Dissemination of Models of Geriatric Care: Facilitators and Barriers

Bruce Leff, MD
Associate Professor of Medicine
Johns Hopkins University Schools of Medicine and Public Health

Institute of Medicine Committee on the Future Health Care Workforce for Older Americans

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Let's Think About…

1. A popular dissemination framework

2. Several geriatric models of care that are working on dissemination activities

3. These models as case studies to describe facilitators and barriers to dissemination

4. How to move ahead

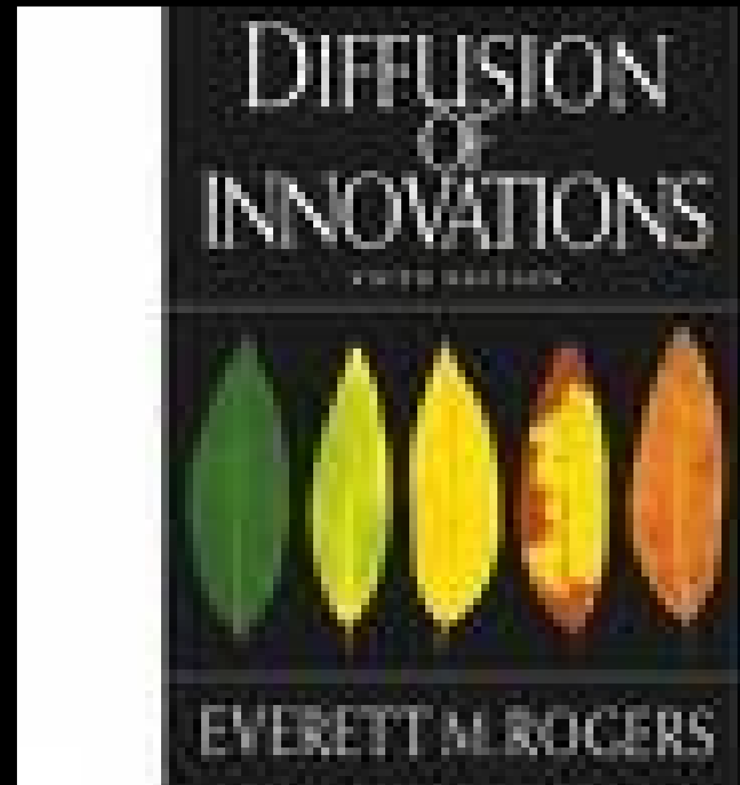
Dissemination Theory

3 Clusters of Influence:

1. Perceptions of the innovation

2. Characteristics of adopters of an innovation

3. Contextual factors: organizational



Rogers EM, Diffusion of Innovations

Dissemination Theory – Perceptions of The Innovation

A. **Relative advantage** – how much better would the innovation be compared with current practice?

B. **Compatibility** – will the innovation fit with values, beliefs, needs, culture of the adopter?

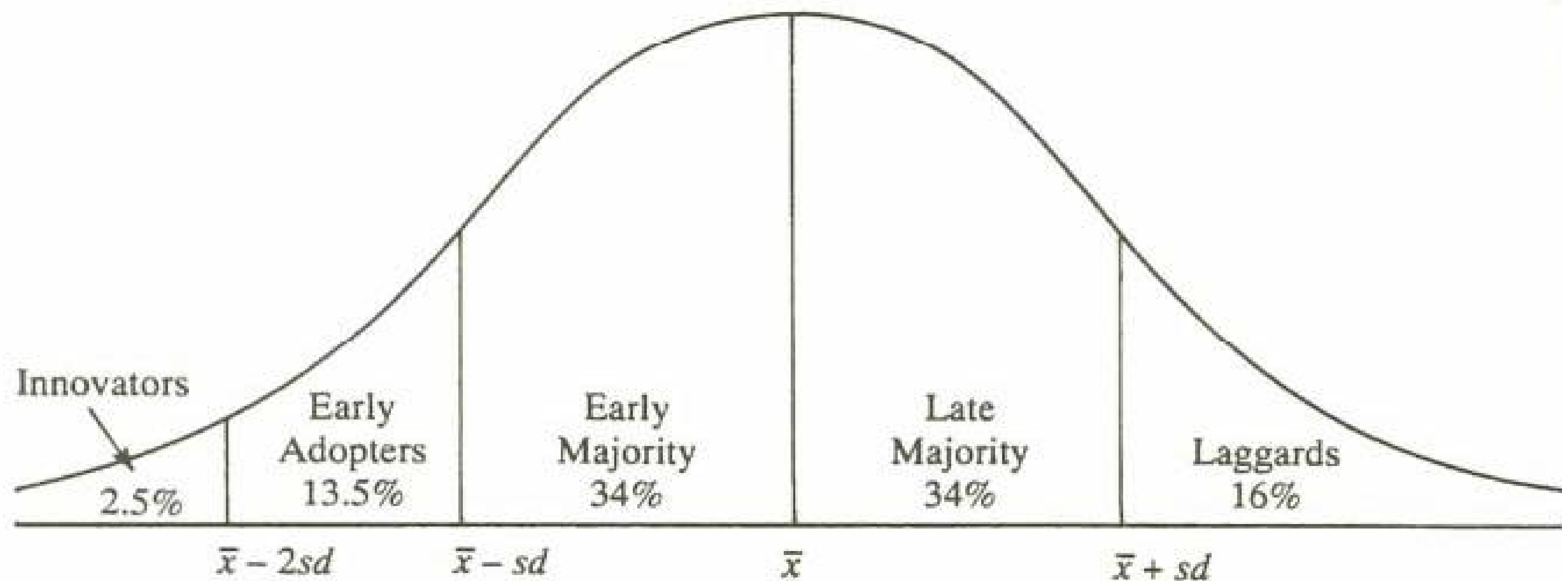
C. **Complexity** - simple is better

D. **Trialability** – can innovation be tested easily before making investment?

E. **Observability** – can you see others try it first – are benefits visible?

Dissemination Theory – The Adopters

Figure 7–2. Adopter Categorization on the Basis of Innovativeness



The innovativeness dimension, as measured by the time at which an individual adopts

Dissemination Theory – Contextual Factors

- Is organization committed to change?
- Is there a champion at multiple levels?
- Does that champion have power to effect change?

Methods

1. **Convenience sample** - review of models that have been evaluated and have been working on dissemination
