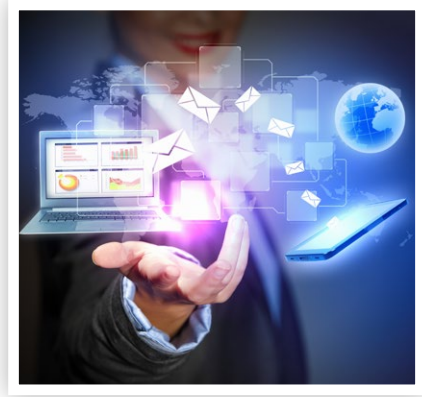


It's a New Game Now: The Evolution of Innovation at UCLA

Molly J. Coye, M.D., M.P.H., chief innovation officer at UCLA Health System, reviewed the lessons learned from her organization's experiences promoting and adopting innovation within a large organization.

SINCE SEPTEMBER 2010, DR. COYE HAS served in a unique role that does not exist in many organizations. While a few pioneering organizations (such as Humana) have had an innovation officer for several years, a few large health systems have created this position only recently. UCLA was relatively early in adopting the trend, as leaders recognized that innovation can accelerate needed changes, often through disruptive ways that are critical to successful transformation.



Transforming UCLA through a Process for Innovation

UCLA's commitment to innovation began before Dr. Coye's arrival. In 2008, the CEO (a psychiatrist) took over the health system after previously serving as head of UCLA's neuropsychology institute. In that job, he ran a department in which half the patients were there involuntarily, which, not surprisingly, led to low morale among both patients and staff. Yet within 18 months of his arrival, the patient experience and patient and staff morale had completely turned around, with 90 percent of patients stating they would return to the institute if they required inpatient care again and they would recommend that others go there as well.

This success led to the psychiatrist's promotion to CEO of the Ronald Reagan UCLA Medical Center, a well-known institution with world-renowned researchers. Upon his arrival, he discovered that the facility could best be described as a "ratty old building." In addition, patients often did not have needed supplies and services (e.g., the hospital did not have enough bedpans), and staff routinely exhibited a condescending attitude toward patients, as if they were "lucky" to be at such a well-known facility. The new CEO committed to turning around the patient experience at the medical center. Through the CI Care initiative (CI stands for "continuous improvement"), the medical center's performance on patient satisfaction metrics rose from the 38th percentile to number-one in the country among academic medical centers (a position that UCLA has held for three years in a row). UCLA now ranks between the 96th and 98th percentile among all hospitals in the country. Even with this performance, however, roughly 20 percent of patients do not have a wonderful experience at the hospital, meaning there is still room for substantial improvement.

Strong leadership drove this turnaround, combined with a commitment to a process that everyone understood (in part due

to it being regularly reinforced by leaders). Every two weeks, the top 200 managers at the medical center conduct CI Care rounds in which they meet with patients (often on their beds or in a private room) and hear firsthand about their experiences. Managers hear about problems and learn what else can be done to improve the patient experience. These rounds provide real-time feedback and help keep the managers "grounded" in their work. Initially done only in the inpatient setting, rounds have now been expanded to primary and specialty ambulatory clinics as well. At the time they were introduced, UCLA's leaders did not think of the rounding

process as "innovative," but in hindsight it was. In fact, this rigid commitment to continual, real-time feedback allowed UCLA to move forward at an accelerated pace. Interestingly, many of the insights gleaned from the rounding cannot be considered novel or pioneering. In most cases, the problems that surface are familiar ones, and the potential solutions do not seem particularly novel, as they often draw on the experiences of others who have already addressed the problem.

"Despite the name, 'innovation' need not be invented. Ninety percent of what needs to be done to transform the U.S. health system and our organizations can be 'borrowed' from others...but that often goes against the grain of someone with the title 'chief of innovation.'"

—Molly J. Coye, M.D., M.P.H.

Applying Innovation throughout the UCLA Health System

Since her arrival, Dr. Coye has worked to apply lessons from the medical center turnaround to the entire health system. Like at the medical center, most of these "innovations" are not new—rather, they come from others, with some customization to meet local needs and circumstances.

Large, historically successful organizations often face challenges when it comes to innovation, as there are often entrenched, "dug-in" interests that resist doing something a different way. Inertia can become a powerful force within these

enterprises. As in the movie *Moneyball* (Billy Beane, general manager of the Oakland Athletics baseball team, faces major resistance when he tries to institute a new system for evaluating the value and talent of prospective players), large organizations often resist change and miss important opportunities, leaving innovation to smaller, non-traditional players. In fact, history is full of market-dominating organizations that failed to foresee innovation, instead leaving it to smaller, more nimble companies. For example, leaders at CBS did not see the same opportunities as did those at CNN. IBM missed the opportunity to create an operating system for personal computers, leaving the start-up company Microsoft to do so. Other large companies also missed out on important opportunities, such as General Motors (which largely missed the move to minivans), Sotheby's (which got upstaged by online auctioneer eBay), and Borders Books (which ceded online book sales to Amazon.com). More recently, the now-dominant Microsoft has missed major opportunities seized by Apple, which has also become dominant and faces threats from new and perhaps more nimble organizations. A similar phenomenon exists in the healthcare industry. In Los Angeles, for example, many large hospitals failed to see the competitive threat posed by independent physician organizations and new types of health plans and insurers.

