Integrating Palliative Care & Geriatrics into Primary Care within an ACO

Care New England

integra Community Care Network

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The Care New England Health System has spent the last few years on a journey to grow systems of care that focus on population health and better coordination of care and improved quality of care. Early in the journey, palliative care and geriatrics were identified as specialties to target for growth and integration. As part of the building of an accountable care organization (ACO), geriatrics and palliative care began efforts to outreach to the community to expand services outside the hospital walls. Community efforts included reaching out to the various affiliated primary care practices to recruit patients for a home based, nurse practitioner driven chronic care management program and to support primary care doctors in the care of complex, frail and often high utilizing older adults. We began to bring our teams (a geriatrician, a palliative care physician and a geriatric and palliative care trained nurse practitioner) to the primary care offices to reach out to the system's primary care doctors to identify high need patients for referral to palliative care or the ACO's home based team.

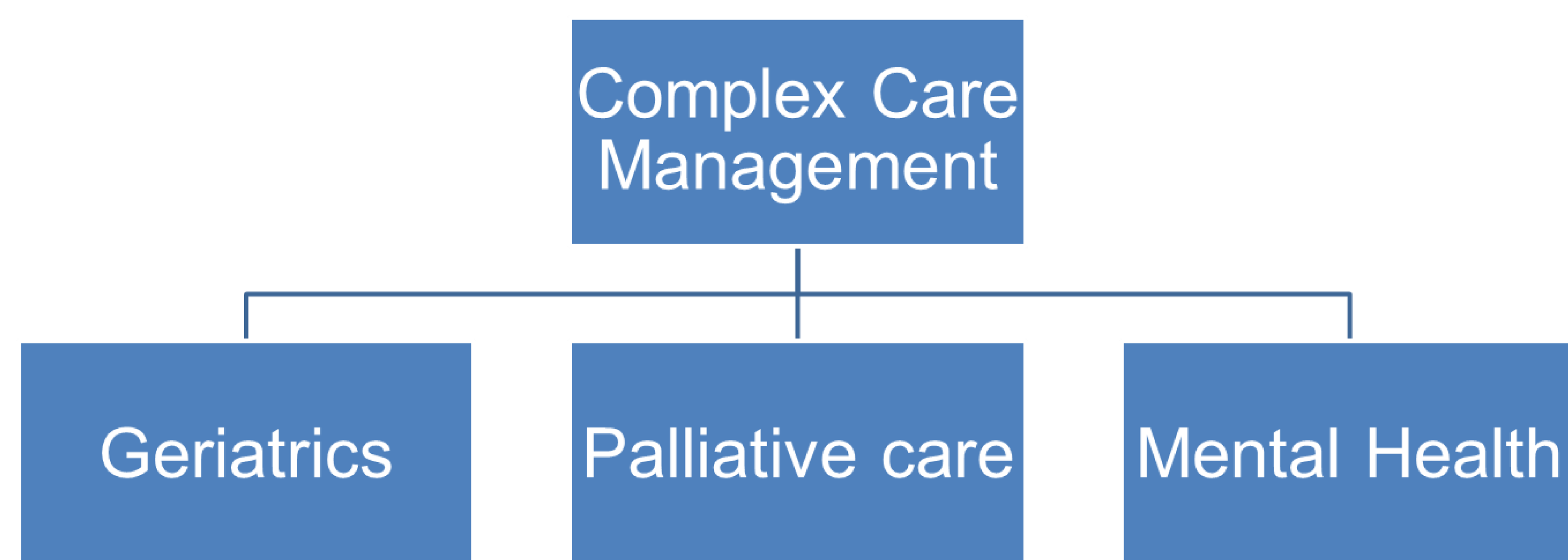
Plan:
In our previous PDSA with Dr. F, we identified that physicians need individualized support for managing patients with Advanced illness. We have put together an offering of tips, tools and techniques based on best practices. We are hoping that this will be useful to physicians during a 6 month training period.

Do:
We met with Dr. R, Dr. F and Dr. VP. They addressed several problems in dealing with older adults with advanced illness: logistics of referral to outpatient PC vs ACO CCM, who is appropriate for referral to Hospice/PC (clinical characteristics of the patients), how to document AD within EPIC, where is the best place to look to see if a conversation has occurred, Medical management of dementia, managing sleep in the elderly. Most importantly to the team: staff training on having EOL/AD conversations with patients

Study:
Physicians are engaged, proactive and really want team based education to utilize all staff to the highest level possible.
Teams want practical information and education.

Act:
We offered 6 meetings once a month to address these issues to the practice team.
Offer pre-survey before the first meeting.
Geriatrics didactics (sleep, dementia meds)
Staff training around EOL Conversations (maybe two sessions)
Documenting and billing for patient goals of care conversations education

At the last session, we will get feedback and complete our next PDSA to inform further dissemination to other practices.



Expenditure	Q1 2015	Q4 2015
30 day all cause readmission (per 1,000 discharges)	196	194
Short term stay hospital d/c (per 1,000 person years)	366	337
SNF discharges (per 1,000 person years)	120	108
ED visits (per 1,000 person years)	869	821
ED visits that lead to hosp. (per 1,000 person years)	290	275

Summary: The efforts are well received and we hope to share this innovative way to bring geriatrics and palliative care into an integrated model into primary care to not only provide care to patients at need, but also to provide education and increased comfort to the staff and physicians practicing in primary care.

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