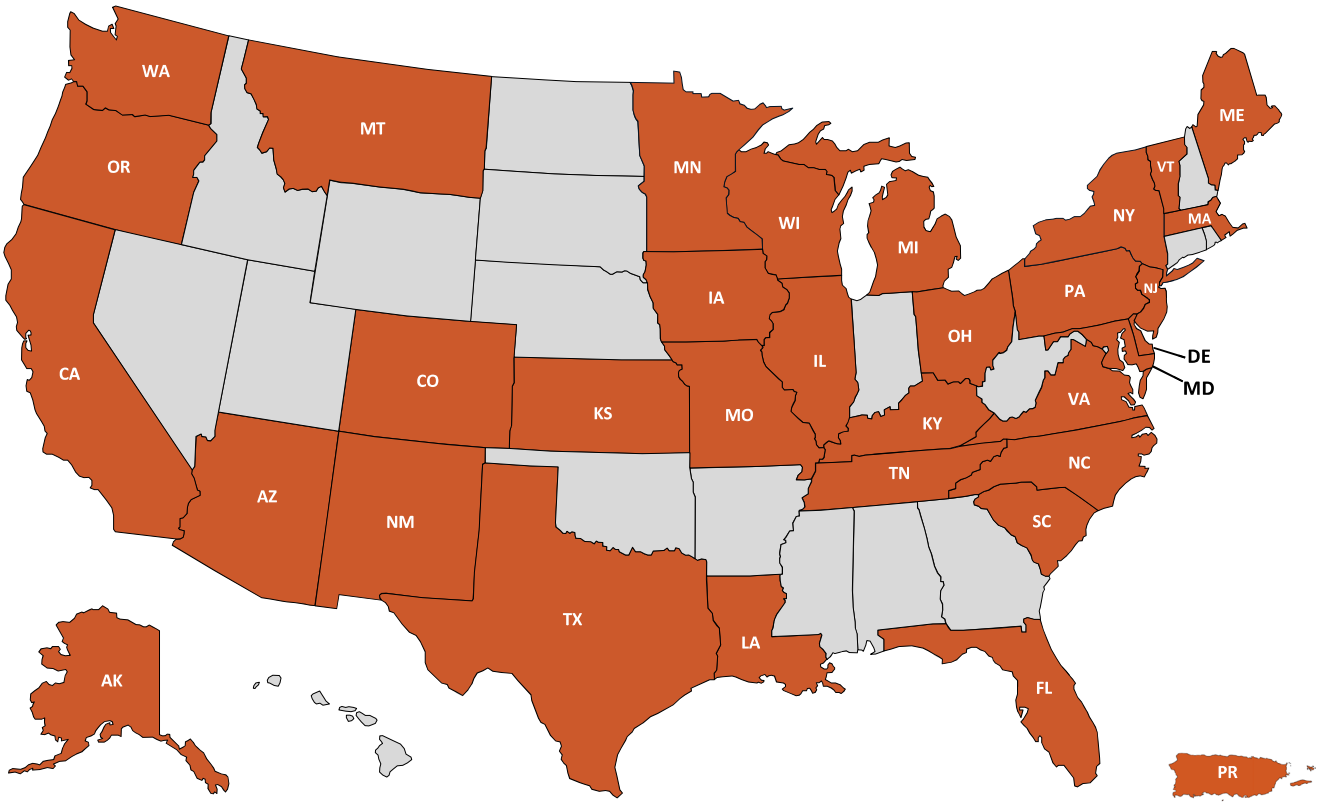
Programs Focusing on High-Need, High-Cost Populations

The Center for Health Care Strategies (CHCS) is working with innovative programs across the country that are testing new models of care for low-income populations with complex medical, behavioral health, and social needs. These programs include an array of approaches — coordinated at the state, health plan, or provider level — to address individuals' health issues, as well as underlying social factors, in order to improve health and cost outcomes.

Through CHCS' extensive work in this area and feedback from others in the field, we have identified programs across the United states that focus on providing care to individuals with the highest need. While not exhaustive, the following map and chart provide an initial inventory of innovative complex care efforts. The list, which includes programs at varying stages of development, will be updated periodically as the field continues to expand. We welcome updates and additions to the content; please send to cthomashenkel@chcs.org.

Identified Programs for Complex Need Populations



ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to advance innovative and cost-effective models for organizing, financing, and delivering health care services. Its work focuses on enhancing access to coverage and services, advancing delivery system and payment reform, and integrating services for people with complex needs. For more information, visit **www.chcs.org**.

