NIA IMPACT COLLABORATORY
TRANSFORMING DEMENTIA CARE

Study Snapshot

Effect of a COVID-Specific Advance Care Planning Intervention on Documentation of Advance Directives and Goals of Care

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"The pandemic is highlighting some of the challenges to documenting and honoring care preferences for assisted living community residents with ADRD."

RATIONALE: Assisted living communities (ALCs) serve over 800,000 vulnerable older adults at high risk of developing complications and dying from COVID-19. Documenting care preferences in the form of an advance directive or medical order reduces receipt of unwanted care during and after the pandemic.

OBJECTIVE: The primary objective of this embedded, pragmatic, cluster-randomized trial (ePCT) is to test the effects of a COVID-specific, advance care planning (ACP) intervention on documentation of care preferences in a target cohort of assisted living community (ALC) residents with Alzheimer's disease and related dementias (ADRD) from 150 ALCs in 3 states.

SETTING: 150 assisted living communities (ALCs) in Minnesota, Wisconsin, and Florida.

POPULATION: People living with ADRD and their family members.

DESIGN: ALCs will be randomly assigned to one of three groups: 1) Usual care; 2) ACP informational website and video sent electronically to family members; or 3) ACP informational website and video sent electronically to family members plus a follow-up ACP discussion with a Bluestone clinician.

OUTCOMES: The primary clinical outcome will be new documentation of a preference for comfort-focused care in the EHR over four months; secondary clinical outcomes will be new documentation DNR or DNI orders in the EHR over four months and the proportion of enrolled residents with any hospitalizations over four months. Implementation outcomes include counts of physician calls with family members and counts of website and video views.

IMPACT: Little is known about the ACP process for ALC residents with ADRD during COVID-19, and the barriers to honoring care preferences in this setting. This ePCT leverages the EHR of a large ALC physician group to identify eligible residents and family members, deliver the intervention, and assess resident outcomes.