



## Health Care Innovation Awards Round One Project Profiles

The Center for Medicare and Medicaid Innovation announced the first batch of awardees for the Health Care Innovation Awards (Round One) on May 8, 2012 and the second (final) batch on June 15, 2012. This list includes both the first and second batch of awardees. Beginning July 1, 2012, these awardee organizations have implemented projects in communities across the nation that aim to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. These projects are funded for three years. Continued funding is contingent on satisfactory performance compared with operational performance measures and a decision that continued funding is in the best interest of the federal government. These profiles have been revised to reflect any updates to the projects as of December, 2013.

**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 Round One application process and are not CMS projections. 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.

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

## **ALLINA HEALTH SYSTEM**

**Project Title:** “Maximum Health at Minimal Cost: A Community- Based Medical Home Model for the Non-Elderly Disabled”

**Geographic Reach:** Minnesota

**Funding Amount:** \$1,767,667

**Estimated 3-Year Savings:** \$2 million

**Summary:** Allina Health System received an award to test a community-based medical home model to serve 300 adults with disabilities and complex health conditions, particularly complex neurological conditions, in the Minneapolis - St. Paul metropolitan area. The intervention will coordinate and improve access to primary and specialty care, increase adherence to care, and empower participants to better manage their own health. Over 25 Independent Living Skills Specialists, Peer Leaders, and other health professionals will be trained with enhanced skills to fulfill the medical home mission. This community-based and patient-centered approach is expected to reduce avoidable hospitalizations, lower cost, and improve the quality of care for this expensive and underserved group of people with an estimated savings of over \$2 million over the three-year award.

## **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, received 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 local community colleges, received an award to train Asian and Hispanic youth as non-clinical health workers for a Patient Navigation Center (PNC). Serving low-income Asian and Hispanic families in Santa Clara County, PNC will provide enabling services, including translation, appointment scheduling, referrals, 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 re-train 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 workforce manager.

## **ATLANTIC GENERAL HOSPITAL CORPORATION**

**Project Title:** “Expand Atlantic General Hospital’s infrastructure to create a patient-centered medical home”

**Geographic Reach:** Delaware, 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 working to improve care for Medicare beneficiaries through a patient centered medical home (PCMH) care model. Through a partnership with the Worcester County Health Department (WCHD), Atlantic General has implemented PCMH standards and principles in all seven of its primary care practices, increasing access for patients needing non-emergency episodic care to reduce hospital admission rates and emergency department visits for these Medicare beneficiaries. The original intent of the grant-funded project was to focus on patients with either a primary or admitting diagnosis of congestive heart failure, chronic obstructive pulmonary disease (COPD), or diabetes, who currently rely on high-cost ER visits and acute care admissions. However, the PCMH team has been able to expand the program to offer services to patients with additional diagnoses.

## **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:** \$6,352,888

**Summary:** Ben Archer Health Center in southern New Mexico has implemented 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 Health Center provides primary health, dental, and behavioral health care to rural Doña Ana County, a medically underserved and health professional shortage area. The Ben Archer Health Center's Health Care Innovation Award uses 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. Project staff provides diabetes and asthma management classes for patients and families. The project implements a culturally-appropriate, immunization methodology utilizing door-to-door outreach campaigns. The staff connects individuals with primary care homes to decrease the cost of complications caused by disease in the predominately Hispanic population.

## **BETH ISRAEL DEACONESS**

**Project Title:** “Preventing avoidable re-hospitalizations: Post-Acute Care Transition Program (PACT)”

**Geographic Reach:** Massachusetts

**Funding Amount:** \$4,937,191

**Estimated 3-Year Savings:** \$12.9 million

**Summary:** Beth Israel Deaconess Medical Center (BIDMC) of Boston, Massachusetts, received an award to improve care transitions and reduce hospital readmissions for Medicare beneficiaries and beneficiaries dually eligible for Medicare and Medicaid. By integrating care, improving patients’ transitions between locations of care, and focusing on a battery of evidence-based best practices, this model is expected to prevent complications and reduce preventable readmissions, resulting in better quality health care at lower cost in the urban Boston area with estimated savings of almost \$13 million over 3 years.

## **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, Optum Data Management, and the Emergency Health Information Technology group at Montefiore Medical Center, received 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, in partnership with SEIU United Long Term Care Workers, Shirley Ware Education Center, SEIU United Healthcare Workers, L.A. Care Health Plan, Contra Costa Health Plan in conjunction with Contra Costa Employment and Human Services Department, SynerMed, St. John’s Well Child and Family Center, Care 1st Health Plan, and the University of California, San Francisco Center for Health Professions, is piloting an intervention project to integrate In-Home Supportive Services (IHSS) providers into the health care system. The project, titled Care Team Integration of the Home-Based Workforce, serves beneficiaries of California’s Medicaid personal care services program (known as IHSS). All beneficiaries are disabled and 85 percent are Medicare-Medicaid enrollees. Our project recognizes the unique position of personal home care aides (PHCAs) with respect to some of the sickest and most costly Medicare and Medicaid enrollees. In most cases, PHCAs are an untapped resource into the health care system. The program focuses on developing the IHSS workforce by training IHSS providers (or PHCAs) in core competencies that will enable them to serve as agents of change and assume new roles with respect to caring for their IHSS consumer. These core competencies include being health monitors, coaches, communicators, navigators, and care aides. 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 program will train an estimated 6,000 IHSS providers.

## **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 received an award to expand its Total Care and Cost Improvement Program (TCCI), which includes its Patient-Centered Medical Home to approximately 25,000 Medicare beneficiaries in Maryland. 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 Program will enhance support for primary care, empowering primary care providers to coordinate care for Medicare beneficiaries with multiple morbidities 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. The TCCI Program will create an estimated 36 jobs. The new workforce will include local care coordinators, and program consultants.

## **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, West 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 select community pharmacies, received 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 and one urban hospitals and 20 primary care practices, trains pharmacists in transformative care and chronic disease management protocols. Through care coordination and shared access to electronic medical records, the project enables 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.

## **CENTER FOR HEALTH CARE SERVICES**

**Project Title:** “A recovery-oriented approach to integrated behavioral and physical health care for a high-risk population”

**Geographic Reach:** Texas

**Funding Amount:** \$4,557,969

**Estimated 3-Year Savings:** \$5 million

**Summary:** The Center for Health Care Services in San Antonio, Texas, received an award to integrate behavioral, mental, and primary health care for a group of approximately 260 homeless adults in San Antonio with severe mental illness or co-occurring mental illness and substance abuse disorders, at risk for chronic physical diseases. Their intervention will integrate health care into existing behavioral health clinics, using a multi-disciplinary care team to coordinate behavioral, primary, and tertiary health care for these people—most of them Medicaid beneficiaries or eligible for Medicaid—and is expected to improve their capacity to self-manage, reducing emergency room and hospital admissions, and lowering cost, while improving health and quality of life and with estimated savings of \$5 million over three years. Over the three-year period, the Center for Health Care Services’ program will hire and train an estimated 22 health care workers, to include two health navigators, ten community guest specialists, and six certified peers support specialists. The care team will provide peer support to generate readiness for change, build motivation, and sustain compliance.

## **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:** Children’s Hospital and Health System received an award to create Care Links, which will support members of Children’s Community Health Plan (CCHP), the system’s Medicaid HMO in Southeast Wisconsin, as they navigate the health care system. Care Links will allow community health navigators to educate and empower health plan members to navigate the health care system, connect with a primary care doctor and receive preventive care and appropriate screenings. Community health navigators will offer services to individuals and families who have had two ER visits within six months. A nurse navigator will work with health plan members diagnosed with asthma who have had one ER or one inpatient stay related to asthma. Both the community navigators and the nurse navigator will reinforce the availability of urgent care and CCHP’s 24/7 nurse advice line. The goal of Care Links is to reduce avoidable ER visits, improve health outcomes (specific HEDIS measures) and reduce cost. Over the three year period, Children’s Hospital and Health System will create nine jobs, including a program manager, community health navigators and nurse navigators.

## **CHRISTIANA CARE HEALTH SYSTEM**

**Project Title:** "Bridging the Divide"

**Geographic Reach:** Delaware, Maryland, New Jersey, Pennsylvania

**Funding Amount:** \$9,999,999

**Estimated 3-Year Savings:** \$376,327

**Summary:** Christiana Care Health System, serving the state of Delaware, received an award to create and test a system that uses a "care management hub" and combines information technology and carefully coordinated care management to improve care for post-myocardial infarction and revascularization patients, the majority of them Medicare or Medicaid beneficiaries. Christiana Care 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, Christiana Care Health System 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:** Arkansas, Texas

**Funding Amount:** \$1,600,322

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

**Summary:** CHRISTUS St. Michael Health System, in partnership with the Community Long-Term Care Facility Partnership Group and University of the Incarnate Word, received an award to implement the Integrated Nurse Training and Mobile Device Harm Reduction Program (INTM). 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 to certain preventable conditions. The project team developed an educational program that includes customized, clinical decision support mobile device training, and interactive didactic sessions. The training, in combination with computerized clinical decision support systems that guide nurses through evidence-based protocols once symptoms are detected and mobile devices loaded with clinical support system software, is anticipated to result in a 20% reduction in readmissions from long term care facilities for CHF and sepsis and fewer failure-to-rescue situations for those patients who are admitted to the hospital.

## **COOPER UNIVERSITY HOSPITAL**

**Project Title:** N/A

**Geographic Reach:** New Jersey

**Funding Amount:** \$2,788,457

**Estimated 3-Year Savings:** \$6.2 million

**Summary:** Cooper University Hospital in conjunction with the Camden Coalition of Healthcare Providers, serving Camden, New Jersey, received an award to better serve approximately 600 Camden residents with complex medical needs who have relied on emergency rooms and hospital admissions for care. The intervention will use nurse led interdisciplinary outreach teams to work with enrolled participants to reduce hospital readmissions and improve their access to primary health care. This approach is expected to result in better health care outcomes and lower cost with estimated savings of over \$6 million. Over the three-year period, Cooper University Hospital's program will train an estimated 22 health care workers, while creating an estimated 16 new jobs. These workers will include non-clinical staff, like AmeriCorps volunteers and community health workers, who will serve as part of the multidisciplinary teams to support care coordination activities.

