

OP61 **DEVELOPMENT AND CERTIFICATION OF QUALITY PATIENT DECISION AIDS**

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Background Individuals with serious illness face complex healthcare decisions which have important and lasting consequences. Person-centered care can be achieved when personal values, goals, and beliefs are aligned with the actual care provided.

Person-centered decision-making requires a) clear, accurate and unbiased information about all options, including risks versus benefits; b) clinician investment and expertise in engaging and communicating with patients; and c) the effective integration of personal values, goals, and beliefs into choices. Person-centered decision aids (PDAs) are tools designed to help patients and providers in the process of shared decision-making. Research shows, high quality PDAs lead to increased knowledge, more accurate risk perception, reduced indecision about care, and improved patient engagement.

Methods Based on criteria developed by the International Patient Decision Aids Standards Collaboration (IPDAS), *Healthier Washington Initiative*, Washington State, USA, developed and implemented a process of certifying PDAs to assure they are effective, accurate, unbiased tools to use in the shared decision-making process. Implementation of quality PDAs can be standardized using the fundamentals described in the National Quality Forum's (NQF) National Quality Partners (NQP) Playbook—Shared Decision-Making in HealthCare.

Results This presentation will review certification criteria for developing high-quality PDAs. A four-phased approach will be discussed that describes the process of developing and certifying three serious illness decision aids and their integration within Respecting Choices[®] person-centered decision-making programs.

Conclusion Development and certification of quality PDAs in healthcare organizations using a standard approach to the decision-making process can support a culture of person-centered care.

OP62 **SUSTAINABLE IMPLEMENTATION OF ADVANCE CARE PLANNING IN ASIA: AN INTERPRETIVE-SYSTEMIC FRAMEWORK FOR NATIONAL DEVELOPMENT**

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Background To examine the underpinnings of Asia's first national Advance Care Planning (ACP) programme, and to identify the dynamics, mechanisms and systemic factors that influence the implementation of ACP in Singapore.

Methods A qualitative interpretive-systemic focus group study with 4 professional stakeholder groups who played critical

roles in the ACP programme. Study included 63 physicians, nurses, medical social worker and allied health workers from 7 public hospitals and specialist center that incorporated ACP into clinical practice.

Results Framework analysis revealed 19 themes, organized into 5 categories including: (1) Life and Death Culture (social perception of death, biomedical model, health system hierarchy, health seeking behaviors), (2) ACP Coordination (institutional leadership, programme receptiveness, interdisciplinary trust, preparatory training), (3) ACP Administration (practice diversity, work flow, operation clarity), (4) ACP Outcomes (care preferences, medical-social dissonance, performance measures, intrinsic values), and (5) Sustainability Shift (public life and death education, holistic end-of-life care training, governance and service alignment, empowered citizenry). These further formed an interpretive-systemic framework of sustainable ACP, reflecting the social, cultural, political, operational and spiritual contexts that support national ACP development.

Conclusion This research provides insights on developmental and implementation challenges of Asia's first national ACP programme. ACP should be supported by public health strategy for enhancing individual, professional, and institutional readiness for end-of-life conversation before programme commencement. It emphasizes the importance of health policy, organizational structure, social discourse, and shared meaning in planning and delivery of ACP to aid care decision making among Asian patients and their families facing terminal illness and mortality.

OP63 **ESTIMATING AND COMMUNICATING PROGNOSIS IN PALLIATIVE CARE: A CROSS-SECTIONAL SURVEY AMONG PHYSICIANS IN THE SOUTHWEST REGION OF THE NETHERLANDS**

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Background Advance care planning is important for patients with an advanced illness and a limited life expectancy. We explored experiences from physicians from different settings with estimating and communicating patients' poor prognosis.

Methods A survey study was performed in 2017 in the Southwest region of the Netherlands among a random sample of physicians working in primary care, hospitals and nursing homes (n=2212).

Results 547 physicians participated: 259 general practitioners (GP's), 205 hospital physicians (HP's) en 83 nursing home physicians (NHP's). In total, 61.1% stated that they can adequately estimate if a patient will die within a year; 66.7% stated that they can adequately estimate a life expectancy of less than three months and 76.1% a life expectancy of less than a week. When a patient is estimated to have a prognosis of less than one year, 75.0% of all physicians indicate that they always/often discuss their wishes for treatment and care. For patients with an estimated prognosis of less than three months, 85.9% of HP's discuss patients' wishes, compared to 96.1% of GP's and 91.6% of NHP's. After hospital admission of patients with a limited life expectancy, 29.0% of GP's and 16.9% of NHP's indicate that they always/often receive adequate information from HP's about patients' wishes.

