PartnerED Care: Coordinated Emergency Department Transitions for Assisted Living Patients With Alzheimer's Disease and Related Dementias

NCT06933849

September 1, 2023

BACKGROUND

For over 800,000 older adults in the US, assisted living communities (ALCs) serve as substitutes for nursing homes.[1] Over time, ALC residents have become increasingly medically complex, with higher rates of comorbidities and cognitive impairment.[2] Over 80% of ALC residents have three or more comorbidities and rates of heart failure, diabetes, and COPD similar to long-stay nursing home (NH) residents.[1] Though there is significant variability across geography and corporations, ALCs are generally staffed 24 hours a day and provide room, board, structured activities and basic IADL/ADL support.[3] Clinical services are delivered by external provider groups, with several groups serving each ALC.

The emergency department has become a key resource for this population, with 49% of ALC residents visiting the emergency department (ED) at least once each year.[4] With each transition in care, including from ALC-ED, there is increased risk of duplicative testing, delays in care, and avoidable hospitalizations due to incomplete or inaccurate information during transfer.[5] These care transitions are particularly fraught for vulnerable patient populations, particularly those living with dementia.[6] Due in part to greater complexity of chronic diseases and fractured care, residents of ALCs commonly experience higher rates of ED utilization, longer stays in the ED, and higher resource utilization within the ED than older adults not living in ALCs or long-term care facilities.[7,8] For these older adults, increased ED and hospital utilization is consistently associated with adverse outcomes including delirium, falls, and accelerated cognitive and functional decline.[9-11]

Previous care transition interventions have included staff education to prevent ED visits, standardized communication tools, computer-based networks, and home visits after ED discharge.[12-15] One such intervention is the Intervention to Reduce Hospitalization from Nursing Homes (INTERACT), a widely accepted and studied quality improvement tool for nursing home (NH)-ED transitions, that has been demonstrated to decrease all-cause hospitalizations by up to 24%.[16] INTERACT is a complex intervention that includes multiple components including educational and clinical strategies to improve NH to ED transfers. Despite its complexity, it has been successfully implemented in a variety of nursing homes.[17-19] However, similar programs have yet to be implemented for ALC-ED transfers.

PartnerED care, a pragmatic care coordination intervention for ALC residents with dementia was adapted from the NH-ED structured communication component of INTERACT to support standardized, closed-loop communication between the ALC outpatient team and ED provider.[7,8] Through improved communication at the time of ALC to ED transfer, PartnerED care aims to reduce hospitalizations within ALC residents. PartnerED care creates a structure in which acute care managers (ACM) will be notified electronically when a resident registers at an ED and will provide key information through a standardized form over the phone regarding the patient and available outpatient resources to the ED clinician. In the proposed embedded pragmatic clinical trial pilot, we will evaluate the feasibility of implementing PartnerED care for patients served by Bluestone Physician Services (Bluestone). We will evaluate feasibility, appropriateness, acceptability, and adherence through qualitative interviews with practitioners and key stakeholders, quantitative surveys using validated tools, and key adherence metrics, These metrics will be captured through a user-defined assessment (UDA) within Bluestone's EMR and will include timing and number of phone calls placed by ACM, type of ED staff contacted, and the ultimate disposition. Further, we will assess our ability to obtain EMR- and claims-based patient-centered outcomes for a future ePCT.

SIGNIFICANCE

The PartnerED intervention is innovative, and aligns with the IMPACT Collaboratory priorities, in the following three ways:

1. Leveraging technology - Uses real-time nudges (electronic notifications sent directly to ACM) to trigger intervention.
2. IMPACT priority setting (ED) - Modify best practice ED tool for NHs to the ALC setting, an underserved sector of the IMPACT portfolio
3. IMPACT established Launchpad partner - Bluestone-driven initiative emerging from a Collaboratory Launchpad partnership, including leveraging data from MEDRIC

RESEARCH DESIGN AND METHODS

The goal of this study is to pilot a care coordination intervention in approximately 300 EDs for 5,500 patients living in approximately 240 ALCs in Florida (FL), Wisconsin (WI), and Minnesota (MN). The population for this pilot will not be randomized. All Bluestone ACO patients with ADRD who have an ED visit during the enrollment window will be included in the analyses. The intervention will only be offered Monday through Friday, between 8 am and 4 pm. Feasibility, appropriateness, and acceptability will be assessed quantitatively and qualitatively. Qualitative, semi-structured interviews will be conducted with four Bluestone ACMs, four Bluestone physicians, four ALC staff, and four ED providers involved in the pilot, to understand barriers and facilitators to implementing the PartnerED program. Feasibility, appropriateness, and acceptability will be assessed quantitatively by surveying all Bluestone ACMs and physicians involved in the program using the Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and Feasibility of Intervention Measure.[20,21]

