Advance Directives in the Nursing Home Setting: An Initiative to Increase Completion and Reduce Potentially Avoidable Hospitalizations

Colleen Galambos, Marilyn Rantz, Lori Popejoy, Bin Ge, and Greg Petroski

aHelen Bader School of Social Welfare, University of Wisconsin–Milwaukee, Milwaukee, Wisconsin, USA; bSinclair School of Nursing, University of Missouri, Columbia, USA; cSchool of Medicine, University of Missouri, Columbia, USA

ABSTRACT
Advance directive (AD) completion can improve transitions between hospitals and skilled nursing facilities (SNF’s). One Centers for Medicare and Medicaid Services (CMS) Innovations Demonstration Project, The Missouri Quality Initiative (MOQI), focused on improving AD documentation and use in sixteen SNF’s. The intervention included education, training, consultation and improvements to discussion process, policy development, increased AD enactment, and increased community education and awareness activities. An analysis was conducted of data collected from annual chart inventories occurring over four years. Using a logistic mixed model, results indicated statistical significance ($p < .001$) for increased AD documentation. Greatest gains occurred at project mid-point. The relationship between having an AD and occurrence of transfer to a hospital was tested on a sample of 1,563 residents with length of stays more than 30 days. Residents who did not have an AD were 29% more likely to be transferred. A logistic regression was conducted, and the results were statistically significant ($p < .02$).

KEYWORDS
Advance care planning; advance directives; end-of-life; nursing homes; rehospitalizations

Background Information
Medical care at the end of life (EoL) can be aggressive, intense, and conflict with patient preferences (Obermeyer et al., 2014). Despite the aggressive care, good outcomes are elusive. The United States spends between $114 and $136 billion annually on nursing home costs with higher expenditures in the last months of life (Ersek & Carpenter, 2013; Walsh et al., 2012). The tendency to provide intense care is present in nursing home settings,
regardless of resident preferences for EoL care (Giuffrida, 2015). This approach can impact the number and type of transitions at the EoL (Ersek & Carpenter, 2013). Medicare spends more than $14 billion annually on nursing home resident hospitalizations, many of which are preventable and unnecessary (USDHHS, OIG, 2013; Rantz, Birtley, et al., 2017). It is speculated that among people eligible for both Medicare and Medicaid, between $625 million and $1.9 billion in expenditures could be avoided annually through using different care approaches (Walsh et al., 2012).

There is growing evidence to suggest that the use of advance directives (AD) and engagement of residents and designated family/legal representatives in advance care planning (ACP) can improve the dying experience (Vasilevskis et al., 2017; Garrido et al., 2015). When honored appropriately, ADS support patient driven care and they are a tool for individual choice in EoL. Honoring ADS can decrease costs of care and protect self-determination at this stage in life through informed palliative care decision making and respecting health care preferences (Vasilevskis et al., 2017; Garrido et al., 2015).

The Missouri Quality Initiative Project

In 2012, as part of a Health and Human Services initiative through the Centers for Medicare and Medicaid Services (CMS), funding opportunities were developed for organizations to test evidence-based clinical interventions to improve health care in nursing homes with the goal of reducing potentially avoidable hospital admissions (CMS, 2015a). The Missouri Quality Initiative (MOQI) was one of seven projects selected under this initiative.

The MOQI partnered with 16 skilled nursing facilities in the Greater St. Louis area to develop and implement a clinical intervention model. Key components of the MOQI intervention included an advance practice registered nurse (APRN) placed at each facility who steered the intervention, provided advance practice care to eligible residents, and staff training to enhance the skills of facility workers. Additionally, an MOQI operations team assisted the APRN with navigating care transitions, medical care, health information technology, quality improvement processes, EoL decision making and care and use of Interventions to Reduce Acute Care Transfers (INTERACT II) tools (Rantz et al., 2014, 2015; Rantz, Popejoy et al., 2017). INTERACT is a quality improvement system aimed at improving identification, evaluation, and management of acute changes in the medical conditions of residents in nursing homes (Ouslander, Bonner, Herndon, & Shutes, 2014). INTERACT is associated with lowering hospitalizations of nursing home residents. The MOQI operations team consisted
of interdisciplinary geriatric care professionals including a project medical
director, a social work care transitions coach (CTC), a health information
technology coordinator, and a nurse INTERACT coach. A PhD prepared
social worker lead the care transitions component and the CTC was a
licensed MSW (Rantz et al., 2014, 2015).

