

Improving Medicaid High-Risk Care Management Overview: King County Care Partners

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After moving to her daughter's home in 2009 to escape an alcoholic, abusive boyfriend, Darlene Clark of Seattle desperately needed help finding permanent housing. Clark, a Medicaid beneficiary, found help in an unexpected place: her health care provider. Through the Harborview Medical Center, Seattle's public hospital, Clark connected with King County Care Partners' outreach specialist Caroline Bacon.

Bacon and her colleagues soon found Clark a scarce senior housing placement, and later helped her land a Section 8-subsidized apartment. They also accompanied Clark, who suffers from heart disease, obesity, and depression, to her medical appointments to help her work with her various physicians to reconcile her medications. Now she says she's doing much better, can get around with a walker and cane, is able to manage her own medical appointments, and isn't feeling depressed any more.

"They came to my rescue," says Clark, now 61. "They helped me get out of that situation, and they were just fantastic."

About King County Care Partners

Clark was one of more than 400 high-cost, high-need Medicaid beneficiaries served by King County Care Partners (KCCP) during the two-year Medicaid care management demonstration program that began in 2009. The program is a collaboration between the Washington State Medicaid program and a set of community partners, including King County Aging and

Disability Services (ADS), Harborview Medical Center, Neighborcare Community Health Centers, Healthpoint Community Health Centers, and Sea Mar Community Health Centers. Originally scheduled to end in June 2012, the program is being continued on an interim basis until the state's "health home" care management model for high-need Medicaid patients is begun.

The original program goals were to reduce Medicaid costs, particularly for preventable hospital admissions and emergency department visits, while creating more seamless care and improving outcomes for these very expensive Medicaid fee-for-service patients. KCCP received support from the Center for Health Care Strategies' *Rethinking Care Program*, which was funded through a \$2.5 million grant from Kaiser Permanente Community Benefit. The initiative supported similar Medicaid case management projects in three other states.

IN BRIEF

Through the *Rethinking Care Program*, the Center for Health Care Strategies partnered with four state pilots to test new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. This profile details the experiences of Washington's *King County Care Partners* project, a community-based, multidisciplinary care management intervention for high-risk Medicaid beneficiaries with both physical and behavioral health conditions. For more information about the *Rethinking Care Program*, visit www.chcs.org.

Washington Medicaid officials feel that the KCCP program shows promise of reducing costs and improving quality and outcomes for high-cost Medicaid patients, particularly those with alcohol- and chemical dependency problems. The program offers important lessons that state officials are using in developing Washington's new Medicaid managed care program, health homes strategy, and Medicare-Medicaid dual eligible integration programs. Those new initiatives will rely on organizations providing community-based, care management services similar to KCCP.

"For Medicaid patients who actively participated, findings are beginning to go in the right direction in terms of inpatient admissions, increased chemical dependency treatment, and decreased homelessness," said Beverly Court, the KCCP research manager for the Washington Health Care Authority, which runs Medicaid. "We learned a lot from the KCCP pilot, such as the value of patient activation and motivational interviewing."

A Community-Based Approach to Care Management

Through KCCP, nurses and social workers working for King County Aging and Disability Services provided community-based care management for high-risk fee-for-service Medicaid patients with chronic medical conditions plus mental health conditions and/or alcohol and chemical dependency issues.

Services included an in-person comprehensive assessment, collaborative goal-setting with patients, coaching in health self-management, joint visits with physicians, help in connecting with community resources such as employment and housing assistance, frequent monitoring, and coordination of care across medical and

mental health systems. KCCP also provided funding for Harborview and other participating clinics to have their own on-site care managers.

The aim was to create a system that integrated medical and other services for high-needs Medicaid patients, led by a community-based organization with deep experience working with community-based resources. "You need to share information about patients and get everyone on the same page," said Dan Lessler, KCCP's medical director and a professor of medicine at University of Washington.

A major focus was on using "motivational interviewing" techniques to engage patients in helping themselves, in contrast to the more traditional approach of telling patients how to improve their health. Participating staff at KCCP and the clinics – who received intensive training in motivational interviewing – said it was powerful in working with patients and also helped improve physician interactions. "The nurses say it has changed their lives and the way they look at patient interaction," says Rosemary Cunningham, KCCP's strategic planning manager. "It has transformed our agency at all levels."

