CARE COMPASS NETWORK

Innovation Fund Program
Round 1

CareFirst – HOMR (Hospital-Patient One-Year Mortality Risk) – By being able to accurately predict the likelihood that a patient may be facing the end of life within the next year, the HOMR provides a realistic framework within which to work and moves care from the reactive to the proactive. This allows for certain vital actions to be taken. For instance, advance directives and surrogate decision makers can be put into place. Providers can have fully informed and realistic care planning discussions with patients. Palliative medicine consultations can be pulled into play. Additional community-based resources can be activated that will support the patient's ability to stay at home and avoid unnecessary hospital utilization. Patients and families can prepare emotionally, socially, spiritually, financially and personally for the end of life. Hospice support can be activated in a timely manner. All of this has been shown to lower the symptom burden for both the patient and the family, reduce costs and actually help the patient live longer. The HOMR was validated on over 640,000 patients and was found to have a 92 to 95% predictive validity on identifying if a patient would die within a year of an index hospital admission.

Cayuga Area Plan – VBP Pilot Plan – CAP intends to expand its model of clinical integration to the Medicaid population by using its experience with commercial payers and partnering with a Medicaid Managed Care Organization (MCO). The Provider Organization will expand its Clinical Integration Program to the Medicaid population, including health initiatives and care coordination efforts. CAP will work with the MCO to create a value-based payment arrangement for Medicaid members in Tompkins County in alignment with the VBP roadmap provided by the NYS DoH.

Guthrie Clinic – CHF Disease Management – Identification of patients with Heart Failure through the Guthrie EMR which can be risk-stratified and immediately begin an intensive management program for those identified as the greatest risk for complications. Proactive identification of patients prevents both cost and suffering for patients. Additional focus will be put on patients with a previous hospital admission for HF exacerbation. All HF patients will be screened by an RN telephonically and enrolled in the program as willing and able. The program will include an in-home visit, setup with self-monitoring tools including a scale and blood pressure cuff, and education. An outpatient care coordinator will follow the patient and assist in management of their disease through telephonic contact on a monthly basis to provide additional motivation and disease-specific education to patients. The program will be overseen by a Medical Director.

Our Lady of Lourdes – ED Coaches – to develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health conditions, improve provider to provider communications and communication with Medicaid Managed Care Organizations (MCOs) in the community and provide supportive assistance to transition members to the least restrictive environment and address environmental factors and social components that are drivers of poor health outcomes.

Our Lady of Lourdes – Mobile Outreach – Mission in Motion will provide Mobile Outreach and Health Navigation services to rural communities in Broome and Tioga counties. A health coach will engage patients through PAM surveys as well as use evidence-based screenings to identify and make referral to treatment for mental health/substance abuse as well as mental/emotional/behavioral health promotion and treatment. The health coach will assist residents with DSS benefits/insurance enrollment assistance and food assistance. Partnering with CBOs, Lourdes will distribute health foods to residents living in poverty and communities experiencing food insecurity. Financial counseling services will be provided to assist the uninsured who are eligible with obtaining Medicaid coverage and connect residents to a medical home. The mobile clinic will be staffed with RNs to administer vaccinations.

Our Lady of Lourdes – Population Health – Patient Outreach and Care Management – Two dedicated Population Health Coordinators will be added to the existing staff. Emergency room utilization will be monitored on a daily basis. Patients will be identified for outreach based on the NYU algorithm for avoidable ED visits. These patients will be contacted to ascertain the reason for accessing care in the ED. Education will be provided regarding primary care services. Patient will be scheduled for a primary care follow-up visit. If the patient does not have a PCP, they will be offered an establishing visit. PAM survey will be administered as applicable. Utilizing HEDIS measures, existing Medicaid beneficiaries will be assessed for open care opportunities. Education on prevention/wellness and management of chronic conditions will be provided to the patient. PCP will be notified of care gap at the time of the patient visit. Confirmation of completed PCP visit will be monitored. If visit does not occur, further outreach will occur.

Our Lady of Lourdes – Video Teleconferencing for Behavioral Health Patients – This project will train a MSW in a web-based and evidenced based problem solving therapy offered through video telehealth. Individuals will have the ability to have video telehealth visits with a MSW anywhere between 2 to 7 times. The visits will concentrate on the PEARLS program from the University of Washington, increasing individuals understanding of the link between their current symptoms and their current problems, increasing the individuals ability to clearly define their problems and set concrete and realistic goals, teaching the individuals a specific, structured problem solving procedure; producing positive experiences of individuals through their ability to solve problems and thereby increase their confidence and sense of control.

Rural Health Network of SCNY – Mobility Management – Mobility Management of South Central New York (MMSCNY) – Get There Call Center. Implementation of a transportation toolkit and voucher program as well as expansion of the GetThere Call Center hours and services from 40 to 60 hours of call center operation per week. The transportation toolkit will serve all nine of CCN's counties. It will be designed by healthcare providers in partnership with mobility management professionals and information technology consultants. It will be web-based include desktop, tablet, a mobile phone app, and hard copy components. Its purpose is to provide easily accessible information to quickly and efficiently address the transportation needs of Medicaid recipients and other transportation-disadvantaged populations served by healthcare providers. The voucher program will serve the South & East RPUs and will be for travel by Medicaid recipients to destinations and services not eligible for Medicaid-funded transportation but essential to their health and prevention hospital re-admissions, etc. Vouchers will be redeemed through the GetThere Call Center's Connection to Care program.