Health Care Innovation Awards: Project Profiles

The CMS Innovation Center has announced the first batch of preliminary awardees for the Health Care Innovation Awards. These organizations will implement projects in communities across the nation that aim to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs. Funding for these projects is for 3 years. This list will be updated as additional projects are selected.

Note: Descriptions and project data (e.g. gross savings estimates, population served, etc.) are 3 year estimates provided by each organization and are based on budget submissions required by the Health Care Innovation Awards application process. While all projects are expected to produce cost savings beyond the 3 year grant award, some may not achieve net cost savings until after the initial 3-year period due to start-up-costs, change in care patterns and intervention effect on health status.

1. 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 of Boston, Massachusetts, is receiving an award to improve care and reduce hospital readmissions for over Medicare and beneficiaries dually eligible for Medicare and Medicaid who represent over 8000 discharges for conditions such as congestive heart failure, acute myocardial infarctions, and pneumonia. 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. Over the three-year period, Beth Israel’s program will train an estimated 11 health care workers, while creating an estimated 11 new jobs. These workers will include care transition specialists who will help integrate care between hospital and primary care practices.
2. 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: $5.0 million

Summary: The Center for Health Care Services in San Antonio, Texas, is receiving an award to integrate behavioral care and health care for a group 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 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 admissions, hospital admissions, and lowering cost, while improving health and quality of life and with estimated savings of $5 million over 3 years. Over the three-year period, the Center for Health Care Services’ program will train an estimated 24 health care workers and create an estimated 24 new jobs. These workers will provide peer support to generate readiness for change, build motivation, and sustain compliance.

3. 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, serving Camden, New Jersey, and adjoining areas, is receiving an award to better serve over 1200 patients with complex medical needs who have relied on emergency rooms and hospital admissions for care. The intervention will use care management and care transition teams to work with these people to reduce avoidable emergency room visits, inpatient hospital admissions, and 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 approximately $6.1 million. Over the three-year period, Cooper University Hospital's program will train an estimated 14 health care workers, while creating an estimated 14 new jobs. These workers will include non-clinical staff, like AmeriCorps volunteers and community health workers, who will serve as part of multidisciplinary teams to support care coordination activities.

4. COURAGE CENTER D/B/A CAMP COURAGE

Project Title: “Courage Center”

Geographic Reach: Minnesota
Funding Amount: $1,767,667

Estimated 3-Year Savings: $2.0 million

Project Summary: Courage Center is receiving 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 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 50 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 vulnerable group of people with an estimated savings of over $2 million over the three year award.

5. 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: South Dakota

Funding Amount: $3,364,528

Estimated 3-Year Savings: $6.2 million

Summary: Delta Dental Plan, which covers over thirty-thousand isolated, low-income, and underserved Medicaid beneficiaries and other American Indians on reservations throughout South Dakota, is receiving 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 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.

6. DUKE UNIVERSITY

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

Geographic Reach: North Carolina and West Virginia

Funding Amount: $9,773,499

Estimated 3-Year Savings: $20.8 million
Summary: Duke University, in conjunction with the University of Michigan National Center for Geospatial Medicine, Durham County Health Department (Durham County, NC), Cabarrus Health Alliance (Cabarrus County, NC), Mississippi Public Health Institute (Quitman County, NC), Marshall University, and Mingo County Health Department (Mingo County, WV) is receiving an award for its plan to reduce death and disability from Type 2 diabetes mellitus among fifty-seven thousand people in four Southeastern counties who are underserved and at-risk populations in the Southeast. The program will use informatics systems that stratify patients and neighborhoods by risk, target communities in need of higher-intensity interventions, and serve as the basis for decision support and real-time monitoring of interventions. Local home care teams will provide patient-centered coordinated care to improve outcomes and lower cost—expecting to reduce hospital and emergency room admissions and reduce through preventive care the need for amputations, dialysis, and cardiac procedures with estimated savings of over $20 million. Over the three-year period, this collaborative program will train an estimated 88 health care workers and create an estimated 31 new jobs. These workers include new types of health workers including information officers, health integrators, and community health workers, who will use novel technologies to facilitate communication, education, and care delivery.

