

## **Health Care Innovation Awards Round Two Project Profiles**

The Center for Medicare and Medicaid Innovation announced the first batch of prospective recipients for the Health Care Innovation Awards program (Round Two) on May 22, 2014 and the second batch on July 9, 2014. These organizations will implement projects in communities across the nation that aim to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. These projects would be funded for three years. Continued funding would be contingent on satisfactory performance compared with operational performance measures and a decision that continued funding is in the best interest of the federal government.

More information on Round Two of the Health Care Innovation Awards can be found at <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html>.

## **ALTARUM INSTITUTE**

**Project Title:** Reducing the Burden of Childhood Dental Disease

**Geographic Reach:** Michigan

**Estimated Funding Amount:** \$9,383,762

**Summary:** The Altarum Institute project will test the impact of an intervention, which integrates primary care providers, dentists and health information technology on dental outcomes for children ages 0 to 17 enrolled in Medicaid or CHIP. Components include: 1) improving identification of children at high risk of dental disease by developing and deploying oral health risk screening tools, leveraging an existing statewide registry to document screenings and risk status, and delivering technical assistance/training to providers on the use of these tools in primary care and non-traditional settings; 2) linking providers through existing state and regional health information exchange infrastructure to establish electronic referral pathways between medical and dental providers, connecting dentists to the referral system, and monitoring the process, providing following-up on incomplete referrals; 3) promoting evidence-based preventive care by educating and preparing primary care providers and dentists to follow standards of care for preventive services such as fluoride varnish, sealants, and cleanings, providing outreach and education to families of high-risk children, coordinating with existing oral health promotion programs, and better aligning provider incentives to increase provision of preventive care; and 4) enabling care management and monitoring by developing and implementing a statewide dental quality monitoring system using recently validated American Dental Association measure sets.

## **AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION**

**Project Title:** SMARTCare

**Geographic Reach:** Wisconsin, Florida

**Estimated Funding Amount:** \$15,871,245

**Summary:** The American College of Cardiology Foundation project will test the implementation of SMARTCare, which is a combination of clinical decision support, shared decision-making, patient engagement, and provider feedback tools designed to improve care for patients with stable ischemic heart disease. SMARTCare aims to achieve the following goals: 1) a reduction of imaging procedures not meeting appropriate use criteria, 2) a reduction in the percentage of percutaneous coronary interventions not meeting appropriate use criteria while achieving high levels of patient engagement and lower rates of complications, and 3) an increase in the percentage of stable ischemic heart disease patients with optimal risk factor modification. While many of these solutions have been studied and proven effective in isolation, this project will test them in combination. The model will be tested at five sites in Wisconsin and five sites in Florida.

## **AMERIGROUP**

**Project Title:** Coaching and Comprehensive Health Supports (COACHES) Program

**Geographic Reach:** Georgia

**Estimated Funding Amount:** \$5,834,485

**Summary:** The Amerigroup project will test an intervention designed to improve outcomes for transitional young adults ages 17 to 20, who are transitioning out of foster care and who will receive

health care coverage until the age of 26 for the first time under the ACA. The program will establish one-on-one coaches, and a support team, who will partner with transitional young adults over the life of the grant period to improve healthy behaviors. The coaches and support team will coordinate with the state's sole Care Management Organization and the case management in the child welfare system provided through Georgia's Division of Family and Children Services. The coach and support team will be a one-stop resource, in which all of the health and social services needed by the youth are pooled and coordinated and through which the members are connected to the scope of services they need. Aims of the program include reductions in hospitalizations through better management of behavioral health conditions, increases in access to primary care physicians, as well as improvement in pregnancy-related outcomes, employment, and education attainment.

## **ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

**Project Title:** eConsults/eReferrals: Controlling Costs and Improving Quality at the Interface of Primary Care and Specialty Care

**Geographic Reach:** New Hampshire, Iowa, Wisconsin, Virginia, California

**Estimated Funding Amount:** \$7,125,770

**Summary:** The Association of American Medical Colleges project will test the scalability of an eConsult/eReferral model for implementation in five partner academic medical centers. The eConsults model, developed by the University of California San Francisco (UCSF), is an electronic consultation and referral (eCR) platform for access to specialty input to address several well-documented gaps in primary care-specialty care communication and coordination and provide a foundation for non-face-to-face, asynchronous electronic consultation. The proposed model has two components, both fully integrated into the Epic electronic health record. The first being implementation of a standardized set of condition-specific referral templates across 12 medical specialties, with additional surgical specialties nearing completion. These templates, developed at UCSF and refined at each academic medical center by a consensus of primary care/specialist clinicians, provide immediate decision support to the primary care provider (appropriateness of referral, recommended pre-referral tests, *etc.*) and ensure that all necessary information is provided to the appropriate specialist. The second component of the model is the eConsult, an asynchronous exchange initiated by the primary care provider to seek guidance from the specialist, who is expected to respond in less than 72 hours. eConsults are completed in lieu of an in-person specialist visit, though the specialist can convert an eConsult to a referral if the situation warrants and the patients will still have the option to seek care with that specialist, if desired. The eConsult system integrates into current care-delivery practices and supports the work of both the primary care provider and the specialist involved in an eConsult exchange.

