Bringing the Conversation to Primary Care

By Ana Tuya Fulton, MD and Kate Lally, MD

December 12, 2017
9:30 AM and 11:15 AM

#IHIFORUM
Disclosures

- Both Drs. Fulton and Lally are faculty on the URI Geriatrics Workforce Enhancement Program grant from HRSA
- Dr. Lally is faculty at the Institute for Healthcare Improvement for the Conversation Ready Initiative
Session Objectives

- Identify the knowledge gaps of primary care teams surrounding the care of patients with complex medical needs.

- Describe a modifiable curriculum that can be used to train health care professionals from numerous disciplines.

- Identify how to assess knowledge and confidence based outcomes of the training protocol.
Audience Poll

- Who’s here and what are your roles?
Why is this important?

- Identifying serious illness and those with poor prognosis is important for several reasons
  - Decision making support
  - Trigger goals of care conversations
  - Planning – living situation, follow up frequency, support
  - Anticipating emergencies, expected complications
  - Preventing unnecessary or harmful interventions
Why is this important?

- High costs at end of life both immediately (3-4 months) and remotely (last 2 years of life)
- These high costs often equate to incongruous care with patient wishes and are causing suffering
- We can do a better job by
  - Identifying the seriously ill
  - Discussing advance care planning early and often
  - Escalating goals of care conversations as prognosis declines
- But teams need training!
Road Map

- Share our about our health system – who we are, our ACO’s experience and what we did, and why
- Describe a grant that supported our efforts
- Primary care teams -- need assessment results
- Review the curriculum we built
- Preview training and clinical outcomes
- Share our plans for next steps
Who Are We at Care New England?

- Care New England by the numbers:
  - 8,063 employees
  - 963 licensed beds
- Four hospitals
- Certified home health /hospice agency
- The Providence Center - ambulatory behavioral health provider
- Affiliated with RI Physician Corporation Primary care
- Integra Community Care Network
  - Integra is responsible for ~ 120,000 covered lives
Geriatrics and Palliative Care at CNE

Geriatrics at CNE

- Inpatient consult service
- Outpatient clinic
- Collaboration with NH’s
- Integration into ACO
- GME

Palliative care at CNE

- Inpatient consult service
- Outpatient clinic
- Home based services
- Integration into ACO
- GME
Conversation Ready Principles

1. **Engage** with our patients and families to understand what matters most to them at the end of life
2. **Steward** this information as reliably as we do allergy information
3. **Respect** people’s wishes for care at the end of life by partnering to develop shared goals of care
4. **Exemplify** this work in our own lives so that we understand the benefits and challenges
5. **Connect** in a manner that is culturally and individually respectful of each patient
High costs in the last year of life
Management of most complex patients

- **Complex Care Management team**
  - Currently about 1270 enrolled
  - Targeted for enrollment based on high utilization markers, frequent hospitalizations or PCP referrals
  - Many of these patients are frail older adults and/or have advanced illness

- **Every patient gets assigned a nurse care manager (NCM)**
  - 11 NCMs plus 2 transition managers, 2 ER NCMs 1 SNF NCMs
  - 5 NP’s, 6 SW’s, 3 MA’s, 5 RS’s (resource specialists)
Management of most complex patients

- Other available resources include
  - Strong social work support
  - NP visits for acute issues and transitions out of the hospital
  - Medical Assistants - perform wellness calls, accompany patient to visits if needed
  - Resource specialists - help with Medicaid applications, transportation booking, etc.

- Oversight by medical directors who include a Geriatrician and Palliative care physician
  - Weekly team meetings to review patient cases with focus on complex medical and social issues
Interdisciplinary Team Meetings
Timing is everything…

Formation of our ACO

Grant funding opportunity
Rhode Island Geriatric Workforce Enhancement Program:

- Improving quality of care and education for older adults, their caregivers and their providers across the state of RI
- This provided a unique opportunity for us at Integra and CNE
-Benefited patients in our affiliated practices
- Benefited providers and staff in our affiliated practices
RI - Geriatrics Workforce Enhancement Program (RI-GWEP)

University of Rhode Island Program in Gerontology

Academic Institutions
University of Rhode Island
College of Health Sciences, Nursing and Pharmacy
Rhode Island College
School of Nursing
School of Social Work
Brown University Medical School