7. 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

Project Summary: Emory University, in partnership with Philips Company (a Tele-Intensive Care Unit contractor) and several medical centers including Saint Joseph’s Health System, Northeast Georgia Medical Center, and Southern Regional Medical Center, is receiving an award to hire more than 40 critical care professionals, including 20 nurse practitioners (NP) and physician assistants (PA) who will be deployed to undeserved and rural hospitals in Northern Georgia. Training in the use of these 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.

8. FINITY COMMUNICATIONS, INC.

Project Title: “EveryBODY Get Healthy”

Geographic Reach: Oregon and Pennsylvania

Funding Amount: $4,967,962

Estimated 3-Year Savings: $8.7 million
Summary: Finity Communications, Inc., is receiving an award to improve health care for high need populations in the greater Philadelphia area. The intervention will use health information technology to track and monitor over 120,000 at-risk patients, create a participant engagement program, develop integrated health profiles and care management plans, and evaluate and reassess treatment on a continuing basis. This holistic approach to health care will reduce the total cost of care through prevention, maintaining wellness, and condition management with estimated savings of approximately $8.7 million. Over the three-year period, Finity Communications, Inc’s, program will train an estimated 13 health care workers and create an estimated 12 new jobs. These workers will support lifestyle change through prevention outreach and wellness education programs.

9. 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, Pennsylvania, Virginia

Funding Amount: $1,939,127

Estimated 3-Year Savings: $1.7 million

Summary: George Washington University is receiving an award to improve care for about 300 patients on peritoneal dialysis in Washington, D.C., and eventually in Philadelphia, Southern Maryland, and Virginia. 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, 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.

10. HEALTH RESOURCES IN ACTION

Project Title: “New England asthma innovations collaborative”

Geographic Reach: Massachusetts, Rhode Island, Connecticut, Vermont

Funding Amount: $4,040,657

Estimated 3-Year Savings: $4.1 million

Summary: Health Resources in Action is receiving an award for a program of its New England Asthma Regional Council, titled the New England Asthma Innovations Collaborative (NEAIC). NEIAC is a multi-state, multi-sector partnership 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. Over the three year funding period, services will be delivered to over 1400 children ages 2-17 with persistent asthma who have had at least one related emergency department visit, observation stay, hospitalization or received a prescription in the 12 months prior to enrollment. The intervention will lower costs of asthma care by delivering cost-effective prevention oriented care in clinics and at home to reduce preventable pediatric-related emergency department visits and hospital admissions with estimated savings of over $4 million. NEAIC will also train an estimated 64 health care workers, while creating an estimated 17 new jobs. These workers will include well-trained community health workers and asthma educators. Finally, NEAIC will work to sustain these cost-effective services by piloting reimbursement methodologies with payers. In sum, NEAIC will create a new type of workforce and service delivery model that targets cost-effective and culturally competent care, which features patient self-management education, environmental interventions and long-term sustainability payment mechanisms of these services.

11. JOSLIN DIABETES CENTER, INC.

Project Title: “Pathways to better health through a new health care workforce and community”

Geographic Reach: New Mexico, Pennsylvania, District of Columbia

Funding Amount: $4,967,276

Estimated 3-Year Savings: $7.4 million

Summary: Joslin Diabetes Center, Inc., is receiving 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 3000 Medicare and Medicaid beneficiaries and low income/uninsured populations 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 workers and health education instructors who will educate patients in managing diabetes and pre-diabetes.

12. 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, is receiving an award to integrate care for one thousand severely mentally ill or severely emotionally disturbed adults and children, many of them Medicare, Medicaid, and/or CHIP beneficiaries, with at least one co-morbidity. Research shows that health care for the
severely mentally ill /severely emotionally disturbed population is often fragmented, ineffective, and inefficient, resulting in poor health and premature death. By providing integrated behavioral health management and preventive care through primary care physicians, other care providers, and social service organizations, the project is expected to improve beneficiary health and reduce avoidable emergency room visits and hospitalizations with estimated savings of approximately $5.8 million. Over the three-year period, Kitsap Mental Health Services’ program will train an estimated 130 health care workers, while generating an estimated 12.5 new jobs, creating a transformed health care workforce cross-trained in behavioral and physical health disciplines.

