidenced-based curricula, providing support of a nurse liaison and designing a summary and alert in the EMR, this program exceeded its goal to initiate 2,000 ACP conversations in primary care.

Other health systems might consider a similar multicomponent intervention to increase ACP.

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EP01.010 CHARACTERISTICS OF HOME-DWELLING PERSONS WITH DEMENTIA AND FAMILIES WHO HAVE INITIATED ADVANCE CARE PLANNING DURING THE COVID-19 PANDEMIC IN JAPAN

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Background Advance care planning (ACP) is an increasing priority for people with dementia during the COVID-19 pandemic. This study aimed to investigate characteristics of home-dwelling persons with dementia and families that are related to ACP implementation.

Methods An internet-based questionnaire survey was conducted with Japanese family caregivers of home-dwelling persons with dementia in June 2021. Registered members of a Japan-based survey company were recruited; inclusion criteria were being aged 40 years or older and having been a primary, non-professional caregiver of a family member with dementia. Respondents rated their level of agreement with six statements regarding advance-care-planning-related concerns. Respondents also evaluated the level of depressive symptoms in persons with dementia using the Neuropsychiatric Inventory (NPI).

Results A total of 379 family caregivers participated in the survey. A total of 155 persons with dementia (40.9%) had initiated ACP, of which 88 (56.8%) had care professionals involved in ACP conversation. Persons with professional involvement showed significantly more severe depressive symptoms and lower family-caregiver concern compared to those who did not initiate ACP.

Conclusion Presence of psychological distress such as depressive symptoms may have been a trigger to initiate ACP among people with dementia. Optimal and proactive ACP approaches need to be developed to address family concern regarding conducting ACP.

EP01.011 COMMUNITY-BASED ADVANCE CARE PLANNING WORKSHOPS TO IMPROVE KNOWLEDGE OF ADVANCE CARE PLANNING AND INCREASE PARTICIPANTS' COMPLETION OF DOCUMENTATION

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Introduction Community rates of Advance Care Planning (ACP) remain low. Eighty-five percent of Australians believe in the importance of discussing their end-of-life care preferences, however, only one third of Australians have had a conversation with family members. Advance Directive/Advance Health Directive completion rates are even lower; 14% for Australians and 7.5% for Western Australians. We

hypothesised that community-based, facilitated ACP workshops would: improve participants' knowledge of ACP, increase the number of conversations regarding end-of-life care preferences, and increase participants' completion of documentation.

Methods The workshops drew upon the transtheoretical and the behaviour change models. Three hundred and forty-two participants completed the workshops aged 43–94 years ($M = 73.05$, $SD = 8.96$). Seventy-two percent of the sample were women, 59.1% resided in metropolitan Perth, 59.2% were born in Australia, and 81.7% were retired. More than half of the participants were married or in a de facto relationship (60.2%), 53% of participants had post high school qualifications, and 39.5% were living with a chronic illness. We collected data using a pre-test post-test research design at two time points, directly prior to the workshop and three months post workshop. We analysed the data using the Generalised Linear Mixed Model.

Findings We found that participants improved their knowledge of Advance Care Planning concepts and were more likely to complete end-of-life documents (Advance Care Plan, Advance Health Directive) and appoint an Enduring Power of Attorney and an Enduring Power of Guardianship.

Conclusion Our findings suggest that theoretically based ACP workshops can ensure family members and health professionals are aware of a person's end of life preferences. These workshops have the potential to prevent burdensome treatments, and to support individuals, families and the health system. Future research could use an experimental design and assess self-efficacy, attitudes, depth of conversations, and where documents are kept.

EP01.012 WHAT CONVERSATION CONTENT DO PHYSICIANS DOCUMENT AFTER IMPLEMENTATION OF SERIOUS ILLNESS CONVERSATIONS AND WHAT DO THEY FIND USEFUL?

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Background The Serious Illness Care Program (SICP) increases documentation about patients' values and priorities. We explored, (1) associations between the quantity/type of elements documented after SICP conversations with patient characteristics and 'Goals of Care' orders and (2) aspects of documentation that different specialties find useful.

Methods (1) Retrospective chart review analysed conversations documented on a standardized 'Tracking Record' (TR) after SICP implementation in an internal medicine teaching unit of a tertiary hospital in Calgary, Alberta, Canada. Alberta's 'Goals of Care Designations' (GCD) physician orders communicate the general focus of a patient's care, specific interventions, and preferred care locations. Univariate and multivariate generalized linear models were used to analyze associations between frequency of elements/domains documented (using a validated SICP codebook) and patient characteristics (age, gender, frailty, language spoken) and their GCD. (2) A qualitative, Interpretive Description study used clinical vignettes and TRs with varying amounts of SICP