ALG SENIOR: ADVANCED CARE DIRECTIVES AS A PART OF CARE PLANS

A TEST CASE FOR INCORPORATING ADVANCED CARE DIRECTIVES INTO THE CARE PLANNING PROCESS FOR A POST-ACUTE, SENIOR LIVING SETTING

ALG SENIOR

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PROJECT PURPOSE

IDENTIFYING THE NEED

OPPORTUNITY

Less than 30% of ALG Senior residents have ACP on file. Given our population's age, limited economic resources, multiple chronic conditions, and average length of stay a proactive, informed approach to end of life planning and care is critical.

When researching what available education options our residents and family members had for ACP there was a gap. Family members and residents had limited information, providers were not actively having the conversation, and our staff had varied levels of education on the topic to help drive these important conversations.

ADVANCED CARE DIRECTIVES...

Are court supported medical directives that enable individuals to make plans about their future health care. ACP's incorporate personal values, preferences, and can be made proactively with loved ones and healthcare providers.

Without ACP's, full life sustaining treatment orders can lead to the administration of potentially unwanted intensive care, a higher burden of unrelieved physical symptoms and emotional distress, and a disproportionate amount of healthcare expenditures.

ALG SENIOR:
TYPICAL RESIDENT PROFILE

AVERAGE AGE: 83

AVERAGE NUMBER OF MEDICATIONS: 12

AVERAGE NUMBER OF CHRONIC HEALTH CONDITIONS: 5

70% HAVE DEMENTIA OR CONGNITIVE IMPAIRMENT

AVERAGE LENGTH OF STAY: 23 MONTHS

70% FEMALE

AVERAGE INCOME $36,000/YR

40% HAVE INCOME OF <$20,000/YR

60% RECEIVE SOME TYPE OF GOVERNMENT ASSISTANCE

93% REQUIRE ASSISTANCE WITH 4+ ADLS

PROJECT QUESTION

Will group education sessions provided to residents, their relatives and staff increase the utilization of Advance Care Planning in the three identified LTC communities?

ENHANCEMENT ACTIVITIES

PLAN TO DRIVE CHANGE

GOAL

Increase the number of ALG Senior residents who have ACPs by 30% in our pilot communities by involving guardians, family members, providers, staff and residents in education sessions.

ENHANCEMENT ACTIVITIES

Sponsorship & Change Champions

Project sponsorship was identified early on as key to our project success. Our plan included sponsorship spine that ran from our C-Suite Team to our communities, and involved our community providers- e.g. physicians and palliative care.

- Executive Team
- Divisional Vice President of Operations (DVPO)
- Area Director of Operations (ADO)
- Executive Directors (in ea. of 3 communities)
- Co-chair at each community (to help drive and sustain change)
- Community physicians
- Local palliative care teams

Change Management

To help manage the change communication about the project began straight away. The project team communicated the project, desired outcomes, and pilot activities regularly in status updates within the project team and in regularly scheduled updates with key stakeholders.

- Weekly and bi-weekly project team calls
- Weekly executive team briefings
- Coach/Executive project sponsor calls
- DVPO, ADO, ED weekly calls
- Primary care physician calls/emails
- Palliative care team calls/emails

ENHANCEMENT ACTIVITIES, CONTINUED

Some of the key deliverables from the project team included:

- Regular reporting on ACP activity using ALG Senior's eMAR system
- Presentation decks for providers, staff, residents and family members
- State approved ACP forms
- ACP Snacks and Facts survey

EVALUATION METHOD

MEASURING ENHANCEMENT ACTIVITIES

EVALUATION

The census, as well as number of ACP's on file in November 2019 were recorded for each pilot community.

To determine the number of ACP's needed to achieve a 30% increase, the project team used the following formula:

Census November 2019 (-) # ACP November 2019 = # (x) .30 = target number for 30% increase

EVALUATION

Though the primary metric for the pilot was the number of ACPs, we also wanted to get a pulse on the quality of the education sessions. We created a survey to track:

- Overall quality
- Informative
- Engaging
- Familiarity with ACP
- Likelihood to create an ACP

EVALUATION

This pilot focused on gaining forward momentum in the number of ACP.

Advanced Care Planning will have a role in the integrated system of care ALG Senior is building. The project team identified additional metrics that would be beneficial subsequent phases of ACP implementation, these include:

- The type of ACP on file. The project team recognized having ANY ACP was good; however, the MOST form preferred as it was the most comprehensive in end of life directives.
- Average length of stay, (currently 23 months).
- Average hospice days, (currently 60 days).

PROJECT RESULTS

PILOT OUTCOMES

EDUCATION SESSIONS

On average someone walked into our information sessions **Moderately Informed** on the topic of advanced care planning (average was 3.06, on a 1-5 rating where 1 indicated not at all familiar with topic and 5 indicated extremely familiar), but **left with a high likelihood of taking action as a result of the session** (Avg 4.67 on a 1-5 rating where 1 indicated very unlikely and 5 indicated the very likely… to create an advanced care plan or make updates to an existing plan based on the information session).