The MOQI team worked collaboratively with nursing facility staff,
administration and residents/designated legal representative to improve
ey early recognition and management of medical conditions associated with
avoidable hospitalizations and implemented preventive services (Rantz
et al., 2014, 2015; Rantz, Popejoy, et al., 2017). EoL communication, goals
of care discussions, and AD decision making was a central component of
the MOQI model. Throughout the course of the project, data was collected
and analyzed to identify the impact this component of the model had on
facility practices and to determine the relationship between rehospitaliza-
tions and having an AD (Galambos, et al., 2016).

Within the first 3 years of the implementation of the MOQI
(2012–2015), the model significantly reduced all cause hospitalizations and
emergency room visits and significantly reduced avoidable hospitalizations
and emergency room visits (Research Triangle Institute International,
2017). Additionally, the MOQI was associated with a statistically significant
reduction in total Medicare expenditures (Research Triangle Institute

End of life, AD, palliative care component

The ACP goals for the MOQI project included (1) Development and imple-
mentation of AD educational programs, (2) Encourage the development of
AD policies and procedures for each facility, including record keeping prac-
tices, (3) Improve the discussion process about ADs with residents and
families, (4) Increase AD enactment for interested residents, (5) Foster a
coordinated approach to care through the use of education and awareness
activities to connect long term care facilities, the surrounding community
and stakeholders.

To achieve these goals, MOQI used an interdisciplinary approach in
sponsored education, training, and discussions about AD’s. The Care
Transitions Team (CTT) coordinated activities with the support of the
medical director, APRN’s, social workers, and facility staff to advance
these goals. The education and decision-making process were respectful of
the resident’s medical condition, clinical circumstances, and personal care
preferences (Rantz et al., 2014, 2015; Rantz et al., 2017; Galambos et al.,
2016). To increase stakeholder involvement, the Advance Care Planning
Stakeholder’s Committee (ACPSC) was developed and comprised of an
interdisciplinary group of key members of the MOQI project and community stakeholders. The ACPSC served as an advisory arm to the project and in this capacity recommended policy direction on EoL care, ACP, and developed community engagement events and educational programs for the MOQI. Activities that were developed and implemented in the project to support ACP goals will be described as they pertain to each of the aims.

**AD education and training programs**

During the initial start-up of the project, MOQI staff and facility staff were surveyed to gauge their knowledge about AD’s and EoL decision making. The information obtained indicated varying levels of knowledge and comfort level on the topic. The MOQI provided a series of education and training events on AD’s. Clinical staff were taught how to engage in AD discussions and prepare for reactions that the discussions might evoke. To practice learned skills, role play was used to help increase the comfort level and discussion ability of clinical staff.

After the initial training of MOQI leadership and clinical team, facility staff were trained on ADs in leadership meetings, clinical rounds, care planning meetings, special staff conferences, and organized continuing education events. One on one coaching also occurred. To obtain success in sustained knowledge, training events were continuous and provided through a variety of modalities including face to face trainings, the use of resource books located at each facility, educational webinars, discussions at organizational meetings, and hosting larger community events. Training occurred on various tools that could be used for ACP including INTERACT materials, the State AD form, and the Missouri Bar Association approved AD form.

The next focus was on increasing knowledge about AD’s and ACP within the resident and family/legally appointed representative population group. Training approaches were customized for each of the 16 facilities. Facility staff worked in tandem with the MOQI team to develop training approaches that worked best for their facility. Some of the more popular approaches included training in family council meetings, introducing the topic of ACP in care conferences, and one on one counseling with the residents and/or legally designated representatives. Also, there were opportunities for residents and family members to attend community events on the topic.

