CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Learning Systems
for Accountable Care Organizations

Integra Community Care Network's Approach to Advance Care Planning

This case study describes Integra Community Care Network's (Integra) approach to improving advance care planning for high-risk beneficiaries. The approach includes (1) developing and deploying a curriculum for accountable care organization (ACO) providers on the principles of geriatric and palliative care; (2) refining the process for enrolling beneficiaries in its complex care management program in order to include a conversation between beneficiaries and providers about the beneficiaries' goals for their care; and (3) supporting the nurse care managers and providers who have these conversations by giving them a discussion guide and a tool for documenting the conversations. Through these efforts, Integra increased the number of completed and documented goals-of-care conversations for beneficiaries in their complex care management program from 39 to 88 percent over the course of 2018. Integra's experience is informative for other ACOs that are interested in improving their approach to advance care planning.

BACKGROUND

Integra Community Care Network (Integra) is an accountable care organization (ACO) formed by a partnership between Care New England and Rhode Island Primary Care Physician Corporation. The ACO joined the Next Generation ACO Model in 2017 and is preparing to transition to the Shared Savings Program in 2020. Integra comprises more than 1,000 providers, including three hospitals and home health, hospice, and ambulatory care centers. In April 2019, Integra served approximately 16,000 aligned beneficiaries across Rhode Island. The providers in its network use 10 electronic health record (EHR) platforms, and the majority of providers use the same one.

Integra's complex care management team provides specialized care for the ACO's beneficiaries with the highest utilization and risk. This team of nurse care managers, nurse practitioners, social workers, pharmacists, and other clinicians serves as an extension of the primary care teams by supporting beneficiaries in their homes. In 2016, Dr. Ana Tuya Fulton, Integra's medical director and a geriatrician, and Dr. Kate Lally, former Integra co-medical director and a palliative care physician, sought to further improve care for high-risk beneficiaries by developing a training curriculum for both primary care providers (PCPs) and the complex care management team on the principles of geriatrics and palliative care, including advance care planning. After the training, Dr. Fulton partnered with Ruth Scott, Senior Director of Population Health for Integra, to adjust the ACO's complex care management enrollment process. In the new process, care managers talk with beneficiaries about their goals of care and then use the EHR to communicate the results of the conversation to the beneficiaries' PCPs.

LAUNCHING THE ADVANCE CARE PLANNING PROGRAM

Integra's first step in launching its advance care planning program was to gather input from providers on how to design a curriculum that would meet their learning needs with respect to care for older adults. In a five-question needs assessment sent to PCPs (Figure 1), Integra asked about the following: the challenges related to caring for older and frail adults, their knowledge of best practices for geriatric care, and their comfort level in holding conversations with beneficiaries about the goals of care. Integra then built on the assessment results by talking in person with the PCPs to discuss their concerns and challenges. Based on the insight yielded by the assessment and related conversations, Integra developed a training curriculum that focused on the principles of geriatric and palliative care, including guidance on how to hold goals-of-care conversations.

Figure 1
Learning needs assessment for PCPs on caring for older adults

1. Identify the top three things that make working with older adults the most challenging for you and your team
2. Describe the challenges you face when having goals-of-care conversations
3. Rate your comfort level in geratrics best practices
4. Rate your comfort level in having goals-of-care discussions
5. Circle all topics that you would be interested in reviewing with our team

TRAINING ON GERIATRIC AND PALLIATIVE CARE PRINCIPLES

Integra took a flexible approach to implementing the training and encouraged primary care practices to select curriculum components based on their needs and interest. For example, some primary care practices elected to participate in all of the one-hour training sessions, whereas others selected a subset of the sessions. Integra required all practices that received the training to participate in sessions on the goals-of-care conversations and geriatric assessment. Though the ACO initially targeted the training to individual primary care practices, it later expanded the sessions to large, interdisciplinary groups that are part of the complex care management team.

The curriculum combines didactic presentations, interactive tabletop discussions, and role-playing sessions that focused on the following topics: (1) strategies for initiating the goals-of-care conversations with beneficiaries; (2) approaches to conducting geriatric assessments; (3) techniques for managing conflicting care preferences between beneficiaries, families, and providers; (4) strategies for pain management in older adults; and (5) challenges of polypharmacy and "de-prescribing." The didactic presentations provided a foundational overview of the principles of geriatric and palliative care; they also delved into approaches to the goals-of-care conversations, such asking open-ended questions and being responsive to beneficiaries' emotions when tackling a difficult subject. To build on the didactic presentations, the ACO provided case scenarios for the interactive tabletop discussions. The participants used the scenarios to explore how the goals-of-care conversation would include different questions depending on whether the beneficiary was healthy, declining in health after an acute event, or recently diagnosed with a terminal condition. To encourage skill-building, the role-playing sessions gave participants an opportunity to act as both the provider and the beneficiary while Integra encouraged them to give each other feedback on body language and other tips for having productive conversations.