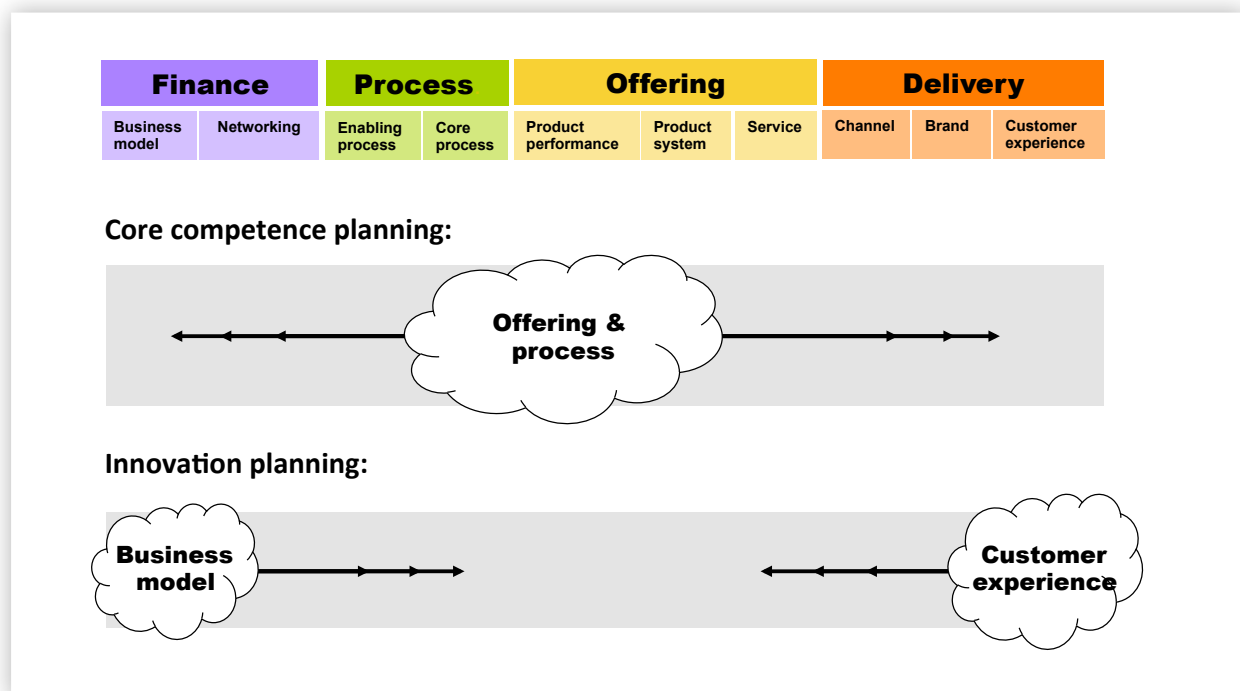
Avoiding this type of inertia and resistance to change is not easy. Rather, it takes strong leaders who are committed to an ongoing, substantial, concerted effort to scan the environment for new opportunities and possibilities, and to take advantage of them when they come along. UCLA Health System has begun to take this approach and to reap the rewards of doing so. The effort

began with the adoption of programs pioneered elsewhere—by the Virginia branch of Bon Secours Health System. Bon Secours put in place a variety of initiatives to control healthcare expenses for its 10,000 Virginia employees, turning a projected 12 percent increase in costs into a 2 percent decline. UCLA has now adopted some of these practices, customizing them to local circumstances.

Success with this type of approach depends on the ability to organize a process and a willingness to do things differently than they have been done in the past. The goal is to find credible programs that have worked in other institutions and adapt them to local circumstances. These programs need not be tested through rigorous controlled trials (which may take three years to complete), but rather should be constantly evaluated and refined as appropriate on a rapid-cycle basis that can be completed in six months or less.