**Develop AD policies and procedures**

To encourage the development of consistent practices related to AD’s and ACP, quarterly leadership meetings were held with facility leadership
(Administrators, Directors of Nursing, Social Service Directors, Education and Training Coordinators, etc.), and led by the MOQI leadership and APRN’s. At these meetings, the CTT regularly presented information on AD’s, provided suggestions for new approaches, and supported facility efforts to increase knowledge and activities supporting ACP, and the development of policies and record keeping on AD’s.

To increase policy development, the Advance Care Planning Stakeholder’s Committee (ACPSC) provided guidance, direction, and developed resources that were shared with facilities. An initial inventory of facility policies on AD’s uncovered that facility policies were varied and ranged from some facilities having complete and specific policies to facilities with no policies. Policies that were exemplar were shared with the other MOQI facilities to use as models. One APRN who served on the ACPSC, under the supervision of the Clinical Practice Lead, developed a comprehensive policy model for facilities to adopt and use. This model was distributed to each facility. Additionally, the CTT developed a resource manual that included training materials and examples of best practice models. Both resources were distributed to facilities.

Another policy and practice change initiative focused on improving communications in the care transition process to ensure that AD’s, treatment preferences, and EoL care are known to sending and receiving facilities. The CTT, The Health Information Technology (HIT) Team, and the APRN worked with facilities and developed policies and workable solutions to improve the flow of information between facilities and hospitals. Safe table discussions were employed to resolve emerged communication issues. HIT solutions were employed in some instances to resolve communication issues such as the transferring of critical clinical information through electronic means, or using AD banners within the electronic clinical record to indicate preference alerts (Alexander et al., 2015).

The daily presence of the APRN in each facility was key to the development and revision of AD policy and practices since the APRN modeled and reinforced best practices. In particular, the APRN was instrumental in helping facilities organize resident records so that there was a designated area in the record for AD’s and code status.

**Improve AD discussion process**

Once participating facilities knowledge about AD’s increased, and as facilities’ policies and practices developed, activities progressed to the improvement of clinical processes that provided the optimum opportunity for residents and legally designated representatives to engage in ACP. With guidance from the APRN and CTC, facilities tested new processes for
having regular AD discussions with residents and families/legal representatives. The MOQI reinforced the practice of discussing care preferences and AD’s at three points in time—change of condition, anytime a resident and family member requested a discussion, or at least annually. Some facilities incorporated discussions at care plan meetings, an ideal time to normalize such conversations as part of a regular routine discussion and plan for care. Other facilities used National Health Care Decisions Day as a time to review with residents their preferences (National Health Care Decisions Day, 2020).

The CTT assisted with discussions and problem solved more effective ways to increase ACP conversations. The CTC was able to visit facilities and contributed to family conversations. A coaching model was developed to improve conversations in facilities. In some situations, the use of a social worker external to the NF created an impartial, non-biased counseling environment and encouraged stronger family engagement. In complicated situations involving multiple problems, an APRN/Social Worker dyad approach was used to address both the behavioral health and medical issues.

**Increase enactment of AD’s**

The MOQI regarded the documentation of resident care choices through AD’s as a first sign in honoring preferences. AD’s are recognized by all stakeholder groups including nursing home facilities, hospitals, and other health care providers. This recognition helps all parties involved identify resident wishes for their care and treatment.

It is important to work toward facility culture change in which opportunities to enact AD’s are presented earlier and often and AC discussions are normalized. All of the activities described in the previous sections were aimed at increasing awareness and changing processes to promote a culture of acceptance and opportunity to enact AD’s. Through these initiatives, we were able to achieve this goal, further explained in the analysis section.

**Community education and awareness campaigns**

The MOQI recognized that an ideal practice is the completion of AD’s before admission to a skilled nursing facility and before a medical crisis occurs. It is important for all personnel working in the social services and medical fields to understand what an AD is, to ask individuals if they have an AD, and to honor enacted AD’s.

Awareness campaigns help to educate the community about AD’s and the importance of them. In addition to the ACPSC, a group of stakeholders met regularly with the CTT to plan community educational initiatives. One
event that was implemented by the MOQI CTT and 7 other community partners, brought representatives from The Conversation Project to conduct an all-day training to over 120 different agencies and their representatives on The Starter Kit, an ACP tool (The Conversation Project, 2020). The Conversation Project also conducted an educational event for the community. This same group of stakeholders organized a lunch and learn webinar series on a variety of topic related to AD’s and ACP featuring experts from various disciples.

