

### ***Integrating the ENABLE Early Palliative Care Approach in Community Cancer Centers: Results of an Implementation Trial (TH321A)***



Marie Bakitas, DNSc NP-C FAAN, University of Alabama at Birmingham School of Nursing, Birmingham, AL. James Dionne-Odom, PhD RN ACHPN, University of Alabama at Birmingham, Birmingham, AL. Maria Pisu, PhD, University of Alabama at Birmingham, Birmingham, AL. Andres Azuero, PhD, University of Alabama at Birmingham, Birmingham, AL. Dilip Babu, MD, University of Rochester Medical Center, Rochester, NY. Lucy Gansauer, MSN, Spartanburg Medical Center, Spartanburg, SC. James Bearden III, MD, Spartanburg Medical Center, Spartanburg, SC. Keith Swetz, MD MA HMDC FACP FAAHPM, UAB Center for Palliative and Supportive Care, Birmingham, AL. Leigh Minchew, DNP RN WHNP-BC PMHNP-BC, University of South Alabama, Mobile, AL. Margaret Sullivan, MS, University of South Alabama, Mobile, AL. Rachel Wells, MSN RN CNL, University of Alabama at Birmingham, Birmingham, AL. Richard Taylor, DNP CRNP ANP-BC, University of Alabama at Birmingham, Birmingham, AL. Yasemin Turkman, PhD MPH CRNP, University of Alabama at Birmingham, Birmingham, AL. Thomas Ramsey, PhD, University of Alabama at Birmingham, Birmingham, AL. Lisa Zubkoff, PhD, Geisel School of Medicine at Dartmouth, Hanover, NH.

#### *Objectives*

- Describe the use of ENABLE (Educate, Nurture, Advise, Before Life Ends) model of early, concurrent oncology palliative care.
- Describe the findings of an early palliative care (EPC) implementation of ENABLE for individuals with newly diagnosed metastatic cancer in rural-serving community cancer centers.

**Background.** Despite national guidelines recommending early palliative care (EPC) for individuals newly-diagnosed with metastatic cancer, it is rarely available in rural community cancer centers serving underserved populations.

**Purpose.** We conducted the first implementation trial of EPC in rural cancer centers using the evidence-based ENABLE (Educate, Nurture, Advise, Before Life Ends) model of early, concurrent oncology palliative care.

**Methods.** Mixed methods case study of a 4-year American Cancer Society-funded 4-site, implementation trial using a virtual learning collaborative in AL and SC. Guided by the RE-AIM (Reach Effectiveness Adoption Implementation Maintenance) framework, we gathered qualitative and quantitative data via monthly reports and yearly in-person site visits using: 1) a RE-AIM Self-Assessment Tool

completed by site staff to measure objectives; 2) EPC General Organizational Index (GOI) to measure capacity for EPC services and implementation progress; and 3) field notes from site interviews and final reports.

**Results.** Baseline patients (n=62) characteristics included: mean age of 58, 70% female, 17% Black or minority, 57% some college, 49% rural dwelling, and 57% non-gynecologic cancer. Sites enrolled at least 58% of the patients they planned to enroll (range: 58%–100%; average: 84%), of which 60% received at least two-thirds of ENABLE content. Reasons for not completing all six sessions included death, unrecorded contacts, or lost to follow up. Longitudinal GOI scores indicated a trend of improved capacity for EPC services at 3 of 4 sites.

**Conclusions.** A 4-site implementation trial found that community cancer centers were able to successfully implement a nurse-led model of early concurrent palliative care facilitated by a virtual learning collaborative that successfully served minorities and rural-dwellers affected by cancer.

**Implications for Research, Policy, or Practice.** Trial feasibility findings will be used to further enhance implementation (early referral, personnel development) strategies in a comparative effectiveness trial in a national cohort of community cancer practices.

### ***Factors Associated with Community Residence at the End of Life: A Population-Based Study (TH321B)***



Melissa Aldridge, PhD MBA BA, Icahn School of Medicine at Mount Sinai, New York, NY. Karen Kendrick, MPH, Icahn School of Medicine at Mount Sinai, New York, NY. Jennifer Reckrey, MD, Icahn School of Medicine at Mount Sinai, New York, NY.

#### *Objectives*

- State the prevalence of decedents by residential setting (community, community with supportive services, and nursing home) at the end of life in a national sample of Medicare beneficiaries.
- Compare the clinical characteristics of decedents across residential setting (community, community with supportive services, and nursing home) at the end of life.
- Explain how socioeconomic factors of decedents are associated with end of life residential setting (community, community with supportive services, and nursing home).

