



## Health Care Innovation Award Profiles SECOND (FINAL) BATCH

The Medicare & Medicaid Innovation Center announced the first batch of awardees for the Health Care Innovation Awards on May 8, 2012. This list includes the second and final batch of awardees. 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. Funding for these projects is for three years.

Note: Descriptions and project data (e.g. gross savings estimates, population served, etc.) are three-year estimates provided by each organization and are based on budget submissions required by the Health Care Innovation Awards application process. While all projects are expected to produce cost savings beyond the three-year grant award, some may not achieve net cost savings until after the initial three-year period due to start-up-costs, change in care patterns and intervention effects on health status.

### ALTARUM INSTITUTE

Project Title: “Comprehensive community-based approach to reducing inappropriate imaging”

Geographic Reach: Michigan

Funding Amount: \$8,366,178

Estimated 3-Year Savings: \$33,237,555

Summary: Altarum Institute, in partnership with United Physicians (IPA) and Detroit Medical Center Physician Hospital Organization, is receiving an award to reduce unnecessary imaging studies for beneficiaries in Southeastern Michigan. This multifaceted intervention will establish a data-exchange system between primary care and imaging facilities to increase evidence-based decision-making among physicians ordering MRIs and CTs in the lumbar-spine, cervical-spine, lower extremities, shoulder, head, chest and abdomen. The goal is to reduce CT volume by 17.4 percent and MRI volume by 13.4 percent over three years, resulting in a 17 percent reduction in imaging costs without any loss in diagnostic accuracy or restrictions on the ordering of tests.

Over a three-year period, Altarum Institute will train a network of area care providers in the use of the program's systems and technology, while creating an estimated 23 jobs for practice consultants, health information analysts, lean practice redesign specialists, and health education specialists.

## ASIAN AMERICANS FOR COMMUNITY INVOLVEMENT

Project Title: "Patient Navigation Center"

Geographic Reach: California

Funding Amount: \$2,684,545

Estimated 3-Year Savings: \$3,373,602

Summary: Asian Americans for Community Involvement (AACI), in partnership with the Career Ladders Project and three community colleges is receiving an award to train Asian and Hispanic youth and veteran AACI case workers as non-clinical health workers for a Patient Navigation Center. Serving low-income Asian and Hispanic families in Santa Clara County, the Center will provide enabling services, including translation, appointment scheduling, referrals, transportation, and application help for social services, as well as after-hours and self-care assistance. Patient navigation will lead to improved access to care, better disease screening, decreased diagnosis time, better medication adherence, a reduction in emergency room visits, and reduced anxiety for patients.

Over a three-year period, Asian Americans for Community Involvement will retrain its current staff of nurses, supervisors, and on-call clinicians and create an estimated 29 jobs. The new workers will include patient navigators, nurse and clinician advisors, and a customer service manager.

## ATLANTIC GENERAL HOSPITAL CORPORATION

Project Title: "Expand Atlantic General Hospital's infrastructure to create a patient-centered medical home"

Geographic Reach: Maryland

Funding Amount: \$1,097,512

Estimated 3-Year Savings: \$3,522,000

Summary: Atlantic General Hospital Corporation, which serves largely rural Worcester County, Maryland, is receiving a grant to improve care for Medicare beneficiaries with either a primary or admitting diagnosis of congestive heart failure, chronic obstructive pulmonary disease, or diabetes, who currently rely on high cost ER visits and Acute Care admissions. The corporation plans to expand infrastructure and create a Patient-Centered Medical Home, increasing access for patients needing non-

emergency episodic care and reducing hospital admission rates and emergency department visits for these Medicare beneficiaries.

Over a three-year period, Atlantic General Hospital Corporation will create three new jobs and train 75 workers. New hires will include a patient care manager, a patient advocate, and a care team coordinator.

## **BEN ARCHER HEALTH CENTER**

Project Title: "A home visitation program for rural populations in Northern Dona Ana County, New Mexico"

Geographic Reach: New Mexico

Funding Amount: \$1,270,845

Estimated 3-Year Savings: \$6,325,888

Summary: The Ben Archer Health Center in southern New Mexico is receiving an award to implement an innovative home visitation program for individuals diagnosed with chronic disease, persons at risk of developing diabetes, vulnerable seniors, and homebound individuals, as well as young children and hard to reach county residents. Ben Archer provides primary health and dental care to rural Dona Ana County, a medically underserved area and health professional shortage area. The program will use nurse health educators and community health workers to bridge the gap between patients and medical providers, aid patient navigation of the health care system, and offer services including case management, medication management, chronic disease management, preventive care, home safety assessments, and health education, thereby preventing the onset and progression of diseases and reducing complications.

Over a three-year period, this program will train an estimated 7.5 workers and will create an estimated 7.5 jobs. The new workforce will include nurses and community care workers. Additionally, Ben Archer Health Center will be providing training to new and existing community health workers and nurses to conduct home visits in a rural farming community.

## **BRONX REGIONAL HEALTH INFORMATION ORGANIZATION (BRONX RHIO)**

Project Title: "The Bronx Regional Informatics Center (BRIC)"

Geographic Reach: New York

Funding Amount: \$12,839,157

Estimated 3-Year Savings: \$15,419,460

Summary: The Bronx Regional Health Information Organization (Bronx RHIO), in partnership with its member organizations and Bronx Community College, Weill Cornell Medical College, and the Emergency Health Information Technology group at Montefiore Medical Center, is receiving an award to create the Bronx Regional Informatics Center, which will develop data registries and predictive systems that will proactively encourage early care interventions and enable providers to better manage care for high-risk, high-cost patients. The project will improve patient outcomes, improve overall health for Bronx residents, reduce the cost of care for Medicare and Medicaid by over \$15 million, and train health care workers to coordinate these quality improvement efforts.

Over a three-year period, The Bronx RHIO will create an estimated 30 jobs, including positions for intervention team members and community health advocates.

## **CALIFORNIA LONG-TERM CARE EDUCATION CENTER**

Project Title: "Care team integration of the home-based workforce"

Geographic Reach: California

Funding Amount: \$11,831,445

Estimated 3-Year Savings: \$24,957,836

Summary: The California Long-Term Care Education Center, partnering with SEIU United Long Term Care Workers (ULTCW), Shirley Ware Education Center (SEIU-UHW), L.A. Care Health Plan, Contra Costa County Department of Aging and Health Services, and the UCSF Center for Health Professions, is receiving an award to integrate personal care attendants into the health care system. This intervention will serve beneficiaries of California's Medicaid personal care services program, the In-Home Support Services (IHSS). All beneficiaries are disabled and 85 percent are dually eligible for both Medicare and Medicaid. The program will train In-Home Supportive Services (IHSS) personal and home care attendants (PHCAs) to assume key roles in the patient's health, including health monitor, coach, communicator, navigator, and care aide. The goal is to reduce ER visits by 23 percent and hospital admissions from the ER by 23 percent over three years. In addition, the project hopes to see a 10 percent reduction in the average length of stay in nursing homes over the same time period.

Over a three-year period, the California Long-Term Care Education Center's program will train an estimated 6,900 health care workers.

## CAREFIRST

Project Title: "Medicare and CareFirst's total care and cost improvement program in Maryland"

Geographic Reach: Maryland

Funding Amount: \$24,000,000

Estimated 3-Year Savings: \$29,213,838

Summary: CareFirst BlueCross/BlueShield is receiving an award to expand its Total Care and Cost Improvement Program (TCCI), a Patient-Centered Medical Home model of care delivery and payment, to 25,000 Medicare beneficiaries in Maryland per year. This approach will move the region toward a new health care financing model that is more accountable for care outcomes and less driven by the volume-inducing aspects of fee-for-service payment. The TCCI model will enhance support for primary care, empowering primary care physicians to coordinate care for multi-chronically ill Medicare beneficiaries and patients at high risk for chronic illnesses. TCCI will result in less fragmented health care, reducing avoidable hospitalizations, emergency room visits, medication interactions, and other problems caused by gaps in care and ensuring that patients receive the appropriate care for their conditions.

Over a three-year period, the CareFirst BlueCross/BlueShield program will train an estimated 672 workers and will create an estimated 28 jobs. The new workforce will include local care coordinators, specialty-based nurse case managers, hospital transition of care coordinators, program consultants, pharmacy managers, clinical pathways hub operations and support workers, operational and data support positions.

## CARILION NEW RIVER VALLEY MEDICAL CENTER

Project Title: "Improving health for at-risk rural patients (IHARP) in 23 southwest Virginia counties through a collaborative pharmacist practice model"

Geographic Reach: Virginia

Funding Amount: \$4,162,618

Estimated 3-Year Savings: \$4,308,295

Summary: Carilion New River Valley Medical Center, in partnership with Virginia Commonwealth University School of Pharmacy, Aetna Healthcare and CVS/Caremark, is receiving an award to improve medication therapy management for Medicare and Medicaid beneficiaries and other patients in 23 underserved rural counties in southwest Virginia. Their care delivery model, involving six rural hospitals and 17 primary care practices, will train pharmacists in transformative care and chronic disease management protocols. Through care coordination and shared access to electronic medical records, the project will enable pharmacists to participate in improving medication adherence and management,

resulting in better health, reduced hospitalizations and emergency room visits, and fewer adverse drug events for patients with multiple chronic diseases.

## **CHILDREN’S HOSPITAL AND HEALTH SYSTEM, INC.**

Project Title: “CCHP Advanced Wrap Network”

Geographic Reach: Wisconsin

Funding Amount: \$2,796,255

Estimated 3-Year Savings: \$2,851,266

Summary: The Children’s Hospital and Health System, Inc., partnering with Children’s Hospital of Wisconsin, Aurora Healthcare, and Wheaton Franciscan Healthcare, is receiving an award to create an Advanced Wrap Network Model (AWN) of culturally sensitive professional, clinical, and social resources to educate Children’s Community Health Plan (CCHP) members on how to effectively navigate the health care system. This intervention, targeted at Medicaid and CHIP beneficiaries in southeastern Wisconsin, will deploy Nurse Navigators and Community Health Navigators to increase use of primary care health homes and reduce emergency room visits and inpatient hospital admissions for beneficiaries. As a result, the program will achieve cost savings, while continuing to improve on HEDIS quality metrics for immunizations, diabetes, asthma, and lead testing.

Over a three-year period, the Children’s Hospital and Health System, Inc., will create an estimated nine jobs, hiring a program manager, nurse navigators, and community health navigators.

## **CHRISTIANIA CARE HEALTH SERVICES**

Project Title: “Bridging the Divide”

Geographic Reach: Delaware

Funding Amount: \$9,999,999

Estimated 3-Year Savings: \$376,327

Summary: Christiania Care Health Services, serving the state of Delaware, is receiving an award to create and test a system that will use a heart disease “data hub” and case managers to improve care for post-myocardial infarction and revascularization patients, the majority of them Medicare or Medicaid beneficiaries. Christiania will integrate statewide health information exchange data with cardiac care registries from the American College of Cardiology and the Society of Thoracic Surgeons, enabling more effective care/case management through near real time visibility of patient care events, lab results, and

testing. This will decrease emergency room visits and avoidable readmissions to hospitals and improve interventions and care transitions. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, Christiania Care Health Services will create an estimated 16 health care jobs, including positions for nurse care managers, pharmacists, and social workers.

