



SCALING AND SPREADING INNOVATION STRATEGIES TO IMPROVE CARDIOVASCULAR HEALTH

Authors

Veronica F. Nieva, PhD
Shannon Fair, RN, MPH

Laura Gray, MPH
Julie Bergmann, MHS

Scaling and Spreading Innovation

Strategies to Improve Cardiovascular Health

September 2012

Authors

Veronica F. Nieva, PhD
Shannon Fair, RN, MPH
Laura Gray, MPH
Julie Bergmann, MHS

Executive Summary

This report presents a summary and findings from an April 2012 event entitled *Million Hearts™ Scaling and Spreading Innovation: Strategies to Improve Cardiovascular Health*, sponsored by the Agency for Healthcare Research and Quality (AHRQ)'s Health Care Innovations Exchange, the Centers for Disease Control and Prevention (CDC) Division for Heart Disease and Stroke Prevention, and the Centers for Medicare and Medicaid Services (CMS), in partnership with the American Heart Association. The event generated valuable findings for the emerging field of scaling and spreading innovation. Findings are summarized here.

Findings

- For an innovation to spread, it is critical to define its core elements, which have to be preserved in all efforts to implement the innovation in other settings, while recognizing the importance of adapting and tailoring other elements to the requirements of each implementation setting. Distinguishing between core and adaptable elements is not a simple task.
- Innovations need to be “packaged” for spread. Their benefits must be clearly and strongly stated in terms that are relevant to each stakeholder audience. Because innovations are often complex, packaging must include an array of implementation aids: training, operational manuals, organization charts, process flows, and the like. Few innovations have the necessary implementation packages.
- In many cases, innovators have no interest, or skill, in spreading their innovations. Thus, for spread to occur, innovators must be connected with spread agents, which can take a variety of forms.
- Many stakeholders have to be activated and aligned in order for innovations to spread effectively. A robust multistakeholder infrastructure

will be needed to speed up the spread of cardiovascular and other innovations throughout the health care sector. For spread efforts to succeed, innovators must engage multiple stakeholders, including hospital/health system leadership, providers, patients and families, communities, employers, public entities, private funders, connectors, adopter organizations, and spread organizations. The benefits to these stakeholders need to be articulated in a compelling and targeted way.

- Potential adopter organizations must provide fertile ground for the innovation. A culture that is generally open to change is critical, but any specific change must align with the organization's current priorities. Organizational change champions are critical to overcome the inevitable barriers that face any effort to do things in a different way.
- Many implementation tactics, at macro and micro levels of organization, must be explored. Some of these tactics have a broad focus, such as organizational partnerships and collaboration by entities that have not traditionally worked together, and the use of media to create awareness and demand for innovative approaches to care delivery. Other tactical considerations are more targeted to individual adopter organizations; these include approaching innovation efforts incrementally versus aiming for more comprehensive programs at the outset, adopting a narrower stand-alone program, and exploring integrated solutions.
- Efforts to spread improvements in cardiovascular health and other innovations may be assisted by transformations that are underway in the health care environment. These include payment systems that are moving from volume-based schemas to ones that emphasize value and outcomes, changing roles and scope of the health care workforce, and development of new provider and delivery systems. The potential for an important role of traditional and new media in promoting the spread of these innovations has yet to be exploited. Scaling and spreading innovations will be facilitated by exploring their possible integration into larger experimental models (e.g., Patient-Centered Medical Homes and Accountable Care Organizations), which will likely become part of the health care landscape in the near future.

Table of Contents

Executive Summary	v
Findings.....	v
Introduction	1
Background on the Million Hearts™ Initiative	1
Event Description	2
Report Overview.....	5
Prepare Cardiovascular Innovations for Spread	6
Identify Core Elements of the Innovation.....	6
Tailor the Innovation to Local Contexts	8
Package the Innovation for Spread	10
Connect Innovators with Spreaders	12
Engage Multiple Stakeholders in Spread Efforts	15
Identifying Stakeholder Groups and Roles	15
Tailoring Message to Various Stakeholders	17
The Provider Pitch.....	18
The Hospital/Health System Leader or Administrator Pitch.....	19
The Employer Pitch	20
The Patient Pitch	21
The Insurer Pitch	23
Exploring New Partnerships	24
Spreading Cardiovascular Innovations	28
Creating Receptivity to the Spread of Cardiovascular Innovations	28
Creating Organizational Readiness to Adopt Innovations.....	31
Implementing Innovations	33

Table of Contents continued

Spreading Innovations in a Changing Health Care Environment	36
Payment Systems	37
The Changing Healthcare Workforce	39
New Provider Organizations	42
Summary and Conclusions	43
References	46
Appendix A.....	47
Invitation	47
Appendix B.....	49
Million Hearts™ Participants.....	49
Appendix C.....	54
Agenda.....	54
Appendix D.....	57
Heart360® Fishbowl Summary.....	57
Appendix E.....	59
Disease Management to Promote Blood Pressure Control Among African Americans Fishbowl Summary	59
Appendix F.....	61
Language Concordant Health Coaches Fishbowl Summary	61
Appendix G.....	63
Medication Therapy Management Fishbowl Summary	63
Appendix H.....	65
Top Ideas from the 3x5 Exercise	65

Introduction

This report provides an overview of lessons learned from the April 2012 *Million Hearts™ Scaling and Spreading Innovation: Strategies to Improve Cardiovascular Health* event sponsored by the AHRQ's Health Care Innovations Exchange,¹ the CDC Division for Heart Disease and Stroke Prevention, and CMS, in partnership with the American Heart Association. This meeting was one of many events associated with the larger Million Hearts™ initiative.

Background on the Million Hearts™ Initiative

Million Hearts™ is a Department of Health and Human Services national initiative aimed at preventing 1 million heart attacks and strokes over a 5-year period from 2012 to 2017. This goal will be achieved by:

- Improving access to effective care;
- Improving the quality of care as related to Aspirin-Blood Pressure-Cholesterol-and Smoking (the ABCS);
- Focusing clinical attention on the prevention of heart attacks and strokes;
- Activating the public to lead a heart-healthy lifestyle; and
- Improving the prescription and adherence to appropriate medications for the ABCS.²

The Million Hearts™ initiative will focus, coordinate, and enhance cardiovascular disease prevention activities across the public and private



For more information on the Million Hearts™ initiative, visit <http://millionhearts.hhs.gov>.

¹The Agency for Healthcare Research and Quality (AHRQ)'s Health Care Innovations Exchange is a central repository of health care service delivery and policy innovations. It features profiles of successful and attempted innovations that describe the innovative activity, its impact, how the innovator developed and implemented it, and other useful information for deciding whether to adopt the innovation. AHRQ's Health Care Innovations Exchange is available at: <http://innovations.ahrq.gov>.

² Million Hearts™: The Initiative. <http://millionhearts.hhs.gov/aboutmh/overview.html>

sectors and demonstrate to the American people that improving the health system can save lives. Finally, Million Hearts™ will scale up proven clinical and community strategies to prevent heart disease and stroke across the nation.³

Event Description

“The ‘what to do’ here is not rocket science. The ‘getting it done’ is harder than rocket science, but this is exactly the group to help us get started.”

Carolyn Clancy, AHRQ

On April 19, 2012, thought leaders from health care systems; federal, state, and local health organizations; health professional and patient organizations; payers and funders/investors; educational and research institutions; and more attended the invitation-only event, *Million Hearts™ Scaling and Spreading Innovation: Strategies to Improve Cardiovascular Health*. The event was designed to foster awareness of innovative ways to improve cardiovascular health and health care delivery and inspire creative thinking about scaling and spreading these cardiovascular innovations throughout the nation. The innovations featured in this event had been demonstrated to be effective. Given this premise, the goal of the day was to discover what it would take to foster broad implementation of these and other successful innovations in order to achieve the goals of the Million Hearts™ initiative.

The attendees were selected to represent the variety of perspectives that would need to work together for scale up and spread efforts to succeed. These stakeholders in cardiovascular health included government representatives, professional associations, insurers/payers, business groups, academic researchers, health care systems, and safety net providers. In Janet Wright’s opening remarks to the participants, she stated, “I will tell you you’re not here by accident. You were actually chosen because of your creativity and ingenuity, and your expertise, not only in your fields and in your organization’s mission, but actually in the ability to apply what you learn where it makes the most difference.” The participants shared real-world success stories on innovative health care service delivery activities that improved blood pressure and cholesterol levels. Facilitated by an innovative agenda, they brainstormed how to spread these successes in order to achieve better heart health in the nation. Appendix A shows the invitation issued, and Appendix B displays the participants who attended this event.

Carolyn Clancy, Director of AHRQ, and Thomas Frieden, Director of CDC, were featured keynote speakers. The event day was divided into three major sections. The morning was devoted to four “fishbowl” sessions, each focusing on an evidence-based innovation on heart health. In the afternoon, the sessions changed focus, moving from specific innovations to broader questions about scaling and spreading health care innovations. Attendees were invited to participate in three “buzz sessions,” each devoted to a broad question related to

³ Million Hearts™: The Initiative. <http://millionhearts.hhs.gov/aboutmh/overview.html>

scale up and spread. The day ended with a “3x5” activity to identify the best ideas generated during the day. The full agenda for the event is available in Appendix C.

Fishbowls

The event started with a plenary “fishbowl” session involving all participants, followed by three concurrent sessions. The four innovations featured in the fishbowl sessions differed in their core elements, implementation settings, and the extent to which they had scaled up and spread these novel practices.



The fishbowl format involved an innovator presentation to a reactor panel whose members represented specific stakeholder perspectives. The panels posed questions and offered guidance to the innovators about issues they might consider in further efforts to spread their innovations. These dynamic sessions identified a range of important issues and challenges to scale up and spread that could be generalized to other efforts to expand innovative practices in cardiovascular health. These conversations were staged in a metaphorical fishbowl, with other participants observing and contributing actively to the discussion.

Brief summaries of the innovations follow below:

- **Heart360®:** In this pharmacist-led, home blood pressure monitoring program implemented in Kaiser Permanente Colorado, participants upload their home blood pressure measurements 3 to 4 times a week to the American Heart Association’s Heart360® Web site. Innovator David Magid described how clinical pharmacy specialists monitor the patients’ blood pressure readings and adjust medication therapy as needed. This program, which has spread to Kaiser Permanente Southern California, has led to improved blood pressure control, increased reduction in blood pressure, and improved patient satisfaction with care for patients with uncontrolled hypertension.
- **Disease Management to Promote Blood Pressure Control Among African Americans:** The purpose of this innovation was to improve blood pressure among African Americans in the Aetna health plan, using a telephonic nurse disease-management program. René Vega described the results of this program: decreased systolic blood pressure and increased frequency of blood pressure self-monitoring among the participants. The program design was combined with another similar pilot study and expanded to Aetna’s Medicaid population.
- **Language Concordant Health Coaches:** This program was implemented in the San Francisco General Hospital Family Health Center. Health coaches who speak the patient’s preferred language team with residents to improve the self-management skills and quality of care of patients who have limited English proficiency and health literacy.

Innovator Hali Hammer described how health coaches conduct a pre-visit meeting, assist during the medical visit, conduct a post-visit meeting, and follow up with the patient 1 to 2 weeks after the visit to offer additional support. The program has led to improvements in the treatment process and clinical outcomes of patients with diabetes, including improved blood pressure and cholesterol levels.

- **Medication Therapy Management:** The North Carolina Pharmacists Association's Asheville Project created a community-based, medication therapy management (MTM) program initially for patients with diabetes and subsequently for hypertension/dyslipidemia, asthma, and depression. As described by one of the innovators, Barry Bunting, the pharmacist-based program resulted in both clinical benefits (i.e., reduced hemoglobin A1C levels, improved blood pressure control, and significant declines in cholesterol and serum triglyceride levels) and financial benefits (i.e., reduced costs across four targeted conditions: diabetes, asthma, cardiovascular disease, and depression; and a positive return on investment). The program has expanded nationally with the support of several organizations, including (but not limited to) American Health Care and the American Pharmacists Association Foundation.

For more information on each of the fishbowls, including a list of the presenters, moderators, reactor panel members, as well as links to the presentations and profiles from the AHRQ Health Care Innovations Exchange, see Appendixes D-G.

Buzz Sessions

In the afternoon, participants joined moderated discussion groups (“buzz sessions”) to discuss general issues related to scaling and spreading health care innovations. Participants were invited to move freely across buzz sessions, depending on their interest in the open-ended discussions. The sessions explored the following questions:

1. How can innovators proactively promote the spread of their innovations? What skills and support do they need to be successful?
2. What do potential adopter organizations need to facilitate their uptake of healthy heart innovations?
3. How can government and private institutions work together to promote the spread and adoption of healthy heart innovations?

3x5 Exercise

In a highly interactive closing activity, participants were asked to identify and rate the best ideas of the day in an exercise using 3x5 index cards. The goal was to identify the top ideas

to support scale up and spread activities related to the Million Hearts™ initiative. To view these top ideas, see Appendix H.

Report Overview

This report summarizes the key themes that emerged from the April 2012 event. The report, based primarily on the transcripts of the fishbowls and buzz session discussions, is organized along the following topics:

- How to prepare innovations that further the Million Hearts™ initiative for spread;
- Differences between the roles of Innovators and Spreaders and how to connect the two;
- Necessity of engaging multiple stakeholders in spread efforts;
- Considerations for implementing Million Hearts™ innovations in various health care settings; and
- How to spread Million Hearts™ innovations in a changing health care environment.

Prepare Cardiovascular Innovations for Spread

“Transition issues’ need to be addressed in moving something from one organization or from a pilot to a larger scale. So things like information systems are needed ... training and identifying staff.”

Marie Schall, Institute for Healthcare Improvement

Taking a successful cardiovascular innovation to scale requires careful preparation. Because complex innovations often include multiple elements, it is critical to distinguish the innovation’s core elements from other elements that can and should be tailored to the particular requirements of different implementing contexts. Participants grappled with the challenge of balancing the need for maintaining fidelity to the innovations’ core elements with the need to tailor the innovation so that it can work well in other settings or populations. In addition, for broad scale up and spread of Million Hearts™ innovations, implementation packages consisting of support materials and services must be developed to assist potential adopters.

Identify Core Elements of the Innovation

“As I think about the intervention that you described and that you’re doing, it really strikes me that there are multiple interventions here. And so part of my challenge is trying to figure out which of these things really make a difference.”