At its start in 2009, KCCP initially focused on about 1,500 high-risk, SSI-eligible Medicaid beneficiaries in King County with chronic illness and behavioral health needs who had received care from one of the participating clinics within the previous year. A predictive modeling tool was used to identify this initial target group of individuals with expected health care costs 50 percent higher than average. Beneficiaries were randomly assigned either to the KCCP demonstration or to a control group whose members would receive care management services after the trial.

During the start-up and pilot phase, the state ended up paying, through KCCP, about \$500 a month for each beneficiary who actively participated. This covered at least three to six months of enrollment outreach, support for care coordinators in the participating clinics, and start-up infrastructure costs such as building a data system. The state mailed multiple carefully crafted letters to the eligible beneficiaries notifying them of the new program and its benefits.

The Critical Role of Consumer Engagement

The state gave the names of the selected beneficiaries to KCCP staff, who then tried to track down the patients by phone and enroll them. That was no easy task given that many of these people lived chaotic lives and some were homeless. The contact information was often out of date, or the person might be ineligible for Medicaid, in jail, or deceased. KCCP's Caroline Bacon said she had to do lots of detective work, checking various data bases, contacting probation officers, or calling the person's listed medical provider.

Some beneficiaries read the state's introductory letter and were receptive to Bacon's follow-up call. But others never received or opened the letter and were guarded when Bacon called. That's where the training in motivational interviewing and respectful listening helped (see *Benefits of Motivational Interviewing* sidebar).

Mary Pat O'Leary, KCCP's clinical supervisor, overheard Bacon making many of these calls. Sometimes, O'Leary says, the person initially would say they weren't interested. "Caroline would say, 'Oh, it sounds like you're already well connected with your doctor.' Then there would be a pause. And Caroline would say, 'Oh, you would like to enroll.' "

Bacon then would start the patient assessment and schedule a time and a place for a nurse care manager to visit the patient. While the care managers preferred to visit patients at home to assess the home environment, they deferred to patients' frequent preference to meet at a library, coffeehouse, the local Recovery Café, at a shelter, or at the KCCP office.



Tia Halberg describes her RN care manager role as "teaching clients to access the tools they need to help themselves." Whether it is a relaxation technique or a medication organizer, the clients learn how to use the tool to promote their own well being.

The Benefits of Motivational Interviewing

Patient activation and engagement were key to the King County Care Partners demonstration program. And motivational interviewing (MI) was at the heart of those engagement efforts.

MI involves listening actively, respectfully, and non-judgmentally to what patients say they want, even if that differs from what the care provider thinks is most important. It requires asking open-ended questions and helping patients balance decisions -- on the one hand this, on the other hand that.

The mantra is: "I'm not here to change you or make you do anything you don't want to do. I'm here to walk beside you." That is often hard, because high-risk Medicaid beneficiaries typically have objective needs that are obvious to health care professionals, who are trained to be prescriptive.

MI "starts with where the patient is" and seeks to develop shared goals between the patient and the provider, says Rosemary Cunningham, strategic planning manager for King County Aging and Disability Services. "These people are in really bad straits and no one has ever listened to them. This gives them a strategy for setting goals they can apply to their lives."

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At the start of the program and on a continuing basis, KCCP staff and clinic providers received extensive training in MI, supported by CHCS. Case managers accompanying clients to physician appointments used motivational interviewing and respectful listening for both the client and physician, which often changed behavior on both sides.

One success story involves a man with generalized anxiety disorder and alcohol dependence. In his first meeting with the nurse case manager, he said he didn't want her telling him what to do. She replied: "I'm not going to tell you what to do. I'm going to walk beside you regardless of the path you take."

In their third meeting, the client said he was thinking about making a change but wasn't yet ready. Subsequent meetings featured ambivalence, more talk about considering change, and problem-solving. It took six months, but the client finally entered a 30-day inpatient chemical dependency treatment program.

A survey of KCCP clients conducted by University of Washington researchers suggested that the MI approach resulted in high patient satisfaction. More than 90 percent said they had a trusting relationship with their case manager, felt they could take charge of their own health, and were able to achieve at least one of their health goals.

While some patients did not show up for scheduled meetings, KCCP staff enjoyed successes in persuading patients who initially turned them away at the door to open up and seek medical or detox treatment. “You have to appreciate the small wins and encourage people on their small steps, such as losing one pound or lowering their blood sugar a little,” O’Leary says. In the end, the program succeeded in signing up more than half the target group, and effectively engaged 45 percent of the total targeted group in active self-management.