STATE/PROGRAM	KEY PROGRAM DETAILS
ALASKA	
Southcentral Foundation	Serves Alaska Natives and American Indians in urban and rural areas; provides comprehensive medical, behavioral health, dental, case management, and advocacy services through its Nuka System of Care.
Alaska Medicaid Coordinated Care Initiative	Serves patients in the Qualis Health system; provides one-on-one case management, including care coordination, scheduling appointments, addressing barriers, and referrals to specialists and social service agencies.
ARIZONA	
Maricopa Crisis Response Network (Phoenix)	Serves individuals with excessive emergency department (ED) use, poly-pharmacy, and serious mental illness; includes focus on care coordination, crisis intervention, connections to housing, and collaboration with law enforcement.
CALIFORNIA	
Patient Health Improvement Initiative (San Diego)	Focuses on reducing inpatient and ED admissions through hot-spotting and care team visits; associated with the Multicultural Health Foundation.
San Francisco Health Plan	Provides comprehensive, community-based care coordination services for the plan's highest-cost beneficiaries.
Alameda Health System (Oakland)	Serves high-utilizing patients using an ambulatory-intensive care unit (ICU) approach to coordinate medical and social care within the safety net hospital system.
Stanford Coordinated Care (Palo Alto)	Serves high-cost employees of Stanford University using an ambulatory-ICU model with a focus on patient activation to reduce costs/improve outcomes.
West County Health Centers and Santa Rosa Community Health Centers' Complex Care Management Project	Serves the most expensive Medicaid patients, using a medical care team, nurse, and patient navigators to coordinate care with a focus on home care.
San Francisco Health Network's Complex Care Management Program	Serves high-risk, high-cost patients in an integrated delivery system; links patients with a nurse, health coach, and medical management team.
Los Angeles Department of Health Services' Care Connections Program	Links individuals with complex needs with community health workers.
Redwood Community Health Coalition	Operates complex care management pilot projects funded by the Center for Care Innovations and Partnership Health Plan.
West County Health Centers	Serves the most expensive Medi-Cal patients through primary care-embedded coordinated case management provided by an interdisciplinary team that addresses unmet medical and non-medical needs.
COLORADO	
Metro Community Provider Network Bridges to Care Program (Aurora)	Reduces inpatient and ED admissions by providing care support through hot-spotting, bedside visits, and home visits from care teams; focuses on treating behavioral health needs.
Northern Colorado Health Alliance – Regional Care Collaborative Organization	Provides care management for patients with Medicaid or Medicare/Medicaid; care managers become intimately involved in patients' lives, including accompanying patients to appointments and meeting patients in their homes.
DELAWARE	
Christiana Care Medical Home Without Walls	Serves individuals who do not have health insurance and who are at risk of frequent hospitalizations by connecting them with a care team to help create and achieve goals, improve treatment adherence, and receive necessary social services.
IOWA	
St Luke's Emergency Department Consistent Care Plan (Cedar Rapids)	Serves individuals with 12 or more ED visits in the past year; helps to formulate a care plan for patient and provides case management services, transportation services, and self-management support.
ED Consistent Care Plan, St. Luke's Hospital	Identifies frequent ED users and connects them with a care team.
Trinity Health Systems	Provides care coordination for patients with complex needs based on risk assessment and stratification, team–based care, patient engagement, and community involvement. "Tri-Navigational Community Care Model" supports patients with needs related to public health, primary care, and behavioral health.
ILLINOIS	
Care Coordination Entities	Provides high-risk, high-need Medicaid populations with integrated care coordination including hospital(s), primary care providers, and mental health and substance abuse providers.
Emergency Patient Interdisciplinary Care project (Chicago)	Targets high-utilizers of ED services, providing links to multidisciplinary care coordination team and leveraging technologies such as health information exchanges and telehealth to serve patients.
FLORIDA	
Bob Janes Triage Center & Low Demand Shelter (Ft. Myers)	Serves as a voluntary pre-arrest program for individuals diagnosed with behavioral health disorders, frequent non-urgent ED utilization and/or misdemeanor offenses; includes short-term shelter, crisis stabilization, clinical assessments, and connections to supports and services.
KANSAS	
KanCare Behavioral Health Homes (statewide)	Provides intensive care management for identified high-utilizing patients with serious mental illness; Medicaid health home program operates through contracts between three integrated health plans and health home partners.