Conclusion The majority of physicians indicate that they can adequately estimate a patient's limited life expectancy and that they tend to discuss patients' wishes if they have a poor prognosis. Information transfer concerning patients' wishes for treatment and care can be improved.

OP64

EXAMINING PATIENT-REPORTED BARRIERS TO TALKING ABOUT ADVANCE CARE PLANNING (ACP) WITH FAMILY PHYSICIANS: A MULTI-SITE SURVEY

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Background Advance care planning (ACP) can improve satisfaction with end-of-life care among patients and families and reduce unwanted treatments. Primary care is an ideal setting in which to facilitate ACP. This study analyzed the reasons why patients find it difficult to discuss ACP with their family physicians.

Methods A self-completed, validated questionnaire about four ACP engagement behaviours and barriers was administered to patients aged 50 and older in 20 family practices in Canada. The questionnaire included an open-ended question about what makes it difficult to talk about ACP with the family physician. Four authors analysed the open-ended comments using thematic content analysis.

Results 810 patients (mean age=66, 55.6% female) participated. Of the 53% (n=428) of patients who had talked to someone about end-of-life medical treatments, only 18% (n=75) had talked with their family physician. Patients identified the following barriers to ACP conversations: 1) They feel too young, healthy and well; 2) They abdicate responsibility to their physician; 3) They worry about a negative impact of ACP on the physician relationship; 4) Inadequate time during appointments; 5) They feel ACP is emotionally difficult to discuss with their physician.

Conclusions Our findings suggest that patients need help preparing for ACP conversations, both to change the perception that ACP conversations only occur at the end-of-life and to normalize these discussions between patients and physicians. There is an opportunity for family physicians, who have long-standing relationships and frequent visits with patients, to have ACP conversations.

OP65

FRAMING ADVANCE CARE PLANNING IN PARKINSON'S DISEASE: PATIENT AND CARE PARTNER PERSPECTIVES

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Background Advance care planning (ACP) is a new core quality measure in caring for individuals with Parkinson's disease (PD) and there are no best practice standards for how to incorporate the ACP process into PD care. This study describes patient and care partner perspectives on ACP to inform a patient and care partner-centered framework for clinical care.

Methods Qualitative descriptive study of 30 patients and 30 care partners affected by PD within a multi-site, randomized clinical trial of neuropalliative care compared to standard care. Participants were individually interviewed about perspectives on ACP, including prior and current experiences, barriers to ACP, and suggestions for integration into care. Interviews were analyzed using theme analysis to identify key themes.

Results Four themes illustrate how ACP is perceived and integrated into clinical care: 1) variation in personal definitions of ACP in the context of PD; 2) barriers to engaging in ACP with PD; 3) role of care partners as active participants in ACP; and 4) influence of a palliative care approach on ACP. Taken together, the themes support clinician initiation of ACP discussions and interdisciplinary approaches to help patients and care partners overcome barriers to ACP.

Conclusions ACP in PD may be influenced by patient and care partner perceptions and misperceptions, symptoms of PD (e.g. apathy, cognitive dysfunction, disease severity), and models of clinical care. Optimal engagement of PD patients and care partners in ACP should proactively address misperceptions of ACP and utilize clinic teams and workflow routines to incorporate ACP into regular care.

OP66

HOW DO PATIENTS WITH LIFE LIMITING DISEASES EXPERIENCE PATIENT-PHYSICIAN COMMUNICATION ABOUT LIFE EXPECTANCY? – AN INTERVIEW STUDY

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Background The Dutch Framework for Palliative Care advises physicians to timely start advance care planning (ACP) in patients with life limiting diseases. Such communication requires disclosure and discussion of patients' limited life expectancy. We explored patients' experiences with such discussions.

Methods Medical specialists from three different hospitals included patients with incurable cancer or late-stage chronic obstructive pulmonary disease (COPD), with whom they had spoken about their limited life expectancy. All 14 patients (7 cancer and 7 COPD) had a semi-structured interview with one researcher about their experiences on those conversations. The interviews were audiotaped, transcribed, coded, and analysed by two researchers.

Results All patients were aware of their limited life expectancy. They were often shocked when their physician had indicated prognosis rather concrete. However, such indications also enabled them to reflect certain treatments and led to conversations about ACP sometimes. Most patients agreed that the physician should initiate conversations about life expectancy, but that the patient should have control of the continuation of that topic. Some patients with COPD who disagreed with this also believed that the pulmonologist lacked the ability to indicate their life expectancy. Factors that facilitated agreeable conversations for the patients were: clear explanations and messages about the disease, prognosis and treatment options, feeling of being heard, sufficient time, and adequate preparation by the physician, an open attitude, and sensitive non-verbal communication.