The CTT organized an annual community-wide National Health Care Decisions Day awareness campaign (National Health Care Decisions Day, 2020). Participating facilities hosted various events including AD enactment clinics, educational events, and celebrations. These events were open to the public, to staff, and to residents and their families, and were successful throughout the course of the project. Media coverage occurred on all events through news articles and radio spots.

Every one of these events helped to build community support, partnerships and awareness about the importance of ACP and AD’s. It helped to solidify our stakeholder base and improved facility/community relations.

The activities and goals discussed increased awareness and the presence of advance directives within the 16 facilities in the MOQI project. The presence of advance directives in the facilities was tested using an annual chart inventory method. A second method examined whether advance directives had an impact on hospitalizations. The Methods section will explain the process, analysis and results.

**Methods**

**Sample and intervention time-line**

The time-period of this study implementation was September 2012 through September 2016. The MOQI intervention was multifaceted, requiring APRN hiring, data base construction for data collection, setting up technology to be used for the transfer of health information, and baseline

<table>
<thead>
<tr>
<th>Resident demographic</th>
<th>% Study facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>66</td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
</tr>
<tr>
<td>Married</td>
<td>31</td>
</tr>
<tr>
<td>Widowed</td>
<td>45</td>
</tr>
<tr>
<td>Never married</td>
<td>11</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>13</td>
</tr>
<tr>
<td>White</td>
<td>88</td>
</tr>
<tr>
<td>Black</td>
<td>11</td>
</tr>
<tr>
<td>Other race/Ethnicity</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Age (population mean)</td>
<td>79</td>
</tr>
</tbody>
</table>

Table 1. Resident Demographics within the Sixteen MOQI Study Facilities.
The education of participating facilities (16). The initial hiring and project start up occurred within the first 9 months of the project from September 2012–June 2013. Table 1 provides demographic data on the residents participating in the project. The sample includes a higher proportion of white widowed women with a mean age of 79. The demographics for residents in participating facilities are similar to the general nursing home population in the state and nation (Centers for Medicare & Medicaid Services, 2015b).

The intervention component of EoL care was not fully implemented until early 2014. In order to measure the impact of the intervention on AD completion and hospitalizations the methodology and results of two analyses will be presented: (1) Annual AD record/chart inventory, and (2) Analysis of the relationship between hospitalizations and AD’s.

**Annual record/chart inventory**

**Methods and data collection**

A secondary data analysis was employed to answer the first research question: Did the MOQI increase AD documentation in facilities? The analysis was specific to AD documentation found in the medical records of MOQI enrollees. As a first step in using advance directives to inform hospitalizations, the MOQI focused on advance directive documentation and the designation of a section on advance directives in the chart in the initial start-up phase. To serve as a baseline, an inventory of AD documentation within the resident records was completed before the MOQI project was fully implemented, from June to December of 2013.

Baseline data were collected by an APRN researcher under the guidance of a senior faculty member. For the baseline data, the APRN visited each of the facilities enrolled in the MOQI study, examined all resident charts, and entered the data into an excel spreadsheet developed by content experts; data were uploaded into SAS and analyzed (Galambos et al., 2016).

A baseline content analysis was conducted of 1,877 medical records of all enrolled residents in each of the 16 facilities within 6 months of facility project start up with the intervention (Galambos et al., 2016).

Subsequently, this same process was repeated in 2014, 2015, and 2016 to determine if the number of enacted AD’s changed during the MOQI intervention, however, during these years, the CTC collected the data under the

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of records reviewed</th>
<th>Percent with AD’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1,876</td>
<td>49</td>
</tr>
<tr>
<td>2014</td>
<td>1,711</td>
<td>65</td>
</tr>
<tr>
<td>2015</td>
<td>1,730</td>
<td>96</td>
</tr>
<tr>
<td>2016</td>
<td>1,544</td>
<td>90</td>
</tr>
</tbody>
</table>

**Table 2. Advance Directives in Medical Record of MOQI Participants: Numbers Over Time.**
supervision of a senior faculty member. The CTC visited each facility and examined the charts of all resident enrollees. The excel spreadsheet developed for the baseline data collection process was also used in 2014, 2015, and 2016. Using the spreadsheet, a biostatistician converted the data from the spreadsheet into SAS to allow for the quantitative analysis.

