The Global Lab for Innovation

Building sustainable healthcare

UCLA Health

the Institute for Innovation in Health
Our definition of “innovation” –
  • Product, service, business model, work process
  • Accelerates the transformation of care
  • May be point innovation or comprehensive
  • Technology enabled but “not about the technology”

UCLA Global Lab for Innovation
Beta Version - Update

September 2014
Global Lab for Innovation:

*Frugal Innovation for Sustainable Healthcare*

The UCLA Health Global Lab **scans domestic and international markets** for high-value innovations that radically reduce cost and improve access to care.

Most health systems and plans are assembling **portfolios of innovations** – internal and external. We work to de-risk the selection of high-value innovations in order to accelerate their spread.
Key Activities

**Global Innovation Scan**
Scouting for innovations that significantly improve cost without reducing access, but can also transfer and scale across diverse marketplaces.

**Adopter Scorecard**
Assessing opportunity for cost, access, transferability, and scalability to help characterize innovations and rank their appropriateness for implementation in different environments.

**Innovation Deep Dives**
Making the facts readily available to assist in making the highest value innovations easier to propagate and scale.
Nominate Innovations

- www.uclainnovates.org → Global Lab page → Nominate an Innovation
- Register as a user and enter the information

Search The Inventory

- The inventory held 60 innovations by late July, through direct invitations to nominate
- Now testing nominations by developer-user diads, triads; revising platform

Yield From The Profiles

- 40 high-value innovations documented, 60 posted
- LA Innovators Forum – safety net pooling of 20 innovations
The Global Lab seeks to be an interactive web destination that fosters the innovation eco-system in which a community of innovators and adopters can thrive and connect.

It is our goal that this site will be a cloud-based accelerator for the spread of sustainable, cost-saving innovations. What makes this unique is the ability for innovations to be validated by adopters, and for adopters to learn the secrets of implementation so that they can work smarter and faster.
Scanning Methodology

- Innovators self-nominate – and 2 independent organizations validate the replication and results
- The primary focus is to identify innovations that reduce the cost of health care, and improve access / add quality?
- Primary approach is through partnerships – 2 models:
  - Nurse-led innovations – home page
    - Link innovations to the home page
    - Build “common set” of core innovations that will accelerate progress toward UHC, equity and good health
    - “Mini-RFPs” for nurse-led innovations
“Bucketing” Innovations

Promising Innovation
Insufficient documentation of savings currently available … assessments planned or underway

Documented Innovation
Sufficient documentation of savings currently available.

Emerging Best Practice
Documented savings, and already >15% disseminated across all targeted population(s)

One Year
Documented savings, can be implemented and achieve savings within 1 year

3 Years
Documented savings, can be implemented and achieve savings within 3 years

Pricing Innovation
Achieves price decrease, but does not reduce utilization
Examples of Innovations Scanned

**Level 1 Savings: Utilization-based savings = 20% or more for target population**

- **Nurse Extender Clinical Aides** (for hospitalized Medicare patients at risk of readmission)
- **Ethnographically Designed Patient Self-Management Kits** (for hospitalized VA patients at risk of readmission)
- **eScheduling from ED to Primary Care Clinics** (for non-acute Medicaid ED users)

**Level 2 Savings: Utilization-based savings > 2% for target population**

- **eConsult** (for Medicaid primary care patients referred to specialty visit)
- **Hospital at Home** (home-based care for acutely ill, frail elderly, replacing hospital care for elderly)
- **Community Paramedics** (EMS delivering primary care in community)
Scorecard may be used by adopters to identify highest value innovations for their organizations

<table>
<thead>
<tr>
<th>Increase access</th>
<th>Overcome barriers including geography (e.g. rural), social infrastructure and lack of/under-insurance, or lack of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcome access barriers</td>
<td></td>
</tr>
<tr>
<td>Decrease cost</td>
<td></td>
</tr>
<tr>
<td>Optimize workflow</td>
<td>Increase process efficiency, decrease time</td>
</tr>
<tr>
<td>Optimize utilization</td>
<td>Ensure utilization is optimized at lowest amount of use necessary</td>
</tr>
<tr>
<td>Optimize workforce</td>
<td>Shift care to lowest cost appropriate person (Enable practice at top of license)</td>
</tr>
<tr>
<td>Optimize location of care</td>
<td>Shift care to the lowest cost appropriate setting (continuum from hospital to home)</td>
</tr>
<tr>
<td>Cost of care</td>
<td>Amount of cost reduction</td>
</tr>
<tr>
<td>Dissemination potential</td>
<td></td>
</tr>
<tr>
<td>Population reach</td>
<td>Total population reached</td>
</tr>
<tr>
<td>Transferability</td>
<td>Potential for transfer across patient populations, settings, and diseases/conditions</td>
</tr>
<tr>
<td>External dissemination barriers</td>
<td>Impact of regulation and payment potential on potential dissemination</td>
</tr>
<tr>
<td>Hospital and Health System Implementation Barriers</td>
<td>Impact of implementation barriers including technology, capital investment, human capital and process re-design required</td>
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<tr>
<td>Customer centricity</td>
<td></td>
</tr>
<tr>
<td>Improve patient experience</td>
<td>Impact on patient satisfaction</td>
</tr>
<tr>
<td>Consumer and Patient Engagement</td>
<td>Impact on patient/family involvement in decision making</td>
</tr>
<tr>
<td>Notable features</td>
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<tr>
<td>Right-sized</td>
<td>Meets but doesn’t exceed patient/provider needs</td>
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<tr>
<td>Lead the market</td>
<td>Uniqueness of solution in solving the problem</td>
</tr>
<tr>
<td>Health outcome</td>
<td></td>
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</table>
Innovation Profile

Nurse Extender Clinical Aides

Nurse extender clinical aides decrease total cost of care and improve patient access by supporting patients in self-management and adherence to prescribed treatments of their condition. One study demonstrated a 58% reduction in readmission rates for high-risk heart failure patients.