The primary clinical outcome will be the proportion of ED visits that result in hospital admissions based on documentation in the Bluestone EMR. Secondary clinical outcomes include proportion of ED visits that result in hospital admissions, length of ED stay in hours by hospital, proportion of eligible ED visits with an ED return visit within 72 hours, and proportion of eligible ED visits with a subsequent hospitalization in the following 60 days based on CMS claims data. Preliminary outcome analyses will compare Bluestone ACO residents with ADRD (intervention) to Bluestone's non-ACO, fee-for-service Medicare patients with ADRD, which is approximately equal in size of the ACO population.

Setting (Sites/Heath Care Systems)

Bluestone delivers 500-600 provider visits per day for over 15,000 patients in ALCs across three states (MN, WI, FL). Approximately 70% of the patients they serve have a dementia diagnosis. Approximately 30% of Bluestone's patients qualify for Medicaid and over 90% are enrolled in Medicare FFS or Medicare Advantage. Bluestone manages its own Medicare (MSSP) Accountable Care Organization, Bluestone ACO, which currently enrolls approximately 5,500 patients. Bluestone has experienced significant growth in patient census, averaging growth of 8% year over year for the past 4 years.

Study population

Table 1. Characteristics of Bluestone's ALC residents

Age, mean	81
Female, %	70
White, not Hispanic, %	81
Black, not Hispanic, %	3.6
Hispanic, %	3.0
Dementia, %	69
Diabetes, %	31
Chronic Obstructive Pulmonary Disease (COPD), %	18
Heart failure, %	37

Table 1 shows the demographic and health characteristics of Bluestone patients. They are on average 81 years old, 70% female, and 69% have ADRD. Approximately 35% of ED visits for this population result in hospital admission. In 2022, 7,272 ED visits by Bluestone ACO patients were attributed to its 65,886 total member months for this population, or 1.3 ED visits/patient year. Of these ED visits, 49% were for ALC residents in Florida, 35% in Minnesota, and 15% in Wisconsin. Bluestone residents have other comorbid conditions that increase risk of hospitalization including 31% with diabetes; 18% with chronic obstructive pulmonary disease (COPD); and 37% with heart failure. Based on previous research done within Bluestone's ADRD population, the racial and ethnic composition is different from national averages (81% white, not-Hispanic compared to 91%). However, we expect this to be more similar once we can fill in missing race/ethnicity data (14% of sample) from the linked claims data that will be available through MedRIC.

During the six-month pilot intervention window, we anticipate approximately 2,500 daytime ED visits excluding weekends by Bluestone ACO patients. Based on the prevalence of ADRD and the racial and ethnic composition of Bluestone ACO patients, we expect a sample size of 1750 ED visits for Bluestone ACO patients with ADRD and 130 ED visits for patients identified as a racial or ethnic minority (i.e. not white, non-Hispanic).

Intervention structure, implementation protocol, and fidelity/adherence monitoring plan

To develop PartnerED, we adapted standardized communication tools used for acute care visits by long stay residents from INTERACT, a QI intervention to reduce hospitalizations, using the FRAME framework.[16,22,23] These proactive modifications were made based on discussions between researchers and Bluestone (including clinical providers, administrative leadership, and the data team). Modifications were made largely

due to differences in the context of delivery of the intervention. Specifically, we have created a script adapted from the INTERACT version 4.5 Hospital transfer form, data list, and checklist that includes key clinical information (**Table 2**) and patient services available as next day primary care appointment and immediate behavioral health referral.

