# A Cluster-Randomized Trial Comparing Team-Based versus Primary Care Clinician-Focused Advance Care Planning in Practice-Based Research Networks

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## BACKGROUND

- Implementing **Advance Care Planning** (ACP) in primary care allows providers, patients, and care partners to develop a mutual understanding of a patient's goals, wishes, and concerns regarding their serious illness.
- Meta-LARC, a network of seven Practice-Based Research Networks (PBRNs) across the United States (n=5) and Canada (n=2), launched the Meta-LARC ACP project in 2017 with funding from the Patient-Centered Outcomes Research Institute (PCORI).

**AIM:** To understand how to conduct ACP that allows patients, care partners, and primary care providers to make heath care plans that effectively consider what matters most to patients as they face serious illness, make choices about care as their illness progress, plan for end-of-life decisions.

## STUDY DESIGN

- A binational, cluster-randomized clinical trial evaluating the comparative effectiveness of two approaches to implementing the Serious Illness Care Program (SICP)[1] in primary care:
  1. **Clinician-focused**: A primary care provider is solely responsible for initiating and continuing ACP conversations with patients and families.
  2. **Team-based**: ACP activities and conversations are conducted collaboratively by a primary care team.
- Practices were provided training and implementation support according to their randomization arm.

### WHO IS INVOLVED?

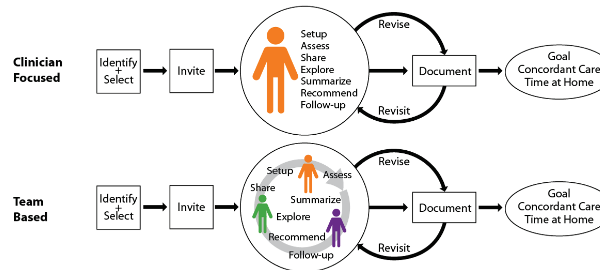
**Primary Care Practices**: Practices in Meta-LARC member PBRNs.
- Attended monthly check-in and quarterly site visits. Clinicians and team members completed two annual surveys after training.

**Patients and Care Partners**: Community living adults with a serious chronic illness and limited life span and their care partners.
- Completed a survey after first ACP conversation, then 6-months, and 12-months later.

**Patient & Family Advisors** (PFAs): PFAs provided the patient and family perspective throughout the project (i.e., development, implementation, data collection and analysis, and dissemination).

## STUDY ARMS

### Serious Illness Care Program




## PARTICIPANT CHARACTERISTICS

### PRACTICES

- 19 clinician-focused (15 US; 4 Canada)
- 21 team-based (15 US; 6 Canada)
- Setting: 50% rural; 20% suburban; 30% urban
- Size: 18% small; 37% medium; 45% large

### CLINICIANS AND TEAM MEMBERS

- 448 clinicians and staff trained (175 in clinician arm; 273 in team arm)
- Team arm: 43% primary care clinicians; 57% care team members

### PATIENTS

- 802 enrolled (408 in clinician arm; 394 in team arm)
- Clinician arm: 75% US; 25% Canada
- Team arm: 63% US; 37% Canada
- Self-rated general health rated 'fair' or 'poor': 32% in clinician arm; 40% in team arm
- Joined study after March 2020: 39%

### CARE PARTNERS

- 148 enrolled (66 in clinician arm; 82 in team arm)
- Clinician arm: 79% US; 21% Canada
- Team arm: 57% US; 43% Canada
- Relationship: 59% spouse; 30% child; 11% other
- Care partner lives with patient: 71%

## PRELIMINARY FINDINGS

### PRIMARY OUTCOME

- Patient-reported goal-concordant care (9 or 10 on 0-10 scale): 64% clinician vs. 58% team at 6-month follow-up . Unadjusted OR 1.30 (0.86-1.96 CI); Adjusted OR 1.32 (0.87-1.96 CI)†

### SECONDARY OUTCOMES

| | Clinician Arm | | Team Arm | | Covariate-Adjusted† | | |
|---|---|---|---|---|---|---|---|
| PROMIS T Scores* | Mean (SD) | n | Mean (SD) | n | Est. Diff. | 95% CI | p |
| PROMIS Anxiety T Sub-Score | 50.9 (9.3) | 301 | 51.4 (9.3) | 275 | 0.43 | (-0.99 to 1.85) | .55 |
| PROMIS Depression T Sub Score | 48.7 (8.4) | 302 | 50.1 (9.2) | 275 | 1.35 | (-0.13 to 2.83) | .07 |

†Estimated using longitudinal generalized linear mixed model that includes study arm, time point, the interaction between study arm and time point, self-rated general health at Time 1, history of or current cancer, enrollment after March 2020, research network (PBRN, used to stratify randomization), and random intercepts for practice and patient.

- Commonly reported **barriers** to ACP implementation by participating primary care providers in Canadian practices included lack of time, competing priorities in a medical appointment, and personal discomfort and self-perceived lack of experience with engaging in ACP.
- Commonly reported **facilitators** to ACP implementation by participating primary care providers in Canadian practices included having the SICP guide or cheat sheet on hand during conversations, incorporating the guide and reminders in patients' electronic medical records, taking the time to practice conducting ACP, and designating a time or appointment to ACP.

## QUESTIONS?

Email METALARC_ACP@ohsu.edu for more information or to be added to our mailing list.

## REFERENCES

1. The SICP was created by a team of palliative care experts (Founding Program Director, Dr. Susan Block) at Ariadne Labs, which is a joint center of Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health in Boston, MA. More information on the program can be found here: https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

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