13. 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: LifeLong Medical Care is receiving an award to further integrate care and encourage healthy behavior, among 3250 seniors and other adults with disabilities who are Medicaid and dual Medicare/Medicaid-eligible beneficiaries. The goal is to reduce avoidable emergency room and hospital visits. The intervention will train adults with disabilities to support adoption of healthy behaviors among their peers and to encourage self management, with the support of a team of nurse care managers. Improved care and better health for these high risk patients will lower costs with estimated savings of approximately $1 million. Over the three-year period, LifeLong Medical Care’s program will train an estimated 60 health care workers, while creating an estimated 60 new jobs. These workers will include peer health coaches and nurse care managers who will facilitate integrated care for seniors and for low-income adults with disabilities. LifeLong will partner with Berkeley’s Center for Independent Living and the Alameda Alliance for Health to achieve program goals.

14. 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: The Mountain Area Health Education Center, serving 16 counties in Western North Carolina, is receiving an award to test team-based enhanced primary care for patients with chronic pain, whose treatment can be both costly and avoidably frequent. The target population for the test includes over 2,000 patients. The intervention will create multidisciplinary teams to provide enhanced primary care, using mid-level providers to co-manage care and providing counseling and medication management services. The result is expected to be better pain control, improved health, a reduction in the frequency of outpatient visits, and additional cost reductions with estimated savings of approximately $2.4 million. Over the three-year period, Mountain Area Health Education
Center’s program will train an estimated 390 health care workers and create an estimated 7.5 new jobs. These health workers will form multidisciplinary teams to provide enhanced primary care to patients with chronic pain in rural North Carolina.

15. THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

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

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

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

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

**Summary:** The National Health Care for the Homeless Council is joining into a cooperative agreement to serve ten communities across various regions in the U.S. to reduce the number of emergency department visits and lack of primary care services for over 1700 homeless individuals. The intervention will integrate 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 with estimated savings of approximately $1.4 million. 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. The workers will include community health workers who will conduct outreach and care coordination.

16. 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 is receiving an award to better serve almost 1000 acute care stroke patients in Jefferson and St. Tammany parishes in Louisiana. The model will employ a stroke management and quality assurance through a telemedicine system called “Stroke Central.” This system will enable care providers to monitor patients, evaluate outcomes, and check on medication and treatment adherence on a real time basis. This process will allow care providers to give telemedical “check-ups” to their patients, improving acute stroke management, improving patients’ quality of life, and lowering cost by reducing complications from urinary tract infections and pneumonia, preventing readmissions, and replacing outpatient visits with estimated savings of almost $5 million. Over the three-year period, Ochsner Clinic Foundation’s program will train an estimated 38.2 health care workers and create an estimated 12 new jobs. These workers will provide tele-consultation, assessment, and monitoring support for stroke care.
17. PITTSBURGH REGIONAL HEALTH INITIATIVE

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

Geographic Reach: Pennsylvania

Funding Amount: $10,419,511

Estimated 3-Year Savings: $74.1 million

Summary: Pittsburgh Regional Health Initiative is receiving 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 25,000 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 $74 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.

18. 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 Regents of the University of California, Los Angeles, are receiving an award to expand a new program to provide coordinated, comprehensive, patient and family-centered, and efficient care for approximately 1000 Medicare and Medicaid beneficiaries with Alzheimer’s disease or other forms of dementia. The UCLA Health System operates in the western area of Los Angeles County. By training and deploying professional and non-professional workers and unpaid volunteers, expanding a dementia registry, conducting patient needs assessments, and creating individualized dementia care plans, the program is expected to reduce hospitalizations and shorten hospital stays, reduce emergency room visits, and improve patient health, caregiver health, and quality of care with estimated savings of approximately $6.9 million. Over the three-year period, the Regents of the University of California, Los Angeles’ program will train an estimated 2500 workers, while creating an estimated 10 new jobs. These workers will include nurse practitioners, who will be trained as dementia care managers. These dementia care managers will in turn help train primary care providers and patient care givers on dementia care.
19. SOUTH COUNTY COMMUNITY HEALTH CENTER

**Project Title:** Ravenswood Family Health Center 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 (Ravenswood Family Health Center) in partnership with Health Plan of San Mateo, San Mateo County Health System, and Nuestra Casa, is receiving an award to create a health disparities collaborative for over 19,000 patients 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 and other chronic conditions. The project will train a care managers that will, in a responsive and culturally appropriate manner, support and motivate patients to follow and adhere to evidence-based care plans. These care managers will also provide assistance in overcoming barriers to obtaining services with estimated savings of over $6 million. Over the three-year period, South County Community Health Center program will train an estimated 60 health care workers and create an estimated 28 new jobs. These trained workers will support patient-center medical teams by coordinating care for patients.

