Case Study: Implementing PROVEN

Pragmatic Trial of Video Education in Nursing Homes

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NIH Collaboratory *Rethinking Clinical Trials®*

Health Care Systems Research Collaboratory

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PROVEN: Objective

- To conduct a pragmatic cluster RCT of an advance care planning video intervention in nursing home patients with advanced comorbid conditions in 2 nursing home healthcare systems

- To test the impact of video-assisted advance care planning on seriously ill residents' transfer to hospital (inpatient, emergency department, or observational stays)

Background: Nursing homes

- Nursing homes are complex healthcare systems
  - 15,000+ nursing homes with ~1.5 million beds
  - 3+ million patients admitted annually
  - Less than 1 million long stay residents
  - Increasingly a site of death
- Patients are medically complex with advanced comorbid illness
- Like hospitals, nursing homes charged with guiding patient decision making by default

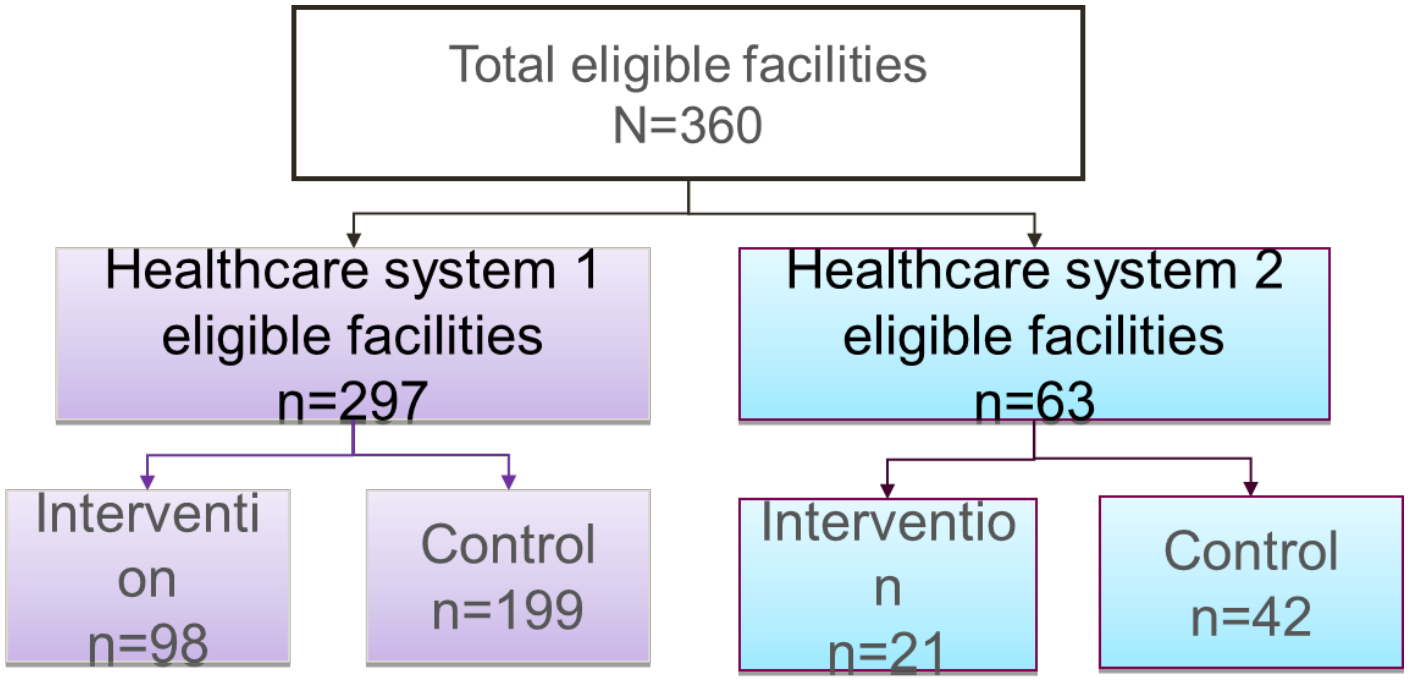
Background: ACP

- Advance care planning
  - Process of communication
  - Align care with preferences
  - Leads to advance directives (e.g., DNR, DNH)

