complex care INNOVATION LAB

CHCS Center for Health Care Strategies, Inc.

# Complex Care Innovation Lab Member Organizations

The *Complex Care Innovation Lab*, supported by Kaiser Permanente Community Benefit and led by the Center for Health Care Strategies (CHCS), brings together leading thinkers in improving care for low-income individuals with complex medical and social needs. Through a variety of strategies, these organizations are making strides in improving the quality and cost-effectiveness of care for this high-need, high-cost population. Below are key details about participating programs and links to more information.

| PROGRAM | REGION | KEY PROGRAM DETAILS |
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| **Boston Health Care for the Homeless Program** | Boston, Massachusetts | Provides and ensures access to the highest quality health care for all homeless men, women and children in the greater Boston area. |
| **Camden Coalition of Healthcare Providers** | Camden, New Jersey | Serves high-need, high-cost patients identified using data-driven processes, and provides them with intensive, time-limited care management services. |
| **Center for Health Care Services** | Bexar County, Texas | As the Local Mental Health Authority, serves individuals with mental illness, substance use disorders, and developmental disabilities; includes a jail diversion program and a campus with integrated service delivery for the homeless. |
| **Commonwealth Care Alliance** | Massachusetts | Serves Medicaid and Medicare beneficiaries with complex medical needs through enhanced primary care, multi-disciplinary care coordination teams, and home-based services. |
| **Community Care of North Carolina** | North Carolina | Statewide network of clinicians, hospitals, pharmacies, health departments, social service agencies and community organizations that provides coordinated care under the medical home model to low-income adults and Medicaid beneficiaries. |
| **CareOregon** | Portland, Oregon | Serves Medicaid beneficiaries with complex needs with integrated, patient-centered care coordination; embeds health resiliency workers in primary care settings to focus on trauma-informed care, housing partnerships, and team-based care management. |
| **Hennepin Health** | Hennepin County, Minnesota | Serves roughly 25 percent of Hennepin County's Medicaid expansion enrollees; unique accountable care organization partnership between county-led health and social service entities. |
| **Johns Hopkins Community Health Partnership** | Baltimore, Maryland | Uses 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, managed care entity and community based organizations. |
| **Los Angeles Department of Health Services** | Los Angeles, California | Serves 5-10% of the agency's patients; links individuals with complex needs to patient-centered medical home-embedded care teams comprised of community health workers, PCPs and RN care managers. |
| **Maimonides Medical Center** | Brooklyn, New York | Through its Brooklyn Health Home, serves individuals with complex chronic illnesses by delivering coordinated and comprehensive medical, behavioral health, and social services; integrated health information technology is used to "virtually co-locate" providers across many partner organizations. |
| **Montefiore Medical Center** | Bronx, New York | Through its Care Management Organization, serves 400,000+ individuals, 5-10% of whom are high risk and receive intensive care coordination services. Has variety of risk-based relationships with Medicare, Medicaid and commercial payers. |
| **Project ECHO** | New Mexico | Serves individuals with complex needs in rural and underserved areas. ECHO Care model uses outpatient intensivist teams that leverage telehealth technology to enable ongoing consultation with hospital-based specialists. |
| **San Francisco Health Plan** | San Francisco, California | Provides comprehensive, community-based care coordination services for the plan's highest-cost beneficiaries. |
| **Southcentral Foundation** | Alaska | 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. |
| **Washington State / King County** | Washington State | Serves high-need, high-cost Medicaid beneficiaries through its Health Home program and Accountable Communities of Health, which combine integrated care, value-based payments, and community-level health care quality improvements. |

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