## **CHRISTUS ST. MICHAEL HEALTH SYSTEM**

Project Title: "Reducing readmissions from nursing home facilities with the Integrated Nurse Training and Mobile Device Harm Reduction Program"

Geographic Reach: Texas and Arkansas

Estimated 3- Year Savings: \$ 3,536,440

Funding Amount: \$ 1,600,322

Summary: The CHRISTUS St. Michael Health System, in partnership with the Community Long-Term Care Facility Partnership Group and Incarnate Word University, is receiving an award to implement the Integrated Nurse Training and Mobile Device Harm Reduction Program (INTM) in Texarkana, TX. The INTM will train nurses to recognize early warning signs of congestive heart failure (CHF) and sepsis in Medicare beneficiaries in nursing home facilities and patients in hospitals who are vulnerable for certain preventable conditions. This training, in combination with computerized clinical decision support systems that guide nurses through evidence-based protocols once symptoms are detected and mobile devices (tablets) loaded with clinical support system software, is anticipated to result in a 20% reduction in readmissions from nursing home facilities for CHF and sepsis and fewer failure-to-rescue situations for those patients who are admitted to the hospital.

Over a three-year period, CHRISTUS St. Michael Health System will train nursing staff to recognize and act upon early warning signs of patient decline, while creating an estimated three health care-related jobs, for a project manager, a nursing support specialist, and an outreach coordinator.

## **THE CURATORS OF THE UNIVERSITY OF MISSOURI**

Project Title: "Leveraging Information Technology to Guide High Tech High Touch Care (LIGHT<sup>2</sup>)"

Geographic Reach: Missouri

Funding Amount: \$13,265,444

Estimated 3-Year Savings: \$16,950,358

Summary: The Curators of the University of Missouri are receiving an award to provide enhanced primary care to Medicare and Medicaid beneficiaries receiving primary care within the University of Missouri Health System, many of them chronically ill. The program will use advanced health information technology, evidence-based treatment planning, and a specialized workforce to coordinate care for both patients and the existing health care team. Through support for disease self-management, improved delivery system design, focus on preventive care, and better decision-making tools, the intervention will strengthen primary care, reduce specialist referrals and the need for acute care, and improve patients' health.

Over a three-year period, The Curators of the University of Missouri's program will train an estimated 420 workers and will create an estimated 30 jobs. The new workforce will include a project coordinator, a business manager, 3 health information analysts and 18 health care coordinators.

## DARTMOUTH COLLEGE BOARD OF TRUSTEES

Project Title: "Engaging patients through shared decision making: using patient and family activators to meet the triple aim"

Geographic Reach: California, Colorado, Iowa, Idaho, Massachusetts, Maine, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, Washington

Funding Amount: \$26,172,439

Estimated 3-Year Savings: \$63,798,577

Summary: The Dartmouth College Board of Trustees is receiving an award to collaborate with 15 large health care systems around the country to hire Patient and Family Activators (PFAs). The PFAs will be trained to engage in shared decision making with patients and their families, focusing on preferences and supplying sensitive care choices. PFAs may work with patients at a single decision point or over multiple visits for those with chronic conditions. It is anticipated that this intervention will lead to a reduction in utilization and costs and provide invaluable data on patient engagement processes and effective decision making—leading to new outcomes measures for patient and family engagement in shared decision making.

Over a three-year period, the Dartmouth College Board of Trustees-sponsored program will train 5,775 health care workers and create 48 positions for patient and family activators.

## DENVER HEALTH AND HOSPITAL AUTHORITY

Project Title: “Integrated model of individualized ambulatory care for low income children and adults”

Geographic Reach: Colorado

Funding Amount: \$19,789,999

Estimated 3-Year Savings: \$12,792,256

Summary: Denver Health and Hospital Authority is receiving an award to create an ambulatory care model that will provide individualized care for patients' medical, behavioral and social needs. This model will target low income children and adults with diverse health care needs. It will coordinate care and offer self-care support between visits, enabled by HIT and team-based patient navigators, and will integrate physical and behavioral health services in existing primary care settings and newly created high risk clinics. The program will reduce reliance on emergency room care and reduce avoidable hospitalizations by providing better access to outpatient and social services, better care management and self-management of care, and better coordination and utilization of existing services, as well as more individualized care for the patients' medical, behavioral and social needs. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, Denver Health and Hospital Authority will hire and train 25 patient navigators and fill 20 new health information technology positions.

## DEVELOPMENTAL DISABILITIES HEALTH SERVICES

Project Title: “Expanding and testing a Nurse Practitioner-led health home model for individuals with developmental disabilities”

Geographic Reach: New Jersey, New York, and Arkansas

Funding Amount: \$3,701,528

Estimated 3-Year Savings: \$5,374,080

Summary: Developmental Disabilities Health Services is receiving an award to test a developmental disabilities health home model, using care management/primary care teams of nurse practitioners and MDs to improve the health and care of persons with developmental disabilities in important clinical areas. The health homes will serve individuals with intellectual and developmental disabilities who receive Medicaid and/or Medicare benefits in New Jersey, the Bronx, and Little Rock, Arkansas, and are eligible for services in each state's Home and Community-Based Services waiver program, as well as individuals who are commercially insured and uninsured. All of these patients are considered high-risk and many have co-morbidities. By integrating care using nurse practitioners as care coordinators and health care providers, the health homes will improve primary care, mental health care, basic

neurological care, and seizure management for these beneficiaries, resulting in reduced emergency room visits and lower out-of home placement and institutionalization.

Over a three-year period, Developmental Disabilities Health Services will retrain and deploy 20 individuals to provide and coordinate primary care and mental health services in health homes for persons with developmental disabilities.

## **EAU CLAIRE COOPERATIVE HEALTH CENTERS, INC.**

Project Title: "Healthy Columbia: recruiting, training, organizing, deploying, and supporting community health teams in low income area of Columbia, South Carolina"

Geographic Reach: South Carolina

Funding Amount: \$2,330,000

Estimated 3-Year Savings: \$14,817,600

Summary: Eau Claire Cooperative Health Centers, Inc., in partnership with the Select Health Managed Care Organization, is receiving an award for a project aimed at improving health outcomes for populations in underserved, low-income areas of Columbia, South Carolina. Eau Claire will use health care teams of nurse practitioners, registered nurses, and community health workers affiliated with a Federally Qualified Health Center to provide patient education, home visits, and care coordination, leading to reduced use of high cost health care services, including emergency room visits and hospitalizations, improved self-management for patients with chronic conditions, a decrease in low birth weight infant care, and improved health outcomes in general. Payers have agreed to reimburse a portion of cost savings.

Over a three-year period, Eau Claire Cooperative Health Centers will create an estimated 22 health care-related jobs, including positions for peer health workers, registered nurses, Nurse Practitioners, a project director, and a community organizer.

## **FAMILY SERVICE AGENCY OF SAN FRANCISCO**

Project Title: "Prevention and Recovery in Early Psychosis (PREP)"

Geographic Reach: California

Funding Amount: \$4,703,817

Estimated 3-Year Savings: \$4,235,801

Summary: Family Service Agency of San Francisco is receiving an award to expand and test its model for Prevention and Recovery in Early Psychosis (PREP) for low-income, largely Latino counties in the San Francisco area. Schizophrenia is estimated to account for 2.5 to 3 percent of United States health care expenditures. Without an intervention like PREP, as many as 90 percent of the patients served would be Supplemental Security Income/Medicare recipients (up from 30 percent now) by the time they reached their 30s. Through evidence-based treatments, medication management, and care management, PREP aims to prevent the onset of full psychosis, and in cases in which full psychosis has already occurred, seeks to fully remit the disease and rehabilitate the cognitive functions it has damaged.

Over a three-year period, the Family Service Agency of San Francisco will train 56 health care providers to use their PREP intervention, while creating 19 jobs for social workers, Nurse Practitioners, vocational counselors, and peer and family aides.

## FEINSTEIN INSTITUTE FOR MEDICAL RESEARCH

Project Title: “Using care managers and technology to improve the care of patients with schizophrenia”

Geographic Reach: Colorado, Florida, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, New York, Oregon

Funding Amount: \$9,380,855

Estimated 3-Year Savings: \$10,080,000

Summary: The Feinstein Institute for Medical Research is receiving an award to develop a workforce that is capable of delivering effective treatments, using newly available technologies, to at-risk, high-cost patients with schizophrenia. The intervention will test the use of care managers, physicians, and nurse practitioners trained to use new technology as part of the treatment regime for patients recently discharged from the hospital at community treatment centers in nine states. These trained providers will educate patients and their caregivers about pharmacologic management, cognitive behavior therapy, and web-based/home-based monitoring tools for their conditions. This intervention is expected to improve patients’ quality of life and lower cost by reducing hospitalizations.

Over a three-year period, the Feinstein Institute for Medical Research will retrain nurse practitioners, physician assistants, physicians, and case managers to use newly available mental health protocols and health technology resources.

## FINGER LAKES HEALTH SYSTEM AGENCY

Project Title: "Transforming primary care delivery: a community partnership"

Geographic Reach: New York

Funding Amount: \$26,583,892

Estimated 3-Year Savings: \$48,021,083

Summary: Finger Lakes Health System Agency is receiving an award for a community-wide outcomes-based payment model for primary care that will serve Medicare and Medicaid beneficiaries in six counties in the Rochester, New York area. The project creates a collaborative of providers, payers, employers, government, patients, social coalitions, and community service organizations to integrate community services with primary care and leverage social and health care resources. Primary care physicians will receive technical, process, and adaptive support, and will be connected with a team of care managers, care coordinators, and community health workers. This approach will strengthen primary care and reduce avoidable hospitalizations, readmissions, and emergency room use.

Over a three-year period, the Finger Lakes Health Systems Agency will train 726 health workers and hire 76 health care providers in positions as care managers, community health workers, community-based care coordinators, and practice improvement advisors.

## FIRSTVITALS HEALTH AND WELLNESS INC.

Project Title: "Improving the health and care of low-income diabetics at reduced costs"

Geographic Reach: Hawaii

Funding Amount: \$3,999,713

Estimated 3-Year Savings: \$4,829,955

Summary: FirstVitals Health and Wellness Inc., in partnership with AlohaCare, is receiving an award to implement and test a care coordination and health information technology plan that will better regulate glucose levels for Medicaid-eligible patients with Type 1 and Type 2 diabetes. FirstVitals will create a secured database that will receive data feeds from wireless glucose meters. The information will be available to integrated care coordinators, patients, physicians and other approved caregivers, informing decisions about care and enabling caregivers to track and monitor glucose levels, improve medication adherence, and increase patient safety and the effectiveness of treatment. The project will reduce complications, slow the progression of the disease, and reduce emergency room visits and hospitalizations.

Over a three-year period, FirstVitals' program will train an estimated 11 workers and will create an estimated 6 jobs. The new workforce will include integrated care coordinators, a clinical diabetes educator, and a medical director.

## FUND FOR PUBLIC HEALTH IN NEW YORK

Project Title: "Parachute NYC: an alternative approach to mental health treatment and crisis services"

Geographic Reach: New York

Funding Amount: \$ 17,608,085

Estimated 3- Year Savings: \$ 51,696,138

Summary: The Fund for Public Health in New York, Inc., in partnership with the New York City Department of Health and Mental Hygiene's Division of Mental Hygiene, is receiving an award to implement Parachute NYC, providing need-adapted treatment model (NATM) interventions for Medicaid beneficiaries and other people with serious mental illness who have a diagnosis of psychosis. Persons with psychosis are likely to rely on crisis-based care and generally lack adequate preventive care. Serving Manhattan, Brooklyn, Bronx, and Queens, the program will use peer health navigators, nurse practitioners, mobile crisis teams, and crisis respite centers to provide early engagement, continuity of care and combined peer and professional community service thus shifting the focus of care from crisis intervention to long-term, community-integrated treatment with access to primary care, improving crisis management and reducing emergency room visits and hospital admissions.

Over a three-year period, the Fund for Public Health in New York and the New York City Department of Health and Mental Hygiene's Division of Mental Hygiene will train 3,800 health care providers and hire approximately 110 new behavioral health workers.