## **AVERA HEALTH**

**Project Title:** Avera Virtual Care Center: Improving Care & Reducing Costs for the Vulnerable Elderly Population

**Geographic Reach:** South Dakota, Minnesota, Iowa, Nebraska

**Estimated Funding Amount:** \$8,827,573

**Summary:** The Avera Virtual Care Center project will test the virtual wrapping of a set of comprehensive, resident-centered, geriatric care services around the long term care population. The project will operate in facilities located in South Dakota, Minnesota, Iowa and Nebraska. The three primary drivers of this project include: building the assessment capability and toolkits of the long term care team of care

providers; providing long term care facility residents with routine and early access to appropriate goal-directed care; and improving management of care transitions. A Virtual Care Team will host INTERACT II training sessions and skill building workshops for long term care staff and will facilitate widespread implementation of INTERACT II tools and treatment algorithms to support earlier identification of urgent issues. The INTERACT II implementation will be further supported by high-quality care planning resources and training to promote alignment of resident care goals and treatment plans. To address the geriatric care access gap, the Virtual Care Team will offer daily rounds, comprehensive geriatric assessments and urgent care visits to address resident health needs in a timely manner. These services will be provided out of a centrally staffed telemedicine hub, spreading the expertise of one team over 30 long term care centers. To maximize safety and continuity across transitional points in care, the Virtual Care Center team will promote the adoption of standardized tools and processes.

## **THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS**

**Project Title:** University of Illinois CHECK (Coordination of Healthcare for Complex Kids)

**Geographic Reach:** Illinois

**Estimated Funding Amount:** \$19,581,403

**Summary:** The Board of Trustees of the University of Illinois project will test a model that will build a "medical neighborhood" via a network of over 40 practices throughout Cook County. This project will improve access to care by bringing care to patients where they live, work, and attend school. UI Health will be a convener of these closely-connected community partners. Multidisciplinary teams, including primary care physicians, specialists, behavioral health specialists, and clinical pharmacists, will collaborate to improve transitions and implement effective disease-specific interventions. Advanced Practice Nurses will lead care management teams and execute care plans with neighborhood-embedded patient navigators. They will use multiple tools, including technology, effective data management, systems redesign, and outreach and community engagement, to build bridges between care sites, care providers, and the family.

## **BOSTON MEDICAL CENTER**

**Project Title:** Massachusetts Alliance for Complex Care (MACC)

**Geographic Reach:** Massachusetts

**Estimated Funding Amount:** \$6,128,059

**Summary** The Boston Medical Center project will test a Collaborative Care Coordination and Consultative Model for Complex Kids (the 4C, or "Foresee" Program) which pairs Complex Care Nurse Care Coordinators and Pediatricians at MACC sites in Boston and Springfield with pediatricians in the community to enhance and improve the care delivered to children with medical complexity in local medical home-like settings. Prior to enrolling in the MACC, families will undergo a comprehensive process of intake, multi-disciplinary assessment and care planning which will be used as the basis for a Comprehensive Care Plan for the child and family. All local pediatricians referring children to the MACC will also have access to consultation by a Psychiatrist, Developmental/Behavioral Pediatrics Specialist, Clinical Social Worker, and Nutritionist. Families will have access to the services of a Family Navigator to help them overcome access barriers, advocate for them, and coordinate among multiple agencies. Families will also have access to behavioral health services provided by the MACC for those in proximity to Boston Medical Center and Baystate and by referral for families in outlying areas. The complex care

Pediatrician will see the patient at least once every six months and the Comprehensive Care Plan will be reviewed and revised at least once annually.

## **CARECHOICE COOPERATIVE**

**Project Title:** Person Centered Care Connections

**Geographic Reach:** Minnesota

**Estimated Funding Amount:** \$3,347,584

**Summary:** The CareChoice Cooperative project will test Person Centered Care Connections, which will build on and expand another successful CareChoice project, Resident Centered Care Connections, in an effort to reduce unnecessary hospitalizations and total cost of care by using four essential care components to address problems and gaps in nursing home post-acute and long term care. The proposed enhanced discharge planning process includes using evidence-based components of Project RED (Re-engineered Discharge) and available technology to create an efficient system for nursing home staff to do the comprehensive education and preparation needed by patients and families to promote a successful patient and residents' transition from care setting to home. Together, these four components of care have proven effective in reducing hospital admissions, enabling patient determined goals of care and improving palliative care for the patient and residents' of CareChoice nursing homes over the past three years.

## **CATHOLIC HEALTH INITIATIVES IOWA CORP., DBA MERCY MEDICAL CENTER DES MOINES**

**Project Title:** Transitioning a Rural Health Network to Value-Based Care

**Geographic Reach:** Iowa, Nebraska

**Estimated Funding Amount:** \$10,171,220

**Summary:** Catholic Health Initiatives Iowa Corporation is receiving an award to test a model to transition a network of rural critical access hospitals to value-based care through improved chronic disease management, increased clinical-community integration and 'lean' process improvement initiatives. Once the value-based care infrastructure has been established, the 25 critical access hospitals, including their 73 primary care clinics, will be enrolled in Mercy's Accountable Care Organization (ACO) and benefit from shared savings, resulting in model sustainability. The model is based on the approach of the Mercy ACO, which has used a similar model in its urban clinics and has achieved successful outcomes. This model includes public and private payers, rural leadership, expertise in barriers to quality care in rural communities, and utilizes Mercy's evidence-based chronic care health coach and disease registry that aim to improve care and reduce costs.