2. **Communication with investigators** of the above listed models when not described in literature
3. **Compiled lists of facilitators and barriers**, identified common themes, grouped themes into Rogers-type categories

- **Limitations**:
  - Innovator viewpoint
  - Lumper
- **Observation**
  - ½ empty, ½ full feel to many of the facilitators / barriers
  - Categories often overlap – will try to avoid repetition

Geriatric Models

Model	Outcomes
Hospital Elder Life Program (HELP)	↓ delirium, costs
Falls prevention	↓ falls
Collaborative depression care (IMPACT)	↓ depression, ↑ function
Transitional care – advanced practice RN	↓ readmissions, costs
Hospital at Home	↓ geri comps, costs
Acute Care for the Elderly (ACE) Unit	↑ function, ↓ nursing home
Care transitions program	↓ readmission
Physician house calls programs, (WHC, CLM)	↓ mortality, ↑ function, ↓ nursing home
Hospital-based palliative care	↓ symptoms,

There are other models out there – some described, some "black market"

Facilitators of Dissemination of Geriatric Models of Care

Facilitators: Perceptions of the Innovation

Relative advantage

- Intuitive appeal of the innovation
- Strong evidence base of patient benefits of intervention
- Solve immediate challenges of adopters
- Save money
- On radar screen of policymakers

Facilitators: Perceptions of the Innovation

Compatibility enhanced …

- Secular trends – population demographics, safety, consumerism, recognition of chronic disease, move towards community care, overcrowded hospitals and ERs
- Patients dissatisfied with health care system and recognize need for change
- Address failures of current system and have PR value
- "Make it rain" – influence care delivery and casting model as solution to immediate challenges– JCAHO
- Good business case, especially those that fit existing clinical & payment paradigms