## HEALTHLINKNOW, INC.

Project Title: "Patient-centered medical home for mental health services in Wyoming and Montana"

Geographic Reach: Wyoming and Montana

Estimated 3- Year Savings: \$ 8,100,000

Funding Amount: \$ 7,718,636

Summary: HealthLinkNow Inc, partnering with a number of local provider groups and health networks in Montana and Wyoming, is receiving an award to provide a Patient Centered Medical Home Program (PCMH) with mental health and substance abuse services in areas where geography and lack of psychiatrists and psychologists complicate access. This model will offer videoconferencing between local patients and HealthLinkNow psychiatrists; instant messaging, email, and telephone calls via HealthLinkNow between providers and patients; and a HealthLinkNow IT platform that allows billing, e-

prescribing, and practice management. The program will improve access to psychiatric consultations, therapy, and long-term mental health case management. Lower cost through reduced hospital admissions and emergency room visits are anticipated.

Over a three-year period, HealthLinkNow will hire 24 health care providers, including both psychiatrists and therapists.

## **HENRY FORD HEALTH SYSTEM**

Project Title: "Mobility: the 6<sup>th</sup> vital sign"

Geographic Reach: Michigan

Funding Amount: \$3,773,539

Estimated 3-Year Savings: \$8,837,501

Summary: The Henry Ford Health System of Detroit, Michigan is receiving an award for an innovative care model that will encourage and support patient mobility during acute inpatient hospitalizations. Their intervention addresses the hazards of immobility during hospitalization, including dehydration, malnutrition, delirium, sensory deprivation, isolation, shearing forces on skin, pressure ulcers, and respiratory complications. Henry Ford Health System expects to reduce hospital-acquired pressure ulcers and ventilator-associated pneumonia, improve quality of care and patient experience of care, and decrease length of stay in the hospital.

Over a three-year period, the Henry Ford Health System will train approximately 21 health care providers, including physical therapists and wound and ostomy-certified nurses.

## **IHC HEALTH SERVICES (INTERMOUNTAIN HEALTH CARE)**

Project Title: "Disruptive Innovation @ Intermountain Healthcare"

Geographic Reach: Utah and Idaho

Funding Amount: \$9,724,142

Estimated 3-Year Savings: \$67,120,215

Summary: Intermountain Health Care Health Services, with 23 hospitals and 185 clinics in Utah and Southern Idaho, is receiving an award to test a new care delivery and payment model using an information technology-based simulation of human physiology, clinical events, and health care systems to forecast which interventions will be most effective in reducing a person's risk, provide risk

stratification metrics for individual patients, and project benefits for specific interventions. Their system will incorporate tracking of depression and its effects on risks and outcomes, and will be paired with a shared savings methodology, possibly with a mechanism for sharing downside risk through a “pre-funded withhold” concept.

Over a three-year period, IHC Health Services will train and hire 12 workers for health information technology-related jobs, including research assistants, data analysts, data warehouse analysts, decision-support analysts, and positions as data architect, management engineer, and project coordinator.

## IMAGING ADVANTAGE LLC

Project Title: "The right exam, at the right time, read by the right radiologist"

Geographic Reach: Illinois

Estimated 3- Year Savings: \$ 14,935,320

Funding Amount: \$ 5,977,805

Summary: Imaging Advantage LLC, in partnership with Vanguard Health Systems and other hospital systems in the Chicago metropolitan area, is receiving an award to re-engineer the end-to-end workflow process for hospital-based imaging services, including by leveraging technology to integrate immediate consultations with radiologists and other decision-support tools into the “front-end” of the patient-care continuum, where imaging exams are ordered and critical care decisions are made. A key objective of the program will be to reduce duplicative and/or clinically unnecessary advanced imaging exams. The program also will (1) deploy a unique disruptive innovation — RealTime QA<sup>®</sup> — which applies “double-blind” interpretations to high-difficulty exams in advance of patient treatment, (2) eliminate preliminary (or “wet”) reads after-hours and (3) materially improve exam turn-around times. As a result, the program will reduce inappropriate advanced imaging utilization, improve quality assurance and, ultimately, improve patient safety and experience. A 30% decrease in CT use and decreased utilization of other imaging modalities is expected. CMS will also be evaluating planned centers in Detroit, San Antonio, and Boston.

Over a three-year period, Imaging Advantage LLC will train 495 workers in health care-related jobs. The new workforce will include clinical staff as well as IT development and operational staff.

## INNOVATIVE ONCOLOGY BUSINESS SOLUTIONS, INC.

Project Title: “Community oncology medical homes (COME HOME)”

Geographic Reach: New Mexico, Florida, Pennsylvania, Ohio, Maine, Georgia, Tennessee

Funding Amount: \$19,757,338  
Estimated 3-Year Savings: \$33,514,877

Summary: Innovative Oncology Business Solutions, Inc., representing 7 community oncology practices across the United States is receiving an award to implement and test a medical home model of care delivery for newly diagnosed or relapsed Medicare and Medicaid beneficiaries and commercially insured patients with breast, lung, or colorectal cancer. Cancer care is complicated, expensive, and often fragmented, leading to suboptimal outcomes, high cost, and patient dissatisfaction with care. Through comprehensive outpatient oncology care, including patient education, team care, medication management, and 24/7 practice access and inpatient care coordination, the medical home model will improve the timelines and appropriateness of care, reduce unnecessary testing, and reduce avoidable emergency room visits and hospitalizations.

Over a three-year period, Innovative Oncology Business Solutions will fill 115.6 new health care jobs, including positions for training specialists, data analysts, patient care coordinators, registered nurses, and licensed practical nurses, as well as for a finance manager and a compliance manager.

## INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Project Title: "Care management of mental and physical co-morbidities: a TripleAim bulls-eye"  
Geographic Reach: Minnesota, Wisconsin, Iowa, Pennsylvania, California, Michigan, Washington, Colorado, Massachusetts  
Estimated 3- Year Savings: \$ 27,693,046  
Funding Amount: \$ 17,999,635

Summary: The Institute for Clinical Systems Improvement (ICSI) of Bloomington, Minnesota is receiving an award to improve care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease. The program will use care managers and health care teams to assess condition severity, monitor care through a computerized registry, provide relapse and exacerbation prevention, intensify or change treatment as warranted, and transition beneficiaries to self-management. The partnering care systems include clinics in ICSI, Mayo Clinic Health System, Kaiser Permanente in Colorado and Southern California, Community Health Plan of Washington, Pittsburgh Regional Health Initiative, Michigan Center for Clinical Systems Improvement, and Mount Auburn Cambridge Independent Practice Association with support from HealthPartners Research Foundation and AIMS (Advancing Integrated Mental Health Solutions).

Over a three-year period, ICSI and its partners will train the approximately 80+ care managers needed for this new model.

## JOHNS HOPKINS SCHOOL OF NURSING

Project Title: "CAPABLE for frail dually eligible older adults: achieving the triple aim by improving functional ability at home"

Geographic Reach: Maryland

Funding Amount: \$4,093,356

Estimated 3-Year Savings: \$6,800,000

Summary: The Johns Hopkins School of Nursing is receiving an award for a Medicare/Medicaid dual eligibles program (Community Aging in Place, Advancing Better Living for Elders –"CAPABLE") that uses a care management team to improve the everyday functioning of complex, frail patients in their own homes. The program will reduce difficulty with activities of daily living and improve medication management, mobility, and health-related quality of life, based on an individualized package of interventions including home visits from occupational therapists and nurses and other services. CAPABLE will reduce nursing home admissions and hospitalizations and improve quality of life for these beneficiaries of Medicare and Medicaid.

Over a three-year period, the John Hopkins School of Nursing will retrain an estimated eight occupational therapists and registered nurses and as well as engage other services.

## JOHNS HOPKINS UNIVERSITY

Project Title: "Johns Hopkins Community Health Partnership (J-CHiP)"

Geographic Reach: Maryland

Estimated 3- Year Savings: \$ 52,600,000

Funding Amount: \$ 19,920,338

Summary: Johns Hopkins University -- in partnership with Johns Hopkins Health System and its hospitals, community clinics and other affiliates; the Johns Hopkins Urban Health Institute; Priority Partners MCO; Baltimore Medical System, a Federally Qualified Health Center; and local skilled nursing facilities, is receiving an award to create a comprehensive and integrated program, the Johns Hopkins Community Health Partnership (J-CHiP). J-CHiP is designed to increase access to services for high-risk adults in East Baltimore, MD, especially those with chronic illness, mental illness, and/or substance abuse conditions. The intervention improves care coordination across the continuum and comprises early risk screening, interdisciplinary care planning, enhanced medication management, patient/family education, provider communication, post-discharge support and home care services, including self-management coaching, and improved access to primary care. The program will target inpatients at The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, expanding to nearly all admissions by year 3. The intervention will also include a specific focus on high risk Medicare and Medicaid

beneficiaries who receive primary care from Johns Hopkins providers in the seven zip code area adjacent to these hospitals. The program will reduce avoidable hospitalizations, emergency room use, and complications and increase access to care and other services.

Over a three-year period, Johns Hopkins University will train and hire 111 new health care workers, including patient/family educators, care coordinators, and behavioral coaches, and will retrain nurse case managers, nurse transition guides, nurse screeners, pharmacists, and physicians already on staff.

## LE BONHEUR COMMUNITY HEALTH AND WELL BEING

Project Title: "Le Bonheur's CHAMP Program: Changing High-risk Asthma in Memphis through Partnership"

Geographic Reach: Memphis and Shelby County, Tennessee

Estimated 3- Year Savings: \$ 4,003,397

Funding Amount: \$ 2,896,416

Summary: Le Bonheur Community Health and Well Being, a division of Le Bonheur Children's Hospital, in partnership with the University of Tennessee Health Science Center, is receiving an award to implement and test a comprehensive community-based care model to "close the loop" in the continuum of care for pediatric asthma patients in the City of Memphis and Shelby County, Tennessee. Their CHAMP (Changing High-risk Asthma in Memphis through Partnership) program will 1) create an inter-agency Asthma Collaborative, using care management teams to integrate care, 2) build a Pediatric Asthma Registry to inform evidence-based treatment, and 3) employ health care coordinators (Registered Respiratory Therapists trained as Certified Asthma Educators) and a social worker to enroll patients in the registry, orient caregivers, check home conditions, encourage medication adherence, and make referrals to the City and County Healthy Homes program for home assessments. The program will prevent deaths from pediatric asthma, reduce emergency room visits and avoidable hospitalizations, reduce asthma exacerbations or episodes, and improve patient and family experiences with the health care system.

Over a three-year period, Le Bonheur's program will serve approximately 800 high-risk pediatric asthma patients between the ages of two and 18. The program will train an estimated 400 workers and will create nine new jobs. The new workforce will include a social worker, six health care coordinators, an asthma program manager, and a data/office coordinator.

## MAIMONIDES MEDICAL CENTER

Project Title: "Brooklyn Care Coordination Consortium"

Geographic Reach: New York

Funding Amount: \$14,842,826

Estimated 3-Year Savings: \$41,759,040

Summary: The Maimonides Medical Center of Brooklyn, New York, in partnership with a broad array of consortium members, including medical, mental health, and social service organizations, insurers, and a labor union, is receiving an award to improve care for adults with serious mental illness who live in southwest Brooklyn. The consortium will use a virtual model of care to inform the coordination of health care and services, enabling medical and mental health providers to communicate with each other and monitor patients through advanced health information technology tools. Maimonides expects this approach to reduce psychiatric and medical hospital admissions by 30 percent and reduce the total cost of care for the population.

Over a three-year period, Maimonides Medical Center will create an estimated 162 jobs, including numerous care management roles and IT implementation roles.

