CHCS Center for Health Care Strategies, Inc.

FACT SHEET | March 2015

Programs Focusing on High-Need, High-Cost Populations

The Center for Health Care Strategies 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 (so-called "super utilizers"). 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.

CHCS conducted a preliminary scan of programs across the United States to identify those that are focusing on the top five percent of high-cost beneficiaries. The following map and chart provide an initial inventory of programs, based on CHCS' scan and feedback from others in the field. The list, which includes programs at varying stages of development, will be updated periodically as the field continues to expand.

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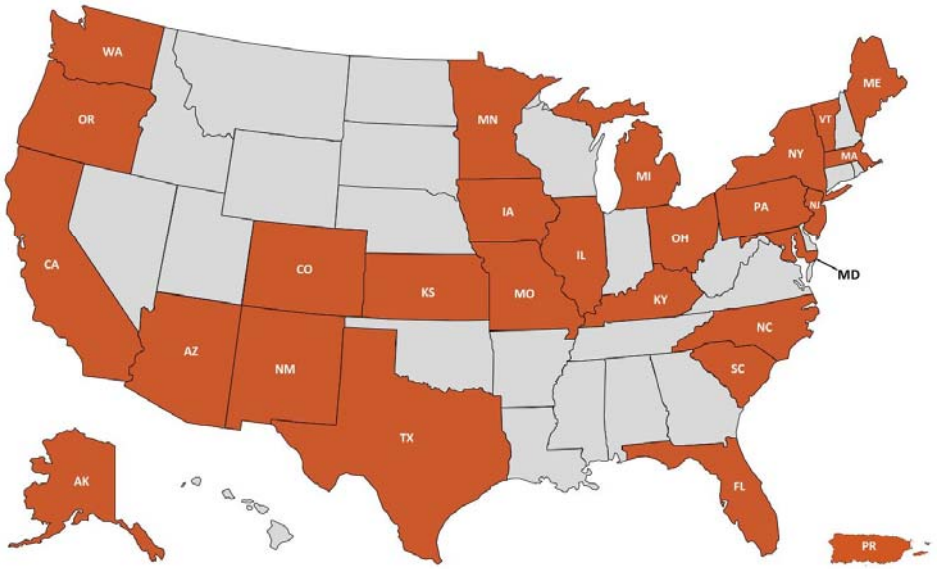

STATE/PROGRAM	KEY PROGRAM DETAILS
ALASKA	
- Southcentral Foundation	• Serves Alaska Natives and American Indians in urban and rural areas; provides comprehensive medical, behavioral health, dental, case management, and advocacy services through its Nuka System of Care.
ARIZONA	
- Maricopa Crisis Response 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.
- Stanford Coordinated Care (Palo Alto)	• Serves high-cost employees of Stanford University using an ambulatory-intensive care unit (ICU) model with a focus on patient activation to reduce costs/improve outcomes.
- Alameda Health System (Oakland)	• Serves high-utilizing patients using an ambulatory-ICU approach to coordinate medical and social care within the safety net hospital system.

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- 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.
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.
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.
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.
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 super utilizers with serious mental illness; Medicaid health home program operates through contracts between three integrated health plans and health home partners.
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.
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.
MARYLAND - Johns Hopkins Community Partnership (Baltimore)	• Provides care coordination services 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 entity.
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.
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.
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.

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NEW JERSEY - Camden Coalition of Healthcare Providers	• Serves high-need, high-cost patients identified using data-driven processes, and provides them with care management services.
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.
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 super-utilizers 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 - Lehigh Valley Super-Utilizer Partnership	• Serves individuals with recurring ED and inpatient visits through connection with primary care providers and home care team visits; focuses on connecting with community-based resources.
- 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.
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 accountable care organization (ACO) model; provides patient-centered medical home with targeted home outreach case management, post-acute care services, and linkages to community supports and services.
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.
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.
VERMONT - 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.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. This fact sheet was developed through CHCS' *Complex Care Innovation Lab*, a national initiative made possible by Kaiser Permanente Community Benefit to uncover new ways to improve care for individuals with complex medical and social needs. For more information, visit www.chcs.org.