Health Care Innovation Awards Round Two Project Profiles

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

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

ALTARUM INSTITUTE

Project Title: Reducing the Burden of Childhood Dental Disease
Geographic Reach: Michigan
Estimated Funding Amount: $9,383,762

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

AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION

Project Title: SMARTCare
Geographic Reach: Wisconsin, Florida
Estimated Funding Amount: $15,871,245

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Project Title: eConsults/eReferrals: Controlling Costs and Improving Quality at the Interface of Primary Care and Specialty Care
Geographic Reach: New Hampshire, Iowa, Wisconsin, Virginia, California
Estimated Funding Amount: $7,125,770

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

AVERA HEALTH

Project Title: Avera Virtual Care Center: Improving Care & Reducing Costs for the Vulnerable Elderly Population
Geographic Reach: South Dakota, Minnesota, Iowa, Nebraska
Estimated Funding Amount: $8,827,573

Summary: The Avera Virtual Care Center project will test the virtual wrapping of a set of comprehensive, resident-centered, geriatric care services around the long term care population. The project will operate in facilities located in South Dakota, Minnesota, Iowa and Nebraska. The three primary drivers of this project include: building the assessment capability and toolkits of the long term care team of care providers; providing long term care facility residents with routine and early access to appropriate goal-directed care; and improving management of care transitions. A Virtual Care Team will host INTERACT II training sessions and skill building workshops for long term care staff and will facilitate widespread implementation of INTERACT II tools and treatment algorithms to support earlier identification of urgent issues. The INTERACT II implementation will be further supported by high-quality care planning resources and training to promote alignment of resident care goals and treatment plans. To address the geriatric care access gap, the Virtual Care Team will offer daily rounds, comprehensive geriatric assessments and urgent care visits to address resident health needs in a timely manner. These services will be provided out of a centrally staffed telemedicine hub, spreading the expertise of one team over 30 long term care centers. To maximize safety and continuity across transitional points in care, the Virtual Care Center team will promote the adoption of standardized tools and processes.

CHILDREN'S HOME SOCIETY OF FLORIDA

Project Title: Improving child well-being through integrating care in a community school setting
Geographic Reach: Florida
Estimated Funding Amount: $2,078,295

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

CLIFFORD W. BEERS GUIDANCE CLINIC, INC.

Project Title: New Haven WrapAround
Geographic Reach: Connecticut
Estimated Funding Amount: $9,739,427

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

FOUR SEASONS COMPASSION FOR LIFE

Project Title: Increasing patient and system value with community based palliative care
Geographic Reach: North Carolina
Estimated Funding Amount: $9,596,123

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

ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

Project Title: Bundled Payment for Mobile Acute Care Team Services
Geographic Reach: New York
Estimated Funding Amount: $9,619,517

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

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Project Title: ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use
Geographic Reach: New York
Estimated Funding Amount: $17,916,663

Summary: The New York City Health and Hospitals Corporation project will test an Emergency Department Care Management model, which expands and enhances a current successful pilot program. This model utilizes a multi-disciplinary team that will comprehensively assess patients who present in the emergency department for an ambulatory-care sensitive condition (ACSC), create a care plan that would avoid an unnecessary hospitalization, and provide ongoing support after discharge, including medication management, education, and linkages with primary care providers. The program will operate in 6 hospitals.

NORTH SHORE LIJ HEALTH SYSTEM, INC.

Project Title: Healthy Transitions in Late Stage Kidney Disease
Geographic Reach: New York
Estimated Funding Amount: $2,453,742

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

REGENTS OF THE UNIVERSITY OF CALIFORNICA SAN FRANCISCO

Project Title: The UCSF and UNMC Dementia Care Ecosystem: Using Innovative Technologies to Personalize and Deliver Coordinated Dementia Care
Geographic Reach: California, Nebraska
Estimated Funding Amount: $9,990,848

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

REGENTS OF THE UNVIERSITY OF MICHIGAN

Project Title: Michigan Surgical and Health Optimization Program (MSHOP): A Multiplex Patient Risk Stratification and Intervention Program
Geographic Reach: Michigan
Estimated Funding Amount: $6,389,850

Summary: The Regents of the University of Michigan project will implement the Michigan Surgical and Health Optimization Program (MSHOP), which focuses on- real-time risk stratification and peri-operative optimization for patients undergoing abdominal surgery. The model aims to improve surgical outcomes in two ways. (1) Real-time risk stratification aims to improve the appropriateness of surgery—in certain

high-risk cases, patients and surgeons will avoid prohibitively high-risk surgical care, focusing on medical and palliative management. Further, real-time risk stratification can identify patients who would be good candidates for the peri-operative prehabilitation program. (2) This peri-operative program aims to enable patients to train for surgery, improving their physiology and mindset through an established outpatient program, leading to better outcomes and reduced costs by preventing complications and reducing length of stay. Over the 3-year period MSHOP will be implemented in 40 Michigan hospitals.