## MARY'S CENTER FOR MATERNAL CHILD CARE

Project Title: "Capital Clinical Integrated Network (CCIN)"

Geographic Reach: Washington D.C.

Funding Amount: \$14,991,005

Estimated 3-Year Savings: \$17,712,000

Summary: Mary's Center for Maternal Child Care in Washington, D.C. is receiving an award to implement and test an integrated clinical network to improve care for chronically ill people in the D.C. area who rely on emergency room (ER) visits for health care. The project will use a city-wide database, care teams, and tele-health to communicate with these patients, develop care plans for them, and personally manage their care as they are gradually transitioned into patient-centered medical homes. The result will be lower cost from reduced dependence on crisis care and ER visits and better health care for people with controllable chronic conditions such as diabetes, hypertension, asthma, and co-occurring mental illness.

Over a three-year period, Mary's Center for Maternal Child Care will train and hire 44 health care workers to serve as care managers and community-based care coordinators.

## MAYO CLINIC

Project Title: "Patient-centric electronic environment for improving acute care performance"

Geographic Reach: Massachusetts, Minnesota, New York and Oklahoma

Funding Amount: \$16,035,264

Estimated 3-Year Savings: \$81,345,987

Summary: The Mayo Clinic, in collaboration with US Critical Illness and Injury Trials Group and Philips Research North America, is receiving an award to improve critical care performance for Medicare/Medicaid beneficiaries in intensive care units (ICUs). Data shows that 27% of such Medicare beneficiaries face preventable treatment errors due to information overload among ICU providers. The Mayo Clinic model will enhance effective use of data using a Cloud-based system that combines a centralized data repository with electronic surveillance and quality measurement of care responses. As a result, Mayo expects to reduce ICU complications and costs.

Over a three-year period, the Mayo Clinic will train 1440 existing ICU caregivers in four diverse hospital systems to use new health information technologies effectively in managing ICU patient care.

## MEDEXPERT INTERNATIONAL, INC

Project Title: "MedExpert International: Quality Medical Management System (QMMS)"

Geographic Reach: Not Geographically Defined

Estimated 3- Year Savings: \$ 50,410,304

Funding Amount: \$9,332,545

Summary: MedExpert International is receiving an award to test its Quality Medical Management System (QMMS) in comparison to a control group. QMMS is a shared decision-making system that provides consumers with educational materials, physician advice, and assistance with interpreting benefits and treatment options using Medical Information Coordinators and staff physicians. QMMS will be available on a national scale to serve approximately 160,000 Medicare, Medicaid, and CHIP beneficiaries. The goal is to improve quality of care, reduce costs, increase transparency, achieve high utilization and satisfaction, and demonstrate model viability.

Over a three-year period, MedExpert International will train and hire approximately 21 health care workers, including medical information coordinators, a medical information coordinator supervisor, a project manager, a senior executive manager, information technology and data engineers, senior engineers, and physicians.

## MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL

Project Title: "Wyoming: a frontier state's strategic partnership for transforming care delivery"

Geographic Reach: Wyoming

Funding Amount: \$14,246,153

Estimated 3-Year Savings: \$33,227,238

Summary: Memorial Hospital of Laramie County (the Cheyenne Regional Medical Center) is receiving an award to transform primary care delivery across Wyoming, a State which faces special challenges because of its low population density and limited health care resources. Memorial Hospital and its partners will retool primary care education, enhance connectivity between hospitals and primary care providers, improve pharmaceutical management of high cost populations, increase medication availability and provider access for vulnerable patients, and address the complex social issues affecting the health of vulnerable populations. Through care redesign, care coordination, and the creation of a State-wide referral database, the project will reduce dependency on hospitals for primary care, increase access to primary care, improve care transitions, and enhance community-based, health-related social service delivery for the comprehensive care of vulnerable populations. The result will be better and more cost-effective use of health care resources and better quality health care.

Over a three-year period, the Cheyenne Regional Medical Center's program will train an estimated 90 workers and create an estimated 33 jobs. The new workforce will include a strategic initiatives director, a strategic performance manager, a financial analyst, support staff, 41 RN care transition coaches, six telehealth registered nurses, and a technical support coordinator.

## THE METHODIST HOSPITAL RESEARCH INSTITUTE

Project Title: "Sepsis Early Recognition and Response Initiative (SERRI)"

Geographic Reach: Texas

Funding Amount: \$14,365,591

Estimated 3-Year Savings: \$48,226,102

Summary: The Methodist Hospital, in partnership with the Texas Gulf Coast Sepsis Network, is receiving an award to identify and treat sepsis before it progresses. Their program targets adult inpatients, including but not limited to Medicare and Medicaid beneficiaries, in acute care hospitals, long term acute care hospitals and skilled nursing facilities in Houston, Bryan, and McAllen, Texas. Sepsis is the sixth most common reason for hospitalization and typically requires double the average length of stay. It complicates 4 out of 100 general surgery cases, has a 30 day mortality rate of 1 in 20, and leads to complications such as renal failure and cognitive decline. In 2009, CMS paid 73% of the costs for all septicemia-related hospital stays. Through improved training, evidence-based and systematic screening

for sepsis, and more timely treatment, Methodist Hospital and its partners will prevent progression of the disease, resulting in reduced organ failure rates, reduced mortality, reduced length of stay, improved patient outcomes, and lower cost.

Over a three-year period, The Methodist Hospital's program will train an estimated 950 bedside nurses in sepsis screening and early recognition of the often subtle signs and symptoms of early sepsis. Additionally, an estimated 50 nurse practitioners will be trained in screening, recognition and early goal directed therapy for sepsis.

## THE METHODIST HOSPITAL RESEARCH INSTITUTE

Project Title: "Delirium detection and prevention across the continuum"

Geographic Reach: Texas

Funding Amount: \$11,785,095

Estimated 3-Year Savings: \$51,744,395

Summary: The Methodist Hospital Research Institute and Methodist Hospital System, in partnership with the Baylor College of Medicine, is receiving an award to improve care for Medicare & Medicaid beneficiaries at risk for delirium and associated complications in the Houston metropolitan area. Delirium increases the risk of falls and unnecessary hospitalizations and reduces the patient's quality of life. Through education, recognition, and prevention efforts by newly certified aides, cases of delirium could be reduced by 40 percent in the targeted population, with a corresponding reduction in hospital admissions and readmissions and improvement in care transitions.

Over a three-year period, the Methodist Hospital Research Institute will hire 27 employees, including certified health care Grand-Aides, and will train practitioners across the Methodist Hospital system on delirium recognition and prevention efforts.

## MICHIGAN PUBLIC HEALTH INSTITUTE

Project Title: "Michigan pathways to better health"

Geographic Reach: Michigan

Funding Amount: \$14,145,784

Estimated 3-Year Savings: \$17,498,641

Summary: The Michigan Public Health Institute, partnering with the Michigan Department of Community Health and the Community Health Access Project, is receiving an award to integrate

community health workers (CHWs) into primary care teams in the county of Ingham and cities of Saginaw and Muskegon. These CHWs will coach patients on self-management of conditions and encourage regular primary care visits. In addition, the program will connect at-risk populations with local care and support services that address social determinants of health that impede achievement of positive health outcomes. This “Pathways Community Hub” model will decrease hospitalizations and emergency department visits by improving adherence to therapy, improving access to primary care and increasing use of preventive care and support services.

Over a three-year period, the Michigan Public Health Institute will train over 231 people and hire 87 people to serve as community health workers, providing care self-management coaching, care navigation services, and care coordination services.

## MINERAL REGIONAL HEALTH CENTER

Project Title: “Frontier Medicine Better Health Partnership”

Geographic Reach: Montana

Funding Amount: \$10,499,889

Estimated 3-Year Savings: \$31,922,800

Summary: Mineral Regional Health Center, partnering with Montana’s frontier and rural health care communities, Mayo Clinic’s Health System’s Practice-Based Research Network (PBRN), Appalachian Osteopathic Postgraduate Training Institute Consortium (A-OPTIC), and iVantage Health Analytics, is receiving an award to develop and implement a Frontier and Rural Performance Network and learning collaborative that will standardize operations and efficiencies across all of the state’s hospitals, including tertiary care centers, critical access hospitals, and rural health clinics in the state. By the third year of the project, there will be a total of 48 critical access hospitals and rural health centers included in the network, serving 100,000 beneficiaries of Medicare, Medicaid, and the Children’s Health Insurance Program. Training will be provided to all participating sites in this network. Support for sites will include health improvement specialists, electronic health record specialists, and data analysis. The goal is to standardize improvement efforts and operational processes based upon best practices, resulting in better health care outcomes and efficiencies.

Over a three-year period, the Mineral Regional Health Center will hire 30 health care workers, including a program director, a chief financial officer, a Chief Medical Officer, and a human resources director and a staff of health improvement specialists, learning center technicians, health analysts, and administrative support workers.

## MOUNT SINAI SCHOOL OF MEDICINE

Project Title: "Geriatric emergency department innovations in care through workforce, informatics, and structural enhancements (GEDI WISE)"

Geographic Reach: Illinois, New York, New Jersey

Estimated 3- Year Savings: \$ 40,124,805

Funding Amount: \$ 12,728,753

Summary: Mount Sinai School of Medicine is receiving an award to integrate geriatric care with emergency department (ED) care in three large, urban acute care hospitals in New York, New Jersey, and Illinois. Emergency room use by older adults has doubled in the past decade and is expected to continue to increase. The Mount Sinai care model will use evidence-based geriatric clinical protocols, informatics support for patient monitoring and clinical decision support, and structural enhancements to improve patient safety and satisfaction while decreasing hospitalizations, return ED visits, unnecessary diagnostic and therapeutic services, medication errors, and adverse events, such as falls and avoidable complications.

Over a three-year period, Mount Sinai School of Medicine's GEDI WISE program will train more than 400 current health care workers and create 22 new jobs. The new hires will include nurses, nurse practitioners, physician assistants, pharmacists, physical therapy, project coordinators, research assistants, data analysts and geriatric transitional care managers.

## NATIONAL COUNCIL OF YOUNG MEN'S CHRISTIAN ASSOCIATIONS OF THE UNITED STATES OF AMERICA (YMCA OF THE USA)

Project Title: "Delivery on the promise of diabetes prevention programs"

Geographic Reach: Arizona, Delaware, Florida, Indiana, Minnesota, New York, Ohio, Texas

Estimated 3- Year Savings: \$ 4,273,807

Funding Amount: \$ 11,885,134

Summary: The National Council of Young Men's Christian Associations of the United States of America (Y-USA), in partnership with 17 local Ys currently delivering the YMCA's Diabetes Prevention Program, the Diabetes Prevention and Control Alliance, and 7 other leading national non-profit organizations focused on health and medicine, is receiving an award to serve 10,000 pre-diabetic Medicare beneficiaries in 17 communities across the U.S. The intervention will focus on community-based diabetes prevention through a national diabetes prevention lifestyle change program, coordinated and taught by trained YMCA Lifestyle Coaches. The goal is to prevent the progression of pre-diabetes to diabetes, which will improve health and decrease costs associated with complications of diabetes,

hypercholesterolemia, and hypertension. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, Y-USA and its partners will train an estimated 1500 workers and create an estimated eight jobs. The new jobs will include communication specialists, a program manager, an administrative manager, a workforce development manager, evaluation specialists, training specialists, and administrative coordinators.