Healthcare System
 Care New England
 Memorial Hospital
 Kent Hospital
 Butler Hospital
 Visiting Nurse Association

Primary Care Networks
 Care Transformation Collaborative of RI
 RI Primary Care Physicians Corporation

Community
 Healthcencic Advisors
 Rhode Island Alzheimer’s Association

State Agencies
 RI Department of Health and the Division of Elderly Affairs

RI-GWEP Steering Committee

Advisory Groups

Project Workgroups
Lessons learned – patient stories

- Review of charts – last year of life
- Home → Hospital → SNF → Hospital → SNF….
- 80 years olds on dialysis – infections, graft issues, frequent hospitalizations
- Advanced heart failure in/out of the hospital and SNF

Themes – Poor quality of life, feeling of powerlessness for both patients and their providers.
  - Missed opportunities to identify serious illness
  - Missed opportunities to talk about goals of care
Primary care team – needs assessment

- To meet patient needs and get primary care buy-in
- Goal to maximize collaboration -- ACO should be an extension of the PCPs office
- We went into the practices to hear from the primary care teams what their needs and challenges were
  - “Many of our patients are approaching end of life, or are frail older adults”
- Over and over again nurses, social workers, physicians asked for training to gain skills in having goals of care discussions and in optimizing identification and management of complex, frail patients
Developing a training protocol

- Learned on the PCP practices – topics, format, audience
  - Small group format
  - Interactive, practice driven topics
  - Case based
- Core topics created for all audiences
  - Goals of Care conversations – basic training & role play
  - Geriatric assessment training – prognostication and decision making support focused

<table>
<thead>
<tr>
<th>Topic</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| Goals of Care Conversations  | 1. Identify the role of different conversations at different stages of health  
2. Describe the advance care planning billing codes and how to use them  
3. Apply improved language around GOC conversations |
| Geriatric assessment and its use in primary care | 1. Describe the components  
2. Appreciate when, in what patients and what scenarios, to use it  
3. Understand which patients to refer for additional evaluation or geriatric consultation |
| Polypharmacy and de-prescribing | 1. Describe the changes in aging physiology that affect prescribing  
2. Understand the need to frequently evaluate medication indications and risk benefit equation in older adults.  
3. Resources/tools |
| Managing conflict between patients, families and providers | 1. Recognize that in life threatening situations anger is a common response  
2. Describe communication techniques for diffusing anger  
3. Deal with conflict and guide patients families through difficult decisions |
| Pain Management in Older Adults | 1. Recognize how to assess and treat pain in older adult with multiple medical issues.  
2. Appreciate what appropriate and inappropriate options are for older adults. |
Expanding the audience…

- Office based nurse care managers, social workers and pharmacists said “we need it too!”
- ACO based nurse care managers, social workers, nurse practitioners and MA’s wanted the training as well
- Expanded the curriculum to these audiences in large group format
Mrs. H

78 year old woman presenting for a routine follow up visit. She has a history of hypertension, chronic kidney disease, depression and anxiety and osteoporosis. She comes in alone, and says things are fine. No acute complaints. She is still taking her vitamin D, calcium and atenolol and takes as needed lorazepam when she gets anxious. She’s been on this for years. Exam and vitals are all within normal limits. She goes home with a plan to follow up in 5-6 months.

• The next day the office gets a call from the daughter: she is more forgetful and they have requested she stop driving.
How do we do better by Mrs. H?

- What would have happened if her daughter hadn’t called?
- How does a health care system better support her? Identify her dementia earlier?
- What are the anticipated emergencies and decisions that she/daughter will have to face?

- Tell us your thoughts….pause for discussion…
GERIATRIC ASSESSMENT CURRICULUM DETAILS
Incorporating best practice

- Give primary care the tools
  - Geriatric assessment tools to identify fall risk, dementia, depression, nutrition and social risk factors
  - Goals of care conversations skills training
  - De-prescribing and risk versus benefit support

- Target the seriously ill – identify and proactively plan
  - What do you add to annual and follow up visits for screening for geriatric syndromes?
Geriatric Assessment for Primary care

- Clinical approach to older patients
- Goes beyond the traditional history and physical using a multidisciplinary and multidimensional approach
- Goal is to better recognize the common geriatric disorders; improve functional status; and quality of life
- Ends with a coordinated, whole patient-focused care plan
Benefits

- Preserve independence and function
- Anticipate problems
- Postpone institutionalization
- Trigger ACP and goals of care discussions
- Better support decision making – role of functional status in decisions

Wieland D. Comprehensive Geriatric Assessment. Cancer Control. 2003: 10(6); 454-462. GRS, Geriatric Review Syllabus. AGS.
When is it most helpful?