## **CHILDREN'S HOME SOCIETY OF FLORIDA**

**Project Title:** Improving child well-being through integrating care in a community school setting

**Geographic Reach:** Florida

**Estimated Funding Amount:** \$2,078,295

**Summary:** The Children's Home Society of Florida project will implement a medical home for students, families, teachers and the community at the Wellness Cottage at Evans High School, which aims to reduce Emergency Department and inpatient utilization, increase sexually transmitted disease

awareness, and address food insecurities and traumatic stress. Four community partners including Children’s Home Society of Florida (child welfare/behavioral health), the University of Central Florida, Orange County Public Schools and Central Florida Family Health Center will operate the Wellness Cottage, a hub for health, social, behavioral health, parental support, and after-school activities. The Central Florida Family Health Center will provide onsite primary care. Health risk assessments will inform health promotion activities. Student health ambassadors will promote healthy lifestyles. Community health workers will help parents remove barriers to care. The University of Central Florida will provide social work, nursing, and medical interns. Primary Health Maintenance Organizations will facilitate access to the clinic and assist in evaluating health costs. Programs and services targeting wellness will be available in the school and community. It is predicted that the services provided at Evans Wellness Cottage will improve both the physical health and behavioral health of students, staff, and adults living in the targeted area. The model is designed to create a safe environment where students can learn better health care seeking behaviors and personal health management. In addition, informal and formal connections will help facilitate the development of trust and establish critical lines of communication to improve access to care at the Evans Wellness Cottage.

## **CITY OF MESA FIRE AND MEDICAL DEPARTMENT**

**Project Title:** Community Care Response Initiative

**Geographic Reach:** Arizona

**Estimated Funding Amount:** \$12,515,727

**Summary:** The City of Mesa Fire and Medical Department is receiving an award to test a model that offers new comprehensive delivery systems and addresses the impact of chronic disease, falls prevention, self-management skills, and medication adherence. The model aims to reduce high-risk patient returns post-discharge and the treat and referral of low-acuity patients from the use of the 911 systems and the emergency department. The program provides low acuity patients with on-site evaluation and treatment; and/or refers patients to more appropriate services, which reduce duplication efforts between emergency rooms and private physician providers. High-risk patients will receive follow up evaluations after discharge to reduce the incidence of readmission. Disease preventative services will be provided including immunizations, falls prevention, home safety inspection, and the safe use of prescribed medications. The Community Care Response Initiative will consist of four units operating 24 hours per day 365 days per year throughout the Mesa area. A physician extender unit is a modified ambulance that takes the team to perform low acuity services or post discharge hospital follow-up. The services provided by this unit are similar to services provided by an urgent care: in depth patient evaluations, behavioral health evaluations, suturing, minor trauma evaluations, cardiac diagnostic capabilities, pain management, prescription services, immunizations, health education, referral services, primary care consultations, sepsis evaluations, post discharge follow ups, and minor diagnostic testing.

## **CLIFFORD W. BEERS GUIDANCE CLINIC, INC.**

**Project Title:** New Haven WrapAround

**Geographic Reach:** Connecticut

**Estimated Funding Amount:** \$9,739,427

**Summary:** The Clifford W. Beers Guidance Clinic, Inc. project will deliver evidence-based, culturally-appropriate integrated medical, behavioral health, and community-based services coordinated by a

multidisciplinary Wraparound Team. Services include: 1) family engagement, recruitment, and education provided by trained community health workers in community-based settings; 2) multidisciplinary triage, screening, and assessment conducted by the Wraparound Team and including assessments of each family's physical, behavioral, and psychosocial risks, needs, and strengths; 3) family-focused care plans developed with the family, family supports, and the Wraparound Team and used to guide care and interventions; 4) care coordination provided by a Wraparound Team and focused on coordinating the provision of appropriate care across multiple care settings, managing care transitions, reconciling and managing medications, and coordinating access to crisis support and wellness and social support services; and 5) wellness and social support services provided at the hubs and at community-based organizations to address chronic and toxic stress (e.g., smoking cessation, parenting courses, diabetes prevention, meditation). The model focuses on high-need families, addresses medical and behavioral health care needs, integrates services across multiple health care institutions, and addresses the "chronic and toxic stress" experienced by the target population families. This project integrates care for families and integrates care delivery across multiple health care and community-based institutions, which will reduce the fragmentation that currently puts families at risk for poor care, poor outcomes, and excessive costs.

## **DETROIT MEDICAL CENTER, VANGUARD HEALTH SYSTEMS**

**Project Title:** Gateway to Health: An Innovative Model for Primary Care Expansion in Detroit

**Geographic Reach:** Michigan

**Estimated Funding Amount:** \$9,966,608

**Summary:** Detroit Medical Center is receiving an award to test a proposal that would make primary care immediately available to individuals who arrive at 4 major inner city Emergency Departments for non-urgent care by establishing adjacent patient-centered medical home clinics. The initial focus will be on improving the care provided to patients with diabetes or asthma, and Emergency Department "super-utilizers" who have 10 or more visits annually. Medicaid fee-for-service beneficiaries will be the dominant target population. The program will expand to include patients with hypertension, congestive heart failure, chronic obstructive pulmonary disease, HIV, and depression. The design is based on the Nuka model in Alaska.

Team-based interaction with the patient will consist of face-to-face visits, telephone contact, and texting. Services will include an initial assessment of patient expectations, screening for depression, and active engagement of patients in their disease management. Coaches and navigators are essential to the model and are expected to have the greatest impact. The ultimate objective is patient wellness through self-management.

The goals of the project are to reduce emergency room service costs for the subset of emergency room patients with non-urgent care needs while concomitantly increasing access to patient-centered medical homes. Detroit Medical Center also hopes to minimize the potential impact that Medicaid expansion under the Affordable Care Act may have on emergency room utilization.

## **FOUR SEASONS COMPASSION FOR LIFE**

**Project Title:** Increasing patient and system value with community based palliative care

**Geographic Reach:** North Carolina

**Estimated Funding Amount:** \$9,596,124

**Summary:** The Four Seasons Compassion for Life project will test a new model for community-based palliative care (in conjunction with Duke University), which spans inpatient and outpatient settings. The model features interdisciplinary collaboration and the integration of palliative care into the health care system, continuity of care across transitions, and longitudinal, individualized support for patients and families. This expands upon a successful program in four Western North Carolina counties to include an additional ten counties. With community-based palliative care, care coordination ensures clinical follow-up of patients as they transition across settings. Standardized assessments and data infrastructure facilitate quality monitoring/improvement and high-quality patient care leading to decreased hospital readmissions.