To date, Integra has held 19 training sessions for five primary care practices and 10 training sessions for large, interdisciplinary groups. To expand the training to practices unable to participate in the in-person sessions, Integra also hosted a series of webinars on the foundational overview of the principles of geriatric and palliative care.

STANDARDIZED TOOL AND WORKFLOW

After the training sessions, Integra explored how providers and the care management team conducted the goals-of-care conversations with beneficiaries. Dr. Fulton joined the complex care management team's biweekly case conferences and observed how the team reviewed the beneficiaries' health status, current needs, and the status of their goals-of-care conversations. In listening to them, Dr. Fulton noted an inconsistency in whether the goals-of-care conversations occurred at all as well as variability in the information that nurse care managers documented after the conversations. To address this gap in care delivery and documentation, Dr. Fulton and Ms. Scott worked together to integrate the goals-of-care conversations into the complex care management enrollment process and also to formalize and promote best practices.

> ***"We focused on goals-of-care conversations because we felt strongly that nearly every patient enrolled in the complex care management program meets the criteria for serious illness, and we should therefore be having discussions to help patients decide what their wishes are and how we can help to ensure that we honor those wishes."***
>
> —Dr. Ana Tuya Fulton, Medical Director, Integra Community Care, and Executive Chief of Geriatrics and Palliative Care, Care New England

Integra developed a standardized tool to support nurse care managers when having goals-of-care conversations with beneficiaries. As part of this effort, the ACO researched existing resources and selected the Serious Illness Conversation Guide, developed by Ariadne Labs,[1] to serve as the basis for its own tool. The tool includes realistic examples of how goals-of-care conversations proceed (see Figure 2) as well as prompts such as the following to help nurse care managers begin the conversations:

- Who would speak for you if you could not speak for yourself?
- I am hoping we can talk about where things are with your illness.
- What is your understanding of where things are with your illness?
- What are your most important goals if your health should worsen?
- What are your biggest fears and worries about the future with your health?
- What abilities are so critical to your life that you can't imagine living without them?

Integra enlisted the help of a nurse care manager on the complex care management team to test whether the tool could be successfully integrated into the complex care management enrollment process. The nurse tested the tool in telephone and face-to-face conversations with beneficiaries and confirmed that it was useful. Having confirmed the tool's effectiveness, Integra disseminated it to the whole care management team and began using it for all beneficiaries.

Integra also asked its information technology department to build the tool into the EHR in order to promote widespread adoption and simplify the documentation process. When a beneficiary enrolls in the complex care management program, the nurse care manager looks to the tool in the EHR to conduct the goals-of-care conversation and then documents the conversation in a specialized field. Other providers, whether in primary care offices or in the hospital, can access to this information about the beneficiaries' wishes when engaging them in decisions about their care.

"We had very good success in reaching the providers and complex care management team through training, but everyone takes to training differently… and training can only go so far. We recognized that we needed to embed the goals of care conversation tool into our EHR so that it was front and center for all members of the team and also a part of their daily workflow."

—Dr. Ana Tuya Fulton, Medical Director, Integra Community Care, and Executive Chief of Geriatrics and Palliative Care, Care New England

Figure 2
Example of a goals-of-care conversation

Q: "My condolences on your husband's passing. It sounds like you make all of your own health care decisions, but who would speak for you if you could not speak for yourself?"

A: "My son, he visits me every day."

Q: "I am hoping we can talk about where things are with your illness."

A: "Yes, that would be fine."

Q: "What is your understanding of where things are with your illness?"

A: "I am not in the best of shape, but I am not in the worst of shape either. I have had 7 heart stents, a stroke last year, and a recent leg infection—that's all. But my biggest loss is that of my husband."

Q: "Would you like to talk about your husband?"

A: "Not right now, maybe the next time you call."

Q: "What are your most important goals if your health should worsen?"

A: "Staying in my home for as long as possible, with extra support."

Q: "What are your biggest fears and worries about the future with your health?"

A: "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."

Q: "What abilities are so critical to your life that you can't imagine living without them?"

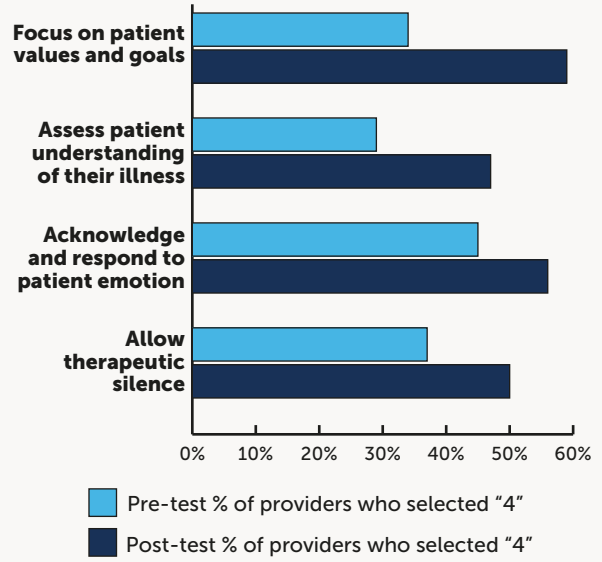
A: "Being in touch with my son."