- Establishing care – 1st visit, annual visit, before a big treatment decision
- Complicated patient – frail, vulnerable, frequently hospitalized elderly
- Transition points
  - new diagnosis, or stressor
  - change in living situation or level of care
  - new functional limitation
  - Red flags – caregiver stress? Depression? Dementia?
Elements

- Physical health and medical concerns
- Mental health and cognition
- Economic and social supports
- Functional status
- Physical environment and living situation
- Prevention and screening
- Advance care planning
Geriatric Assessment “Light”

Review ADL’s
• Bathing, Dressing, Grooming, Toileting, Continence, Walking, Eating, Transferring

Review IADL’s
• Telephone, leaving home, shopping, meals, housework, taking medications, money management

Functional assessment – mobility/frailty
Geriatric Assessment “Light”

**Depression Screening**
- Geriatric Depression Scale OR PHQ 2 and 9

**Cognitive Screening**
- Mini – Cog or MMSE or MOCA

**Geriatric review of symptoms**
Cognitive Assessment

- **Mini Cog – Clock and three item recall**
  - 0/3 = impaired, 1-2/3 use clock to classify (abnormal = impaired)
  - Clock is normal if all numbers present in sequence and hands display time correctly and are appropriate length
Gait and Mobility - Function

- Up and Go test

Timed Get Up and Go (TUG) Test:

1. Stand up from a chair
2. Walk 10 ft. forward
3. Turn around and walk back to the chair
4. Sit down on the chair
5. Time taken for these actions
Quick Screen

- ADL/IADL review, Depression screen, Mini-cog, ROS, Timed up and go
- Applies to any practice setting
- Choose the tool that fits best and ideally is in your EMR!
- 5-10 minutes
- Use your team!

The Hartford Institute for Geriatric Nursing. https://consultgeri.org/tools/try-this-series
Value?

- Mounting evidence to show – correlations of gait speed and TUG with morbidity/mortality
- Better identification of who will do well or poorly with dialysis when incorporating geriatric assessment
- Cancer treatment studies
- Pre-operative risk – elective surgery (joint replacement)
- Delirium risk
How is Mrs. H really doing?

- She lives alone in a senior high rise and has been eating more processed, prepared food because she doesn’t cook anymore and relies on neighbors and friends to bring her groceries.
- Family took the car away.
- Mrs. H stopped going to her church and social outings because she can’t always remember to get there and feels anxious on public transportation.
- She has had 2 falls in the last 6 months.
- She has lost about 8 pounds in the last 6 months.
- Cognitive testing shows evidence of mild – moderate dementia.
Mrs. H

- Comes in for diagnosis of dementia with daughter
- Medication review conducted for fall risk – multiple BP meds adjusted and target re-addressed (was orthostatic)
- Home health aides put in place to help with meal prep and self care and daughter does medications
- OT home safety evaluation for home modification
- Daughter completes Health Care Proxy and takes on finances
Tying it all together

- Screening for functional status can better inform decisions around prognosis
- It’s not just about disease status; adding function, cognition, social supports provide a more comprehensive picture
- Incorporating components of screening into wellness visits, and routine office practice pays dividends back
QUESTIONS?
GOALS OF CARE
CURRICULUM DETAIL
Am I taking away hope? Does this patient trust me?

Emotions and Cognition

Do I trust this person? Does she recognize how this will affect my life?

Let’s talk about your illness

Words

What are my options?

Provider

Patient

Borrowed with Permission from Dr. Lauge Sokol Hessner
Conversation Stoppers

Almost half say they frequently or sometimes feel unsure of what to say during conversations about end-of-life care.