Facilitators: Perceptions of the Innovation

Complexity

- Simple models best: use existing personnel, minimal additional training, exist within one care silo
- Aligned with current incentives and reimbursement structure

Trialability and Observability

- Relatively inexpensive
- No regulatory issues
- Well packaged
- Up and running models

Facilitators: Adopters

- Find adopters that:
  - Need to manage financial risk
  - Want active partnership between with innovator
  - Have a positive view of geriatrics

Facilitators: Contextual Factors

- Adaptation of the model to users
- Trusting relationships and frequent communication
- Align and create incentives
- Choose adoption partners wisely for visibility
- Endorsement by high profile groups (IOM)

Barriers to Dissemination

Barriers: Perceptions of the Innovation

Relative Disadvantages:

- Models incompletely described in literature
- Researchers don't develop information relevant to adopters
- Lack of financial incentives – absolute or relative
- Geriatric issues viewed as not important
- Limitation of model to older adults

Barriers: Perceptions of the Innovation

Compatibility:

- Geriatrics not a disease model – that is what health care system focuses on
- Fill-in the cracks models – therefore undervalued
- Patients don’t know or care about geriatric issues
- No societal mandate
- Different cultures in academia and business
- Medicare reimbursement

Barriers: Perceptions of the Innovation

Complexity, Trialability, Observability:

- Team model is complex
- Can't pull models off the shelf
- Often not very observable – if so, not necessarily suited to the specific issues of an individual adopter
- Scope of practice issues for nurses, SWs, etc

- ***Geriatric models are complex clinical interventions***
  - Made up of various interconnecting parts
  - "Black box" interventions