**Original Research Background.** Residence in the community in the last phase of life has increased substantially in the last two decades and encompasses a range of different types of residential care environments.

**Research Objectives.** Determine the associations between demographic, clinical, and socioeconomic characteristics and residential setting at the end of life.

**Methods.** We used the Medicare Current Beneficiary Survey (2011-2013) linked to administrative data. We characterized residential setting as community, community plus supportive services (e.g., personal care, medication assistance, meal preparation, transportation), or nursing home. We used multinomial logistic regression to identify characteristics associated with residential setting at the end of life.

**Results.** Of 1,385 decedents, 53.8% resided in the community, 7.7% in the community with supportive services, and 38.5% in nursing homes. Those in the community with supportive services and those in nursing homes had similar clinical characteristics including high rates of dementia (36.4% and 43.2%) and ADL impairment (2.3 and 3.1) but different socioeconomic characteristics. Those in the community without supportive services had higher rates of cancer and were more likely to be younger, married, and non-white than those in other settings. Higher education was independently associated with residing in the community with supportive services versus nursing homes (OR=2.1, 95% CI 1.1, 4.2) and versus residing in the community without supportive services (OR=3.4, 95% CI 1.7, 6.8).

**Conclusion.** Socioeconomic factors are associated with whether individuals remain in the community with supportive services or reside in nursing homes at the end of life independent of clinical and functional characteristics. A combination of clinical, functional, and socioeconomic factors are associated with residing in the community without supportive services at the end of life.

**Implications for Research, Policy, or Practice.** Understanding characteristics associated with use of varying residential care models will lead to a more comprehensive picture of the palliative care needs and consequences of the increase in community residence at the end of life.

### *Community-Based Conversations About Advance Care Planning Using Patient Navigators (TH321C)*



Regina Fink, PhD AOCNCHPN FAAN, University of Colorado Anschutz Medical Campus, Aurora, CO. Danielle Kline, MS, University of Colorado Denver, Aurora, CO. F. Amos Bailey, MD FACP FAAHPM, University of Colorado Hospital, Aurora, CO. Daniel Handel, MD, University of Colorado School of Medicine, Denver, CO. Hillary Lum, MD PhD, University of Colorado School of Medicine, Aurora, CO. Stacy Fischer,

MD, University of Colorado School of Medicine, Aurora, CO.

#### *Objectives*

- Develop an effective model for community-based advance care planning activity in rural Colorado populations facing traditional barriers created by low rates of English language fluency and healthcare access.
- Adapt, refine, and evaluate a program that can be implemented in other community settings and underserved populations.

**Background.** Widespread community engagement in advance care planning (ACP) is achievable in community settings through multi-faceted approaches, as supported by implementation literature.

**Aim Statement.** To adapt an ACP group visit model to increase ACP engagement in rural underserved Colorado communities.

**Methods.** Our statewide rural initiative utilizes patient navigators (PNs) to facilitate ACP conversations in churches, libraries, schools, businesses, nursing homes, clinics, local government districts, and area health education centers. Two bilingual lay PNs trained in an ACP group session framework facilitated one-hour English and Spanish sessions in a comfortable, confidential space. Participants receive bilingual informational materials including *Frequently Asked Questions*, an easy-to-read Advance Directive (AD) ([www.prepareforyourcare.org](http://www.prepareforyourcare.org)), and goal setting worksheets. Participants are encouraged to discuss their understanding and concerns about choosing a medical decision maker and completing a comprehensive AD. Participants are invited to complete the ACP Engagement survey (ACP-4) immediately post session.

**Results.** To date, we conducted 67 community-based sessions engaging 929 participants; 64.6% female, 42% ethnically diverse. Post session ACP-4 (51% response rate) showed 28% planned on naming a decision maker in the next 6 months and 22% in the next 30 days; 25% were ready to talk about future healthcare decisions with their decision maker in the next 6 months and 22% in the next 30 days; 31% were ready to talk to their provider about healthcare preferences in the next 6 months and 16% in the next 30 days; 31% were ready to complete an AD in the next 6 months and 23% in the next 30 days. Evaluations showed 56% were extremely satisfied, 43% were satisfied, with 98% reporting the session was the right length of time.

**Conclusions and Implications.** PNs effectively engaged underserved and ethnically diverse rural Colorado populations in community-based settings. Our model can be readily adapted by other healthcare settings to improve ACP in underserved populations.