## **DELTA DENTAL PLAN OF SOUTH DAKOTA**

**Project Title:** "Improving the care and oral health of American Indian mothers and young children and American Indian people with diabetes on South Dakota reservations"

**Geographic Reach:** North Dakota, South Dakota

**Funding Amount:** \$3,364,528

**Estimated 3-Year Savings:** \$6.2 million

**Summary:** Delta Dental of South Dakota, which covers over thirty-thousand isolated, low-income, and underserved Medicaid beneficiaries and other American Indians on reservations throughout South Dakota, received an award to improve oral health and health care for American Indian mothers, their young children, and American Indian people with diabetes. Providing preventive care will help avoid and arrest oral and dental diseases, repair damage, prevent recurrence, and ultimately, reduce the need for surgical care. The project will also work with diabetic program coordinators to identify and treat people with diabetes. By coordinating community-based oral care with other social and care provider services, the model is expected to reduce the high incidence of oral health problems in the area, improve patient access, monitoring, and overall health, and lower cost through prevention with estimated savings of over \$6 million. Over the three-year period, the Delta Dental of South Dakota Circle of Smiles program will train an estimated 24 health care workers and create an estimated 24 new jobs. These workers will be comprised of registered dental hygienists and community health representatives who will treat and educate patients and coordinate their dental care.

## **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:** The goal of the project is for Denver Health to transform its primary care delivery system to provide individualized care to more effectively meet its patients' medical, behavioral and social needs. This model provides team-based care, coordinates care across health settings and offers self-care support between visits enabled by health information technology (HIT) and team-based patient navigators who reach out to patients in a variety of ways. It also integrates physical and behavioral health services in collaboration with the Mental Health Center of Denver (MHCD) in existing primary care settings and in newly created high-risk clinics for the most complex patients. Over the three-year grant period, Denver Health’s 21st Century Care program will ensure increased access to care by 15,000 people, improve overall population health for Denver Health patients by 5 percent, improve patient satisfaction with care delivered between visits by 5 percent without decreasing satisfaction with visit-based care, and decrease total cost of care by 2.5 percent relative to trend.

## **DEVELOPMENTAL DISABILITIES HEALTH SERVICES**

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

**Geographic Reach:** Arkansas, New Jersey, New York

**Funding Amount:** \$3,701,528

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

**Summary:** Developmental Disabilities Health Services received 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. This health home model serves 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 the 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 are improving 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.

## **DUKE UNIVERSITY**

**Project Title:** “From clinic to community: achieving health equity in the southern United States”

**Geographic Reach:** Mississippi, North Carolina, West Virginia

**Funding Amount:** \$9,773,499

**Estimated 3-Year Savings:** \$20.8 million

**Summary:** Led by Duke University, the Southeastern Diabetes Initiative (SEDI) is a project that supports integrated teams implementing a model for improving health outcomes and quality of life for those suffering from type 2 diabetes mellitus (T2DM) in the Southeastern United States. The majority of funds are being used to (1) harvest data from all electronic sources in each county to create a comprehensive, integrated data warehouse to accurately reflect clinical and social data that can be represented at the individual, neighborhood, and community level, and (2) use that data to implement spatially-enabled informatics systems that risk stratify patients and neighborhoods, allowing implementation of an intense clinical intervention from a multi-disciplinary team that provides care to the highest risk patients as well as additional individual and neighborhood interventions to moderate risk patients and neighborhoods - providing real-time monitoring of individuals and populations with T2DM and serving as the basis for decision support and evaluation of interventions. A spatially-enabled analytical platform has been created via an electronic health record integrated data warehouse that covers the vast majority of Durham and Cabarrus County, North Carolina residents (representing urban and rural African Americans and Hispanics in North Carolina), Mingo County, West Virginia, and Quitman County, Mississippi (rural African Americans in the Mississippi Delta). Our collaborative team includes the Mississippi Institute for Public Health; Center for Rural Health at Joan C. Edwards School of Medicine, Marshall University; the Mingo County, West Virginia Diabetes Coalition and Williamson Health and Wellness Federally Qualified Health Center in Williamson, West Virginia; the Appalachian Regional Commission; the Durham County Department of Health in Durham, North Carolina; Duke University Medical Center; the Cabarrus Health Alliance in Kannapolis, North Carolina and Cabarrus Community Health Centers in Concord, North Carolina; and the National Center for Geospatial Medicine at the University of Michigan.

## **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 and BlueChoice Medicaid Managed Care Organizations, 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, and a project director.

## **EMORY UNIVERSITY (CENTER FOR CRITICAL CARE)**

**Project Title:** “Rapid Development and Deployment of Non-Physician Providers in Critical Care”

**Geographic Reach:** Georgia

**Funding Amount:** \$10,748,332

**Estimated 3-Year Savings:** \$18.4 million

**Summary:** Emory University, in partnership with Philips Company and several regional medical centers including Saint Joseph’s Health System, Northeast Georgia Medical Center, East Georgia Regional Medical Center and Southern Regional Medical Center, received an award to hire more than 40 critical care professionals, including 20 nurse practitioners (NP) and physician assistants (PA) who are training at Emory’s University Hospitals, Saint Joseph’s Hospital and Grady Memorial Hospital and deployed to underserved and rural hospitals in Georgia. Additional training in the use of tele-ICU services for supervision of those NP and PA providers as well as for support of nurses and allied health personnel will reach an additional 400 clinical, technical and administrative support professionals who form the local hospital critical care teams. This innovative strategy will serve over ten thousand Medicare and Medicaid beneficiaries and aim to mitigate problems associated with the lack of critical care doctors in the region, improve access to quality health care, and lower costs associated with inefficient care and a lack of transport services which could save approximately \$18.4 million over 3 years.

## **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 expanded its Prevention and Recovery in Early Psychosis (PREP) to two low-income, largely Latino counties in Central and Northern California, San Joaquin (Stockton) and Monterey (Salinas). 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. Family Service Agency of San Francisco has trained over 20 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:** Florida, Indiana, Michigan, 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 received 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 eight 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 Systems Agency (FLHSA) received an award to enhance primary care in the Finger Lakes region of New York State. Focusing on primary care practices with large panels of adult Medicare and Medicaid patients, selected participants will receive a fully-funded care manager, technical and financial assistance towards patient-centered medical home certification, and inclusion in an innovative payment model developed in collaboration with local payers. The primary goal of these supports is to reduce hospital admissions, hospital readmissions, and emergency department usage. Over a three year period, the FLHSA will select sixty-five primary care practices, fund and train over

seventy-five healthcare professionals, and establish reimbursement methods sustain these activities past the grant timeframe.

## **FINITY COMMUNICATIONS, INC.**

**Project Title:** “EveryBODY Get Healthy”

**Geographic Reach:** Pennsylvania

**Funding Amount:** \$4,967,962

**Estimated 3-Year Savings:** \$8.7 million

**Summary:** The Finity Communications, Inc. model is designed to improve health care for over 120,000 high-need Medicaid beneficiaries in the Greater Philadelphia area. The innovation uses health analytics technology to track risk criteria and update integrated health profiles, and to deploy targeted alerts, outreach, wellness, and support services in a closed-loop environment that evolves with successful behavioral change. The innovation includes providing Peer Mentors to support ongoing engagement and healthy behavioral change. This integrated approach to health care is expected to reduce the gaps in care and lead to improved health care, better health, and reduced costs for individuals with diabetes, heart disease, hypertension, asthma, and high-risk pregnancy.

## **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, received 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 who have the complication of peripheral neuropathy. FirstVitals will create a secured database that will receive data feeds from a combination of wireless glucose meters and tablets, which are expected to improve health education and social networking around diabetes management issues. The "real time" 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 foot ulcers and amputations and attendant complications, and reduce emergency room visits and hospitalizations. Over a three-year period, FirstVitals’ program will involve and educate dozens of healthcare workers, train an estimated 11 to 12 healthcare coordinators and will create an estimated 7 to 9 jobs. The new workforce will include integrated care coordinators both clinical and non-clinical, a clinical diabetes educator, and a medical director.

## **FOUNDATION FOR CALIFORNIA COMMUNITY COLLEGES**

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

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

**Funding Amount:** \$6,852,153

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

**Summary:** City College of San Francisco (CCSF), University of California at San Francisco, and Yale University are collaborating to address the health care needs of high risk/high cost Medicaid and Medicaid-eligible individuals with chronic conditions released from prison. Targeting eleven community health centers in seven states 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 healthcare 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, this innovation will create an estimated 22 jobs and train an estimated 49 workers. The new workforce will include 12 community health workers, 11 part-time panel managers, two part-time project coordinators, one research analyst and two part-time project staff.

## **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, received an award to implement Parachute NYC, a citywide approach to provide a “soft-landing” for individuals experiencing psychiatric crisis. This new program offers community centered options that focus on recovery, hope — and a healthy future. Parachute NYC uses mobile treatment teams, crisis respite centers, and a peer operated Support Line to provide early engagement (including a dedicated program for first episode psychosis), continuity of care and combined peer and non-peer 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. Parachute NYC serves communities in Manhattan, Brooklyn, Bronx, and Queens.

## **GEORGE WASHINGTON UNIVERSITY**

**Project Title:** "Using Telemedicine in peritoneal dialysis to improve patient adherence and outcomes while reducing overall costs"

**Geographic Reach:** District of Columbia, Maryland, Virginia

**Funding Amount:** \$1,939,127

**Estimated 3-Year Savings:** \$1.7 million

**Summary:** George Washington University received an award to improve care for 300 patients on peritoneal dialysis in Washington, D.C., and eventually in Virginia and Maryland. The intervention will use telemedicine to offer real-time, continuous, and interactive health monitoring to improve patient safety and treatment. The model will train a dialysis nurse workforce in prevention, care coordination, team-based care, telemedicine, and the use of remote patient data to guide treatment for co-morbid, complex patients. This approach is expected to improve patient access to care, adherence to treatment, self-management, and health outcomes, while reducing cost of care for peritoneal dialysis patients with complex health care needs by reducing overall hospitalization days with estimated savings of approximately \$1.7 million. Over the three-year period, George Washington University's program will train an estimated three health care workers and create an estimated three new jobs. These workers will provide clinical support and health monitoring via the web to home dialysis patients.

## **HEALTHLINKNOW, INC.**

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

**Geographic Reach:** California, Montana, Washington, Wyoming

**Funding Amount:** \$7,718,636

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

**Summary:** HealthLinkNow Inc, partnering with a number of local provider groups and health networks in Montana and Wyoming, is received 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 costs 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.