Table 2: Key patient information shared with ED
Reason for transfer
Recent critical values (vital signs, lab values)
Advance directive: code status/"what matters most"
Baseline ADLs
Mobility and Walking Baseline
Baseline cognitive function
Emergency contacts
Previous hospitalizations and ER visits
Medical problem list
Medication list
Current housing situation
Care plan from PCP
Care plan from Behavioral health team (if present)
PCP contact information

Of note, INTERACT is a multicomponent intervention designed to be implemented by nursing home staff.[16,23] PartnerED utilizes the standardized communication script alone. By excluding key educational and clinical pathway elements, the fidelity to INTERACT is unknown. However, there is a robust literature supporting the use of standardized communication with care transitions.[24]

This intervention leverages several unique features of the Bluestone's EMR system including an electronic notification system for ED registration, Bridge ADT message and email, and existing case management staff (acute care managers - ACMs), who can implement the intervention. For this pilot, ACMs employed by Bluestone will monitor emails and Bridge messages for notification of ED registration by study participants. Once notified that a patient is in the ED, ACMs will complete a chart review within the Bluestone EMR. The ACM will then call within 60 minutes of ED registration during business hours (8:00AM - 4:00PM) and relay clinical information related for expedited assessment to the ED clinical team.

Bluestone will build a user-defined assessment (UDA) within their EMR to capture important adherence and outcome information, including ACM call within one hour of ED registration; successful contact by ACM with an ED provider; ED disposition, type of ED staff contacted, and primary care team updated. This UDA will be utilized by ACMs to track pilot participants and document implementation outcomes. These data will be sent to Brown weekly for adherence monitoring. Specifics for the chart review including locations of key information for patients, scripts for communication with the ED, and documentation guidelines will be written to policy and procedure templates and shared with ACM staff via training modules.

Data Sources, Elements, and Collection Protocol

Bluestone EMR and MedRIC: Patient identification (aim 1), Adherence metrics (aim 2b), and Clinical outcomes (aim 3)

Bluestone is unique among ALC provider groups in that it has an integrated EMR. Bluestone's self-hosted EMR data contains detailed information on patient demographics, physical and cognitive function, active condition lists (including dementia diagnoses), medication administration records, documentation of advance directives and hospice use, and other medical orders. As a part of this pilot project, a UDA will be developed and utilized for all patients participating. ACMs will track adherence metrics within the UDA (Table 3).

Table 3: Data elements from Bluestone EMR

Bluestone EMR via MedRIC			CMS Claims via MedRIC
Resident identifiers from EMR	**Adherence metrics from UDA**	**Primary Outcome from UDA**	**Outcomes from CMS claims**
ALC identifiers	Time to ACM call after ED registration	ED disposition*	ED disposition*
Active diagnosis codes (ICD-10)	ACM successfully contacted ED provider		Length of ED stay (hours)
Functional and cognitive status assessments	Type ED staff contacted		72-hour ED return visit
Physician orders (treatments, diagnostic tests, etc.)	ED disposition		60-day subsequent hospitalization
Medication orders	Primary care team updated		
Advance directives / code status (full code, DNR, DNH, DNI)			

*ED discharge, observation stay, inpatient stay

As a NIA IMPACT Launchpad partner, Bluestone will send their complete EMR record, including UDA data, to MedRIC - the Medicare and Medicaid Resource Information Center (MedRIC) on a weekly basis. Brown analysts will use these data for routine monitoring of adherence and evaluation of outcomes. Claims data will also be collected via MedRIC during the study period. Rather than request CMS data through the typical process, which is prohibitive to this pilot structure given its cost and months-long approval process, NIA has arranged a program whereby NIA

funded studies that would like to merge their study data to CMS data can do so through this new program and use their linked data on MedRIC's secure enclave. There is no cost, the application process is relatively quick, and data are available with the same lag time as is available through CMS directly. To our further benefit, we will leverage the experience that Bluestone and Dr. McCreedy (co-I) have already gained from successfully setting up another project under this program. That study uses the same linked data that will be needed for this study. We are cognizant of the limitations of using CMS data to measure our outcomes. For example, all enrolled residents have fee-for-service Medicare claims and we anticipate a six month delay in ascertainment of claims for this population. See TIMELINE for details.

For this pilot, we will measure our primary outcome (proportion of ED visits for Bluestone patients in a given hospital which result in inpatient hospitalization) based on ED disposition as tracked by the ACM within the UDA. This method is limited because the data may be missing or misreported. However, because of the four to six month lag in claims data and the need to complete the pilot within the one year timeframe, we will use this method as the primary outcome measure. However, we will also be able to obtain the outcomes (primary and secondary) for patients enrolled in months four and five. Success criteria: (1) obtaining ED disposition from the UDA for 85% of patients enrolled in the pilot and (2) obtaining ED disposition from CMS claims for 95% of the subsample enrolled in months four and five of the pilot.