Foster Gesten, New York State Department of Health

Many health care innovations, like the ones featured in the Million Hearts™ event, consist of complex combinations of new activities, organizational structures, and professional roles. The outcomes of these complex innovations result from the mix of planned interventions with the attributes—systems, policies, resources, and culture—of the organizational context in which the interventions were originally implemented. Thus, when these tested interventions are considered for scale up and spread, it is critical to identify the core components of the innovation—those critical items that “make the difference”—and distinguish these from other characteristics that are less central and may be modified as necessary, depending on the particular circumstances of the adopting settings. In fact, step one of the World Health Organization’s (WHO) nine-step plan for developing a scale up strategy is to identify the key components of an innovation (WHO 2010). Moderator Paul Plsek summarized threads of the participant discussions in terms of the importance of breaking an innovation down into “simple rules or minimum specifications”—the two to three key ingredients in each innovative program—and ensuring that efforts to scale and spread the innovation maintain fidelity to these key ingredients.

Throughout the Million Hearts™ event, participants and reactor panel members asked each innovator about the core elements that made his or her innovation successful, which would therefore have to be maintained in any spread initiative.

In the first fishbowl presentation of the event on the Heart360® program, innovator David Magid of Kaiser Permanente Colorado articulated the core elements of the program to include (1) a home blood pressure monitoring program and (2) clinical supervision of readings with prescription modification as needed. Magid explained how home blood pressure monitoring is not enough by itself to obtain the desired clinical outcomes and that the second element—clinical supervision and medication adjustments as needed—was necessary to achieve lower blood pressure results.

During discussions about the Language Concordance Health Coaches innovation, Foster Gesten, from the New York State Department of Health, identified five interventions: (1) focus on patients at highest risk of poor outcomes if they are not able to self-manage their chronic illness (at San Francisco General Hospital, they targeted diabetic patients with hgbA1c > 8); (2) health coaching, which entailed providing self-management support to patients; (3) language concordance (i.e., using health coaches who speak the patient’s preferred language); (4) monitoring patients’ progress and outcomes in monthly meetings; and (5) telephonic follow-up support with the patients after the visit and serving as a liaison between the patient and the clinician. After articulating these components of the Health Coaches innovation, Gesten challenged the innovator, Hali Hammer, to identify the core of her innovation. She responded: “The part of this that I think is really most valuable and that has the most far reaching multifaceted impact is training people who are not the most highly educated, highly trained, and expensive people on the health care team to provide self-management support and to teach people how to take their medications.”

In the fishbowl session on the Medication Therapy Management innovation, also referred to as the Asheville model, discussion centered on the core elements that distinguished this model from other disease management programs. The centrality of the pharmacist role to the innovation was a subject of debate. Although the innovator Barry Bunting argued that

“there is a unique aspect that a pharmacist brings to the plate,” especially when the primary treatment is drug therapy, he conceded that a health care professional “touching [patients] more frequently than they’re currently being touched in the system” is what is most important. In other adaptations of the original Asheville model, the program has demonstrated success through the use of diabetes educators, nurses, and even respiratory therapists in asthma programs.

These discussions during the Million Hearts™ event underscored the realization that identifying the core of an innovation is not necessarily an easy task. It may be helpful to conduct formal analyses of the core components of innovative programs to identify what is essential for a program to succeed when replicated and which pieces are more flexible (DHHS/SAMHSA/CSAP 2002). However, such analyses may not always succeed in shedding light on this complicated question. Speaking about the Asheville Medication Therapy Management innovation, for example, Barry Bunting noted that, despite extensive analysis over 5 years, researchers at the University of North Carolina were unable to identify which elements in this innovation were most critical to its success.

Tailor the Innovation to Local Contexts

“What are the essential elements of the models that we were looking at, and then how can we look at different settings and see how they might be applied? ... The understanding and the recognition for the need for adaption is certainly an important one.”

Marie Schall, Institute for Healthcare Improvement

As a counterpoint to the discussions on the importance of maintaining fidelity when implementing tested innovations, conversations throughout the Million Hearts™ Scaling and Spreading Innovation event focused strongly on the need for adaptation—specifically, tailoring interventions to the local context where they will be implemented. Conference participants agreed that it is essential to consider what tailoring may be needed so that the program will succeed when spread. Evidence of effectiveness is usually confined to the setting in which the data were generated. Typically, evidence on “external validity,” or how the findings may generalize to other contexts, is not available. Thus, the potential adopter faces the challenge of taking that successful model and implementing it using different health care providers or targeting a different population.

Health Care Providers

Tailoring the innovation to a new context may involve investigating whether the innovation’s basic parameters might need to be modified in the new setting. For example, who are the key players in implementing the innovation? The question that surfaced about the centrality of the pharmacist role in the Heart360® and Asheville innovations (discussed

in the previous section) illustrates this avenue for adaptation. In Kaiser Permanente Colorado, innovator David Magid had utilized pharmacists to monitor the blood pressure readings and modify medication prescriptions. Gregory Pawlson of Blue Cross Blue Shield pointed out that other providers, such as panel managers, could review the blood pressure readings and follow up with nurse practitioners or physician assistants when abnormal readings are identified. Agreeing with the possible flexibility on this element of the innovation, Magid referenced a similar initiative in Great Britain wherein patients themselves made the changes to the blood pressure medication based on instructions from health care providers. Summing up the possibilities for altering the central role of the health care provider in other implementations of the Heart360® innovation, moderator Paul Plsek cited Clayton Christensen, an influential innovation theorist, who suggested that innovation often consists of finding someone less expensive and more accessible to fulfill functions that were traditionally carried out by more senior professionals.

A variation on considering who might be pivotal in implementing the innovation is to think in terms of using teams in place of individual professionals. Mark Smith, from the MedStar Institute for Innovation, suggested that the Asheville model could be tailored and improved upon by using a team of physicians and pharmacists. This care team could improve efficiencies in that it could “shorten the feedback loop of pharmacist’s observation, suggesting it required intervention, as opposed to having the patient have to then go to the doctor’s office. If they know and trust each other, a phone call, a message ... and we’ll adjust the medication right then.”

Target Populations

Tailoring an innovation might take the form of changing the target population. For example, René Vega explained how Aetna’s culturally sensitive innovation to promote blood pressure control among African Americans can be tailored to a variety of populations, defined in ethnic (e.g., Latinos), age (e.g., Medicare), or economic (e.g., Medicaid) terms. The success of the early pilots has encouraged Aetna to implement the innovation within broader populations insured by Aetna. Similarly, Hali Hammer’s San Francisco innovation, Language Concordant Health Coaches, could easily expand beyond its current target population, high-risk patients with diabetes, to other high-risk populations, as well as to other populations with limited health literacy. In fact, participants in the Million Hearts™ event pointed out that the goals of the Health Coaches innovation—to improve self-management and quality of care—apply broadly to most populations who receive health care services.

Package the Innovation for Spread

“There’s all the (new) operations and implementation issues ... you don’t want to reinvent the wheel every time. There’s a lot of opportunity for shared learning at that local level where they may have commonalities in those intricacies of implementation.”

Adam Zavadil, Alliance of Community Health Plans

Potential adopters of any novel care delivery process typically need significant assistance in implementing the interlocking processes, technologies, and organizational role changes that make up complex health care innovations. Meeting participants noted that, for the cardiovascular innovations to spread broadly across the country, the challenges of adopting and implementing new ways of working would be aided by the availability of support materials and services for the innovation. Their views are supported by an analysis of four national quality campaigns conducted by Yuan et al. (2010), which found that having practical implementation tools and guides to link innovations with widespread adoption was a key strategy for achieving spread of innovative programs.

However, while spread packages were identified as a critical element for the spread of healthy heart innovations, only one innovation of the four featured during the event, the Asheville Medication Therapy Management model, had moved to this stage of development. In 2005, the American Pharmacists Association (APhA) Foundation secured grant funding from several large pharmaceutical companies to spread the Asheville approach to ten cities, with a particular focus on diabetes. To launch the Diabetes Ten-City Challenge, the APhA developed materials and assistance for large employers implementing the program. The APhA Foundation subsequently supported adoption of the program for other conditions in these ten cities.

There is no well-developed checklist for what might constitute an innovation’s “spread package.” Examples of materials that might constitute a “spread package” may be seen in the Asheville innovation and other innovations that have been scaled and spread to multiple adopter organizations (e.g., the Nurse Family Partnership,⁴ the Hospital Elder Life Program [HELP],⁵ and the Green House® Project⁶ [Home-like Nursing Homes]). Some examples include communication about evidence of the program’s effectiveness, training materials, job descriptions and organizational charts, frequently asked questions (FAQs), step-by-step manuals/toolkits (“cookbooks”), and descriptions of workflow procedures. Additionally, information on procedures for quality control and auditing the program can help others maintain fidelity to the work product or measures conducted. Other useful materials include sample communication materials, such as letters, flyers, posters, etc., that can be used to publicize the initiative and garner support. In addition, the methods or approaches for conducting outreach can also be a helpful material for an adopter to access.

⁴ Nurse Family Partnership. <http://www.nursefamilypartnership.org>

⁵ Hospital Elder Life Program (HELP). <http://www.hospitalelderlifeprogram.org>

⁶ Green House® Project. <http://thegreenhouseproject.org/>

“Spread packages” might also include services as well as materials. The spread organizations noted above provide consultation and technical assistance in addition to implementation materials. Participants also pointed to the usefulness of peer learning networks that provide the opportunity for individuals who are implementing a program to talk to one another, keep momentum going, and troubleshoot implementation barriers. An example of this peer support and mentoring network was provided through the AHRQ Health Care Innovations Exchange to assist in the spread of the Community Care Coordination Pathways model.⁷

The experience of the Asheville innovation and other national innovation campaigns points out that development of spread packages and assistance requires considerable resources and focused effort. Funding for the development of spread packages has typically come from the government agencies (e.g., CMS, AHRQ, and CDC) and philanthropic foundations (e.g., Hartford Foundation, The Robert Wood Johnson Foundation, and the American Heart Association). Discussions during the Million Hearts™ event suggested that complementary funding might be desirable from the private sector, such as from national and state business coalitions on health. Representatives from these types of organizations spoke about the interest among their employer members and potential willingness to support these kinds of services.

It is not obvious who should develop spread packages and at what point this effort lies with the innovator of the program or with spread organizations. More information pertaining to the relationship between innovators and spreaders is presented in the next section, “Connect Innovators with Spreaders.”

⁷ Program uses “Pathways” to confirm those at-risk connect to community-based health and social services, leading to improved outcomes. <http://www.innovations.ahrq.gov/content.aspx?id=2040>

Connect Innovators with Spreaders

“You’ve innovated something in your setting that works really very well, and it isn’t your responsibility to necessarily think about or make it work in other settings. So, where are the champions that take this ... and take it further?”

Gregory Pawlson, Blue Cross Blue Shield of America

Innovators are often clinicians, academics, or health care professionals who develop creative programs to address local needs and challenges. Though these efforts can produce valuable information that can be used to improve health care delivery on a larger scale, innovators are generally not concerned with propagating their program across a variety of settings and/or do not have the skill set necessary to do so. The work of spreading an innovation is often unfamiliar—and possibly uncomfortable—for the innovators, and it may be neither possible nor practical for innovators to acquire proficiency in the many areas required to comprehensively spread an innovation. Though there may be a subset of innovators who want to be spreaders, these individuals are somewhat rare, representing more of the exception than the norm. Rather, many innovators do not view themselves in the spreader role, indicating the need to link innovators with spread agents who can offer targeted expertise in spreading innovations. Encapsulated in the questions posed by Veronica Nieva of Westat, “How do we help these innovators (who are not spreading their innovations)? Do they need to be partnered with other kinds of people who might help them spread? What is the setup? What is the infrastructure for spread for that kind of innovator?”

Overall, participants supported the idea that the role of the innovator is distinct from that of the spreader. As previously noted, innovators are frequently clinicians who are attempting to solve a local problem and/or academics who want to contribute to the research field and publish their work. They often do not conceptualize or design an innovation with the goal of spreading it beyond their home setting and do not have the time, knowledge, or desire needed to promote the spread of their innovation on a larger scale. Herbert Smitherman from Wayne State University & Health Centers and Detroit Foundation, Inc., summarized this concept in his comments during Hali Hammer’s fishbowl presentation, noting that “what Hali is doing ... is trying to solve a local problem in her community, and I

don't look at it as even Hali's role or any of these innovators to really try to help us ... scale and spread." Hali Hammer also provided some insight into the mindset of academic clinicians regarding how they view their role in developing and spreading innovations: "In academic medicine, what we do is we publish. We study, and then publish, and that's our proxy for an agent getting the word out." Recognizing the spectrum of players needed to spread an innovation, Hammer advocated for the role of spread agents, urging, "We need a person who will understand the beauty of what we are doing, and whose job it is to go to other places and help them figure out how to spread our innovation." As she and many others acknowledged, innovators could greatly benefit from working with spread agents, described by Marie Schall from the Institute for Healthcare Improvement (IHI) as "people who will work with innovators to help them package, sell, and share whatever their innovation may be." The idea of using spread agents is supported by others who identified the need for "intermediary" organizations to facilitate spread. For example, Cooley and Kohl (2005) assert that originating (innovating) organizations and adopting organizations could benefit from an intermediary organization focused on the scaling up process.

Beyond assisting innovators with spreading their innovations, spread agents may also be needed to recognize worthwhile innovations that would be useful and spreadable to other health care providers, systems, or settings. Innovators may not have the "bird's-eye view" to know that they are doing innovative work that could be used to improve health care across the nation. Carolyn Clancy, Director of AHRQ, highlighted this idea: "Oftentimes when you visit an exciting community or a health care system and they're doing something totally amazing, they kind of tend to believe that since we're doing it, so is everybody else." She used the example of the Henry Ford Health System's innovative approach to screening all patients for depression: They assumed this was common practice until they attended a national meeting and learned the contrary. This anecdote demonstrates that innovators may not always recognize the ways in which they are transforming practice or the merits of their work, and having spread agents who can detect these innovations and facilitate their spread could have a meaningful impact on the quality of health care in America.

Once the benefits and purpose of spread agents have been established as a more abstract concept, identifying who spread partners might be and what roles they might play are important next steps. Participant comments and learnings from previous scale up and spread efforts undertaken by the AHRQ Innovations Exchange indicate that understanding the roles and identities of spread agents continues to develop and evolve. In addition to the spread agents who directly help innovators package and "sell" their innovations, another role is the connector: individuals or groups who can bridge different stakeholder communities and serve as an intermediary between innovators and adopters. Possible connectors may be advisory boards or consultants who have the resources and capabilities to link innovators with funders, adopters, or even spread agents or other stakeholders. Connectors can orchestrate the involvement of the stakeholders and generate momentum to spread an innovation.

