Internal Marketing 101
Geriatric Medicine

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Definition

Utilize (traditional external) marketing methods to “market” yourself within your organization
In practice

- Branding
For geriatrics

1. “Sell” geriatric services laterally
   - Outside your section (dept/division)

2. “Sell” up to the Board
   - Understand value-added when
     - Resources scarce
     - Marginal value produced
       - (metric?)

3. “Sell” down to your geriatric staff
References

- TRV Davis. Management decisions. 39/2. 2001. 121-130
Organization of session

- 15 min didactic
- 10 min example together
- 20-25 min practice at tables
After this session, learners will be able to:

- Identify a “customer” (new or old)
- Suggest a new approach to a customer to initiate or strengthen geriatric service
- Identify/consider stakeholders in a service
- “Market” service based on the above
If your environment

• Identifies, promotes as 1º service line
  - Geriatrics, or
  - Senior care, or
  - Senior health

- Then
- Consider another session!
SUMMA home page:
Ten services listed
Senior health is one of them
Cleveland Clinic: 17 “Institutes” listed
Senior health is NOT there
Marketing 101
Competing as a Commodity

• All products, services are commodities
  - Even healthcare?
• Services judged on “quality”
  - Equality of service when outcome is equal quality?
• Belief: Value may not be just clinical service
• But:
  - Un-quantified value is un-marketable value
Requirements to have your commodity valued

- “Buyer’s” needs - know them
- Perception of you by the buyer
- Differentiation from other providers
- Sustainable service
Goal: to be different

• Target a market
• Offer needed set of activities
• Provide unique mix of value
  - Different than
    • What you offered before
    • What others (in/out) offer
Target Market

- New client base
- Different than current client base
- Preferably new or customized service
Role of internal marketing

Assess current activity (service, customer, value).
Assess mission/goals. Aligned?

Assess Need.
Consider setting, customer, stakeholders, current service(s)

Identify a differential advantage

Develop a strategy.
Include customer & internal, external stakeholders

Implement

Pilot Test a new or revised service

Internally Market

Adapted from Eric Berkowitz. Leading in Healthcare. Cleveland Clinic 2011
Example
We’ll do it together

- We used to offer an inpatient Comprehensive Geriatric Assessment
- CGA
CGA

• Multidimensional, multidisciplinary evaluation
• Patients: older adults
  - Usually 75+
• Data on medical, psychosocial, & function
• Utilize information to
  - Diagnose (new) conditions
  - Alter treatment plan
  - Address nutrition, rehab needs
  - Suggest post-acute care (placement? OP f/u?)
  - Assist case management
Inpatient geriatrics consultation
Before 2008 intervention

- Only few per month
- RVU pressure
  - Unable to block schedule of provider
  - Too few consultations
“Market” benefit of CGA

- Personal meetings with key GIM & hospitalists and chief residents
- Intranet distribution list
- Didactics to residents/fellows
  - CGA
  - Polypharmacy
- GIM grand rounds
  - Transitions of care
  - Geriatric update
- Nurse manager, CM, APN presentations
Following marketing “blitz”

- A few additional consultations
  - Then back to a trickle
- RVU pressure
Perhaps we shouldn’t be doing this?

- What is our goal or our mission?
The primary goal of the Center for Geriatric Medicine (CGM) is to coordinate geriatric services to the CCHS patient population throughout all settings of care- inpatient, outpatient, home, emergency, and post-acute care settings.
Who is the customer for geriatric services

- Patients first?
- Not the patient
- The customer “purchases” your service

  - The hospitalist
Stakeholders

- **Internal:**
  - Geriatric physician staff, fellows
  - Assistants, schedulers

- **External stakeholders**
  - IP Nursing, CM, SW
  - Rest of primary care team:
    - GIM residents, med students
    - Nurse practitioners, physician assistants
  - Psychiatry consultants
  - Patients, families
If we could help with care of older hospitalized adults, what would you like us to do?

**Customer (hospitalists):**
- We really respect you BUT
  - Don’t prolong my length of stay (2008)

**Stakeholders:**
- **Nursing:** we love older adults. Reduce falls
- **Case Managers:** facilitate discharge
  - Help us with difficult families
- **Later: QPSI** (Quality and Patient Safety Institute) - reduce readmission
Who is addressing customer needs currently?

- **Length of stay**: Huddle
Who is addressing stakeholder needs currently?

- **Falls Reduction:** SERS
- **Facilitating discharge:**
  - CM/SW centered family meetings
  - Psychiatry re: capacity eval
- **Readmission rates:** multi-disciplinary task forces (nursing, hospitalists)

SERS: - Safety Event Reporting System
What is really the role for geriatric consultation here?

- Evaluate the hospital service
  - EPIC - easy
  - Disclosure: don’t do it this way
- Who is hospitalized
- Duration hospitalization
- Geriatric diagnoses
  - The dog that didn’t bark
Number hospitalized (first 29 in EPIC)

Days

Age range (years)

18 - 49

50 - 69

70 +
Median Days in Hospital at that time

- **18 - 49**: 8 / 29
- **50 - 69**: 5 / 29
- **70 +**: 16 / 29
x-section of consecutive 29 hospitalized pts

CI = cognitive impairment (the dog that didn’t bark)
Cognitive problems in the hospital

- No chart had delirium as a diagnosis
  - “Confused” or “poor historian”
  - “New onset dementia”
  - “New onset depression”
  - “Not interested in therapy”
  - “Not interested in discharge planning”
Customers/stakeholders are not relating their needs to delirium

Delirium- unrecognized

- **Hospitalists**: delirium is associated with longer length of stay
- **Nursing**: delirium is associated with falls, restraints, etc
- **CM**: families don’t understand prognosis of delirium
- **QPSI**: delirium & readmission relationships more indirect
Adverse Outcomes of Delirium

- Functional Decline
- Falls
- Nursing Home Placement
- Prolonged Hospital Stay (LOS)
- Increased Costs of Hospitalization
- Increased Risk of Mortality

Delirium Mortality over 12 months

Leslie. Arch IM 2005
Who is addressing delirium now?