## **NEMOURS ALFRED I. DUPONT HOSPITAL FOR CHILDREN**

Project Title: "Optimizing health outcomes for children with asthma in Delaware"

Geographic Reach: Delaware

Estimated 3- Year Savings: \$ 4,743,184

Funding Amount: \$ 3,697,300

Summary: Nemours/ Alfred I. duPont Hospital for Children, partnering with Delaware Health and Social Services, Division of Medicaid and Medical Assistance, and Division of Public Health, the South Wilmington Planning Network, Healthy Kids Collaboration in Kent County, Sussex County Health Promotion Coalition, United Way of Delaware, and University of Delaware is receiving an award to enhance family-centered health homes by adding services for children with asthma and developing a population health initiative in the neighborhoods surrounding targeted primary care practices. The intervention will also increase coordination of services by integrating care with community support services and local government initiatives to provide healthier environments for children with asthma in schools, child care centers, and housing, and by deploying community health workers to serve as patient navigators and provide case management services to families with high needs. The goal of this model is to reduce asthma-related emergency room use and asthma-related hospitalization among pediatric Medicaid patients in Delaware by 50% by 2015 with incremental declines in 2013 and 2014.

Over a three-year period, Nemours Alfred I. duPont Hospital for Children's program will train over 50 workers, from the existing and newly hired workforce, in both clinic and community settings, developing a close relationship between primary care practices and the surrounding communities. It will create an estimated 16 jobs, including community health workers, licensed mental health professionals, a project director, a certified asthma educator, an organizational development specialist, and an evaluation specialist.

## NORTH CAROLINA COMMUNITY NETWORKS

Project Title: "Building a statewide child health accountable care collaborative: the North Carolina strategy for improving health, improving quality, reducing costs, and enhancing the workforce"

Geographic Reach: North Carolina

Funding Amount: \$9,343,670

Estimated 3-Year Savings: \$24,089,682

Summary: North Carolina Community Care Networks, Inc., in partnership with the academic medical centers at Carolinas Medical Center-Charlotte, Duke University Health System, University of North Carolina Hospitals, Vidant Medical Center-East Carolina, and Wake Forest Baptist Health, as well as the children's units at Cape Fear Valley Health, Cone Health, Mission Hospital, New Hanover Regional Medical Center, Presbyterian Healthcare, and WakeMed Hospitals, is receiving an award to form a Child Health Accountable Care Collaborative. This Collaborative will provide care coordination through embedded specialty care managers in the offices of specialists and through "parent navigators" who will work with patients in their homes. The program addresses the shortage of both pediatric primary care physicians and subspecialists, and will serve 50,000 Medicaid and CHIP children with chronic disease for whom care is costly and fragmented. The result will be reductions in avoidable emergency room visits, hospitalizations, and pharmacy costs, with improved access to care and better quality of life for the children served.

Over a three-year period, North Carolina Community Care Networks Inc. will train an estimated 42 workers and will create an estimated 44 jobs. The new workforce will include children's specialty care managers and parent navigators. Parent navigators are trained to aid families in navigating the complex medical services needed by their children.

## NORTHEASTERN UNIVERSITY

Project Title: "Integrating industrial and system engineering (ISE) methods into healthcare improvement"

Geographic Reach: Massachusetts, North Carolina, Washington

Estimated 3-Year Savings: \$60,780,907

Funding Amount: \$8,000,002

Summary: The Healthcare Systems Engineering Institute at Northeastern University is receiving an award to establish a regional system engineering extension center that will embed proven evidence-based industrial and system engineering (ISE) improvement methods into local healthcare organizations, similar to as used in other complex industries. This demonstration project will launch a network of similar centers across the U.S. to significantly improve care, cost, safety, and quality starting first in Massachusetts, expanding to Washington and North Carolina states during the grant period, and continuing thereafter. Engineers and healthcare professionals will be cross trained in applying these

methods to important healthcare problems and work together in engineer-clinician project teams, integrating industrial engineers directly into health systems, establishing internship and summer residency programs, and creating trans-disciplinary curricula for engineers, clinicians, and healthcare managers. The overall goal is to measurably demonstrate the clear value of ISE methods and such a regional extension program, expanded nationally, to significantly lower costs, improve access, and achieve better outcomes, leading to better care and higher patient safety.

Over a three-year period, Northeastern University's program will train an estimated 81 workers in healthcare systems engineering methods and create an estimated 10 new jobs to educate students, oversee applied projects, and manage experiential education.

## **NORTHLAND HEALTHCARE ALLIANCE**

Project Title: "Improving health for the elderly in North Dakota one community at a time"

Geographic Reach: North Dakota

Funding Amount: \$2,726,216

Estimated 3-Year Savings: \$2,966,280

Summary: Northland Healthcare Alliance is receiving an award to implement a modified version of the PACE model in rural North Dakota. The Alliance will hire and train care coordinators in seven rural communities, connecting interdisciplinary teams via teleconferences and telemedicine. It will use existing long-term care or assisted living programs and sites to provide coordinated services to the frail elderly, increasing services and expanding options for the elderly to remain in safe environments in the community. The goal of this model is to reduce avoidable admissions to nursing facilities and decrease hospital stays, leading to lower costs per person and a higher quality of life.

Over a three-year period, Northland Healthcare Alliance's program will train an estimated 11 workers and will create an estimated 10 jobs. Roles will include community care coordinators and interdisciplinary team members.

## **PACIFIC BUSINESS GROUP ON HEALTH**

Project Title: "Intensive outpatient care program"

Geographic Reach: California

Funding Amount: \$19,139,861

Estimated 3-Year Savings: \$25,280,570

Summary: The Pacific Business Group on Health is receiving an award to work with various provider groups and health plans in rural and urban counties throughout the States of Arizona and California to improve care coordination for 30,000 Medicare and dual-eligible Medicare-Medicaid beneficiaries at risk from multiple chronic conditions. This model will use care managers embedded in primary care practices, payment reforms, and active learning networks to help build infrastructure and spread best practices among a wide set of providers. The goal is fewer emergency room visits, a reduction in avoidable hospitalizations, better mitigation of disease, and reduced complications as a result of intensive care management.

Over a three-year period, Pacific Business Group on Health's program will train over 410 people, while creating an estimated 211 jobs for Registered Nurses, project managers, a project director, a clinical director, a grants manager, information technology analysts, and administrative support staff.

## **PALLIATIVE CARE CONSULTANTS OF SANTA BARBARA**

Project Title: "Physicians quick response service"

Geographic Reach: California

Funding Amount: \$4,254,615

Estimated 3-Year Savings: \$3,229,481

Summary: Palliative Care Consultants of Santa Barbara is receiving an award to provide health care services to the frail elderly in times of crisis. The intervention will create new options for frail elderly to access rapid assessment and treatment in their homes through a Rapid Response Team (RRT) dispatched to the homes of seniors who have fallen ill. This approach will reduce delays in care for the frail elderly and create lower exposure to hospitalization-related risks. Specially trained first responders will arrive within one hour to initiate the in-home assessment and triage process. The focus of this initiative is to provide active treatment to frail elderly patients in their home. The goal is to reduce emergency room visits and avoidable hospital admissions, increase patient satisfaction, and provide better, more immediate care through a system that is patient-centered and timely.

Over a three-year period, Palliative Care Consultants of Santa Barbara's program will train an estimated 32 workers and create an estimated 20 jobs. New workers will include first responders, a project manager, enrollment specialists, and administrative assistants.

## **PEACEHEALTH KETCHIKAN MEDICAL CENTER**

Project Title: "Better health through coordinated care: a plan for southeast Alaska"

Geographic Reach: Alaska  
Funding Amount: \$3,169,386  
Estimated 3-Year Savings: \$3,384,627

Summary: PeaceHealth Ketchikan Medical Center, partnering with PeaceHealth Medical Group in Ketchikan and Prince of Wales is receiving an award to improve primary care coordination for patients with chronic disease in rural Alaska. Increased use of a nurse practitioner and care coordinators will extend the care teams' reach to patients and allow a greater opportunity for collaboration with Public Health Services and other community agencies toward the improvement of population health. The clinical educator will be working closely with the University of Alaska and other educational resources to develop training curriculum for Medical Office Assistants that serve these rural communities. It is anticipated that these interventions will permit an increased focus on preventive care, leading to a decrease in utilization of acute care and emergency services and overall improvement in patient health and the quality of care, while at the same time reducing costs. Over a three-year period, PeaceHealth Ketchikan Medical Center's program will train an estimated 28 workers, while creating an estimated 8 new jobs. These new workers will serve as the core project team and will include a program coordinator, clinical educator, nurse practitioner, and RN care coordinators.

## PHARMACY SOCIETY OF WISCONSIN

Project title: "Retooling the pharmacist's role in improving health outcomes and reducing health care costs"

Geographic Reach: Wisconsin  
Funding Amount: \$4,165,191  
Estimated 3-Year Savings: \$20,448,864

Summary: The Pharmacy Society of Wisconsin is receiving an award to better integrate pharmacists into clinical care teams. This project, expanding the successful Wisconsin Pharmacy Quality Collaborative (WPQC), will transform the pharmacist's role from drug dispensers to drug therapy coordinator and manager. Participating pharmacists will work collaboratively with physicians and other prescribers to revise prescription drug therapies in accord with evidence-based standards of care, targeting participants with diabetes, chronic heart failure, asthma, and geriatric syndromes. These patients are typically prescribed numerous medications, change locations of care, and/or are non-adherent to evidence-based therapies prescribed for them. The result of the intervention will be better medication adherence, better medication therapy management, and better health, with a decrease in adverse events and complications and more appropriate, evidence-based medication therapy.

Over a three-year period, the Pharmacy Society of Wisconsin's program will train an estimated 1,200 workers and will create an estimated 7 jobs. Regional implementation specialists and clinical pharmacists will train community pharmacists across the state.

## **PROSSER PUBLIC HOSPITAL DISTRICT**

Project Title: "Prosser Washington Community Paramedics Program"

Geographic Reach: Washington

Funding Amount: \$1,470,017

Estimated 3-Year Savings: \$1,855,400

Summary: Prosser Public Hospital District, serving a large, rural area in Washington State, is receiving an award for a program through which physicians can send a community paramedic (CP) to visit a patient of concern, providing in-home medical monitoring, follow-ups, basic lab work, and patient education. The area has high rates of obesity, high cholesterol, diabetes, heart attacks/coronary disease, and angina/stroke. Emergency room visits and readmissions are high and preventive care is limited, with poor follow-up care for chronic illnesses and frequent missed appointments. By expanding the role of the emergency medical services, CPs can increase access to primary and preventive care, provide wellness interventions, decrease emergency room utilization, and improve outcomes.

Over a three-year period, Prosser Public Hospital District's program will train an estimated 10 workers including community paramedics, medical information coordinators, RN case managers and medical doctors.

## **PROVIDENCE PORTLAND MEDICAL CENTER**

Project Title: "Redesigning service delivery through the Tri-County Health Commons"

Geographic Reach: Oregon

Funding Amount: \$17,337,093

Estimated 3-Year Savings: \$32,542,913

Summary: The Providence Portland Medical Center, in partnership with CareOregon, Providence Health & Services, Kaiser Permanente, Legacy Health, Oregon Health and Science University, the Coalition of Community Health Centers, Multnomah County, Clackamas County, and Washington County, is receiving an award to develop a Medicaid Coordinated Care Organization (CCO). This CCO will integrate care delivery for Medicaid and Medicare/Medicaid dual-eligible beneficiaries through an unprecedented level

of cooperation among traditional competitors. The program will include a Care Coordination Registry with real-time alerts to enable care coordination across all service sites, standardized discharge and transition processes from hospitals to primary care (with care transition teams to coordinate at-risk discharges), emergency room navigation services to divert non-urgent cases to primary care, and intensive patient support services through community-based and cross-disciplinary care teams. The result should be reduced use of emergency rooms, fewer avoidable hospital readmissions, and better access to a more appropriate and cost-effective level of health care services.

