According to the Health Care Advisory Board, intensive care management for the highest risk chronically ill population presents the greatest opportunity to improve quality and lower costs in a shared savings environment. The needs of the top 1-2% of these patients often outstrip the resources typically found in a primary care office. Due to multiple comorbidities, these patients usually have multiple providers with multiple care plans and no coordination between providers. This leads to adverse patient outcomes and avoidable healthcare utilization. Although geriatricians are specially trained in the interdisciplinary care management approach to coordinate the care of the highest risk elderly, patients in greatest need of interdisciplinary care management are generally referred to a geriatrician only as a consult. This diminishes the ability of geriatrics to impact primary care decisions. Since research has shown that the best outcomes are obtained when interdisciplinary teams not only make care recommendations, but are also responsible for ensuring their implementation, we have implemented a high risk clinic that blends geriatrics and primary care in an interdisciplinary team environment. Our clinic follows the Healthcare Advisory Board's recommendations to connect care that has traditionally existed in silos. Instead of deploying care managers to multiple PCPs, our model refers patients to a central primary care clinic with geriatrics and interdisciplinary team oversight. At the clinic, patients receive a comprehensive biopsychosocial assessment and an interdisciplinary team generates a care plan that is aligned with patient goals. The care plan is shared with all providers using a common EMR. Continuity of care is assured by ongoing care management, frequent follow up and close attention to transitions in care. Outcomes we will track include: avoidable healthcare utilization, length of stay during hospitalizations, completion of advance care planning, patient/caregiver satisfaction and medication appropriateness. The proposed project seeks to ramp-up enrollment to reach all of the potential 200-250 high risk patients within our ACO. Participation in the Practice Change Leaders program will strengthen the applicant's skills regarding developing a business case for the clinic model, building partnerships across service lines and managing conflict to expedite the ramp-up process. Through this process we hope to establish a collaborative process with the ACO for advancing new geriatric models of care that contribute to shared savings and consistently lead to participation from affiliated providers.