Another similar yet slightly different spread agent is the "spread organization." Spread organizations were distinguished as having some mission, activities, or purpose to support the spread of innovations and may include organizations such as IHI, Quality Improvement

Organizations (QIOs), professional societies, technical assistance centers, and more, though these organizations may have somewhat different functions or strengths for spreading innovations. For example, IHI has well established channels, collaboratives, and frameworks for large-scale spread of innovative programs (Massoud et al. 2006). QIOs are present in each state and charged with improving the effectiveness, efficiency, and quality of health care services, a mission that is aligned with and ripe for spreading innovations. Professional societies knit together similar providers across the country and have the potential to create far-reaching awareness of innovative programs through their dissemination channels, while technical assistance centers can offer support to both innovators and adopters about the operational steps needed to spread or implement an innovation.

In the rare cases when an innovation has built sufficient momentum to create an interested market, it may be feasible to build a spread organization that operates on a commercial basis. For example, HealthMapRx™ was designed to help potential adopters implement the successful medication therapy management program popularized in Asheville. HealthMapRx™ provides consultation and specialized training, development of pharmacist networks, templates, and reports on patient data. Another successful example of creating a private consulting practice to spread an innovation is the formation of Action Pact Development, LLC, which evolved from earlier efforts to spread the household nursing home model started at the Meadowlark Hills Retirement Community in Manhattan, Kansas.⁸ Such efforts to build commercial consulting spread organizations are still relatively rare in health care.

New types of spread agents may emerge as the call for health care transformation escalates. Some participants in the Million Hearts™ event suggested that the role of the spread agent could be undertaken by other stakeholder groups. For example, David Pope, CreativePharmacist.com Brands, suggested that AHRQ, CDC, CMS, and other Federal agencies are well positioned to serve as spread agents, asserting that they have the capability to “be able to attach people together to say hey, I’ve been there. I’ve created something. Let me help you along.” Adam Zavadil, Alliance of Community Health Plans, also described an interesting peer network model. He shared how members of the alliance created a network of implementers who were attempting to adopt a medical home innovation within their communities. The adopter “champions” who were going to implement the practice changes in their own organizations used the support network to talk to one another, keep momentum going, and troubleshoot implementation barriers, which resulted in successful spread of the innovation.

Again, though the mechanisms, roles, and characteristics of spread agents are continually evolving, it is clear that the onus to spread an innovation does not rest solely with its creator. Instead, there must be a spreader infrastructure to connect innovators and their ideas to adopters who can benefit from them. The absence of such an infrastructure will likely slow down spread efforts, ultimately hindering progress toward significant improvements in health care.

⁸ Building a Consultation Path for Spreading Innovation in Long-Term Care.
<http://www.innovations.ahrq.gov/content.aspx?id=3406>

Engage Multiple Stakeholders in Spread Efforts

“Patients, purchasers, providers ... we all have to actually be advocates for this kind of change in health care.”

Veronica Goff, National Business Group on Health

The Million Hearts™ event was a unique opportunity to gather perspectives from various stakeholder groups on scaling and spreading innovative strategies for improving cardiovascular health. It was specifically designed as a forum to convene multiple stakeholders, and the sessions were conceptualized to maximize the opportunity to capture these perspectives. As a result, the event produced rich insights about the types of stakeholders, both traditional and somewhat unconventional, that should be engaged in the scaling and spreading of these innovations and their roles in catalyzing this process. Discussions also emphasized the importance of strategically crafting messages to appeal to the specific stakeholders’ interests and motivations, focused on how and when to engage stakeholders in innovation development and spread efforts, and explored potential ways in which public and private stakeholders can partner to spread innovations.

Identifying Stakeholder Groups and Roles

Learnings from the Million Hearts™ event, as well as previous scale up and spread efforts undertaken by the AHRQ Innovations Exchange, emphasize the need to engage multiple stakeholders to spread an innovation. Though the work of these groups sometimes exists in separate siloes, their purposes are inherently interrelated and their actions can also

profoundly affect the scalability of an innovation. Meeting participants identified these stakeholders as having an important role to play in the scale up of innovations:

- **Hospital/Health System Leadership:** Hospital and health system leaders often decide which innovations are generated or adopted within their organization or endorse the uptake of innovation through the allocation of resources or other support.
- **Providers:** Providers have direct access to patients and many innovations affect, either directly or indirectly, how they deliver care. They are often at the genesis of an innovation and can champion (or resist) the adoption of innovation. Their acceptance of an innovation is crucial for it to spread.
- **Patients and Families:** Patients and families have a role in both developing and disseminating an innovation. Their input can be critical to improving the quality and effectiveness of innovations, which in turn can help to build momentum for spread. They can also help market and create demand for innovations.
- **Communities:** The successful spread of innovations requires deep knowledge of the community context in which the innovations are occurring, including demographics, culture and values, and health-related challenges.
- **Employers:** Employers, whether small or large, fully insured or self-funded, have a stake in promoting the spread of successful health care innovations due to their vested interest in the health of their employees.
- **Insurers:** Health insurers, both public and private, influence the spread of innovations through payment structures and the programs they offer to their beneficiaries.
- **Public Entities:** Federal, state, and local governments can foster spread by changing payment methods, providing incentives, passing laws, and establishing regulations.
- **Private Funders:** Private sector organizations such as foundations, venture capitalists, and others have a key role to play in spreading innovations by funding spread efforts and providing sources of capital and expertise at different stages of dissemination.
- **Connectors:** “Connectors” can bridge different stakeholder communities and serve as intermediaries between innovators and adopters. Advisory boards and consultants can serve as connectors, making it easier for innovators to obtain multiple stakeholder opinions on their interventions, including the ways in which they need to be refined to speed adoption. Innovators can also tap connectors for help with forming spread teams and eliciting support from funders, insurers, and other key stakeholders.

- **Adopter Organizations:** Adopter organizations are the ultimate target of spread activities. Depending on the nature of the innovation, the adopter organization may be very different ranging from a group practice to a hospital or from a health system to a state health department. This stakeholder category is broad and often encompasses a combination of many of the discrete stakeholder categories (e.g., providers, health system or hospital leaders, insurers). An adopter organization’s culture and willingness to attempt new innovations will create the demand for innovations (i.e., “pull”) or determine if dissemination efforts (i.e., “push” activities) are successful in stimulating the implementation of innovations.
- **Spread Organizations:** Newly emerging and developing stakeholders, organizations such as state QIOs, the IHI, technical assistance centers, professional organizations, and others, are dedicated to large-scale dissemination and spread of innovations. Though the role these organizations play in the spread process is still forming and evolving, they represent an important and increasingly influential stakeholder group.

Spread efforts will require these stakeholders to venture beyond their familiar worlds to recognize and actively leverage their complementary roles, though these roles may differ depending on factors such as the nature and setting of the innovation, the maturity of the spread effort, and the scope of the scale up and spread plan.

Tailoring Message to Various Stakeholders

“Everybody is tuned into that station ‘what’s in it for me,’ and that’s just human nature.”

Paul Plsek, Paul E. Plsek & Associates, Inc.

For an innovation to spread, its benefits must be communicated in a targeted, compelling way to stakeholder audiences. It is critical to thoughtfully identify what the benefits are for each stakeholder and articulate them in a manner that resonates with the different groups. In addition to his quote above, Paul Plsek asserted that “there has to be a sense of tapping into intrinsic motivation ... to do this because I can see a benefit for myself and for others.” Similarly, Barry Bunting, American Health Care, indicated that his experience with spreading his Medication Therapy Management innovation revealed that “what really flips the lever to activate someone to become at least modestly passionate about this is the personal connection of why this matters to them.” Fashioning the “sell points” of an innovation to address the key motivating factors for each stakeholder group was recurrently emphasized as necessary to convince stakeholders that an innovation would be worthwhile to implement or support on a larger scale. This concept spurred a wealth of suggestions from participants, which ranged from specific recommendations for the innovations discussed at

the meeting to more general points of interest or considerations to emphasize when approaching the various stakeholder groups.

In presenting the case to decisionmakers in adopting organizations, arguments must be brief and memorable—they have to be brief enough to be an “elevator speech” or fit into “bumper stickers.” As noted by MaryAnne Elma from the American College of Cardiology: “If it can’t be said on a bumper sticker, you’re not going to remember it.” Making succinct points about a program is not easy; innovator Hali Hammer articulated the difficulties of doing this by stating, “It would be hard for me, even in an elevator speech much less a bumper sticker, to tell people why I’m so excited about health coaching for self-management support and medication adherence.” However, the participants from the event all agreed that a brief and memorable message is important for an innovation to spread.

For illustrative purposes, the following section describes key concepts of interest to the following stakeholders: providers, hospital/health system leaders, employers, patients, and insurers. These groups represent only a subset of the stakeholders mentioned in the previous section, but they were selected because the meeting discussions focused on strategies to appeal to their interests and increase the chances they are willing to adopt or champion an innovation.

The Provider Pitch

“It’s not clear that the benefits will be that visible always to those who are actually doing the work, and that is always, I think, a critical factor in enabling spread.”

Bruce Siegel, National Association of Public Hospitals and Health Systems

As noted by MaryAnne Elma from the American College of Cardiology, “To make [an innovation] meaningful, you have to connect it to what people are really feeling and dealing with. Otherwise it is going to feel like an addition to what they’re doing versus an improvement.” This rings especially true for providers, who are often on the sharp end of an innovation. These providers are challenged to do increasingly more with less time and resources, all while trying to deliver the best patient care. As Bruce Siegel (National Association of Public Hospitals and Health Systems) commented, providers are not as concerned with cost savings. Instead, they are interested in the benefit to their workflow and patients. He stated, “When I see the benefits cast in terms of dollars, that may mean a lot to the CFO, and that’s great, but I wonder about the benefits to those on the front line.” This reasoning argues that in presenting an innovation to providers it is important to position the idea in terms of benefits to the patient and efficiencies and improvements in how they deliver health care versus dollars and cents.

The experiences of two innovators support this approach. Barry Bunting shared how he avoided push-back from community physicians when spreading the Asheville Medication Therapy Management innovation by reaching out to them prior to rolling it out to explain

how the innovation would work and how it would assist them and their patients in reaching their goals. Hali Hammer, San Francisco General Hospital Family Health Center, pointed to the importance of highlighting provider satisfaction when championing the spread of the Health Coaches innovation, stating, “We need people to continue doing primary care, and working with a health coach is incredibly satisfying [for the provider]. You really feel like you provide better care and are not spending a lot of time repeating the same messages over and over again.” These anecdotes suggest that these types of messages particularly resonate with providers and enhance the likelihood of securing their buy-in.

For providers, *who* delivers the message is perhaps as significant as its content. The messenger is part of the message. Mark Smith of MedStar Health observed that a strength of the Medication Therapy Management innovation was that the message was coming from a fellow provider. He indicated that this approach likely resonates better with physicians and comes across as more relatable, as opposed to coming from a managed care organization or State entity, which may be perceived as being too intrusive or designed to interfere in the way the provider practices medicine.

Beyond these factors, providers may also be influenced to adopt or participate in innovations through the use of incentives. René Vega of Aetna described how his company offered free continuing medical education credits to physicians for completing cultural competency training as part of his innovation. Though some participants questioned if continuing education credits were enough of an incentive to secure and sustain provider participation, this is another example of using targeted strategies to influence provider behavior.

The Hospital/Health System Leader or Administrator Pitch

“Within your own setting how do you justify [the innovation] to your own CEO or CFO? What are the things that they aren’t going to do in order to do this, and how do you say this is more important?”

Foster Gesten, New York State Department of Health

As this quote reveals, hospital and health system leaders weigh different factors when deciding to support or adopt an innovation. These leaders often have an eye toward the bottom line and are faced with decisions that pit one program against another, as finite resources require tradeoffs among which innovations the organization prioritizes and pursues. They are primarily interested in programs that improve performance while achieving efficiency and also reducing costs. For example, David Magid from Kaiser Permanente Colorado explained the need to underscore the productivity features of the Heart360® innovation when approaching health system administrators, stating that “instead of talking about how the innovation improves blood pressure or patient satisfaction, we actually say, well, this is more efficient and we can take care of more patients.”

These leaders also respond to economic analyses that address the cost effectiveness of the innovation and its likelihood to produce a return on investment (ROI). Participants viewed this information as being powerful and persuasive to organizational decisionmakers. Herbert Smitherman, Wayne State University & Health Centers Detroit Foundation, Inc., spoke about his experience using cost-related data to make the case for an innovation: “Economic analysis helps me more when I work with the medical school or with the health system administrative leadership. We talk about investment, and it helps if I can at least have an economic case to bring to the table because ultimately if it doesn’t make economic sense, those who have the resources are not going to invest in it.” From a practical standpoint, Barry Bunting described how ROI projections for the Asheville Medication Therapy Management innovation differ depending on the nature of the medical condition. Early positive ROI, usually within the first year, was obtained for the diabetes program, whereas the positive ROI trends for the hyperlipidemia and hypertension programs do not emerge until the second or third years. Though this comment alludes to some of the challenges associated with calculating ROI and other cost-centric outcomes for health care innovations, it is evident this type of information plays a prominent role in spreading an innovation and is crucial to include and present to health system stakeholders.

Finally, another recommendation was to look beyond cost savings in isolation and consider the larger potential impact of an innovation from a systems perspective. Bruce Siegel summarized this concept, asking, “Is it better to think about [the innovation] perhaps, not only as a cost saver, but as something that can improve access, something that can reduce crowding in the family health center, something that can free up beds that can be used for patients who really need to be in those beds, something that can decompress the emergency department and overall just take work out of the system, work we can’t afford to support anymore?” Depending on the scope of the leader’s influence or authority, this systems- focused positioning could also be a convincing sell point.

The Employer Pitch

“That will help, I think, sell the idea ... knowing that people are actually not spending a half day going to see the doctor for a checkup.”

