

COVENANT
Health Network

Grant Application

**ASET--Unconnected Healthcare Providers
Health Information Exchange (HIE) Grant Program Application**

**Covenant Health Network (Lead Applicant)
and
John C. Lincoln Health Network**

**Executive Sponsor & Contact Information
for person completing the application:**

**Matt Luger, CEO
Covenant Health Network
3877 North 7th Street, Suite 240
Phoenix, Arizona 85014
Phone: (602) 287-0484
Email: mluger@covenanthealthnetwork.org**

Date of Application: November 16, 2012

Total Dollar Amount Requested: \$ 100,000

ASET--Unconnected Healthcare Providers Health Information Exchange (HIE) Grant Program Application

Project Description and Partner Relationship/Collaborative Structure

Covenant Health Network (Lead Applicant) is a 501(c)3 non-profit post-acute care service delivery network, established in 1997. Headquartered in Phoenix, Arizona, Covenant (CHN) is comprised of 90 post-acute care facilities including Skilled Nursing Facilities, Assisted Living Centers, HUD subsidized congregate Housing and Adult Day Health, operating in the States of Arizona, Colorado, New Mexico and Mississippi. Additionally, Covenant owns and operates a variety of ancillary lines of service in the post-acute environment including several hospices, an outpatient rehabilitation company, a pharmacy and home health agencies. Covenant Health Network business entities currently serve approximately 15,000 clients daily. Half of the current client population resides in Arizona, with a heavy concentration in Maricopa County. This subsection of the client population will be the focus of the grant programming.

Each Covenant Health Network Provider currently uses one of several post-acute Electronic Medical Records Systems. These systems, although efficient at managing patient medical information within each discrete entity, cannot transmit or receive HIE data from either the JC Lincoln hospitals or Physicians Network, who collectively utilize the EPIC EMR system. Consequently, care transitions to and from acute and primary care providers to post-acute care providers are disjointed and haphazard; relying on faxes, phone calls or paper records, when remitted.

The John C. Lincoln Health System is a non-profit community-based organization, founded in 1927. It is comprised of two acute care hospitals, numerous primary care and urgent care centers throughout Maricopa County, Arizona and the JC Lincoln Physician Network, which is among the largest physician practice organizations in the state of Arizona, servicing more than 250,000 patients annually. The JC Lincoln Health system (JCL) was approved in 2012 by CMS as an Accountable Care Organization.

JCL and CHN have formed a strategic partnership with the following goals and objectives:

1. Create an integrated care delivery system “powered” by multi-disciplinary care planning across the entire health delivery continuum, with all health providers, from primary care to acute care to post-acute services having access in real-time to a common patient EMR data base.
2. Promote seamless transitions across the care continuum in order to improve population health, reduce the incidence of duplicative procedures and diagnostics and to materially reduce the frequency of hospital readmissions within the 30-day period post-discharge.
3. Establish interoperability among the diverse EMR platforms currently in use across the applicant health delivery settings.

4. Ensure that all participating providers receive critical care planning data in real-time, such as laboratory and other diagnostic test results, patient care summaries, patient history and physical reports and current medication regimen documentation.

Geographic Area/Demographics of Population Served

The project will serve to meet the health needs of the elderly and physically disabled population, throughout Maricopa County. The population to be served under the grant are predominately low income.

More than 70% of the patients served by CHN entities are dually eligible (Medicare/Medicaid) indigent clients. JCL is a Disproportionate Share hospital serving a high percentage of low income “no-pay” clients.

To date, post-acute providers have been precluded from applying for or receiving funding under the Federal HIE Incentive Program, in order to implement HIE Solutions. Additionally, post-acute providers have lacked access to capital to make their EMR systems compatible with those systems that are prevalent in the hospital and primary care settings. Similarly tight economics prevent the participant post-acute providers from abandoning their different legacy EMR systems, in favor of adopting a single HIE platform that can push and pull data to JCL’s EMR system.

The grant funds will be used primarily to engage a highly qualified Health Data Management Solutions vendor who will develop “bridge” interface software to enable the sharing of critical patient-specific health information across the different participant care settings. This, in turn will provide the following tangible benefits, in terms of care coordination and delivery:

1. Optimize Discharge Planning

Provide clinical coordinators with tools to create and communicate custom-tailored longitudinal care plans for high-risk patients.

2. Proactive Identification

Identify high-risk patients for tracking to reduce the likelihood of hospital readmissions.

3. Effective Care Coordination

Allow for early identification of gaps in care”, such as failure to fill a prescription, out of range clinical indicators, etc.

4. Caregiver Engagement

Improve communication between diverse caregivers, assuring a common base of data and knowledge regarding patient status/conditions.

CHN, in cooperation with the selected vendor and the IT Coordinators at each participant care delivery site, will ensure training of all caregiver staff so as to optimize the value and accessibility of shared HIE data.