## HEALTH RESOURCES IN ACTION

**Project Title:** “New England asthma innovations collaborative”

**Geographic Reach:** Connecticut, Massachusetts, Rhode Island, Vermont

**Funding Amount:** \$4,040,657

**Estimated 3-Year Savings:** \$4.1 million

**Summary:** The “New England Asthma Innovation Collaborative” (NEAIC) is a multi-state, multi-sector partnership convened by the Asthma Regional Council of New England (ARC), a program of Health Resources in Action (HRIA), that includes health care providers, payers, and policy makers aimed at creating an innovative Asthma Marketplace in New England that will increase the supply and demand for high-quality, cost-effective health care services delivered to Medicaid children with severe asthma. Our goal is to create a sustainable infrastructure that robustly delivers evidence-based cost-effective asthma care to New England children with severe disease, and creates viable Medicaid reimbursement mechanisms to support these programs over the long-term. The targeted population is high-cost Medicaid and CHIP pediatric patients (2 – 17 years), with a focus on those with uncontrolled symptoms that have a history of using expensive urgent care. NEAIC includes following components:

1. Workforce development: NEAIC will: a) sponsor Asthma Training to increase the number of well qualified cost-effective providers, including certified asthma educators (AE-Cs) and community health workers (CHWs) with a specialty in asthma; and b) explore CHW asthma credentialing program that payers and provider practices across NE have requested and can benefit from. All of this will contribute to higher quality and culturally competent care, and we believe will help to support innovative Medicaid reimbursement as a result of demonstrated cost-effective outcomes.
2. Rapid service delivery expansion for over 1300 high-risk children with asthma in Connecticut, Rhode Island, Massachusetts, and Vermont. NEAIC employs the following components of care: 1) Asthma self-management education 2) Home environmental assessment with the provision of minor-to-moderate environmental intervention supplies to reduce asthma triggers; and 3) Use of non-physician providers shown to be cost-effective deliverers of this level of care, particularly community health workers (CHWs) and certified asthma educators (AE-Cs).
3. Committed Medicaid payers in several New England states will work to sustain these programs by piloting reimbursement methodologies with the service providers, should the service model results demonstrate the goals of delivering better health, improving care and lowering costs..
4. A Payer and Provider Learning Community across all six New England states to rapidly disseminate demonstrated improvements to the quality and cost of asthma care, share viable reimbursement systems developed, successfully incorporate CHWs into the asthma care team, and disseminate best practices. The Learning Community builds on ARC’s existing networks and partnerships across the region, and is meant to increase awareness about these successful models with the goal of broader adoption across New England.

NEAIC’s components build in continuous quality improvement measures through rigorous data collection/analysis, strong partnerships, and commitments from interested payers and policy makers.

The establishment and promotion of CHWs as strong health care delivery partners addressing environmental conditions as part and parcel of the disease management program, with reimbursement by payers, make this an innovative model for broad dissemination and potential for replication across the nation.

## **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 (HFHS) of Detroit, Michigan received an award for an innovative care model that encourages and supports patient mobility for patients at risk for hospital – acquired pressure ulcers (HAPUs) and ventilator-associated pneumonia (VAP) during acute inpatient hospitalizations. The interventions include mobility and skin assessments, repositioning, range of motion exercises, assistance with ambulation and mobility/skin related patient and family education. The goal is to reduce HAPUs and associated costs, VAP, improve patient satisfaction and decrease length of stay.

Over a three-year period, HFHS will create approximately 20 jobs for health care providers, including a project manager, rehab therapists, wound care certified nurses and patient mobility assistants.

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

**Project Title:** “Disruptive Innovation @ Intermountain Healthcare”

**Geographic Reach:** Idaho, Utah

**Funding Amount:** \$9,724,142

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

**Summary:** Intermountain Health Care, with 22 hospitals and 185 clinics in Utah and Southern Idaho, received 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 used to support population management interventions, and 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, Intermountain 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

**Funding Amount:** \$5,977,805

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

**Summary:** The goal of the Project is to further the goals of better care for individuals, better health for populations and reduced costs through improvements in care by reengineering the hospital-based radiology service delivery model at Vanguard Health Chicago ("VHC"), a four-hospital system in Chicago, Illinois, for which Imaging Advantage is the exclusive provider of radiology services system-wide. To achieve this goal, at VHC, Imaging Advantage will, among other steps:

- A. Develop and deploy a suite of proprietary "front-end" referring physician decision-support tools designed to reduce or eliminate duplicative and/or clinically unnecessary radiology exams and, in the process, reduce CMS' costs and patients' cumulative radiation dosage exposures;
- B. Implement a comprehensive total quality management ("TQM") program, including Imaging Advantage's proprietary RealTime QA® program, one of the only proactive quality assurance programs in the country. The RealTime QA® program applies double-blind reads to high-difficulty radiology exams before the patient is treated, forcing better patient-care outcomes and reducing risks (and costs) of patient readmission;
- C. Eliminate "wet" or preliminary reads practices in VHC's emergency departments, including reads by non-radiologists, in all instances where preliminary reads are not clinically advisable; and
- D. Produce material improvements in VHC's final-report turnaround time, widely regarded as the significant limiting factor in hospital efficiency and cost control.

## **INNOVATIVE ONCOLOGY BUSINESS SOLUTIONS, INC.**

**Project Title:** "Community oncology medical homes (COME HOME)"

**Geographic Reach:** Florida, Georgia, Maine, New Mexico, Ohio, Texas

**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 received 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 one of the following seven cancer types: breast, lung, colon, pancreas, thyroid, melanoma

and lymphoma. 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 extended clinic hours, patient education, team care, medication management, and 24/7 practice access and inpatient care coordination, the medical home model will improve the timeliness 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:** California, Colorado, Massachusetts, Michigan, Minnesota, Pennsylvania, Washington, Wisconsin

**Funding Amount:** \$17,999,635

**Estimated 3-Year Savings:** \$27,693,046

**Summary:** The Institute for Clinical Systems Improvement (ICSI) of Bloomington, Minnesota received 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 received 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 Johns 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

**Funding Amount:** \$19,920,338

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

**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 (BMS) - a Federally Qualified Health Center, and local skilled nursing facilities, received 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 adult admissions by the end of year 3. The intervention will also include a specific focus on high risk Medicare and Medicaid beneficiaries who receive primary care from Johns Hopkins clinics and a BMS clinic 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 more than 75 new health care workers, including nurse educators, nurse transition guides, case managers, community health workers, and health behavior specialists, and will retrain care coordinators, patient access line case managers, clinical pharmacy specialists, community health workers, and physicians already on staff.

## **JOSLIN DIABETES CENTER, INC.**

**Project Title:** "Pathways to better health through a new health care workforce and community"

**Geographic Reach:** District of Columbia, New Mexico, Pennsylvania

**Funding Amount:** \$4,967,276

**Estimated 3-Year Savings:** \$7.4 million

**Summary:** Joslin Diabetes Center, Inc., received an award to expand a successful program for diabetes education, field testing, and risk assessment. Their “On the Road” program will send trained community health workers into community settings to help approximately 5100 unique participants (most of whom are Medicare/Medicaid beneficiaries and /or low income/uninsured) understand their risks and improve health habits for the prevention and management of diabetes. The program will target at risk and underserved populations in New Mexico, Pennsylvania, and Washington, D.C., helping to prevent the development and progression of diabetes and reducing overall costs, avoidable hospitalizations, and the development of chronic co-morbidities with estimated savings of approximately \$7.4 million. Over the three-year period, Joslin Diabetes Center’s program will train an estimated 27 workers, while creating an estimated 9 new jobs. These workers will include community health advocates and health education instructors who will educate patients in managing diabetes and pre-diabetes with the goal of re-engaging them into the healthcare system.

## **KITSAP MENTAL HEALTH SERVICES**

**Project Title:** “Race to health: coordination, integration, and innovations in care”

**Geographic Reach:** Washington

**Funding Amount:** \$1,858,437

**Estimated 3-Year Savings:** \$5.8 million

**Summary:** Kitsap Mental Health Services of Kitsap County, Washington received an award to coordinate and integrate care for one thousand severely mentally ill adults and 100 severely emotionally disturbed children with at least one co-morbidity almost all of them Medicaid, Medicare, and/or CHIP beneficiaries. Research shows health care for the severely mentally ill/severely emotionally disturbed population is often fragmented, ineffective, and inefficient, resulting in poor health and premature death. Through multi-disciplinary care coordination teams providing integrated behavioral health (mental health and co-occurring substance use disorder) management, tighter care coordination with primary care, and a bi-directional model supporting community-based primary care providers with psychiatric consultation, training, and brief interventions, the project is expected to improve beneficiary health and reduce avoidable emergency room visits and hospitalizations with an estimated savings of approximately \$1.7 million. Over the three-year period, KMHS will train an estimated 130 health care workers, generate an estimated 11.5 new jobs, and create a transformed health care workforce cross-trained in behavioral and physical health disciplines.

## **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

**Funding Amount:** \$2,896,416

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

**Summary:** Le Bonheur Children's Hospital, Division of Community Health and Well Being and the University of Tennessee Health Science Center are collaborating to serve children with high-risk asthma in Memphis/Shelby County, Tennessee. CHAMP features an asthma registry, a repository of critical information on all CHAMP patients that will be accessed by a variety of providers caring for the patients. Additionally, the registry is a means to document all CHAMP activities, track all elements of the CHAMP monitoring plan, and produce reports for use in the PDSA process. Patients receive medical care and assessment by CHAMP physician sub-specialists. The Community Coordination team, comprised of two Asthma Care Coordinators and 4 Community Health Workers who are supervised by a Licensed Clinical Social Worker, provides asthma education; environmental assessment; coordination with schools and child care; and provides help with barriers to asthma management. The final component is the collaboration with the primary care physicians, school health, and other community partners. The self-monitoring aspects of CHAMP are managed by a program evaluator and a data analyst. CHAMP aims to reduce emergency room visits, avoidable hospitalizations, school absence due to asthma, and child deaths due to asthma. Additionally CHAMP seeks to improve school attendance, improve quality of life, and improve the experience of health care, all at a lower cost of care.

## **LIFELONG MEDICAL CARE**

**Project Title:** "Health Care Innovation Challenge: LifeLong complex care initiative to achieve the Triple Aim"

**Geographic Reach:** California

**Funding Amount:** \$1,109,231

**Estimated 3-Year Savings:** \$1.1 million

**Summary:** The LifeLong Complex Care Initiative merges the strengths of a community health center, LifeLong Medical Care, and an independent living center, Center for Independent Living, to provide coordinated, interdisciplinary team care for adults with disabilities who are at high-risk of poor health outcomes and avoidable utilization of high-cost emergency room and inpatient care. The project targets the 20% highest risk patients among a population of 3250 seniors and other adults with disabilities who are Medicaid and dual Medicare/Medicaid beneficiaries living in Alameda County, California and are members of the Alameda Alliance for Health. By the end of the three-year demonstration, the collaboration seeks to improve health outcomes and utilization patterns such that consumers are healthier, more satisfied with their care, and less likely to utilize high-cost services, with a goal of

approximately \$1 million in cost savings. The intervention trains adults with disabilities as peer coaches, to support consumers to identify and work towards self-directed health goals, such as healthy lifestyle modifications, disease self-management, and increased independence. The peer coaches are partnered with RN care managers, who facilitate integrated care and provide practical services including health education, medication reconciliation, and self-management support.