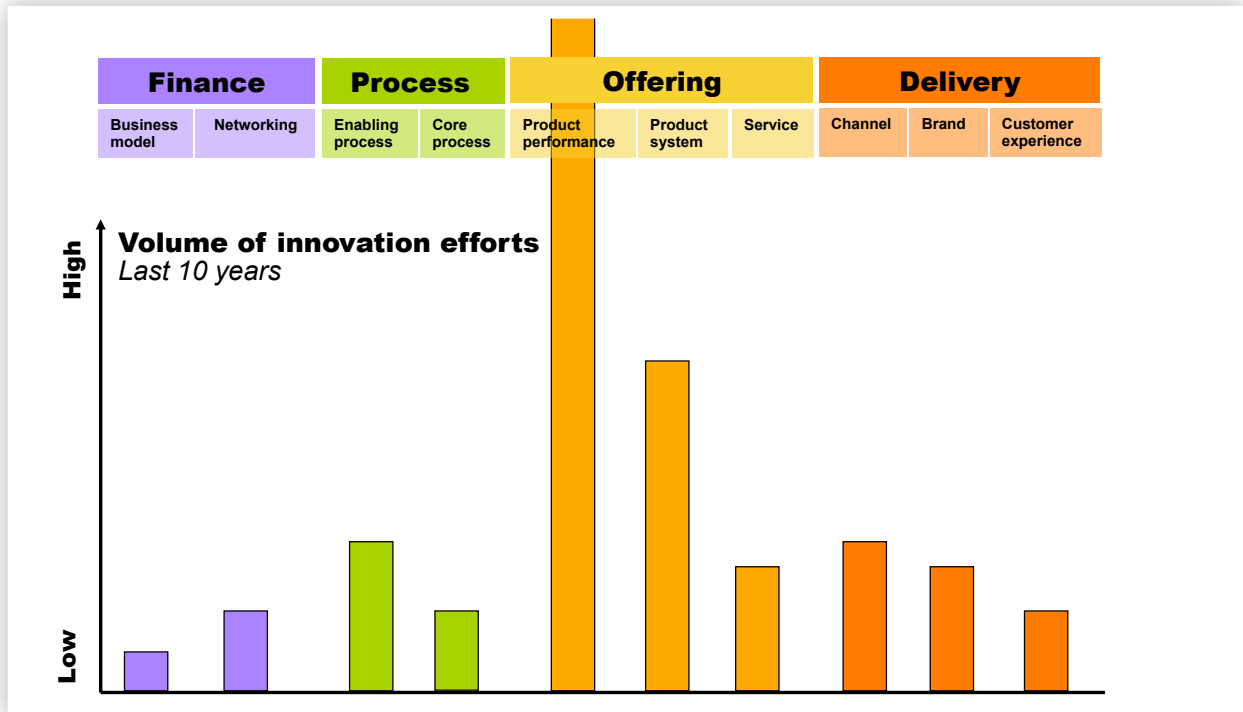
Joseph Schumpeter, often referred to as the father of modern economics, distinguished between an “invention” and “innovation.” An invention requires the spending of cash to create a new idea or product. By contrast, an “innovation” involves taking ideas and turning them into cash, or in the case of healthcare organizations, using them to make progress against established performance targets related to patient satisfaction and other areas. This definition distinguishes between the creation of a new product or service (invention) and the adoption of new ideas or even business models within an organization (innovation). As Exhibits 1–3 illustrate, there are various types of innovation, including those related to finance, processes, product offerings, and delivery. Over the last 10 years, however, large healthcare organizations have focused disproportionately on the middle, emphasizing new

Exhibit 1: Using Innovation Types Strategically



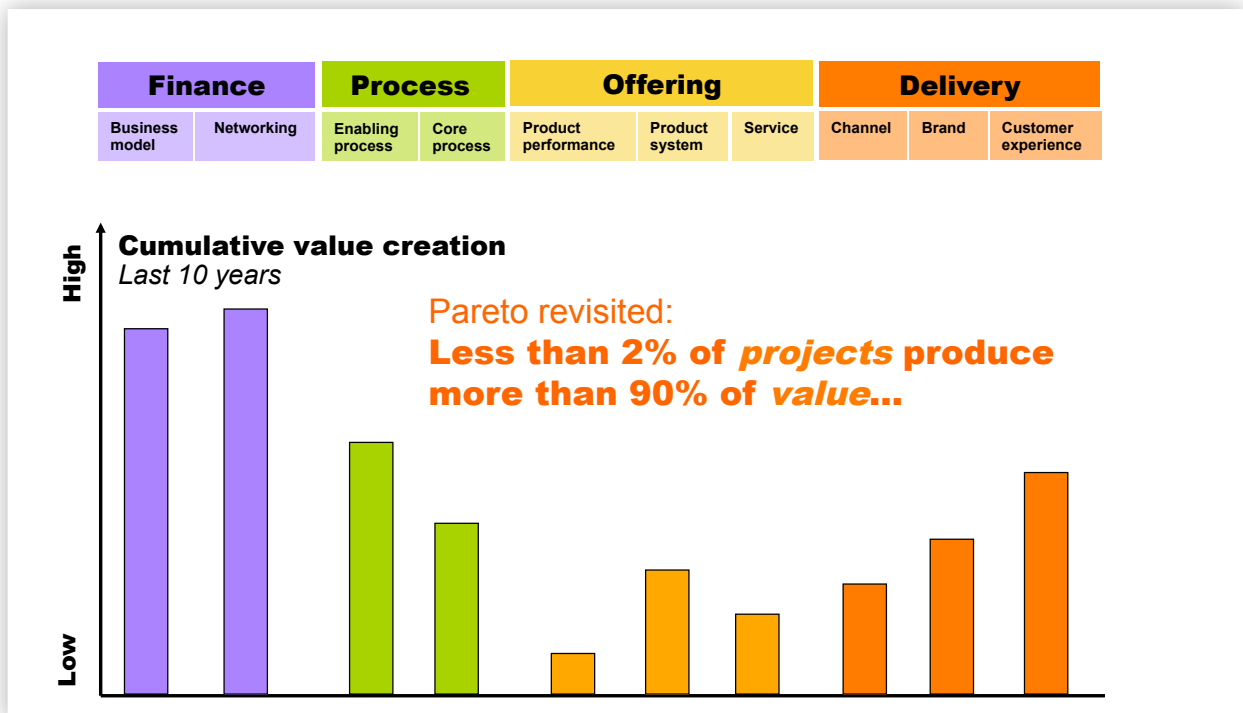
Source: The Doblin Group.

