Scaling in the health care delivery system: Linking funding to success

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Scaling: what is it?

- Reproducible new business model
- Changed use of current resources
  - Practice redesign/ changes in team functioning
  - Implementation of new process in existing systems
  - Workforce training leading to practice change
- Paradigm shift

- Inclusivity in scaling: underserved and vulnerable patients/ communities
Implementation is a science

Leaders of the work described here include:

**Annual Wellness Visits**
- Amy Ehrlich MD
- Tara Cortes PhD RN FAAN (Hartford Institute for Geriatric Nursing, New York University)
- Sybil Hodgson MD
- Regional Aid for Interim Needs (R.A.I.N.)
- Medical directors, physicians, nurses, and social workers at multiple sites
- ... and many others
- Funder: HRSA/ GWEP

**Serious Illness initiative**
- Deborah Swiderski MD
- Allison Stark MD
- Maria Gbur MD
- Fabienne Daguihl MD
- Ryna Villar MD
- Kathleen Remairais RN MSN
- Joyce Wong LCSW
- Medical directors, physicians, nurses, and social workers at multiple sites
- ... and many others
- Funder: Ariadne Labs
Example 1: Improving quality of care using the Annual Wellness Visit (AWVs)

• The AWV is a Medicare-defined visit structure and represents an opportunity to improve quality care for older adults

• At baseline, some elements of the AWV were integrated into our system (e.g. depression screening), and others (cognitive screening) were not

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Montefiore Medical Group

- 22 primary care sites located in Bronx and Westchester County, NY
  - 9 FQHCs
- 3 urgent care sites
- 300,000 unique patients
  - 41,000 adults > 65 years old
Despite all the campaigns to end The Bronx’s ranking as New York State’s unhealthiest county, our borough came in dead last once again.

What’s worse is the glaring disparity when just across the river, Manhattan is one of the healthiest in the state and the average life expectancy is higher at 84.5 compared to The Bronx where its only 80.4.
Data source: New York City Neighborhood Health Atlas from American Community Survey (2010-2014)
Implementation strategies that supported success at scale

- **Piloted** at subset of sites before larger implementation
- **Comprehensive training**
  - AWV-specific training for providers and staff at each site
  - Clinical education sessions provided by academic geriatricians to primary care providers
  - Education booklet including clinical pathways (dementia, falls) -- provided a resource for management decisions and for referral options in our system
- **Operational-academic partnership**
  - Integration into electronic medical record
  - Increased visit revenue aligns with existing business model
  - Included as an institutional quality measure
How has this work mattered for patient care?

- Over 8,000 AWV completed in community health centers through June 2019

- Increased **cognitive screening** in primary care practices
  - In review of the first 5,870 cognitive screens
    - 442 had positive screen
    - 142 (32% of positive screens, 2.4% of all screens) had abnormal picture-based memory impairment screen
  - Of these 142 people
    - 60 were referred to neurology
    - 13 to geriatrics
    - 47 to CBOs and/or CHHAs
Example 2: Serious Illness Conversations

• Serious Illness Conversation Guide developed by Ariadne Labs

• Piloted in our system in 2018-9 to test acceptability and feasibility in a low-resource primary care setting
  – Two Federally Qualified Health Centers
  – 14 family physicians trained, plus RN and SW colleagues
  – 39 patients (ages 51-92) identified by their primary care physician began the SI conversation with their doctor.

• Scaling:
  – Three additional community health centers are in planning stages to launch SI conversations in internal medicine practices
Feasibility testing allows us to adapt our approach and prepare for scaling

• Training and implementation strategy needed to be adjusted to our setting

• **Qualitative study** of providers gives us data to supplement the lessons learned by project leadership:
  
  • Strong provider engagement
    • Almost universal sense that, although difficult, these conversations are always good for the relationship and the care of the patient
    • Emotional toll of these conversations felt by providers
  
  • Time is the major missing resource
    • Sometimes conversations happen spontaneously, sometimes planned visit with family included
  
  • The language in the Guide often needs to be rephrased
    • Backgrounds of doctor and patient are often different (formal education, native language, cultural/ racial/ ethnic backgrounds)
  
  • High rates of poverty and complex social needs
Setting up for success at scale

*Shift from acceptability/ feasibility to normalization of practice*

Apply lessons from pilot stage
- Leverage high level of **physician investment**
- Replicate **setting-appropriate** training strategy
- Explore ways to mitigate **time pressures** through team-based efforts and/or improved scheduling
- Address issues of **cross-cultural communication** and **social support needs** during training/ coaching

Create infrastructure and momentum to support scaled effort
- Expand learning collaborative
- Utilize patient panel reports to help identify patients
- Create tracking capabilities in EMR for SI conversations
- Link to billing
Summary: Some takeaways on funding

• Strategic time-limited investment can catalyze change
  – Funding must be for adequate time period and take into account the stages of implementation
  – Clearly define deliverables, with accountability
  – Identify and address key success factors for launch, scaling, and integration of the initiative
  – Recognize and support the network of unfunded internal partnerships and champions

• Large-scale project is a lot of small-scale projects
  – with common objectives and a shared mental model and implementation strategy;
  – supported by centralized resources, institution-wide messaging, and collaborative learning