## **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:** Maimonides Medical Center of Brooklyn, New York, is pioneering improvements in care for adults with serious mental illness who live in southwest Brooklyn. In partnership with a broad array of medical, mental health, and social service organizations, insurers, and a labor union, Maimonides is: 1) providing enrolled patients with a core multi-disciplinary care team; 2) enabling medical and mental health providers to communicate with each other and monitor patients through advanced health information technology tools; 3) training a workforce of care managers and care navigators; 4) implementing uniform care standards; and 5) enhancing coordination of care through use of a web-based, electronic care plan. Maimonides expects this approach to reduce psychiatric and medical hospital admissions and reduce the total cost of care for the population, while creating approximately 50 new jobs, focused primarily in care management roles. At the same time, Maimonides is working to transition the reimbursement model for this population from “fee for service” to an integrated “total cost of care” through new, innovative financial arrangements with payers that build sustainability of the program beyond the three-year period of the Innovation Award.

## **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. received an award to implement and test an integrated clinical network to improve care for high-utilizing chronically ill Medicaid recipients in the D.C. area, including those who rely on emergency room visits for primary health care. The project will use care teams and telemedicine 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 hire and train 42 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, Oklahoma

**Funding Amount:** \$16,035,264

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

**Summary:** The Mayo Clinic received an award to improve critical care performance for Medicare and Medicaid beneficiaries in intensive care units (ICUs). The goal of this project is to develop and test a novel acute care interface with built-in-tools for error prevention, practice surveillance, decision support and reporting (ProCCESs AWARE - Patient Centered Cloud-based Electronic System: Ambient Warning and Response Evaluation). In preliminary studies, these novel informatics support builds on advanced understanding of cognitive and organizational ergonomics, have significantly decreased cognitive load of bedside providers and reduced medical errors. Using a cloud-based technology, AWARE will be uniformly available on either mobile or fixed computing devices and applied in a standardized manner in medical and surgical ICUs of geographically diverse acute care hospitals predominantly serving Medicare and Medicaid patients. The impact of ProCCESs AWARE on processes of care and outcomes in study ICUs will be evaluated using standardized step-wedge cluster randomized study design expected to enroll more than 10,000 critically ill patients during the three year study period. 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:** California, Idaho, Texas, Washington

**Funding Amount:** \$9,332,545

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

**Summary:** MedExpert International received 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 access to world-expert physician advice, educational materials, and assistance with interpreting benefits and treatment options using Medical Information Coordinators and staff Physicians. QMMS will be available in selected geographic markets across the country to serve approximately 180,000 Medicare 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 38 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:** Nebraska, Wyoming

**Funding Amount:** \$14,246,153

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

**Summary:** The Wyoming Institute of Population Health, a Division of the Memorial Hospital of Laramie County (d/b/a Cheyenne Regional Medical Center), has assembled five strategic partners to deploy population health strategies in communities across Wyoming, creating medical neighborhoods to transform rural care delivery. Focus is placed on patients, wellness, and evidence-based chronic care delivery. 28 transforming PCMHs function as the core of the medical neighborhoods facilitating care coordination, developing inter-professional care teams, developing individualized care plans for complex patients, and maintaining connections with community-based services for referral and follow-up. Pharmacists, linked virtually by telehealth to the PCMHs, assist in medication therapy management and patient education. Patients hospitalized for serious illness or injury have a particular need for continuity between sites of care and transitions are facilitated by registered nurses specially trained in rural care transitions. Wyoming’s innovative Medication Donation Program has been expanded statewide to link the un/under-insured to prescription assistance. Telemedicine is utilized to facilitate physician desktop solutions, improving access to specialists, enhancing coordination between sites of care, and supporting clinical decision making. Payers/Purchasers, including the state Medicaid program, are partnering to play key roles in providing incentives for care coordination and sustainability. Over 30 jobs have been created through this effort. For more information, visit [www.cheyenneregional.org/hcia-app](http://www.cheyenneregional.org/hcia-app).

## **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, received 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. 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 3,000 bedside nurses in sepsis screening and early recognition of the often subtle signs and symptoms of early sepsis. Additionally, an estimated 200 second level responders 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:** Houston Methodist and Houston Methodist Research Institute, in partnership with the Baylor College of Medicine and Grand Aides Foundation, received an award to improve care for Medicare & Medicaid beneficiaries at risk for delirium and associated complications in the Houston metropolitan area. Delirium increases risk of falls, unnecessary hospitalizations, long-term cognitive impairment, and death. Through education, recognition, and prevention efforts 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 12 employees and subcontractors will hire an additional 15, including advanced-practice nurse practitioners, nurse educators, volunteer supervisors, and pharmacists. The project team will train more than 1,000 practitioners across five Houston Methodist hospitals, offering patients at risk for delirium targeted interventions including home health visits, nurse navigator follow up phone calls, volunteer visits for inpatients, and medication monitoring.

## **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 (MPHI), in partnership with the Michigan Department of Community Health (MDCH) and local community agencies, implements the Michigan Pathways to Better Health (MPBH) initiative. MPBH supports the CMS goals of better health, better care, and lower cost by assisting beneficiaries to address social service needs and link them to preventive health care services.

MPBH is based on the Pathways Community HUB Model developed by Drs. Sarah and Mark Redding of the Community Health Access Project (CHAP). Community Health Workers (CHWs) are trained and deployed to assist Medicaid and/or Medicare adult beneficiaries with two or more chronic conditions with health and social service needs (such as primary care, housing, food, and transportation). In other states, the model has improved health outcomes and lowered healthcare costs.

Three high-need counties (and selected adjacent counties) are served: Ingham, Muskegon and Saginaw. In each county, a number of organizations work together to implement the model. The Lead Agency is the fiduciary, managing contracts and finances, and providing project oversight. Referrals to the program are made by healthcare providers, social service agencies, CHWs, and other community agencies. The Pathways Community HUB conducts outreach, accepts referrals, determines client eligibility, enrolls clients and assigns clients to a Care Coordination Agency (CCA). The HUB also manages the IT function, provides quality monitoring and improvement, and reports on outcomes to the CCAs and the community. CCAs deploy and manage the CHW workforce, receiving assignments from the HUB. Partners work together to identify, recruit, and train CHWs who live in the community. Before serving clients, CHWs receive training based on a curriculum developed by Dr. Sarah Redding. As CHWs work in the field, they are mentored by experienced CHWs and supervised by a registered nurse and/or social worker. CHWs do not provide direct healthcare or human services, but link clients to these services.

Over three years, MPBH will employ 75 CHWs and serve over 13,000 clients. The project will demonstrate the role of CHWs and Pathways Community HUBs in improving health outcomes and chronic disease management, while lowering healthcare costs by an estimated \$17,498,641.

## **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, Appalachian Osteopathic Postgraduate Training Institute Consortium (A-OPTIC), and iVantage Health Analytics, received 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 and critical access hospitals. By the third year

of the project, there will be a total of 25 critical access included in the network, serving over 52,000 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, technology 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 35 health care workers, including a program director, associate director, chief financial officer, chief clinical officer, LEAN/community collaborative specialist, workforce development officer, team coordinator, and a human resources director as well as a staff of health improvement specialists, technology specialists, health analysts, and administrative support workers.

## **MOUNTAIN AREA HEALTH EDUCATION CENTER**

**Project Title:** "Regional integrated multi-disciplinary approach to prevent and treat chronic pain in North Carolina"

**Geographic Reach:** North Carolina

**Funding Amount:** \$1,186,045

**Estimated 3-Year Savings:** \$2.4 million

**Summary:** Mountain Area Health Education Center (MAHEC), serving 16 counties in western North Carolina, received an award to test team-based enhanced primary care for chronic pain patients. The project aims to improve patient outcomes and quality of care, increase community involvement and evidence-based clinical care training for providers, and reduce unintentional drug overdose rates. The test's target population consists of over 2,000 patients. Clinical services commenced at MAHEC Family Health Center in January 2013, and an additional three sites will launch after July 2013. The intervention creates multidisciplinary teams to provide enhanced primary care, using mid-level and behavioral health providers to co-manage care with physicians. To support the three year goal of adding 7.5 regional healthcare positions, sites receive funding, specialty training and onsite consultation. To reduce prescription drug overdose rates, community coalition leaders in all sixteen counties have been selected. The project's anticipated achievements are improved patient health and pain control, decreased outpatient visits, reduced unintentional drug overdose, and additional cost reductions of approximately \$2.4 million.

## **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 Jersey, New York

**Funding Amount:** \$12,728,753

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

**Summary:** The Icahn School of Medicine at Mount Sinai received an award to implement a new model of geriatric emergency care in three large, urban hospitals: The Mount Sinai Medical Center in New York City, St. Joseph's Regional Medical Center in Paterson, NJ, and Northwestern Memorial Hospital in Chicago, IL. Geriatric Emergency Department Innovations in care through Workforce, Informatics and Structural Enhancements (GEDI WISE) is a multidisciplinary collaboration that has embraced a new care paradigm, the geriatric emergency department, which has transformed both the physical environment and processes of care in these three emergency departments (ED). GEDI WISE uses evidence-based geriatric clinical protocols, informatics support for patient monitoring and clinical decision-making, 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, GEDI WISE will train more than 400 current health care workers and create 22 new jobs including nurses, nurse practitioners, pharmacists, physical therapists, project coordinators, 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

**Funding Amount:** \$11,885,134

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

**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 serving prediabetic Medicare beneficiaries in 17 communities across 8 states in the U.S. The intervention delivers community-based diabetes prevention through a nationally-recognized diabetes prevention lifestyle change program, coordinated and taught by trained YMCA Lifestyle Coaches. The goal is to prevent the progression of prediabetes 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, a grant administrator, a workforce development manager, data specialists, training specialists, and administrative coordinator.