Exhibit 2: Leading to a Shift in Value Creation



Source: The Doblin Group, Doblin analysis.

Exhibit 3: Leading to a Shift in Value Creation (continued)



Source: The Doblin Group, Doblin analysis.

products such as heart valves or hip implants. However, the projects on the edges—those focused on new financial arrangements or delivery models—create the lion’s share of the value.

The key is not to fall in love with a particular gadget or high-tech “gizmo.” As **Exhibit 4** illustrates, innovations come in a variety of forms, ranging from new business models to entirely new customer experiences. For example, Nike created a whole new distribution channel (NikeTown) to connect with customers in resort and tourist cities, an approach that helped make Nike products “glamorous” to young children. Virgin Airways completely reinvented itself to become a “hip” airline, while Lexus became the first organization to create an entirely new customer experience.

First Step: Creating the Burning Platform

Like most academic medical centers, UCLA faces a large, never-ending set of strategic challenges, as outlined in **Exhibit 5**.

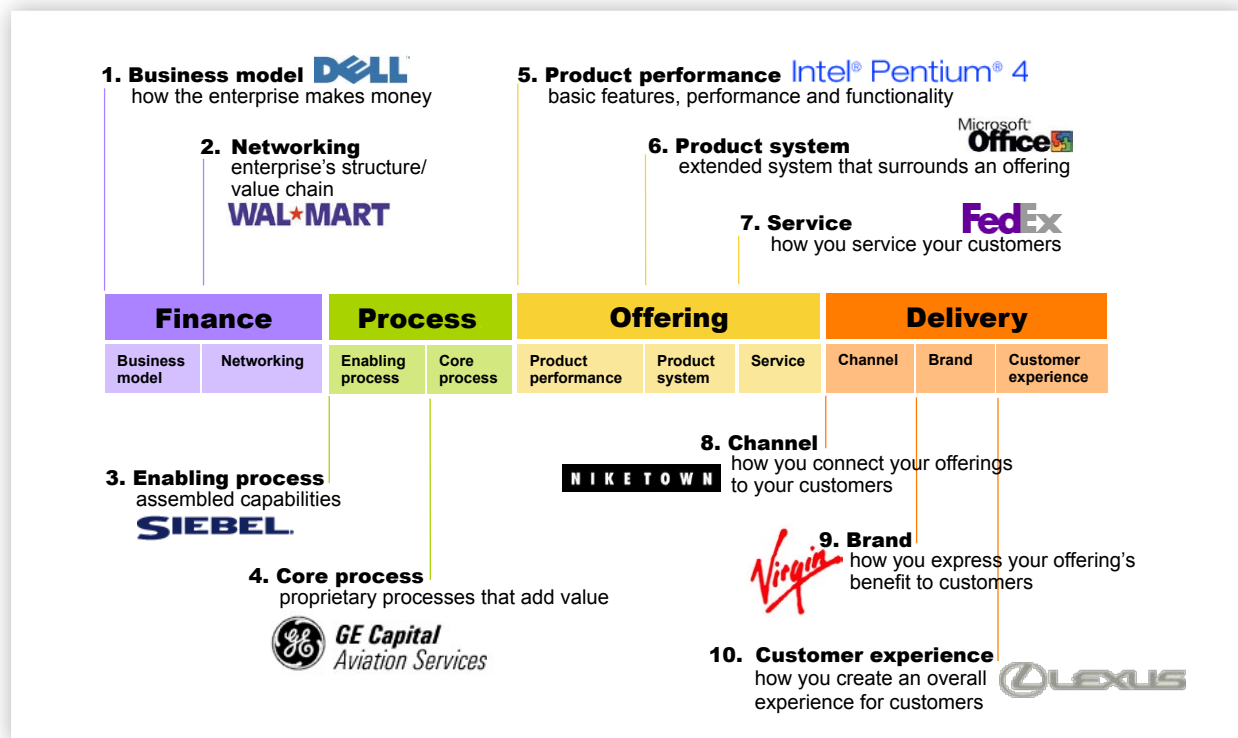
To illustrate the severity of these challenges to key stakeholders within the organization, UCLA contracted with an outside company (Navigant) to work with internal finance and strategic planning staff to model what would happen if the organization maintained the status quo. While UCLA is doing well today, this analysis made it clear that impending cuts to Medicare reimbursement and other changes would quickly lead to financial problems, with all financial reserves exhausted shortly after 2015.

