

theme. Videos included a cultural explanation of the need for such communication.

Conclusion. Partnering with RSAA pastors and healthcare providers resulted in the development of a series of training videos that focus on culturally respectful communication methods for clinicians caring for RSAs with serious illness.

Implications for Research, Policy, or Practice. Enhancing clinicians' knowledge of culturally appropriate communication has the potential to build trust and meet RSAA patients' goals of care.

Engaging Diverse English- and Spanish-Speaking Older Adults in Advance Care Planning: The PREPARE Randomized Clinical Trial (FR421D)



Rebecca Sudore, MD FAAHPM, University of California, San Francisco and San Francisco VA, San Francisco, CA. Mary Katen, BA, University of California, San Francisco, San Francisco, CA. Ying Shi, PhD, University of California, San Francisco, San Francisco, CA. John Boscardin, PhD, University of California, San Francisco, San Francisco, CA. Stacy Osua, BS, University of California, San Francisco, Sacramento, CA. Deborah Barnes, PhD MPH, University of California, San Francisco, San Francisco, CA.

Objectives

- Describe the design and implementation of free, easy-to-use, patient facing advance care planning tools (www.prepareforyourcare.org), particularly for vulnerable and disenfranchised populations.
- Describe the comparative efficacy of an online advance care planning program called PREPARE (www.prepareforyourcare.org) plus an easy-to-read (5th-grade reading level) advance directive versus an advance directive alone on new advance care planning documentation and self-reported advance care planning engagement without additional clinician or system-level interventions.

Original Research Background. Advance care planning (ACP) improves value-aligned care; yet, it remains sub-optimal among diverse patient populations. To mitigate literacy, cultural, and language barriers, we created easy-to-read advance directives (ADs) and a patient-directed, online ACP program called PREPARE in English and Spanish.

Research Objectives. To compare the efficacy of PREPARE plus an easy-to-read AD (PREPARE arm) to an AD alone to increase ACP documentation and patient-reported engagement.

Methods. We conducted a comparative efficacy randomized trial from February 2014 to November 2017 in four San Francisco, safety-net, primary-care clinics among English- or Spanish-speaking adults age ≥ 55 years, with ≥ 2 chronic or serious illnesses. Participants

were randomized to the PREPARE arm or the AD alone. There were no clinician/system-level interventions. Staff were blinded for all follow-up assessments. The primary outcome was new ACP (i.e., legal forms and/or documented discussions) at 15 months. Patient-reported outcomes included ACP engagement at baseline; 1 week; and 3, 6, and 12 months using validated surveys. We used intention-to-treat, mixed-effects logistic and linear regression, controlling for time, health literacy and baseline ACP, clustering by physician, and stratifying by language.

Results. The mean (SD) age of 986 participants was 63.3 years (± 6.4); 39.7% had limited health literacy; and 45% were Spanish-speaking. No participant characteristic differed between arms; retention was 85.9%. Compared to the AD alone, PREPARE resulted in higher ACP documentation (adjusted 43% vs. 32%; $p < 0.001$) and higher self-reported increased ACP engagement (98.1% vs. 89.5%; $p < 0.001$). Results remained significant among English and Spanish speakers.

Conclusion. The patient-facing PREPARE program and an easy-to-read AD, without clinician/system-level interventions, increased ACP documentation and patient-reported engagement, with statistically higher gains for PREPARE for both English- and Spanish-speaking older adults.

Implications for Research, Policy, or Practice. These tools may mitigate literacy and language barriers to ACP, allow patients to begin planning on their own, and could substantially improve the process for diverse, English- and Spanish-speaking populations.

1:30–2:30 pm

Concurrent Sessions

The Practice of Palliative Medicine in Developing Countries—Part One (FR430)



Natalia Carafizi, MD MPH, Charity Foundation for Public Health, Chisinau, Moldova. Mohd Khilji, MD, S P Medical College, Bikaner, India. Atif Waqar, MBBS, Aga Khan University Hospital, Karachi, Pakistan.

Objectives

- Learn how physicians in specific countries provide palliative care to their patient populations often with limited resources.
- Recognize specific cultural and political challenges to developing palliative care clinical, educational and research programs.
- Describe roles of different health care providers practicing palliative care and how they meet the needs of their local populations.

