



Six children's hospital initiatives have been awarded multi-million dollar grants by the Center for Medicare and Medicaid Innovation to explore new ideas to improve patient care and reduce health care costs.

# EXPLORING INNOVATION

**THE AFFORDABLE CARE ACT** created the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) to test innovative payment and health care delivery models. Earlier this year, CMS announced more than 100 health care innovation awards. Several of the funded projects focus on improving children's health care, including grants awarded to children's hospitals. The six children's hospitals that received grants and are leading initiatives are:

- **Nemours/Alfred I. duPont Hospital for Children**, Wilmington, DE
- **UH Rainbow Babies & Children's Hospital**, Cleveland
- **Nationwide Children's Hospital**, Columbus, OH
- **Women & Infants Hospital of Rhode Island**, Providence
- **Le Bonheur Children's Hospital**, Memphis, TN
- **Children's Hospital of Wisconsin**, Milwaukee

These projects, whether serving high-risk pediatric asthma patients or expanding an accountable care organization focused solely on children receiving Medicaid, all offer ideas on how to improve delivery of care and reduce costs—elements vital to creating an effective and sustainable health care system.

## Nemours/Alfred I. duPont Hospital for Children

In Delaware, 11 percent of children are diagnosed with asthma; only five states in the country have higher percentages of children diagnosed with asthma. Delaware children under age 4 are twice as likely to be hospitalized with asthma as any other age group and are four times as likely to have an asthma-related hospitalization as adults. The Nemours project, “Optimizing Health Outcomes for children with asthma in Delaware,” has been developed with the goal of reducing the asthma-related emergency department utilization among pediatric Medicaid patients in Delaware by 50 percent and asthma-related hospitalization by 50 percent by 2015 with incremental declines in 2013 and 2014.

To achieve these goals, Nemours will launch a new phase of health system transformation, continuing a process begun in 2004 when Nemours broadened its mission from medical care to include health promotion and disease prevention. To integrate medical care with community-based population health, Nemours developed a unique population-based strategy that will explicitly link pediatric primary care with a focused asthma intervention. This linkage will result in a new model of service delivery and health promotion in three communities—an urban community, a growing rural/suburban area with a military base, and a rapidly growing rural area.

This project has three primary drivers:

- **Enhancement of family-centered medical home:** The project will introduce new services for children with asthma and develop a well-coordinated, interdisciplinary approach that combines the expertise of physicians, nurses, care coordinators, licensed mental health professionals and community health workers. The project will bring subspecialty asthma care into the primary care

practices and ensure evidence-based best practice in primary care.

- **Development of “integrator” model surrounding each primary care site:**

The project will integrate experienced community liaisons that focus on technical assistance to community groups into the primary care practice-based team. They will partner with neighborhood leaders to develop the infrastructure in schools, child care, housing and other systems to reduce asthma triggers and promote a healthier environment in the targeted ZIP codes.

- **Deployment of a “navigator” workforce:**

The project will deploy community health workers, who will provide case management of non-medical needs for small caseloads of high-need families with at least one child with asthma; collaborate with the project evaluation team to document the non-medical issues that affect health; and participate on the medical home team, bringing non-medical and community issues to attention of clinicians and others on the team.

## UH Rainbow Babies & Children’s Hospital

University Hospitals Case Medical Center’s Rainbow Babies & Children’s Hospital received \$12.7 million awarded by the CMMI for sustainable plans to improve care, lower costs and improve the overall health of children.

UH Rainbow submitted a proposal to deliver CMMI’s three goals—better health, improved care, and lower costs—through the implementation of a multidisciplinary workforce that Children’s Hospital calls the University Hospitals Rainbow Care Connection. The key component of UH Rainbow Care Connection is a physician extension team that creates collaborations with primary care providers, hospitals, managed care and other health professionals in order to provide children with the

highest quality of care resulting in reduced costs.

UH Rainbow Care Connection will target more than 65,000 children with Medicaid insurance as well as include children with other insurance across northeastern Ohio.

UH Rainbow Care Connection includes three core programs:

- **Practice-tailored facilitation:** Health care professionals will provide customized education, training, and enrollment in quality improvement initiatives to primary care offices. The physician extension team will collaborate with primary care physicians to improve access.
- **Telehealth:** Provides 24/7 access to nurses and physicians who provide advice, referrals and care coordination through an extensive system of telephone triage, community-based telehealth facilities and instant alert devices that connect homes to on-call personnel
- **Support services:** Multidisciplinary teams including health care professional advocates will provide integrated services for behavioral health and programs for children with complex chronic conditions, assisting primary care physicians with evaluations, home-based assessments, and care coordination.