Like other academic medical centers (some of which are already going out of business), UCLA had no choice but to transform itself.

Additional analyses (depicted in **Exhibit 6**) made it clear, moreover, that no single strategy could solve the organization’s problems. For example, cutting unit costs alone would not be enough, nor would aggressive marketing of the organization’s advanced specialty care services (this approach was the first thing suggested by specialists within the organization, who view their services as one of UCLA’s unique core assets). In fact, even a doubling of specialty volumes (an unrealistic goal) would delay the organization’s financial reckoning by only about a year. Similar conclusions were reached about the merits of substantially increasing primary care capacity and creating an insurance product.

This analysis served to create a burning platform that laid out a realistic picture of what the organization faced in the absence of major transformation. It helped to turn the conversation around internally, convincing key stakeholders of the need for comprehensive changes. In fact, the only approach that seemed likely to work was to embark on a wide range of strategies, including an ambitious plan to create a larger provider network and a cost-cutting program designed to take 20 to 30 percent of all costs out of the system within the next two or three years. (This approach is reflected in the top line of **Exhibit 6**.) This analysis set the stage for major innovation, as it laid out explicit targets of where the organization needed to go and how it would attempt to get there.

Exhibit 4: 10 Types of Innovation: It’s Not Just Products



Source: The Doblin Group.

Exhibit 5: Analyzing the Core Strategic Challenges

Threats to Clinical Revenues

- ✓ Medicare payment reductions: lower base payments, lower market basket adjustments, productivity adjustments (all in the ACA)
- ✓ P4P: nonpayment for readmissions or HAI
- ✓ State Medicaid funding reductions
- ✓ Commercial payment following governmental lead
- ✓ Disproportionate Share Hospital (DSH) payment reductions
- ✓ MAP Clinic Patient/Payer pushback and SGR “Doc Fix”
- ✓ Increased governmental and regulatory burden

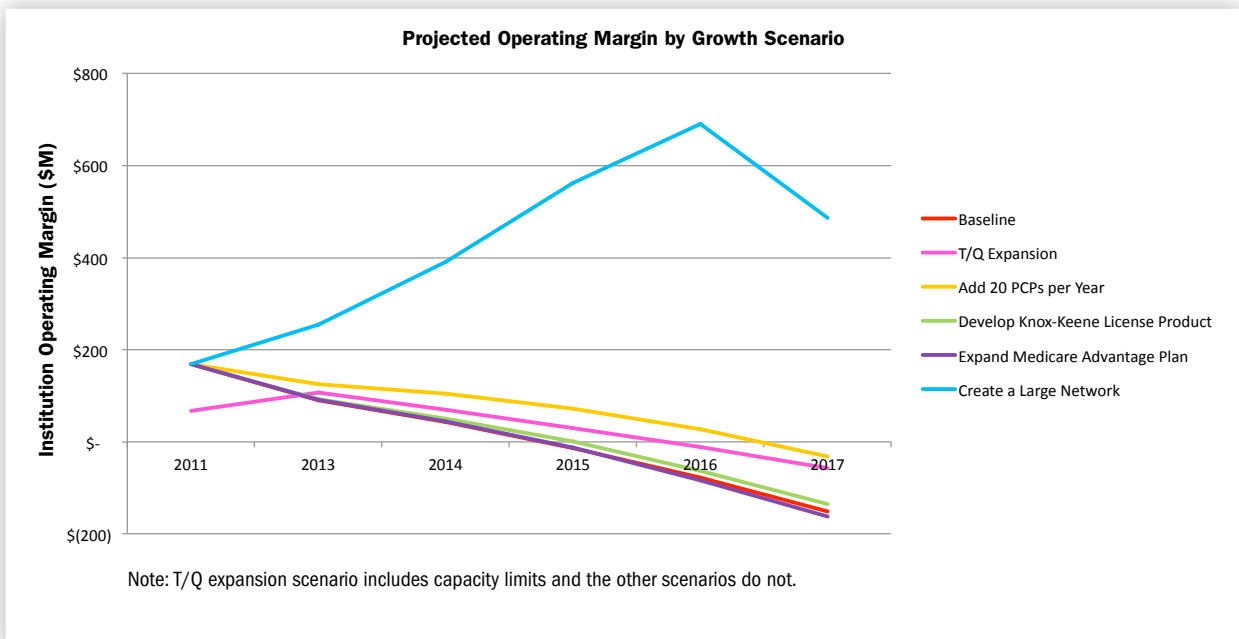


Threats to Medical Education and Research Revenues

- ✓ Reduced IME payments
- ✓ Limits on tuition income
- ✓ Reduced grants and contracts (both funding and wage limits)
- ✓ Potential GME reallocation
- ✓ Unfunded UC costs (\$200M by 2017 for UCLA)

Source: Navigant.

Exhibit 6: Investigating Strategic Options—and Discovering the Urgency of Innovation



Source: Navigant.

