EDITORIAL

Barriers to Implementation of Geriatric Medicine Programs: When Advocacy Meets Reality

Geriatric medicine has long relied on interdisciplinary teams for the day-to-day management of frail elderly adults, as well as those with major geriatric syndromes such as dementia, incontinence, falling, and failure to thrive. These teams vary in composition according to the underlying clinical concern but generally include a core of a physician, a nurse, and a social worker.

Over the past 15 years, the Coordinated Care Model (CCM) has emerged. It supplements the standard interdisciplinary team with a trained care coordinator, a strategy that has been found to be effective in managing a variety of common geriatric problems such as dementia and depression, as well as disadvantaged individuals with multiple conditions.[1–3] A CCM can exist as a freestanding consultative service or can take responsibility for the primary care of individuals.

With respect to dementia, studies indicate that CCM teams, which generally include a physician, nurse, social worker, care coordinator, and neuropsychologist, can reduce behavioral and psychologic symptoms, although they cannot influence the decline in cognition, and enhance the well-being of informal care providers.[4,5] The CCM includes many elements not ordinarily seen in routine primary care, such as support group participation, informal telephone support, special attention to function when individuals transition from one care or living situation to another, and careful attention to the physical and mental status of informal caregivers.

Given the established clinical value of the CCM, there is an important question related to its cost. In 2014, the cost of the Healthy Aging Brain Center (HABC), a consultative CCM clinic for individuals with dementia at Eskenazi Health, an urban public safety net system in Indiana, was evaluated.[1] It was found that the HABC had lower costs (expressed as hospital charges in 2012 dollars) of $980 to $2,856 per patient per year. Although this is described as a "net savings," the costs included may not have fully accounted for some other funds available to establish the program that came from the Centers for Medicare and Medicaid Services, the National Institutes of Health, and local philanthropies. Regardless, the core finding is that this program, proven to be of clinical value, is not costly and may even save money.

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So if you have a program that has been shown to offer clinical benefit and may be, at a minimum, cost neutral, how do you incorporate it into your hospital or health system in a sustainable way?

Elsewhere in this issue, Boustani and colleagues from the Indiana University Center for Health Innovation and Implementation Science, present the experience of establishing the HABC program at Eskenazi Health from the perspective of implementation science.[6] They used the agile implementation method, which resulted in establishment of the HABC in a sustainable mode for over a decade. Agile implementation includes proactive surveillance and confirmation of the clinical opportunity, selecting the right solution, localizing the selected solution, evaluating the effectiveness of the program and providing feedback, and expanding and spreading.

We have much to learn from implementation science, and the experience at the HABC provides valuable lessons for those who are trying to establish innovative geriatric care programs, but in addition to the strategies inherent in agile implementation, there are some practical matters, often quite variable from institution to institution, that need to be considered in such initiatives. I have been involved in efforts to establish new initiatives, mostly but not all clinical, in three phases of my career. These include leading an academically based clinical and research program in geriatrics (Harvard/ Beth Israel, 10 years); serving as President and CEO of one of the country's largest academic medical centers, including a large hospital and a school of medicine (Mount Sinai, 12 years); and serving as CEO and chairman of one of the nation's largest health insurance companies (Aetna, 6 years). Based on this experience, I offer the following practical considerations and suggestions to supplement the lessons that Boustani and colleagues present from their perspective of implementation science.

1. THIS IS NOT RESEARCH! Establishment of clinical services that have previously been shown to be effective and financially feasible is not research. Do not confuse establishment of a new proven clinical program with a research project to establish its utility. Avoid the temptation to load the program with research components and costs just so you can answer a few more research questions about the effect of the intervention. This would slow things down and add costs and might put off some patients and referring physicians.

2. EMPHASIZE CARE NOT TRAINING. Too often new interdisciplinary clinical initiatives fail because they

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are weighed down with too many trainees. One can imagine a cooperative care clinic with the core interdisciplinary team surrounded by medical students, residents, fellows, nursing, and social work students. Be cautious here and focus on establishing the clinical value and efficiency.

3. SECURE SUPPORT OF KEY LEADERS. Boustani and colleagues note the importance of executive and administrative support. This is crucial, but support of clinical leadership is just as essential. In a program such as HABC, you need to secure the support not only of the CEO of the hospital or health system, but also of the chairs of the relevant departments that will send you patients, such as medicine and neurology. This support has to be vocal and widely disseminated within the departments.

4. ESTABLISH TRUST. Clinicians are often concerned that new programs targeted at patients with a specific disorder or in a specific age group may be in the business of stealing their patients. Establishment of an advisory committee of the chairs and some division chiefs of relevant departments can be of great assistance not only in increasing awareness of your program (see 5 below), but also in establishing trust in you as colleagues who will work with them to the benefit of their patients. If possible, identify a respected senior clinician from a referring group or department who can lead the advisory committee and serve as a champion for your initiative.

5. KNOW YOUR CUSTOMERS AND MARKET TO THEM AGGRESSIVELY. Failure to do this is often a source of failure. Passionate dedicated teams will send out an e-mail announcing the establishment of their wonderful new program and wait patiently for the phone to ring. They are surprised when it doesn't. Do you ever wonder why you see the same ads on TV over and over, often one right after another? As advertising executives have long known, you must send many messages in order for individuals to be aware of what you are doing and even more messages to actually influence behavior. It is critical to establish a strong, effective marketing strategy within the health system at the outset. Identify your customers at all levels, because not only do physicians send you patients, but also nurses and social workers can have an important effect in generating referrals.

6. SECURE A GOOD PHYSICAL LOCATION. Too often geriatric initiatives are relegated to inconvenient or remote locations, sending a message to the medical center that this activity is not central to the core of the mission. Make every effort to be located as close to the center of clinical action as possible, even if it means accepting space that is not as high quality as what you are offered in a location not close to the core of the hospital or medical center.

7. DESIGN FOR INDEPENDENCE. Although you may need a grant or philanthropic support to establish your program, be sure to design it so that it can be independent of such support once it is up and running. Build for independence, not dependence, and you will be more secure.

Not all of these suggestions are relevant to every new initiative, but I have found over the years that these simple practical things are often overlooked in the excitement of establishing new initiatives. If attention is paid to these practical issues up front, success is more likely.

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