Quantitative: feasibility, appropriateness, and acceptability (aim 2a)
Feasibility and acceptability will be assessed quantitatively using the Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and the Feasibility of Intervention Measure (FIM).[21] AIM, IAM and FIM are four item measures of implementation success that were specifically designed to be pragmatic and have demonstrated strong psychometric properties including content validity, discriminant content validity, reliability, structural validity, structural invariance, known-groups validity, and responsiveness to change.[20] Each measure has four items with a response scale from completely disagree (1) to strongly agree (5). The scale is created by averaging responses. This will be done separately for the AIM, IAM, and FIM.

We will administer a survey to all Bluestone ACMs and Bluestone physicians involved in this pilot study. We will ask for responses with regard to the Bluestone ACO population with ADRD as well as for the Bluestone ACO population with ADRD when considering health-equity-relevant features including race, ethnicity, and socioeconomic status.

Qualitative: feasibility, appropriateness, and acceptability (aim 2a)
Semi-structured interviews will be completed with four Bluestone ACMs, four Bluestone providers, four ALC staff, and four ED providers. We will make every effort to recruit participants that represent the backgrounds of the people delivering and receiving the intervention.

Bluestone ACM Recruitment: We will ask Bluestone leadership to nominate four Bluestone ACMs to participate in semi-structured interviews. The research assistant will contact the ACMs recommended by corporate leadership, explain the study, and provide an opt-out for participation.

Bluestone Provider Recruitment: We will ask Bluestone leadership to nominate four Bluestone providers representative of the people delivering intervention to participate in semi-structured interviews. The research assistant will contact the providers recommended by corporate leadership, explain the study, and provide an opt-out for participation.

ALC Staff Recruitment: We will use the baseline EMR data to identify four ALCs (one for each staff member interviewed) with varying numbers of residents with dementia and numbers of residents who identify as a racial or ethnic minority. Bluestone leadership and/or the physician working in the ALC will approach the director to ask if s/he would participate in an interview. The director will nominate a member of the direct care staff for an interview.

ED Provider Recruitment: We will reach out to leadership teams of EDs (across the three states represented) that have a catchment area that is representative of people participating in the intervention. If ED leadership agrees, the research assistant will contact the providers recommended by ED leadership, explain the study, and provide an opt-out for participation.

Data Collection. We will develop semi-structured interview guides which align with our study objectives, to include exploration of: (1) the process for Partner ED, including process for communicating with EDs by ACMs; (2) impressions of Partner ED intervention and its impact on patient care; (3) challenges with communicating with the ED; (4) impact of health-equity-relevant features of patient population served including race, ethnicity, and socioeconomic status. Our approach will be guided by the Practical Robust Implementation and Sustainability Model (PRISM) framework.[25] The PRISM includes perspectives of different types of stakeholders to first understand their experiences while considering factors related to the external environment and infrastructure needed for implementation and sustainability. Drafts of interview guides will be reviewed by the entire team and discussed via phone conference. The final interview guide will be pilot tested to identify unclear questions and to ensure each interview does not exceed the allotted 30 minutes for direct care staff. Interviews will be digitally recorded with consent and transcribed verbatim. The IRB determined this does not meet the criteria for human subject research, as we are asking ACMs, Bluestone and ED physicians and ALC staff about their work processes and their perceptions of these processes (key informant interviews).

Analytic plan.

We will demonstrate the feasibility of identifying and enrolling ALC residents with ADRD (N=1750 ED visits anticipated) in real time using a pragmatic approach.

ALC residents with ADRD will be identified pragmatically using the Bluestone EMR. We will obtain EMR data for all Bluestone ACO patients with an ED visit during the study period. Patients will be identified as having a diagnosis of ADRD using the following ICD10 codes commonly used (primary identification strategy): F01.50-51; F02.80-81; F03.90-91; F04; F05; F06.1; F06.8; G13.8; G30.0,1,8,9; G31.01,9; F02.80-81, F03.90-91; F04; F05; F06.1; F06.8; F41.81; G13.8; G30.0; G30.1,8,9; G31.01,09; G31.1-2; G31.2; G94; R54.[26]

We will also assess the validity of our ADRD identification strategy by conducting a random medical record review (N=50) of two percent of patients, stratifying based on the expected 70% prevalence of ADRD within our population. We will review patients identified as having ADRD (N=35) and flagged as not having ADRD (N=15) by ICD10 codes. We will report error rate, positive predictive value, and negative predictive value.

