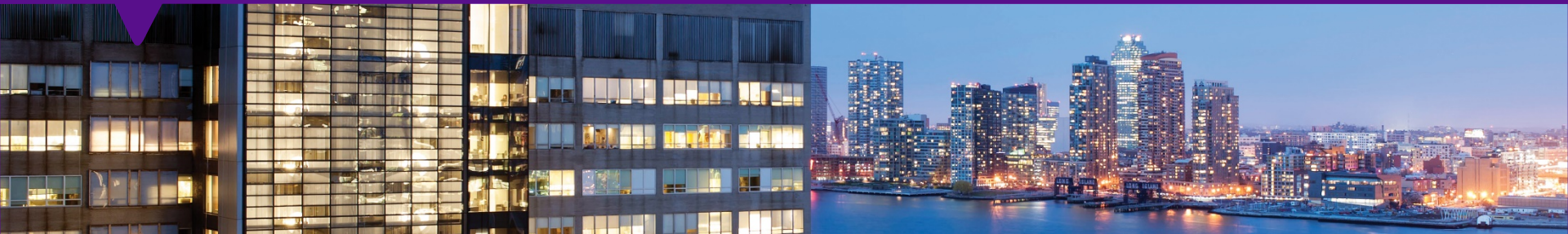




Ronald O. Perelman Department of  
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# ADOPTION OF PRIMARY PALLIATIVE CARE FOR EMERGENCY MEDICINE (PRIM-ER) : A MIXED-METHODS STUDY USING RE-AIM

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# Disclosure

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# Emergency Care

- Window to population health
- Research agenda to end disparities and address the needs of society's most vulnerable



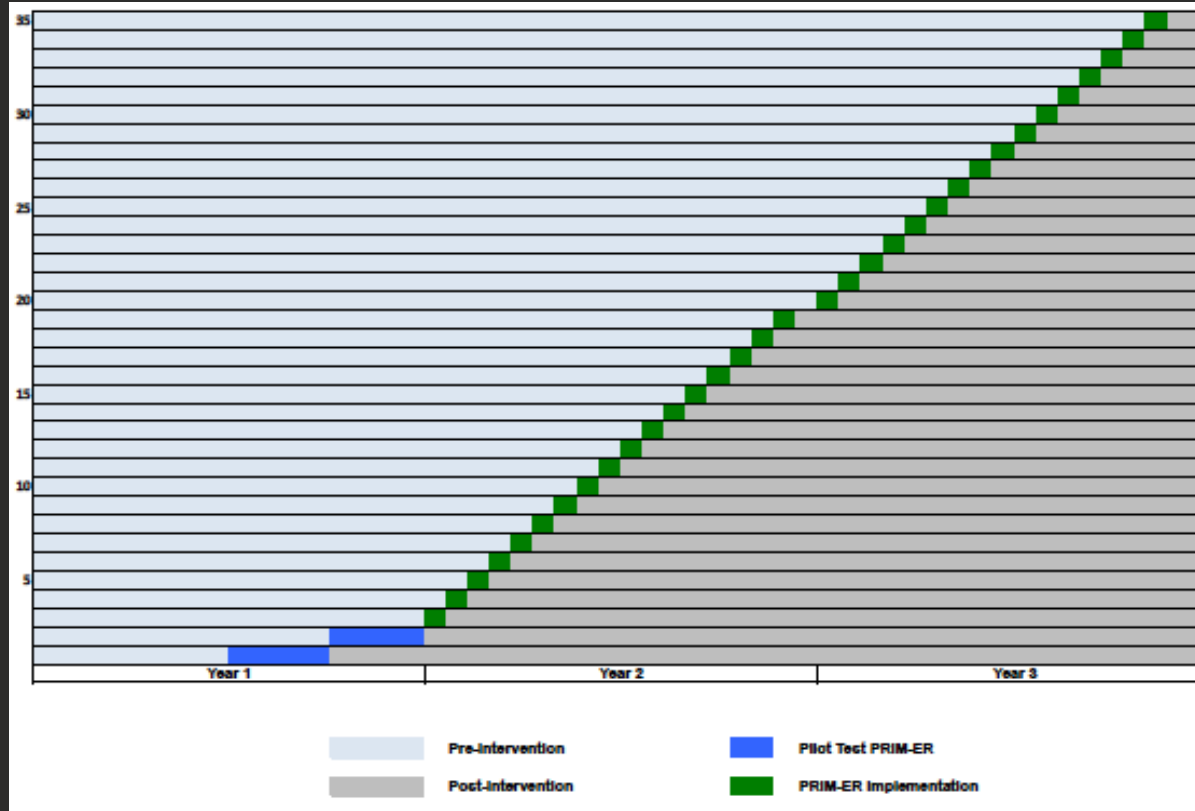
## Background

- 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

# Overall Primary Palliative Care for Emergency Medicine (PRIM-ER) Study Design<sup>1</sup>

- Pragmatic, cluster-randomized stepped wedge design to test the effectiveness of primary palliative care education, training, and technical support in 35 EDs
- Measure the effect using Medicare claims data on:
  - ED disposition to an acute care setting
  - Healthcare utilization 6 months following the index ED visit
  - Survival following the index ED visit

# Cluster Randomized, Stepped Wedge Trial @ 35 EDs



# PRIM-ER Intervention Components

1. Evidence-based, multidisciplinary primary palliative care education
  - a. Education in Palliative and End-of-life Care (EPEC-EM)
  - b. End-of-Life Nursing Education Consortium (ELNEC)
2. Simulation-based workshops on communication in serious illness (EM Talk);
3. Clinical decision support (CDS); and
4. Provider audit and feedback.