EDUCATION SESSION DATA

1. Quality: 4.875

   Scale: 1-very poor, 2- poor, 3- fair, 4-good, 5 excellent

2. Informative: Yes

   Scale: yes/no

3. Engaging: Yes

   Scale: yes/no

4. ACP: 3.06

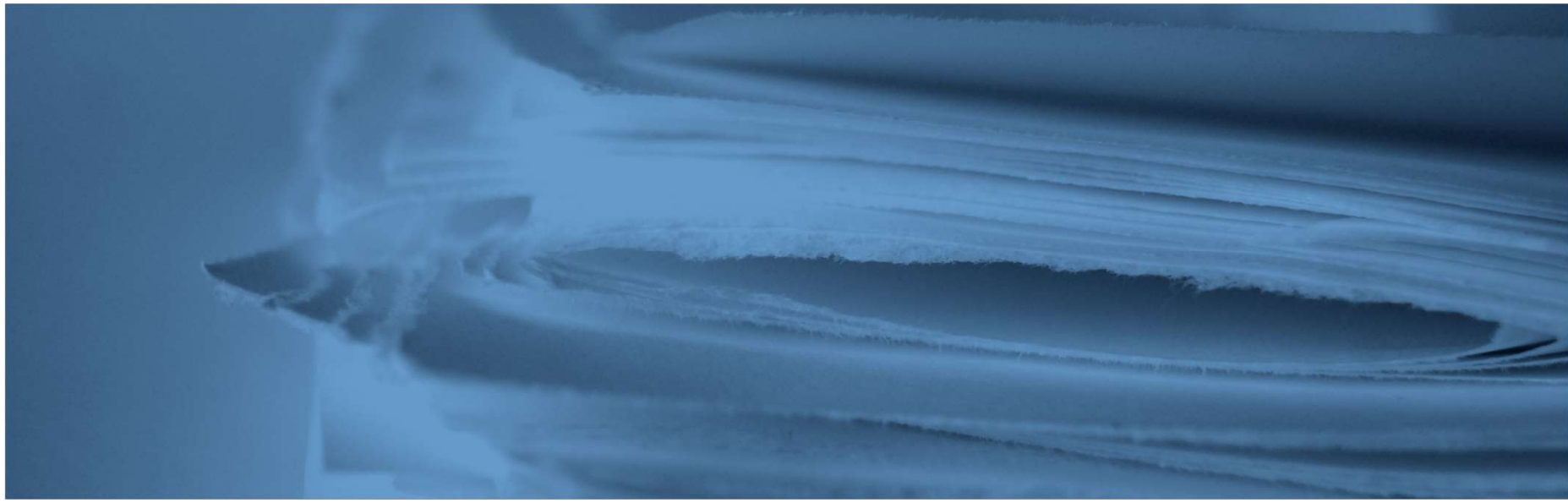
   Scale: 1-not at all familiar, 2- slightly familiar, 3-moderately familiar, 4-very familiar, 5-extremely familiar

5. Likelihood to create an ACP (or make updates to an existing one) based on information session

   Scale: 1-very unlikely, 2- unlikely, 3-neutral, 4-likely, 5-very likely

ADVANCED CARE PLANS

The target outcome of **a 30% increase in ACP's was achieved for two of the three pilot communities**. Although the goal was not met for community 1, the goal was exceeded for community 2 and almost doubled for community 3.



ADVANCED CARE PLAN DATA

6 The number of ACP's on file for each community on May 11, 2020 were compared to those from November 2019. The percentage increase was calculated using the following formula:

new # of ACP (-) original # of ACP (=) difference (÷) original # of ACP (=) percentage increase.

	ACP's November 2019	ACP's May 2020	Target Increase ACP's	Actual Increase ACP's	Percent Increase
Community 1	26	33	14	7	27%
Community 2	25	34	4	9	36%
Community 3	47	73	6	26	55%
Overall	140	98	24	42	43%

CONCLUSION

PROJECT LIMITATIONS & REFLECTIONS

PROJECT LIMITATIONS:
COVID-19 PANDEMIC

The Covid-19 pandemic drastically changed the daily operations of LTC communities, notably:

- Face to face visits are no longer allowed for family
- Most healthcare appointments are conducted virtually

The disruption has negatively impacted the continued focus on ACP at admission and during the care planning process.

PROJECT LIMITATIONS:
COMMUNITY PARTICIPATION

Variance in outcomes between communities, at least partially, can be attributed to:

- the level of commitment by key staff, and
- the outreach activities at each community.

PROJECT LIMITATIONS:
PROVIDER PARTICIPATION

The Covid-19 pandemic also affected the level of involvement the local palliative care organizations as opportunities for face to face contact were limited.

Given the sensitive nature of the topic, as well as the rural locations of the pilot communities, the project team believes engagement was lower than it would have been had face to face appointments continued.

PROJECT LIMITATIONS:
PROJECT TEAM

Two of the five members of the project team were furloughed at the end of March 2020 and the remaining team members assumed additional responsibilities following the furloughs.

