Primary Palliative Care for Emergency Medicine (PRIM-ER)

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Research in emergency care

Window to population health

Research agenda to end disparities, & address the needs of society's most vulnerable

Background

Increasing ED visits by older adults with serious illness

Most prefer to receive care at home and to minimize life-sustaining procedures

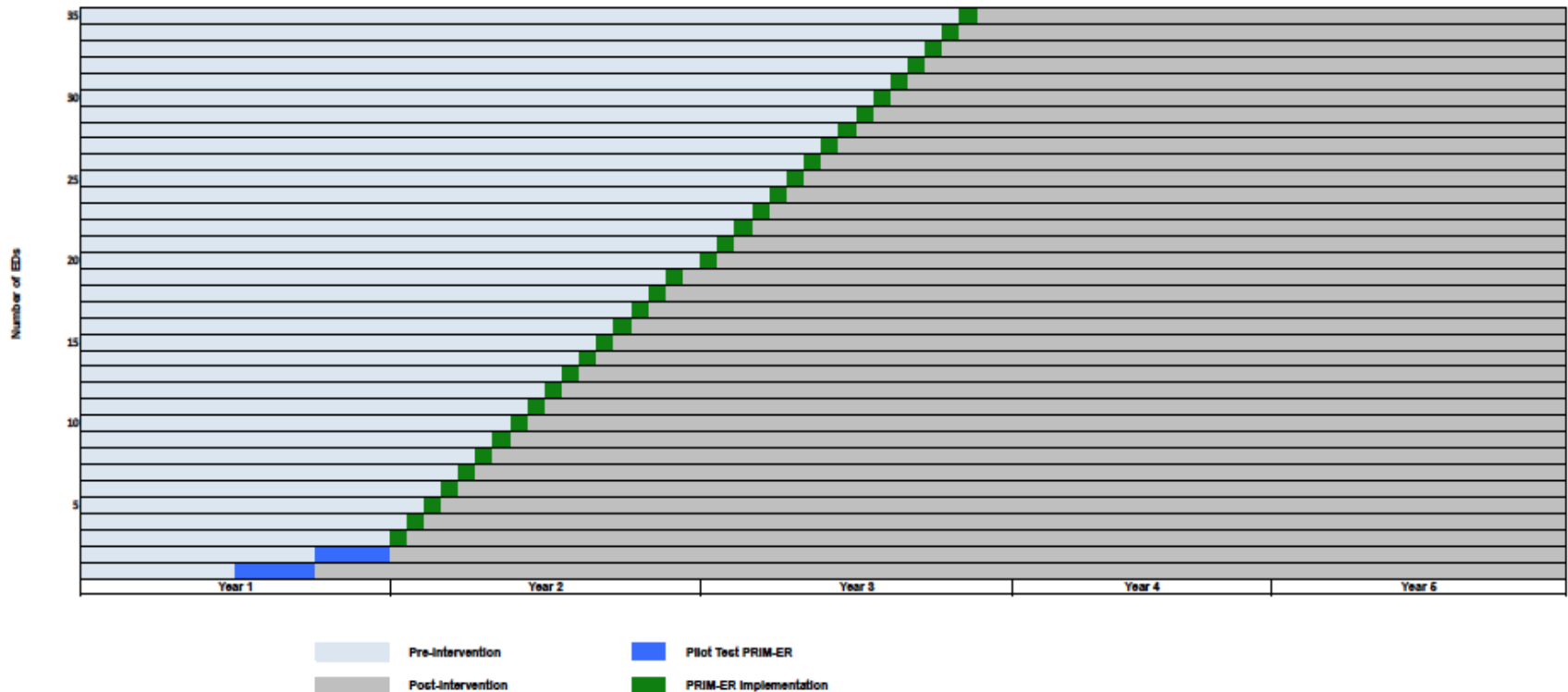Palliative care improves quality of life and decrease health care use
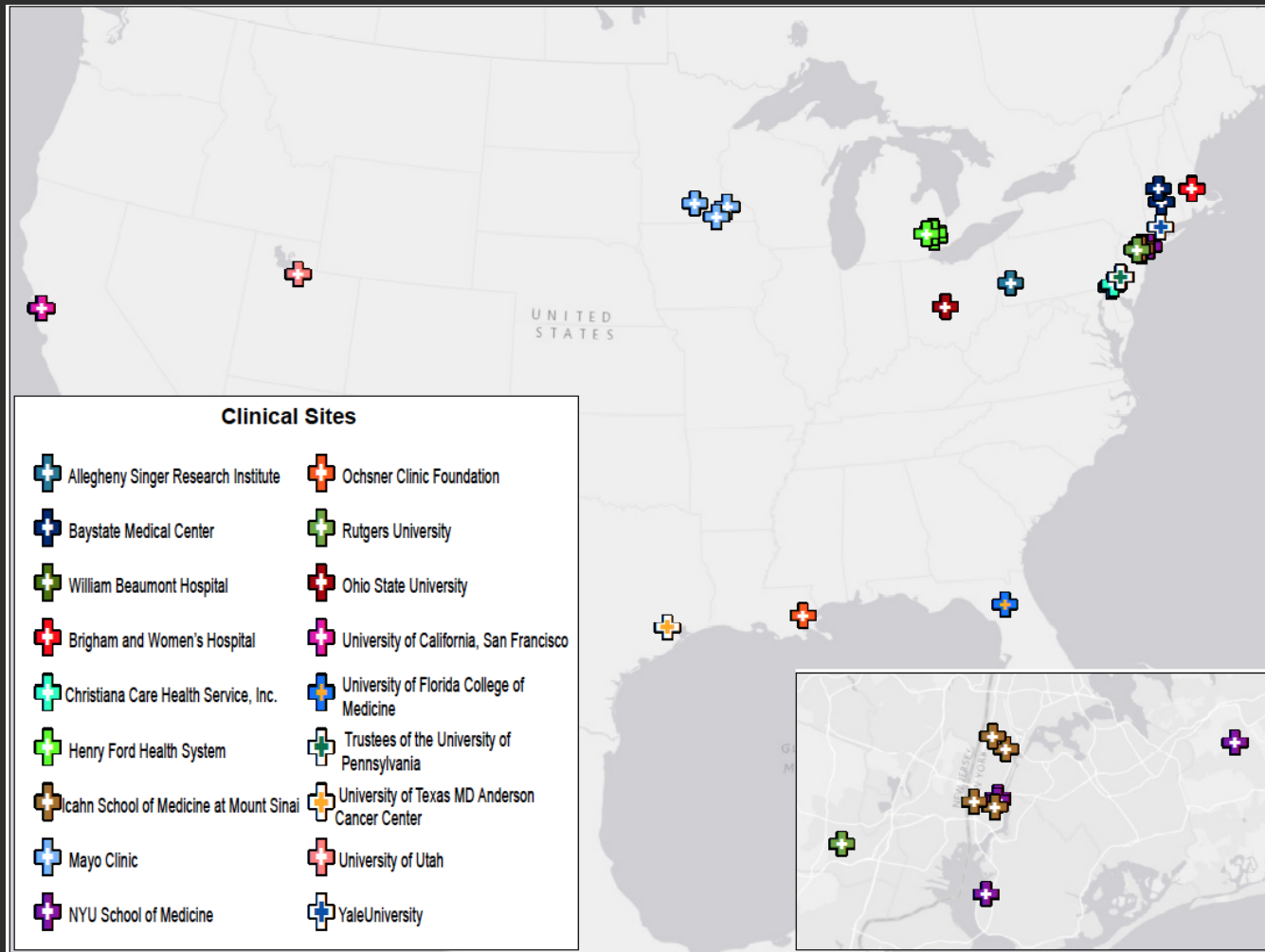
Default Approach