UH Rainbow Care Connection will be implemented in stages over six months. More than 50 health professionals will be either hired or trained to implement the model.

## Nationwide Children’s Hospital

Partners for Kids (PFK) is the largest and oldest accountable care organization in the nation focused solely on Medicaid children. Established by Nationwide Children’s Hospital, PKF has achieved important results for health improvements and cost savings in pediatric care. PFK currently serves 301,000 Medicaid-enrolled children disproportionately located in central and

southeastern Ohio rural and inner city areas and accepts full business risk for clinical and financial outcomes. It employs a pay-for-performance system for improving access and quality in primary care combined with population health initiatives offered in partnership with other health care providers, governmental departments and community agencies. PKF also offers care coordination to achieve the triple aim of better care, better health and lower cost. To date, PKF has reduced neonatal intensive care unit length of stay, reduced premature birth rate, decreased pediatric emergency room visits, increased immunizations for high risk children and reduced costs.

PKF and Nationwide Children's Hospital, together with new partner Akron Children's Hospital, were recently awarded a \$13.1 million Health Care Innovation Grant from CMS. With support from the state of Ohio, this funding will expand the PKF model to cover a total of 517,000 Medicaid-enrolled children in 46 of 88 Ohio counties, covering the urban northeast to the southern tip of the state, including rural central and southeastern Appalachian counties.

The expansion of the PKF model of health care delivery represents a new national innovation, a model not being tested anywhere else by the CMS. Specifically, the expanded PKF model will:

- Cover 517,000 children, including more than 200,000 Medicaid-enrolled children in the Akron and northeastern areas of Ohio
- Cover 25,000 previously excluded disabled children who constitute a large portion of pediatric medical costs
- Add a shared savings component that benefits patients, provider organizations, the state of Ohio and federal Medicaid programs
- Rapidly deploy an expanded health care workforce with a focus on increasing access for high-risk rural and urban underserved populations

- Evaluate health, quality of care and cost savings outcomes among PKF regions compared to historical trends and other areas of Ohio to determine the viability and replication of this care delivery model

More information available at [www.partnersforkids.org](http://www.partnersforkids.org).

## Women & Infants Hospital of Rhode Island

Modern neonatal care has resulted in dramatic improvements in the survival of premature infants. As a result, significant numbers of infants with special health care needs are leaving the hospital. Once at home, they can require oxygen, cardiorespiratory monitoring and multiple medications. Infants with complex medical issues have increased rates of emergency room visits and hospital readmission after discharge from the neonatal intensive care unit (NICU).

Women & Infants Hospital Transition Home Plus Program was developed in 2007 with generous funding from CVS Caremark Charitable Trust to assist families of the most vulnerable premature infants who are at risk of medical problems once they are discharged from the hospital. Transition Home Plus is a successful model of coordinated care that has been shown to reduce readmission after infants leave the NICU.

Caring for a particularly high-risk infant post-discharge is extremely challenging for many families, especially those facing additional economic, social and environmental issues. Transition Home Plus provides NICU and home-based specialized, therapeutic support and education for families of the most vulnerable infants and is closely linked with primary care providers in the community. A multidisciplinary team of physicians, nurse practitioners, social workers, nutritionists, occupational therapists and bilingual staff works with each family based on needs. This program has resulted

in significantly fewer readmissions with the greatest effect for low-income families.

Through the Health Care Innovation Awards, Women & Infants Hospital is receiving more than \$3.2 million to expand the Transition Home Plus Program over three years for approximately 2,400 Rhode Island mothers with preterm babies. Under the leadership of Betty Vohr, M.D., medical director of the Neonatal Follow-Up Program in the Department of Pediatrics at Women & Infants Hospital and professor of pediatrics at The Warren Alpert Medical School of Brown University, the intervention will train and deploy family care teams to offer education and support and monitor the infants' growth and development. It will also support primary care providers who help care for this at-risk population. The result will be reduced emergency room visits, fewer hospital readmissions and decreased neonatal morbidity.

