

support people with mild cognitive impairment (MCI) and a family care partner. We used a human-centered design process, rapid-cycle prototyping, and qualitative methods to adapt an ACP-GV intervention to individuals with MCI and a study partner. In 2019, we convened a longitudinal cohort of six patient-study partner stakeholders in three focus groups to suggest intervention adaptations. We also conducted a single arm study of four ACP-GV interventions (n=13 dyads total) that were iteratively refined with input from the longitudinal focus groups and intervention participant feedback. Decision tools, resources and videos were used to describe the concept of ACP and flexibility in selecting a medical decision maker. Many ACP-GV participants strongly agreed that the group discussion gave them useful information (81%) and would recommend the ACP-GV to a friend (85%). Pre- and post-ACP readiness surveys indicated that participants were significantly more ready to talk to their medical decision maker about ACP ($p=0.028$), while study partners perceived their loved ones less ready to speak to their doctor about ACP following the intervention ($p=0.031$). Use of rapid prototyping allowed testing of different resources and tools aimed at helping individuals with MCI and their study partners discuss ACP. Future work is needed to understand the feasibility of implementing an ACP-GV intervention for individuals with MCI into clinical settings.

CLINICIAN DISTRESS: A CONCEPT CLARIFICATION

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In 2017, The National Academy of Medicine created the Action Collaborative on Clinician Well-Being and Resilience given the staggering statistics around distress and burnout, which is particularly high while caring for seriously ill older adults. This distress may be physical, emotional, spiritual, moral, ethical, existential or in degrees and combinations of multiple forms. Many crossover concepts are present in the literature, including moral distress, role stress, compassion fatigue, empathy, emotional labor, post-traumatic stress disorder, vicarious traumatization, and second victim. Because of the number of crossover concepts, we employed the Norris concept clarification method examining similar concepts to create an operational definition, construct a model, and develop possible research hypotheses of clinician distress. Articles were identified through PubMed, CINAHL, PsychINFO, and SCOPUS with the expert assistance of a nurse librarian. Similar concepts in the literature were compared and contrasted with an emphasis on what encompasses clinician distress. Based on synthesis of the literature and existing concepts, clinician distress is defined as experiencing one or more negative emotions before, during, or after a clinical encounter that impacts the quality of care the clinician is able to provide to the patient. The result of this analysis provides some clarity around clinician distress and its surrogate terms, which presents opportunities for further investigation.

EVALUATING AN ADVANCE CARE PLANNING SKILLS TRAINING FOR MEDICAL, NURSING, AND SOCIAL WORK STUDENTS

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Advance care planning (ACP) helps to ensure future healthcare is congruent with individual preferences. Curricula for health-focused professions rarely include ACP content. This is a repeated measures evaluation of an innovative, interprofessional student training to enhance the ability to lead ACP discussions. Outcomes were measured via self-report surveys at two timepoints (baseline = T1 [n = 35]; posttraining follow-up = T2 [n = 20]) and included validated measures of communication self-efficacy, ACP self-efficacy, and interprofessional teamwork. Data collection from a third timepoint (T3), following randomized group assignment is currently underway. The matched T1-T2 sample (N = 17) included students from medicine (64.7%), nursing (17.6%), and social work (17.6%). Participants were largely young (M=26 years), non-Hispanic (94.0%), White (59.0%), and female (71.0%). Paired t tests examined change from T1 to T2 for all outcomes. Despite worse communication self-efficacy (Mdiff=1.6, $p<.001$) and ACP self-efficacy (Mdiff=.92, $p<.001$), perceptions of interprofessional teamwork improved (Mdiff=3.0, $p=.008$). These T1-T2 findings mirror results from similar, prior research, which subsequently discovered that both self-efficacy outcomes and their effect sizes for change worsened at T2, but ultimately and substantially improved at T3. These fluctuations suggest participants initially overestimated their self-efficacy related to ACP at T1 and corrected their appraisals at T2. Other studies should account for this self-correction. Further replication is needed to understand the dip that appears to occur before anticipated improvements occur.

HOSPICE FAMILY CAREGIVERS' USE OF AUDIO DIARIES

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Previous work has shown that emotional processing as part of diary writing improves well-being during and after stress. The purpose of this study was to determine the feasibility of verbal/audio diaries for home hospice family caregivers (HFCGs). We also describe diary content. As part of an ongoing multi-site, prospective longitudinal study, HFCGs of cancer patients report daily fluctuations in patients' and their own symptoms via an automated telephone system, including a recorded diary entry. HFCGs are randomly assigned instructions to either discuss additional symptoms or discuss their thoughts and feelings. Thirty-six (85.7%) participants to date have completed at least one audio diary. For this preliminary analysis, we selected the 14 longest diary recordings from each condition (n=28) to content analyze using Linguistic Inquiry and Word Count (LIWC) and NVivo 12. Participants are 78.6% female, 53 years of age on average, and most are spouse/partner (46.4%) or adult child (35.7%) caregivers. There was no difference in the overall positivity (23%) or negativity (77%) of words in either condition, but participants asked to express thoughts/feelings used significantly more anger-related terms ($p=0.04$) while those asked to describe symptoms used significantly more anxiety-related terms ($p = 0.003$). Time was the most common theme in both conditions but arose more frequently

in the symptom condition ($p=.08$). Our findings suggest that most audio diaries are feasible for HFCGs, but varied prompts may facilitate different types of emotional expression. Future research should assess potential impact on emotional well-being and bereavement adjustment.

