

# King County Care Partners

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# Agenda

- Context: the medically vulnerable and the “safety net”
- King County Care Partners
- The patients
- System improvements
- Future direction

# Case Presentation

Sarah is a 39 y.o. woman with a history of recently diagnosed bipolar disorder, hypertension, obesity, arthritis and diabetes. Sarah lives alone; she has applied for but not yet received social security disability. Sarah has health insurance through Washington State's Medicaid program, and receives a small monthly check from the state that she lives on.

Sarah has a primary care provider in the general medicine clinic at a local community hospital; she is also followed by a psychiatric nurse practitioner at a local mental health center. Sarah's blood sugar and blood pressure are poorly controlled. Sarah does not have a good understanding of her health conditions.

Sarah's PCP is unaware that Sarah is receiving mental health care at a MHC (Sarah never thought to tell her PCP this). As a result, her PCP is unaware of recent changes in the psychiatric medicines Sarah is taking. One day, Sarah is found in her apartment by the apartment manager lethargic and confused. She is transported and admitted to a local hospital with diabetic hyper-osmolar coma.

# Medically Vulnerable

- “Medically vulnerable patients are those whose impediments to care are social or medical, that is, related to culture, education, transportation, language, homelessness, legal status or difficult health problems such as chronic disease, mental illness, substance abuse or HIV.”
  - T King, et al. Medical Management of Vulnerable and Underserved Populations. McGraw Hill, New York, 2007.

“Noncompliance is not a patient problem, it is a system failure.”

Paraphrasing Paul Farmer

# The Health Care Safety Net: A Medical System for the Medically Vulnerable

- Core safety net providers usually include clinics and hospitals that have as their mission and/or are legally obligated provide care to serve patients regardless of ability to pay
- The core safety net provider in King County are community clinics and Harborview
- In King County, a large proportion of Medicaid patients receive care from safety net providers

# Falling Through the Safety Net

- Patient factors
  - Language
  - Education
  - Health Literacy
  - Priorities – “food before medicine”
  - Safety
  - Knowledge/understanding
  - Trust
  - Confidence
- System factors
  - Complex
  - Bureaucratic
  - Fragmented
  - Impersonal
  - Intimidating

# Reinforcing the Safety Net

- Patient level interventions
  - Empowerment
    - Knowledge and skills
    - Increased self-efficacy
  - Trust
  - Collaboration
  - Caring
    - “Research reveals that patients reporting greater trust and more collaborative relationships with clinicians have increased adherence to medication and treatment regimens and better health outcomes.” T. King, et al. Medical Management of Vulnerable and Underserved.

# Reinforcing the Safety Net: System Level Interventions

- Communication
- Coordination
- Connection
- Advocacy

# Social Ecologic Model



The diagram consists of seven concentric circles on a dark blue background. The circles are shaded in a gradient from light blue at the center to dark blue at the outer edge. Each circle contains a text label in bold yellow font with a black outline. The labels are arranged from the innermost circle to the outermost circle.

**Management by  
Patient**

**Family Involvement**

**Clinical Expertise**

**Work/School Support**

**Community Awareness, Support, and Action**

**Community-Wide Environmental Control Measures**

**Conducive Policies**

# King County Care Partners: Mission

KCCP brings together organizations that serve medically vulnerable Medicaid clients to improve clinical outcomes and decrease unnecessary utilization by providing community-based RN care management that empowers patients and enhances coordination, communication and integration of services across safety-net providers.