PRIM-ER

1. Evidence-based, multidisciplinary primary palliative care education (EPEC-EM, ELNEC);

2. Simulation-based workshops on communication in serious illness (EM Talk);

3. Clinical decision support; and
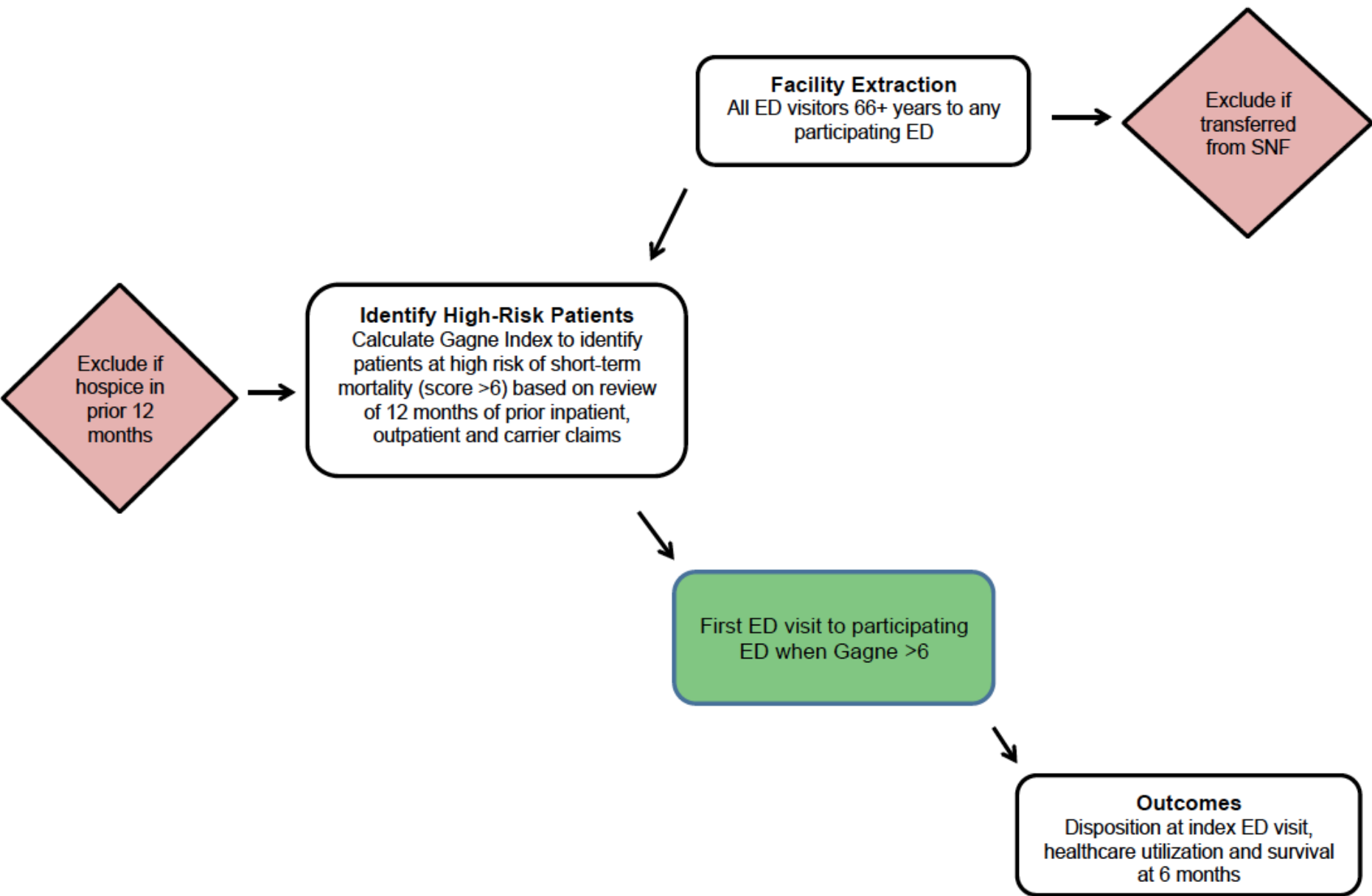
4. Provider audit and feedback.

Cluster Randomized, Stepped Wedge Trial Across 35 EDs

18 Health Systems

Clinical Sites

- Allegheny Singer Research Institute
- Baystate Medical Center
- William Beaumont Hospital
- Brigham and Women's Hospital
- Christiana Care Health Service, Inc.
- Henry Ford Health System
- Icahn School of Medicine at Mount Sinai
- Mayo Clinic
- NYU School of Medicine
- Ochsner Clinic Foundation
- Rutgers University
- Ohio State University
- University of California, San Francisco
- University of Florida College of Medicine
- Trustees of the University of Pennsylvania
- University of Texas MD Anderson Cancer Center
- University of Utah
- YaleUniversity