Benchmark of success: We will consider this aim completed once we have identified patients with ADRD with our primary identification strategy, conducted a medical record review, and calculated the error rate, PPV and NPV based on this review. These data will be shared with Bluestone in the form of written reports and the broader public through publications and conference presentations.

Aim 2a. We will determine the feasibility, appropriateness and acceptability of implementing the PartnerED intervention for ALC residents with ADRD.

Quantitative: For the AIM, IAM, and FIM, no specific cut-off scores have been published. A higher score is associated with great acceptability, appropriateness, and feasibility, respectively. We have defined success criteria as: 85% or greater proportion of respondents with a total score of four or higher indicating “agreement” or “complete agreement” with items on the AIM, IAM, and FIM.

Qualitative: Interviews will be coded to predetermined (objective driven) and data generated themes.[27] We will have weekly meetings to revise objective themes and consider additional emerging themes. Potential changes to interview guide or other data collection tools will also be discussed. All transcripts will be independently coded by two team members. Initial code definitions will be modified based on team discussions and additional themes will be added based on consensus vote. An audit trail will capture all changes to the coding scheme, to include: the date the change was made, the reason for the change, the new or revised code definition, and two data examples that would be coded under the new or modified theme. NVivo (QSR International, Melbourne, Australia) will be used for data management of coded transcripts.[28] Qualitative results will be presented by theme and strata.

Benchmark of success: We will consider this aim completed once we have conducted interviews for all targeted participants (N=16), transcribed the interviews, performed a thematic analysis, and quantified AIM, IAM, and FIM for the Bluestone ACO population as well as when considering health-equity-relevant features. These data will be shared with Bluestone in the form of written reports and the broader public through publications and conference presentations.

Aim 2b) We will determine adherence when implementing the PartnerED intervention for ALC residents with ADRD.
Implementation adherence will be evaluated overall (among all patients with ADRD) and in a prespecified, minoritized subpopulation.

The purpose of this pilot is to demonstrate adherence for implementation outcomes with a goal of (1) 85% ED visits with an ACM call within one hour; (2) 70% ED visits with successful contact by ACM with an ED provider; and (3) 90% of patient visits have key metrics recorded by the ACM in the EMR (ED disposition, type of ED staff contacted, primary care team updated). We will test each of these three outcomes independently. Adjusting for multiple comparisons, we want alpha 0.015 (0.05/3) and beta 0.2. With an anticipated sample size of 1750, we anticipate having the power to test these three adherence outcomes. We will also anticipate having the power to do a secondary analysis examining adherence outcomes among the residents who are a racial or ethnic minority (i.e. are not white, non-Hispanic) (expected N=130 ED visits).

Benchmark of success: We will consider this aim completed once we collected key adherence outcomes and established if the pilot was successful based on prespecified go no-go criteria. These data will be shared with Bluestone in the form of written reports and the broader public through publications and conference presentations.

Aim 3a: We will demonstrate the feasibility of assessing clinical outcomes using pragmatic methods among ALC residents with ADRD.
The primary clinical outcome will be the proportion of eligible ED visits that result in an inpatient admission identified by ACMs and documented in the UDA. As mentioned above, given the anticipated six month lag in CMS claims data, the primary and secondary clinical outcomes including length of ED stay, 72-hour return visit to the ED, and 60-day rehospitalization will be obtained from the MedRIC enclave.

Benchmark of success: We will consider this aim completed once we have obtained ED disposition (primary outcome) for all pilot participants based on the Bluestone UDA and ED disposition from the UDA (primary outcome) and all primary and secondary outcomes from the CMS claims for participants enrolled in months two to six of the study period. These data will be shared with Bluestone in the form of written reports and the broader public through publications and conference presentations.

Exploratory analysis) We will perform an exploratory analysis assessing the effect of the PartnerED intervention on the primary outcome
We will conduct a matched cohort design to analyze the proportion of ED visits resulting in hospital admission among Bluestone ACO patients with ADRD receiving PartnerED compared to Bluestone FFS patients with ADRD who did not receive PartnerED during the study window. Will perform a patient-level analysis with ACO and FFS (non-ACO) patients (matched on functional and cognitive impairment, age, sex, and comorbidities) that accounts for facility-level effects. Although this analysis is limited due to possible spillover effects as both groups will be seen in the same EDs, this exploratory analysis could further clarify the effect of PartnerED on hospitalization.