## **FUND FOR PUBLIC HEALTH IN NEW YORK, INC.**

**Project Title:** Project INSPIRE NYC (Innovate & Network to Stop HCV & Prevent complications via Integrating care, Responding to needs and Engaging patients & providers

**Geographic Reach:** New York

**Estimated Funding Amount:** \$9,948,459

**Summary:** The Fund for Public Health in New York is testing a model that will identify persons with Hepatitis C viral (HCV) infection utilizing the New York City Department of Health and Mental Health HCV surveillance database, electronic medical and laboratory records from participating facilities, and referrals from neighborhood organizations that perform HCV testing. Eligible persons will undergo an interdisciplinary, comprehensive medical and behavioral health assessment, for substance use and social support and benefits needs. Patients' behavioral health will be assessed using the Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C), to identify areas of psychosocial functioning that require attention before and after beginning HCV treatment. HCV and related co-morbidities will be managed within an integrated, patient-centered clinical and behavioral health environment. Primary care and/or HIV providers will be supported by addiction medicine specialists, psychiatrists and hepatologists, who will be available for telemedicine-based consultation. Providers will be trained and mentored in HCV care and treatment by the institutions' hepatologists. Web-based teaching modules and weekly case management videoconferences with hepatologists and providers from all participating clinics will be used. Patient management will be supported and facilitated by care coordination, defined as health system navigation and patient support to keep medical appointments, health promotion, medication adherence assistance, and coaching for improvement of self-sufficiency skills. Comprehensive care coordination programs and integrated care have been shown to improve health outcomes and reduce hospitalization and emergency department visits.

## **GEORGE WASHINGTON UNIVERSITY**

**Project Title:** PREVENTION AT HOME: A Model for Novel use of Mobile Technologies and Integrated Care Systems to Improve HIV Prevention and Care While Lowering Cost

**Geographic Reach:** Washington D.C.

**Estimated Funding Amount:** \$23,808,617

**Summary:** The George Washington University project will test a model that will utilize mobile technologies and optimize the prevention and care continuum (early detection, treatment adherence, retention in care, viral load suppression, decreased hospitalizations) for HIV+ individuals. The project

will bring together a consortium of stakeholders including community outreach organizations, clinical care systems, a hospital, a managed care organization, the DC Department of Health, and DC Medicaid to share integrated IT systems. Together these systems will provide Medicaid members with the ability to receive online education, the option of ordering home testing and home specimen collection for sexually transmitted infections and HIV, receive sexually transmitted infection and viral load test results, receive e-prescriptions and support linking and relinking to care. Additionally, the systems will provide community health workers (CHW) with a mobile tool to collect recruitment data, to guide counseling, testing and linkage services, and will provide CHW with a list of active patients to provide care coordination who have detectable viral load, missed clinic visits, missed medication refills, emergency room visits or hospitalizations. Finally, the system will allow CHW and /or patients to generate a care plan that will be integrated into the primary care provider's electronic health record, to facilitate continuity of care.

## **ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI**

**Project Title:** Bundled Payment for Mobile Acute Care Team Services

**Geographic Reach:** New York

**Estimated Funding Amount:** \$9,619,517

**Summary:** The Icahn School of Medicine at Mount Sinai project will test Mobile Acute Care Team (MACT) Services, which will utilize the expertise of multiple providers and services already in existence in most parts of the United States but will transform their roles to address acute care needs in an outpatient setting. MACT is based on the hospital-at-home model, which has proven successful in a variety of settings. MACT will treat patients requiring hospital admission for selected conditions at home. The core MACT team will involve physicians, nurse practitioners, registered nurses, social work, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team will provide essential ancillary services such as community-based radiology, lab services (including point of care testing), nursing services, durable medical equipment, pharmacy and infusion services, telemedicine, and interdisciplinary post-acute care services for 30 days after admission. After 30 days, the team will ensure a safe transition back to community providers and provide referrals to appropriate services.

## **JOHNS HOPKINS UNIVERSITY**

**Project Title:** Comprehensive home-based dementia care coordination for Medicare-Medicaid Dual Eligibles in Maryland

**Geographic Reach:** Maryland

**Estimated Funding Amount:** \$6,384,190

**Summary:** The Johns Hopkins University project will test the implementation of Maximizing Independence at Home (MIND), an Alzheimer's disease / Dementia (AD) -targeted care coordination model that systematically assesses and addresses the critical barriers to adults with AD remaining in their home. The target population is adults eligible for Medicare and Medicaid (Duals) in the Baltimore region. The model creates a broad link between community health agencies, medical providers and community resources, and innovatively synthesizes the expertise and experience of non-clinical community workers, nurses, physicians, and occupational therapists. Delivered over 18 months, MIND addresses 21 care need domains for patients and caregivers. The interdisciplinary team performs comprehensive, in-home, AD-related needs assessments followed by individualized care planning and

implementation of six basic care strategies (resource referrals, environmental safety, dementia care education, behavior management skills training, informal counseling, problem-solving), on-going monitoring, and assessment and planning for emergent needs. Each component of the intervention is based on clinical practice guidelines and prior research, and is combined for maximum impact.