Facility Extraction
All ED visitors 66+ years to any participating ED

Exclude if transferred from SNF

Exclude if hospice in prior 12 months

Identify High-Risk Patients
Calculate Gagne Index to identify patients at high risk of short-term mortality (score >6) based on review of 12 months of prior inpatient, outpatient and carrier claims

First ED visit to participating ED when Gagne >6

Outcomes
Disposition at index ED visit, healthcare utilization and survival at 6 months

12 months prior → Index ED visit → 6 months post

Intervention Milestones

Develop and finalize all intervention components to be implemented

Clinical Decision Support (CDS) system	A.1.a.i. Develop CDS system at NYU Perelman.	6/15/2018
	A.1.a.ii. Test usability with emergency physicians from two pilot sites.	8/15/2018
	A.1.a.iii. Finalize CDS system once average system usability scale is at least 68 and then deploy across two pilot sites.	9/15/2018
Clinical workflow and resource packets	A.1.b.i. Develop and test clinical workflow and resource packets at pilot sites through qualitative interviews with key informants.	8/15/2018
	A.1.b.ii. Develop and test clinical workflow and resources packets at all 18 health systems through qualitative interviews with key informants.	11/15/2018
	A.1.b.iii. Tailor CDS system to all 18 health systems based on results of workgroups with key informants.	12/15/2018
Emergency provider education and training	A.1.c.i. Tailor existing online learning management system for providers to access and track educational activities.	6/15/2018
	A.1.c.ii. Deploy EM Talk, EPEC-EM, ELNEC and online palliative care basics at one pilot site for all emergency providers.	8/15/2018
	A.1.c.iii. Adjust volume and length of curriculum at second pilot site so that eligible providers complete an average of at least 75% of mandatory education and training activities.	9/15/2018

Clinical Decision Support:
Example Graphical User Interface

NYU School of Medicine
NYU LANGONE MEDICAL CENTER

Usability Testing: ED Process Map
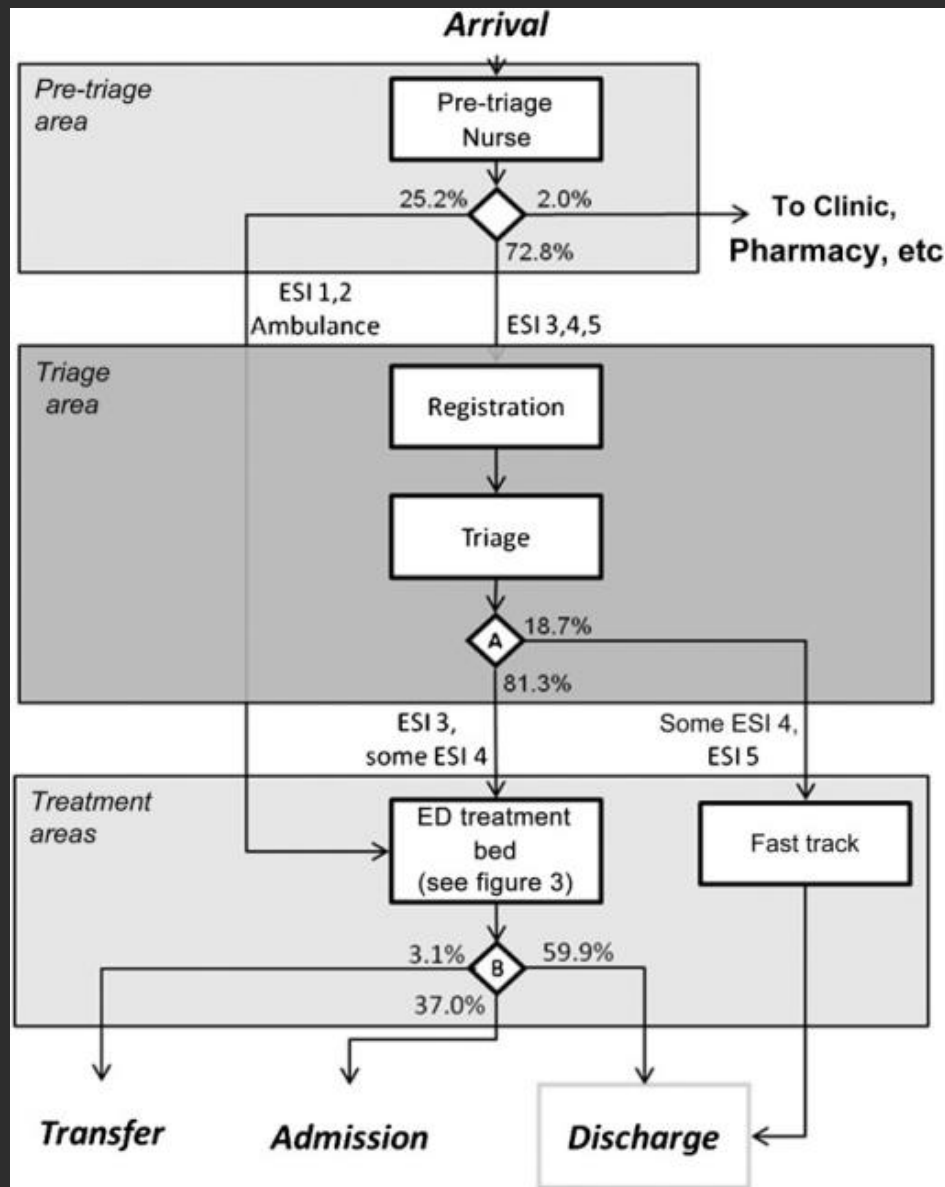
Data Collection Milestones