20. 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 is receiving 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 “Health.eRx” 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 an estimated 90 individuals from this high-poverty, diverse community. This includes high school youth who will to 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 (CHIEfs), who will assist patients in using the Health.eRx 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.

21. 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 practice plan affiliated with the Department of Emergency Medicine at the University at Buffalo is receiving an award to deploy community health workers in emergency departments (EDs) to identify high-risk patients and link them to primary care, social and health services, education, and health coaching. The program targets 2300 Medicare and Medicaid beneficiaries who have had two or more emergency department visits over 12 months at two ERs in urban Buffalo, New York. These patients account for 29% of all ED patients; and, 85% and 54% of all hospital inpatients are admitted through each 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. These community health workers will identify high-risk patients and link them to primary care, social and health services, education, and coaching.

22. UNIVERSITY HOSPITALS OF CLEVELAND

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

Geographic Reach: Ohio

Funding Amount: $12,774,935

Estimated 3-Year Savings: $13.5 million

Project Summary: University Hospitals (UH) Rainbow Babies and Children’s Hospital at UH Case Medical Center is receiving an award to improve care for approximately 65,000 children with Medicaid with high rates of emergency room (ER) visits, complex chronic conditions, and significant behavioral health problems in several counties across northeastern Ohio. University Hospitals of Cleveland are partnering with Ohio Medicaid, CareSource, WellCare, 4 community mental health agencies, Cuyahoga Community College, Cleveland Schools, Head Start, InstantCare, and HealthSpot. The intervention will offer health care advice, referrals, and care coordination services through telehealth and home nurse hotlines; provide practice-tailored facilitation for primary care providers; and provide financial incentives to primary care physicians who reach quality performance targets, agree to offer extended hours, and make themselves available to treat these vulnerable children. Over 50 nurses, care coordinators and other health professionals will be hired and/or retrained to implement the model. The result should be better health care, with fewer avoidable ER visits, hospitalizations and lower cost — with an expected savings of over $13 million over three years.
23. UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

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

Geographic Reach: New Mexico and Washington

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, which will serve areas of New Mexico and Washington. The program is based on eight years of success in New Mexico and two years in Washington State. The intervention will identify 5000 high cost, high-utilization, high-severity patients and uses a team of “primary care intensivists,” specifically trained in care for complex patients with multiple chronic diseases, working in concert with area managed care organizations and care providers, with estimated savings of over $11 million during the funding time frame. Over the three-year period, the University of New Mexico Health Sciences Center’s program will train an estimated 150-300 workers, while creating an estimated 8 new jobs. These workers will help increase primary care physicians’ capacity to treat and manage complex patients.

24. 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 receiving an award to provide quicker access to specialists in order to reduce costs and to improve the quality of acute 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 over 3400 patients in medically underserved areas in Southwest Colorado. 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.

25. VANDERBILT UNIVERSITY MEDICAL CENTER

Project Title: “Reducing hospitalizations in Medicare beneficiaries; a collaboration between acute and post-acute care”
**Geographic Reach:** Tennessee

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

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

**Summary:** Vanderbilt University Medical Center, in partnership with National HealthCare Corporation, is receiving 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.

26. **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:** The Women and Infants Hospital of Rhode Island is receiving an award to improve services for approximately 2400 mothers in Rhode Island who have pre-term babies. The intervention will hire, train and deploy family care teams to offer education and support and monitor infants’ growth and development. It will also support primary care providers who help provide care for this at-risk population. The result is expected to be reduced emergency room visits, fewer hospital readmissions, and decreased neonatal morbidity. This approach is expected to lower cost while improving health and health care for pre-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 13 new jobs. The program will train and deploy these workers as part of Family Care Teams to offer education and support and monitor infants’ growth and development.