STATE/PROGRAM	KEY PROGRAM DETAILS
KENTUCKY	
Kentucky Super Utilizer Program	Medicaid program serves individuals with 10 or more ED visits in one year; includes 16 hospitals using the Kentucky Health Information Exchange and coordinated care teams.
LOUISIANA	
Catholic Charities Health Guardians	Serves high-need individuals identified in the ED by pairing them with a health navigator who facilitates intensive medical and behavioral health care management and connects beneficiaries to wraparound social services.
MASSACHUSETTS	
Commonwealth Care Alliance	Serves Medicaid and Medicare beneficiaries with complex medical needs through enhanced primary care, multi-disciplinary care coordination teams, and home-based services.
Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program	Pilot projects at 25 Massachusetts community hospitals seeking to reduce inappropriate hospital use and enhance behavioral health care services with a primary focus on socially and medically complex populations; currently in the second phase piloting the intervention statewide.
MARYLAND	
Johns Hopkins Community Partnership (Baltimore)	Provides care coordination using community health workers and patient navigators to link high-need patients to health and social services; partnership between Johns Hopkins' medical school, primary care physician network, home care service and managed care.
Sinai Hospital of Baltimore and HealthCare Access Maryland	Pilot program designed to link frequent ED utilizers to care coordination services for 90 days, then hand off to longer-term resources.
Western Maryland Health System, Center for Clinical Resources	Serves patients with high hospital utilization to help them manage their chronic health conditions on an outpatient basis; uses information technology alerts to contact care managers when the patient arrives in the ED or is admitted to the hospital.
MAINE	
MaineCare Health Homes (statewide)	Serves individuals with multiple chronic conditions; Medicaid health home program includes partnerships between enhanced primary care practices and community care teams for high-need, high-cost patients.
MICHIGAN	
Spectrum Health: Center for Integrative Medicine (West Michigan)	Serves individuals with frequent ED visits, providing care coordination to address a range of bio-psychosocial issues using intake, pain and addiction services, and complex medical teams.
Genesys Healthworks	Genesys' "Familiar Faces" program serves high-risk frequent ED users by supporting patient self-management, particularly in developing health behavior changes.
MINNESOTA	
Hennepin Health (Hennepin County)	Serves roughly 25 percent of Hennepin County's Medicaid expansion enrollees; partnership between county-led health and social service entities.
MISSOURI	
Truman Medical Centers Guided Chronic Care (Greater Kansas City region)	Serves individuals with multiple chronic conditions providing home care team visits, disease management, health coaching, and connection to community-based services.
MONTANA	
Mountain Pacific Quality Health Special Innovation Project 2	Serves high-need, high-cost individuals across rural Montana by connecting them with community resources; Camden Coalition of Healthcare Providers is providing technical assistance.
NORTH CAROLINA	
Community Care of North Carolina Transitional Care Model (statewide)	Serves high-risk/high-cost individuals undergoing transitions in care; provides care management with a focus on patient self-management skills and follow-ups with appropriate providers.
Duke University Hospital Home Base Program	Serves patients with complex physical and behavioral health diagnoses who show ineffective patterns of health care utilization by implementing individualized care plans developed by a multidisciplinary care team.
NEW JERSEY	
Camden Coalition of Healthcare Providers	Serves high-need, high-cost patients by using health care data and hotspotting to identify individuals for intensive care management.
Greater Newark Healthcare Coalition	Coordinates care for high-utilizing hospital patients in Newark, New Jersey using data analytics and hotspotting.
Trenton Health Team and Healthy Greater Newark ACO	Serves its neediest patients by using a city-wide health information exchange to support Community-wide Clinical Care Coordination teams.
NEW MEXICO	
ECHO Care Complex Care Program	Serves individuals with complex needs in rural and underserved areas. Model uses outpatient intensivist teams that leverage telehealth technology to link with hospital-based specialists.
NEW YORK	
Health Homes (statewide)	Serves high-risk individuals with complex medical and psychosocial needs; Medicaid health home program involves partnership between delivery systems, health plans, and community-based organizations.