This approach will lower costs while improving health and health care for preterm babies in Rhode Island with estimated savings of approximately \$3.7 million. Over the three-year period, the Women & Infants program will train an estimated 120 health care workers while creating an estimated 13 new jobs.

## Le Bonheur Children's Hospital, Memphis, TN

Le Bonheur Children's Hospital Division of Community Health and Well-Being has been awarded a CMMI grant to improve services for children who have experienced frequent emergency room visits and hospitalizations due to asthma. The program is called CHAMP, "Changing High-risk Asthma in Memphis through Partnership," and strives to close the loop in providing care to high-risk asthma patients. The goals of the program are:

- Prevent deaths from pediatric asthma
- Reduce emergency department visits and hospitalization

- Reduce asthma exacerbations or episodes
- Lower overall health care costs
- Improve patient and family experience with the health care system

Program components of the CHAMP program are:

- **Registry:** An electronic database tracks all medical encounters, treatment and assessments. Data are Web-based and accessible to providers in the community as well as caregivers and those providing care for patients at school.
- **Community-based services/education and management:** Registered respiratory therapists aided by social work staff will evaluate homes and schools for asthma triggers, provide education and services to families and school personnel, and make referrals for other services. They will manage care by tracking current encounters, responding to the patient and family, and connecting with primary care physicians.
- **Asthma Collaborative Partnership:** Includes patients and families, community physicians, local health departments, TennCare managed care organizations, and school nurses working to inform development of the registry, its functionality, and how service components interface with the community.
- **Education:** The project will train professionals and caregivers to build skills and knowledge in the management of asthma. All respiratory therapists will be trained as certified asthma educators and healthy home evaluators. Additionally, each year of the grant 10 school nurses will be trained as certified asthma educators. For medical professionals, the program will develop an asthma elective for resident physicians. Community partners will be trained in the use of the asthma registry.

- **Measuring outcomes:** The outcomes will be measured by improvement in the quality of life for children with asthma, increase in use of community care and decrease in use of hospital-based services, and reduction in overall health care costs.

## Children's Hospital of Wisconsin, Milwaukee

Children's Hospital and Health System of Wisconsin has been awarded a \$2.8 million CMMI grant to create an Advanced Wrap Network Model (AWN) of culturally sensitive professional, clinical and social resources to educate members of Children's Community Health Plan (CCHP), a 45,000-member Medicaid health maintenance organization serving southeastern Wisconsin, on how to effectively navigate the health care system. CCHP is a member of Children's Hospital and Health System.

The AWN will be supported by staff within the CCHP as well as external stakeholders including community advocates, school nurses, local emergency departments and primary care providers. As a multidisciplinary team, these professionals will work with CCHP to promote the AWN with their patients and will provide workspace within their clinics to encourage CCHP staff to personally meet with members.

The AWN will specifically engage CCHP members who visited the emergency department twice within six months and members diagnosed with asthma who received care in higher acuity settings (emergency department or inpatient). AWN nurse navigators will guide CCHP members and providers through the managed care system and promote appropriate and timely access to services. Concurrently, community health navigators will educate and empower families on how to successfully navigate the health care system, connecting members to a primary care medical home,

promoting preventive care, facilitating appointment keeping, and providing education and resource referrals. The overall goal is for members to receive the right care, at the right time, in the right place.

"This model of care was created because we all believe we can achieve cost savings in providing health care, while maintaining and even improving safety and quality," says Bob Duncan, president of CCHP. "We are committed to helping individuals and families find health homes and reduce avoidable emergency department visits by at least 7 percent. While these changes are designed to save millions of dollars, they also will lead to better coordination of services to improve HEDIS [Healthcare Effectiveness Data and Information Set] quality metrics around asthma, immunizations, diabetes and lead testing, which are all known to have marked disparities among traditionally underserved populations. We strongly believe this model will result in increased satisfaction both among the families served and the medical community."

Over the three-year period of the grant, an estimated nine jobs will be created, including nurse and community health navigators.

### CHANGING HEALTH CARE DELIVERY

As made evident by these grants, children's hospitals across the country are creating alternative care models to improve the delivery of coordinated pediatric health care. These six programs as well as other initiatives under way at children's hospitals demonstrate that many options have sustainable payment models to reduce costs while improving quality of care for children. ✦

Information compiled from grant recipients by Elizabeth Parry, assistant director, policy analysis, Children's Hospital Association.