During conversations about end-of-life care, how often do you feel unsure of what to say? Would you say:

- Frequently: 8%
- Rarely or never: 20%
- Sometimes: 38%
- Not too often: 34%
- Frequently or sometimes: 46%

Physicians who have had end-of-life training are more likely to say they rarely or not to often feel unsure about what to say (60% compared to 52% of those without training).

Physicians more likely to experience uncertainty around what to say in these conversations include racially/ethnically diverse physicians, women, and younger respondents.

More than half say they find conversations about end-of-life care more challenging than rewarding.

In general, do you consider conversations about end-of-life care to be:

- More challenging: 53%
- More rewarding: 35%
- Both/DK: 12%

Physicians who have had end-of-life training are more likely to say they find these conversations to be rewarding (46% compared to 30% of those without training).

Goals of Care Training

- Table top, interactive didactic on basic conversation skills utilizing a case at various stages (well, serious illness, advanced serious illness)
- Role play sessions using a conversations skills checklist and expert observer feedback
  - ESRD, Dementia, COPD
- Ongoing conversation skills feedback through weekly team meetings with medical directors
Ms. Smith is a 68-year-old woman with hypertension, hyperlipidemia, and history of smoking. She was recently diagnosed with emphysema/COPD. She’s coming in for a routine follow-up for her hypertension with her daughter.

- Does she need “a conversation”? And at this stage, what’s the goal of a conversation?
- How would you begin a conversation?
- How could you use your team?
- How do I document and bill for this?
- Have you used the new codes? Have you faced any difficulty with these?

At age 71 she was sick enough to be admitted to the ICU. While she was in the ICU, there was confusion about who her decision maker was. She is now in your office for routine follow-up a month after that admission, still weakened from her pre-admission state, but otherwise is doing well. Her daughter is with her in the office today.

- At this stage, what’s the purpose of “the conversation”? And How can I begin “the conversation,”
- How could you use your team?
- What if Mrs. Smith doesn’t want to discuss this?
- How would you address the issue between her son and daughter?
- What if the son or daughter disagrees with the patient’s wishes?
- How would you document, and bill for it?

Ms. Smith is now no longer able to walk around the block as she had been able to, and now can only go to and from the bathroom before getting so short of breath that she has to stop and rest. She starts the visit by telling you how tired she is. You and she talk more, and it becomes clear that she doesn’t want to have to go back to the hospital if it isn’t necessary. She really prefers to stay at home. Her daughter is with her again today.

- At this stage, what’s the purpose of “the conversation”? And How can I begin “the conversation”?
- How can I introduce palliative care, and help the patient make a transition to hospice when the time is right for her?
- How could you use your team?
- How do I document and bill for “the conversation”?
- What are some difficult situations surrounding this that you have seen?
You are going to the home of Mrs. Jones and her sister/caretaker/dPOA Mrs. Brown. Mrs. Jones has just been discharged from an 8 day hospitalization for aspiration PNA which was complicated by respiratory failure and delirium. She required BiPAP, but did not require intubation. Notes from her hospitalization indicated that Mrs. Jones appeared frightened and agitated and was frequently pulling at her BiPAP. She required a 1:1 sitter for much of her stay. Mrs. Jones appears frail and weak, but refused SNF and is getting PT at home, although the PT notes indicate that she has difficulty following the plan of care. She has been referred to Complex care management after d/c from the hospital. You note that she was a full code on discharge, even after multiple discussions about goals of care and code status. You are meeting with her today to start a relationship and discuss goals of care.

Patient:
You are afraid of the hospital and get easily confused there. You did not like wearing the BiPAP mask and are not able to comprehend why that was important. Being in the ICU was the most frightening time of the hospitalization and you have a sense that you would not want to go back there.

Sister/dPOA:
Your older sister helped raise you when your mother was ill and you are very close to her. She was always a fighter and fought for you and your siblings for many years. Your sister always avoided doctors and hospitals and did not like medical intervention. You want to “do everything” to keep you sister alive as long as you can, but do not want to prolong her dying. You are worried about her nutrition and come from a family background where food = love and are worried about her not eating much.
Clinician name:__________________  Faculty Name:__________________