Please join AAHPM's International Scholars for a panel discussion. Each scholar will present for 10-15 minutes on the state of the practice of palliative care in their home country, with an emphasis on the roles of physicians, nurses, and other healthcare providers; the status of education and research in the field; and the unique challenges facing patients and providers. There will be time allotted after each presentation to field questions and dialogue from the audience. Prepare to be educated and inspired by these accomplished individuals who are leading and advancing the field of hospice and palliative medicine in their countries of origin.

Promoting Resilience and Longevity in Palliative Medicine: A Focus on Being Well While Being Productive (FR432)



Rita Manfredi, MD FACEP, George Washington University School of Medicine, Washington, DC. Martha Roberts, MSN ACNP PNP, Marymount University, Arlington, VA. Carol Ramsey-Lucas, MDIV, Washington DC VA Medical Center, Washington, DC. Jan Bull, MA, Maryland University of Integrative Health, Laurel, MD. Rebecca Goett, MD FACEP, Rutgers New Jersey Medical School, Newark, NJ.

Objectives

- Describe the dimensions of wellness for the palliative clinician and develop strategies to sustain wellbeing.
- Construct a personalized wellness tool box for use in the clinical setting for all members of the palliative team and identify methods of implementation.
- Discuss validated measurement tools to assess wellbeing individually and departmentally.

The high prevalence of burnout in palliative clinicians, 62% in recent studies, suggests that palliative and hospice care practice may be more demanding and stressful than previously thought. The current unmet demand for more palliative providers and services in a setting where patients are increasingly complex contributes to the deficiency of wellness and resiliency in clinicians. It is critical for providers and their departments to recognize the impact of burnout and lack of resilience on patient safety, quality of care, and satisfaction of patient, family, and staff.

The National Academy of Medicine recently launched the Clinician Well-Being Knowledge Hub, a comprehensive resource promoting clinician well-being at the individual and system levels. Such resources provide a framework where being well can be seen as an evolving process through which a provider achieves his or her full potential.

To achieve this goal, how will providers in hospice and palliative medicine tackle the issues surrounding

resilience, burnout, and "unwellness"? In this concurrent session, wellness will be represented as a multi-spoked wheel containing all the dimensions necessary for professional wholeness and balance in the specialty. Clinicians from multiple disciplines will discuss a common framework individuals and departments can utilize to build a collegial mental model for being well, building resilience and preventing burnout while being productive clinically.

Review of case examples, didactics, and discussion will illustrate how a palliative clinician can positively impact his or her individual wellness. Validated tools, such as the Professional Quality of Life, which measure compassion, quality of life, and resilience, will be discussed. Since departmental wellness significantly impacts individual wellness, solutions and strategies will be presented which improve wellness at both levels. Exemplary approaches which promote longevity, increase satisfaction, and promote recruitment and retention of palliative providers will be highlighted.

Effectively Engaging the Faith-Based African-American Community in Advance Care Planning (FR433)



Valerie Steinmetz, BA, Emory University, Atlanta, GA. Janice Bell, PhD MN MPH, University of California, Davis, Sacramento, CA. Jill Joseph, MD PhD, University of California, Davis, Sacramento, CA. Cynthia Carter Perrilliat, MPA, California State University East Bay, East Bay, CA.

Objectives

- Discuss the formation and operation of the Alameda County Care Alliance Advanced Illness Care (ACCA) Programs in the faith-based African-American community.
- Discuss the evolution of the ACCA programs and evaluation for broad community impact.
- Review ACCA strategies, milestones and outcomes toward increasing awareness of advance care planning in the African American community.

Only 1/3 of all Americans and 19% of African-American adults over age 65 have documented their end-of-life care wishes. Similar disparities exist in discussion of values and preferences for end-of-life care, sharing of wishes for health care providers and family and formal completion of advance directives. To address these disparities and increase awareness of advanced care planning (ACP), the Alameda County Care Alliance (ACCA) has engaged fourteen denominationally diverse churches, their congregants and pastors using a faith-based community-based participatory approach to: 1) provide lay care navigation support to persons needing advanced illness care and their families/caregivers to meet spiritual, advance care planning, health, social, and caregiving needs; 2) better understand the