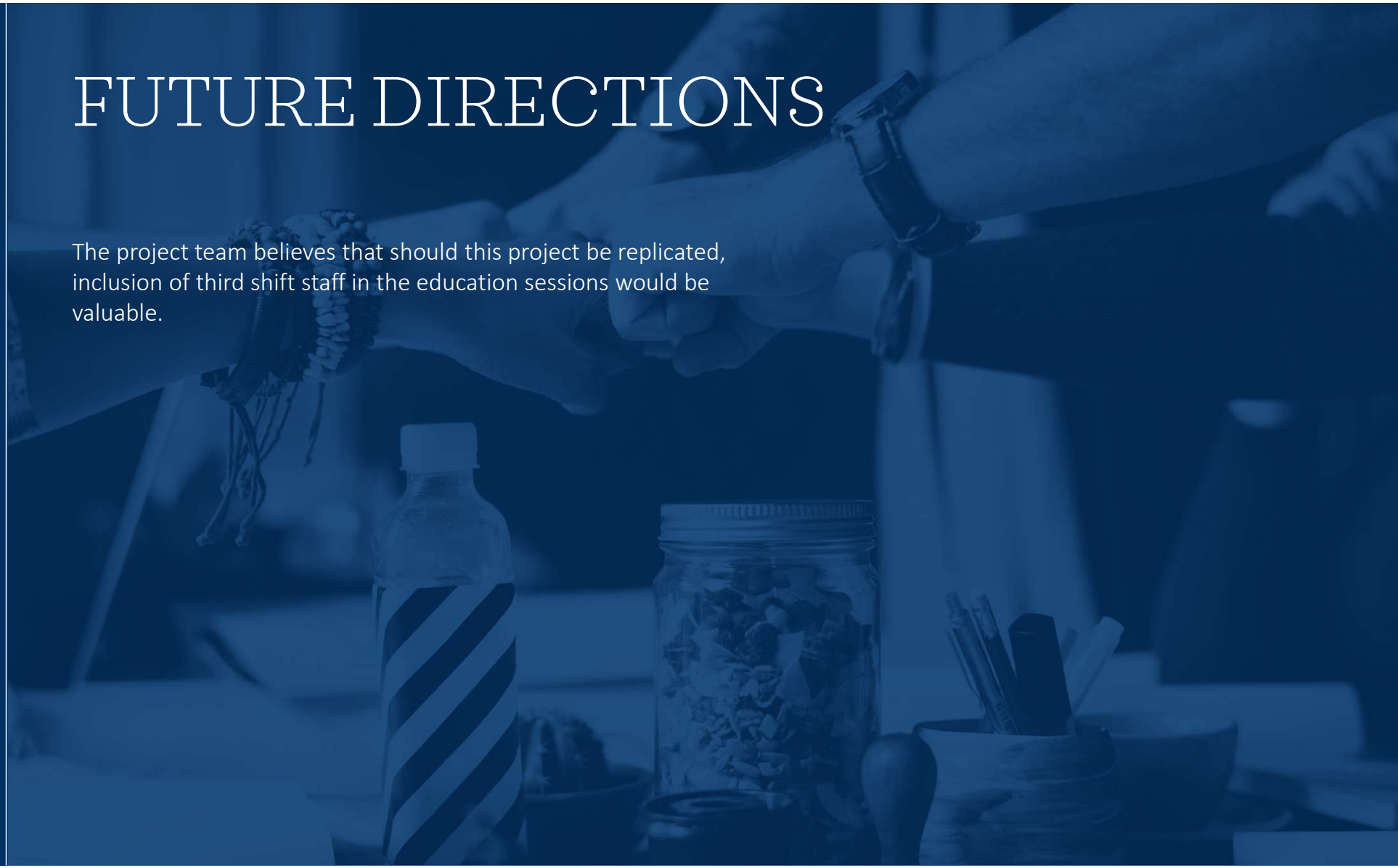
PROJECT LIMITATIONS:
LITERATURE REVIEW

The review of the literature was completed by a team member who was furloughed and eventually laid off. This review was not successfully transferred.

The project team believes that should this project be replicated, inclusion of third shift staff in the education sessions would be valuable.

FUTURE DIRECTIONS

The project team believes that should this project be replicated, inclusion of third shift staff in the education sessions would be valuable.



FINAL REFLECTIONS

Advanced Care Planning will have a role in the integrated system of care ALG Senior is building.

Though the COVID-19 pandemic resulted in many disruptions to the project, ACP is more salient now than ever before. With this in mind, it is the opinion of the project team that, in the long-term, the global pandemic may actually prompt an increased focus on ACP in LTC settings.

Through the GLPI course and project work the team was able to pilot ACP implementation in the communities where we successful met our goal of 30% increase in the number of ACPs. We were also able to identify how we may pivot the project to be more successful in a Company-wide launch, including:

- Embedding more community team members to champion change, drive adoption, and sustain momentum
- Building ACP into the admission and care planning process, with routine checks to drive accountability
- Solving for virtual and contactless education solutions in a COVID-19 world
- Contracting ACP expectations/"House Rules" with providers to ensure participation
- Evolving measures of success to focus on resident outcomes- e.g. avg. length of stay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