Phases of Developing Evidence for Complex Clinical Interventions

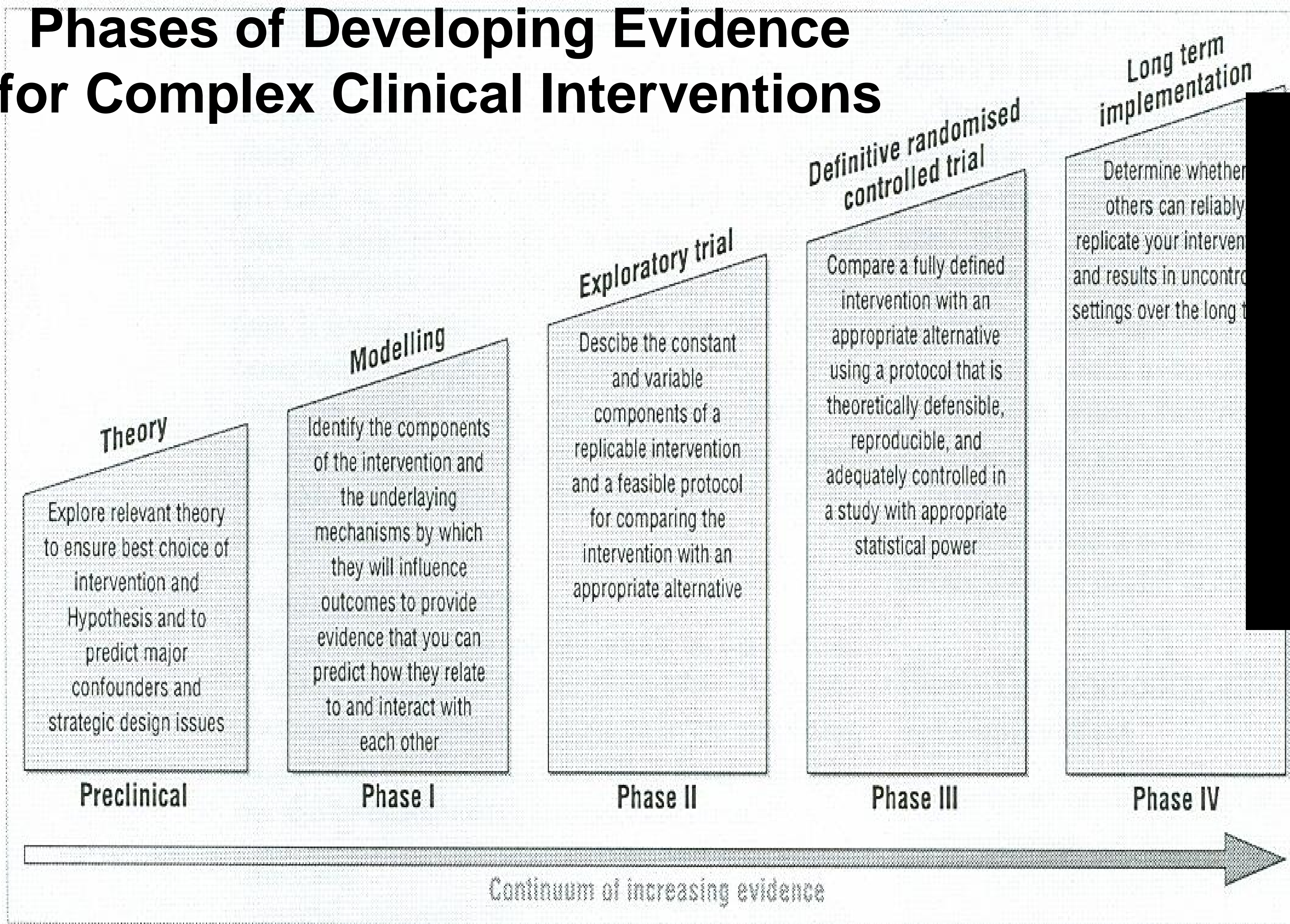


Fig 1 Sequential phases of developing randomised controlled trials of complex interventions

BMJ 2000;321:694

Evaluation and Dissemination: Pill v Complex Clinical Interventions

Easy Stuff

1. Pill is a pill is a pill
2. First pill is same as n^{th} pill – what you have studied remains the same during study
3. Health care provider influence relatively limited wrt delivery of pill or device
4. RCT data “valid”

Hard Stuff

1. All complex interventions of the same type are different
2. Intervention on 1st day is different from intervention at on n^{th} day at the same place – what you have studied has changed during study
3. Providers key to intervention
4. Many models cross silos of care
5. RCTs and “black box” issues

Barriers: Adopters

- Complex stakeholder consortium – insurers, health systems, professions, Medicare - customer not visible
- Specialized workforce with insufficient # 1° providers
- Health care systems focus on procedure-oriented disease, not syndromes
- Hard to work across silos
- Business suspicious of commitment of academic innovators to adopting organization
- Business adopters desire competitive advantage and secrecy