**Data analysis and results**

Table 2 provides a descriptive picture of AD documentation over the 4-year period. While the number of charts reviewed declined over the years due to project attrition, the percent of medical records with an AD steadily increased through 2015 and reduced slightly in 2016. During the project, the percent of residents with AD’s increased from 49.5% in 2013 to 65% in 2014 to 96.6% in 2015 to 90% in 2016.

<table>
<thead>
<tr>
<th>Year v 2013</th>
<th>Odds ratio</th>
<th>95% Confidence limits</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2.13</td>
<td>1.85–2.45</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>2015</td>
<td>38.90</td>
<td>29.45–51.40</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>2016</td>
<td>11.56</td>
<td>9.50–14.07</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

Table 3 displays the AD documentation changes over time. A logistic mixed model was employed with the facility treated as the random effect and an R-side variance to account for residual correlation due serial measurements from the same facilities. The independent variable was year with 2013 as the reference year. The overall test was statistically significant (\(p < .001\)) and each successive year was compared with 2013. The odds of a resident having an AD in their chart increased from 2013 to 2014 (OR = 2.13, 95% CI, \(p < .0001\)), and from 2014 to 2015 (OR = 38.90, 95% CI, \(p < .0001\)), and held steady from 2015 to 2016 (OR = 11.56, 95% CI, \(p < .0001\)). Interpreting the descriptive statistics and the logistic mixed model, it can be determined that over the course of the MOQI project (2013–2016), AD enactment and documentation increased from baseline, and the gains continued to remain significant during the four years of the project.

**Hospital transfers and advance directives**

**Methods and data collection**

As stated previously, honoring resident AD choices in the care they receive was an important component of the MOQI. These choices may include exercising all care options or selecting a non-aggressive approach, all which can be documented using the AD. Since the purpose of the MOQI was to reduce potentially avoidable hospitalizations, our focus was on whether
documented AD choices for non-aggressive care were honored to reduce unwanted hospitalizations as indicated on AD documents; this also supports self-determination of the resident. Additionally, the state in which MOQI was conducted is a “right to life” state, so if a resident did not have an AD, then the subsequent approach is aggressive care. Reducing unwanted hospitalizations as indicated on AD documents supports self-determination of the resident. Therefore, the research question driving this second analysis was: What is the relationship between having an AD and the occurrence of transfer?

A relational, web-based, secure database was a key data collection strategy employed in the study. The APRNs working in each nursing home accessed the database and updated data elements as a part of their clinical workflow. Over 200 data elements were collected to monitor the implementation of the intervention and measure outcomes throughout the study. Items included details of all transfers to hospital, AD documentation and review during transfer, and items for all other components of the MOQI intervention (Rantz, Popejoy, et al., 2017). This database was used for the reported analysis of hospital transfers and ADs.

### Data analysis and results

To measure potential effects of the intervention emphasis on EoL care, the first date range of July 1, 2014 was selected for analysis when this part of the intervention was fully implemented in facilities; the final date was the study end of September 30, 2016. This provided 27 months of data for analysis and three potential time periods for a longitudinal analysis of the changes that occurred regarding decisions for hospital transfer. The 9-month time frames were judged by clinicians as being likely to detect changes in the clinical decision-making about enacting changes in ADs as health conditions changed, honoring those directives, and seeking treatment within the nursing home, key emphases of the intervention. Clinician researchers wanted to see if the data reflected progressively more advanced directives enacted by residents and decisions to treat within the facility; the 9-month time frames enable an analytic approach to measure this. The time intervals of nine months each included the following time frames: July 1, 2014–March 31, 15; April 1, 2015–December 31, 2015; January 1, 16–September 30, 16.