Veronica Goff, National Business Group on Health

Participants also considered the need to engage employers in the spread of innovations. This stakeholder group received particular attention since two of the featured innovations (the Aetna Disease Management and the Asheville Medication Therapy Management programs) were employer-based programs. Similar to the health/hospital leader perspective, the key points identified for employers related to efficiency and cost savings. Barry Bunting stated that he typically reports back to employers to “indicate bottom line dollars and cents.” This involves looking at per-person costs before and after enrollment in the program, with a particular focus on the net costs (payments to the care managers and pharmacist coaches,

costs of the incentives, cost of administering the program) and bottom line ROI. René Vega of Aetna explained that he views the employer as a client and indicated that interactions should focus on what the employer is trying to achieve around improvements in clinical quality and health care costs. By understanding what programs are currently in place, we are then able to work with the employer to identify benefit solutions to best meet the needs of the employer's employees and dependents. In addition, we work with the employer to develop approaches to monitor and track the effectiveness of the innovation that is implemented.

Even when an innovation is not employer-based, employers can still be influential in the adoption process. In addition to the efficiency and cost saving arguments put forth in the section above, an innovation's impact on employee productivity was thought to be a powerful positioning statement. In the case of David Magid's pharmacist-led, home blood pressure monitoring program, Veronica Goff (National Business Group on Health) observed that by promoting home blood pressure monitoring, individuals were able to avoid more frequent visits to their physician's office for hypertension management. Using this innovation as an example, the impact on worker absenteeism and productivity is a noteworthy outcome from the employer standpoint, and presenting this information to employers could spur interest in the innovation and prompt them to advocate for its adoption.

The Patient Pitch

“For patients, we know that zero copayment, lower burden, 90-day prescriptions, simpler regimens, once a day, all of these are critically important.”

Thomas Frieden, CDC

The patient, a critical stakeholder in successful implementation of innovations, has a central role in spreading and scaling innovations. Successful innovations depend on patient participation. For patients to participate actively in innovative programs, participation must be simple and easy.

Innovations that have built-in convenience benefits for patients facilitate their participation. For example, the Heart360® home blood pressure monitoring innovation helps individuals save work time by avoiding doctors' visits. As Veronica Goff pointed out, this benefit for individual participants, as well as for their employers, can be emphasized in efforts to spread the innovation. Bruce Siegel echoed this concept, contending that this innovation could have a “huge potential for low-income populations who are in working families, who can't take off a day or half a day to go to the doctor, and perhaps wait longer than they'd like to actually see the physician.” He suggested that publicizing this benefit can inspire uptake. This idea relates to limiting the burden of health care on patients, a concept

coined “minimally disruptive health care” by Dr. Victor Montori of the Mayo Clinic⁹ and reflected in Thomas Frieden’s comments, quoted above. Patients are interested in health care innovations that not only improve their care, but also decrease the extent to which a health condition interferes with their daily lives. Often, managing health conditions, especially chronic conditions, entails complex medication regimens that require many appointments with multiple providers and specialists. This can be extremely time-consuming, taking a toll on patients and severely affecting their work and home lives. Thus, innovations that minimize the time and effort required of patients can be pivotal in making these innovations attractive to patients and their families.

It is also important for innovations to avoid unintended costs to patients, which may discourage their participation. David Magid spoke about the added expense for purchasing a blood pressure cuff with a USB adapter, which allows remote transmission of blood pressure readings, a component of his innovation. He stated that patients would not want to spend the extra money for a more expensive, technology-enabled blood pressure cuff, requiring a health plan or other payer to bear the cost difference or subsidize the price of the equipment for patients. This anecdote is an example of how meaningful increased out-of-pocket payments can be for patients. Considering this, the cost benefits, or at least the cost-neutral benefits, of an innovation could be a significant message for patients.

The discussions above suggest ways in which innovations can be structured in order to encourage patient participation. Yet, even with well-structured innovations, financial incentives may still be needed to promote patient involvement. Two of the featured innovations (Aetna’s Disease Management program and the Asheville Medication Therapy Management innovation) included a financial incentive component for the patient, both of which were designed to increase patient participation. As an innovation spreads and grows, some participants questioned whether patient incentives were financially feasible or sustainable. Yet, patient incentives were recognized as a useful way to spur patient engagement and show an appreciation for their time and involvement in their care.

Another suggestion from the meeting centered on the need for a patient champion who would influence other patients to participate in the program. The idea of a patient champion in the spread of innovations is a new counterpoint to the more typical endorsement for a clinical or provider champion for the innovation. During the Medication Therapy Management fishbowl, the discussants agreed that the best champion to ensure participation in the program is not a clinician or a purchaser, but a patient. As Paul Plsek stated, “An untapped resource that would cause more spread to happen is the patient voice, getting patients the word of mouth ... demanding these kinds of services.” A patient champion who is respected and trusted by other patients can make patients more open to participating in the health innovation and potentially lead to the marketing of the program to other patients.

Barry Bunting further provided an example of patients motivating other patients: “At least 50 percent of the individuals who enrolled after the first two years enrolled because a

⁹ Link to presentation from the IHI 13th Annual International Summit, March 2012, <http://app.ihl.org/tv/default.aspx#video=2f2c56f9-5a27-4b45-9f53-4e0c0906b192>

participant in the program who they worked with encouraged them by saying this has helped me. 'You just mentioned you have diabetes, are you in the program?' 'No.' 'Well you need to be. It really helped me, plus you can save money.' Never underestimate the value of word of mouth. I wish we could bottle that." David Magid, Kaiser Permanente Colorado, also touched on this point and further connected patient involvement and engagement to program sustainability. "So unless there is an engagement of the member to the process and the program, there won't be any sustainability, so we have to keep our members engaged, interested in their own health and the responsibility to themselves."

The Insurer Pitch

"I think one of the things that could potentially be most useful to convince any payer, even the largest of payers, is simply recognizing that you're already paying."

Barry Bunting, American Health Care

An axiom in health care is if you are not going to get paid for a service or innovation, it is not going to happen. This premise has direct implications for the spread of innovations and inherently relates to the willingness of a health insurer to reimburse for an innovation. The role of payment in spreading innovations is explored in more detail in the section entitled, Spreading Innovations in a Changing Health Care Environment, but generally this makes the sell to insurers especially critical.

One of the challenges with getting insurers on board with spreading an innovation is that the positive effects are sometimes not realized until much later. This point was expressed by David Magid who stated, "The benefits and the long-term benefits of preventing heart attack and stroke and so forth, while it's clearly very important to the people here at this meeting, it's hard to argue that the organization that implements that will really ever see that benefit themselves." To counter this concern, Adam Zavadil, Alliance of Community Health Plans, proposed that it is important to focus on other short-term benefits, such as increasing efficiency or improving patient satisfaction. "You've got to bring the payers in by showing them not just the savings that are going to come in the long term, but what else can you bring to the table that will maybe get rid of some overuse and still keep that other part of the triple aim around a good patient experience." Adam Zavadil continued, emphasizing the need to convey a realistic projection of how the innovation will work for the insurer, "There is a bigger issue. Purchasers are told over and over again—if you invest in this, we get more, and you'll get the savings later. And yet every year, every purchaser is faced with ... the bill going up, and it doesn't stop, and there's never the savings. Even if a program works well, the problem is that there's other things that are coming in that are replacing that spending with something else. I think to make these kinds of proposals [to insurers] work best, what we found in our community, is come with both a give and a get of what's going to happen."

Barry Bunting also shared insights about garnering the attention of health insurers from his practical experience working with insurers to spread the Asheville innovation. These experiences have shown that insurers are concerned with the cost impact and value proposition. He said, “The people that really need to hear the message are the payers. Those that are currently paying for the care that we all acknowledge is not great, but okay ... we need to show them that paying for something else makes sense ... what they’re really interested in is the bottom line.”

Representing a large insurer, Aetna, René Vega offered a thoughtful perspective about the factors typically weighed by his organization in determining the merits of pursuing or adopting an innovation. He indicated that Aetna looks for information that addresses the needs of both external customers and internal stakeholders, stating, “We want [our external customers] to understand that we are looking for the members’ best interest in terms of outcomes. We can look at the customers’ employee base, look at the data that are there, build an employee health profile, and then we can look for evidence-based solutions to address those issues and concerns ... the internal stakeholders want to develop a program that will improve health care for the population. It is about doing the right thing, doing the appropriate research, adding to the research base, and then as a by-product of that being a differentiator in the market.” Drawing from this statement, one can conclude that the extent to which an innovation can hit the “pain points” of an insurer’s customer base as well as the mission-oriented and business-focused needs of the insurer will likely increase its appeal to this stakeholder group.

It is important to note that discussions focused primarily on private insurers, and the perspective of the public insurers should be explored in the future.

Exploring New Partnerships

“We all know we have to do something different. Now the question is how we go about it.”

Bruce Siegel, National Association of Public Hospitals and Health Systems

Breaking down the comfortable limits of stakeholders and creating systems or collaborations across these groups represent important steps in the spread process—it takes a village of stakeholders to spread an innovation. Partnerships between more conventional, commonly identified stakeholders in spreading health care service delivery innovations are crucial for spread activities to flourish, but they should not be the stopping point. Meeting participants challenged each other to look beyond these “usual suspects” and generate ideas for new, innovative partnerships that could also serve a meaningful purpose in expediting spread activities.

One possible approach to forming new partnerships is to identify existing organizations that have a potential investment in an innovation but are not typically viewed as spread partners. For example, Adam Zavadil suggested that pharmaceutical companies could play a

role in spreading the Asheville Medication Therapy Management innovation. Since increased use of prescription medications by promoting patient adherence is a component of the innovation, Adam speculated, “Is there an incentive for a pharmaceutical company ... to come in and say, we’ll take on some of the risk for you, health insurer or large employer. If you don’t end up making the money that you thought you were going to on this, then we’ll take some of that risk on.” Lisa Simpson, AcademyHealth, spoke about exploring opportunities for spreading the Heart360® innovation to retail settings, stating, “The other thought about the expansion is ... the increasing presence in the marketplace of large pharmacies such as Wal-Mart, Target, Walgreens, and other retail clinics. They’re seen as sort of the new wave of primary care providers and being able to leverage them even more, is that another way to diffuse this?” Another participant applauded efforts to create partnerships with electronic health records (EHR) or health information technology vendors, noting that both the Federal and State governments are “often meeting with [EHR] vendors locally to try to get them to be responsive to specific projects like Million Hearts™, Patient-Centered Medical Homes, and so on.” Partnering with these types of vendors to ensure the products they create support the data collection and process improvement needs of these national initiatives could be a fruitful approach.

Non-traditional partnerships may also entail creating new roles for traditional players. For example, Barry Bunting advocated possible spread functions for insurance consultants or brokers. These individuals advise health plans, often presenting ideas for improvements and prospective innovations to their health plan clients, and could partner with innovators to help spread their innovations. New types of organizations may also be part of new partnerships. Marilyn Laken, Medical University of South Carolina, described her work with the Outpatient Quality Improvement Network in South Carolina, stating that they “take the ICD-9 codes off the back ends of whatever EMR a practice has ... and come out with audit and feedback reports that go back to the providers. Our job is to, as Tom Frieden was saying, gather the data, take a look at the metrics, and give each provider feedback on how they are doing.” Dr. Laken stated that the network then uses grant funds from the CDC to hire nurse practitioners to spread and support innovations through rapid cycle quality improvement.

Partnerships with business coalitions were also frequently cited as a unique but promising approach to promote the spread of innovations. Specifically, one audience member representing a business group on health described a business venture that was developing a structure to support employers in implementing and sustaining innovations. His experience indicated that employers can “provide accountability, systems, and resources, but [they] don’t know how to do it or don’t have the time and energy to find and implement these programs.” He explained that his business group is “designing a plan where a coalition becomes the gatherer of the data...to show the employer that proven practices and technologies implemented within their organization are having an impact for health and productivity.” Another suggestion was that business coalitions join together with payer coalitions to provide an alternate source of funding that can be a source of sustainability for spread efforts. Teresa Titus-Howard, CMS, spoke about her experiences with a coalition of employers that came together to form a trusting network and share data both among the

participating employers and with other public health partners, indicating that these types of partnerships are not only feasible but can serve a distinct role in the spread process.

A type of partnership that received particular attention during the meeting was that between public and private entities. Despite their differences in scope, influence, responsibilities, and regulatory functions, public and private organizations have strengths that complement each other and have great potential, through partnerships, to be a powerful force in promoting the spread of innovations. Private sector organizations have expertise and resources for determining what products and services appeal to specific markets, and they have well-established conduits for moving products and services to various populations. The public sector has a wealth of population health data and regulatory influence to prompt adoption among a large audience. One participant contrasted the differences in stability and control that typifies the two sectors: “On the public side there’s much more external control and influence over strategic direction and in some cases a 4-year cycle where you know that things will change ... there is much more internal control and flexibility on the private sector side. You might find more stability theoretically in the private sector.”

When combined, these entities together not only possess wide sway over key stakeholder groups and a potent arsenal of information and skills, but also hold the potential, from a macro- to micro-level, to affect the many factors that contribute to an innovation’s spread. This may be especially true in the case of the Million Hearts™ campaign, where both public and private entities also have a significant stake in achieving the goals outlined in the initiative. As an audience member keenly reflected, “The challenge that was put before us ... is not a different challenge for the public or the private sector. They’re the same people ... It’s the same problem ... Health costs are killing us. They’re killing the public sector, and they’re killing the private sector ... We’re essentially talking about the same issue.” This confluence of a shared problem may represent a unique opportunity to rally public and private partners around the Million Hearts™ campaign in an effort to leverage their complementary roles and spread innovations that improve cardiovascular health.

Beyond the theoretical merits of public-private partnerships, audience members cited examples that could be integrated into a possible roadmap for advancing the spread of innovations through public-private partnerships. According to the meeting participants, the work of the Beacon Communities surrounding Meaningful Use of EHRs is one successful model of a large-scale public-private partnership, where the government provides the incentives and standards, and private organizations focus on the implementation and products.

Meeting participants advocated that spread efforts should concentrate first on exploring existing partnerships or entities as a vehicle for spread, instead of developing new public-private partnerships. As one audience member stated, “Trying to find existing frameworks for folks who are working together to [spread innovations], I think, is one approach to try to figure this out, versus reinventing new structures in which public and private come together.” State QIOs were one such example of an existing structure for spread offered by the audience. With representation nationwide in every state, the QIO contractors were viewed as having current projects and missions that pair nicely with the Million Hearts™

campaign and related spread efforts. Other recommendations included The Robert Wood Johnson Foundation Aligning Forces for Quality¹⁰ and various programs involving the patient-centered medical home. Pursuing these and other synergistic efforts has the potential to increase the endurance, reach, and sustainability of Million Hearts™ innovations.

