Structured advanced care planning facilitated by care managers

Background
The Agency for Healthcare Research and Quality (AHRQ) research indicates that most severely or terminally ill people have not participated in advance care planning. Less than half of people have completed an advanced care plan, and more than one out of four older Americans face questions about medical treatment near the end of life but are not capable of making the decisions.1,2 However, care managers of patients with an advance directive who have discussed its content with the patient reported greater understanding, better confidence in their ability to predict the patient’s preferences, and a stronger belief in the importance of having an Advance Directive. The AHRQ continues to fund research to improve the quality of care at the end of life.3

Advanced Care Pilot Overview
A large, national health insurer launched a pilot of care manager facilitated structured advanced care planning discussions. People being served as part of the educational pilot program represent some of the most complex and chronically ill people insured by this plan. As part of the pilot, care managers were trained to conduct guided conversations pertaining to advance care planning. Care managers assessed the participant readiness in having these conversations and used appropriate questions to better educate participants to make informed decisions as to end of life options.

• The goal of the Advanced Care Pilot was to increase advanced directives completion, assist patients and caregivers in recognizing when hospice is appropriate, and evaluate and address concerns regarding treatment, caregiver cues, symptoms, and other quality of life issues.

Objective
To evaluate the Advanced Care Pilot program by reviewing process metrics in order to determine whether this pilot would be suitable to a larger population.

Methods
• Design: Program evaluation
• Population: The pilot included two participant groups. All participants were required to be cognitively capable, defined as alert and oriented.
  1. High severity patients who had been receiving long term in home care management for ≥30 days in the East Central Region (OH, TN, KY, WV, VA) and had a high lifetime challenge.
  2. Functionally-challenged patients who had been receiving telephonic care management for ≥30 days in the same region, excluding TN, and had a moderate morbidity burden.
• Timeframe: 6 months (June – November 2013)
• Program Process:
  1. Twenty care managers (CM) participated in 2-person and 9 virtual team coaching training sessions on the structured discussion approach.
  2. Care managers were selected based on skill level, dedication, comfort, confidence, and current performance and their direct supervisor’s support.
• The structured discussions assessed participant readiness in having these conversations, values and goals, decision makers, treatment preferences and decisions, and development and communication of the plan.
• Reporting and evaluation:
  - This program evaluation reported the following process metrics, as documented by the care managers during the Advanced Care Planning Pilot.
  - Number of participants
  - Timeframe
  - Population
  - Achieve Care Manager Questions
  - Assess Participant Readiness & Understanding
  - What is your understanding of your condition? What changes do you expect? What are your fears or concerns with respect to medical treatments? Can you tell me about these conversations and what kind of decisions do you think they are asked to make? What do you think the benefits are of having a living will and a durable power of attorney?
  - Explore Values & Goals
  - What are your fears or concerns with respect to your illness progressing? What are your fears or concerns with respect to medical treatments or life-sustaining treatments? Can we discuss these things again after you have had some time to think about it?

Results

Figure 1. Number of participants

Figure 2. Number of process metrics achieved (N=275)

Figure 3. Process metrics achieved by participant type (%)

Figure 4. Average time for structured discussions

Conclusions
In this Advanced Care Planning Pilot, advanced directives were updated or completed and hospice services were reviewed for several participants.
1. A higher percentage of the high severity group who received in home care management had structured discussions, completed or updated advanced directives, and reviewed hospice services compared to functionally-challenged patients receiving telephonic care management.

Implications
This pilot was determined not to be scalable to a broader population, and alternative approaches for advanced care planning currently being evaluated.

Recommendations from this pilot include:
1. Baseline advanced care planning for all care managers across the range of experience
2. Observation of successful care managers to identify consistent elements of these interactions to replicate
3. Further explore family readiness and barriers to determine if there is need for targeted resources for families and caregivers

Limitations
This program evaluation reported trend, not individual metrics on participant type.

• This report does not include:
  - The influence patients and caregivers think more about it?
  - The impact of shared decision-making and the capacity of care providers to deliver appropriate end of life care.

References

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