# PILOT COMPLETED: HOW DID THEY DO IT?



# METHODS/RATIONALE

# Analysis using RE-AIM Theory<sup>8</sup>

R- Reach

E- Effectiveness

**A- Adoption**

I- Implementation

M- Maintenance

# Filling a gap in RE-AIM

- Few studies use qualitative research to explain “how” and “why” results happened<sup>2,3</sup>
- Lack of reporting on adoption data<sup>2,4,5,6</sup>
- Need for greater understanding of the contextual factors that influence staff and setting adoption of interventions such as organizational climate<sup>4</sup>

## Mixed methods approach

- Quantitative data
  - Intervention completion (targets/outcomes)
  - Provider Attitudes and Knowledge Survey at baseline<sup>7</sup>
- Qualitative data
  - 6 interviews representing stakeholders from each site
  - Deductive and inductive coding to identify themes
  - Atlas.ti for data management

# RESULTS

# Site characteristics

	Location	Inpatient Beds	Admissions	ED Visits	Full-time Emergency Providers	Full-time Emergency Nurses
Site 1	New York-Northern New Jersey Metropolitan Statistical area	531	14,017	84,880	28	89
Site 2	New York-Northern New Jersey Metropolitan Statistical area	1099	14,531	80,045	59	108

# Quantitative results: Education adoption

## Intervention Adoption

	EM Talk No. Providers Trained (%)	ELNEC No. Nurses Trained(%)
Site 1	22 (79%)	70 (79%)
Site 2	54 (92%)	91 (84%)



## Qualitative results

1. Institutional leadership support
2. Established quality improvement (QI) processes



# Institutional leadership support

*“If you don’t have leadership support, forget about it.”*  
(Site 1 Physician Champion)

# Institutional leadership support

- a) Mandate attendance for educational components
- b) Substitute for faculty development
- c) Provide protected time for CDS development

# Institutional leadership support

Ex: Mandatory attendance for EM Talk

*“Our chairman was like, “If you are off, you are coming. This isn’t an ‘Oh, maybe, yay’ activity. This is: We have a grant. You’re coming.””* (Site 1 Principal Investigator)

## Qualitative results

1. Institutional leadership support
- 2. Established quality improvement (QI) processes**

# Established QI processes

- a) Cross-disciplinary communication
- b) Data auditing/performance feedback

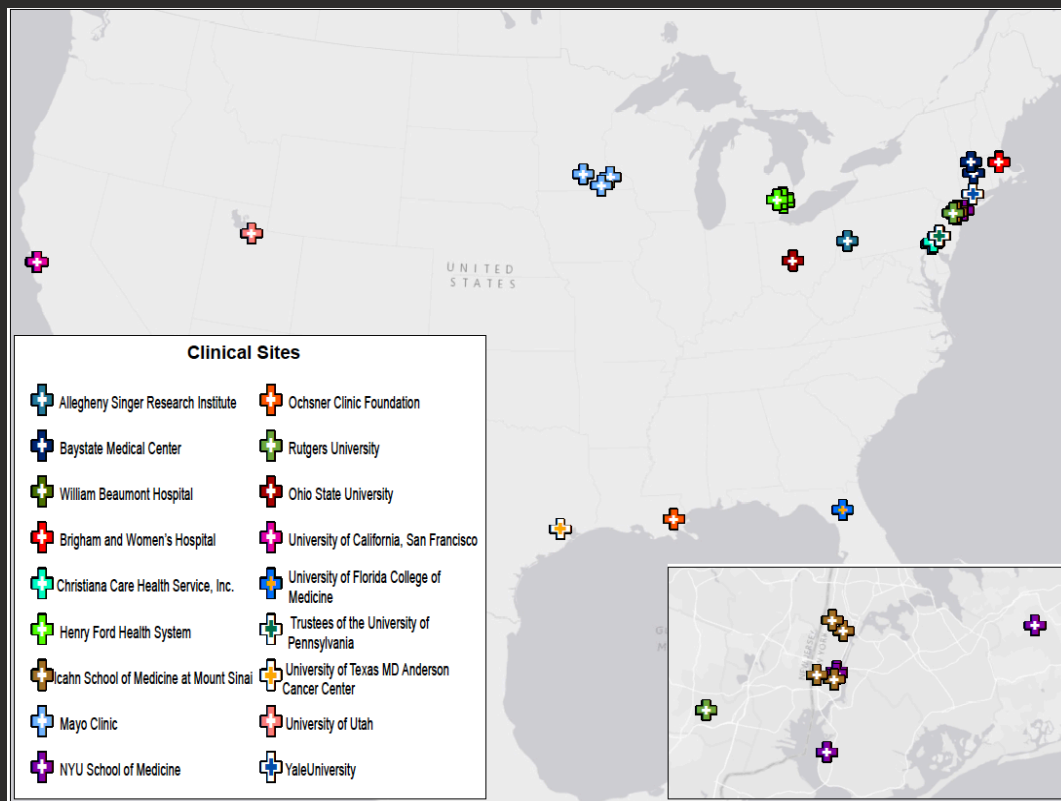
# Established QI processes

Ex: Data auditing/performance feedback

*“We really track our issues on a white board right outside the ED [...] It's very front and center. We give a lot of personalized feedback to our attendings.”* (Site 2 Principal Investigator)

# D&I IMPLICATIONS

# 35 EDs, 18 Health Systems





# Conclusions

1. Mandate training sessions
2. Schedule PRIM-ER education into dedicated faculty development time
3. Provide protected time for PRIM-ER trainings and CDS development
4. Build on existing QI processes to enhance cross-disciplinary communication and CDS integration



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# References

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# THANK YOU!

Questions?

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