- **1° medical team**: most
  - Acute change mental state
  - “Suddenly” developed dementia
  - Nsg notes: confused; disinterested
  - Most depression = ? hypoactive delirium
- **Psychiatry IPC**: substantial.
  - Include pharmacological tx AND expediting “expert eval” when patient lacks capacity
- **Neurology IPC**: some
- **Geriatrics IPC**: few
Differential advantage of geriatric IPC for delirium

• Neurology- not interested once not a stroke
• Psychiatry- focus on diagnosis & acute pharmacological management; capacity
• Geriatrics- potential for a “comprehensive”, one-stop shopping for delirium treatment
  - Diagnose, pharmacologic mgt
  - Identify/address polypharmacy
  - Address fall risk explicitly
  - Advance directives; identification goals
  - Optimizing discharge planning
  - Avoid prolongation of LOS
Consider new focus for IPC: Delirium

- **Revised Mission IPC**
  - Target cognitive issues
  - Dx/treat serious inpatient condition of elders
  - Reduce hazards hospitalization
  - Advise on optimum disposition
  - Educate staff/ housestaff
  - Educate pts/families

- **Goals**
  - Implement nsg detection tool
  - Address/reduce polypharmacy
  - ↓ onset delirium
  - Garner housestaff interest in geriatrics
  - ↑ delirium QI/research

Mission/Goal of targeting delirium in the IP setting: Appears to be aligned with the goal of the CGM
Caveat

- Minimize need for dual consultations
- “Expert eval” or “Capacity” statements
- Psychiatry
  - Usually does them
  - “Customers” expect it
- Geriatric skill for capacity eval’s
  - Part of fellowship training but
  - Needs updating; practice
Strategy

Arrangement with key stakeholder:

- **Psychiatry:**
  - Any c/s for 3D’s over certain age
    - Diversion to geriatric consultation
  - Exclusions: mental health
    - Bipolar
    - Schizophrenia
Potential Impact on customer, stakeholders

- **Hospitalists:**
  - “Don’t increase my LOS”
- **Nursing:**
  - Less interruption of care
  - Fewer falls
- **Psychiatry:** fewer consultations
  - That’s OK with them for > 1 year
  - Training session re: capacity
- **Case Managers:** joint goal-setting; fine tune discharge, expedite capacity statement
Potential Impact on customer, stakeholders, continued

- **Neurology**: no impact
  - Still be called for delirium w/ focal neurologic signs or seizures

- **Geriatric rotators**: More opportunity to train in IPC

- **GIM trainees**:
  - ↑ appreciation geriatrics on IP svc
  - ↑ applicants to geriatric fellowship?
Pilot test

- Hospital medicine floors
- (initially avoiding surgical floors)
Internal Marketing in order

- Psychiatry consult team
  - Staff + “quarterback”
- Flyer developed
  - Email distribution lists
- Case Manager/ SW
- Nurse practitioner/ Physician Assistant
- Resident lectures, small group
- GIM/ hospitalist staff meetings
Customer Marketing Message

- Inpatient Geriatric Consultation
  - If think LOS will be longer than medically expected due to
    - Mental state change or confusion
    - Delirium, Dementia, Depression
    - Disposition difficulties due to capacity
  - Polypharmacy, weight loss, falls
    - Affecting hospital care, \( \uparrow \) LOS

\( \text{LOS} = \text{length of stay} \)
Implementation

- Roll-out: medicine floors
- Then: cardiology units
- Evolving:
  - Emergency department
  - post-op thoracic surgery
2008 New Geriatric Consults

Cleveland Clinic Geriatric IPC experience
P = directed to geriatrics from Psych QB
Cleveland Clinic Geriatric IPC experience

P = directed to geriatrics from Psych QB
New Geriatric Consults by team

GM: 180
Card: 50
Neuro: 10
Psych: 40

2008: [Green]
2011: [Red]

Psych = directed to geriatrics from Psych QB
Outcome

- Substantial ↑ in IPC
  - Reflect appreciation of geriatrics among hospitalists
- LOS: stable overall - did not look at sub-groups
- Readmission:
  - Decreasing (multi-factorial)
- Knowledge/appreciation of geriatrics
  - Did not do pre/post
  - Other metrics: delirium as diagnosis?
- Spawned research/QI projects in delirium detection plus order-sets in EPIC
- Internal candidates for geri fellowship
  - Not yet but hoping
Summary of IPC experience

- Assessment of customer needs
- More than “marketing” tool
  - Reshape product
  - Retool geriatricians (expert eval)
- Opportunity move forward
  - Other clinical customers
  - Research, QI
- Reassessment will be needed to maintain/increase inpt geriatric services
Meet our CCF Geriatrics Team

Barbara Messinger-Rapport, M.D.
Director, Center for Geriatric Medicine

Amanda Lathia, M.D.
Coordinator, geriatric medical student rotation
GACA awardee

Ronan Factora, M.D.
Director, Geriatric Medicine Fellowship

Quratulain Syed, M.D.
Coordinator, geriatric resident rotation

Anne Vanderbilt, CNS
Center for Geriatric Medicine
Chair, CCHS SERS
More CCHS Geriatric Specialists

Missing pictures for Drs. Mirza, Dhingra, Sanitato, Eren
Questions?
Role of internal marketing
Cleveland Clinic

Every life deserves world class care.