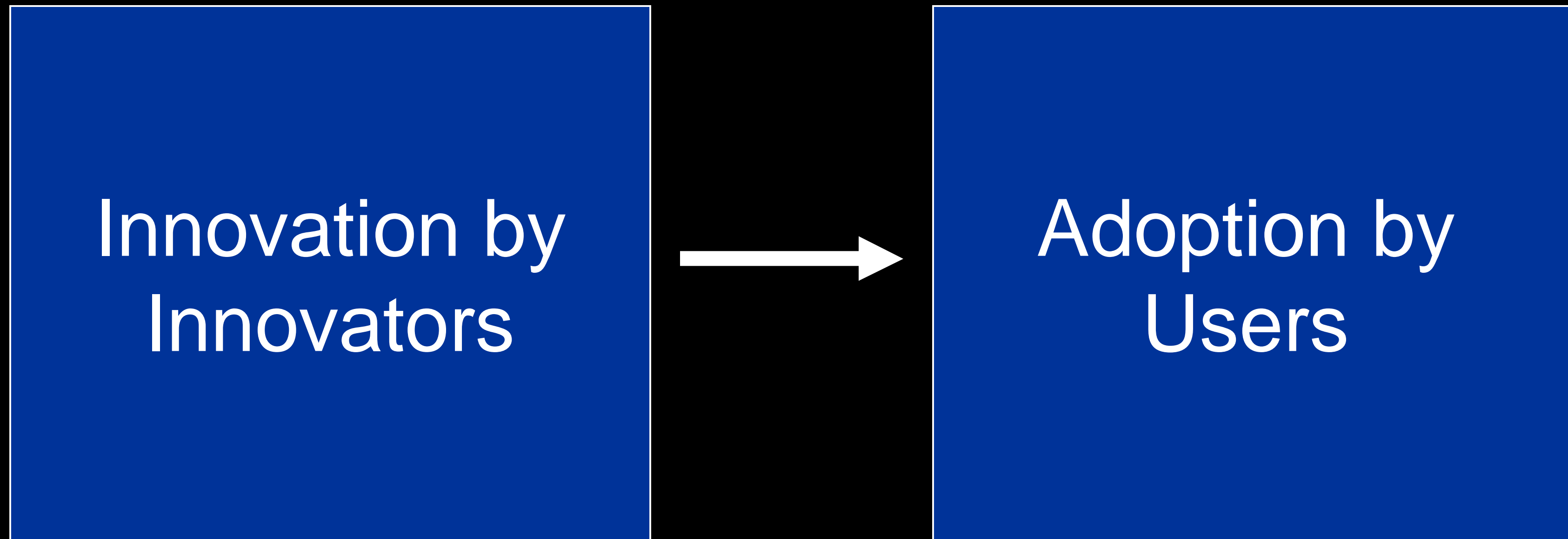
Barriers: Contextual Factors

- Changing cultures is hard work
- Geriatrics is bad marketing
- Gaining internal support challenging
- Clinician leadership and practitioner expertise not available
- No two adopters are alike
- Lack of knowledge and expertise

Barriers: Business Issues

- Hospitals chase reimbursement
- Low ROI compared with other potential investments
- With silos, money savings doesn’t accrue
- Start up costs of intervention and obtaining LT funds
- Making model fit with work processes, information systems, etc
- Benefits of models – clinical and financial are long term – payment system and priorities focus on short term results - models not allowed to mature
- Financial benefits diffused in the health system – models undercapitalized
- System can’t easily value cost or error avoidance
- Scalability - demand management when successful