Implementation of the health information exchange will enable 8 pilot facility SNFs from within the Covenant Health Network to share key clinical data with the doctors from the JCL Physicians Network and the JCL hospitals, to promote timely assessment and interventions following patient changes in condition. The result should be lower incidence of hospital admissions and readmissions for the target population. Additionally, CHN will be recruiting and implementing a position of Care Transitions Coordinator who will follow the patient target population across all care settings. These initiatives should result in more timely clinical interventions and appropriate referrals to the lowest cost and least restrictive level of care, when transfers are warranted.

Covenant Health Network will serve as the Fiscal Agent for this project. The Project Lead will be Matt Luger, CEO, Covenant Health Network. A copy of his resume is attached to this application.

This application is a joint application and a Letter of support from the John C. Lincoln Health System is attached.

Communications of the progress of the pilot will be generated by the Care Transitions Coordinator and disseminated to all program participants on both a monthly and as-needed basis.

The Chief Information Officers of all participant providers will serve as liaisons between the software development organization, CHN, JCL and the pilot SNFs.

The following Project Team Members will be involved in this initiative:

Matt Luger	CEO Covenant Health Network	Overall Project Manager
Nathan Anspach	VP, John C. Lincoln Physician Network	Project Liaison to JCL Physicians
Nancy Whitt	Director of Post-Acute Services	JC Lincoln Health System – Project Liaison
Heather Jelanak	Director, John C. Lincoln, ACO	Project Liaison to JCL ACO
Bonnie Wood	Director of Business Development, CHN	Project Liaison to CHN SNFs
To be hired	Covenant Care Transitions Coordinator	Project Liaison for Clinical Integration and Data Coordination

Line Item Budget

1.	Software engineering and conversion to connect 8 post-acute pilot facilities (SNF) EMR systems to exchange health information data with EMR currently used by JCL hospitals and Physicians Network including hardware and interfaces.	\$88,000
2.	Hiring of a Care Transitions Coordinator (RN) to oversee seamless care ‘hand-offs’ between participating providers and the implementation of multi-disciplinary care planning across all care settings.	\$90,000
3.	Fringe benefits for Care Transitions Coordinator (at 23%).	\$20,700
4.	Project management by Lead Applicant – 25 hours/month @ \$75/hour.	\$11,250
5.	Orientation and training for staff at participant provider entities regarding data exchange. (3 hours per post-acute facility; 3 hours for JCL hospital staff; 3 hours for JCL Physician Network staff) @ \$90/hour.	\$2,700
	Total Expense.....	\$212,650
	Grant Funding.....	\$100,000
	In-Kind Services by Applicant Organizations.....	\$112,650

Project Work Plan

The following project time-line has been established:

January 1 – January 31, 2013	Develop project technical work specifications and interview qualified HIE vendors to engage.
February 1 – February 15, 2013	Final vendor selection. Contracts executed and beta test sites (2 Covenant SNFs) selected for initial conversion installation. Care Transitions Coordinator hired and begins orienting with all participant providers.
February 15 – March 15, 2013	Training offered to care staff in pilot facilities, JCL hospitals and JCL Physician Network. Live beta test transmission and receipt validated. Care Transitions Coordinator implements tracking system for all participant facilities to monitor rates of 30-day hospital readmissions.

March 15 – April 30, 2013	Implementation of HIE rolled out in remaining 6 Covenant SNFs. Staff training precedes rollouts. Data validation process continues.
April 30 – June 30, 2013	Care Transitions Program fully integrated throughout all participant SNFs, hospitals and physician practice groups. 30-day Hospital readmission data is benchmarked against Federal averages to gauge impact of care coordination and data exchange efforts. EMR systems for all participant settings (SNF, Physician Group, JC Lincoln Hospitals) linked to allow real-time data exchange.

Assurances

The applicants agree to comply with all the terms and conditions, as outlined in the provisions of Part V – Award Information, on the grant notice.

Summary

The Unconnected Healthcare Provider Health Information Exchange Grant Program will enable the critical first steps in the process of connecting patient information systems between primary care providers, acute care providers and post-acute care providers. Absent such efforts, longitudinal care delivery will continue to be under-coordinated, potentially either duplicative or deficient and unnecessarily expensive.

The project will permit previously unaffiliated healthcare providers to collaborate more effectively in managing a patient population across multiple care settings. Covenant Health Network and the John C. Lincoln Health System, as non-profit community-based organizations, are committed to improving the scope and quality of population health, with a particular emphasis on care delivery to the low income and medically underserved. It is our joint expectation that an ASET grant award will serve as a catalyst in creating a more coordinated and effective care delivery model for seniors in Maricopa County.

Thank you for your review and consideration.

Attachments: Letter of Support – John C. Lincoln Health Network
Project Lead Resume – Matthew Luger, CEO, Covenant Health Network



November 16, 2012

Manisha Patel
Project Manager
Arizona Strategic Enterprise Technology (ASET) Office
State of Arizona
100 N. 15th Avenue, Suite 400
Phoenix, Arizona 85007

TO WHOM IT MAY CONCERN:

This letter is in support of the grant application of Covenant Health Network and John C. Lincoln Health System for the Unconnected Healthcare Providers Health Information Exchange (HIE) Grant Program.

