PHM Care Continuum iSolve Grant

Mass General Brigham's Population Health Management Care Continuum Team is pleased to announce the launch of our PHM Care Continuum iSolve Grant for 2022. Our mission is to optimize system-wide performance through appropriate post-acute utilization by getting patients to the right level of care at the right time. The iSolve Grant will allow RSOs (Regional Service Organizations) to develop new interventions focused on optimizing skilled-nursing facility utilization. This grant will assist RSOs in developing systems to meet the 2022 Internal Performance Framework SNF utilization measure. Successful projects will be evaluated for their potential to scale across the network.

Appropriate skilled-nursing facility (SNF) utilization is a critical component of the Mass General Brigham (MGB) Population Health Management Value-Based Care strategy. SNF utilization at MGB is high relative to national benchmarks and other top-performing healthcare systems. It is also a high area of cost, accounting for 6% of total Medicare expenditures for MGB Medicare Shared Savings Program Accountable Care Organization patients in 2019. Many patients also want to be discharged home, and this may improve quality of care due to increased access to MGB clinicians and subspecialists and decreased exposure to institutional care settings which can be harmful to elderly, frail patients.

Chosen RSO projects will be aimed at **understanding** SNF utilization through QI efforts, human-centered design, and/or implementing an intervention with a promising solution through a collaborative and cohesive approach. This grant provides awardees with the opportunity to collaborate with the PHM Care Continuum team and Springboard, a user-centered design team at MGB.

Eligibility:

Mass General Brigham's 9 RSO affiliates are eligible to apply for this grant.

MGB's RSOs

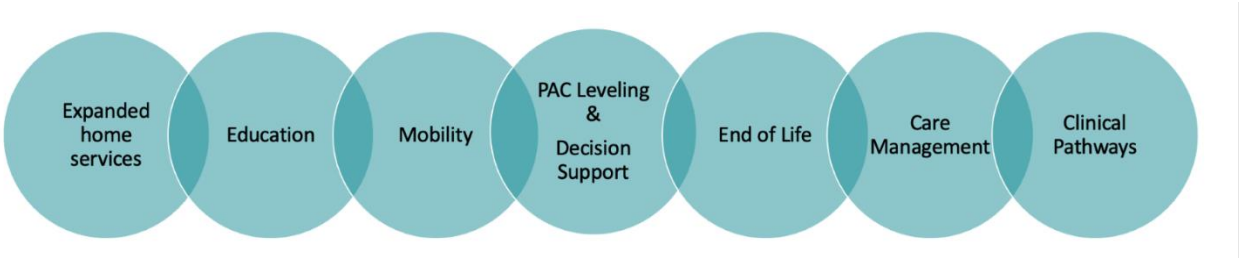
- Brigham and Women's
- Charles River
- Cooley Dickinson
- Emerson
- Mass General
- Milford Regional
- Newton Wellesley
- North Shore
- Pentucket

*Please note that there is no limit on the number of project proposal submissions per RSO.

Application Context:

This intervention list summarizes efforts and best practices of other institutions including academic medical centers and large organizations committed to value-based care. It was created based on market research, including literature review and interviews.

Applicants are to provide a proposal that focuses on **understanding or decreasing SNF utilization** under one of the following domains:



Expanded home services: With increased support in the home, more patients can return home sooner and potentially also avoid hospitalization.

Education: Initiatives focused on ongoing education of best practices will provide peer mentorship and the opportunity to learn from each other's successes and challenges.

Mobility: Immobility is associated with poor clinical outcomes, including increased mortality. Increased mobility during admission has been shown to decrease the need for post-acute care including SNF as well as have improved clinical outcomes, including decreased mortality and decreased length of stay.

Post-Acute Care Needs Leveling & Decision Support: Standardize and clarify post-acute care discharge criteria and language. Ensure different specialties (nursing, rehab, MD/APPs) and clinicians are using similar criteria to standardize post-acute care recommendations.