MILESTONES

This project has a 12-month timeline. To ensure the project milestones are reached, we will work in parallel for each aim (**Table 3**).

Table 3: PartnerED milestones

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Aim 1												
IRB approval	X	X										
Identification Bluestone ACO patients with ADRD within the EMR using ICD10 codes			X	X								
Validation of ADRD identification strategy with random medical record review (N=50)			X	X								
Aim 2a: qualitative												
Identification of 4 ACMs, 4 Bluestone physicians, 4 ALC staff, and 4 ED staff for interviews			X	X								
Finalize interview guides			X	X								
Conduct and transcribe interviews of key stakeholders (N=16)					X	X						
Identify key themes for faciliators and barriers							X	X	X			
Aim 2a: quantitative												
Conduct survey capturing FIM, IAM, AIM for Bluestone ACMs and physicians							X	X				
Descriptive analysis of FIM, IAM, and AIM									X	X		
Aim 2b												
Finalize intervention materials (policy, procedures, training guides)	X	X										
Implement intervention within ACO population			X	X	X	X	X	X				
Collection of implementation adherence outcomes			X	X	X	X	X	X	X			
Analyze implementation adherence metrics										X	X	
Aim 3												
EMR data transfer including primary outcome*			X	X	X	X	X	X	X			
CMS data transfer									X	X	X	X
Analyze feasibility of outcome identification											X	X
Dissemination of results												
Present results at a national conference											X	X
Publication of results											X	X

* Follow-up time for length of ED stay, 72-hour return visit to the ED, and 30 day rehospitalization (secondary outcomes)

Aim 1: Months 1-2, we will seek institutional review board (IRB) approval for both Aims, including a waiver of consent for embedding and implementing PartnerED. In **Months 3-4**, we will identify Bluestone ACO patients with ADRD within the EMR using ICD10 codes. We will then validate this identification strategy with a random medical review.

Aim 2a: Months 3-4, we will identify key stakeholders (ACMs, Bluestone physicians, ALC staff, and ED staff) for qualitative interviews. **Months 3-4**, we will finalize interview guides. **Months 5-6**, we will conduct and transcribe semi-structured interviews. **Months 7-9,** Interviews will be analyzed for key themes. **Months 7-8**, we

will conduct surveys of Bluestone physicians and ACMs involved in PartnerED to capture AIM, IAM, and FIM and descriptive analyses will be performed **Months 9-10**.

Aim 2b: Month 1-2, we will finalize intervention materials. **Months 3-8**, we will implement PartnerED for the Bluestone ACO population. **Months 3-9**, we will collect adherence metrics in near real-time with data transfers from Bluestone EMR to MedRIC. **Months 10-11**, we will perform analysis on implementation adherence metrics.

Aim 3: Months 3-9, we will collect the primary outcome, proportion of ED visits in a given hospital which result in hospital admissions, based on UDA in near real-time with data transfers from Bluestone EMR via MedRIC. **Months 9-12**, given the anticipated 6-month delay in CMS claims data via MedRIC, we will collect the primary outcome and secondary outcomes, of note proportion of eligible ED visits in a given hospital with a subsequent hospitalization in the following 60 days will require an additional two month delay for data to mature. **Months 10-12**, we will assess feasibility of collecting outcome data based on what we have obtained from the Bluestone EMR and CMS.

Dissemination of results

We will publish the ADRD identification strategy (aim 1), thematic analysis of semi-structured interview (2a) and survey results (2b) during the study period. Given the time lag, we will need to publish clinical outcome results and exploratory analysis (aim 3) after the study period. For major findings and program description manuscripts, we will target general medicine, specialty aging, emergency medicine national conferences and journals such as JAMA, The Journal of the American Geriatrics Society, The Journal of the American Medical Directors Association, The Gerontologist, and The Annals of Emergency Medicine.

FUTURE DIRECTIONS AND NEXT STEPS

If proven feasible and acceptable, this pilot study will directly inform the development of a full-scale, Stage IV effectiveness ePCT of the Partner ED intervention. This pilot encompasses only a subset of Bluestone patients and only is being performed during weekdays 8a-4p. If able to prove this intervention to be feasible, it could be expanded to the full Bluestone fee-for-service (FFS) population. It could also serve as a catalyst for funding expansion of case management resources for weekend and evening coverage. The goal would be to apply for funding as a Demonstration Project through the IMPACT Collaboratory or equivalent mechanism.