## **MONTEFIORE MEDICAL CENTER**

**Project Title:** Bronx Behavioral Health Integration Project (BHIP): Across the Lifespan in Urban Safety Net Primary Care Settings

**Geographic Reach:** New York

**Estimated Funding Amount:** \$5,583,091

**Summary:** The Montefiore Medical Center project will test implementation of the Bronx Behavioral Health Integration Project (B-HIP), which aims to improve the health of Bronx residents through two interrelated mechanisms, first by engaging patients with serious behavioral health needs and secondly by screening for, identifying and addressing behavioral health co-morbidities in a Collaborative Care Management (CCM) model. The target population includes Medicare, Medicaid beneficiaries and persons eligible for both programs. As part of routine primary care, patients of all ages will be screened for behavioral health conditions using validated instruments. Those with behavioral health needs will be managed by an CCM team of a primary care physician, psychiatrist, social worker or psychologist and care manager that supports the primary care team by providing screening, assessments, treatment and follow-up care with measurement-based tracking, stepped care algorithms and self-management and behavioral action techniques.

## **NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS**

**Project Title:** Coordinating All Resources Effectively (CARE) for Children with Medical Complexity

**Geographic Reach:** California, Colorado, Florida, Missouri, Ohio, Pennsylvania, Texas

**Estimated Funding Amount:** \$23,198,916

**Summary:** The National Association of Children's Hospitals and Related Institutions, Inc., part of Children's Hospital Association, in partnership with children's hospitals and National Institute for Children's Health Quality, is receiving an award to test Coordinating All Resources Effectively (CARE) for children with medical complexity (CMC), which aims to inform sustainable change in health care delivery through new payment models supporting improved care and reduced costs for CMC. The population of focus is CMC who have medical fragility and intense medical and coordination of care needs that are not well met by existing health care models. This model aims to improve care and reduce overall health care expenditures for CMC by 1) creating a medically-appropriate tiered system of care so that CMC of varying needs are cared for in the most appropriate settings to meet patient and family needs while lowering costs, 2) designing a payment system that will both sustain these programs and provide sufficient flexibility so that services will meet patient and family needs and 3) creating a learning system so that programs and payers across the country serving this population can rapidly learn from each other to improve care and design and implement effective payment models. At the center of the proposed care model are the principles of accessible, coordinated, continuous, compassionate and family centered care/shared decision making as articulated in the concept of the medical home, which

has been associated with fewer hospitalizations, less emergency department use, better health, and lower costs of care.

## **NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL**

**Project Title:** Medical Respite Care for People Experiencing Homelessness

**Geographic Reach:** Minnesota, Oregon, Connecticut, Washington, Arizona

**Estimated Funding Amount:** \$2,673,476

**Summary:** The National Health Care for the Homeless Council (NHCHC) is receiving an award to test a model that will provide medical respite care for homeless Medicaid and Medicare beneficiaries, following discharge from a hospital with the goal of improving health, reduce readmissions, and reduce costs. Medical respite care is defined as acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to stay in a hospital; these programs can provide a cost-effective discharge alternative for hospitals and provide patients with a place to receive ongoing post hospital care while working on their health and housing goals. The service model will incorporate evidence based practices including transitional care, patient centered self-management goal setting, and case management to address socio-economic and other factors affecting health outcomes and access to timely and appropriate care.

## **THE NEBRASKA MEDICAL CENTER**

**Project Title:** Remote Interventions Improving Specialty Complex Care (RIISCC)

**Geographic Reach:** Nebraska

**Estimated Funding Amount:** \$9,993,626

**Summary:** The Nebraska Medical Center is receiving an award to test the Remote Interventions Improving Specialty Complex Care (RIISCC) model, which aims to employ remote patient monitoring for 90 days post-discharge by utilizing telehealth consultations for participants at one of two community health centers located within the target geographic areas. Participants will receive telehealth equipment as well as an orientation to the program which includes 90 day remote monitoring, weekly calls from remote monitoring coaches to discuss critical values and provide education and coaching, a retinal eye imaging scan and follow up consults with an ophthalmologist if needed, a nutritional consult with a registered dietician, and gift card incentives to encourage participation and retention. The target population resides in medically underserved areas and often experience barriers in access to health care.

## **NEW YORK CITY HEALTH AND HOSPITALS CORPORATION**

**Project Title:** ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use

**Geographic Reach:** New York

**Estimated Funding Amount:** \$17,916,663

**Summary:** The New York City Health and Hospitals Corporation project will test an Emergency Department Care Management model, which expands and enhances a current successful pilot program. This model utilizes a multi-disciplinary team that will comprehensively assess patients who present in the emergency department for an ambulatory-care sensitive condition (ACSC), create a care plan that would avoid an unnecessary hospitalization, and provide ongoing support after discharge, including

medication management, education, and linkages with primary care providers. The program will operate in 6 hospitals.

## **NORTH CAROLINA COMMUNITY CARE NETWORKS, INC.**

**Project Title:** Optimizing the Medical Neighborhood: Transforming Care Coordination through the North Carolina Community Pharmacy Enhanced Services Network

**Geographic Reach:** North Carolina

**Estimated Funding Amount:** \$15,106,050

**Summary:** North Carolina Community Care Networks, Inc. project will test a model focused on community based pharmacists who will deliver medication management services to patients with at least one chronic condition and have over 80% of their medications filled within the last 100 days at a specific pharmacy. The pharmacist will utilize PHARMAceHOME, a pharmacy information exchange platform, to understand both the patient's prescription history in order to deliver effective medication management services and support the coordination of care by serving as an extension of the patient centered medical home care manager. These services are expected to reduce hospital readmissions and visits to the emergency department by providing patients with the medication assistance they need proactively.