Project example: Documenting case management and physical therapy assessment workflows to better understand barriers to discharge home.

End of Life: Patients with repeated SNF admissions experience remarkably high mortality, indicating opportunity to provide additional support with end-of-life resources such as palliative care consultation, hospice referral, serious illness conversations, and advance care planning.

Care Management: Care management and case management are critical stakeholders in the discharge process. Established SNF networks and clinical networks can be foundational programs for managing SNF utilization and population health.

Clinical Pathways: Develop clinical pathways for disease states that are known to be high risk for SNF discharge that focus on improving care and decrease post-acute needs.

Example: Pre-op optimization or education clinics with pre-surgical discharge planning and pre hab referral for high-risk patients, for example within the Geriatric-pre op clinic.

Grant Recipient Requirements:

- Partner with the Care Continuum team and Springboard to work on this effort
- Submit project status reports on a bi-weekly basis to MGB. The report will include the current weeks completed tasks, upcoming tasks, outstanding decisions, and any risks/barriers
- Provide the Care Continuum team with documentation on how grant funds were allocated

- Present project updates at the SNF Utilization Learning Collaborative in September or November depending on your organization's assigned date
- Define success metrics and track project success. Findings will be reported to the Care Continuum team monthly for the first 6 months post project implementation and every 6 months following (as appropriate)
- If your intervention decreases SNF utilization, your team will act as champions by providing feedback and supporting intervention scaling intervention within the system
- Within 2 weeks following project completion, submission of an executive summary and slide deck to the Care Continuum team

Award Package:

Budget: All selected projects will be awarded up to $50,000.

Payment Release Schedule: Funds will be released in two tranches, one at the beginning of the project, and the second after achieving agreed upon milestones

Performance Metrics: Access to the Care Continuum claims dashboard, 4Next data, and PACT data.

Partner Collaboration:

- Each awardee will have the opportunity to collaborate on their initiative with the PHM Care Continuum team and Springboard
- This will include mentored project implementation and evaluation with specific focus on product/idea iteration based on implementation and scaling complexity

Timeline:

Milestone	Date
RFP Announced	Wednesday, April 20, 2022
Application Drop-in Session*	Monday, May 2, 2022, at 4:00pm
Application Deadline	Monday, May 23, 2022, at 5:00pm
Award Announcement	Monday, June 13, 2022
Initial Fund Release**	Monday, June 13, 2022
RSO Project Kick-off	Tuesday, July 5, 2022
Final fund Release**	Monday, August 15, 2022
Learning Collaborative- RSO Project Interventions	Tuesday, September 20, 2022
Learning Collaborative- RSO Project Interventions	Tuesday, November 15, 2022

*If you'd like to attend, please follow the Zoom link **here.**

**The type of project and resources required will determine the timing and amount of funds released.

Application:

Directions:

Please complete the application below outlining your project area of focus, problem, proposed solution, objectives, and major deliverables. Additionally, the Care Continuum team asks that a budget form is completed and a signed leadership buy-in letter that includes a statement of support is submitted with the application.

For any additional questions, please submit them to: PHMCareContinuum@partners.org

We will hold a Care Continuum/Springboard drop-in session for questions regarding the Care Continuum iSolve Grant on May 2, 2022.

Application Link: 2022 Care Continuum Spark Grant Application

Application Criteria:
Please keep the criteria below in mind when defining your project and completing the application.

Project Description	• Identify a problem and potential solution • Clear project objectives and defined key milestones • Outline metrics to measure project outcomes and success
Effort	• Obtain leadership buy-in • Confirm stakeholder project participation • Confirm ability to initiate project no later than the end of July 2022
Cost	• Practical proposal of how funds will be allocated • Capable of paying additional project costs above grants funds • Specify approach to sustain financial costs following implementation if applicable
Impact	• Align with Care Continuums mission and strategy • Short-term and long-term impacts • Direct impact on understanding or improving SNF utilization and patient care