used a multivariable model with county-level fixed effects to assess factors associated with enrollment in hospice from the community.

Results. Pathways to hospice did not change from 2011 to 2018, with 37.2% enrolling in hospice directly after hospital discharge and 47.5% enrolling within 30 days after hospitalization. However, hospice pathway strongly varied by illness and state of residence, with decedents with cancer more likely to enroll in hospice from the community and those with dementia more likely to enroll from the nursing home. In addition, those enrolled in MA were more likely to enroll in hospice from the community, even in adjusted models (AOR 1.7, 95% CI 1.65-1.68).

Conclusion(s). The locations of care before hospice have not changed between 2010 and 2019 and continue to be driven by inpatient hospital stays, although they are influenced by illness, region, and MA enrollment.

Impact. Understanding how region and MA shape hospice use may help improve care and access to hospice.

Variation in Benzodiazepine and Antipsychotic Prescribing Among Hospice Agencies (CO203D)

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Outcomes.

1. The attendee will be able to explain and recognize patient-level factors associated with benzodiazepine and antipsychotic prescribing in hospice
2. The attendee will be able to explain and recognize hospice agency-level factors associated with benzodiazepine and antipsychotic prescribing in hospice

Importance. Benzodiazepines and antipsychotics are routinely prescribed for symptom management in hospice, but they are not without important risks. An understanding of the factors associated with prescribing of these medications is important.

Objective(s). Examine patient- and hospice-agency-level characteristics associated with incident prescribing of benzodiazepines and antipsychotics in hospice.

Method(s). Retrospective cohort study of a 20% sample of Medicare beneficiaries newly enrolled in hospice from 2014 to 2016, restricting to those without benzodiazepine (N = 169,688) or antipsychotic (N = 190,441) prescription fills in the 6 months before hospice enrollment. The primary outcome was incident (i.e., new) prescribing of a benzodiazepine or antipsychotic in hospice. A series of multilevel Cox regression models with random intercepts for hospice agency were fit to examine the association of incident benzodiazepine and antipsychotic prescribing with patient and hospice agency characteristics.

Results. A total of 91,728 (54.1%) and 58,175 (30.5%) hospice beneficiaries were newly prescribed a benzodiazepine or antipsychotic across 4,347 hospice agencies. The prescribing rate of the hospice agency was the strongest independent predictor of incident psychotropic prescribing. Compared to those in agencies in the lowest quartile of benzodiazepine prescribing, those in agencies in the highest quartile were 10.7 times more likely to be newly prescribed a benzodiazepine (adjusted hazard ratio [AHR] 10.7, 95% CI 10.1-11.3). Those in agencies in the highest quartile of antipsychotic prescribing were 51.7 times more likely to receive an antipsychotic (AHR 51.7, 95% CI 44.3-60.4) compared to those in the lowest quartile. Results remained consistent, accounting for comfort kit prescribing.

Conclusion(s). Enrollment in a high-prescribing hospice agency was the characteristic most strongly associated with incident prescribing of benzodiazepines or antipsychotics, exceeding every other patient-level factor.

Impact. While it is unclear what the "right" level of prescribing is in hospice, this significant variation may reflect a strong local prescribing culture across individual hospice agencies.

Rapid Poster Abstracts

Pilot Randomized Controlled Trial of an Advance Care Planning Video Decision Tool for Patients with Advanced Liver Disease (RP301)

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Outcomes.

1. Identify current barriers to the delivery of advance care planning to patients with chronic liver disease
2. Interpret the results of a randomized control trial of an advance care video decision support tool

versus verbal narrative control and compare outcomes of patients randomized to the video intervention or control arms of the trial

Importance. Transplant-ineligible patients with advanced liver disease rarely receive timely advance care planning (ACP). Tools are needed to educate these patients about medical interventions available at the end of life to promote ACP.

Objective(s). To assess the feasibility, acceptability, and preliminary efficacy of an ACP video decision support tool for improving transplant-ineligible advanced liver disease patients' knowledge about and preferences for end-of-life care.

Method(s). In this single-site pilot randomized controlled trial, intervention participants watched a 5-minute ACP video decision support tool depicting 3 levels of goals of care: life-prolonging care (cardiopulmonary resuscitation [CPR] and intubation), life-limiting care (hospitalization, no CPR or intubation), and comfort care. Control subjects received a verbal narrative of these 3 levels of goals of care. The primary outcome was feasibility (≥60% enrollment rate). Secondary outcomes included acceptability of the video, patients' knowledge of end-of-life care options (6-item test; range 0-6), and postintervention goals-of-care and CPR and intubation preferences.

Results. We enrolled 85% (50/59) of eligible patients randomly assigned to the video (n = 26) or verbal (n = 24) arm. Preferences to receive CPR (69% vs. 70%; p = 0.99) and knowledge assessment scores (3.3 vs. 3.2; p = 0.45) were similar between both arms at baseline. In the video arm, 81% of patients reported being very comfortable watching the video. Patients in the video arm had higher mean knowledge scores (5.7 vs. 4.8; $p < 0.001$) and were less likely to prefer to receive CPR compared to patients in the verbal arm (35% vs. 63%; p = 0.09).

Conclusion(s). An ACP video decision support tool to improve knowledge about and preferences for end-of-life care is both feasible and highly acceptable to transplant-ineligible patients with advanced liver disease with a high enrollment rate and promising preliminary efficacy.

Impact. Future studies should examine the efficacy of the ACP video for increasing the quality of end-of-life care for patients with advanced liver disease.

Examining Shared Decision Making in Hospice Interdisciplinary Team Meetings (RP302)

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Outcomes.

1. Identify 9 essential elements of shared decision making
2. Discuss family and staff differences in definitions of problems

Importance. Bi-weekly interdisciplinary team (IDT) meetings are a requirement in hospice but can at times be a source of frustration for staff, who spend several hours in them and perceive them to have limited utility.

Objective(s). Shared decision making (SDM) is a central tenet of hospice, yet patient and family participation in plan-of-care meetings is rare. As part of a clinical trial involving family in IDT meetings, the objective of this study was to analyze the use of SDM in IDT meetings.

Method(s). Family members who participated in IDT meetings in four hospice agencies between 2008 and 2021 were interviewed and their meetings were audio-recorded and transcribed. A framework analysis identified elements of SDM and the benefits and barriers perceived by family. A consensus coding process was used between two coders and the study principal investigator.

Results. Sixty-two hospice IDT meetings were transcribed and coded. The least often observed SDM elements were discussion of risks and benefits for potential solutions and the discussion of patient and family values. Family members and staff had differing ideas of presenting problems. Family members were interviewed about their experience in the meetings and expressed both appreciation and frustration with the experience.

Conclusion(s). IDT meetings would benefit from an efficient structure to support informed discussion, including the definition of presenting problems. Additionally, a pre-meeting process to prioritize cases needing more discussion would seem valuable. Similarly, a standard SDM process could provide a supportive discussion framework for the elements of SDM. Finally, the meetings could benefit from documentation tools supporting rapid information sharing, eliminating "verbal reports" and providing time for problem solving.

Impact. Advanced prioritization, a shared information tool, and a standardized SDM structure could result in a more efficient environment for family participation and SDM.

Experience with an Electronic Practice Alert in Primary Care: Results from the Meta-LARC Advance Care Planning Study (RP303)

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