qualification of ACP facilitators and family physicians, education of all regional health care actors relevant for the care of n/h residents, and coordination within and between participating institutions.

Primary hypothesis is a reduced rate of unwanted hospital admissions. Secondary hypotheses include increased rates of residents whose preferences are known and followed in pre-defined critical treatment decisions, residents dying in the n/h (versus in hospital) according to their preference, and residents, their families, and their caregivers who appreciate congruence between treatment wanted and delivered. Additionally, we plan a comprehensive process evaluation and a health economic analysis.

Conclusion While ACP has been repeatedly shown to be clinically effective in n/h, recent data from the Netherlands indicate it may not. Our trial, funded by the Innovation Fund of the Federal Joint Commission, will provide elaborate, 8 days facilitator qualification involving 24 hours of role plays with simulated patients, and it will be the first to study hospitalisation rate in all residents of participating n/h.

P42 ACP IMPLEMENTATION IN GERMANY: A PROGRESS REPORT OF THE POLITICAL FRAMEWORK AND ITS TRANSLATION INTO PRACTICE

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Background In December 2015, §132g was introduced into Social Code Book V. It provides financial coverage of advance care planning (ACP) for residents in long-term care institutions and institutions for persons with disabilities. At the end of 2017, the sickness funds and care home providers defined the details of the implementation in a mutual agreement.

Methods Policy analysis with description and critical reflection of the relevant regulations and the current status of ACP implementation in Germany.

Results Since early 2018, German care homes can get reimbursement for ACP-facilitators (1/4 full time equivalent for 100 residents), who can be either employed by the care home, by its carrier or by a regional cooperating partner. The mutual agreement specifies the structure and content of the planning process and defines the qualification requirements for ACP-facilitators, but not for facilitator trainers. Furthermore, the agreement calls for intra- and inter-institutional coordination, but does not provide for adequate workforce. Since 2016, there have been courses qualifying some 270 ACP-facilitators and 35 trainers, and several institutional ACP implementations. To promote the quality of the ACP-implementations, a German ACP-association (the DiV-BVP e.V.) was founded in 2017 to further develop facilitator and trainer curricula using simulated patient supported role plays, the contents of ACP-conversations, and of their adequate documentation.

Conclusions While §132g Social Code Book V provides a historic opportunity to implement ACP in German care homes, there are still major challenges to overcome, especially regarding facilitator qualification and institutional and regional implementation of the ACP system.

P43 PUTTING PIECES TOGETHER – A MULTIDISCIPLINARY TEAM IMPLEMENTING RESPECTING CHOICES IN A QUATERNARY HEALTH SYSTEM DEMONSTRATING REAL CHANGE AND SUSTAINABILITY

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The zenith of implementing the Respecting Choices systems approach to person centered and family oriented care is to provide person-centered decision making for each individual that honors current and future healthcare preferences. It is essential to understand that challenges exist for a quaternary health system to honor each individual's preferences. Challenges include but are not limited to; (1) assuring conversations are initiated and completed (2) broken or insufficient communication regarding healthcare preferences as result of conversations, and (3) difficulty in healthcare providers accessing information on preferences in real-time. This presentation will describe how a multidisciplinary ambulatory care team implemented this person centered decision making as foundational to achieving the quadruple aim. Outcomes include: For calendar year 2017: 334 enrolled. After enrollment: 90% had a person centered decision making conversation started, 80% had an Advance Directive uploaded into the EHR and 97% had a documented code status. Median survival after enrollment is 36 months with a overall cost of care reduction of \$455 per member per month during the time enrolled in the program. Further, 70 (43%) transferred to hospice with an average LOS in hospice of 50 days, and a median LOS in hospice of 29 days. This is compared to an overall hospice average LOS: 61.6 days and median LOS of 16 days. Likelihood to refer this program to others is 95%. Provider satisfaction is one of the highest of the 3600 providers in the delivery system.

P44 IMPROVING ADVANCE CARE PLANNING (ACP) DOCUMENTATION IN FREQUENT DEPARTMENT OF GERIATRIC MEDICINE (GRM) ADMITTERS WITH DEMENTIA IN AN ASIAN HOSPITAL

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Aim To improve the percentage of completed ACP documentation of eligible recurrent admitters (3 or more admissions within the last 1 year with no prior ACP documentation on admission) with background dementia to ward 7D under department of GRM from 7% to 60% within 6 months

Implementation Micro and macro flow charts were created to evaluate the processes in conduct of ACP. Root causes for reduced ACP documentation were identified via Ishikawa diagram and Pareto Chart. Through multiple PDSA (Plan, Design, Study, Act) cycles, the following interventions were conducted: creation of mandated workflow for ACP, reminders to offer ACP and incorporation of ACP in clinical delivery through documentation of ACP status in interim discharge summary and daily clinical problem list.