Date:____________

Basic Interviewing Skills

_____ Introduction—nurse introduced him/herself
_____ Comfort—nurse put patient at comfort, ensured privacy
_____ Nurse assumed a comfortable interpersonal communication distance
_____ Nurse made appropriate eye contact
_____ Nurse’s posture was open (was leaning forward, didn’t cross arms over chest, etc.)
_____ Used language that was clear and understandable; no medical jargon
_____ Nurse was attentive to comments—nodding head, used verbal cues (“yes”, “hmm”, “I see”)
_____ Nurse gave me opportunity to ask questions
_____ Nurse responded to emotion with empathy
_____ Nurse answered questions in a straightforward manner
_____ Nurse suggested a follow-up plan
_____ used therapeutic silence if appropriate

Assess the understanding of diagnosis and prognosis

_____ How are things going?
_____ What is your understanding of what has happened?
_____ What have the doctors told you about your condition?
_____ Tell me more...
_____ Can you explain what you mean?
_____ Can you tell me what you are worried about?
_____ Nurse clearly articulated the current status of the disease
      _____ Explained why the illness is advanced
      _____ Reviewed treatments that have been tried
      _____ explained the probable course of the advanced illness
      _____ clarified the treatment options

Goal: Therapeutic communication

_____ Nurse asked patient to articulate personal goals: What matters most?

Goal Setting/DNR Skills

_____ Nurse asked patient to articulate personal goals
_____ Nurse discussed the use of CPR within the context of the disease, and prognosis
_____ Nurse asked about surrogate decision maker
_____ Nurse gave information about dPOA/MOLST if appropriate

Adapted with permission for Medical College of Wisconsin. David Weissman, MD
End-of-Life Care Conversations: Medicare Reimbursement FAQs

The changes in Medicare reimbursement policy that went into effect January 2016 provide an opportunity for more clinicians and patients to engage in conversations about preferences for care at the end of life. However, many people are confused about where to start. Whether you are uncertain about the new rules for CMS reimbursements or about starting those conversations with patients, this document will help you understand this new landscape for end-of-life care conversations.

Before getting started, check to see if a local coverage determination has been made, and check with your local billing expert to ensure your practice is compliant with their recommendations. Make sure that the new reimbursement codes have been added to your system’s billing apparatus. These codes may not be available until your facility approves them for use.

1. Do these new codes need to be used in the context of an illness?
   No. In fact, any medical management must be billed separately.

2. What are the new advance care planning (ACP) codes from CMS that became active in 2016?
   - 99497 – ACP (including the explanation and discussion of advance directives, such as standard forms with completion of such forms, when performed, by the physician or other qualified health professional)
   - 99498 – Each additional 30 minutes (list separately in addition to code for primary procedure)

3. How much time must be spent to use the new codes?
   More than half of each interval must be used. For example:
   - Use 99497 if you meet or exceed 16 minutes.
   - Use 99497 + 59498 if you meet or exceed 45 minutes.

4. Does the conversation have to be in-person to use the new codes? Does it have to be with the patient?
   The conversation has to be in-person (you cannot use the codes for telehealth), but it doesn’t have to be with the patient. It can be with a surrogate or family members.

5. What are the documentation requirements?
   - Total time in minutes

6. How much do payers reimburse for these codes?
   - 99497 = 1.5 RVUs
   - 99498 = 1.4 RVUs

7. Are there limits to the number of times that the new codes can be used?
   There are no limits to the number of times the codes can be used. ACP can be addressed as needed with a change in condition. Each time they are used, 99497 should be used for the first 30 minutes and 99498 should be used for each additional 30 minutes.

8. Which health care providers can be reimbursed for having ACP discussions with patients under the new rule? Can physicians charge for the codes if another staff member engages the patient in the ACP discussion?
   Physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAs) (i.e., those who are authorized to independently bill Medicare for Current Procedural Terminology (CPT) services) are the only providers who can use these codes.
   “Incident to” rules apply in the outpatient setting. This means that a provider can use these codes if they perform an initial service and a non-billing team member (e.g., registered nurse, social worker) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider.