<table>
<thead>
<tr>
<th>% Transfer with AD</th>
<th>% Transfer without AD</th>
<th>Odds ratio</th>
<th>95% Confidence limits</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.26</td>
<td>36.33</td>
<td>1.29</td>
<td>1.030–1.615</td>
<td>&lt;.02</td>
</tr>
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N=1,563; 65% of the sample had an AD and 35% of the sample did not.
Next, for each 9-month period, we applied the following inclusion criteria: (1) Residents who had transfers, (2) Residents whose AD status remained unchanged during the 9-month time period; and (3) Residents who remained in nursing facility for more than 30 days. The final data set used for the analysis yielded an N of 1,563 unique residents.

A logistic regression with random intercepts analysis was conducted to compare the occurrence of transfers for residents who had and did not have an AD with the nursing facility used as random effect and number of days for residents stayed in nursing facility a co-variate.

Table 4 addresses the frequency of occurrences of transfer by AD status for MOQ residents (n=1563); 65% of the sample had an AD and 35% did not. The percent of those with an AD who were transferred is at 30.26% and without an AD who were transferred at 36.33%. A logistic regression with random intercepts analysis was employed to compare the occurrence of transfers for residents who had and did not have AD’s. The nursing facility as random effect and the number of days that resident stayed in NF as co-variate. The results indicate that there are 29% higher odds of transfer for those without an AD relative to those with an AD. In other words, the results indicate the odds of occurrence of transfer for residents who did not have an AD increased 29% compared to the odds of transfer for residents who had an AD (OR = 1.29, 95% CI:1.030–1.615, p < .0267). Within our sample, those residents without an AD were more likely to be transferred than residents who had an AD.

Discussion

As part of the MOQI goals to reduce potentially avoidable hospitalizations, the MOQI recognized the importance of ADs and ACP in achieving this goal. To that end, ACP and end-of-life decision making became a central focus of the initiative. Clear and consistent education and training were a major means to achieve our end results to create a culture within each facility so that regular opportunities for ACP discussions occurred with appropriate residents (those residents who did not have cognitive impairment) family members/designated legal representative. The literature supports the role that health care professionals can have in facilitating needed and appropriate discussions (Blacker, Head, Jones, Remke, & Supiano, 2016; Giuffrida, 2015). In fact, nurses and social workers often educate older adults on the complexities of AD’s (Bern-Klug & Kramer, 2013; Gazarian et al., 2019; Stein et al., 2017), which assist in normalizing these types of conversations which then can lead to AD enactment. Our project found the use of nurse/social work clinical teams to plan, lead and conduct
these discussions was a successful approach to AD enactment and in helping to facilitate regular communication about these matters.

Before MOQI involvement within the 16 facilities, ADs and ACP discussions were not observed as a priority. Through regular and consistent training of facility staff, and ongoing coaching from the APRN and CTC, these types of discussions became a priority as did creating opportunities for residents to enact ADs.

The results of the annual AD inventory attests to the success of this component of the project. The MOQI increased AD documentation after year one of the project. The most gains were made at midpoint of the project; gains were sustained throughout the course of phase one, supporting the impact of the project on these activities.

Our results are also supported by Houben et al.’s (2014) finding that increased communication on ACP can lead to an increase in AD completion. Health care professionals are in a strong position to help facilitate such discussions. Pollack, Morhaim, and Williams (2010) notes that older adults prefer to receive AD information from health care providers. Developing a culture of acceptance for these conversations supports resident preferences while increasing opportunities.

As the MOQI project progressed, it was apparent that in order for the impact of advance planning discussions to be more impactful, family/legally designated representatives needed to be connected to the process earlier and regularly (with permission from the resident). They are a strong part of the culture of acceptance process, as Bern-Klug (2014) asserts in the Goals of Care as Guiding Stars model. As family involvement in ACP conversations occurred, decisions about care transitions became smoother. Our experience is supported by Song et al.’s (2015) finding that surrogate decision makers experience less anxiety and depression when EoL wishes are discussed in a structured setting.