Examples of Innovation at UCLA Health System

UCLA leaders believe that innovation will serve to accelerate the organization's transformation from a fee-for-service (FFS) to value-based system. To that end, UCLA has embarked on an ambitious effort to pioneer innovations that promote achievement of the national goals for healthcare reform through the Institute for Healthcare Improvement's "Triple Aim,"² which seeks to improve the patient care experience, enhance population health, and reduce the costs of care. UCLA has added a fourth aim as well—improving the experience of those who provide care to patients, as the only way to sustain transformation is to make the experience satisfying and engaging for everyone involved. To that end, UCLA measures physician and staff satisfaction with all new initiatives; the goal is to generate strong enthusiasm for the changes, rather than just tolerance.

As shown in **Exhibit 7**, these innovations span the entire continuum of care (primary, secondary, tertiary, quaternary), and involve a variety of affiliations and partnerships with key stakeholders.

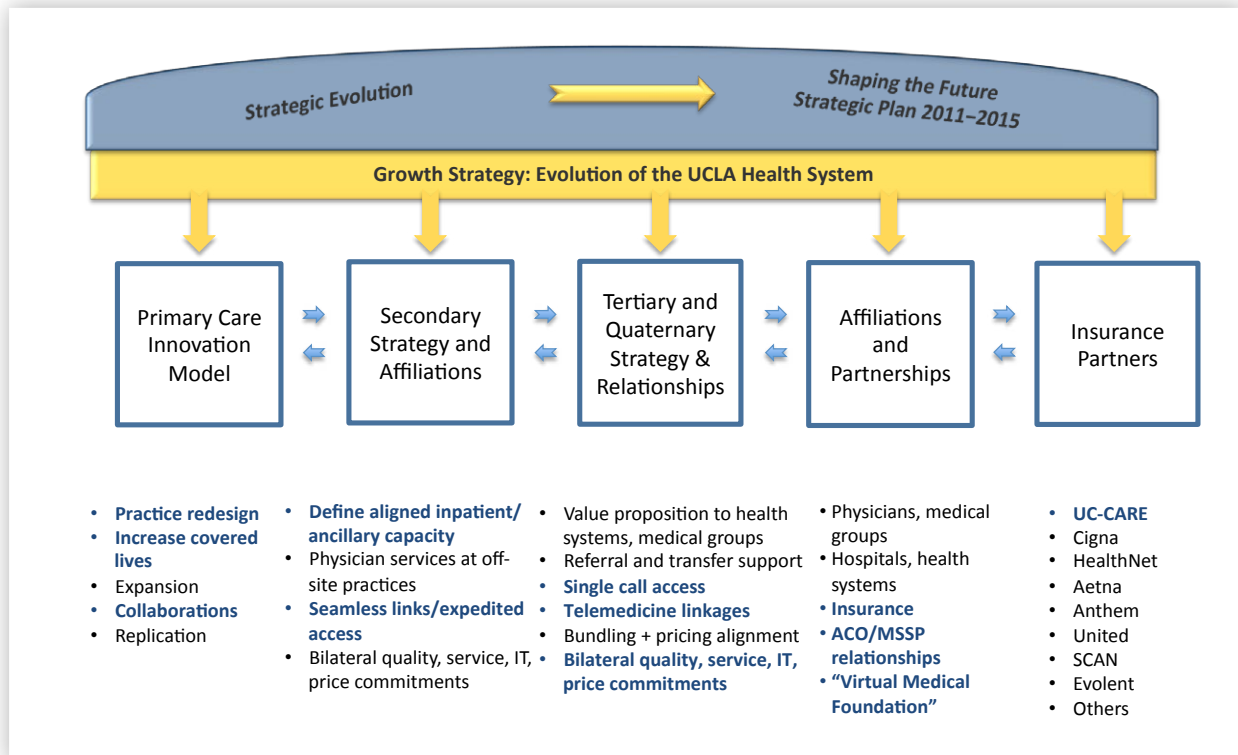
Examples of a handful of UCLA's most successful innovations include:

- In-home palliative care:** UCLA is adopting and customizing a program pioneered by Kaiser Permanente Southern California in which community-based providers (often social workers) begin having conversations with seriously ill patients and their families and caregivers in the home about how they want to handle end-of-life care when the time arrives. The program does not

require that a doctor testify that a patient has six or fewer months to live. Rather, the goal is to have these conversations earlier, rather than waiting for the patient to end up in the hospital or clinic. A well-controlled trial at Kaiser found that this approach reduced the net costs of care by 30 percent in the last year of life while also improving quality of life for patients and families. Kaiser is now spreading the innovation throughout the region and may adopt it in other parts of the country as well. Dr. Coye's innovation group is now adapting this innovation to the unique needs and environment at UCLA.

