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ALL RISE WITH INNOVATION

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ALL RISE WITH INNOVATION

BY BETH WALSH

EVERYONE IS TALKING ABOUT INNOVATION IN HEALTHCARE. In theory, innovation improves care and outcomes and lowers costs but in practice, innovation requires a lot of groundwork. Innovation centers keep popping up and each has its own mission and motive. *Clinical Innovation + Technology* spoke with the leaders of several U.S. innovation centers to learn more about these organizations. What do they hope to achieve and how, who is involved and is this a trend or an integral part of healthcare going forward? Read on to find out.

The U.S. healthcare industry was facing a crisis with or without the healthcare reform law, says Terry Leach, RN, executive director of the University of California Center for Health Quality and Innovation in Los Angeles, but the legislation "accelerated the conversation."

Leach's varied experience, from health policy professor to public health nurse to healthcare attorney, showed her that confining the provision of illness care to the four walls of a hospital results in treatment episodes, not a wellness paradigm. The question is how to use hospitals most efficiently, she says. When people use the emergency department as their primary care provider, "that's a prime example of misallocation of resources contributing to increasing spending of healthcare dollars." The 18 percent of U.S. gross domestic product going to healthcare is not sustainable. The upward trending of that percentage was heading for a crisis that "demanded that every stakeholder get involved."

GETTING OFF THE GROUND

Among its five medical centers, UCLA had expertise in virtually every field and could support a multidisciplinary innovation center and began to do so in October 2010. The bumps in the road have come in cataloging where that expertise lay and learning how to identify and disseminate best practices.

The center does not aim to reward researchers for autonomous behavior, she says. "The only way we're going to survive as a system is if we inculcate collaboration into our mission. But there is no science of teamwork or collaboration." The first request for proposals was deliberately written to encourage projects that used interdisciplinary teamwork and where patient centeredness was one of the objectives, she says.

They expected to get about 10 RFPs during that first round but received more than 100. To manage the work, they created an operations committee that included the chief medical officers of all five medical centers and the majority of chief nursing officers.

One of the major questions for all projects is how to work with patients as partners in their healthcare. "That's a whole new paradigm for academic medical centers," Leach says. RFPs are geared to rechannel the "vast intellectual capacity at the University of California and help us create a cadre of innovators." Those that receive funding

are expected to mentor others, take advantage of the institution's leadership training and participate in the center's annual colloquium to share their work.

"There's a lot more than money we can give people to help them become a successful change agent. Money is great but it's not enough." Very few successful people work in a vacuum, she says, so they now ask that applicants identify a mentor to help them innovate on their home campus.

'LEARNING IS SOCIAL'

The MacColl Center for Health Care Innovation, part of the GroupHealth Research Institute in Seattle, also focuses on relationships, says Director Michael Parchman, MD, MPH. The center was established 20 years ago by Edward H. Wagner, MD, MPH, considered the father of the chronic care model, as a result of GroupHealth's nonprofit, consumer-driven culture.

"The natural receptor sites for this kind of work were safety net settings," says Parchman, where Wagner started off building an evidence base around chronic care. Over the past 20 years, the center has built a lot of strong relationships and ties to safety net organizations across the country. "A lot of what we do is facilitate learning by helping connect these safety net clinics and health centers in a way that they can learn from each other. Learning is a social activity."

Those safety net providers keep the MacColl team grounded, he adds. "We've taken time to visit with them, find out about their challenges."

The center is very tightly connected to the GroupHealth delivery system. "We have our feet firmly grounded in the operation side of things which serves as a reality check as far as what will or won't work in the real world."

Past success drives current projects, Parchman says. "Work by the MacColl team around improving chronic illness care led to our work with the Commonwealth Fund on the Safety Net Medical Home Initiative, an effort to support primary care re-design around medical home principles in federally qualified health centers. That work, in turn, led to funding from the Robert Wood Johnson Foundation as the national program office for Primary Care Teams: Learning from Effective Ambulatory Practices. Here, we are identifying workforce innovations across 30 primary care settings in the U.S. that improve the delivery of team-based care. So, one builds upon another in an iterative process."

Like many other innovation centers, MacColl is entirely dependent on soft money, Parchman says, including government funding and grants. "There's not an infrastructure built for doing this work. The money is there one day and gone the next so we're scrambling to find the next dollar. We're not a business and have no products we sell, no deliverables."

"In healthcare delivery, what we're missing is the innovations going on all the time that just are not recognized," he says. "We don't have a way of systematically identifying and disseminating innovation. There is a lot of potential for improvement if all we would do is look for who is doing it well and determine how we can replicate it."