Application Profiled Here:
Grand-Aides for Heart Failure Patients

What it is

Nurse extender clinical aides are care coordinators who work under close supervision of a nurse, nurse practitioner, or physician. These aides are typically individuals with some prior training and experience in health care (e.g., Certified Nurse’s Aide) who receive approximately three weeks of initial training in “care modules” for support of patients with specific diagnoses or conditions. Their primary objective is to support the patient in self-management and adherence to prescribed treatments of their condition. They work with patients in clinics, EDs, home visits, and telephone calls, and use tablets to communicate with nurse supervisors during patient encounters.

Summary

Application Profiled: Grand Aides for HF

<table>
<thead>
<tr>
<th>Category</th>
<th>Documented, Focused</th>
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</thead>
<tbody>
<tr>
<td>Savings</td>
<td>● Level 2</td>
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<tr>
<td>Access</td>
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<td>Experience</td>
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<td>Engagement</td>
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<td>Outcomes</td>
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<td>Potential for Spread</td>
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<tr>
<td>User Sites</td>
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</table>
Problems addressed

- Inadequate patient education and management in post-discharge transition period.
- Avoidable hospital admissions, readmissions, and ED visits for conditions that can appropriately be cared for at lower levels of care.
- Risk of nosocomial infections and other complications secondary to hospital care.
- Risk of failures in transitions of care between hospital and home, including inadequate education and management.
- Need for coordination of clinical care, education, and training.

How it works

**Grand-Aides USA** provides needs assessments, customized protocols and manuals, training and supervision instructions to help health care provider systems establish a nurse extender clinical aide program. It also offers assistance in data collection, analysis, reporting and evaluations during the first three years of operations.  

Each Grand-Aide (G-A) uses customized questionnaires to assess patient status and needs. With nurse oversight, a G-A offers advice, support, and education and, like a “good grandparent,” uses a “tough love” approach to engage patients.

A G-A can care for 75-250 patients depending upon the patients’ acuity. A nurse may supervise 3 to 4 G-As.

When used to reduce hospital readmissions, G-As make home visits every day for 5 days immediately after discharge and then decrease visits gradually while making daily telephone calls to patients. For most cases, visits and telephone calls stop one month post discharge. G-As reinforce the discharge plan and administer questions customized to the patient’s condition, and then review the patient’s use of medications with telemedicine supervision by the nurse supervisor.

In ED settings, G-As under nurse supervision assess and advise patients who do not require ED-level care.

In primary care settings, G-As meet patients in the clinic and arrange to make home visits to get to know the patient and family. When a patient or family caregiver calls, the G-A asks questions following protocol for the relevant conditions. G-As are also used to give care to selected “walk-in” pediatric patients, thus reducing the rate of physician visits.

Savings are achieved by G-As reducing rates of hospital admissions and readmissions for recently discharged patients, non-acute ED visits, and unnecessary office visits to physicians.

Innovators


Complexity (How complex are the organizational requirements)

**Focused.** A G-A program can be operational within three months. Supervisory training takes three days. Recruitment time for hiring G-As will vary with the market. G-As once hired can be trained in three to four weeks. Fees for a small to medium-sized delivery system cost an estimated average of $50,000.
Savings

Yes. In a pilot for post-discharge management of HF patients, 30-day all-cause readmissions decreased by 58%. Additional studies have demonstrated savings for heart failure patients (preventing readmissions), pediatric outpatients (reducing physician visits), and in pediatric ED patients (reducing non-acute visits).

- Pediatric non-acute ED visits: 74% of non-acute cases were averted from a physician ED visit through a G-A encounter supervised by a nurse.
- Walk-in pediatric cases: 62% of cases were averted from an MD visit through a G-A encounter under nurse supervision.

Access

Yes. Patients discharged from hospitals receive home visits, support and education. Outpatients gain prompt access to G-As rather than having to wait for an appointment with a physician or nurse practitioner. Capacity of physicians and nurses to see other patients was increased by diversion to G-As.

Patient experience

Likely, but not documented. In the heart failure Grand-Aides program at the University of Virginia, only 4% of heart failure patients dropped out of the G-A arm of the study in 6 months.

Engagement

Likely, but not documented. Patients trained by G-As in self-management and 89% of the patients assigned to a G-A self-reported that they “missed only occasional doses.” (No comparator data was available)

Outcomes

Yes. In the heart failure patients, there was a 77% reduction in HF-related readmissions and a 58% reduction in all-cause HF readmissions compared to case-matched patients in the previous year without Grand-Aides support.
We are looking for innovations from around the globe that help health systems to reduce costs and increase access. Please nominate an innovation that meets our criteria and would be a candidate for adoption by our community. We look forward to reviewing your submission, connecting with you, and publishing a profile of your innovation here with our growing collection of solutions.

1. Innovation Contact

Name *

Email address *

Phone number