RESULTS

Integra conducted a pre- and post-training survey to measure the training participants' confidence with the principles of geriatric and palliative care. The participants reported that after the training, they were more confident in addressing the beneficiaries' values and goals, in assessing their understanding of their illness, in acknowledging the emotional aspects of advance care planning, and in allowing for therapeutic silence. Figure 3 shows the results of the pre- and post- survey for the role-play portion of the training, focusing on the highest response option on a four-part Likert scale.

[1]For more information, visit: https://www.ariadnelabs.org/areas-of-work/serious-illness-care/

Figure 3
Pre- and post-training survey responses for the role-play training session: providers' selecting the highest response "4"



Source: Integra Community Care Network

After modifying the complex care management enrollment process, Integra assessed the change in the percentage of beneficiaries enrolled in the care management program whose goals-of-care conversations had been documented. In January 2018, conversations had been documented for 39 percent of the beneficiaries. After the training and after the practices included the guidance tool in the EHR, the number of beneficiaries with documented goals-of-care conversations rose steadily through the year, reaching nearly 88 percent of beneficiaries by December 2018 (Figure 4).

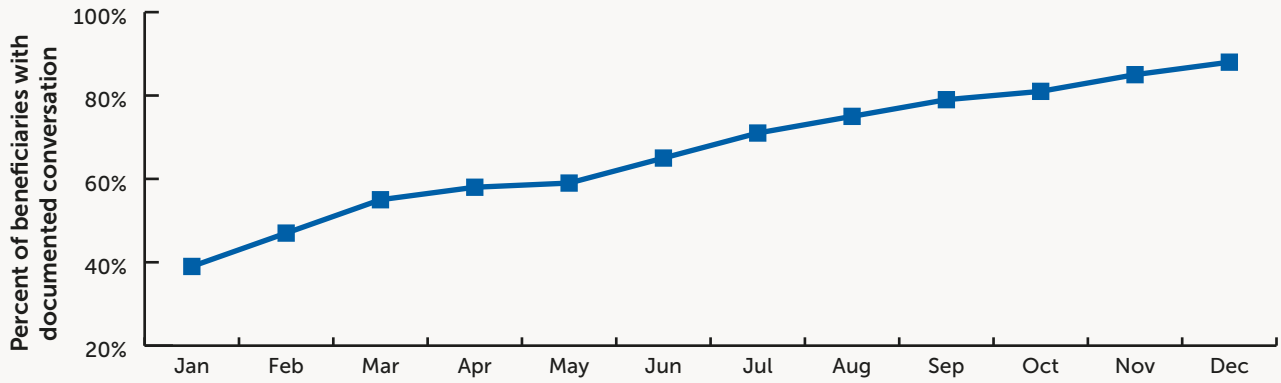
LESSONS LEARNED

Integra emphasized the importance of engaging providers when developing the training curriculum and also using provider input to tailor the training sessions to their unique interests and learning styles. Integra found that the needs assessment and the in-person conversations effectively identified the providers' gaps in understanding and supported the early design of the training sessions. When launching the training, Integra learned from providers that the timing and location might limit participation. To address this barrier, Integra held the training sessions at the practice facilities and at a time selected by the providers. In addition, Integra created a webinar-based training session for providers unable to join the in-person sessions.

Integra also reflected on the need to support providers through skill-building opportunities and coaching in order to make the goals-of-care conversations a routine part of patient care. Integra used the tabletop discussions and the role-playing training sessions to give participants a low-stress environment in which they could practice the conversations. After the training, Integra's experienced geriatricians and nurse care managers have been available to talk with other clinicians about difficult conversations with beneficiaries to the mutual benefit of everyone involved.

> *"The care management staff need champions who will be there when they need to talk through a difficult conversation that didn't go as they planned. Provide on-going support . . . you can't just do one training session and walk away.*
>
> —Dr. Ana Tuya Fulton, Medical Director, Integra Community Care, and Executive Chief of Geriatrics and Palliative Care, Care New England

Figure 4
Percentage of completed goals-of-care conversations for chronic care management beneficiaries in 2018



Source: Integra Community Care Network

NEXT STEPS

Integra has begun to gather feedback from providers on how to expand the goals-of-care conversation initiative to all patients and on how to improve the quality of information that is derived from the documented conversations. The ACO expects that next steps will include building new support tools into the EHR and/or refining the training curriculum. Integra also plans to assess the beneficiaries' satisfaction with the conversations in order to raise their awareness and that of their caregivers about why these conversations are so important to the development of a treatment plan. For more information on Integra's advanced care planning work, see their recent publications.

REFERENCES

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About the ACO Learning Systems project
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For more information, contact the ACO Learning System at ACOLearningActivities@mathematica-mpr.com.