- Electronic access to specialists:** UCLA is building tight relationships with community hospital systems, helping them to provide specialty care within their organizations through electronic technologies. This approach serves to strengthen partnerships with these hospitals, rather than the traditional conflict where academic medical centers are accused of trying to "steal" patients from community hospitals. (UCLA leaders have no interest in alienating these potential partners, particularly since the medical center does not have the capacity to care for these patients.) For example, UCLA plans to adopt use of the e-ICU (electronic intensive care unit) program that monitors ICU beds in remote hospitals through a central hub staffed by specialists. The hub allows for real-time electronic audio and video feeds, with clinicians in the hub even able to read changes that occur on a patient's monitor. They can also communicate with the patient and family members, and can support ICU nurses by giving them instant access (with the push of a button) to an advanced

Exhibit 7: UCLA Strategic Response



Source: UCLA Health System.

2 For more information, visit www.ihl.org.

specialty nurse in critical care nursing and an intensivist physician. This program has reduced ICU mortality by an average of 20 percent in more than 40 hospitals and health systems that have adopted the technology in the U.S.; currently 13 percent of all ICU beds in the country are monitored with the tele-ICU. UCLA plans to implement this in a collaborative approach that will offer the program to hospitals throughout the state, in collaboration with intensivists at the University of California, Davis and other participating hospitals. Community hospitals benefit from this approach, as they get to keep more severely ill patients (and the revenues they generate) without adding significant costs. UCLA benefits by leveraging its expertise and avoiding the need to build additional ICU capacity. Constructed appropriately, this approach can serve as an enduring platform that facilitates long-term collaboration among hospital partners. In addition to the e-ICU program, UCLA has a variety of other programs within an “e-Access hub” that allows clinicians to talk to patients and doctors at remote facilities.

- **Retail clinics:** UCLA recently signed a contract with CVS Caremark to co-brand its MinuteClinic facilities in Los Angeles County and establish UCLA physicians as medical directors for the clinics. Research suggests these clinics offer high-quality, guideline-based care, with nurses working according to evidence-based protocols. Most clinic patients have insurance, and roughly half do not have a primary care provider (creating the potential to generate new referrals for UCLA primary care clinics). These clinics can interface electronically with UCLA’s EHR, allowing UCLA to know when one of its patients goes to the clinic, and allowing clinic staff to see the hospital records of patients they are serving. Rather than building its own retail network, UCLA leaders feel that this strategy allows them to meet the growing demands of patients for convenient, timely primary care. A recent study found that MinuteClinics offer better quality and generate higher levels of satisfaction than the typical primary care office.

Going forward, UCLA will continue to build on these innovations. For example, within the e-Access arena, UCLA will be putting in place a system to allow a primary care doctor to securely email a specialist for advice about a patient. Depending on the situation, the specialist can give the physician advice on how to treat the patient and/or suggest that the patient be referred for a specialty visit. This approach has been used at Mayo Clinic (in internal medicine) and within the San Francisco Medicaid program (in 18 different specialties), and has led to a 40 percent decline in the number of patients needing a specialty visit. At Mayo, it helped to free up time slots in capacity-constrained programs. UCLA is also considering contracting with an outside company, Teladoc, that employs physicians who take patient phone calls and use protocol-driven questions to determine the appropriate next course of action, such as no action required (i.e., the patient is fine or will be fine without further medical intervention), an office visit, or an emergency department (ED) visit. This approach has been adopted by a number of employers, leading to a 50 percent drop in absenteeism. The company now offers the same service to hospital systems that do not have enough capacity to handle demand for primary care services. Using these and other types of

innovations, the average primary care doctor will one day be able to handle between 6,000 and 10,000 patients, as each physician will be supported by sophisticated technology and a team of non-physician providers.

The ultimate goal is to create a “neural network” for regional distribution of specialist expertise, with UCLA being the leader of the network in some areas and a partner in others. The network will offer electronic consultations and referrals; supervised training and education; tele-health “hubs” reaching into the home and community; and remote management of services or institutions through the extension of expertise and leadership. It will be supported by advanced technology, a clinical data repository, clinical decision support, and a workforce with new knowledge, skills, and capabilities.

“Leaders must be humble...do not assume you offer the best care possible or that every patient wants to go to a physician. Observe what patients do when given the opportunity, and liberally borrow others’ ideas.”

—Molly J. Coye, M.D., M.P.H.

