ACP PEACE: Advance Care Planning: Promoting Effective and Aligned Communication in the Elderly

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ACP PEACE

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Objective

- To test implementation of an advance care planning (ACP) program that combines clinician communication skills training and patient video decision aids
- Focused on patients with advanced cancer and their clinicians in oncology settings

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Study design

- Stepped-wedge, cluster randomized trial
- 4500 patients aged 65 years and older with advanced cancer
- 36 oncology clinics in 3 healthcare systems

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Outcomes

- Advance care plans completion
- Medical orders for resuscitation preferences
- Palliative care consultations
- Hospice use
- Will also characterize detailed patient-centered outcomes in a subgroup of 450 patients, including video declarations of individual preferences

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Participating healthcare systems

- Duke Health
- Northwell Health
- Mayo Clinic

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Barriers/challenges

- Incomplete and variable content of structured data ACP documents
- Impacts of the COVID-19 pandemic
- Transition to online communication skills training
- Transition to emailing/texting/mailing links to videos
- In-person vs. telehealth visits
- Revised Design

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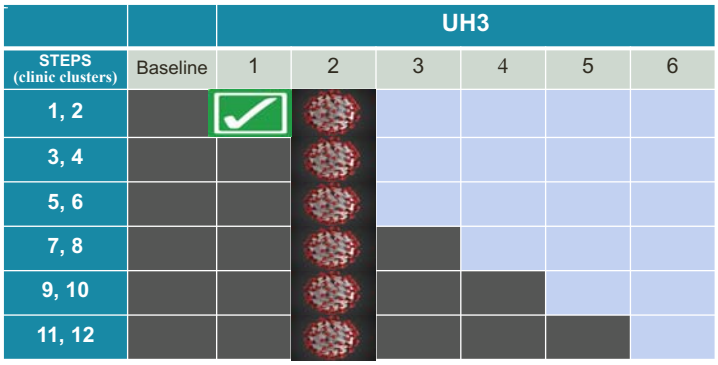
Original Design



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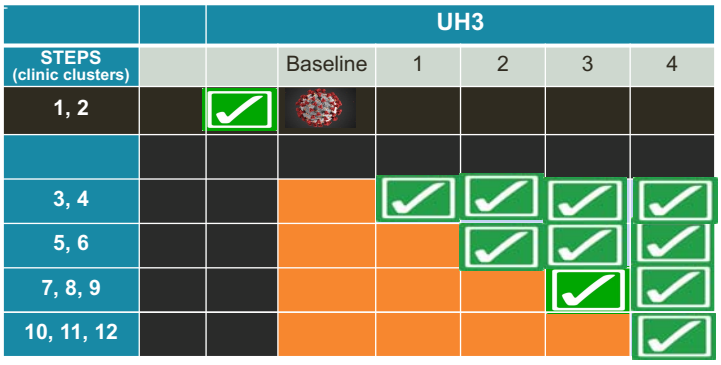
Revised Design



- Steps 1-2: ACP rates before and after intervention
- Steps 3-12: Intervention effect post-COVID-19

- **COVID-19 effect:** Will estimate pre-COVID ACP rate from original baseline plus Step 1; post-COVID ACP rate from Step 2 data. Will also examine trends over time.

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Data Challenges

Table 3. Chart Review Content of Structured Data Advance Care Planning Documents by Classification

Chart review classification N = *total number of documents*	*Site 1 (N = 55)*[a]	*Site 2 (N = 176)*[a]	*Site 3 (N = 132)*[a]	*Overall (N = 363)*
1. Data elements that represent unique advance care planning documents (correct)				
Advance directive/description of EOL wishes	14 (25.5)	104 (59.1)	1 (0.8)	119 (32.8)
MOLST/out of hospital code status	0 (0.0)	17 (9.7)	7 (5.3)	24 (6.6)
Post-mortem instructions	0 (0.0)	4 (2.3)	0 (0.0)	4 (1.1)
HCP/DPOA for health care	13 (23.6)	22 (12.5)	33 (25.0)	68 (18.7)
Total correct documents	**27 (49.1)**	**147 (83.5)**	**41 (31.1)**	**215 (59.2)**
2. Data elements that represent blank, not available/completed documents, or those that do not represent ACP (incorrect)				
Blank or incomplete document	0 (0.0)	4 (2.3)	2 (1.5)	6 (1.7)
Reports as asked, but not completed	0 (0.0)	0 (0.0)	29 (22.0)	29 (8.0)
Reports as available, but document not present	18 (32.7)	1 (0.6)	13 (9.8)	32 (8.8)
Wrong document (i.e., Consent Form, Procedural Safety Checklist, HIPAA Release)	2 (3.6)	11 (6.2)	6 (4.5)	19 (5.2)
Total incorrect documents	**20 (36.4)**	**16 (9.1)**	**50 (37.9)**	**86 (23.7)**
3. Duplicate documents (identical to another form)	**8 (14.5)**	**13 (7.4)**	**41 (31.1)**	**62 (17.1)**

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Solutions/lessons learned

- Online trainings and viewings are highly acceptable
- Hybrid is here to stay (in-person and telehealth)
- Redundancy in intervention exposure (EHR, text, in-person, waiting room, etc.)
- Stepped-wedge design is not the design of choice
- “We argue that the mere popularity and novelty of the SW-CRT should not be a factor in its adoption. In situations when a conventional parallel-CRT is feasible it is likely to be the preferred design.”

Ellenberg SS. The Stepped-Wedge Clinical Trial: Evaluation by Rolling Deployment. JAMA. 2018 Feb 13;319(6):607-608. doi: 10.1001/jama.2017.21993.

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