## **NORTH SHORE LIJ HEALTH SYSTEM, INC.**

**Project Title:** Healthy Transitions in Late Stage Kidney Disease

**Geographic Reach:** New York

**Estimated Funding Amount:** \$2,453,742

**Summary:** The North Shore-LIJ Health System, Inc. project will implement the Healthy Transitions (HT) Program, which aims to improve late stage chronic kidney disease costs and outcomes. The model is based on a successful pilot and aims to integrate and coordinate aspects of chronic kidney disease care. The primary interventions center on improving patient education and preparation for renal replacement treatment, increasing home dialysis and preemptive transplantation, home safety, dietary counseling, depression screening, advanced directive counseling, detecting medication errors, identifying hospitalization risk and intervening to reduce risk. Nurse care managers will work in close collaboration with treating nephrologists. The HT chronic kidney disease informatics system creates a daily report with alerts that drives key care processes.

## **REGENTS OF THE UNIVERSITY OF CALIFORNIA SAN DIEGO**

**Project Title:** San Diego: A Health Attack and Stroke Free Zone - HSF - Z

**Geographic Reach:** California

**Estimated Funding Amount:** \$5,820,416

**Summary:** The Regents of the University of California San Diego project will test implementation of the Health Attack and Stroke-Free Zone (HSF-Z) program, which aims to impact population health through four related, regional areas of work: (1) activate high risk patients by increasing awareness of risk factors, increasing understanding of their disease state, and increasing commitment to their physician's recommendations through the Be There campaign, (2) promote evidence based practices for heart attack and stroke prevention in the physician community through peer education and sharing best

practices, (3) test novel, cost-effective technology solutions to enhance adherence to care plans, patient satisfaction, provider satisfaction, and health outcomes, and (4) implement the HSF-Z intervention for treatment of cardiovascular risk factors for 4,000 patients. The HSF-Z model is based on the premise that significant reduction of blood pressure and cholesterol levels is possible using evidence based practices and achieving patient adherence. The model targets both patients and primary care clinical teams and will also explore the use of emerging wireless and other technologies to monitor patient progress and compliance.

## **REGENTS OF THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO**

**Project Title:** The UCSF and UNMC Dementia Care Ecosystem: Using Innovative Technologies to Personalize and Deliver Coordinated Dementia Care

**Geographic Reach:** California, Nebraska

**Estimated Funding Amount:** \$9,990,848

**Summary:** The Regents of the University of California San Francisco (USCF) project will implement Care Ecosystem, an innovative clinical program that builds on the UCSF Memory and Aging Center's 15-year history of offering high-quality dementia care, while incorporating the University of Nebraska Medical Center's (UNMC) specialized expertise in functional monitoring and rural dementia care. Whereas most dementia care today is crisis-oriented and reactive, this model emphasizes continuous and personalized care. The target population is Medicare beneficiaries and persons dually eligible for Medicare and Medicaid. By supporting family caregivers, keeping patients healthy, and helping them prepare together for advancing illness, this model aims to improve satisfaction with care, prevent emergency-related health care costs, and keep patients in the home longer. The primary point of contact for patients and families will be a Care Team Navigator (CTN) with 24/7 availability. An innovative "dashboard" with both CTN and patient portals will drive efficient and personalized communication between the CTN, care team, and the patient and family. The 4 modules of Care Ecosystem are as follows. The Caregiver Module will include educational forums and connect families with community resources. The Decision-Making Module will facilitate proactive medical, financial, and safety decisions. The Medication Module will track and reduce inappropriate medications or doses and trigger a pharmacist review when indicated. The Functional Monitoring module will use smartphones and sensors to rapidly detect and respond to changes in functional status, which is particularly important for patients living remotely, alone, or who are at-risk for acute declines.

## **REGENTS OF THE UNIVERSITY OF MICHIGAN**

**Project Title:** Michigan Surgical and Health Optimization Program (MSHOP): A Multiplex Patient Risk Stratification and Intervention Program

**Geographic Reach:** Michigan

**Estimated Funding Amount:** \$6,389,850

**Summary:** The Regents of the University of Michigan project will implement the Michigan Surgical and Health Optimization Program (MSHOP), which focuses on- real-time risk stratification and peri-operative optimization for patients undergoing abdominal surgery. The model aims to improve surgical outcomes in two ways. (1) Real-time risk stratification aims to improve the appropriateness of surgery—in certain high-risk cases, patients and surgeons will avoid prohibitively high-risk surgical care, focusing on medical and palliative management. Further, real-time risk stratification can identify patients who would be good candidates for the peri-operative prehabilitation program. (2) This peri-operative program aims to

enable patients to train for surgery, improving their physiology and mindset through an established outpatient program, leading to better outcomes and reduced costs by preventing complications and reducing length of stay. Over the 3-year period MSHOP will be implemented in 40 Michigan hospitals.

## **SEATTLE CHILDREN'S HOSPITAL**

**Project Title:** Pediatric Partners in Care (PPIC)

**Geographic Reach:** Washington

**Estimated Funding Amount:** \$5,561,620

**Summary:** The Seattle Children's Hospital project will test implementation of Pediatric Partners in Care (PPIC), which aims to provide a tiered set of community-based care management services for the participating children, their families, and their primary care providers. Care management efforts will focus on improving the care coordination and providing expert consultative resources to patients, families, and providers: (1) Review of health records of all 3,000 children against a standard set of criteria; (2) Establishing priorities for active care management by health care utilization history and health severity scores; (3) Care management by a community-based team of a registered nurse Care Manager and a Community Health Coordinator; (4) Development of a comprehensive care plan for those in care management; (5) Training/education and empowerment of the families of enrolled children; (6) Consultations with and training for their primary care physicians and specialists. PPIC's interventions aim to improve the health care of the target population by providing a higher level of coordination of care between the many different facets of the health care system with whom these children interface on an all-too-frequent basis.