Innovation Dissemination

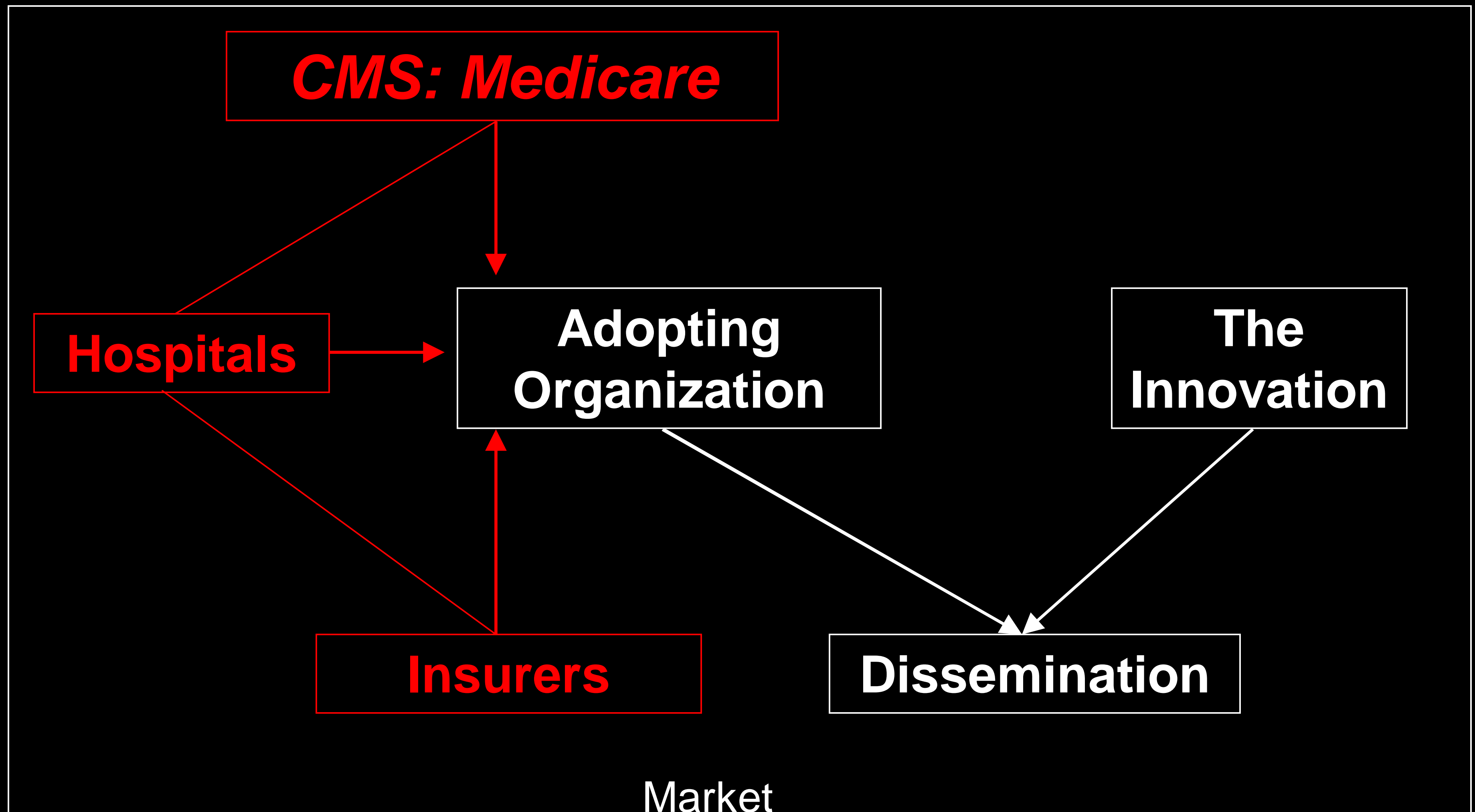


Assumptions:

- Innovation adoption is a social phenomenon
- Process passive, unplanned, informal, decentralized

Medicare Reimbursement System

Critical Influences on Dissemination of Geriatric Innovations



Adapted from Commonwealth Fund, 1-12 July 2004 and Al Siu, Also from Harvard Business School.
http://hbswk.hbs.edu/itam/5676.html

Barrier – Medicare Reimbursement

- Reimbursement is provider and setting, not patient focused
- MC must apply program rules uniformly, can't reward performance
- MC's elaborate statute-based review of new procedures makes geriatric-type models difficult to support without major legislative changes
- MC statutes very specific about which providers and suppliers care eligible to be paid and under what circumstances – non MD personnel not recognized to receive payment

Health Aff (Millwood). 2003 Jan-Jun;Suppl Web Exclusives:W3-37-53

Medicare Reimbursement System Provides the Wrong Incentives

- Hospital payments create incentives for hospitals to invest mainly in relatively profitable surgical conditions and procedures

- Incentives drive career choices, managed care fees, evaluations of productivity, and investment in healthcare infrastructure

Courtesy of Al Siu

How to Move Ahead

How to Move Ahead

- Focus on Incentives, incentives, incentives *(www.ifihc.org)*
  - For people to enter primary care and geriatrics
  - For the work of interdisciplinary care teams
  - For health encounters that are not face-to-face
  - To work across silos of care
  - Rectify the current perverse incentives in the system
  - To move away from a solely disease-based model

- Reimbursement codes – can be targeted to certain patients, providers, involve bundling, require documentation, done as demonstration projects

- Social marketing for geriatrics – invest in this!