Over a three-year period, Providence Portland Medical Center's program will train an estimated 54 workers. It will create an estimated 62 jobs. These new workers will include community outreach workers, emergency department navigators, a survey processing team, and qualitative interviewers.

## **THE RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA**

Project Title: "Proactive Palliative Care and Palliative Radiation Model"

Geographic Reach: Virginia

Funding Amount: \$2,571,322

Estimated 3-Year Savings: \$2,920,639

Summary: The Rector and Visitors of the University of Virginia is receiving an award to improve care for patients with advanced cancer. The program will integrate data from multiple sources to help providers proactively identify opportunities for evidence-based care interventions that have been shown to improve quality of care, increase survival, and reduce costs. In addition to various aspects of care, the program includes a specific redesign of radiation therapy to provide highly effective single-day treatment for cancer that has spread to the bone. By limiting unnecessary travel for frequent radiation treatments and delivering more rapid radiation therapy to reduce tumor size this initiative is expected to decrease complications from metastatic disease. Over a three-year period, Rector and Visitors' program will train an estimated 65 workers and create three new jobs to support this project.

## **REGIONAL EMERGENCY MEDICAL SERVICES**

Project Title: "REMSA Community Health Early Intervention Team (CHIT)"

Geographic Reach: Nevada

Estimated 3-Year Savings: \$ 10,500,000

Funding Amount: \$ 9,872,988

Summary: The Regional Emergency Medical Services Authority of Reno, Nevada, a non-profit provider of ground and air ambulance services, in partnership with Renown Medical Group, the University of Nevada-Reno School of Community Health Sciences, the Washoe County Health District, and the State of Nevada Office of Emergency Medical Services, is receiving an award to create a Community Health Early Intervention Team (CHIT) to respond to lower acuity and chronic disease situations in urban, suburban, and rural areas of Washoe County Nevada. CHIT is designed to reduce unnecessary ambulance responses, as well as hospital admissions and readmissions, while improving the patients' health care. A central component to the success of CHIT is the adoption of a new non-emergency phone number to provide an alternative pathway to care for patients with lower acuity problems. Goals of this initiative include reductions in non-urgent emergency department visits, unreimbursed emergency department costs, hospital admissions, and hospital readmissions, as well as decreased hospital stays, fewer ambulance transports, and improved overall health care and continuity of care.

Over a three-year period, the Regional Emergency Medical Services Authority's program will train an estimated 22 workers and create an estimated 22 jobs. The new workforce will include community paramedics, communication specialists, an educator, continuous quality improvement coordinators, an outreach coordinator, an information technology specialist, a statistician, an administrative support specialist, and a project director.

## **THE RESEARCH INSTITUTE AT NATIONWIDE CHILDREN'S HOSPITAL**

Project Title: "Partners for Kids Expansion"

Geographic Reach: Ohio

Estimated 3- Year Savings: \$ 51,714,650

Funding Amount: \$ 13,160,092

Summary: The Research Institute at Nationwide Children's Hospital, in partnership with Akron Children's Hospital and its integrated physician group, is receiving an award to expand its Partners for Kids (PFK) program in Ohio, serving over 492,000 Medicaid children enrollees and 25,000 children with disabilities (the most costly pediatric population). PFK will enhance provider incentives and improve access for high risk rural and urban underserved populations through comprehensive medical home-based services and the rapid deployment of an expanded health care workforce focusing on behavioral health, complex care, and high risk pregnancy.

## **RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY (THE CENTER FOR STATE HEALTH POLICY)**

Project Title: "Sustainable high-utilization team model"

Geographic Reach: California, Colorado, Missouri, Pennsylvania

Funding Amount: \$14,347,808  
Estimated 3-Year Savings: \$67,719,052

Summary: Rutgers, The State University of New Jersey, is receiving an award to expand and test a team-based care management strategy for high-cost, high-need, low-income populations served by safety-net provider organizations in Allentown, PA, Aurora, CO, Kansas City, MO, and San Diego, CA. Led by Rutgers' Center for State Health Policy, the project will use care management teams (including nurses, social workers, and community health workers) to provide clients with patient-centered support that addresses both health care needs and the underlying determinants of health. Teams will assist patients in filling prescriptions, finding housing or shelter, applying for health coverage or disability benefits, handling legal issues, finding transportation, treating depression, managing chronic illness, and coordinating appropriate specialty care. After patients are stabilized, the care management team will transition them to local primary care medical homes. By improving beneficiaries' access to ambulatory medical and social services, the project will improve patient outcomes and reduce preventable hospital inpatient and emergency room utilization.

Over a three-year period, Rutgers' program will train an estimated 155 workers and will create an estimated 43 jobs. The new workforce will include community health workers.

## **ST. FRANCIS HEALTHCARE FOUNDATION OF HAWAII**

Project Title: "Preventing hospitalizations in very high-risk patients"  
Geographic Reach: Hawaii  
Funding Amount: \$5,299,706  
Estimated 3-Year Savings: \$10,393,944

Summary: St. Francis Healthcare Foundation of Hawaii is receiving an award for telehealth-based home monitoring for very high risk patients with complex health care needs to prevent hospitalizations. The program will use care management teams that include physicians and trained nurse clinicians to develop individualized care plans, monitor patients' health, manage adherence to medication and care, and intervene as necessary. The goal is to reduce preventable hospitalizations and readmissions by 40% as compared to a control group and to improve patients' health and quality of life.

Over a three-year period, St. Francis Healthcare Foundation of Hawaii's program will train an estimated 20 workers and create an estimated 15 jobs-for nurse clinicians, a data clerk, research and administrative assistants, an associate project director, and a project director.

## ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.

Project Title: "Tele-critical care and emergency services"

Geographic Reach: Idaho, Nevada, Oregon

Funding Amount: \$11,762,777

Estimated 3-Year Savings: \$12,567,875

Summary: St. Luke's Regional Medical Center is receiving an award for remote intensive care unit (ICU) monitoring and care management in rural southwestern and central Idaho and eastern Oregon. Critical care for patients in ICUs will be provided by physician intensivists working in teams with care providers and coordinators working on site and in a central monitoring unit. Through early identification of patients in need of specialized care, improved care coordination, and standardized clinical quality practices, the program will reduce ICU days, increase access to specialty care, and provide more appropriate and timely care for patients.

Over a three-year period, St. Luke's Regional Medical Center, Ltd's program will train an 110 workers, while creating an estimated 24.5 jobs for critical care nurses, health care assistants, information technology (IT) support and IT analysts, clinical educators, accountants, billing specialists, financial analysts, an IT project manager, a business analyst, a medical director, and an operations director.

## SANFORD HEALTH

Project Title: "Sanford One Care: transforming primary care for the 21<sup>st</sup> Century"

Geographic Reach: Iowa, Minnesota, North Dakota and South Dakota

Funding Amount: \$12,142,606

Estimated 3-Year Savings: \$14,135,429

Summary: Sanford Health is receiving an award to transform health care delivery through the full integration of primary and behavioral health care in South Dakota, North Dakota and Minnesota clinics. Sanford's enhanced fully integrated medical home model features patient-centered collaborative teams of primary and behavioral health professionals. The Medicare, Medicaid and CHIP beneficiaries along with the Native American and multicultural populations will benefit significantly from this award. This model of workforce development and rapid process redesign, along with the integration of behavioral health and primary care, will improve clinical outcomes and drive efficient utilization of resources.

Key aims include transforming the role of Primary Care, integrating RN Health Coaches and Behavioral Health Triage Therapists, fully integrating behavioral health care into the medical home model, maximizing Information Technology and standardizing transparent clinical metrics. Tele-health technology will allow patients at remote clinic sites to access enhanced clinical services including psychologists and psychiatrists. Over a three-year period, Sanford Health's program will train an

estimated 425 health care providers creating enhanced clinical and patient engagement skills, as well as create an estimated 23 jobs in the areas of clinical services, behavioral health, and information technology.

## **SAN FRANCISCO COMMUNITY COLLEGE**

Project Title: "Transitions clinic network: linking high-risk Medicaid patients from prison to community primary care"

Geographic Reach: Alabama, California, Connecticut, District of Columbia, Massachusetts, Maryland, New York, and Puerto Rico

Funding Amount: \$6,852,153

Estimated 3-Year Savings: \$8,115,855

Summary: The San Francisco Community College District (City College of San Francisco), in partnership with the University of California San Francisco and Yale University, is receiving an award to address the health care needs of high-risk/high-cost Medicaid and Medicaid-eligible patients released from prison, targeting eleven community health centers in six states, The District of Columbia, and Puerto Rico. The program will work with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers trained by City College of San Francisco to help these individuals navigate the care system, find primary care and other medical and social services, and coach them in chronic disease management. The outcomes will include reduced reliance on emergency room care, fewer hospital admissions, and lower cost, with improved patient health and better access to appropriate care.

Over a three-year period, the San Francisco Community College District's program will create an estimated 12.3 jobs and train an estimated 53.7 workers. The new workforce will include 7 community health workers, 11 part-time panel managers, 2 part-time project coordinators, one research analyst and two part-time project staff.

## **SOUTH CAROLINA RESEARCH FOUNDATION**

Project Title: "HOME CARE +, a care coordination model for persons receiving home care to prevent hospital, ER and nursing home admission"

Geographic Reach: South Carolina

Estimated 3- Year Savings: \$ 3,100,611

Funding Amount: \$ 2,884,719

Summary: The South Carolina Research Foundation is receiving an award to test a care coordination model for home care recipients in three areas of South Carolina. The project will train personal care aides to serve as home care specialists, working on teams with on-call nurses and home care consultants to provide chronic disease management, health care coaching, and care coordination on a long-term basis. This approach will improve care continuity, medication adherence, disease management, and access to community-based services and reduce referrals to nursing homes, avoidable hospitalizations, and emergency room visits.

Over a three-year period, the South Carolina Research Foundation will create an estimated 16 jobs. These workers will include a program manager and home care coordinators.

## SOUTHEAST MENTAL HEALTH SERVICES

Project Title: "TIPPING POINT: Total Integration, Patient Navigation and Provider Training Project for Powers County, Colorado"

Geographic Reach: Colorado

Estimated 3- Year Savings: \$ 1,875,000

Funding Amount: \$ 1,405,924

Summary: Southeast Mental Health Services is receiving an award to coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill residents of rural Prowers County, Colorado. The program will employ trained patient navigators to increase patients' access to primary and behavioral care, preventive care, and early intervention services, offering team-based education and coaching to improve both population health and self-management of disease. The results will include a reduction in emergency room visits and other high cost interventions, mitigation of the progress of chronic disease, better health habits, and better care and quality of life for these vulnerable patients. Southeast Mental Health Services will contract with Otero Junior College to develop a magnet "Health Navigator" training program to serve current and future healthcare workers across rural Colorado. Over a three-year period, Southeast Mental Health Service's program will train an estimated 62 workers and create an estimated 8.25 FTE jobs. The new workers will include health navigators, instructors, a marketing/communications assistant, and a project manager.

## SUTTERCARE

Project Title: “Advanced Illness Management (AIM)”

Geographic Reach: California

Funding Amount: \$13,000,000

Estimated 3-Year Savings: \$29,388,894

Summary: Suttercare Corporation is receiving an award to expand their Advanced Illness Management program (AIM) across the entire Sutter Health system in Northern California, serving patients who have severe chronic illness but are not ready for hospice care, are in clinical, functional, or nutritional decline, and are high-level consumers of health care. Such patients generally experience poor care quality, but account for a disproportionate share of Medicare spending. AIM addresses these issues through a complex medical home model that uses nurse-led interdisciplinary teams to coordinate and deliver care that encourages patient self-management of chronic illness, that modifies disease course and provides symptomatic relief. The program will improve care and patient quality of life, increase physician, caregiver, and patient satisfaction, and reduce Medicare costs associated with avoidable hospital stays, emergency room visits, and days spent in intensive care units and skilled nursing facilities.

