Innovation Accelerates the Transformation of Healthcare

BY MOLLY JOEL COYE, M.D., M.P.H., UCLA HEALTH

Innovation: Provide employers a convenient 24/7 telephone and Web access to physicians for their employees, and find emergency room visits cut dramatically—disrupting patterns of emergency room use by patients, and routine office hours for physicians. ***Innovation:*** Provide early in-home visits by social workers, nurses, and physicians for palliative care, and find the net cost of care in the last year of life cut by one-third, decreasing estimates of the need for hospital beds for an aging population and shifting workforce requirements. ***Innovation:*** Offer remote monitoring and co-management for intensive care units to provide 24/7 intensivist and critical care nursing coverage, and find the mortality and complication rates in ICUs declining while net revenues improve. ***Innovation:*** Give primary care physicians a structured email system for asynchronous communication with specialists, and find the need for in-person referrals falling by an average of 40 percent across more than a dozen specialties.

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The above are examples of innovations: new business models and care processes for healthcare that create exceptional value, accelerate the transformation of care, and reduce (yes, reduce) the cost of care. For health system leaders, and especially for boards of directors, the challenge to innovate proves imperative. By definition, innovation is disruptive and difficult—but a few guidelines can help steer the process. Several years ago, UCLA Health established its Institute for Innovation, and with the generous help of many advisors, set the following guideposts, described in more detail below:

- Innovation should be strategic.
- Innovation should create value.
- The best innovation is design-driven.
- Most innovations will be externally sourced.
- Multiple innovations require enterprise scale.

First, innovation should be strategic. Creating a culture of innovation does not mean fostering an appreciation of every new idea. Instead, your leadership should link proposed innovations directly to the strategic objectives of the health system, and critically assess their potential impact and timeframe. This focused approach still relies upon the cultural evolution of the organization, but the education and participation of stakeholders throughout the system begins to generate a "fly wheel" of energy and inventions aligned with your strategy. For boards, this means regarding innovation as a critical investment, not a casual experiment.

Value is the central challenge of healthcare today. Neither the purchasers of care—employers, the government, and increasingly, consumers themselves—nor the recipients of care receive good value when compared with other industrialized nations or even against the best performers within the U.S. The transformation of care is moving forward, far too slowly, but inexorably: health systems are learning to share risk, manage population health, align incentives, integrate and coordinate care, make results transparent, and empower consumers and patients to assume a more active role in managing their own health. The most important innovations, therefore, move us swiftly toward cost reduction by redesigning care—not reducing unit price. For boards, this means critically examining proposals from your system leadership that focus on traditional cost cutting, and asking how planned innovations can tackle costs.

Successful innovation today is "design-driven," meaning that the discovery process begins with the design requirements of the end-users—in this case, patients. This approach allows greater degrees of freedom in disrupting and transforming existing patterns and processes, and follows a decade of success in the use of this approach for other sectors of the economy. With the end-users or purchasers of healthcare in mind, we might ask such questions as: How can we produce care that costs 20–30 percent less? How can we provide primary care when the number of physicians and advanced practice nurses will never meet demand forecasts for aging boomers? How can we establish routinely cooperative, satisfying, and educational relationships between referring physicians and our specialists across states and national borders as well as within our region?

The vast majority of innovations will be sourced outside your organization. There is no premium on "invented here," especially when there is a growing wealth of innovations to draw upon. In fact, we already invent far more solutions than will ever reach widespread adoption. In *Crossing the Quality Chasm*, the Institute of Medicine reported that an innovation shown to be beneficial requires an average of 17 years for it to be adopted in medical practice.[1] Innovators, then, should focus primarily on

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1 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* The National Academies Press, 2001.

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finding and exploiting high-value innovations already developed by other provider systems, health plans, employers, and community-based services. For would-be inventors we often draw on the adage of technology developers that "every new customer is a beta." Even the most tautly designed product will need tweaking by a new customer. For boards, this means persistently asking for expected investment and yield, at every phase in innovation and transformation.

Multiple, systematic, and rapid-cycle innovations also require enterprise scale. It takes staff, time, and expertise to scan for, evaluate, plan, and implement them. Larger, aggregated health systems have an advantage in this regard, but smaller systems can take advantage of collaborations with other systems, health plans, and local employers. Managing an "innovation portfolio" means having large and small, short- and longer-term projects all underway simultaneously. For boards, this means supporting partnerships that provide access to important innovations and shared learning with others tackling the same challenges.

Perhaps our most useful discovery at UCLA Health was the creation of an "Innovation Life Cycle" that includes two critical stages not commonly found in innovation programs: chartering and transformation/implementation. In the early phases of the cycle we define the opportunity, select the innovation, and design its adoption, then present this plan to our executive leadership for chartering. Chartering entails an explicit commitment to full deployment at scale if the piloted innovation fulfills our expectations for impact. The subsequent launch of the pilot also kicks off the transformation/implementation phase, in which operations staff members actually lead in iterative rounds of detailed design, trial, and expansion. Because implementation rapidly moves into operations, successful pilots rapidly lead to full deployment. UCLA physician leadership has expressed strong support for this model, and has adopted it for all the components of our strategy. Boards may want to ask their leadership teams what method or process will be used to manage innovations through completion, and how progress will be monitored along the way.

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None of this means that innovation is easy or straightforward. Clayton Christensen, the Harvard-based author of *The Innovator's Dilemma* and other seminal works on disruptive innovation, first pointed out that large, dominant organizations in any sector innovate slowly because they continue to profit from the existing business model.[2] Innovators require protection from the antibodies of the larger institution; without separate status and some degree of license to pursue strategies that may eventually threaten the parent company's business model and work processes, innovation is stymied. Healthcare leaders often remark on the difficulty of building integrated, affordable care systems while payment systems continue to reward piecework—comparing this task to "changing the wings on an airplane while you are flying." John Kotter, a leading authority on leadership and system change, recently published the results of a multi-year effort to understand how large organizations can innovate, in *Accelerating Change*.[3] His work confirms the importance of protected environments for innovation to allow the development of new systems while the larger ecosystem remains inhospitable. For health systems with well-established managerial hierarchies, Kotter suggests, establishing parallel innovation networks allows creativity and problem-solving while maintaining an active flow of information and learning between the networks and traditional structures.

And finally, there is very good news: every health system in the U.S. has a ready-made, practical, and very useful platform for innovations in the new world of value-based population health management: healthcare for our own employees. Integrated delivery systems that have pioneered this approach have shown extraordinary results in employee health and wellness, satisfaction, and reductions in trend for net costs of care—often with the use of substantial incentives linked to participation in wellness and coaching programs. In this setting, innovations developed for employers and health plans can be easily translated into delivery system offerings, with even greater "stickiness" due to our own physicians' endorsement. For boards, this means that they can do good and do well: encourage the organization's leadership to move rapidly to organize comprehensive employee health programs, and expect to realize savings due to innovation.

The Governance Institute thanks Molly Joel Coye, M.D., M.P.H., chief innovation officer, UCLA Health, for contributing this article. She can be reached at mcoye@mednet.ucla.edu.

2 Clayton M. Christensen, *The Innovator's Dilemma: The Revolutionary Book That Will Change the Way You Do Business,* Harvard Business School Press, 1997.

3 John P. Kotter, "Accelerate!," *Harvard Business Review,* November 2012.