PLANNING FOR WAVES

Others take a more drastic view of the future. Advisory company Oliver Wyman traditionally took "a beefy, high-impact problem and built an intellectual property platform around it," says Tom Main, partner and the firm's U.S. market leader for health and life sciences. The company's Innovation Center brings together more than 40 senior leaders from 10 health sectors working collaboratively to improve the cost and quality of U.S. healthcare and predicates on the idea that it is "impossible for the market to truly bend the trend while improving value in its current structure. Major change is a given."

Main began working on the Oliver Wyman Health Innovation Center late in 2011 and conducted 50 interviews of CEOs in the market. "We found a lot of like-minded people who wanted to drive change." CEOs became the innovation center's working body collaborating to develop new answers. "We cast a carefully constructed but wide net because we think the answers to move healthcare to a sustainable track require fundamentally new approaches and leadership."

Tom Main, Partner and U.S. Market Leader Health & Life Sciences for Oliver Wyman consulting firm, speaks during the Oliver Wyman Health Innovation Center's 2013 summit.

As a business advisor, Main says Oliver Wyman believes heavily in the power of competition. The companies they have engaged are the players that are going to drive the change. He cites incredible work accomplished on the clinical and academic sides but "we're trying to champion business models. We haven't been short on innovation. We have been terribly short on diffusion. We have allowed innovation to be trapped in silos." His goal is to break that cycle and accelerate the level of diffusion.

The center has developed a vision of three broad waves of transformation that will occur over the next 15 years: (1) patient-centered care, (2) retail and

engaged consumers, and (3) personalization and the science of prevention. "The market has been obsessed with short-term thinking," says Main. His firm felt it was critical to develop a "roadmap" that creates a long–term pathway. "We have a disruptive view of the health market where people can obtain full genomic sequencing in a retail kiosk for less than $100 within the next five or so years," he says. "When it happens, wave three could eliminate most diagnostic errors, lead to more effective personalized treatment, and change the game on disease prevention and early interventions."

One way to drive signfiicant change is getting organizations that don't normally interact to start communicating, such as health plans and social and mobile companies. "Traditional players and innovators from inside and outside the industry need to be collaborating to create change." New business models designed from the consumer's point of view will change the game, causing consumers to expect from healthcare what they already see as the new normal from Apple and Amazon, he says.

The innovation and collaboration prize is big. "We predict $1 trillion in value will shift from incumbent players to new entrants over the next 10 years."

Another trajectory of change is consumer engagement. "People are more plugged in than ever, but so far few of the health apps put all of the pieces together."

Main sites several barriers to these changes. The current fee-for-service model, for example, "motivates transactional medicine, rewards volume and, until recently, rewarded mistakes." The economic unit, he says, needs to be the whole person or disease, not a touch or visit. Reinventing the reimbursement model causes providers and patients to invest in prevention. "The underlying economic model is standing in the way of massive change."

Main says the market has made strides with EHRs but the big value improvements will come from using patient information for predictive modeling, earlier health interventions, better care coordination across care teams, and, eventually, real-time clinical insights at the point of care. Maturing technologies like big data, low-cost sequencing and personalized evidence-based guidelines will just continue to accelerate the possibilities.

Any conversation about healthcare costs, Main says, must include the 15 percent of the U.S. population with more than one chronic disease who drive more than half the costs. "We have already invented and replicated the fundamental care models and engagement programs needed to dramatically improve the cost, quality and lives of poly-chronic Americans," he says. "We have simply not diffused the answers. This is our most significant near-term opportunity."

The innovation center's workgroup is "trying to accelerate the pace of change and build businesses that deliver what a sustainable future health market requires—radically better cost, quality and consumer experience."

DRIVING DISRUPTION

The Center for Innovation at the University of North Carolina is working to provide that motivation. The center was implemented last year and comprises an Innovation Council, Innovation Leadership Group and plans for an Academy of Innovators to engage in forums aimed at furthering healthcare innovation, says Carol Lewis, associate director.

There are different models for healthcare innovation centers, say Lewis. Some focus on research, discovery and innovation around devices, technologies and drugs; some focus on commercialization or services, technologies and devices that have an enterprise component. "Our primary focus is demonstrating innovative ways to transition from the current fee-for-service environment to a fee-for-value opportunity. You have to continue to have a financial business model that supports that—that becomes the really tricky piece."

CMS Innovation Center under scrutiny

The Centers for Medicare & Medicaid Services is pushing innovation, too. The Center for Medicare and Medicaid Innovation (CMMI) was created in November 2010 pursuant to the Patient Protection and Affordable Care Act (ACA) to test new models and delivery programs, including new incentive structures from fee-based to value-based care for more coordination, better outcomes and lower costs. The center's 10-year, $10 billion budget has come into question, however, by legislators concerned about excessive spending.

CMMI Director Richard Gilfillan, MD, defended the center during a Senate Finance Committee hearing in March. Overall, the CMMI director expressed confidence that the three dozen models tested by the center will yield programs effective at improving quality outcomes. "Providers and stakeholders are eager to redesign care and participate in models that reward quality and coordination and decrease cost," he added.