## **THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK**

**Project Title:** MySmileBuddy": Demonstrating the Value of Technology-assisted Non-surgical Care Management in Young Children

**Geographic Reach:** New York

**Estimated Funding Amount:** \$3,870,446

**Summary:** The Trustees of the Columbia University in the City of New York project will test a model that uses family-level, peer-counseled, and technology-assisted behavioral risk reduction strategies, aims to divert children with early- and advanced-stage early childhood caries (ECC) from high-cost surgical dental rehabilitation (DR) to low-cost non-surgical disease management (NSDM). Together, parents and community health workers (CHWs) will use MySmileBuddy (MSB), a mobile tablet-based health technology, to plan, implement, and monitor positive oral health behaviors, including dietary control and use of fluorides, which arrest ECC's progression. MSB was designed with a strong theoretical basis, which applies key principles of risk-based triage, early intervention, individualization, and motivational interviewing. MSB is designed to enhance parental knowledge, skills, and self-efficacy to reduce caries-related risk factors, proportionate to their child's ECC experience. CHWs will meet in person with parents of children with early-stage ECC bimonthly for 1 year, and with parents of children with advanced-stage ECC weekly for the first 4 weeks, then bimonthly thereafter for the remainder of the year. Additionally, CHWs will provide tailored telephone intervention between in-person meetings to provide additional support and reinforce behavior change goals. CHWs will also assist parents in scheduling semiannual dental examinations at affiliated sites.

## **UNIVERSITY HOSPITALS CASE MEDICAL CENTER**

**Project Title:** Evidence-Conformant Oncology Care

**Geographic Reach:** Ohio

**Estimated Funding Amount:** \$4,675,384

**Summary:** The University Hospitals Case Medical Center project will test a model to improve care for patients with complex cancer, including patients with late-stage disease, significant comorbidities, or demonstrated need for high health care utilization. The model will test an intervention that includes (1) early and ongoing palliative care consultation, including a psycho-social and symptom-based quality of life assessment, (2) development and delivery of clear therapeutic and supportive plans of care to improve the communication among all the parties in the patient's care, (3) improved education and engagement of the patient and his/her family or caregiver, and (4) patient assignment to a quality navigator, who would follow the patient throughout his/her course of active disease treatment. In this model, the navigator will maintain a dialogue with the patient and the patient's entire medical care team to promote adherence to the patient's personal plan of care.

## **UNIVERSITY OF KANSAS HOSPITAL AUTHORITY**

**Project Title:** Rural Clinically Integrated Network to Improve Heart Health and Stroke Survival for Rural Kansas

**Geographic Reach:** Kansas

**Estimated Funding Amount:** \$12,523,441

**Summary:** The University of Kansas Hospital Authority will test a model to implement the Rural Clinically Integrated Network (RCIN) to Improve Heart Health and Stroke Survival for Rural Kansas, which will form a collaborative governance structure to create a trust environment through which independent providers serving Northwest Kansas can define and refine the entire care continuum for that population. Through clinical integration, these providers - from the hometown primary care physician to the state's academic medical center - will become a team accountable for population health. The RCIN will develop "regional hubs" staffed by providers and health coaches serving multiple communities. The RCIN resembles another uniquely rural business entity: the agricultural service cooperative. By working through a jointly owned and operated association, independent farmers secure resources and market products more efficiently than acting alone. Similarly, RCIN members will pursue collaborative implementation of clinical interventions to improve care and lower costs.

Initially, the RCIN will focus on patients at risk for or suffer from heart attack or stroke, including deployment of collaborative guidelines, pathways, and patient engagement strategies. RCIN will implement ST-elevation myocardial infarction and stroke regional systems of care. The RCIN will expand use of telehealth, robust health information exchange, "big data" analysis, and population health management, all in ways a single provider could not accomplish.

## **UNIVERSITY OF NEW MEXICO HEALTH SCIENCE CENTER**

**Project Title:** Access to Critical Cerebral Emergency Support Services (ACCESS)

**Geographic Reach:** New Mexico

**Estimated Funding Amount:** \$15,120,767

**Summary:** The University of New Mexico Health Science Center project will test expansion of the existing tele-health infrastructure (11 hospitals) to form a statewide 30 hospital telehealth system (THS). In conjunction with Net Medical Xpress Solutions, the model test will provide remote emergency neurological consultation using inexpensive audiovisual equipment and software. The goal of this model is to prevent unnecessary transport to tertiary care hospitals when non-operative care is appropriate. The Implementation of THS aims to improve the access to emergency neurological care statewide. Around the clock triage by on call ACCESS staff will allow rural emergency departments to improve timeliness of emergency care, decrease avoidable inpatient admissions, and prevent unnecessary transfers.

## **THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL**

**Project Title:** Better Back Care: A Comprehensive Strategy for Improving Function and Outcomes While Reducing Overutilization and Costs

**Geographic Reach:** North Carolina

**Estimated Funding Amount:** \$6,034,888

**Summary:** The University of North Carolina at Chapel Hill project will test the implementation of Better Back Care (BBC), a new care delivery model for new onset low back pain that aims to improve the patient's experience and outcomes, reduce costs of care, and deliver an outpatient bundled payment methodology. BBC leverages the use of evidence-based care in a medical neighborhood of primary and specialty care providers through a patient-centered, coordinated care model that supports and educates patients and includes them in treatment decisions. The model will utilize patient education and shared decision making tools, as well as nurse patient navigators, who will coordinate care with primary care providers. Over the award period, BBC aims to improve adherence to evidence-based, patient-centered treatment approaches leading to improved clinical outcomes and satisfaction, while reducing the use of imaging, injections, and surgery for patients with new onset low back pain in a five-county area of North Carolina. BBC plans to create a medical neighborhood linking approximately 60 primary care providers in general internal medicine, family medicine, and geriatrics, with the UNC spine program, an existing multidisciplinary team of 10 specialty providers employing evidence-based, patient-centered approaches.