Over a three-year period, the Suttercare Corporation’s program will train an estimated 192 workers and will create an estimated 89 jobs. The new workforce will include training care transition teams comprised of social workers, nurse practitioners, clinical pharmacist and home care aides.

## TransforMED

Project Title: “Multi-community partnership between TransforMED, hospitals in the VHA system and a technology/data analytics company to support transformation to PCMH of practices connected with the hospitals and development of “Medical Neighborhood”

Geographic Reach: Alabama, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Oklahoma, West Virginia

Funding Amount: \$20,750,000

Estimated 3-Year Savings: \$52,824,000

Summary: TransforMED, in partnership with 12 VHA-affiliated hospitals throughout the county, is receiving an award for a primary care redesign project to support care coordination among Patient-Centered Medical Homes (PCMH), specialty practices, and hospitals, creating “medical

neighborhoods.” The project will use a sophisticated analytics engine to identify high risk patients and coordinate care across the medical neighborhood while driving PCMH transformation in a number of primary care practices in each community. Truly comprehensive care will improve care transitions and reduce unnecessary testing, leading to lower costs with better outcomes.

Over a three-year period, TransformMED’s program will train an estimated 3,024 workers and create an estimated 22 jobs. The new workers will include an innovation project manager, project control specialists, project managers, an implementation team, a project team, an integration architect, an application trainer, and a population health management advisor.

## TRUSTEES OF INDIANA UNIVERSITY

Project Title: “CommunityRx System: dissemination of the aging brain core program”

Geographic Reach: Indiana

Funding Amount: \$7,836,084

Estimated 3-Year Savings: \$15,659,916

Summary: The Trustees of Indiana University are receiving an award to improve care for Medicare beneficiaries with dementia or late-life depression within a safety net health system in Marion County, IN. Many of these beneficiaries are dually eligible for Medicare and Medicaid. Partners in the project include Wishard Health System, Wishard Hospital, the Indiana University Geriatrics Program, the IU Center for Aging Research, The Healthy Aging Brain Center, the Indianapolis Discovery Network for Dementia, the Indiana Clinical and Translational Sciences Institute, the IU Simulation Center at Fairbanks Hall, the Indiana Network for Patient Care, and the Regenstrief Institute. The model, based on a successful pilot study, provides individualized and integrated care through a multidisciplinary care team staffed by nurse-practitioners, nurses, and care coordinators. These teams will work with patients, families, primary care providers, and specialists to develop patient-specific care plans, deliver evidence-based protocols, and respond to real-time monitoring and feedback, improving care and lowering cost through care management.

Over a three-year period, the Trustees of Indiana University’s program will train an estimated # workers. It will create an estimated 25 jobs—for positions including advanced practice care coordinators, nurses, medical care coordinators’ assistants, social workers, and a medical director.

## THE TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

Project Title: "A rapid cycle approach to improving medication adherence through incentives and remote monitoring for coronary artery disease patients"

Geographic Reach: New Jersey and Pennsylvania

Funding Amount: \$4,841,221

Estimated 3-Year Savings: \$2,787,030

Summary: The University of Pennsylvania is receiving an award for a program to improve medication adherence and health outcomes in post-discharge patients who are recovering from acute myocardial infarctions in metropolitan Philadelphia and adjoining areas of New Jersey. Such patients typically have high rates of poor medication adherence and hospital readmissions and are costly to monitor through intensive case management. The intervention will increase medication adherence through telemonitoring and a visual and audible "reminder" system. It will also retrain social workers as engagement advisors to monitor adherence, offer incentives, and enlist patient support from family and friends. The result will be improved health outcomes and lower cost. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, the Trustees of the University of Pennsylvania's program will train an estimated 21 workers, while creating an estimated seven jobs for investigators, clinical social workers, clinical nurses, software programmers, project co-directors, and a project director.

## THE TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

Project Title: "Comprehensive longitudinal advanced illness management (CLAIM)"

Geographic Reach: Pennsylvania

Funding Amount: \$4,361,539

Estimated 3-Year Savings: \$9,427,468

Summary: The Trustees of the University of Pennsylvania are receiving an award to test a comprehensive set of home care services for Medicare and/or Medicaid beneficiaries with advanced cancer who are receiving skilled home care and have substantial palliative care needs, but are not yet eligible for hospice care. The program will serve five counties in the metropolitan Philadelphia area. Using care coordination and planning, the intervention will provide in-home support, symptom management, crisis management, and emotional and spiritual support for beneficiaries with advanced cancer, enabling them to remain in their homes and avoid unnecessary hospitalizations.

Over a three-year period, the Trustees of the University of Pennsylvania's program will train an estimated 64 workers. It will create an estimated 16 jobs for home health aides, social workers, and licensed practical nurses.

## UNIVERSITY OF ALABAMA AT BIRMINGHAM

Project Title: "Deep South Cancer Navigation Network (DSCNN)"

Geographic Reach: Alabama, Florida, Georgia, Mississippi, Tennessee

Funding Amount: \$15,007,263

Estimated 3- Year Savings: \$49,815,239

Summary: The University of Alabama at Birmingham (UAB) and the UAB Comprehensive Cancer Center are receiving an award extending a regional network of lay health workers to expand comprehensive cancer care support services through a five state region. Working through the participating UAB Cancer Care Network affiliate sites, these patient navigation teams will improve adherence to care plans and educate cancer survivors on healthy behaviors. The intervention is designed to serve Medicare and Medicaid beneficiaries with complex or advanced disease and those with psycho-social barriers to appropriate care, many living in medically underserved inner city and rural communities. Each navigation team will include an RN site manager, health system navigators, community navigators, and a community educator. It is expected that the intervention will result in better adherence to evidence based care plans, reduced reliance on hospitals and emergency rooms for care, earlier acceptance of palliative and hospice services, and a better overall quality of life for cancer survivors.

Over a three-year period, UAB's program will train an estimated 150 lay health workers and create an estimated 56 new jobs. The new workforce will include community navigators, system navigators, data entry assistants, administrative assistants, community coordinators, Registered Nurse site managers, training managers, an evaluation and reporting manager, a communications and public relations manager, and an administrative director.

## UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Project Title: "Cost-effective delivery of enhanced home caregiver training"

Geographic Reach: Hawaii, Arkansas, California, Texas

Funding Amount: \$3,615,818

Estimated 3-Year Savings: \$1,286,251

Summary: The University of Arkansas for Medical Sciences is receiving an award for enhanced training of both family caregivers and the direct-care workforce in order to improve care for elderly patients requiring long-term care services, including Medicare beneficiaries qualifying for home healthcare services and Medicaid beneficiaries who receive homemaker and personal care assistant services. Inadequate training of the direct care worker has been shown to have a direct impact on the quality of care to the elderly. By enhancing the training of the direct-care workforce, the increasingly complex care needs of the older adult can be better managed in the home, leading to fewer avoidable hospital admissions and readmissions, better preventive care, better compliance with care, and avoidance of unnecessary institutional care. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, The University of Arkansas for Medical Sciences' program will train an estimated 2100 workers and will create an estimated four jobs. The new workforce will include a project manager, a nurse educators and an administrative assistant. Additionally, this program will train home care givers in rural areas using distance education. Through tuition and textbook support this program will increase the number of certified caregivers providing direct care to elderly adults.

## THE UNIVERSITY OF CHICAGO

Project Title: "Integrated inpatient/outpatient care for patients at high risk of hospitalization"

Geographic Reach: Illinois

Funding Amount: \$6,078,073

Estimated 3-Year Savings: \$18,750,000

Summary: The University of Chicago is receiving an award to test a model of care delivery that reasserts the importance of an ongoing doctor-patient relationship. The project will use multidisciplinary teams—including Registered Nurses, Licensed Practical Nurses, social workers, and medical assistants led by Comprehensive Care Physicians (CCPs)—to provide consistent care to Medicare beneficiaries before, during, and after hospitalizations. CCPs will perform rounds in hospitals 48 weeks per year, ensuring they see patients and monitor their health consistently. The targeted population will include beneficiaries with a high probability of hospitalization, making it more likely that CCPs will encounter their patients during rounds in the hospital.

Over a three-year period, The University of Chicago program will train an estimated 26 workers and will create an estimated 11 jobs. The new workforce will include a programmer, 4 research assistants, 5 comprehensive care physicians, 2 nurses, a social worker and a medical office assistant.

## UNIVERSITY OF HAWAII AT HILO

Project Title: "Pharm2Pharm, a formal hospital pharmacist to community pharmacist collaboration"

Geographic Reach: Hawaii

Funding Amount: \$14,346,043

Estimated 3-Year Savings: \$27,114,939

Summary: The University of Hawaii at Hilo and its College of Pharmacy, in partnership with Hawaii Health Systems Corporation and Hawaii Pacific Health, community pharmacies in rural counties of Hawaii, the Hawaii health insurance exchange, and Hawaii Health Information Corporation, is receiving an award to improve medication reconciliation and management for the elderly in three rural counties of Hawaii. The program will integrate pharmacists into hospital and ambulatory care teams and use health information technology for decision-making support and to enhance communication, particularly between hospital pharmacists and community pharmacists. The result will be better care transitions, a reduction in adverse events, improved medication adherence, and better-informed, more patient-centered decisions about medication therapies, leading to reduced hospitalizations, readmissions, and emergency room visits and better health care and health for the patients served.

Over a three-year period, the University of Hawaii at Hilo's program will train an estimated # workers and create an estimated # jobs. The new workers will include a pharmacist project coordinator, a certified project management professional, a physician leader/care transition expert, a measurement and evaluation expert, a contracts administrator, and an administrative assistant.

## UNIVERSITY OF IOWA

Project Title: "Transitional care teams to improve quality and reduce costs for rural patients with complex illness"

Geographic Reach: Iowa

Estimated 3- Year Savings: \$ 12,500,000

Funding Amount: \$7,662,278

Summary: The University of Iowa, in partnership with the 11 hospitals comprising its Critical Access Hospital Network, is receiving an award to improve care coordination and communication with practitioners in ten rural Iowa counties. The program will serve Medicare, Medicaid, and Medicare/Medicaid dual-eligible beneficiaries and privately insured and uninsured patients who have complex illness, including psychiatric disorders, heart disease, kidney disease, cancer, endocrine and gastrointestinal disorders, and geriatric issues. The program will coordinate care through teams comprised of nurses, social workers, and pharmacists along with specialty physicians (including psychiatrists) using telehealth and web-based personal health records. The program is based on the University of Iowa's significant past experience in creating telehealth care teams for patients with

diabetes, chronic obstructive pulmonary disease, and heart failure. It will increase access to services and specialty care, improve care transitions and care coordination, and decrease avoidable hospital readmissions of complex patients in rural counties in Iowa.

Over a three-year period, the University of Iowa's program will train an estimated 22 workers and will create an estimated 28 jobs. The new hires will include eleven community coordinators, two project managers, a program secretary, an outcomes analyst, a qualitative analyst, a database manager, nurse team leaders, social workers, and an informatics director.

## UNIVERSITY OF MIAMI

Project Title: "Expanded activities of school health initiative"

Geographic Reach: Florida

Funding Amount: \$4,097,198

Estimated 3-Year Savings: \$5,620,017

Summary: The University of Miami, in partnership with Medicaid health plans, the University of Florida College of Dentistry, the Miami Dade Area Education Center, the Center for Haitian Studies, the Larkin Residency program, and Overtown Youth Center, is receiving an award to improve care and access to care for children in four communities in the Miami-Dade County area who have health problems that include asthma, obesity, type II diabetes, and STDs. This intervention will expand the services and utility of school-based health clinics, increase collaboration with other care providers, services, and school-health stakeholders, and enhance use and sharing of health information technology. A team-based approach will be used to improve care and expand services, employing community health workers, nursing assistants, and dental hygienists and taking advantage of telehealth opportunities. The program will lower cost through preventive and more appropriate care and increase access to care, services, and benefits.