- Better advance care planning associated with improved outcomes

- Advance care planning suboptimal in nursing homes
  - Not standardized
  - Low advance directive completion rates
  - Not reimbursed
  - Regional and racial/ethnic disparities

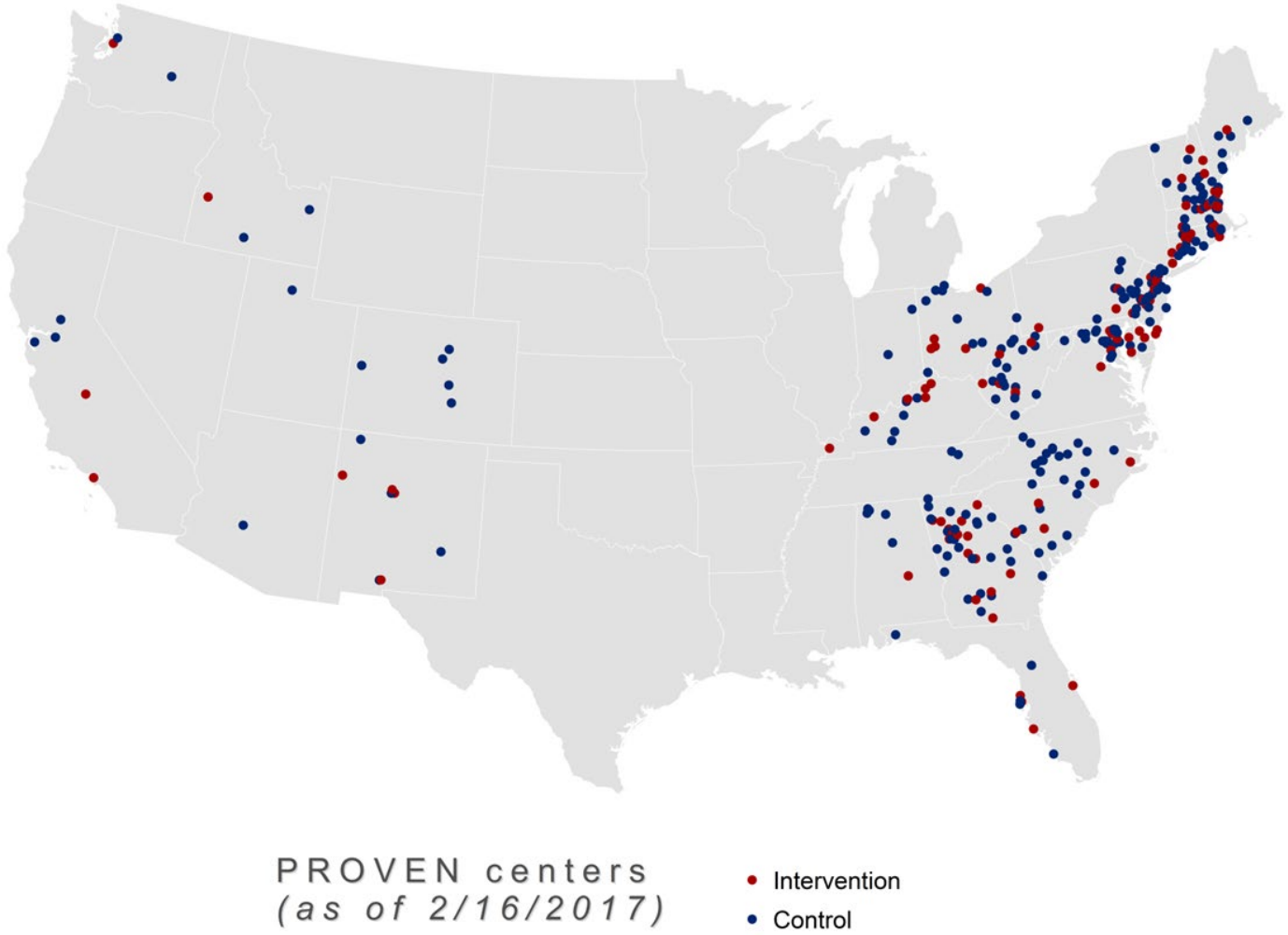
Facilities


Total eligible facilities
N=360
Healthcare system 1
eligible facilities
n=297
Healthcare system 2
eligible facilities
n=63
Interventi
on
n=98
Control
n=199
Interventio
n
n=21
Control
n=42