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

**Project Title:** "Community health workers and HCH: a partnership to promote primary care"

**Geographic Reach:** California, Illinois, Massachusetts, Nebraska, New Hampshire, North Carolina, Ohio, Texas

**Funding Amount:** \$2,681,877

**Estimated 3-Year Savings:** \$1.5 million

**Summary:** The National Health Care for the Homeless Council is working with twelve communities across various regions in the U.S. to reduce the number of emergency department visits and lack of primary care services for over 500 homeless individuals. The intervention integrates community health workers into Federally Qualified Health Centers to conduct outreach and case coordination for transitioning this population from the emergency department to a health center, thus reducing unnecessary emergency department visits and improving quality of care for this population. Over the three-year period, National Health Care for the Homeless Council's program will train an estimated 101 health care workers, while creating an estimated 17 new jobs and saving approximately \$1.0 million.

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

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

**Geographic Reach:** Delaware

**Funding Amount:** \$3,697,300

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

**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, and United Way of Delaware, received an award to enhance family-centered medical homes by adding services for children with asthma and developing a population health initiative in the neighborhoods surrounding targeted primary care practices. The intervention also increases 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. This goal will be accomplished by focusing on three distinct strategies: 1. Enhancement of the family-centered medical home by adding new services for children with asthma and developing a well-coordinated interdisciplinary approach to managing asthma care; 2. Development of a sustainable network of evidence-based supports and services surrounding each of the three targeted primary care sites, using the "integrator" model that Nemours has already adopted; and 3. Deployment of a "navigator" workforce that incorporates non-

medical needs into the provision of care for children with asthma that promotes respiratory health and addresses environmental asthma triggers throughout the target communities.

## **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:** Community Care of North Carolina (CCNC) began a three year program in August 2012 called the Child Health Accountable Care Collaborative (CHACC) to improve the quality and cost-effectiveness of care associated with children who have complex, chronic illnesses. CCNC comprises fourteen local networks dispersed throughout the state of North Carolina. A fundamental component of this program is the use of an embedded Specialty Care Manager (SCM) whose primary role is to coordinate care between the pediatric subspecialist and the primary care physician (PCP). These SCMs are embedded in all five Academic Medical Centers (Carolinas Medical Center, Duke University, Vidant Medical Center, University of North Carolina, and Wake Forest Baptist Medical Center) as well as seven tertiary Medical Centers (Cape Fear Valley Medical Center, CMC Northeast, Mission Hospital, Moses Cone, New Hanover Regional Medical Center, Presbyterian Medical Center and Wake Med). The first SCMs began seeing patients in January 2013 after orientation and initial training. Patient Coordinators are also embedded, in collaboration with the SCMs, in medical centers with high volumes of children to assist the SCMs. A Patient Treatment Plan (PTP) was introduced to facilitate collaboration between pediatric subspecialists and PCPs. This PTP is updated by the SCMs during subspecialist visits or any hospitalization to ensure the PCP has the most current information needed to manage the child in a medical home environment. The CHACC Gastroenterology workgroup has also developed Co-Management Guidelines for Pediatric Constipation and GERD, which have been widely disseminated to the PCP group as well as residency programs throughout the state.

## **NORTHEASTERN UNIVERSITY**

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

**Geographic Reach:** Massachusetts, North Carolina, Washington

**Funding Amount:** \$8,000,002

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

**Summary:** The Healthcare Systems Engineering Institute at Northeastern University received an award to conduct a National Demonstration Project of the value that the systems engineering methods used in other complex industries can also be used to reduce healthcare costs, improve quality and safety,

reduce waits and delays, and improve clinical outcomes and overall population health. Under this award, Northeastern will create a model regional healthcare systems engineering extension center that partners with several local healthcare systems, applies systems engineering methods to targeted common problems to significantly impact the goals of better outcomes, better health, and at lower costs, and develops an implementation plan for national spread. This award funds the first phase of a larger scale 10-year project to establish a national network of similar healthcare systems engineering regional extension centers across the U.S. that develop and embed regional industrial and systems engineering improvement science academic departments and other resources into their local healthcare systems, saving billions annually while training a targeted future workforce of 15,000 healthcare systems engineers.

## **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 received an award to implement a modified version of the Program of All-Inclusive Care for the Elderly (PACE) model in rural North Dakota. The Alliance will hire and train Community Care Coordinators in seven rural communities who will use a team approach to coordinate the care for the program participants. It will use existing long-term care or assisted living programs and sites to provide coordinated services to the frail elderly. The Northland Care Coordination for Seniors program was developed to keep seniors in the community to live in their home healthier, safer and more independently. The program provides participants, their families, caregivers, and professional health care providers more flexibility to meet health care needs, improve care and the quality of life for those enrolled. The goal of this model is to reduce avoidable admissions to nursing facilities and decrease hospital stays leading to lower health care costs per person while improving the health and health care for the participants. Over a three-year period, Northland Healthcare Alliance’s program will create an estimated eight jobs that include Community Care Coordinators, Data Analyst and Administrative staff for the Northland Care Coordination for Seniors program.

## **OCHSNER CLINIC FOUNDATION**

**Project Title:** “Comprehensive stroke care model through the continuum of care”

**Geographic Reach:** Louisiana

**Funding Amount:** \$3,867,944

**Estimated 3-Year Savings:** \$4.9 million

**Summary:** Ochsner Clinic Foundation received an Innovation Award to provide improved care to almost 1,000 acute care stroke patients in Jefferson and St. Tammany Parishes in Louisiana. This project will employ model stroke management techniques and quality assurance that is facilitated by telemedicine technology. In addition to utilizing telemedicine for acute stroke management, an in-hospital team of trained Advanced Practice Nurses called "Stroke Central" will enable care providers to monitor patients, evaluate outcomes, and check on medication and treatment adherence on a real time basis. Post hospital care will be facilitated in the home by a trained Nurse and Lay Health Educator Team called "Stroke Mobile" and will focus on recovery and risk factor management to prevent stroke recurrence. Facilitated by telemedicine, these processes will allow care providers to provide real-time and proactive monitoring of their patients, improve acute stroke management, improve patients' and caregivers' quality of life, lower costs by reducing complications from urinary tract infections and pneumonia, prevent readmissions, and replace outpatient visits. These novel processes will save an estimated \$5 million over the life of the grant. Over the three-year period, Ochsner Clinic Foundation's program will train multidisciplinary providers and will create an estimated 12 new jobs. These workers will provide teleconsultation, assessment, and monitoring support for stroke care.

## **PACIFIC BUSINESS GROUP ON HEALTH**

**Project Title:** "Intensive outpatient care program"

**Geographic Reach:** Arizona, California, Washington

**Funding Amount:** \$19,139,861

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

**Summary:** The Pacific Business Group on Health received its award to partner with provider groups in Arizona, California and Washington for the Intensive Outpatient Care Program (IOCP). Care managers embedded in primary care practices provide psychosocial and medical support for 27,000 predicted high-risk patients with chronic illness. The program aims to improve patient experience and clinical outcomes, reduce avoidable emergency room visits and hospitalizations, and spread best practices across a wide network of partners and, ultimately, other providers. Over a three-year period, Pacific Business Group on Health's program will train over 410 people to spread best practices across a wide network, while creating an estimated 211 jobs for Care Coordinators and project 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 received an award to provide health care services to the frail elderly in times of crisis. The name of their program is “DASH,” Doctors Assisting Seniors at Home. 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 physicians, first responders, a project manager, enrollment specialists, and an administrative assistant/communication specialist.

## **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, AK and Craig, AK continues to use Health Care Innovation Awards funding to improve primary care coordination for patients with chronic disease in rural southeast Alaska. One nurse practitioner and four care coordinators are extending the clinical team’s reach and have coordinated care for an estimated 600 patients through more than 1000 face-to-face visits and phone calls. Preventive intervention with patients through follow-up phone calls after discharge from hospital have resulted in increased access to the clinic and decreased referrals to the emergency room due to lack of appointment slots. Additional staff, working in various capacities, works to ensure patients are being tracked properly and clinical staff are properly trained to understand medical records and reports. The project’s RN clinical educator works with office staff to increase competencies and is developing a formal educational track for medical office assistants with the University of Alaska in Ketchikan. The funding permits PeaceHealth to employ eight employees, train an estimated 28 existing employees, and increase access to its clinic by 20%.

## **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 received an award to better integrate community pharmacists into clinical care teams. This project, expanding the successful Wisconsin Pharmacy Quality Collaborative (WPQC), will transform the pharmacist's role from drug dispenser to drug therapy coordinator and manager. Participating pharmacists will work collaboratively with members of the health care team to focus MTM services on patients with diabetes, 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 will support community pharmacists across the state to successfully deliver the outcomes of the WPQC program.

## **PITTSBURGH REGIONAL HEALTH INITIATIVE**

**Project Title:** Creating a Virtual Accountable Care Network for Complex Medicare Patients

**Geographic Reach:** Pennsylvania, West Virginia

**Funding Amount:** \$10,419,511

**Estimated 3-Year Savings:** \$74.1 million

**Summary:** Pittsburgh Regional Health Initiative received an award for a plan to create specialized support centers, staffed by nurse care managers and pharmacists, to help small primary care practices offer more integrated care within the service areas of seven regional hospitals in Western Pennsylvania. The project will focus not only on approximately 19,000 Medicare beneficiaries with COPD, CHF, and CAD, but also the general primary care population of this area. The resulting teams will provide support for care transitions, intensive chronic disease management, medication adherence, and other problems associated with a lack of communication in health care systems at large and the resulting fragmentation of health care for patients. This approach is expected to reduce 30-day readmissions and avoidable disease-specific admissions with estimated savings of approximately \$41 million. Over the three-year period, Pittsburgh Regional Health Initiative's program will train an estimated 450 health care workers and create an estimated 26 new jobs. These workers will combine core competencies in the management of specific diseases with primary care support skills, and will be trained in evidence-based pathways of care.

## **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 of Benton County, serving a large, rural area in Washington State, received an award for a program through which physicians can send a community paramedic (CP) to visit patients of concern. The CPs provide reinforcement of discharge instructions, disease process education, post-abdominal surgery follow-up, medication clarification and social service referrals. 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 are increasing access to primary and preventive care, providing wellness interventions, decreasing emergency room utilization, and improving outcomes. Over a three-year period, Prosser Public Hospital District's program will train an estimated 10 community paramedic workers.