One function that might be conducted best under the auspices of public-private partnerships is data sharing. However, this collaboration often faces formidable challenges because of differing perspectives on data ownership. One meeting participant observed, “One of the largest barriers in our community with getting government and private institutions together is whatever the activity they’re involved in, ultimately there is going to be some release of some data. The public sector wants to be extremely open about releasing all of this data to the public, and the private sector goes ‘no way’.” The sync (or sometimes disconnect) between public policies and private institutions is another factor shading the perception of the utility of public-private partnerships. As one participant stated, “Usually the [public and private] intentions are shared, but the way policies play out, I think oftentimes slows the ability to work together and make progress.”

Overall, the Million Hearts™ meeting underscored the need for both public and private participation in an initiative of this magnitude. The public sector can provide the impetus and resources, while the private entities can incorporate changes into their infrastructure and processes that are not as much endangered by administration or political changes. Engaging both public and private partners in the adoption process and integrating this initiative into the government, communities, health care systems and practices, and ultimately the lives of Americans, is necessary for achieving enduring impact.

¹⁰ Robert Wood Johnson Foundation Aligning Forces for Quality.
<http://www.rwjf.org/en/about-rwjf/program-areas/quality-equality/programs-and-grants/aligning-forces-for-quality.html>

Spreading Cardiovascular Innovations

Cutting across the sessions at the Million Hearts™ event were considerations around the many factors that can affect the spread of cardiovascular innovations across various health care settings. The broad environment needs to be made receptive to the need and possibilities for improvements in care. How can “fertile soil” be cultivated for the successful spread of new practices in cardiovascular care? Successful spread requires each health care organization to decide to adopt and implement these innovations. What factors affect whether initial interest translates into adoption and sustainable implementation of these new practices? What roles are critical during the early stages of implementing the innovation? And what tactical issues might be considered in designing efforts to embed novel practices within existing organizational structures?

Creating Receptivity to the Spread of Cardiovascular Innovations

Integrating Million Hearts™ Goals into Ongoing Initiatives

To create “fertile soil” for the spread of cardiovascular innovations, meeting participants emphasized the need for Federal government agencies to support the goals of Million Hearts™ within other programs, funding opportunities, and portfolios rather than pursuing the Million Hearts™ initiative as a completely separate endeavor. They suggested that integrative efforts across the Federal sector will allow the private sector to respond in a



more coordinated and efficient manner to the Million Hearts™ initiative. To illustrate this point, one audience member remarked, “[Organizations] have funds that come from meaningful use. They have funds that come from Patient-Centered Medical Homes. They have different requirements for both ... They don’t have the flexibility in the funding that allows them to fill gaps and cross utilize.” Other related

recommendations were to integrate the Million Hearts™ initiative into the work of the Center for Medicare and Medicaid Innovation (CMMI). An example of how this could be done was to ensure that the “ABCS” are included or measured as part of the CMS initiatives (e.g., pioneer Accountable Care Organization [ACO] model, shared savings initiatives, or the comprehensive primary care model).

Incorporating heart-healthy activities that reflect the aims of Million Hearts™ into daily culture was another variation of the full integration idea—“from what food we offer in cafeterias and vending machines, to the policies that we’re setting, and to the things that we are measuring,” as articulated by one participant. Though it was suggested that all organizations strive for this type of integration, meeting participants singled out the public sector, as a large employer, as being well positioned to serve as a role model. One audience member reminded, “We keep forgetting the Federal and State governments are huge employers. We should start talking about government as employers,” and another noted, “An important part of the conversation is getting the public sector to act as an employer and do it themselves ... ‘walk the walk’” and set an example.

Using Media to Promote Stories of Change

“[Use] not just the print media but the broadcast media and get the stories out because so many of these innovations, if they could be brought into telenovela or into other things that demonstrate to consumers, to patients what’s going on, that would promote change.”

Robert Like, Robert Wood Johnson Medical School

Media can be used to help health care innovations “go viral.” Media can be used to expose providers and patients to innovations in an engaging and comprehensible manner, possibly inspiring providers to consider implementing innovative programs in their health care settings and creating patient demand for similar types of health care services. Many channels of media are now available to bring attention to successful innovations, including traditional media (e.g., daily newspapers or nightly television news), and new media (e.g.,

online blogs, Twitter, or LinkedIn Groups). Successful exposure is created by combining the use of media to reach target audiences in multiple ways. Regardless of which media are used, bringing successful innovations to the attention of those at the “sharp end”—patients, providers, health care staff—can help to create demand for innovation.

The Asheville Medication Therapy Management innovation provides one example of the value of media exposure. This innovation was featured on NBC Nightly News and was later spread in many parts of the country.

Thomas Frieden, Director of the CDC, threw out the challenge of “Everywhere, Now!” when he addressed the participants at the event. An innovation that is successful in improving people’s health needs to be everywhere immediately. In his opinion, lack of a sense of urgency is the most frequent cause of failed change efforts. Urgency can be generated by using the media to make people aware of the importance and possibility of change.

Dr. Frieden’s sentiment was carried throughout the day, and its value was demonstrated during the interactive 3x5 activity concluding the day. Asked to select the best ideas that emerged from the day’s discussions, participants identified two media-related ideas as among the most important—the need to “involve other media outlets to share the stories of innovators in the Million Hearts™ campaign” and the need to “get more press on the successful innovations.” Action on these ideas has the potential to create the “everywhere now” urgency that was called for by Dr. Frieden.



Combining Stories and Data to Motivate Change

Evidence about the effectiveness of an innovation often takes the form of quantitative data, covering a variety of areas such as clinical outcomes, process or activities, cost, value, and efficiency. Quantitative data illuminate the need for improvement within health care organizations and larger communities, and help document the improvements resulting from implementing innovations. Dr. Frieden emphasized the role of solid real-time data to support quality improvement. “One of the things that holds us back is an inability to see what the data are showing in real-time ... Focused-in information systems are critical to overcoming the barriers to quality improvement.”

However, numbers alone may not be sufficient to catalyze change. The Million Hearts™ event emphasized the importance of patient stories as a powerful complement to quantitative evidence about an innovation’s impact. Patient stories create the personal connection that can serve as a motivator for change. Barry Bunting stated, “What really gets [adopters], and what really flips the lever to activate them to making this something that they become at least modestly passionate about is the personal connection of why this

matters to them.” MaryAnne Elma, American College of Cardiology, seconded this sentiment: “To make it meaningful, you have to connect it to what people are really feeling and dealing with.” Patient stories can go a long way to connecting potential adopters with why an innovation is necessary and what it means to those in their community.

Creating Organizational Readiness to Adopt Innovations

Openness to Change

Organizational culture was repeatedly discussed as an important foundation for successful implementation of innovations. How receptive is a given setting to a new idea or intervention? Million Hearts™ participants underscored the importance of organizational patterns of behavior that rewarded proactive interest in continuous learning about new ways to improve care. Such proactive learning cultures are not yet the norm in most health care organizations. As Barry Bunting of American Health Care pointed out, “People are so stuck in what they’re doing that they’re not aware of the innovations that are out there. So they need to know that the change is possible.”

However, openness to change can be embedded into an organization’s way of operating. René Vega, Aetna, discussed how his organization’s culture of innovation is demonstrated in a systematic, three-step process used to develop, evaluate, and integrate innovations into the routine work of the organization. “Aetna’s three-step approach [is] research, pilot, and integration of the enterprise.” In this process, Aetna first researches elements of a potential innovation to be operationalized, implements a pilot study to identify which elements are successful, and combines these successful elements into an enterprise-wide initiative.

A key reference to see if your organization has the ability to adopt an innovation is the AHRQ Will It Work Here? A Decisionmaker’s Guide to Adopting Innovations, available at <http://www.innovations.ahrq.gov/guide/InnovationAdoptionGuide.pdf>.

Organizational Priorities

Every organization has competing priorities for its finite focus, time, and resources. Often, timing is a critical factor for an innovation’s adoption and spread—innovations have to be viewed as a solution to a problem that the organization currently views as a priority. Changing priorities may affect the fate of an innovation. David Magid, Kaiser Permanente Colorado, discussed how his organization’s priorities shifted over time. Organizational priorities aligned with the Heart360® innovation when it started—blood pressure was seen as a high priority problem. However, general improvements in blood pressure readings among the Kaiser Permanente population over time contributed to lower priority on blood pressure, and along with it, support for the innovation diminished in his organization. He said, “We are [now] very much at the top [in blood pressure control], and so it’s not quite the priority that it was when we started the project. And in an organization of our size which is a

little more than half a million people, we have limited bandwidth to do big projects ... [and this project] requires a lot of resources and energy to do, and with a number of other priorities that we have, it's just not on the list at the top." Because of this decline in organizational support, the program could not muster the attention and resources necessary to expand throughout the Kaiser Permanente Colorado system.

Innovation Champions and Obstacles

"There's a difference between kind of being generally supportive and sort of getting on your horse with your sword in your hand and marching into battle."

David Magid, Kaiser Permanente Colorado

The importance of a champion is a truism in the literature on the diffusion and adoption of innovations. Not only must there be a champion ready to "march into battle," as David Magid colorfully stated in his description of conditions that were needed to spread the Heart360® innovation, but there must be continuity in the champion role. René Vega, Aetna, seconded David Magid's point on champions. He stated, "You need to have a dedicated champion, a committed individual. Hopefully, one that will be there through the entire course of the program." Champions connect with leadership, keep the health care team motivated, and overall, they help sustain the innovation.

Comparisons of the conditions surrounding the implementation of the Heart360® innovation in the Kaiser Permanente systems in Colorado and Southern California underscored this point. When the initial champion left Kaiser Permanente Colorado, support for the program diminished, leading to a cessation of spread within the Colorado system. In contrast, implementation of the Heart360® innovation in Southern California Kaiser has been successful because of the presence of a strong champion. "Joe Handler ... who runs the hypertension program in Kaiser Southern California ... is definitely one of those guys on the horse with the sword ... He has brought together the sponsorship he needs to try and move this quickly, and they're already starting a pilot with over 600,000 patients."

The role of the champion was also emphasized by Barry Bunting in discussing the spread of the Asheville Medication Therapy Management innovation. While this innovation has spread to many communities, "There have been some attempts to do it where it hasn't worked. Part of that may be due to ... the need for a champion ... for individuals in that community to actually step up to the plate."

Champions are critical to "march into battle" in order to address the many organizational barriers that stand in the way of implementing innovations. By their very nature, health care innovations disrupt the traditional ways of working in an organization, and it is often difficult to synchronize all parts of the organization that need to make these changes. This coordination, or lack thereof, is critical to the uptake of programs. René Vega touched on Aetna's challenges with organizational coordination during his presentation. He stated that the adoption of his blood pressure innovation, even in an organization like Aetna, which has

a built-in process for coordination challenges, can hinder the uptake of innovations. “You still need to work within the population and the various departments within your organization—medical services, member services, sales, and the like—so that they can coordinate their activities. It is really imperative that there be cross functional integration among the units. Of course, the bigger the organization, and the more complex it is, the more difficult it’s going to be as opposed to a ten-physician, one-site clinic.” Coordination is difficult because many different facets in the organization need to work together in order for the innovation to be successful. Resistance by any one of these areas may block efforts to change the status quo.

The challenge of organizational coordination is not the only organizational barrier to innovation. Many times key individuals may have their own reasons to be critical of new programs. The Million Hearts™ event participants debated when and how to engage the naysayers. One perspective offered was that it was essential to engage naysayers in initial talks about program adoption—if the naysayers are absent from the early discussions, one will not know how the program can be sabotaged at a later point. On the other hand, early objections can derail a program before it can gain momentum. A compromise position was offered by Judy Hannan from the CDC: “I think one of the things about ... inertia and naysayers is you have to engage them early and separate from the group ... You have to build their trust, build their confidence if [you’re] going to be listened to, and you have to engage them offline first.” Sometimes the loudest of naysayers, once convinced, will become the greatest of champions.

Implementing Innovations

Throughout the day, participants in the Million Hearts™ event discussed several tactical issues that adopting organizations would need to consider in working out the implementation tactics for embedding the innovation into the organization’s daily routines.

Incremental vs. Radical Change

There was much debate at the event whether to approach innovative efforts incrementally or aim for more comprehensive programs at the outset. Bruce Coles, New York State Department of Health, brought up this point during the Aetna fishbowl. New York has a “lot of different programs across the state who are doing quality improvement projects, and we get two opinions—one says you’ve got to work with low hanging fruit on one single thing because at the practice level it’s very difficult to implement standards for a variety of different projects if you want to get things moving and up to scale. On the other hand, others have taken the track of [taking on] multiple [conditions] but they are multiple years into their project before they even have their patient portals ready to start telling the story, so both have their drawbacks.” Mr. Coles got right to the heart of the debate: Do you

implement solutions incrementally, addressing easier problems first in order to achieve early success and build trust and momentum before incrementally scaling up? Or, do you aim to create a more comprehensive program that may delay implementation and demonstration of success?

For many reasons, change often happens incrementally in practice. Radical change can be seen as too risky, and health care organizations tend to be risk averse. Stepwise implementation is easier to start, and this approach makes changes easier to assimilate, particularly for complex innovations. Drawing from an extensive literature in managing organizational change, *Will It Work Here? A Decisionmaker's Guide to Adopting Innovations*,¹¹ suggests the use of small-scale trials, limited in time or scope, and phased in over time. Aetna is a good example of an organization that does precisely this. As noted above, they have a vetted three-step approach: research, pilot, and finally integration of the innovation into the enterprise's routines.

Narrow Focus, Stand-Alone vs. Integrated Solutions

Mark Smith, MedStar Health, brought up a similar point in considering the Medication Therapy Management innovation. He questioned the usefulness of building stand-alone solutions for particular conditions, such as controlling blood pressure or cholesterol levels. He said, "I'm always worried about building stuff on a one-off basis in solving a one-off problem ... as opposed to building an extensible, fungible infrastructure that could be pointed to solve many problems ... in other clinical domains." His statement gets at an important issue for any narrowly focused clinical innovation. For people with multiple conditions, focused innovations may reinforce a fragmented approach to delivering care, which may be inconvenient, inefficient, as well as potentially ineffective.

