

List of Center for Medicare and Medicaid Innovation Awards in the District

More information about the CMS Innovation Center Awards can be found at <http://innovation.cms.gov>

Health Care Innovation Awards

The objectives of the Health Care Innovation Awards Round One were to:

- Engage a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field and that produce better care, better health, and reduced cost through improvement for identified target populations.
- Identify new models of workforce development and deployment and related training and education that support new models either directly or through new infrastructure activities.
- Support innovators who can rapidly deploy care improvement models (within six months of award) through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with other public and private sector partners.

Foundation for California Community Colleges: *Transitions clinic network: linking high-risk Medicaid patients from prison to community primary care*

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 including the District of Columbia and Puerto Rico, the program will work with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers trained by City College of San Francisco to help these individuals navigate the 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.

George Washington University: *Telemedicine in peritoneal dialysis to improve patient adherence and outcomes while reducing overall costs*

George Washington University received an award to improve care for 300 patients on peritoneal dialysis in the District of Columbia 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.

Joslin Diabetes Center, Inc.: *Pathways to better health through a new health care workforce and community*

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 the District of Columbia 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 reengaging them into the healthcare system.

Mary's Center for Maternal Child Care: *Capital Clinical Integrated Network (CCIN)*

Mary's Center for Maternal Child Care 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 25 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.

Health Care Innovations Award – Round Two

The second round of Health Care Innovation Awards differs from the first round in that CMS specifically sought innovations in four areas: rapidly reducing costs for patients in outpatient hospital and post-acute settings; improving care for populations with specialized needs; testing improved financial and clinical models for specific types of providers; linking clinical care delivery to preventive and population health.

George Washington University: PREVENTION AT HOME: A Model for Novel use of Mobile Technologies and Integrated Care Systems to Improve HIV Prevention and Care While Lowering Cost

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

Federally Qualified Health Centers Advanced Primary Care Demonstration –

Unity Health Care- The demonstration project, operated by CMS in partnership with the Health Resources Services Administration (HRSA), tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. Participating FQHCs were expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they were paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agreed to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA).

**Independence at Home Demonstration – Medical House Calls Program at MedStar
Washington Hospital Center**

Under the Independence at Home Demonstration, the CMS Innovation Center worked with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs.

**Bundled Payments for Care Improvement (BPCI) Initiative: Model 2 - District Hospital
Partners L P Dba George Washington University Hospital Washington, DC**

The Bundled Payments for Care Improvement initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

Model 2 involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under this payment model, Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 2 episodes. The total expenditures for a beneficiary's episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate performance compared to the target price. In Model 2, the episode of care includes a Medicare beneficiary's inpatient stay in the acute care hospital, post-acute care and all related services during the episode of care, which ends either 30, 60, or 90 days after hospital discharge.