Finally, building a stakeholder and community base that values and supports EoL decision making and ACP is critical to strengthening the acceptance of ADs as an important tool to honor older adult’s health care wishes. Early completion of AD’s will help ensure that preferences are communicated to health care providers and significant others. Creating a community of acceptance in which there are multiple venues to receive education about ADs and increasing opportunities for people to complete an AD will help support earlier enactments. The least ideal time to have AD conversations is during a medical crisis. Building community-based support is particularly important in states that favor right to life laws over the right to choose EoL care. The MOQI found the development of such a community contributed to project success and sustainability. Isaacson (2017) offers creative ideas for how such community educational programs could evolve into peer led activities and a method that supports cultural sensitivity.
The main goal of the MOQI was to reduce potentially avoidable hospitalizations and one method to achieve this goal is earlier ACP. The MOQI set out to explore the relationship between having an AD and hospital transfers. We viewed the result of ACP as AD completion. Our findings indicated a significant relationship between having an AD and fewer hospital transfers. This finding is supported by Vasilevskis et al. (2017) recommendation that early ACP reduces potentially avoidable readmissions from skilled nursing facilities and Miller et al.’s (2016) findings that residents with palliative care consultations had lower rates of hospitalizations with rates lowest when consultations were furthest from death.

The findings have several implications for social workers. First this project demonstrates the important role that social workers have in protecting the self determination of nursing home residents through encouraging AD enactment and respecting the care choices conveyed in these documents. Furthermore, social workers were instrumental in insuring that the AD documents were updated and truly reflected the wishes of the residents. These implications point to the importance of education and training on advance directives, and EoL care in social work courses, curriculum, and continuing education events so that social workers are prepared to undertake these tasks. Additionally, in this project, social workers were encouraged to work as members of an interdisciplinary team to support advance care planning in participating nursing home facilities. As part of the formal education process of social workers, skill development on working in interdisciplinary teams should be an integral part of social work curriculum. An important part of the MOQI project was the planning and sponsoring of community education and awareness events. Social workers led these initiatives which speaks to the importance of social work skills and training in macro interventions and to the capacity of social workers to be leaders in EoL care. Finally, this project demonstrates the critical contributions social workers make to the development of a nursing home culture that respects ADS and respecting choice in EoL care.

Limitations include the sample of participating facilities is small from one geographic region of the country. Because the MOQI Initiative is a part of a larger CMS demonstration project, there were limitations imposed by conforming the design of the intervention within original guidelines so that all participating national sites could be analyzed as a group as well as individually. Some data collection elements were prescribed for group comparisons. Every effort for consistency in the implementation of the intervention across the 16 facilities was made by the research team. A consistent approach was reinforced through consultation and coaching by the CTT, quarterly leadership meetings conducted by the MOQI leadership and attended by the clinical leadership teams of all 16 facilities, and on-going education and training for reinforcement of key processes.
Conclusions

The MOQI project attempted to create a culture change within 16 SNF in terms of institutional practices on providing opportunities for AD enactment, ACP, and education and training in these areas. Education and coaching activities provided by the MOQI in 16 SNF’s served to increase AD completion and AD documentation over three years, and this change was sustained.

Additionally, ADs were associated with fewer hospitalizations. This study demonstrates the potential benefit of ACP and completing AD’s as one means to reduce potentially avoidable hospitalizations and it supports the need for continued education in this matter. ACP discussions should occur early, prior to a medical crisis. The use of nurse/social work teams to facilitate educational opportunities and provide counseling and the use of a facility APRN for ongoing coaching proved to be a successful approach to facilitate earlier discussions about EoL preferences.

Acknowledgments

We want to acknowledge the participation of 16 NHs in the St. Louis area, particularly members of the Advance Care Planning Stakeholder’s Committee, the Stakeholder’s Education Planning Committee, Social Service Directors and their staff, facility administrators, the APRNs, and other staff of the MOQI Initiative. Without everyone’s support and hard work, the advances of the initiative would not have been possible. Financial Disclosure: This project was supported by grant numbers 1E1CMS331080 and 1E1CMS331489 from the Centers for Medicare & Medicaid (CMS) Innovations Center and Medicare-Medicaid Coordination Office (http://innovation.cms.gov/initiatives/rahnfr/) that focuses on improving care and outcomes for Medicare-Medicaid enrollees residing in nursing facilities.

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