Case Management Approach

Assigned care managers would accompany patients on clinic visits to their primary care physicians and encourage the patients to collaborate with the doctors on self-management plans. The care managers also would try to keep all the providers informed about what was going on with their patients. They would convene regular meetings with providers to discuss patient status and solve problems in the program’s operations, including electronic hurdles in sharing patient data.

The typical KCCP client had a primary care physician, one or more physician specialists, a mental health provider, entitlement program caseworkers, and perhaps a nutritionist, a diabetic educator, and a social worker. That complexity can be very confusing, especially for patients with limited education, cognitive or psychosocial impairments, and language barriers.

“There are a lot of cooks in the kitchen and it’s challenging for one person, such as the primary care physician, to see the big picture,” says Debra Morrison, behavioral health program manager at Neighborcare Health. “It’s invaluable to have someone pulling together the pieces, facilitating communication. I think a lot of the patients who

participated gained a lot. They felt cared for, made progress on their goals, and learned to utilize health care service more effectively.”

Still, the overall results of the demonstration were mixed. A University of Washington evaluation report earlier this year did not find evidence of significant savings in overall Medicaid costs for patients offered KCCP services, possibly because only 45 percent actively engaged in the services and the average follow-up was only one year.

Lessler argues, though, that achieving 45 percent engagement – meaning completion of a patient assessment and development of patient health goals – was a relative success given the experience of other programs around the country.

Similarly, the evaluation of the pilot found there were no significant net Medicaid savings for patients who actually participated in KCCP. But this group showed significant increases in desirable utilization of services – including outpatient visits, prescription drugs, home care and support, mental health, and chemical dependency treatment – along with decreased homelessness.

In addition, unplanned hospital admissions increased at a slower rate for active KCCP patients than for the control group, and also resulted in a two percent decrease in monthly per-beneficiary costs compared with a 49 percent increase in the control group. The program seemed particularly effective for participating beneficiaries with alcohol or drug problems. For patients in this group, total Medicaid costs dropped, possibly because they were more likely to receive alcohol- or chemical dependency treatment.

“What you see overall is KCCP clients received more access to needed services,

a reduction in hospital admissions preceded by an emergency room visit, and decreases in homelessness,” said Toni Krupski, a research associate professor at University of Washington.

“But the impact is not enough at this time to offset the actual cost of the intervention. The intervention may hold down medical costs primarily for those with alcohol and drug treatment needs.”



Care Manager Jeanette Choate. Says KCCP client Delores, “Jeanette helped me with so many things, including finding a doctor who understands me and who is concerned about my health. Even though I’m not in the program anymore, I still use the things I learned from Jeanette every day. I am so grateful to have had the chance to be in this program.”

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She noted, however, that high-cost Medicaid patients with serious chronic problems may need to be followed for two to four years to see the full impact of KCCP’s efforts

Future Prospects

In July, Washington began moving all Medicaid-only, SSI-eligible, disabled beneficiaries into five private managed care plans under its new Healthy Options program. Based on findings from KCCP as well as other chronic care management programs in the state, Washington is requiring the plans to provide community-based care management services to the estimated 48,000 Medicaid-only high-risk beneficiaries statewide, and it is negotiating with the plans on how to do this, says Bea Rector, project director for the state Aging and Disability Services Administration. All plans will have to offer a state-certified care management network.

KCCP’s Lessler expresses hope that his and his colleagues’ work in organizing a community-wide care management system, which was beginning to have a significant impact, will provide a framework for care management in the state. “The ability of managed care organizations to break even or make a profit will depend on how well they manage these very sick people,” he says. Similarly, the state acknowledges the KCCP pilot as a valuable investment, having cultivated a seasoned team of experts on complex Medicaid populations headed by Dr. Lessler—a particularly important resource as the state looks toward health homes and the Medicaid expansion.

Author Harris Meyer is a Washington State-based freelance journalist who has been writing about health care policy and delivery since 1986.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries.

This spotlight is a product of CHCS' *Rethinking Care Program*, which is developing and testing new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. It is made possible by Kaiser Permanente. For more information about the *Rethinking Care Program*, as well as tools for improving care management for Medicaid beneficiaries with complex needs, visit www.chcs.org.