- Identify and align with powerful champions – JAHF, RWJ, Atlantic Philanthropies, consumer groups, professional organizations, large business consortiums, strategic consulting firms, politicians

How to Move Ahead

- Need alternative to a business model driven by more hospitalizations and procedures
  - PACE or Provider-sponsored Special Needs Plans (SNPs) for chronic illness
  - Medical Home framework (paying a Care Management Fee plus sharing in Medicare savings)
- Just putting more money into the system is impractical and unrealistic – zero sum game

Courtesy of Al Siu

How to Move Ahead

- New model for research
  - Partnerships between “business” and academia
  - Learn from each others worlds
- Research on dissemination of interventions
  - Targeting
  - Adapting models to organizations
  - Defining and measuring the relevant outcomes

How to Move Ahead

- Focus on dissemination
- Center to Advance Palliative Care
  - Bottom up (help professionals establish programs), top down approach (support policy, reimburse change, research, education) needed to embed palliative care into health system
  - Tools and tech assistance, social marketing, business case, outcomes focus, partnerships
  - 30% US hospitals with palliative care program, ~ 100% in VA
- This takes $$!

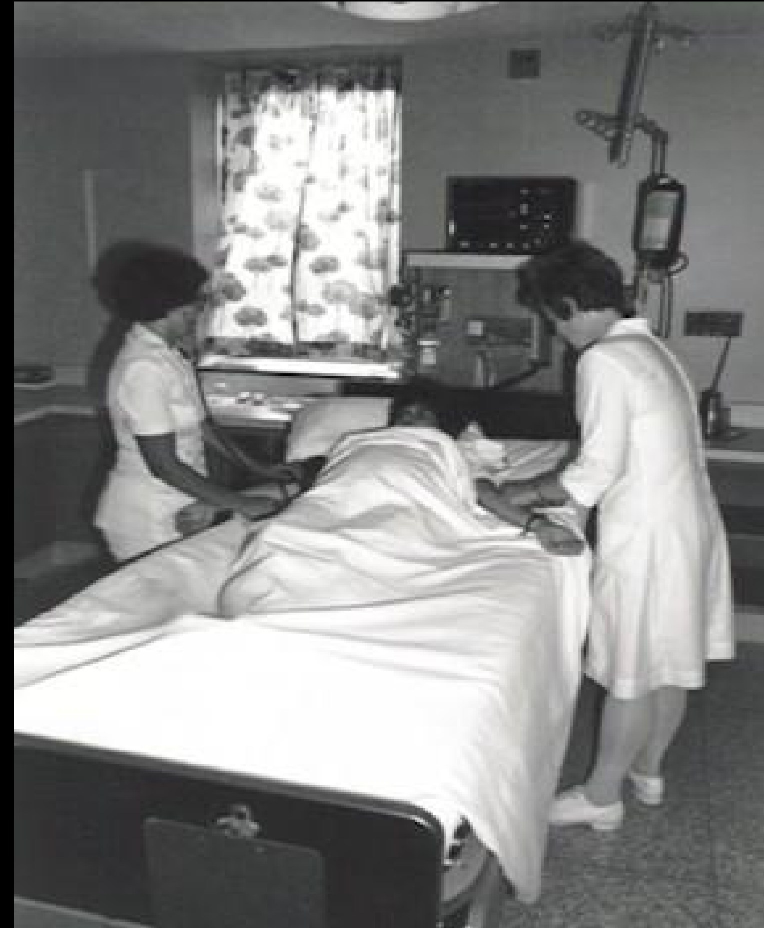
Courtesy Diane Meier

- Center to Advance Geriatrics Care – new Atlantic Philanthropies initiative

Conclusion

- Popular dissemination theory useful, but incomplete when it comes to dissemination of geriatric models of care
- Scientific data alone are insufficient to effect change
- Incentives and external pressures absolutely necessary to bring about changes in the system to create a favorable climate for dissemination of geriatric models

Even Big Time Models Took Time



Are we being too hard on ourselves?