However, "We are all eager to see results, but we need to be realistic. It'll take time to see improvements," he said. Typically, a model requires 12 months of experience, and three months after that period for claims to fully enter the system for analysis, Gilfillan said, adding that health outcome metrics will come into focus before data on total cost of care.

As legislators repeatedly questioned whether taxpayers are getting enough for their money, Gilfillan said, "We appreciate the resources we have and there is a great amount of work to be done. We are confident we'll come back at some future time and be able to demonstrate that to you."

Stay tuned.

THE GROWTH OF INNOVATION CENTERS

Innovation centers are popping up all over the place, says **Michael Parchman, MD, MPH**, director of the MacColl Center for Health Care Innovation, Seattle. "I think it's time for the field and the people developing these things to come to some agreement on what is an innovation—how do we define it, how do we recognize it and how do we spread it."

Most people define innovation as "a groundbreaking, game-changing invention that totally changes the way we think about something. The reality is that a lot of innovations are small, designed for a specific setting and context and work well in that setting and context. Because of that, it's sometimes difficult to spread them because the improvisation implemented to solve the problem is unique to their setting and patient population."

Terry Leach, RN, executive director of the University of California Center for Health Quality and Innovation in Los Angeles, says perhaps we should call innovation centers survival centers. "You cannot extract 18 percent of our country's wealth for healthcare and do it so inefficiently and not have significant blowback." She says hospitals that don't get involved in disruptive innovations to combat inefficiency will suffer. With increasing transparency surrounding outcomes, "for survivability sake, every provider has to do what other providers of business services do: demonstrate their value.

"Whatever organization you set up to determine how your people are going to offer more value to their payers, it's going to be necessary," Leach says. "It's about economic viability and, most importantly, delivering better patient care."

Organizations seeking to increase their focus on innovation are advised not to recreate the wheel, says Carol Lewis, associate director of the Center for Innovation at the University of North Carolina. "There are a lot of people doing this and willing to share their experience and help others interested in establishing resources around innovation."

Collaboration "will help forward the work of the industry," she says. "It's hard work but with some tenacity, we can all move forward."

The Center for Innovation developed from an advanced healthcare practice UNC conducted with Blue Cross Blue Shield of North Carolina (BCBSNC). That practice was so successful and disruptive for how to deliver primary care that UNC decided to set a resource center to make more of these pilots happen, Lewis says. The center is trying to find and execute projects that are focused on disruptive and novel innovation to get to a lower overall cost of care."

There are numerous challenges to the work, not the least of which is funding, Lewis says. "A lot of what we do is not sustainable today." The organization needs interim funding to buy time to demonstrate their efforts' value. "Bringing together disciplinary efforts that would not normally take place in the healthcare industry creates challenges and complexity," she says.

UNC partnered with BCBSNC to align incentives for their advanced practice—Carolina Advanced Health. "Blue Cross is sharing the medical expense savings that we achieve in that practice," Lewis says. The group focuses on helping patients with chronic illness do a better job of staying healthy to avoid high-cost, healthcare services. There are smaller patient panels so patients have greater access to their providers and the practice uses a team-based care model, integrating several disciplines. The practice has seen more than 1,000 patients and experienced "a phenomenal response. The patients absolutely love the place." It's too early for a cost evaluation so they have yet to determine if the financial model works.

Payers are very interested in making this change as well, Lewis says, because "the financial risk is probably the greatest risk. It's a matter of finding out how to navigate from here to the future." Medicare, Medicaid and BCBSNC are the predominant payers in North Carolina. "All three are investing significant effort in the same transformation."

Lewis says the group is trying to integrate all the elements of the continuum of care under one umbrella to align incentives and better manage the overall cost and quality of care. "It's a big transition for the state that will involve data analytics." One significant problem, however, is that data are held in disparate databases in different organizations. Databases for pharmacies, hospitals, ambulatory care, primary care and specialists aren't linked. "One of our greatest technological needs is the combining of these datasets so we can do meaningful analytics that produce meaningful information for decision making. It's a critical piece but it's expensive and difficult."

Innovation centers are necessary now, Lewis says. "Some innovation needs to be driven with dedicated resources that think about innovation, promote innovation and disrupt the current thinking of their organization and make innovation happen. Without dedicated resources, it will be very difficult to make the transition."

The center's proximity to a university medical school provides support and a platform for training. Preparing the workforce of the future is important, Lewis says, including how people are licensed and training them to use newer technologies. "If physicians aren't comfortable using technologies such as telehealth, they won't be able to carry forward with that kind of work." Existing providers face fears because they were trained one way and those methods keep changing. "They need additional training about the risks of new technologies and how to incorporate them into the workflows of their practices."

With so much work happening in this area and covering everything from training to devices to workflows to reimbursement, change is going to come. CIT