Barry Bunting, American Health Care, agreed on the importance of treating the "whole person," not just one medical condition. "What we realized, even though our initial program was targeting diabetes, is you get the whole person ... They're in a diabetes program, but they also have migraines, they have prostate issues, they have Raynaud's, you get the whole thing." Bunting continued on to say that a pharmacist cannot look only at a patient's diabetes medicines; instead pharmacists will look at the patient as a whole and consider the migraines, the prostate issues, and other conditions, in addition to the diabetes. One approach to this problem, coordinating a particular innovation with other treatments, was suggested by René Vega, when he discussed his experience with Aetna's Disease Management program. "About a third [of all patients] may in fact either be hypertensive or pre-hypertensive. Anything you can do in collaboration with other groups is going to ... make [the hypertension innovation] more successful."

David Magid, Kaiser Permanente Colorado, noted that the decision to design a stand-alone innovation or a more comprehensive approach may depend on the innovator's goals.

¹¹ Will it Work Here? A Decisionmaker's Guide to Adopting Innovations.
<http://www.innovations.ahrq.gov/guide/InnovationAdoptionGuide.pdf>

He said, “If you are testing out a new technology [such as the blood pressure cuff in the Heart360® innovation], it may make sense to initially test that out in a specific group like we did with hypertension. On the other hand, if you’re trying to improve cardiovascular health, then you really want to take a broader approach, and you want to be addressing hyperlipidemia, smoking, exercise, and so forth.”

Using Technology to Support Implementation

In an era of rapidly changing technology, adopting organizations may consider modifying the technological infrastructure used in implementing cardiovascular innovations. In the discussion of Magid’s Heart360® innovation, participants noted how the use of alternative technology can help ease the implementation burden. Although patients in Magid’s innovation were required to use computers with Internet access, he pointed out that this may not be the preferred mode of transmission in other settings. Using another form of technology, such as smart phones, could make this program accessible to more patients. A system using Bluetooth or another transmission technology would allow data transfer over a cellular phone instead of requiring a computer and Internet access. Herbert Smitherman, Wayne State University and Health Centers Detroit Foundation, Inc., agreed that in his community, using cellular phone technology would be more effective for his low-income patient population. As noted, this demonstrates how no two health care organizations are alike, so it is necessary for an adopter to think about how technology can apply in his or her setting to ease the implementation burden.

Technology can also be employed to ease the burden for the affected providers. Barry Bunting utilized technology to ease the provider burden and enhance the Asheville Medication Therapy Management innovation. Three to four years into the program, he recommended that the pharmacists begin to document visit notes in an EMR. “It just isn’t going to work if it takes them longer to document their visit than it did to see the patient,” Bunting stated. The biggest positive evolution in the Asheville program was the efficiency gained from shifting paper-based documentation to the EMR.

Spreading Innovations in a Changing Health Care Environment

“There is more than a realization; there’s an acceptance that we are going to have to do less with less. The idea that we’re going to keep getting payment levels going up and keep doing more for patients with more resources, it’s OVER ... We’re going to do less with less with superior outcomes ... The pressures are going to be intense.”

Bruce Siegel, National Association of Public Hospitals and Health Systems

The innovations featured during the Million Hearts™ event have the potential of contributing to the initiative’s ambitious goal of preventing a million heart attacks or strokes, if they spread widely across the many health care delivery organizations in the country. As noted in the sections above, the spread of these and other innovations depends on getting the innovations ready for spread and activating the relevant stakeholders that can affect the ability of adopting organizations to successfully implement the innovations. In addition, successful spread must recognize the widespread impetus to transform the health care ecosystem in fundamental ways.

This push toward transformation has been coalescing over the recent decades, with growing consensus that the country’s costly health care system delivers only mediocre outcomes. For example, a recent report by the Commonwealth Fund (2011) notes that, despite having the most expensive health care system, the United States ranks last overall compared with six other industrialized countries—Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom—on measures of health system performance in five areas: quality, efficiency, access to care, equity and the ability to lead long, healthy, productive lives.

The need to obtain more value from health care investments becomes more acute given the national (and international) economic pressures. State programs are particularly vulnerable. As Diane Justice (National Academy for State Health Policy) said: “What’s not sustainable ... are programs that are funded with state general revenues, funded with Federal block grant funds. All of those are shrinking.”

Health reform in the public and private sectors may continue to generate tremendous incentives for delivery and payment changes, as well as certainly enlarge the patient population who will demand care. Thus, the system will be challenged to find new avenues to augment the already short supply of primary care physicians to deliver basic health care services.

In recent years, we have seen increasing experimentation in new approaches across the health care delivery spectrum. Experiments in new delivery and payment models, such as Patient-Centered Medical Homes and ACOs are being explored. With government support, various states, including New York and California, are moving toward creating incentive structures that are oriented toward value and patient outcomes. In these experiments, payment models are evolving from the traditional volume-based fee-for-service models to new outcome- and value-based models. Many of these experiments are taking advantage of new technologies that can make and facilitate the use of information more efficiently, easily, and inexpensively.

The discrete cardiovascular innovations featured in the Million Hearts™ event focus on specific and bounded microsystems within the health care systems. Scaling and spreading these innovations will be facilitated by exploring possible integration into these larger experimental models, which will likely become part of the health care landscape in the near future.

Payment Systems

“This is one of the things that makes the spread of innovation so hard in health care—the status quo is formalized into the payment system, so we get paid to do what we’ve always done.”

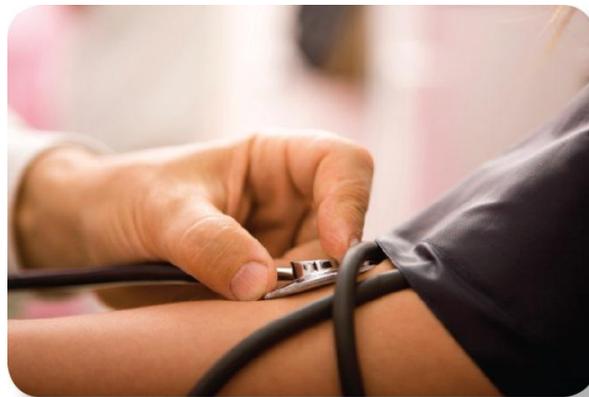
Paul Plsek, Paul E. Plsek & Associates, Inc.

Many innovative services are not covered under the traditional fee-for-service payment model. The Million Hearts™ innovations highlighted the challenge of spreading services that are not now reimbursed by third-party insurers. Business groups are concerned with these gaps. In the words of Veronica Goff, from the National Business Group on Health, “[Innovative services] are the kinds of things we want to buy ... but we are not really set up to pay for these right now. We’ll need to address that.” Moving away from volume-oriented fee-for-service payment systems toward new global models that combine elements of existing capitated payment systems with performance-based incentives was seen by participants as necessary for the spread of the Million Hearts™ innovations. For example, the Heart360® program was successfully implemented within the Kaiser Permanente system,

which has a capitated payment system. Implementation of this program under fee-for-service systems will be difficult, as most insurers will pay only for office visits, not for the home blood pressure monitoring that is at the core of the innovation. Scaling innovations like Language Concordant Health Coaches will also run into payment issues, since insurers will not usually reimburse for the services of health coaches and other types of “physician extenders” who can improve access to care for many types of patients, especially those outside of the linguistic or cultural mainstream. Again, implementation of the Language Concordant Health Coaches innovation in San Francisco has been facilitated by the UCSF capitation payment system.

While capitation is seen as a solution that will address many challenges to paying for innovative services, other approaches were also offered. Certain innovative services may spread within supportive, but narrowly defined settings. For example, the Medication Therapy Model originating in Asheville, North Carolina, has been adopted nationwide by more than 60 self-insured employers. Dissemination outside the self-insured employer segment has required creative negotiations. In one municipality, Blue Cross Blue Shield implemented the Asheville program using a carve-out (i.e., an approach that provides coverage for specific health care services under funding separate from general health care services). Medicaid waivers provide one path to funding these kinds of services. Waivers have been negotiated in various states to cover specific services outside of the main contract. In California, for example, Hali Hammer persuaded state Medicaid offices to cover the costs of health coaches, arguing for the Health Coaches’ benefits to Medicaid populations and cost savings to Medicaid programs.

Apart from issues related to volume-oriented fee-for-service systems and outcomes-oriented global payments or capitated systems, payment structures also create misaligned incentives. Benjamin Bluml, speaking about his organization’s efforts to spread the Asheville model, said, “The challenge we’ve continually seen is to get payers to ... properly align the incentives so they can improve the outcomes and control the costs.” Pressures exist to deliver services which are reimbursed, even if these approaches are not necessarily the most effective or efficient. Referring to the temptation to follow the revenue, even in mission-oriented teaching hospital settings such as the San Francisco General Hospital Family Health Center, Hali Hammer said, “We take care of a lot of uninsured people. So whenever we saw a person with Medicaid, bingo. We’re getting a lot of reimbursements, so why would we want to have a health coach talk to them rather than having them come back for an office visit? We all knew that was not the right way to provide care, and we didn’t do that.”



Incentives are also misaligned with regard to timing. Costs for implementing innovative practices, as well as payments for these services need to be paid up front, but in many

instances, the benefits are accrued many years later. The Heart360® innovation, which requires payments up front for blood pressure monitoring in order to prevent heart attacks many years later, is an example of this issue. Given the high level of customer turnover in the health insurance industry, insurers who pay for preventive services may not realize the savings accrued from avoided illnesses many years later.

Million Hearts™ experts agreed that the payment systems for health care must change in order to provide for new services that would improve outcomes, while reducing costs. Million Hearts™ experts also suggested it may be useful for such innovative programs to connect with pilots that involved some form of global payment, such as demonstrations of Medical Home or ACO models. As noted previously, the tide is turning, albeit slowly, toward payment structures that incentivize providers on value rather than volume. These emerging structures will facilitate the spread of innovations that are not covered by traditional fee-for-service payment schemas.

The Changing Healthcare Workforce

“The only way, in this country, we’re going to be able to improve quality, reduce cost and preserve employment in the health care field is by using every member of the team to their fullest potential, to the top of their license ...”

Thomas Frieden, CDC

Already there is a shortage in the supply of primary care physicians, and this shortage may become more acute with the health reform initiative when many currently uninsured individuals obtain health insurance. One solution to this shortage is using other clinicians who can carry out some of the functions that have traditionally been reserved for physicians. The innovations featured in the Million Hearts™ event provide examples of workforce changes that could become standard in the health care system of the future.

Changes in Clinicians’ Scope of Practice

Several innovations featured in the Million Hearts™ event involved innovative pharmacist services, with these clinicians in roles beyond their traditional boundaries. In the case of the Heart360® program, pharmacists monitor home blood pressure readings, adjust medication (with general physician oversight) and provide counseling to hypertensive patients. These expansive functions were allowed in Colorado—but not in all states—where pharmacists’ scope of practice includes the ability to adjust medication regimens and provide other treatment. As of May 2011, at least 44 states authorize physician-pharmacist collaborative practice agreements to provide drug therapy management for any health condition specified in a written physician protocol (Odum and Whaley-Connell 2012).

Related to scope of practice changes, new provider categories, such as the “clinical pharmacist practitioner” designation can be created. Paralleling the designations of Nurse

Practitioners and Physician Assistants, Clinical Pharmacist Practitioners are considered medical providers who are approved to provide reimbursable drug therapy management services. They are “experts in the therapeutic use of drugs, who are primary sources of scientifically valid information and advice and who generate, disseminate, and apply new knowledge that contributes to improved health and quality of life” (Saseen et al. 2006).

Broadening roles of various types of clinicians can require adjustments on the part of physicians who may have traditionally considered certain functions as exclusively belonging to physicians only. Adjustments are easier when physicians see these changes as easing their own burden. Instead of viewing these changes as infringements on their scope and authority, physicians may see them as mechanisms to allow them to focus on more complex medical tasks.

Clinicians whose roles are newly broadened may also need to adjust to these new requirements. Barry Bunting, who has worked tirelessly to promote the Asheville-based Medication Therapy Management innovation said (video interview), “As a pharmacist, we typically think of ourselves as providing a product: medication. There needs to be a greater emphasis on the service—the knowledge that goes along with that product, improving outcomes—not just providing a product.”

Use of Non-Clinician Aides

“It’s the Clayton Christensen idea of trying to ... find someone less expensive [and] more accessible. So you're always looking for other ways of doing things in a less expensive and more accessible [way] and whatever that is, [using] a pharmacist, a nurse, [or] a trained volunteer even in some cases.”

Paul Plsek, Paul E. Plsek & Associates, Inc.

As noted above, innovative definitions of the scope of clinician practice can generate improvements in access and quality of care, as well as reduce costs. Further improving the workforce value proposition, a variety of paraprofessional roles are emerging to augment the traditional roles of medical professionals. The health coaches used at San Francisco General Hospital Family Health Center is one example of these new developments. Other paraprofessional roles include “promotoras” (community health workers often utilized in Hispanic/Latino communities), health system navigators, and peers/volunteers. Not only do these roles provide personalized connections to the often fragmented and inaccessible health care system, they often go beyond the usual narrow boundaries of medical care, approaching individuals holistically and connecting them to other needed services such as transportation and housing.

Team-Based Care and Cultural Competency

Team-based care that is sensitive to the needs of different segments of health care customers is core to many service delivery innovations. Pressures toward efficient care delivery and growing demands for higher quality coordinated care have created the realization that providing high-quality health care is a “team sport.” In the Asheville innovation on medication therapy management, for example, pharmacists work collaboratively with physicians. In the Health Coaches innovation, health coaches work in tandem with medical residents. Training for health care professionals has been slow to include this perspective in its curricula, although recent initiatives such as the TeamSTEPPS® delivery system (developed by AHRQ and the U.S. Department of Defense) have started to address this gap among practicing health care professionals.

Similarly, there is a growing realization that cultural sensitivity is a desirable competency for health care professionals and their organizations. According to Robert Like, Robert Wood Johnson Medical School, some states (e.g., New Jersey, California, New Mexico, Washington, and Connecticut) have included cultural competency in licensure requirements for physicians. Insurers such as Aetna and Blue Cross Blue Shield now offer Continuing Medical Education (CME) credits for cultural competency training, although uptake is still reportedly slow. Recently, the Joint Commission, the National Committee on Quality Assurance, and the National Quality Forum have developed initiatives to address health disparities and cultural competency at the organizational level.