## **VENTURA COUNTY HEALTH CARE AGENCY**

**Project Title:** COPD Access to Community Health (CATCH)

**Geographic Reach:** California

**Estimated Funding Amount:** \$4,136,499

**Summary:** The Ventura County Health Care Agency project will test implementation of Chronic Obstructive Pulmonary Disease (COPD) Access to Community Health (CATCH), a community-based care coordination program based on the chronic care model. Care coordination activities include: (1) clinical, psychosocial, and environmental assessments; (2) care plan development with the primary care providers (PCPs); and (3) specialist input. The development of the care plan is based on 2013 Global Initiative for Chronic Obstructive Lung Disease guidelines that include: patient education and self-management training; care management; community referral and coordination; home visitation; monitoring and feedback; and follow-up and reassessment. Community outreach will include community education, risk assessment, screening, and referral to PCPs/medical homes. Health internet

technology integration and clinical provider/PCP training will be implemented to promote evidence-based practices. The model aims to improve stability of the COPD condition and reduce emergency room visits, inpatient days, and overuse of PCPs. Integration of clinical care guidelines in clinical practice will significantly reduce costs by ensuring patients access the appropriate level of care (nurse, PCP, pulmonologist or other specialist) for their condition.

## **VILLAGE CENTER FOR CARE**

**Project Title:** VillageCare's Treatment Adherence through the Advanced Use of Technology (TAAUT)

**Geographic Reach:** New York

**Estimated Funding Amount:** \$8,781,296

**Summary:** The Village Center for Care project will implement "Treatment Adherence through the Advanced Use of Technology (TAAUT)". This project aims to increase patient activation for people living with HIV/AIDS by increasing access to professional and peer support for health behavior change and compliance. The program expects to improve adherence by providing timely, tailored interventions through virtual visits, social media, and text messaging. Professional Adherence Care Managers will work with patients to create goals and recommend interventions from the advanced technology available. In addition, peers will be leveraged to provide one-on-one encouragement and advice, while the private social network will serve as a platform for both clinician and patient access. Customized, timely healthcare information and messages will be sent to patients through the portal and in turn, clients can provide timely information to their CAMs.

## **WASHINGTON UNIVERSITY SCHOOL OF MEDICINE IN ST. LOUIS**

**Project Title:** A Contraceptive Center of Excellence: an innovative health services delivery and payment model

**Geographic Reach:** Missouri

**Estimated Funding Amount:** \$4,034,879

**Summary:** The Washington University School of Medicine in St. Louis project will test an intervention that aims to provide quality family planning services to women who are at the highest risk for unintended pregnancy using a contraceptive provision model developed by the Contraceptive CHOICE Project (CHOICE). CHOICE demonstrated that removing barriers to choice of contraception increased the use of long-acting reversible contraception and significantly reduced the rate of unintended pregnancies. This project will test implementation of the CHOICE model for primarily Medicaid beneficiaries in the St. Louis area including: 1) structured, evidence-based contraceptive counseling; 2) education of providers about long-acting reversible contraceptive methods and evidence-based guidelines for contraceptive provision; 3) removal of patient barriers to family planning services; and 4) post-visit contraceptive support.

## **WISCONSIN DEPARTMENT OF HEALTH SERVICES**

**Project Title:** Special Needs Program for Children with Medical Complexity

**Geographic Reach:** Wisconsin

**Estimated Funding Amount:** \$9,457,875

**Summary:** The Wisconsin Department of Health Services project will test an intervention that aims to enhance and expand the Special Needs Program (SNP) model that is currently in place at Children's Hospital of Wisconsin (CHW). The model establishes a dedicated care team consisting of physicians, nurse practitioners, nurse care coordinators, lay navigators, and other ancillary staff as necessary to work specifically with those children with some of the highest ongoing medical needs. The care team works with the children through every step of the process, coordinating care across specialists, educating the family on care transitions and how to best care for children in the home, and communicating care plans with local primary care physicians. The intervention has been in place in a more limited format at CHW for over a decade, and has proven results of reducing inpatient hospital costs by more than 50%. This proposal also expands the SNP to an ambulatory setting, allowing for identification of high-needs children who may not be at an inpatient hospital need of care, but still have high medical complexity. A third arm of this proposal is that the SNP model (intensive inpatient focus) will be expanding to a second tertiary pediatric center in Wisconsin to test scalability of the intervention.

## **YALE UNIVERSITY**

**Project Title:** Paramedic Referrals for Increased Independence and Decreased Disability in the Elderly (PRIDE)

**Geographic Reach:** Connecticut

**Estimated Funding Amount:** \$7,159,977

**Summary:** Yale University will test a model targeting elders and others with impaired mobility who contact 9-1-1 for falls or lift assists but choose to remain at home. Emergency Medical Services providers are trained to perform enhanced evaluations during the initial 9-1-1 call. Paramedics are trained to make follow-up visits to perform detailed risk assessments, home medication reviews, and referrals to primary care doctors and skilled home services. The expanded paramedic workforce with advanced training is a community-based resource that will improve care coordination and health outcomes for elders staying in their homes. Pilot studies have shown that similar interventions decrease repeat ambulance transports, reduce inpatient hospitalizations, and lower health care costs. Because lift assist patients share many risk factors, such as advanced age, cognitive and physical disability, limited mobility, social isolation, and polypharmacy, with patients who fall, the program's community interventions are modeled after evidence based fall prevention strategies.