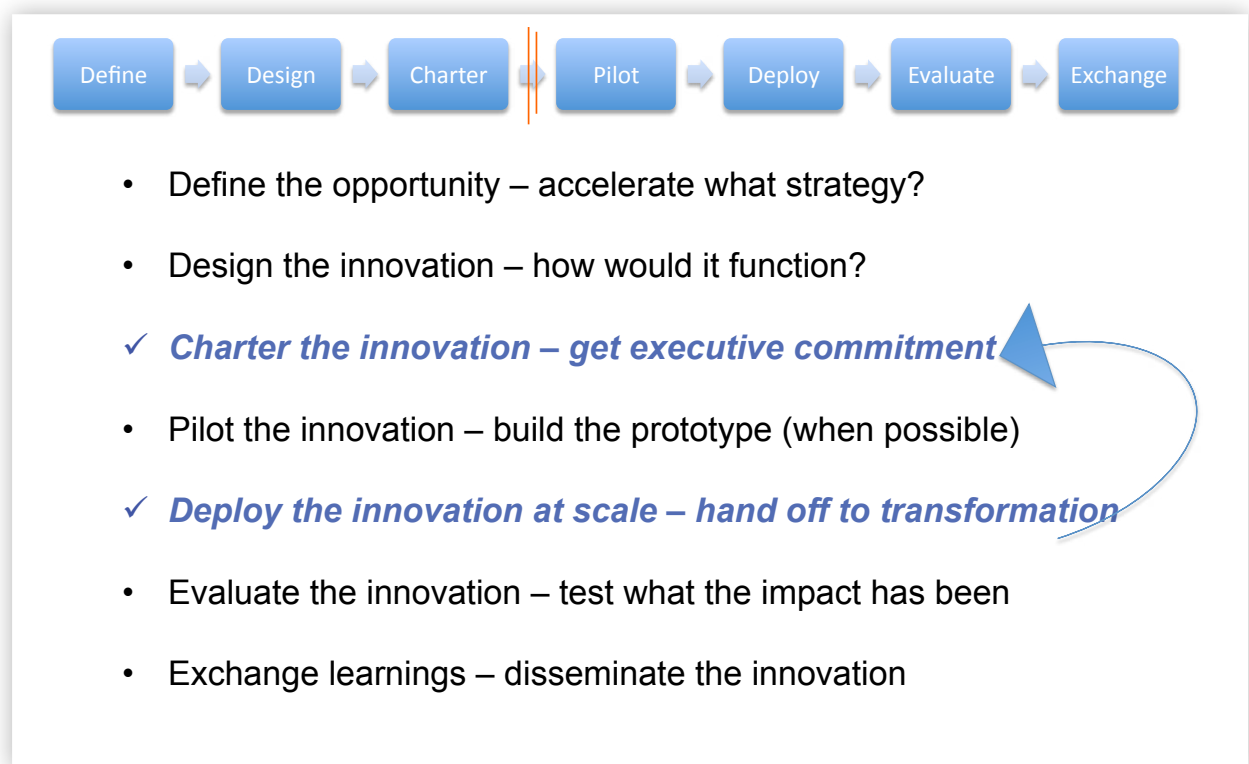
Lessons Learned

Dr. Coye’s experiences have generated a variety of lessons learned on how best to use innovation to transform a large organization:

- **Create the burning platform:** Everyone must understand and buy into the need for major transformation. Without this buy-in, innovative ideas will stall. The goal is to create an “instinct” within the organization for new ways of doing things, something that has been foreign to staff in most large entities.
- **Think process, not product or technology:** Innovation should be thought of as organizing a process rather than inventing a new product or technology. Innovation often stems from a new business model or service plan, not a “flashy” new gadget.
- **Steal shamelessly:** The process involves constantly scanning the horizon for the best performers and “stealing shamelessly.” Many best performers will be honored to see others using their ideas.
- **Partner with operational staff:** Innovation should not be the lead or endgame. Rather, innovate in partnership with operational staff members who will have to carry out the innovations, including the chief operating officer, the head of nursing, and nurses with front-line responsibility.
- **Address stakeholder concerns:** Key stakeholders may have legitimate concerns, and the failure to address them can doom an innovation from the start. For example, UCLA faced pushback from clinic physicians who were concerned that e-Access programs could cut patient volumes and hurt their revenues. Leaders agreed to keep these physicians “whole” financially if this problem materialized. To date, revenues have held up, but the commitment from leaders convinced the doctors to support the programs. Now primary care doctors are proactively approaching UCLA because they want to join the system, which offers better options for them than other organizations.

- **Create transformation groups:** Do not hand off innovations directly to busy operations staff. Rather, create the capacity for transformation through dedicated project staff charged with figuring out how to integrate the change into operations. For example, Geisinger Health System has a dedicated transformation office that includes staff with expertise in data and analytics, quality and safety, and finance. This group is “on the hook” for actually accomplishing the change, something that those in the innovations group are not in a position to do.
- **Secure leadership support (and resources):** Underfunded innovations will generally fail. To avoid this problem, rigorously screen ideas and make sure that executive leaders support them and are willing to dedicate the resources needed to succeed. (**Exhibit 8** outlines the life cycle of a lasting innovation at UCLA, which includes the key step of getting executive commitment.)
- **Avoid fads:** Innovation is not about following the latest fad or trend; it must be a core strategy of the organization.
- **Learn from others:** Key staff, including physicians and front-line workers when possible, should visit pioneering organizations to see how innovations work firsthand, including how they affect patient flow and workflows.
- **Monitor and share data on program impact:** Constant monitoring and data sharing help to maintain enthusiasm for innovation among key stakeholders. For example, Dr. Coye is a member of a small executive group that runs the UCLA Health System. She routinely shares key data with this group demonstrating the impact of various programs and how they help the organization meet key strategic objectives. Data sharing should also extend beyond the executive group to involve other key stakeholders, including front-line employees who will be energized when they see how innovations are making a difference for patients.

Exhibit 8: The UCLA Innovation for Impact Life Cycle



Source: UCLA Health System.