John C. Lincoln Hospital(s) and Physician Network will collaborate with Covenant Health Network on the implementation of the HIE Exchange and Care Transitions Program as outlined in the grant application. It is our belief that the ability for Unrelated Health Care Providers to share critical patient data in real-time is essential to the goals of our respective organizations improving quality and efficiency across the health care continuum.

Thank you for your consideration of our joint application in this important initiative.

Sincerely,

A handwritten signature in black ink, appearing to read "Nathan L. Anspach".

Nathan L. Anspach, FACHE, FACMPE
Senior Vice President
Physician Network and Accountable Care

MATTHEW LUGER

4701 East LeMarche
Phoenix, AZ 85032
(602) 482-2763

RESUME

EDUCATION:

Master of Public Administration, University of Arizona, Tucson, Arizona - 1977. Major: Retirement Housing and Long Term Care Administration.

EXPERIENCE:

March 2001 to
Present:

CEO, Covenant Health Network
Chief Executive Officer for a strategic alliance of 90 long-term care facilities in Arizona, Colorado, New Mexico and Mississippi. Negotiate managed care contracts, conduct group purchasing, offer management consulting and quality improvement programs.

February 2005 to
Present

MANAGING PARTNER, Alliance Purchasing Network
Operate national non-profit Group Purchasing organization for 500 member facilities, serving 70,000 seniors.

June 1994 to
March 2001:

EXECUTIVE DIRECTOR, Kivel Campus of Care . . .
Chief Executive Officer for multi-level geriatric campus with five corporations, including skilled nursing, sub-acute, behavioral, HUD and market rent housing and home and community based services. Responsible for negotiating and administering managed care contracts, statutory compliance, financial performance and total quality management.

October 1987 to
December 1994:

ADMINISTRATOR, Kivel Care Center, Phoenix, Arizona.
Chief Operating Officer for 191 bed non-profit nursing care corporation, with multiple facilities. Direct a staff of 210 employees.

January 1979 to
September 1987:

ADMINISTRATOR, Delaware County Home and Infirmary Delhi, New York. Served as Chief Executive Officer for 199 bed public nursing home with multiple levels of care. Directed staff of 250 employees. Implemented RUGS-II Case Mix monitoring system to maximize facility reimbursement.

September 1977 to
January 1979:

ASSISTANT ADMINISTRATOR, Delaware County Home and Infirmary, Delhi, New York.

**ADMINISTRATIVE/MANAGEMENT
CONSULTANT EXPERIENCE:**

1984 - Present

Provided consulting services for a variety of healthcare systems in the following areas:

- * Managed Care
- * Medicare/Medicaid Maximization
- * Regulatory compliance/Quality Assurance
- * Interim administration for "troubled" facilities
- * Cost reduction and occupancy enhancing strategies

Client List

The Hospital SNF - Sidney, New York
A.O. Fox Hospital SNF - Oneonta, New York
Community Hospital SNF - Stamford, New York
Eastern Star Retirement Center - Phoenix, Arizona
Westminster Village - Scottsdale, Arizona
Colorado Association of Homes & Services for the Aging
Texas Association of Homes & Services for the Aging
Kansas Association of Homes & Services for the Aging
Maryland Association of Nonprofit Homes for the Aging
Retired Servicemans League Villages - NSW, Australia

**PROFESSIONAL AND
COMMUNITY
AFFILIATIONS:**

Certification: Specialist in Gerontology, University of Arizona, 1977

Licensed Nursing Home Administrator, State of New York, 1979, State of Arizona, 1988

Licenses

Insurance Agent Licensure, Arizona Department of Insurance. Casualty, Disability, Life and Property, August 2001

Chair, Board of Directors, Arizona
LeadingAge Arizona, 1994 - 1996
Board Member 1990 - 1998

President, Arizona Board of Examiners for
Nursing Care Institution Administrators, 1998.
Board Member 1995 - 2001

Governor's Appointee, Arizona State Medicaid Advisory Committee, 1995 - 2000

Chair, American Association of Homes and Services for the Aging - Long Term Care Financing and Payment Committee, 1990.

Member, Health Policy Committee, American Association of Homes and Services for the Aging, 1992 - 1996.

Board Member, Alliance Senior Technology Solutions, 2009 - present

Recipient, Award of Honor - Arizona Association of Homes for Aging, 1993.

Member, Alzheimer's Advisory Committee, Arizona Governor's Advisory Council on Aging, 1990 - present.

Member, Rules Task Force, Arizona Department of Health - Office of Health Care Licensure, 1992 - present.

Editorial Board, Long Term Care Administration Manual, Aspen Publishers, 1990 - present.

President, NYS Association for Public Residential Health Care Facilities, 1986 - 1987.

Resource Staff Appointment, New York State Senate Committee on Rural Resources (Health Care Issues), 1983 - 1985.

Contributing Author, "The Dietary Department as an Adjunct to Milieu Therapy"; Contemporary Long Term Care Administrator Magazine, February 1979.

Contributing Author, "Negotiating Non-OBRA Related Add-Ons"; Payment Negotiation Guides for State Associations, American Association of Homes for the Aging Technical Brief, 1992.

REFERENCES:

AVAILABLE UPON REQUEST.