Your Conversation Starter Kit
When it comes to end-of-life care, talking matters.
## Documenting the Conversation

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who was in the room</td>
</tr>
<tr>
<td>What was discussed</td>
</tr>
<tr>
<td>Understanding of Illness</td>
</tr>
<tr>
<td>Spiritual factors</td>
</tr>
<tr>
<td>Reflections on family/personal losses</td>
</tr>
<tr>
<td>Why making the decision they are making</td>
</tr>
<tr>
<td>Was advance directive offered/filled out</td>
</tr>
<tr>
<td>Follow up</td>
</tr>
</tbody>
</table>
Modifying Existing Tools

GOALS OF CARE CONVERSATION:

1) I offered my condolences on her husband passing away and then asked her that it sounds like you make all of your own decisions but who would speak for you if you could not speak for yourself? 
   My son, he visits me every day.

2) I am hoping we can talk about where things are with your illness? 
   Yes, that would be fine.

3) What is your understanding of where things are with your illness? 
   I am not in the best of shape but I am not in the worst of shape either. 
   Tell me more- she said I have had 7 heart stents, a stroke last year, a recent leg infection- that's all. But my biggest loss is that of my husband. Would you like to talk about your husband? Not right now, maybe the next time you call.

4) What are your most important goals if your health should worsen? 
   Staying in my home for as long as possible, with extra support.

5) What are your biggest fears and worries about the future with your health? 
   I don't have any now. I put all of my affairs in order when my husband was sick-before my biggest fear was leaving all of this for my son to do.

6) What abilities are so critical to your life that you can't imagine living without them? 
   Being in touch with my son.
QUESTIONS?
Pre- and post-test score averages

Adapted with permission from: https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
## Goals of Care and Geriatric Assessment Pre & Post Evaluation Data

<table>
<thead>
<tr>
<th>Goals of Care – Table Top Training</th>
<th>Pre-test mean</th>
<th>Post-test mean</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How confident are you in your ability to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on patient values and goals</td>
<td>2.97</td>
<td>3.54</td>
<td>-6.06***</td>
</tr>
<tr>
<td>Assess patient understanding of their illness</td>
<td>2.97</td>
<td>3.43</td>
<td>-4.82***</td>
</tr>
<tr>
<td>Acknowledge and respond to patient emotion</td>
<td>3.06</td>
<td>3.57</td>
<td>-5.41***</td>
</tr>
<tr>
<td>Allow therapeutic silence</td>
<td>3.00</td>
<td>3.56</td>
<td>-4.62***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals of Care – Role Play Training</th>
<th>Pre-test mean</th>
<th>Post-test mean</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How confident are you in your ability to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on patient values and goals</td>
<td>2.97</td>
<td>3.53</td>
<td>-5.81***</td>
</tr>
<tr>
<td>Assess patient understanding of their illness</td>
<td>2.91</td>
<td>3.35</td>
<td>-3.65**</td>
</tr>
<tr>
<td>Acknowledge and respond to patient emotion</td>
<td>3.15</td>
<td>3.50</td>
<td>-4.24***</td>
</tr>
<tr>
<td>Allow therapeutic silence</td>
<td>2.94</td>
<td>3.35</td>
<td>-4.31***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geriatric Assessment Training</th>
<th>Pre-test mean</th>
<th>Post-test mean</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How confident are you in your ability to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe the main components and domains of geriatric assessment.</td>
<td>1.86</td>
<td>3.64</td>
<td>-11.06***</td>
</tr>
<tr>
<td>Perform and interpret an assessment of cognitive function such as the Mini-Cog</td>
<td>2.05</td>
<td>3.76</td>
<td>-8.22***</td>
</tr>
<tr>
<td>Perform and score a test of mobility and function such as the timed up and go test</td>
<td>1.90</td>
<td>3.71</td>
<td>-8.45***</td>
</tr>
<tr>
<td>Understand how to use the tool kit of geriatric assessment to identify patients who need further assessment and who would benefit from additional evaluation.</td>
<td>1.76</td>
<td>3.62</td>
<td>-9.97***</td>
</tr>
</tbody>
</table>
Geriatrics & Palliative Care training ACO patient outcomes: Advanced Directives
Future plans

- Integration with specialists – training curriculum and case conferencing with ACO team
- Nephrology specific training – 6 sessions planned for faculty, staff, dialysis centers
- Patient focused conversation training using conversation starter kit
- Work with New England QIO to bring across the region – webinar and in-person expansion of the curriculum
Thanks

Questions?

- Kate M. Lally, MD, FACP: kmlally@kentri.org
- Ana Tuya Fulton, MD, FACP: afulton@carene.org