# King County Care Partners (Est. March 2007)



# Aging & Disability Services

- Highly experienced and well regarded as a nexus for the provision of community-based services
- Lead agency; manages project
  - Contracts
  - Budget and timeline
  - IT design and implementation
  - Coordinate operations
- Provides RN Care Management

# Clinics

- Participating clinics
  - CHCKC
  - Harborview
  - PSNHC
  - Seamar
- Serve as “Medical Homes” for eligible Medicaid clients

# Information & Assistance

- Senior Services, non-profit community agency
- Screen high risk clients
  - Send introductory letter
  - Coordinate with clinics to find hard-to-reach clients
  - Screen using Health Risk Assessment
  - Refer to RN Care Management
  - Refer to services i.e. transportation, food stamps, housing

# UW Clinical Informatics Research Group

- Develop cross-system medical record
  - Contact Tracking
  - Demographics
  - Health Risk Assessment
  - Comprehensive Assessment
  - Care Plan
  - Summary for medical providers
  - Reporting and billing

# Enrollment

- “Top down”
  - Eligible Medicaid patients identified by DSHS using claims data
    - Patients who are connected to participating clinics
    - “Risk bands” based on proprietary modeling software categorize patients by risk of future utilization
- “Bottom up”
  - Participating clinic systems identify and refer eligible clients who based on clinical judgment would likely benefit
- Risk stratified client list provided to Senior Services “Information and Assistance (I&A)”
  - Introductory letter mailed to all eligible clients
  - High risk clients contacted by phone and offered enrollment and additional assessment

# RN Care Manager

## Assessment and Care Management

- Schedules “home visit” and conducts comprehensive assessment with enrolled clients
- Notifies patient’s medical home/PCP re: client’s enrollment in KCCP
- Joins client at medical home/PCP visit
- Provides medical home/PCP with RN contact info
- Coaches client re: setting and attaining self-management goals
- Coordinates care with clinics, other providers (esp. Mental Health/RSN)
- Links clients to community resources and disease specific care management as indicated

# The RN Role

- Coach
- Advocate
- Clinician
- Coordinator/facilitator

# The Patients

## ■ Demographics

- Median age = 53
- Race/ethnicity
  - 55% Caucasian
  - 24% African American
  - 10% Asian
  - 4% Hispanic
  - 2% American Indian

## ■ Medically complex

- 44% screen positive for major depression
- 27% at risk for limited health literacy
- 20% at risk drinkers (alcohol)

# Evaluation

- DSHS led
  - “Abeyance” group as control
  - Client satisfaction
  - Healthcare utilization
- KCCP
  - Pre-post assessment
    - Client self-reported measures (depression, self-efficacy, etc)
    - Disease specific measures

# Quality Improvement

## Community-oriented Systems Integration

### ■ Mental health

- RSN medical director works with KCCP to develop and implement strategies that promote communication/coordination of care across primary care and mental health centers
- Example: KCCP RN's ask enrollees seen in RSN for consent to share records between mental health provider and PCP medical home
- KCCP RN's maintain regular contact with RSN providers and case managers to coordinate services and reduce duplication

# Quality Improvement Community-oriented Systems Integration

- High utilizers
  - KCCP RN's participate in King County “high utilizers” work group
  - Focus on coordinating resources across community
- Homeless
  - Regular coordination with Healthcare for the Homeless

# Quality Improvement

## KCCP “partner” focused integration

- Weekly operations meeting with partners
- Joint education and training
- RN’s have access to clinic systems EMR’s (beginning with HMC) – integration of KCCP notes into clinic medical record
- KCCP RN supervisor participates in monthly chronic care improvement process improvement meetings at HMC
- Presentations by ADS and KCCP Medical Director to KCCP clinic systems
- Funding for clinics to improve chronic care systems
  - Creation of clinic system-based “care coordinator” function

# Success, Opportunity and Challenge

- Success
  - Integrated community-based system of care
  - Improving clinical outcomes and optimizing utilization one client at a time
- Opportunity
  - Extend program reach and impact
- Challenge
  - Extraordinary burden of disease and psychosocial complexity/deprivation among enrolled clients
  - Operational/administrative
    - Identification of eligible clients, enrollment, etc
  - Resource limitations

# Care Partners

## Making a Difference

- Motivation fed by tough-minded optimism
- Staying power
- Ideas worth striving for
  - John Gardner, former Secretary of HEW and founder of Common Cause, in *Self-Renewal*, 1963