Develop, test, and finalize data collection procedures

Tracking education and training activities	B.1.b.i. Develop tracking and reminder system in learning management system for educational and training activities.	8/1/2018
	B.1.b.ii. Test tracking and reminder system in learning management system to ensure threshold reached.	9/15/2018
	B.1.b.iii. Finalize tracking and reminder system to achieve an average of at least 75% completion of assigned activities across all eligible providers at pilot sites.	11/15/2018
Fidelity of EM Talk	B.1.c.i. Develop and test procedures for monitoring fidelity of EM Talk curriculum.	8/15/2018
	B.1.c.ii. Refine training until $\geq$ 80% fidelity of EM Talk curriculum at the trainer (adherence to training curriculum, including cases presented and remediation plan) and participant level (demonstrate acquisition of skills, including empathic statements and attending to emotion).	10/15/2018
Primary and secondary endpoints	Finalize primary and pre-specified secondary endpoints with guidance from NIH Collaboratory Design and Biostatistics workgroup.	7/15/2018
Medicare claims	B.3.a. Approval for use of Medicare claims data provided by the Centers for Medicare and Medicaid Services.	11/1/2018
	B.3.b. Develop code for cleaning and analysis of Medicare claims data based on final version of primary and secondary endpoints.	12/15/2018

Barriers Scorecard

Barrier	Level of Difficulty*				
	1	2	3	4	5
Enrollment and engagement of patients/ subjects		X			
Engagement of clinicians and health systems				X	
Data collection and merging datasets		X			
Regulatory issues (IRBs and consent)		X			
Stability of control intervention	X				
Implementing/delivering intervention across healthcare organizations				X	

Data Sharing Plan

Make readily available to qualified researchers, health care delivery organizations, research institutions, and government health care systems:

New clinical workflows

Data analysis codes

Study Protocols

De-identified study dataset

Data Sharing Obstacles

Use of Virtual Research Data Center (VRDC) to analyze Medicare Claims data

Conflicting federal, state and city policies

Proprietary information (Vital Talk)

Protection of Human Subjects

SINGLE IRB

Institutional capacity and cost

PATIENTS

Waiver of informed consent HIPAA authorization as minimal risk and >300,000 patient participants

PROVIDERS

Potentially sensitive provider-level performance data

African proverb

If you want to go fast, go alone.

If you want to go far, go together.