## **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, on behalf of Health Share of Oregon, received an award to launch the delivery system transformation of Oregon’s largest Medicaid Coordinated Care Organization (CCO). As a CCO, Health Share is integrating care delivery for Medicaid beneficiaries through an unprecedented level of cooperation among traditional competitors. Known as the Health Commons Project, this work aims to create an integrated patient-centered system to improve care coordination, care quality, and health outcomes among high-cost, high-acuity Medicaid patients while reducing overall health care costs. Through the implementation or expansion of five complementary care model interventions, including the hiring of new community outreach workers and patient guides and the development of a member registry, care will be coordinated more efficiently and effectively across multiple organizations. Additionally, enhanced systems for learning, collaboration, and workforce development are being created. The goal is to develop a sustainable system of care delivery across our community, which will reduce emergency department visits and avoidable hospital readmissions and improve the health of the population. Over a three-year period, this project will create an estimated 67 jobs.

## **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 the Visitors of the University of Virginia received an award to improve care for patients with advanced cancer. The program emphasizes patient reported outcomes as a key source of patient data for longitudinally tracking patient status and outcomes. This shared data system will be used for multi-disciplinary care coordination to improve quality of care, increase survival, and reduce costs mainly through prevention of emergency room visits and hospitalizations. The patient reported outcomes database will be directly integrated into the EPIC Electronic Medical Record and will alert the health care team of critical changes in patient status to allow for rapid interventions. The care model includes a weekly multi-disciplinary Supportive Care Team meeting to address management of the most critical patients requiring rapid coordination of multi-disciplinary care plans for optimal patient care. The program includes a redesign of radiation therapy workflow to allow for a rapid single-day treatment for cancer that has spread to bone with the goal of the entire process being completed in 1-2 hours and providing rapid pain relief and less treatment related toxicity than standard palliative treatments due to the targeting of the radiation. Over a three-year period, Rector and Visitors’ program will train an estimated 65 workers and create three new jobs to support this project.

## **REGENTS OF THE UNIVERSITY OF CALIFORNIA, LOS ANGELES**

**Project Title:** “UCLA Alzheimer’s and dementia care: comprehensive, coordinated, patient-centered”

**Geographic Reach:** California

**Funding Amount:** \$3,208,540

**Estimated 3-Year Savings:** \$6.9 million

**Summary:** The UCLA Alzheimer’s and Dementia Care is a coordinated, comprehensive, patient and family-centered program with the aims of achieving better health, better care and lower cost of care for patients with dementia. The program has five key components: 1. patient recruitment and a dementia registry; 2. structured needs assessments of patients and their caregivers; 3. creation and implementation of individualized dementia care plans; 4. monitoring and revising care plans as needed; and 5. providing access 24/7, 365 days a year for assistance and advice. The program’s geographic focus is the Western area of Los Angeles County where we have established partnerships with five community-based organizations (CBOs) that serve dementia patients. Three geriatric nurse practitioners have been hired as Dementia Care Managers who perform patient needs assessments and monitoring, formulating and revising care plans with input from the program’s medical director and in partnership with the referring physician.

## REGIONAL EMERGENCY MEDICAL SERVICES

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

**Geographic Reach:** Nevada

**Funding Amount:** \$9,872,988

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

**Summary:** The Regional Emergency Medical Services Authority's (REMSA) Community Health Programs (CHP) are creating new care and referral pathways which ensure patients who have entered the 9-1-1 emergency medical services system with urgent low acuity medical conditions receive the safest, and most appropriate, levels of quality care. In addition, post-discharge patients with conditions such as congestive heart failure will receive in-home follow-up care. The *Nurse Health Line* provides 24/7 assessment, clinical education, triage and referral to health care and community services via a non-emergency nurse health line available to all Washoe County residents regardless of insurance status. *Community Health Paramedics* are specially trained to perform in-home delegated tasks to improve the transition of care from hospital to home, perform point of care lab tests and improve care plan adherence. The *Ambulance Transport Alternatives* program provides alternative pathways of care for 9-1-1 patients, including transport of patients with low acuity medical conditions to urgent care centers and clinics, transport of inebriated patients directly to the detoxification center, and transport of psychiatric patients directly to the mental health hospital. In cooperation with the community's health care partners, these programs will safely improve patient-centered care, reduce ambulance transports, reduce emergency department visits, reduce hospital readmissions, improve patient satisfaction and reduce overall health care costs. The Regional Emergency Medical Services Authority (REMSA) of Reno, Nevada, is a non-profit provider of emergency and non-emergency paramedic ambulance services.

## THE RESEARCH INSTITUTE AT NATIONWIDE CHILDREN'S HOSPITAL

**Project Title:** "Partners for Kids Expansion"

**Geographic Reach:** Ohio

**Funding Amount:** \$13,160,092

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

**Summary:** The Research Institute at Nationwide Children's Hospital, in partnership with Akron Children's Hospital and its integrated physician group, received 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, received 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 integrated 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 managing chronic illness, including filling prescriptions and coordinating appropriate specialty care, in addition to addressing social service needs such as identifying stable housing, applying for health coverage or disability benefits and facilitating transportation arrangements. 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’s program will create an estimated 43 jobs across multiple health care professions.

## **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:** Home Outreach Program & E-health (H.O.P.E.), supported by St. Francis Healthcare Foundation of Hawaii, received a Health Care Innovation Award from the Center of Medicaid and Medicare Services in June 2012. This initiative addresses healthcare costs associated with both hospitalizations and <30-day readmissions, with the goal of improving patient outcomes and reducing healthcare spending. The program consists of two high-risk groups: outpatients with complex health care needs identified by an algorithm and patients discharged from hospitals with the diagnosis of congestive heart failure, pneumonia, or acute myocardial infarction. In the first group, Prevention of 1-Year Hospitalization, the emphasis will be on changing behavior, using home telehealth equipment with nurse clinician oversight as a reinforcing tool for patients to experience the impact of improved adherence with medications and other treatments. In the second group, Prevent <30-Day Readmission, the focus will be on the transition to home of potentially unstable patients with the emphasis on the daily clinical measurements outlined in their physician’s plan of care and supported by nurse clinician

oversight. Data will be collected regularly to evaluate patient outcomes, patient and workforce satisfaction, and cost effectiveness of the program. 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.

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

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

**Geographic Reach:** Idaho, Oregon

**Funding Amount:** \$11,762,777

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

**Summary:** St. Luke's Regional Medical Center received 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 estimated 110 workers, while creating an estimated 24.5 jobs for clinical and support specialists.

## **SANFORD HEALTH**

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

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

**Funding Amount:** \$12,142,606

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

**Summary:** Sanford Health received an award to develop an innovative and sustainable primary care delivery model for patients with chronic disease through workforce development, enhanced technology and the integration of behavioral health. Primary care clinics in South Dakota, North Dakota and Minnesota will be equipped to provide proactive outcomes-based care for patients with chronic disease and help patients manage their own healing and healthy behaviors. This new model of care will result in improved outcomes, better patient experience and reduced patient costs. Over a three-year period, Sanford Health's program will train an estimated 425 health care providers in enhanced clinical and patient engagement skills.

## **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

**Funding Amount:** \$2,884,719

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

**Summary:** The South Carolina Research Foundation received an award to test a care coordination model for recipients of home care that are nursing home level of care in South Carolina. The project uses a person-centered coaching approach by a Home Care Consultant (nurse) to engage the participant as a team member in their health care decision making. Through a team approach consisting of their personal care aide who receives a 12 module chronic disease management curriculum and care coordination on a long term basis, this approach will encourage the proper care at the proper time, care continuity, medication adherence, disease management, reduce avoidable hospitalizations, and emergency room visits and increase the length of time to transition to a nursing home.

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.

## **SOUTH COUNTY COMMUNITY HEALTH CENTER**

**Project Title:** "Ravenswood Family Health Care Innovation Project"

**Geographic Reach:** California

**Funding Amount:** \$7,302,463

**Estimated 3-Year Savings:** \$6.2 million

**Summary:** South County Community Health Center, Inc. dba: Ravenswood Family Health Center (RFHC) in partnership with Health Plan of San Mateo, San Mateo County Behavioral Health and Recovery Services, Nuestra Casa and Voices of Recovery, is receiving an award to create a health care home for over 19,000 patient visits or 6,400 patients per year over three years living in our southeast San Mateo County, California service area. The majority of patients have diabetes, asthma, serious mental illness and other chronic conditions. The project will train paraprofessional Health Coach/Panel Managers that will, in a responsive and culturally appropriate manner, support and motivate patients to follow and adhere to evidence-based care plans. These Health Coach/Panel Managers together with a Social Worker and Nurse Care Transition Coordinators will work with the provider to reduce avoidable emergency room visits, hospital admissions and readmissions, and in overcoming barriers to obtain health and social support services with estimated savings of over \$6 million. Over the three-year period, the South County Community Health Center, Inc. Ravenswood Family Health Innovation program will train an estimated 60 health care workers and create an estimated 28 new jobs. These trained workers will

support patient-centered medical teams that will manage a panel of patients that include identified high risk, high cost and high care utilizers.

## **SOUTHEAST MENTAL HEALTH SERVICES**

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

**Geographic Reach:** Colorado

**Funding Amount:** \$1,405,924

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

**Summary:** Southeast Mental Health Services received an award to coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill residents of rural Prowers County, Colorado. The program employs Bachelor-level 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 is contracting with Otero Junior College to provide a "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 CORPORATION**

**Project Title:** "Advanced Illness Management (AIM)"

**Geographic Reach:** California

**Funding Amount:** \$13,000,000

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

**Summary:** Sutter Health 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 goals of the program are to 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.

## **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 received 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.

## **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, Indiana, Kansas, Kentucky, Maryland,

Massachusetts, Michigan, Mississippi, Nebraska, North Carolina, Oklahoma, South Dakota, West Virginia

**Funding Amount:** \$20,750,000

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

**Summary:** TransforMED received an award for a primary care redesign project across 15 communities 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, provided by a vendor, Phytel, 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. TransforMED will work with VHA to capture learnings from leading performers. Cost trends will be identified via claims data using an analytic tool provided by a

vendor, Cobalt Talon. Over a three-year period, TransforMED's program will train an estimated 3,024 workers and create an estimated 22 jobs.

## **TRUSTEES OF DARTMOUTH COLLEGE**

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

**Geographic Reach:** California, Colorado, Idaho, Iowa, Maine, Massachusetts, 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 High Value Healthcare Collaborative (HVHC) received an award led by The Trustees of Dartmouth College to implement patient engagement and shared decision making processes and tools across its 15 member organizations for patients considering hip, knee, or spine surgery and complex patients with diabetes or congestive heart failure. The program will hire and train 48 health coaches across the 15 member organizations to engage patients and their families in their health care and health decisions.