PROVEN: Primary Outcome

- No. hospital transfers/1000 person-days alive among long-stay (> 100 days) Medicare beneficiaries ≥ 65 with advanced dementia, CHF or COPD
- Medicare Claims
- Transfers = admissions, observation stays, emergency room visits
- Up to 12-month follow-up
- Censored on Switch to MA: last date of FFS Medicare coverage

Distribution of PROVEN nursing homes



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PROVEN: Intervention

- 24-month accrual; 12-month follow-up
- Suite of 5 advance care planning videos
  - Goals of Care, Advanced Dementia, Hospitalization, Hospice, ACP for Healthy Patients
- Offered facility-wide
  - All new admits, at care-planning meetings for long-stay, readmission
- Flexible (who, how, which video)
- Tablet devices, internet via URL and password
- Training: corporate level, webinars, toolkit

Why should nursing home systems want to participate in PROVEN?

- Medicare rehospitalization penalty prompted hospitals to build networks of low rehospitalization providers
- ACOs trying to control post-acute spending
- CMS implementing a re-hospitalization penalty to apply to SNFs in 2018
- Leadership views goal to reduce transfers that are inconsistent with patient preferences

Longer Term Rationale

- One NH company was developing an ACO;
  - Financially and clinically accountable for long stay patients
- Another NH company was developing an Institutional Special Needs Plan (HMO)
  - Financially and clinically accountable for long stay patients
- ACP Implementation viewed as a challenge for both

Challenges during implementation

- Changes at healthcare system partners
  - Changes in corporate office
  - Changes in participating facilities
- Changes in health care policy environment
- Changes in regulatory environment

Healthcare system partners

- CHALLENGE #1: turnover in key partner staff
  - Both of our healthcare system partners experienced turnover (twice) in the system implementation liaison role.

- SOLUTIONS:
  - Kept engaged with senior leadership in our healthcare system partners.
  - Provided one-on-one trainings and orientations with newly-hired implementation liaisons.
  - Began including implementation liaisons on our monthly steering committee calls.

Healthcare system partners

- CHALLENGE #2: turnover in ACP Champion staff
  - More than half of nursing home had at least 1 Champion turnover.

	# of NHs	% of NHs
No turnover in ACPCs	55	46.22%
1 ACPC loss	39	32.77%
2 ACPC losses	22	18.49%
3 ACPC losses	2	1.68%
5 ACPC losses	1	0.84%
Total intervention NHs	**119**	

Data as of 2/15/2017

Health Care System Partners

- Changes in Health Care Policy Environment
  - New Option to pay MDs/NPs for ACP conversation
  - Declining Length of Stay with Medicare Advantage growth
  - Planning for new SNF payment system
- More intensive Quality Inspection Schedule

Healthcare system partners

- CHALLENGE #3: divestitures
  - At one partner, a total of 12 nursing homes were divested after they were randomized to the study sample.*
  - These divestitures occurred after the ACP Video Program had launched.

Lessons & implications for ACP

- Videos selected because standardized and ready for broad implementation
- Unanticipated complications in the “mechanics” of introducing videos into daily operations—seemed so simple!
- Just showing video doesn’t mean going to next step of advance directives
- Lots of anecdotal stories of families’ resistance to discuss advance directives
- Since MDs & NPs can now bill for advance care planning, perhaps that is best strategy
- But still a challenge even if MDs & NPs can be reimbursed

Lessons and implications for PCTs

- Integrating interventions into health care systems means changing standard operating procedures
- Implies a mandate from management, not a research project
- Continuum of intervention complexity; easy to substitute one thing for another, hard to change clinical guidelines and practices
- Even corporate buy-in may not be enough; essential to have fully engaged local and regional managers