Over a three-year period, the University of Miami's program will train an estimated 60 workers and will create an estimated 25 jobs. The new workforce will include community health workers, dental hygienists, physicians and nurse practitioners.

## UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER

Project Title: "Brookdale Senior Living (BSL) Transitions of Care Program"

Geographic Reach: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Nevada, Massachusetts, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin

Estimated 3-Year Savings: \$9,729,702

Funding Amount: \$7,329,714

Summary: The University of North Texas Health Science Center (UNTHSC), in partnership with Brookdale Senior Living (BSL), is receiving an award to expand and test the BSL Transitions of Care Program which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living and dementia specific facilities in Texas and Florida. In addition, community dwelling older adults who receive BSL home health services will be included in the Transitions of Care Program. Over the course of the award the program will expand to other states where BSL communities are located. The program will employ clinical nurse leaders (CNLs) to act as program managers. CNLs will train care transition nurses and other staff on the use of INTERACT and health information technology resources to help them identify, assess, and manage residents' clinical conditions to reduce preventable hospital admissions and readmissions. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults.

Over a three-year period, the University of North Texas Health Science Center's program will train an estimated 10,926 workers and create an estimated 97 jobs for clinical nurse leaders and other health care team members.

## UNIVERSITY OF RHODE ISLAND

Project Title: "Living Rite-A Disruptive Solution for Management of Chronic Care Disease (a focus on adults with disabilities: intellectual and developmental diagnoses and dementia patients with 2 or more chronic conditions)"

Geographic Reach: Rhode Island

Estimated 3- Year Savings: \$ 15,526,726

Funding Amount: \$13,955,411

Summary: The University of Rhode Island is receiving an award for a plan to use interdisciplinary care management teams, including community health workers, combined with using the Multiple Health Behavior Change technique to teach patients how to best manage their chronic diseases, to provide comprehensive and preventive care for intellectually and developmentally challenged dual eligible beneficiaries of Medicare and Medicaid 20 and older who are citizens of Rhode Island. By integrating the efforts of a large group of state agencies, major health systems, educational institutions, disability organizations, and service providers, the program will deliver seamless and comprehensive care in an

efficient manner, improving health care and lower cost for dual eligible beneficiaries of Medicare and Medicaid.

Over a three-year period, The University of Rhode Island (URI) program will train an estimated 226 workers and will create an estimated 31 jobs. The new workforce will include 14 clinical health professionals, 8 peer wellness coaches, peer and family mentors, 5 administrative and support staff for the new Living Rite Center teams and URI will hire two research associates, a program assistant, and a business manager to manage the grant. Additionally, this program will provide training, education and job placement for 21 persons with disabilities in healthcare service occupations.

## UNIVERSITY OF SOUTHERN CALIFORNIA

Project Title: "Integrating clinical pharmacy services in safety-net clinics"

Geographic Reach: California

Funding Amount: \$12,007,677

Estimated 3-Year Savings: \$43,716,000

Summary: The University of Southern California is receiving an award to integrate clinical pharmacy services into safety net clinics, providing medication therapy management, disease state management, medicine reconciliation, medication access services, patient counseling, drug information education, preventive care programs, provider education, and quality improvement review for care providers and for the underserved and vulnerable populations of Santa Ana, Huntington Beach, and Garden Grove. This will improve medication adherence, confirm the appropriateness and safety of medication use, and reduce avoidable hospitalizations and emergency room visits, while improving patient and population health.

Over a three-year period, The University of Southern California program will train an estimated 17 workers and will create an estimated 27 jobs. The new workforce will include a programmer, a project manager, six pharmacists, and six pharmacy residents. Additionally, this program will partner with the East Los Angeles Occupational Center technician training program to develop curricula that will expand the roles of the 27 pharmacy technicians who will be trained to perform patient navigator and data management duties in clinical pharmacy teams.

## UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Project Title: "Project SAFEMED"

Geographic Reach: Tennessee  
Estimated 3- Year Savings: \$ 3,160,844  
Funding Amount: \$2,977,865

Summary: The University of Tennessee Health Science Center, in partnership with Methodist LeBonheur Healthcare's Methodist North Hospital and Methodist South Hospital, QSource, United Healthcare, BlueCross BlueShield and its BlueCare Medicaid plan, Southwest Tennessee Community College, the Tennessee Pharmacists Association, and the Bluff City, Bin Sina, and Memphis Medical Societies, is receiving an award to improve medication adherence and effective medication usage among high-risk patients in the northwest and southwest sections of Memphis, TN. The program will serve vulnerable adults (20-64) and seniors 65+ insured by Medicaid and/or Medicare who have multiple chronic diseases, including hypertension, diabetes, coronary artery disease, congestive heart failure, and chronic lung disease, as well as polypharmacy and high-inpatient utilization. Through teams of pharmacists, nurse practitioners, pharmacy technicians, and licensed practical nurse outreach workers based in outpatient centers, the program will work with primary care physicians and local pharmacies to provide comprehensive medication management. This approach will reduce avoidable prescription drug utilization, prevent adverse drug events, reduce resulting patient morbidity and mortality, reduce avoidable hospital admissions, and lower cost. At the same time it will improve medication adherence, disease management, and patient health.

Over a three-year period, the University of Tennessee Health Science Center's program will train an estimated 8 workers, while creating an estimated 11 jobs. The new positions will include outreach workers, outreach directors, and pharmacy techs.

## THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

Project Title: "Comprehensive care provided in an enhanced medical home to improve outcomes and reduce costs for high-risk chronically ill children"

Geographic Reach: Texas  
Estimated 3- Year Savings: \$ 4,272,968  
Funding Amount: \$ 3,701,370

Summary: The University of Texas Health Science Center at Houston is receiving an award to improve care for children under 18 in the wider Houston area with chronic illnesses, including congenital anomalies, pulmonary problems, gastro-intestinal problems, neurologic problems, cerebral palsy, mental retardation, and a 50% or more estimated risk of hospitalization per year. The program will provide comprehensive care through a special high-risk children's medical home where both primary and specialty services are provided in the same clinic during the same visit. The clinic is staffed by a diverse team of pediatricians and pediatric nurse practitioners who are highly trained and experienced and continuously accessible to treat these complex children. Through intensive integrated and

coordinated care, the program will reduce serious illnesses, emergency room visits, hospitalizations, pediatric ICU admissions, total hospital and ICU days, and total health care costs, and will improve the care, health, and quality of life for these fragile children.

Over a three-year period, the University of Texas Health Science Center at Houston's program will train an estimated 35 workers. It will create an estimated six jobs, in addition to the positions for a project director, a medical director (pulmonology), an associate medical director (allergy/immunology), pediatric nurse practitioners, health care educators, a health care economist, and consultants in a pediatric infectious disease, gastroenterology, and neurology.

## VALUEOPTIONS, INC.

Project Title: "Using recovery peer navigators and incentives to improve substance abuse Medicaid client outcomes and costs"

Geographic Reach: Massachusetts

Funding Amount: \$2,760,737

Estimated 3-Year Savings: \$7,841,498

Summary: ValueOptions, Inc., and its subsidiary, Massachusetts Behavioral Health Partnership, is receiving an award to test care coordination to reduce repeated utilization of detox services among beneficiaries who have 2 or more detox admissions. The project uses patient navigators, recovery planning, and other support services. Four providers will implement the intervention, serving northeastern Massachusetts, southeastern Massachusetts, greater Boston, and the central portion of the state. By linking beneficiaries with appropriate treatment and recovery services, the model will improve their health outcomes, reducing costs by avoiding preventable emergency room visits and hospitalizations.

Over a three-year period, ValueOptions, Inc.'s program will train an estimated 75 workers and will create an estimated 75 jobs. The new workers will include patient navigators and trainers and support staff.

## VANDERBILT UNIVERSITY

Project Title: "MyHealth Team: regional team-based and closed-loop control innovation model for ambulatory chronic care delivery"

Geographic Reach: Tennessee and Kentucky

Estimated 3- Year Savings: \$ 27,269,705

Funding Amount: \$18,846,090

Summary: Vanderbilt University is receiving an award to improve ambulatory chronic disease management for high-risk, high cost patients with hypertension, congestive heart failure, and diabetes, many of them beneficiaries of Medicare and Medicaid, in 18 rural and urban counties in Tennessee and Kentucky. To improve disease management, Vanderbilt will create inter-professional health care teams and enhanced health information technology (HIT), including disease registries and evidence-based decision support integrated into the clinical workflow. Because an inter-professional staff with access to HIT will improve communication, care planning and monitoring, the health care teams will be better able to respond to patients between office visits, track and follow up acute care episodes, and provide advanced alerts and decision-making support, resulting in improved coordination of outpatient care and reduced hospital admissions and emergency room visits.

Over a three-year period, the Vanderbilt University program will train an estimated 45 workers and will create an estimated 45 jobs. The new workforce will include registered nurses and medical assistants.

## VINFEN CORPORATION

Project Title: "Community-based health homes for individuals with serious mental illness"

Geographic Reach: Massachusetts

Funding Amount: \$2,942,962

Estimated 3-Year Savings: \$3,792,020

Summary: The Vinfen Corporation, in partnership with Bay Cove Human Services, North Suffolk Mental Health, Brookline Mental Health, and Commonwealth Care Alliance (a non-profit managed care organization), is receiving an award to integrate health care and behavioral health care for individuals with serious mental illness in metropolitan Boston. The program will embed nurse practitioners backed by primary care doctors in existing psychiatric rehabilitation teams, creating community-based health homes that will provide better care at lower cost for a population at risk for severe chronic disease and often in need of critical care. Care management counselors and peer counselors will help people self-manage their medical and behavioral health issues. Telehealth technology will enable health care teams to monitor patients, prioritize care, and intervene as necessary. As a result, the program will improve the health of individuals with serious mental illness, increase their access to health services, reduce the impact of their disorders, and reduce avoidable use of acute services.

Over a three-year period, Vinfen Corporation's program will train an estimated 57 workers. It will create an estimated 11 jobs for health outreach workers, nurse practitioners, a primary care physician, and a project manager.

## WELVIE LLC

Project Title: "Shared decision making for preference-sensitive surgery"

Geographic Reach: Ohio

Funding Amount: \$6,767,008

Estimated 3-Year Savings: \$20,349,081

Summary: Welvie, LLC, is teaming with Anthem Blue Cross and Blue Shield in Ohio is receiving an award for a program that will enable patients to make better-informed decisions about preference-sensitive surgery. A significant amount of elective surgery occurs because patients do not fully understand their treatment options, resulting in avoidable patient harm, patient dissatisfaction with care, and higher costs. Through decision-making support, health care information services, and peer counseling, Welvie's approach will enhance consumer experiences, increase surgery literacy, improve surgical outcomes, and reduce the incidence of inappropriate surgeries (notably those cases where known risks outweigh potential benefits). The program will serve traditional Medicare beneficiaries, as well as certain Medicare Advantage PPO enrollees in Ohio.

Over a three-year period, Welvie's program will train an estimated 11 workers and will create an estimated 14.82 jobs. The new workforce will include a project director, a medical director, nurse care managers, an implementation specialist, a technology specialist, a reporting analyst, an analytics and provider development team leader, a communication specialist, a training and peer counseling development team leader, a quality assurance and compliance specialist, a finance manager, and customer service representatives.