Transforming Complex Care Site Descriptions

Health care policymakers, payers, and providers increasingly recognize the need for integrated care models for patients with complex needs — a population that accounts for disproportionate health care costs. *Transforming Complex Care*, made possible with support from the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies, is a multi-site demonstration aimed at refining and spreading effective care models for high-need, high-cost patients. Under the national initiative, six organizations are working to enhance existing complex care programs within a diverse range of delivery system, payment, and geographic environments. Following are site summaries:

AccessHealth

AccessHealth is a non-profit organization in Spartanburg, South Carolina that connects the county's uninsured population to medical homes and partners with community organizations to address patients' social determinants of health.

Demonstration Population: Medicaid and uninsured patients with one or more chronic conditions and frequent emergency department (ED) visits.

Demonstration Activities:

- Add a community health worker to multidisciplinary care coordination team;
- Research and implement a case severity tool; and
- Establish quality improvement methods to streamline workflow.

Mountain-Pacific Quality Health Foundation

Mountain-Pacific Quality Health Foundation is a quality innovation network-quality improvement organization that works to improve care for Montana residents by forging partnerships with health care stakeholders across the state.

Demonstration Population: Medicare, Medicaid, uninsured, veterans, Indian Health Service, and commercial patients with two or more chronic diseases and two or more hospital admissions in six months.

Demonstration Activities:

- Test the use of tablets to facilitate relationships and information sharing among patients, providers, and community care teams, particularly in rural areas; and
- Work with payers to develop sustainable funding for rural care coordination and community care teams.

OneCare Vermont

OneCare, a multi-payer accountable care organization in Vermont, coordinates care for individuals throughout the state, and is committed to identifying and engaging high-risk and at-risk populations.

Demonstration Population: Medicare, Medicaid, and commercial patients located in four targeted communities, identified as high-risk using the Johns Hopkins Adjusted Clinical Groups System.[1]

Demonstration Activities:

- Train community health teams in using analytic tools to stratify populations and evaluate interventions;
- Train community health teams in quality improvement methods, with the goal of refining and standardizing care management approaches across the state; and
- Deploy project management staff across the community health teams to provide cross-organizational support and promote sustainability.

[1] Johns Hopkins Adjusted Clinical Groups System: http://acg.jhsph.org/index.php?option=com_content&view=article&id=46&Itemid=366

Redwood Community Health Coalition

Redwood Community Health Coalition is a network of health centers in Northern California, including several that operate complex care management pilot projects funded by the Center for Care Innovations and Partnership Health Plan.

Demonstration Population: Medicare, Medicaid, and uninsured patients with patterns of: high ED or hospital utilization; multiple prescriptions; chronic illnesses; uncontrolled conditions; chronic pain; and/or homelessness.

Demonstration Activities:

- Enhance existing complex care management approaches through an FQHC learning collaborative;
- Develop care coordination standards to be implemented across the FQHC network; and
- Assess program implementation and impact on clinical and financial outcomes.

ThedaCare

ThedaCare, a community health system serving residents in Eastern Wisconsin, stratifies patients by risk and uses a multidisciplinary care team to develop care plans and manage patient care.

Demonstration Population: Medicaid, Medicare, and commercial patients stratified by clinical factors, utilization patterns, and psychosocial needs.

Demonstration Activities:

- Incorporate paramedics into care teams to: provide health education and follow-up care, facilitate appropriate ED use, and enhance access to community referrals and primary care;
- Convene a community advisory board to better coordinate and address patients' medical and social needs; and
- Expand complex care to an additional cohort of high-risk patients.

VCU Health System

VCU Health System's Complex Care Clinic, part of Virginia Commonwealth University, uses a team-based care model, including partnerships with social service providers and behavioral health organizations, to manage care for medically and socially complex patients in the greater Richmond area.

Demonstration Population: Medicaid and uninsured patients with incomes less than 100 percent of the federal poverty limit and at least one of the following: five or more chronic illnesses; under age 50 and diagnosed with Type 2 diabetes with complications; or six or more ED visits or two inpatient hospital stays in three months.

Demonstration Activities:

- Add two outreach workers to its care coordination teams;
- Employ "cold spotting" techniques to identify geographic areas that lack connections to social services and community providers; and
- Evaluate the impact of the care coordination efforts on patients' health.