STATE/PROGRAM	KEY PROGRAM DETAILS
OHIO	
Health Collaborative's ED Care Coordination Pathway (Cincinnati and Cleveland)	Serves individuals with frequent ED visits, using a community-based outreach team that includes a community health worker and AmeriCorps volunteers who coordinate services; multi-disciplinary clinical advisory team includes social workers, hospital case managers, physicians, and behavioral health staff.
Better Health Greater Cleveland's Red Carpet Care for Patients in Greatest Need OH (Cincinnati and Cleveland)	Serves individuals with complex needs in "clinics-within-clinics" in National Committee for Quality Assurance-certified patient-centered medical homes staffed by interdisciplinary care teams; linkages with 10 area hospitals to identify and monitor high-utilizing patients in the community.
OREGON	
HealthShare of Oregon and CareOregon (Portland)	Serves Medicaid population with complex needs with integrated, patient-centered care coordination; uses health resiliency workers to focus on trauma-informed care, housing partnerships, and team-based care management.
PENNSYLVANIA	
Reading Health System, Project Connect	Identifies patients who are likely to return to the ED, in particular individuals with behavioral health issues; provides patients with care managers and nurse navigators for follow-up appointments and medication management, with a focus on health literacy.
South Central PA High-Utilizer Learning Collaborative	Serves individuals with frequent ED and inpatient visits by more effectively integrating physical and behavioral health and social services; partnership of five regionally based health systems: the Crozer-Keystone Health System, Lancaster General Health, Pinnacle Health System, Wellspan Health, and Neighborhood Health Centers of the Lehigh Valley and Widener University.
University of Pittsburgh Medical Center (UPMC) Health Plan	Through a partnership with the Western Psychiatric Institute, a team of mobile nurses and social workers collaborate to treat UPMC's most complex, high-cost members.
PUERTO RICO	
Triple-S Salud	Operates a pilot program based on the Camden Coalition of Healthcare Providers' outreach model through a partnership with Triple-S Salud, Inc. (Blue Cross and Blue Shield of Puerto Rico), and the Puerto Rican Health Insurance Administration.
SOUTH CAROLINA	
Greenville Health System	Serves Medicaid clinic and uninsured patient populations through an ACO model; provides patient-centered medical home with targeted home outreach case management, post-acute care services, and linkages to community supports and services.
AccessHealth Spartanburg	Serves low-income Spartanburg residents by connecting them to medical homes and providing wrap-around case management.
TENNESSEE	
The Jackson Clinic	Serves individuals with recurring ED visits by connecting them with registered nurses serving as clinical care coordinators.
CareMore	Provides disease management services to individuals with chronic illnesses (e.g., congestive heart failure, diabetes, asthma/chronic obstructive pulmonary disease); has branches in Arizona, California, Iowa, Nevada, Ohio, and Virginia, as well.
TEXAS	
Center for Health Care Services (San Antonio)	Serves individuals with mental illness, substance use disorders, and developmental disabilities through the designated Local Mental Health Authority; includes a jail diversion program and on-site housing facility in an innovative treatment model.
Brazos Valley Care Coordination	Serves frequent ED individuals who are at risk of disconnecting from health care by linking them with a community health worker for care coordination.
VERMONT	
OneCare Vermont	Vermont's largest multi-payer accountable care organization identifies high-risk, high-cost patients and clinical teams further identify patients at high risk. OneCare leverages the care coordination of Vermont's Blueprint for Health's interdisciplinary care teams.
Vermont Blueprint for Health Chronic Care Initiative (statewide)	Serves the top five percent highest-cost Medicaid beneficiaries in the state; provides care management, access to pharmacist, dietitians, and additional practice supports.
University of Vermont Medical Center	Operates a program serving patients who have poorly controlled chronic conditions or who frequently and inappropriately use the ED by connecting them with a multidisciplinary care team to coordinate care.
VIRGINIA	
Virginia Commonwealth University Health System	A cross-disciplinary team at the Virginia Coordinated Care Complex Care Clinic provides care for medically and socially complex patients in the Richmond, Virginia area, with partnerships with social service providers and behavioral health organizations.
Virginia Coordinated Care for the Uninsured	Provides coordinated care for individuals without health insurance.
WASHINGTON	
Health Homes (statewide)	Serves high-risk, high-cost individuals with multiple chronic conditions, including mental illness and substance use disorders; Medicaid health homes partner with care coordination organizations to provide services.
Whatcom Alliance for Health Advancement	Provides intensive case management for high-utilizers and runs a pilot program for eligible Medicaid beneficiaries' case management; partners with social service providers throughout Whatcom County, including a homeless center, public services, and charity care.
Consistent Care	Serves high-utilizing ED patients by creating individualized plans of care that are available to EDs via an information exchange.
WISCONSIN	
ThedaCare	High-utilizing patients, identified using an electronic health record-based risk calculator, are provided with supportive services, in-home visits, case management, behavioral health care, and life skills training; also connects patients to community organizations.
NorthLakes Clinic	Serves patients in rural northwest Wisconsin with high ED utilization patterns. The program is a network of FQHCs.