Million Hearts™ event participants emphasized the importance of providing stronger incentives, perhaps even mandates, to enhance the skill sets of current health care professionals in areas like cultural sensitivity. Christine Heasley of Highmark pointed to their pay-for-performance program for medical offices that incorporate best practices to eliminate health care disparities, including cultural competency training. At the same time, the Million Hearts™ experts pointed to the need to integrate these topics into the earlier education of medical professionals. Fran Griffin from the CMS Innovation Center said, “We’re getting to people too late ... To really go forward successfully with these types of initiatives, we need to get to physicians, pharmacists, nurses, physical therapists ... while they’re in their training programs This is a fundamental part of your education.”

New Provider Organizations

“The increasing presence in the marketplace of our large pharmacies, Wal-Mart, Target, Walgreens, and retail clinics ... they are seen as the new wave of primary care providers.”

Lisa Simpson, AcademyHealth

Not only is the workforce for delivering health care services changing, but so are the institutions involved in providing care. The number of retail clinics has burgeoned since 2005, representing a new channel for delivering health care services more conveniently and economically (Deloitte Center for Health Solutions 2009). Most retail clinics are located in local pharmacies, but increasingly they have been emerging in other settings, such as grocery stores and big box retailers. Retail clinics have even moved into airport settings in Atlanta and Philadelphia.¹² Typically staffed by nurse practitioners or physician assistants, these clinics have gained favor among health care consumers because of their accessibility and speed of service, and they have been particularly convenient for the uninsured.

Retail clinics provide basic primary and urgent care services in places and times that meet people’s simple health care needs. They may provide important ways to augment the current and increasing shortage of primary care providers. While initially, there were fears that retail clinics would substitute for traditional health care providers, their complementary nature has become clearer in recent years. These clinics have started to align with physician practices as well as large acute care health systems, including the Mayo Clinic in Minnesota, Cleveland Clinic, and the Allina hospitals.

These types of alignments may be the wave of the future, aligning with the trend toward integrated ACOs, making it clear that retail clinics can complement, rather than replace, traditional providers of health care services.

¹² Airport Clinics Provide Quick Access to Low-Cost, Routine Services for Travelers, Airport/Airline Employees. <http://www.innovations.ahrq.gov/content.aspx?id=1753>

Summary and Conclusions

“We want ... to deputize you, and I hope that you have been inoculated with the Million Hearts™ virus and will take that forward.”

Janet Wright, Million Hearts™ Executive Director

The *Million Hearts™ Scaling and Spreading Innovation: Strategies to Improve Cardiovascular Health* event was a 1-day invitational event at which experts, stakeholders, and health care systems explored issues related to spreading innovations that could contribute greatly to the Million Hearts™ goal of preventing a million heart attacks and strokes. The participants were selected to represent the variety of perspectives that would need to be considered in order to assure the success of potential large-scale initiatives to scale up and spread these and other innovations aimed at achieving the goals of the Million Hearts™ initiative. The day-long dialogue, facilitated by a creative meeting format, encouraged the open discussion of the many challenges that would have to be addressed for successful spread of novel and effective health care practices.

Four innovations from the AHRQ Health Care Innovations Exchange served to anchor the thinking for the day. The variety embodied in these innovations—in methodology, setting, staffing, and sponsorship—combined with the varied participant perspectives to uncover many important issues. To summarize:

- For an innovation to spread, it is critical to define its core elements, which have to be preserved in all efforts to implement the innovation in other settings, while recognizing the importance of adapting and tailoring other elements to the requirements of each implementation setting. Distinguishing between core and adaptable elements is not a simple task.
- Innovations need to be “packaged” for spread. Their benefits must be clearly and strongly stated, in terms that are relevant to each stakeholder audience. Because innovations are often complex, packaging must include an array of implementation aids: training, operational manuals, organization charts, process flows, and the like. Few innovations have the necessary implementation packages.

- In many cases, innovators have no interest, or skill, in spreading their innovations. Thus, for spread to occur, innovators must be connected with spread agents, which can take a variety of forms.
- Many stakeholders have to be activated and aligned in order for innovations to spread effectively. A robust multistakeholder infrastructure will be needed to speed up the spread of cardiovascular and other innovations throughout the health care sector. For spread efforts to succeed, innovators must engage multiple stakeholders, including hospital/health system leadership, providers, patients and families, communities, employers, public entities, private funders, connectors, adopter organizations, and spread organizations. The benefits to these stakeholders need to be articulated in a compelling and targeted way.
- Potential adopter organizations must provide fertile ground for the innovation. A culture that is generally open to change is critical, but any specific change must align with the organization's current priorities. Organizational change champions are critical to overcome the inevitable barriers that face any effort to do things in a different way.
- Many implementation tactics, at macro and micro levels of organization, must be explored. Some of these tactics have a broad focus, such as organizational partnerships and collaboration by entities that have not traditionally worked together, and the use of media to create awareness and demand for innovative approaches to care delivery. Other tactical considerations are more targeted to individual adopter organizations; these include approaching innovation efforts incrementally versus aiming for more comprehensive programs at the outset, adopting a narrower stand-alone program, and exploring integrated solutions.
- Efforts to spread improvements in cardiovascular health and other innovations may be assisted by transformations that are underway in the health care environment. These include payment systems that are moving from volume-based schemas to ones that emphasize value and outcomes, changing roles and scope of the health care workforce, and development of new provider and delivery systems. The potential for an important role of traditional and new media in promoting the spread of these innovations has yet to be exploited. Scaling and spreading innovations will be facilitated by exploring their possible integration into larger experimental models (e.g., Patient-Centered Medical Homes and ACOs), which will likely become part of the health care landscape in the near future.

These lessons elicited from the Million Hearts™ event suggest elements of a roadmap for building the infrastructure needed for large-scale spread of cardiovascular innovations in order to achieve the ambitious goals of the Million Hearts™ initiative. To prevent a million heart attacks and strokes within 5 years, urgent efforts are needed at all levels of the health care system. The thought leaders participating in this event identified key activities needed to extend the work of the innovation developers to a critical mass of other health care organizations. They noted that these activities are challenging, and they require new partnerships and new ways of working at many levels in the many different organizations that make up the nation's health care system. Can these thoughts move from the idea stage to urgent action?

References

The Commonwealth Fund Commission on a High Performance Health System. *Why not the best? Results from the national scorecard on U.S. health system performance*. The Commonwealth Fund, October 2011. Available at: <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Oct/Why-Not-the-Best-2011.aspx?page=all>.

Cooley L, and Kohl R. *Scaling up—from vision to large-scale change, a management framework for practitioners*. Washington, DC: Management Systems International; 2005.

Deloitte Center for Health Solutions. *Retail clinics: update and implications—2009 report*. Available at: <http://www.deloitte.com/us/retailclinics>.

Massoud MR, Nielson GA, Nolan K, et al. *A framework for spread: from local improvements to system-wide change*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006.

Odum L, and Whaley-Connell A. *The role of team-based care involving pharmacists to improve cardiovascular and renal outcomes*. *Cardiorenal Med* 2012;2:243–250.

Saseen JJ, Grady SE, Hansen LB, et al. *Future clinical pharmacy practitioners should be board-certified specialists*. American College of Clinical Pharmacy. *Pharmacotherapy* 2006; 26(12):1816–1825. Available at: http://www.accp.com/docs/positions/whitepapers/wp_phco200612.pdf.

U.S. Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP). *Finding the balance: program fidelity and adaptation in substance abuse prevention, executive summary of a state-of-the-art review*. 2002 Conference Edition. Washington, DC: DHHS SAMHSA CSAP; 2002. Available at: http://www.enap.ca/cerberus/files/nouvelles/documents/CREVAI/Baker_2002.pdf.

World Health Organization. *Nine steps for developing a scaling-up strategy*. Geneva: WHO; 2010.

Yuan CT, Nembhard IM, Stern AF, et al. *Blueprint for the dissemination of evidence-based practices in health care*. The Commonwealth Fund, May 2010.

Appendix A

Invitation



You are cordially invited to attend

Million Hearts™ **Scaling and Spreading Innovation** Strategies to Improve Cardiovascular Health

WHEN

Thursday, April 19, 2012
8:30 am–3:30 pm

WHERE

Kaiser Permanente Center for Total Health
700 Second Street NE Washington, DC 20002

Million Hearts™ is a national initiative to prevent 1 million heart attacks and strokes over the next five years. This event will explore innovative ways to improve cardiovascular health and health care across the country.

Join thought leaders like yourself from health care systems, state and local health organizations, health professional and patient organizations, payers and funders/investors, educational and research institutions, and more at this **invitation-only** event. Share real-world successes and brainstorm ways to spread these innovative approaches for better health.

The day is structured to be highly interactive with exciting discussions and activities. The agenda features dynamic speakers sharing their success stories countered by reactor panel members. These reactors will bring specific perspectives and provide commentary about what is needed for scaling and spreading innovations. You too will contribute by sharing your insights throughout the day!

Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, and **Tom Frieden**, Director of the Centers for Disease Control and Prevention, will be featured speakers at the event.

You will receive a **login and password to join the online Million Hearts™ community** for this event after confirming your attendance.

We hope you'll join us for an exciting exchange! For more information about Million Hearts™, visit millionhearts.hhs.gov.

This event is **by invitation only**. There is no travel support available for attendees.

This meeting is sponsored by the [Agency for Healthcare Research and Quality Health Care Innovations Exchange](#), the [Centers for Disease Control and Prevention Division for Heart Disease and Stroke Prevention](#), and the [Centers for Medicare and Medicaid Services](#), part of the [U.S. Department of Health and Human Services](#), in partnership with the [American Heart Association](#).

Appendix B

Million Hearts™ Participants



PARTICIPANTS



Nancy Artinian
Wayne State University
n.artinian@wayne.edu



Aaron Auyeung
Palladian Partners, Inc.
aarona@palladianpartners.com



Oxiris Barbot
Baltimore City Health Department
oxiris.barbot@baltimorecity.gov



Monica Barnette
Palladian Partners, Inc.
mbarnette@palladianpartners.com



Harriett Bennett
Agency for Healthcare Research
and Quality
harriett.bennett@ahrq.hhs.gov



Julie Bergmann
Westat
juliebergmann@westat.com



Benjamin Bluml
American Pharmacists Association
Foundation
bbluml@aphanet.org



Rosemary Botchway
Primary Care Coalition of
Montgomery County, MD, Inc.
rosemary_botchway@primarycarecoalition.org



Barry Bunting
American Health Care
b.bunting@americanhealthcare.com



Deborah Carpenter
Westat
deborahcarpenter@westat.com



Jim Chase
Minnesota Community Measurement
chase@mncm.org



Eileen Ciccotelli
Virginia Business Coalition
on Health
eciccotelli@myvbch.org



Carolyn Clancy
Agency for Healthcare Research
and Quality
diana.henry@ahrq.hhs.gov



Bruce Coles
New York State
Department of Health
fbco1@health.state.ny.us



Judi Consalvo
Agency for Healthcare Research
and Quality
judy.consalvo@ahrq.hhs.gov



Michael Danko
Palladian Partners, Inc.
mdanko@palladianpartners.com



Melissa Dorsey
Centers for Medicare and
Medicaid Services
melissa.dorsey@cms.hhs.gov



MaryAnne Elma
American College of Cardiology
melma@acc.org



Lauren Elsberry
Centers for Disease Control
and Prevention
lmE@cdc.gov



Shannon Fair
Westat
shannonfair@westat.com



Scaling and Spreading Innovation

PARTICIPANTS



Dean Fixsen
National Implementation
Research Network
dean.fixsen@unc.edu



Thomas Frieden
Centers for Disease Control
and Prevention
htk7@cdc.gov



Kay Gallagher
Westat
kaygallagher@westat.com



Lynne Garner
Donaghue Foundation
garner@donaghue.org



Foster Gesten
New York State
Department of Health
fg01@health.state.ny.us



Veronica Goff
National Business Group
on Health
goff@businessgrouphealth.org



Helene Goldstein
American College of Cardiology
hgoldstein@acc.org



Laura Gray
Westat
lauragray@westat.com



Fran Griffin
Centers for Medicare and
Medicaid Services
fran.griffin@cms.hhs.gov



Hali Hammer
San Francisco General Hospital,
Family Health Center
hhammer@medsch.ucsf.edu



Judy Hannan
Centers for Disease Control
and Prevention
jhannan@cdc.gov



Shelby Hays
Palladian Partners, Inc.
shays@palladianpartners.com



Christine Heasley
Highmark Inc.
christine.heasley@highmark.com



Laura Herrera
Maryland Department of Health
lherrera@dhrmh.state.md.us



Jane Hooker
National Association of
Public Hospitals and Health Systems
jhooker@naph.org



Mollie Howerton
Centers for Medicare and
Medicaid Services
mollie.howerton1@cms.hhs.gov



Philip Huang
Austin/Travis Health &
Human Services Department
philip.huang@austintexas.gov



David Johnson
MidAtlantic Business Group
on Health
jdjohnson@cmd.com



Diane Justice
National Academy for
State Health Policy
djustice@nashp.org



Madeleine Konig
American Heart Association
madeleine.konig@heart.org



Emily Krebs
Palladian Partners, Inc.
ekrebs@palladianpartners.com



Susan Ladd
Centers for Disease Control
and Prevention
bgy9@cdc.gov



Marilyn Laken
Medical University of
South Carolina
lakenm@muscc.edu



Cindy Lamendola
Preventive Cardiovascular
Nurses Association
cindylam@stanford.edu



Scaling and Spreading Innovation

PARTICIPANTS



Robert Like
Robert Wood Johnson
Medical School
like@umdnj.edu



David Magid
Colorado Permanente Medical Group-
Institute for Health Research
djmagid@gmail.com



Russ Mardon
Westat
russmardon@westat.com



Brian Mittman
U.S. Department of Veterans Affairs
brian.mittman@va.gov



Valentine Neira
Palladian Partners, Inc.
vneira@palladianpartners.com



Veronica Nieva
Westat
veronicanieva@westat.com



Mary Nix
U.S. Department of Health and
Human Services
marynix@hhs.gov



Michaela Oakley
Palladian Partners, Inc.
moakley@palladianpartners.com



John O'Brien
Centers for Medicare and
Medicaid Services
john.o'brien@cms.hhs.gov



William Oetgen
American College of Cardiology
woetgen@acc.org



Katrina Pardo
George Washington University
katrina.pardo@gwumc.edu



Greg Pawlson
BlueCross BlueShield of America
gregory.pawlson@bcbsa.com



Heather Pierce
Palladian Partners, Inc.
hpierce@palladianpartners.com



Paul Plsek
Paul E. Plsek & Associates, Inc.
paulplsek@directcreativity.com



David Pope
CreativePharmacist.com Brands
david@creativepharmacist.com



Christopher Powers
Centers for Medicare and
Medicaid Services
christopher.powers@cms.hhs.gov