High Value Healthcare Collaborative (HVHC) is implementing a bundle of services related to the care of sepsis patients across 13 health care systems around the country. The overall goal of this project is to utilize process improvement strategies to implement specific services at 3- and 6-hours post diagnosis as defined by the Surviving Sepsis Campaign (SSC) and National Quality Forum (NQF) guidelines for the care of severe sepsis or septic shock. Over three years, this intervention aims to improve optimal adherence to sepsis bundled care by 5%, reduce the burden of chronic morbidity from sepsis-associated chronic organ dysfunction, and achieve a 5% relative rate reduction in the number of patients with sepsis requiring long-term acute care or sub-acute nursing care after an incident episode of severe sepsis.

## **TRUSTEES OF INDIANA UNIVERSITY**

**Project Title:** "Dissemination of the aging brain care program"

**Geographic Reach:** Indiana

**Funding Amount:** \$7,836,084

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

**Summary:** The Aging Brain Care (ABC) program incorporates the common features of several evidence-based collaborative care models into one program designed to deliver high quality, efficient medical care to older adults suffering from one or both of these conditions. The ABC program was implemented as a small pilot within Wishard Health Services and, now in operation for over 2 years, has progressed through multiple quality improvement cycles to effectively serve more than 200 patients and their

informal caregivers. The services of the ABC program will be expanded to serve more than 2,000 Medicare and Medicaid beneficiaries with dementia or late-life depression across the entire county-wide system of community health centers and to Indiana University Health Arnett primary care. The goals of the project are to reduce the behavioral and psychological symptoms of dementia, improve patients' or informal caregivers' satisfaction and access to care, improve the quality of dementia and depression care, and reduce acute care utilization for patients and their informal caregivers. The ABC program will develop and deploy a robust workforce training program capable of producing 26 care coordinators and care coordinator assistants.

## **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:** Delaware, New Jersey, New York, Pennsylvania

**Funding Amount:** \$4,841,221

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

**Summary:** The University of Pennsylvania received an award for a program to improve medication adherence and health outcomes in patients who have recently been discharged from the hospital with acute myocardial infarction. 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 remote monitoring, medication reminders, incentives, and support from family and friends. It will also retrain social workers as engagement advisors to provide additional support as needed. 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, University of Pennsylvania's program will train an estimated 21 workers, while creating an estimated seven jobs for investigators, clinical social workers, a software developer, project coordinators, 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 received an award to test a comprehensive set of home care services for patients with cancer who are receiving skilled home care and have substantial palliative care needs, but are not yet eligible for hospice care. The program serves five counties in the

metropolitan Philadelphia area. Using care coordination and planning, the intervention provides in-home support, symptom management, crisis management, and emotional and spiritual support, enabling patients to remain in their homes and avoid unnecessary hospitalizations. Over a three-year period, the program will create an estimated 19 jobs for home health aides, social workers, nurses, and other clinical and administrative staff.

## **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 received 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 Health System Cancer Community Network associate sites, the program seeks to create a national model for improving the quality of cancer care while decreasing unnecessary hospital utilization and enhancing patient satisfaction.

The program, named "Patient Care Connect," is designed to serve Medicare beneficiaries with complex or advanced stage cancers, including 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 and specially trained non-clinical patient navigators. The navigation teams will focus on helping patients by providing information about their cancer treatment, empowering patients to make informed choices about their care, providing emotional support and problem-solving, assisting with overcoming common barriers to cancer treatment, and helping patients make wise use of healthcare resources.

It is expected that the program will result in a reduction in emergency room visits and unnecessary hospital utilization, earlier acceptance of palliative and hospice services, better adherence to evidence based care plans, and an improved overall quality of life for cancer patients.

## **UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

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

**Geographic Reach:** Arkansas, California, Hawaii, Texas

**Funding Amount:** \$3,615,818

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

**Summary:** The University of Arkansas for Medical Sciences received 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 2,100 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 in the form of microcredit loans, 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 received 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 CHICAGO**

**Project Title:** “CommunityRx system: linking patients and community-based service”

**Geographic Reach:** Illinois

**Funding Amount:** \$5,862,027

**Estimated 3-Year Savings:** \$6.4 million

**Summary:** The University of Chicago Urban Health Initiative in partnership with Chicago Health Information Technology Regional Extension Center (CHITREC) and the Alliance of Chicago Community Health Services received an award to develop the CommunityRx system, a continuously updated electronic database of community health resources that will be linked to the Electronic Health Records of local safety net providers. In real time, the system will process patient data and print out a “HealthRx” for the patient, including referrals to community resources relevant to the patient’s condition and status. Aggregated data on patient diagnoses and referrals will be used to generate CommunityRx reports for community-based service providers to use to inform programming. The program will serve over 200,000 patients on the South Side of Chicago most of whom are Medicare, Medicaid and CHIP beneficiaries. The CommunityRx system will train and create new jobs for a combined total of over 200 individuals from this high-poverty, diverse community. This includes high school youth who will collect data on community health resources as part of the Urban Health Initiative’s MAPSCorps program. It will also include the creation of a new type of health worker, Community Health Information Experts (CHIEs), who will assist patients in using the HealthRx and engage community-based service providers in meaningful use of the CommunityRx reports. The CommunityRx builds on infrastructure supported by ARRA funding from the National Institute on Aging. Anticipated outcomes include better population health, better use of appropriate services, increased compliance with care, and fewer avoidable visits to the emergency room with estimated savings of approximately \$6.4 million.

## **UNIVERSITY EMERGENCY MEDICAL SERVICES**

**Project Title:** “Better health through social and health care linkages beyond the emergency department”

**Geographic Reach:** New York

**Funding Amount:** \$2,570,749

**Estimated 3-Year Savings:** \$6.1 million

**Summary:** University Emergency Medical Services, a physician practice plan affiliated with the Department of Emergency Medicine at the University at Buffalo, and in partnership with Erie County Medical Center (ECMC), is deploying community health workers to work with frequent emergency department (ED) utilizers and meaningfully link them to primary care, social and health services, education, and provide health coaching. The program targets 2,300 Medicare and Medicaid beneficiaries who have had two or more emergency department visits over 12 months in urban Buffalo, New York. Patients are recruited in the emergency department and referred by the ECMC Primary Care Clinics and other hospital affiliated programs. These patients account for 29% of all ED patients and 85% of all hospital inpatients are admitted through the hospital’s emergency department. Health coaching and improved access to primary care is expected to result in lower ER utilization, reduced hospital admissions, and improved health with estimated savings of approximately \$6.1 million. Over the three

year period, University Emergency Medical Service's program will train an estimated 13 health care workers and create an estimated 13 new jobs.

## **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 has received an award to implement Pharm2Pharm, a care transition and coordination model designed to improve patient safety and reduce medication-related hospitalizations and emergency room visits. This formal hospital pharmacist-to-community pharmacist collaboration (called “pharmacist-to-pharmacist” or “Pharm2Pharm”) closes gaps in care as patients transition from hospital to community settings. This model has been implemented in all three rural counties of Hawaii, where physician shortages are particularly severe. 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.

## **UNIVERSITY HOSPITALS OF CLEVELAND**

**Project Title:** “Transforming pediatric ambulatory care: the physician extension team”

**Organizations:** University Hospitals (UH) Rainbow Babies and Children’s Hospital at UH Case Medical Center partnering with Ohio Medicaid, CareSource, WellCare, 4 community mental health agencies, Cuyahoga Community College, Cleveland Schools, Head Start, InstantCare, and HealthSpot

**Geographic Reach:** Ohio

**Funding Amount:** \$12,774,935

**Estimated 3-Year Savings:** \$13.5 million

**Summary:** University Hospitals Rainbow Babies & Children’s Hospital received funding to create a pediatric program to improve care, overall health and lower costs for children in Northeast Ohio. Rainbow Care Connection is one of the first pediatric accountable care organizations (ACO) in the country.

Rainbow Care Connection is a new type of multidisciplinary model geared to produce needed change in pediatric ambulatory care. The model creates meaningful relationships across pediatric primary care providers, hospitals, patients and managed care organizations to drive change and achieve the three objectives of better care, better health and lower cost.

Rainbow Care Connection will impact 200,000 children in northeast Ohio, one-third of whom will be Medicaid enrollees, and will create a sustainable pediatric ambulatory care system that improves health, improves care and reduces costs. Specific goals include: increase primary care provider adherence to evidence-based national quality measures; improve care and health of children with complex chronic conditions through an innovative broad comprehensive care coordination program; improve access and coordination of behavioral health services; and decrease avoidable emergency department visits and hospitalizations.

## **UNIVERSITY OF IOWA**

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

**Geographic Reach:** Iowa

**Funding Amount:** \$7,662,278

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

**Summary:** The University of Iowa, in partnership with 10 Critical Access Hospitals (CAHs), is improving care coordination and communication with practitioners in nine rural Iowa counties. The program serves adults in these counties and selected contiguous catchment areas in which a CAH serves large numbers of patients. Adults are served without regard to whether they are Medicare, Medicaid, Medicare/Medicaid dual-eligible beneficiaries privately insured or uninsured. The aim is to assist adults with complex illness being discharged from the University of Iowa Hospitals & Clinics from psychiatric and internal medicine departments. Their complex issues may include psychiatric disorders, heart disease, kidney disease, endocrine and gastrointestinal disorders, pulmonary and geriatric issues. The program coordinates care through teams comprised of nurses, social workers, and pharmacists along with specialty physicians (including psychiatrists) using a care coordination protocol that informs, facilitates and ensures post discharge care and incorporating telehealth and web-based personal health records. The program is based on the University of Iowa's significant past experience in care coordination and 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 10 community care 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 Center for Haitian Studies, the Larkin Residency program, and Overtown Youth Center, received 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 has resulted in an expansion of services and utility of school-based health clinics, increased collaboration with other care providers, services, and school-health stakeholders, and enhanced usage and sharing of health information technology. A team-based approach is being utilized to improve care and quality of services. This approach incorporates community health workers, nursing assistants, and dental hygienists while 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 NEW MEXICO HEALTH SCIENCES CENTER

**Project Title:** “Leverage innovative care delivery and coordination model: Project ECHO”

**Geographic Reach:** New Mexico

**Funding Amount:** \$8,473,809

**Estimated 3-Year Savings:** \$11.1 million

**Summary:** The University of New Mexico Health Sciences Center is receiving an award for its ECHO Project. The goals of the ECHO® model is to improve the quality of care and reduce the total cost by at least 3.5% in 2,500 high-need, high-cost Medicaid beneficiaries in New Mexico, and to increase overall primary care capacity to diagnose and provide the best treatment for these complex patients. The ECHO Care™ program will expand the capacity of the primary care workforce through participation in a TeleECHO™ clinic dedicated to co-managing complex care for patients with significant multi-morbidity, including mental health and substance abuse. In addition to this new Complex Care teleECHO Clinic, a new type of primary care clinical team will care for these patients with complex medical, behavioral and social needs at provider sites located around New Mexico. This “outpatient intensivist team” (OIT), has the potential to dramatically improve care and reduce costs for the Medicaid beneficiaries experiencing high utilization of services.