HOW MANY PEOPLE NEED PALLIATIVE CARE AND HOW MANY MISS OUT?

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With an ageing population and growing burden of chronic disease, the number of people requiring palliative or end-of-life care (P&EOLC) is set to rise. It is imperative to develop a comprehensive understanding of the quality and equity of P&EOLC provision to promote sustainable health systems. The aim of this presentation is to report an observational study of $N=3,171$ decedents across a Local Health Network to: 1) estimate the proportion who need, access and miss out on P&EOLC in the last 12 months of life, and 2) identify differences by clinical and sociodemographic characteristics. Analysis was performed on multiple integrated datasets containing routinely collected health and mortality data. Estimation methods based on underlying cause of death were applied to determine those decedents who could potentially benefit from P&EOLC. Results identified potential benefit to 75% of decedents, of which 62% received P&EOLC and 13% missed out. Decedents aged 85 years or more and from a residential aged care facility showed the lowest proportion of access. Decedents with diagnosis of liver or kidney failure and dementia received more P&EOLC than were expected to benefit. Multivariate logistic regression identified that diagnosis and no other clinical or sociodemographic factor was significantly associated with likelihood of accessing specialist palliative care, with cancer showing highest likelihood and heart failure lowest likelihood. This research highlights the value of population-based estimates to provide a 'whole of system view' of quality and equity of P&EOLC, with ready translation for service planners around resource allocation for need and likely benefit.

IMPACT OF CULTURE AND RELIGION ON END-OF-LIFE DECISIONS AMONG ADVANCED CANCER PATIENTS IN DEVELOPING COUNTRIES

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Palliative care and end of life decisions are important components of quality care at the end-of-life. Individual's perception of cancer diagnosis is affected by their customs and traditions, religious orientations and stigma. Culture and religion as a social determinant of health affects people's interpretation of health and illness and is a major factor in deciding the type of care at end of life and death. The

purpose of the review was to identify factors related to culture and/or religion that impact decision making at end of life among advanced cancer patients their primary family caregivers and healthcare providers. An extensive literature search was conducted in Psych Info, PubMed, Philosophy Index, Atlas Religion, and Academic Search Premier databases for primary studies on the topic. Primary studies conducted only in developing countries and among healthcare providers, advanced cancer patients and their primary family caregivers were included. Five studies met the inclusion criteria: two primary studies, one methodological paper, and two on perspectives. The studies reported economic status of the patient, family, culture, and religious beliefs as factors that affected decision making at the end of life. Improving cancer care in developing countries requires the accommodation of the culture, traditions, and religious beliefs of both healthcare providers, patients and family. Culturally appropriate care model is therefore needed to enhance palliative and end of life care in developing countries. Leininger's Cultural Care Theory seem an appropriate path to take.

INTEGRATED MULTIDISCIPLINARY APPROACH TO ADVANCE CARE PLANNING FOR VULNERABLE OLDER ADULTS

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Advance Care Planning (ACP) is increasingly recognized as a crucial step to ensure patients receive medical care that consistent with their overall goals and values; however it remains suboptimal among vulnerable older adults. The objective was to determine whether a nurse navigator led ACP pathway plus a provider-facing EMR documentation program called ACPsmart improves ACP documentation within the EMR within an Accountable Care Organization (ACO) for vulnerable older adults. This was a randomized, pragmatic, effectiveness clinical trial was conducted from November 1, 2018 to November 1, 2019, at 8 primary care practices. Patients 65 years or older within an affiliated ACO with multimorbidity plus physical impairments, cognitive impairments, and/or frailty were included. Participants were randomized to either a nurse navigator led ACP pathway (NN) or usual care (UC). The primary outcome was documentation of new ACP discussion within the EMR at 12 months along with the quality of ACP discussions. Among 759 randomized patients (379 NN / 380 UC, mean age 77.7 years), compared to usual care, the NN led ACP pathway resulted in a higher rate of ACP documentation (42.2% vs 3.7%, $p<0.001$). There was also higher completion rates of ACP legal forms (24.3% vs 10.0%, $p<0.001$), MOST forms (10.3% vs 1.1%, $p<0.001$), along with documentation of medical decision maker (64% vs 35%, $p<0.001$). The nurse navigator led ACP pathway plus ACPsmart documentation program increased documentation of ACP within the EMR. This may mitigate prior barriers to ACP and could substantially improve ACP documentation within the EMR.