Marie Schall
Institute for Healthcare Improvement
mschall@ihi.org



James Schmucker
Lancaster County Business Group
on Health
jschmucker@lccid.com



Mark Schoeberl
American Heart Association
mark.schoeberl@heart.org



Michael Schooley
Centers for Disease Control
and Prevention
mschooley@cdc.gov



Andrew Shin
Centers for Medicare and
Medicaid Services
andrew.shin@cms.hhs.gov



Bruce Siegel
National Association of Public Hospitals
and Health Systems
bsiegel@naph.org



Lisa Simpson
AcademyHealth
lisa.simpson@academyhealth.org



Chinara Smith
Centers for Medicare and
Medicaid Services
chinara.smith@cms.hhs.gov



Scaling and Spreading Innovation

PARTICIPANTS



Mark Smith
MedStar Health
marks.smith@medstar.net



Herbert Smitherman, Jr.
Wayne State University & Health Centers
Detroit Foundation, Inc.
hcslynnh@aol.com



Teresa Titus-Howard
Centers for Medicare and
Medicaid Services
teresa.titus-howard@cms.hhs.gov



Tara Trudnak
AcademyHealth
tara.trudnak@academyhealth.org



Aisha Tucker-Brown
Centers for Disease Control
and Prevention
htj1@cdc.gov



Kendall Van Pool
BlueCross BlueShield Association
kendall.vanpool@bcbsa.com



René Vega
Aetna
vegar@aetna.com



Patrick Wayte
American Heart Association
patrick.wayte@heart.org



Andrew Webber
National Business Coalition on Health
awebber@nbch.org



Robin Weil
Virginia Health Quality Center
rweil@vaqio.sdps.org



Andre Williams
Association of Black Cardiologists
awilliams@abcario.org



Janet Wright
Centers for Medicare and
Medicaid Services
janet.wright@cms.hhs.gov



Adam Zavadi
Alliance of Community Health Plans
azavadi@achp.org

Appendix C

Million Hearts™ Scaling and Spreading Innovation

Strategies to Improve Cardiovascular Health

Thursday, April 19, 2012

Kaiser Permanente Center for Total Health

700 Second Street NE

Washington, DC 20002

Agenda

- | | |
|------------------|---|
| 8:00 am–8:30 am | Registration |
| 8:30 am–8:40 am | Welcome and Introductions
<i>Janet Wright, Executive Director, Million Hearts™</i> |
| 8:40 am–8:50 am | Burning Platform
To inspire creative thinking about sustaining, scaling, and spreading successful interventions for better cardiovascular health.
<i>Carolyn Clancy, Director, Agency for Healthcare Research and Quality</i> |
| 8:50 am–10:00 am | Innovation Fishbowl: Heart360®
In this session, David Magid will provide a 10-minute overview describing the Heart360® innovation and issues related to its implementation in 10 Kaiser clinics in Colorado. In this pharmacist-led, home blood pressure monitoring program participants upload their home blood pressure measurements 3-4 times a week to the American Heart Association's Heart360® Web site. Clinical pharmacy specialists monitor the patients' blood |

Agenda – continued

pressure readings and adjust medication therapy as needed. This program has led to improved blood pressure control, increased reduction in blood pressure, and improved patient satisfaction with care for patients with uncontrolled hypertension. David Magid will discuss possible ways in which the program might be spread to other organizations.

In response to the presentation, reactor panel members from stakeholder organizations will offer their unique perspectives and also pose questions to David Magid.

10:00 am–10:15 am **BREAK**

10:15 am–11:25 am **Innovation Mini-Fishbowls**

After the plenary session, participants will attend one of 3 break-out groups, modeled on the large group session, to provide attendees an opportunity to discuss how other innovative approaches for cardiovascular health might be scaled up and spread broadly to other institutions.

1. Disease Management to Promote Blood Pressure Control Among African Americans

Aetna created this program to determine whether a telephone-based nurse disease management program was more effective than a home monitoring program to increase blood pressure control among African Americans enrolled in a national health plan. The results showed lower systolic blood pressure and a higher frequency of self-monitoring among participants.

Presenter: René Vega, Aetna

2. Language Concordant Health Coaches

In this program, language concordant health coaches (i.e., those who speak the patient's preferred language) team with residents to improve the self-management skills and quality of care of patients who have limited English proficiency and health literacy. Coaches, who work in tandem with a resident, conduct a pre-visit meeting, assist during the medical visit, conduct a post-visit meeting, and follow up with the patient 1 to 2 weeks after the visit to offer additional support. The program has led to improvements in the treatment process and clinical outcomes of patients with diabetes, including improved blood pressure and cholesterol levels.

Presenter: Hali Hammer, San Francisco General Hospital Family Health Center.

Agenda – continued

3. Medication Therapy Management Innovation

The American Pharmacists Association Foundation's Asheville Project created an employer-based long-term medication therapy management program to reduce the risk for high blood pressure and high cholesterol with the help of community pharmacists. Participants achieved lower blood pressure levels, experienced fewer cardiac events, and missed fewer days of work.

Presenter: Barry Bunting, American Health Care

11:25 am–11:40 am **Report back from Mini-Fishbowls**

11:40 am–12:40 pm **LUNCH BREAK**

12:40 pm–12:50 pm **Welcome Back and Burning Platform**

To continue to inspire creative thinking about sustaining, scaling, and spreading successful interventions for better cardiovascular health.

Thomas Frieden, Director, Centers for Disease Control and Prevention

12:50 pm–2:00 pm **Buzz Sessions: Heart-to-Heart on Readiness for Spread**

Drawing on pre-event and the day's discussion topics, participants join discussion groups focused on what is needed to support the spread of healthy heart innovations, such as:

- *How can innovators proactively promote the spread of their innovations? What skills and support do they need to be successful?*
- *What do potential adopter organizations need to facilitate their uptake of healthy heart innovations?*
- *How can government and private institutions work together to promote the spread and adoption of healthy heart innovations?*

2:00 pm–2:25 pm **Report back from Buzz Sessions**

2:25 pm–2:45 pm **3X5 Exercise to identify the best ideas of the day.**

2:45 pm–3:00 pm **Closing Remarks and Evaluation**

Janet Wright, Executive Director, Million Hearts™

3:00 pm **ADJOURN**

Appendix D

Heart360® Fishbowl Summary

In this pharmacist-led, home blood pressure monitoring program participants upload their home blood pressure measurements 3 to 4 times a week to the American Heart Association's Heart360® Web site. Clinical pharmacy specialists monitor the patients' blood pressure readings and adjust medication therapy as needed. This program has led to improved blood pressure control, increased reduction in blood pressure, and improved patient satisfaction with care for patients with uncontrolled hypertension.

Key Players

Fishbowl Presenter:

- **David Magid** is Director of Research for the Colorado Permanente Medical Group (CPMG), the Director of External Affairs for the Kaiser Permanente Colorado Institute for Health Research (IHR), and Chair of the Kaiser Permanente National Research Council. He is also an Associate Professor of Emergency Medicine and Preventive Medicine at the University of Colorado Health Sciences Center.

Moderator:

- **Paul Plsek**, Paul E. Plsek & Associates, Inc.

Reactor Panel:

- **Nancy Artinian** is the Associate Dean for Research and Director of the Center for Health Research at Wayne State. [Perspective: CVD Provider, Specialist]

- **MaryAnne Elma** is Director of Quality Innovation and Implementation at the American College of Cardiology. [Perspective: CVD Specialist, Potential Adopter]
- **Veronica Goff** is Vice President at the National Business Group on Health. [Perspective: Health Care Purchaser]
- **Bruce Siegel** is President and CEO of the National Association of Public Hospitals and Health Systems. [Perspective: Purchaser, Potential Adopter]
- **Lisa Simpson** is the President and CEO of AcademyHealth, and its advocacy arm, the Coalition for Health Services Research. [Perspective: Policy Expert]

Innovation Presentation

The presentation with accompanying audio is available at http://millionhearts.hhs.gov/aboutmh/innovation_exchange/Magid/index.htm.

Innovation Profile

A full description of the innovation appears in the AHRQ Health Care Innovations Exchange at <http://www.innovations.ahrq.gov/content.aspx?id=3222>.

Appendix E

Disease Management to Promote Blood Pressure Control Among African Americans Fishbowl Summary

The purpose of this innovation was to determine whether telephonic nurse disease management was more effective than a home monitoring program for controlling blood pressure among African Americans who were enrolled in a national health plan. The results of this program have been decreased systolic blood pressure and an increased frequency of blood pressure self-monitoring among the participants.

Key Players

Fishbowl Presenter:

- **René Vega** is a Senior Medical Director of Aetna Medicaid.

Moderators:

- **Judi Consalvo**, AHRQ, and **Veronica Nieva**, Westat

Reactor Panel:

- **Robert Like** is Professor and Director of the Center for Healthy Families and Cultural Diversity, Department of Family Medicine and Community Health, UMDNJ-Robert Wood Johnson Medical School. [Perspective: Culture Competence, training emphasis]
- **Brian Mittman** is co-Editor-in-Chief of the journal *Implementation Science* and Director of the VA Center for Implementation Practice and Research Support. [Perspective: Innovation and Implementation Expert]

- **Patrick Wayte** is Vice President of Marketing and Health Education for the American Heart Association (AHA). [Perspective: Stakeholder]

Innovation Presentation

The presentation with accompanying audio is available at http://millionhearts.hhs.gov/aboutmh/innovation_exchange/Vega/index.htm.

Innovation Profile

A full description of the innovation appears in the AHRQ Health Care Innovations Exchange at <http://www.innovations.ahrq.gov/content.aspx?id=3402>.

Appendix F

Language Concordant Health Coaches Fishbowl Summary

In this program, language concordant health coaches (i.e., those who speak the patient's preferred language) team with residents to improve the self-management skills and quality of care of patients who have limited English proficiency and health literacy. Coaches, who work in tandem with a resident, conduct a pre-visit meeting, assist during the medical visit, conduct a post-visit meeting, and follow up with the patient 1 to 2 weeks after the visit to offer additional support. The program has led to improvements in the treatment process and clinical outcomes of patients with diabetes, including improved blood pressure and cholesterol levels.

Key Players

Fishbowl Presenter:

- **Hali Hammer** is the Medical Director for the Family Health Center at San Francisco General Hospital.

Moderators:

- **Madeleine Konig**, AHA, and **Shannon Fair**, Westat

Reactor Panel:

- **Foster Gesten** is the Medical Director for the Office of Health Insurance Programs in the New York State Department of Health [Perspective: State Medicaid Organizations and Policy Expert]

- **Diane Justice**, Senior Program Director, National Academy for State Health Policy, focuses her work on long-term and chronic care issues facing states. [Perspective: State Programs Expert]
- **Gregory Pawlson** is the Executive Director of Quality Innovation for the Blue Cross Blue Shield Association (BCBSA) [Perspective: Innovation Expert and Payer]
- **Herbert Smitherman** is Assistant Dean of Community and Urban Health, and Assistant Professor of Internal Medicine at Karmanos Cancer Institute, Wayne State University School of Medicine. He is also President and CEO of Health Centers Detroit Medical Group, a Federally Qualified Health Center Look Alike in the city of Detroit. [Perspective: Federally Qualified Health Center (FQHC) and Community Health Expert]

Innovation Presentation

The presentation with accompanying audio is available at http://millionhearts.hhs.gov/aboutmh/innovation_exchange/Hammer/index.htm.

Innovation Profile

A full description of the innovation appears in the AHRQ Health Care Innovations Exchange at <http://www.innovations.ahrq.gov/content.aspx?id=2835>.

Appendix G

Medication Therapy Management Fishbowl Summary

The American Pharmacists Association Foundation's Asheville Project created a community-based, medication therapy management (MTM) program for patients with hypertension/dyslipidemia. In this program, pharmacists provide both education and long-term medication therapy management to reduce the risks of hypertension and dyslipidemia. The program, provided over a 6-year period in 12 community and hospital pharmacy clinics in Asheville, N.C., resulted in both clinical and financial benefits. This program resulted in numerous clinical benefits, including reduced hemoglobin A1C levels, improved blood pressure control, and significant declines in cholesterol and serum triglyceride levels. The program also reduced costs across four targeted conditions (diabetes, asthma, cardiovascular disease, and depression) and produced a positive return on investment.

Key Players

Fishbowl Presenter:

- **Barry Bunting** is the Vice President of Clinical Services for American Health Care.

Moderators:

- **Susan Ladd**, CDC, and **Deborah Carpenter**, Westat

Reactor Panel:

- **Ben Bluml** is the Vice President for Research at the American Pharmacists Association Foundation. [Perspective: Pharmacy Profession]

- **Mark Smith** is the Director of MedStar Institute for Innovation and the Chairman and Professor of Emergency Medicine at Georgetown University School of Medicine. [Perspective: Physician Profession]
- **Andrew Webber** is President and CEO of the National Business Coalition on Health (NBCH). [Perspective: Purchaser]
- **Adam Zavadil** is the Director of Market Strategy and Analysis at the Alliance of Community Health Plans [Perspective: Insurers]

Innovation Presentation

The presentation with accompanying audio is available at http://millionhearts.hhs.gov/aboutmh/innovation_exchange/Bunting/index.htm.

Innovation Profile

A full description of the innovation appears in the AHRQ Health Care Innovations Exchange at <http://www.innovations.ahrq.gov/content.aspx?id=3380>.

Appendix H

Top Ideas from the 3x5 Exercise

During the Million Hearts™ Scaling and Spreading Innovation Event, attendees participated in an interactive exercise using 3x5 index cards. In this activity, they identified the top five ideas of the day to support scale up and spread activities related to the Million Hearts™ initiative.

1. Involve other media outlets to share the stories of our innovators and the Million Hearts™ campaign
2. Smart use of health care team, pharmacists, nurse, etc.
3. Get more press on the successful innovations
4. Invite patients/community members to become active members of quality improvement innovation development, implementation scaling and spread teams to provide their perspectives—i.e., move from continuous quality improvement (CQI) to participatory quality improvement (PQI)
5. Health care providers listening to patient innovators*
6. “Community” data to share among “players”*

** Ideas five and six were equally ranked by participants*