Medicaid has been an active partner with ECHO Care™ from its inception, and continues to be strongly

committed to its success. Multiple Medicaid MCOs will fund the OITs based on the patient population cared for by the OIT at each provider site as well as compensate the multidisciplinary team of specialists at the Complex Care teleECHO Clinic for consultative services.

The high-need and high-cost Medicaid population to be served by ECHO Care™ is being identified through the assistance of researchers at New York University who have developed a methodology to select the most complex and costly patients whose costs can be impacted with comprehensive and coordinated care. Strategies for sustaining these savings beyond the project time period include the maintenance of increased capacity of OITs to manage complex patients and the formulation of a replicable reimbursement model utilizing the ECHO® prototype as a core element of healthcare delivery.

## **UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER**

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

**Geographic Reach:** Colorado, Florida, Kansas, Texas

**Funding Amount:** \$7,329,714

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

**Summary:** The University of North Texas Health Science Center (UNTHSC), in partnership with Brookdale Senior Living (BSL), is developing and testing the Brookdale Senior Living 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 skilled nursing facilities in Florida, Colorado, Kansas and Texas. 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 Brookdale Senior Living Transitions of Care 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

**Funding Amount:** \$13,955,411

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

**Summary:** The University of Rhode Island's Living Rite Innovations project is delivering holistic coordinated care through the project's two Living Rite Centers. The Centers, with their three part goal of (1) Health care: designed to improve care for adults with intellectual and developmental disabilities and /or Alzheimer's disease and are dual eligible beneficiaries of Medicare and Medicaid. The Centers provide comprehensive chronic care management in order to coordinate services between multiple community providers, improve health and decrease unnecessary hospitalizations and ER visits. The Centers' interdisciplinary team includes physicians, nurse-practitioners, RNs, pharmacists, OTs, PTs, and dietitians. (2) Well-being: Through the Centers' healthy behavior change models, clients are being trained how to best manage their chronic diseases.(3) Employment: Using the Employment First philosophy, the Centers provide career development, benefits planning and job placement services to assist clients in attaining jobs. Furthermore, Living Rite project plans to help people with disabilities outside the centers to become employed. Lastly, the creation of the URI-Intra-Professional Health Education Center will certify various health professional students as qualified interdisciplinary team members.

## **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 aims to improve healthcare quality, enhance medication safety, and reduce overall healthcare costs for high-risk, underserved populations. These aims will be achieved by: 1) integrating comprehensive clinical pharmacy services in patient-centered medical homes, and 2) spreading the services to other organizations through workforce development and web-based two-way communication.

The model is serving the underserved and vulnerable populations of Santa Ana, Huntington Beach, and Garden Grove. The selected area represents the epicenter of uncontrolled chronic disease - almost half the population is foreign born and 47% of the population lives below 200% of the Federal Poverty Level (FPL). Providing comprehensive medication management and drug safety protocols to these chronically-ill populations is expected to reduce overall treatment costs and achieve net cost savings.

## UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

**Project Title:** "Project SAFEMED"

**Geographic Reach:** Arkansas, Mississippi, Tennessee

**Funding Amount:** \$2,977,865

**Estimated 3-Year Savings:** \$3,160,844

**Summary:** The University of Tennessee Health Science Center, in partnership with Methodist LeBonheur Healthcare's Methodist North Hospital and Methodist South Hospital and community partners received an award to improve care transitions with an emphasis on medication management among high repeat utilizing 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 with presence of polypharmacy or high risk medications. Through multidisciplinary teams encompassing pharmacy, nursing, and social work based in outpatient centers, the program will enhance discharge planning, improve post-discharge outreach and follow-up, increase access to community based services and coordinate care across providers and settings. In addition, pharmacy technicians and licensed practical nurses will serve as outreach workers engaging patients through home visits, intense phone follow up, and group based support sessions. This approach will improve medication adherence to safe and effective medication regimens, overall chronic disease self-management, health services utilization patterns, and patient experience of care. Over a three-year period, the University of Tennessee Health Science Center's program will develop 5 new roles for direct care staff and create 11 jobs in the healthcare field.

## 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

**Funding Amount:** \$3,701,370

**Estimated 3-Year Savings:** \$4,272,968

**Summary:** The University of Texas Health Science Center at Houston received 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.

## **UPPER SAN JUAN HEALTH SERVICE DISTRICT**

**Project Title:** "Southwest Colorado cardiac and stroke care"

**Geographic Reach:** Colorado

**Funding Amount:** \$1,724,581

**Estimated 3-Year Savings:** \$8.1 million

**Summary:** The Upper San Juan Health Service District is improving care for cardiovascular disease and risk through a multifaceted approach in order to reduce costs and to improve the quality of care in rural and remote areas of southwestern Colorado. The care delivery model will offer cardiovascular early detection and wellness programs, implement a telemedicine acute stroke care program, use telemedicine and remote diagnostics for cardiologist consultations, and upgrade and retrain its Emergency Medical Services Division staff to manage urgent care transports and in-home follow-up patient care for patients in medically underserved areas in Southwest Colorado. A cardiovascular patient navigator integrates care through the continuum and assists in removing barriers, resulting in better care through all phases of the intervention. The program will provide access to cardiologists and neurologists and is expected to reduce cardiovascular risk, improve patient outcomes, create healthier communities, and reduce health care costs with estimated savings of approximately \$8.1 million. Over the three-year period, the Upper San Juan Health Service District's program will train an estimated 25 paramedics and telehealth clinicians and create 13 new jobs. These workers will provide a new type of clinical team that will improve care outcomes for rural cardiovascular patients.

## **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., with its subsidiary, Massachusetts Behavioral Health Partnership, received an award to test care coordination to reduce repeated utilization of detox services among beneficiaries who have 2 or more detox admissions. With Brandeis University as a research partner, the project uses

patient navigators, recovery planning, and behavioral interventions to support member recovery. Four providers will implement the interventions, 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, hospitalizations and detox readmissions.

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 support staff.

## **VANDERBILT UNIVERSITY**

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

**Geographic Reach:** Kentucky, Tennessee

**Funding Amount:** \$18,846,090

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

**Summary:** Vanderbilt University received an award to improve chronic disease management, care coordination, and transition management for high-risk, high cost patients with conditions such as hypertension, congestive heart failure, and diabetes. Many of these patients are beneficiaries of Medicare and Medicaid, living 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 care and reduced hospital admissions, readmissions, 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.

## **VANDERBILT UNIVERSITY MEDICAL CENTER**

**Project Title:** "Reducing hospitalizations in Medicare beneficiaries; a collaboration between acute and post-acute care"

**Geographic Reach:** Kentucky, Tennessee

**Funding Amount:** \$2,449,241

**Estimated 3-Year Savings:** \$8.7 million

**Summary:** Vanderbilt University Medical Center, in partnership with National HealthCare Corporation and two other Post-Acute Care facilities, received an award for a program designed to reduce inpatient re-hospitalization by 17% and improve patient experience for approximately 27,000 Medicare and beneficiaries dually eligible for Medicare and Medicaid in ten counties in Tennessee, including rural and underserved areas. Their project will offer improved hospital discharge planning, evidence-based interventions, and improved clinical responsiveness at post-acute facilities with estimated savings of approximately \$8.7 million. Over the three-year period, Vanderbilt University Medical Center’s program will train an estimated 30 health care workers and create an estimated 4.6 new jobs. These workers will coordinate discharge planning and care transitions for patients and help integrate clinical responsiveness into post-acute care settings.

## **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:** Vinfen Corporation, in partnership with Bay Cove Human Services, North Suffolk Mental Health Association, Brookline Mental Health Center, Commonwealth Care Alliance, Robert Bosch Healthcare, and Dartmouth University received an award to integrate primary and behavioral health care for individuals with serious mental illness in the metropolitan Boston area. The project embeds Nurse Practitioners, backed by a primary care physician, into existing community based psychiatric rehabilitation and recovery teams, creating community based health homes that provide better care at lower cost for a population at risk for severe chronic disease. Embedded Health Outreach Workers teach participants to manage their behavioral and physical health effectively and more independently. This care team uses telehealth technology to monitor participants’ signs and symptoms, prioritize care and deliver necessary interventions. As a result, the project aims to improve the health of participants, increase their access to primary and specialty health care and reduce the use of costly acute care services.

## **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 to 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 surgery decision-making support, both online and offline, Welvie's approach enhances consumer experiences in relation to preference-sensitive surgeries, increases surgery literacy, improves surgical outcomes, and reduces the incidence of surgeries where known risks outweigh potential benefits. The program serves 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 includes 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.

## **WOMEN & INFANTS HOSPITAL OF RHODE ISLAND**

**Project Title:** "Partnering with parents, the medical home and community provider to improve transition services for high-risk preterm infants in Rhode Island"

**Geographic Reach:** Rhode Island

**Funding Amount:** \$3,261,494

**Estimated 3-Year Savings:** \$3.7 million

**Summary:** Women and Infants Hospital of Rhode Island received an award to improve services for approximately 2400 families in Rhode Island who have pre-term or high-risk full term babies with a Neonatal Intensive Care Unit (NICU) admission of 5 or more days. The Partnering with Parents intervention has hired, trained and deployed Early-Moderate Preterm, Late Preterm, and high-risk full term family care teams to offer education and support to parents during the transition from the NICU to home, and monitor infants' growth and development. The program also supports primary care providers who help provide care for this at-risk population and has partnered with home nursing agencies throughout the state to coordinate infants' care post discharge. The results are expected to be reduced emergency room visits, fewer hospital readmissions, and decreased neonatal morbidity. This approach is expected to lower costs while improving health and health care for pre-term and high-risk full term babies in Rhode Island with estimated savings of approximately \$3.7 million. Over the three-year period, Women & Infants Hospital of Rhode Island's program will train an estimated 120 health care workers and early intervention providers, while creating an estimated 12 new jobs. The Partnering with Parents program is training and deploying these workers as part of Family Care Teams to offer education and support and monitor infants' growth and development.