Results Root causes for low ACP documentation were ACP was not mandatory as part of clinical service delivery, lack of

educational materials on ACP and exclusion of ACP in clinical notes. After multiple interventions over 6 months, mean monthly completed ACP documentation rose from baseline of 5.5% to 28.8%, with highest achievable completion of ACP documentation at 50%. Though the target of completed ACP documentation was not met, there was an increase in the number of ACP discussions and documentation conducted by the department with increase awareness. This promotes a community of practice where ACP is offered readily.

Conclusion Changes in work processes and incorporation of ACP as part of clinical service delivery can improve ACP engagement in patients with dementia and their caregivers.

P45 PHYSICIANS' PERCEIVED ACCEPTABILITY OF A QUESTION PROMPT LIST FOR DEMENTIA AT THE END OF LIFE

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Background Question prompt lists can support communication between patients, relatives and professional caregivers. Examples of questions encourage to ask about topics that are relevant to patients and relatives, which may, for example, enhance participation in decision making and improve outcome. We developed a question prompt list about end of life for people with dementia and their relatives. Physicians' endorsement of its use and perceived acceptability is essential for effective implementation.

Methods In 2018, we surveyed 65 physicians (elderly care physicians and general practitioners) to evaluate the list. The survey was based on decision aid evaluation methodology including a validated acceptability scale ranging 15–75 with scores of 45 and meaning the aid is acceptable. Subsequently, we interviewed those physicians with either very high or very low acceptability scores.

Results The mean acceptability score was 51, but the physicians differed substantially in their evaluations of acceptability (SD 11). One third (32%) felt unable to answer the questions in the question prompt list. The interviews indicated this was bothering for some, and we explored this using the quantitative data. With inability to answer all questions, acceptability was lower and more variable (46 SD 13 vs. 54 SD 8).

Conclusions When accompanied by physician guidance and training, the question prompt list may fill a gap in seeking ways to develop advance care planning specific to dementia. An improved version of the question prompt list will be tested as part of two innovative advance care planning interventions.

P46 IMPROVING THE QUALITY OF PREFERRED PLAN OF CARE DISCUSSION USING A COMPANION GUIDE FOR PATIENTS WITH ADVANCED DEMENTIA

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Background For patients with advanced dementia, preferred plan of care conversations helps to improve end of life

outcomes by creating an opportunity for their carers to discuss about the circumstances in which they would prefer to limit life prolonging treatments and instead opt for an approach that prioritizes quality of life.

A discussion aid provides patients and families with structured information about clinical choices and help enhance the clinical decision making.

This will improve time efficiency and quality of informed decision making by increasing disease specific knowledge, reducing decisional conflict and promote evidence-based treatments.

Objectives Use of a discussion guide to improve the quality of discussion for patients with advanced dementia.

Methodology This study was a cross sectional study conducted in August 2018. The target population are physicians in the department of Geriatric Medicine, Tan Tock Seng Hospital. A discussion aid was designed to present balances, evidence-based information about risk, benefits and alternatives of clinical decisions to aid in discussion of end of life care in patients with advanced dementia.

Results Of the 43 physicians surveyed, 30% of them strongly agreed; 62% agreed; 4% Neither agree nor disagree and 2% disagree that the discussion aid will improve quality of ACP discussions.

Conclusion Most of the physicians surveyed felt that the discussion guide will improve the quality of communication and ACP discussion in patients with advanced dementia. They are also likely to use this guide for future ACP discussions.

P47 IMPACT OF THE MENTAL CAPACITY ACT ON PLACE OF DEATH IN HEART FAILURE PATIENTS WITH OR WITHOUT COMORBID DEMENTIA

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Background The Mental Capacity Act (MCA) came into force in England in 2007 to foster surrogate decision making, considered particularly relevant to advance care planning for those at the end of life. This study examined the impact of the MCA on the place of death (PoD) for heart failure (HF) patients sometimes affected by the loss of capacity.

Methods A national population-based retrospective cohort study of death registry data (DRD) in England, 2001–2016. All patients dying from HF (ICD-10: I50) were included. Capacity status designation was based on documentation of dementia (ICD-10: G30, F01, F03) as a comorbidity on DRD. Using binomial regression analysis, we compared PoD of HF decedents with and without comorbid dementia before and after MCA enactment.

Results 113,773 HF patients were included of whom 7,473 (6.5%) had dementia, these tending to be older, female, and with more comorbidities. 66% and 19% of HF patients with capacity died in the hospital or care home, respectively, the two commonest PoDs; in contrast, corresponding figures for those without capacity were 49% and 43%. Hospice as a PoD was rare ($\leq 0.5\%$) in both groups. Over the above period encompassing MCA implementation, PoD for HF patients with capacity shifted from hospital to home or care home (adjusted prevalence ratio (APR): 1.024[95% CI: 1.021–1.026]; $p < 0.001$); this trend less evident in those lacking capacity (APR: 0.995[0.981–1.010]; $p = 0.51$).