complex care INNOVATION LAB

CHCS Center for Health Care Strategies, Inc.

PROFILES IN INNOVATION

Dan Lessler, MD, MHA, was named chief medical officer for the Washington State Health Care Authority, effective May 2013. He is a medical professor at the University of Washington School of Medicine and previously served as senior associate medical director for Harborview Medical Center in Seattle. Among many other local and statewide efforts, Dr. Lessler helped to found King County Care Partners, a community-based partnership dedicated to improving care for complex patients.

ABOUT THE INNOVATOR

Dr. Dan Lessler has worked in public hospital systems for over 20 years, first in San Francisco and then in Seattle, and thrives on the non-stop energy and mission of these safety-net institutions. Throughout his career, he has spearheaded projects aimed at generating systems change in health care, particularly through fostering community partnerships. He is now looking at opportunities to impact health policy at the state level as chief medical officer for Washington State's Medicaid program.

Dr. Lessler credits his residency training in San Francisco's county hospital system as the spark that ignited his passion for working with health care's most complex and vulnerable populations. During that time, he primarily cared for underserved populations – patients with multiple physical, behavioral, and social needs – who were simply grateful to be receiving care. "I loved the atmosphere, the *esprit de corps,* and the sense of mission that characterized the work," he says. He also deeply appreciated the intellectual challenge of the work, which fed his desire to develop systems of care that could better serve people with complex needs.

In addition to maintaining an active primary care practice throughout his career, during his 20-plus years at Harborview Medical Center in Seattle, Dr. Lessler has worked locally and statewide on efforts to improve the quality and reduce the cost of care for complex patient populations. He served on the founding board, and subsequently, the Quality Improvement Committee, of the Puget Sound Health Alliance, a nonprofit that brings together patients, providers, employers, health plans, and other entities across five counties to improve health care through performance measurement, reporting, quality improvement, consumer engagement, and payment reform efforts.

> "It's difficult to know with complex patients just how long they will need your services, because everyone is different. For some people, you can help them within six months or so, by getting them housed or connected to other resources. Others should probably be intensively case managed forever."

In 2007, Dr. Lessler helped establish King County Care Partners (KCCP), an intensive care management program for some of the county's highest-risk Medicaid patients. Under his leadership, KCCP earned national attention as a highly effective community-based partnership that developed mutually trusting relationships among all involved entities in order to enhance coordination, communication, and integration of medical and social services.

Most recently, Dr. Lessler was selected as the new chief medical officer for Washington's Medicaid program, effective May 2013. As the state prepares for Medicaid expansion under the Affordable Care Act, Dr. Lessler will use his experience as both a clinician and systems-change agent to tackle the challenges and opportunities presented by health care reform.

The Center for Health Care Strategies' Complex Care Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together leading innovators working to improve care for vulnerable populations with complex medical and social needs. Participants will explore new ways to advance complex care delivery at the local, state and national level. These profiles highlight Innovation Lab participants. For more information, visit www.chcs.org.

ABOUT THE INNOVATION

King County Care Partners

Program Description: King County Care Partners (KCCP)* was a partnership between the Washington State Medicaid program and a group of community partners, including Aging and Disability Services of Seattle and King County (ADS), the University of Washington Center for Advancing Integrated Mental Health Solutions, Harborview Medical Center, Neighborcare Community Health Centers, Healthpoint Community Health Centers, and Sea Mar Community Health Centers. These entities worked collaboratively to manage care for high-risk Medicaid beneficiaries with complex needs, in order to improve the quality and reduce the cost of care.

Population: Adult, supplemental security income (SSI)-eligible, Medicaid-only beneficiaries in King County, Washington, with comorbid mental health/substance use disorders and physical health needs, who were at 1.5 times the average risk for future utilization. Clients were identified using the state's Predictive Risk Intelligent System (PRISM) software.

Delivery Model: A list of individuals identified by the state through PRISM was provided to KCCP staff, who then attempted to track down each individual by phone – often having to search additional databases for information and call various agencies. KCCP staff were trained in motivational interviewing techniques to engage clients initially and throughout their enrollment. Once enrolled, clients were assigned to a multidisciplinary care management team for up to 12 months. The team included a nurse (lead), outreach worker, and social worker, all of whom were employed by ADS. Nurse care managers carried caseloads of about 50 clients, for whom they conducted screenings and risk assessments, collaboratively developed a care plan, and addressed barriers to care. Care managers also connected clients with additional community and social services, and accompanied them to provider visits. The care management teams worked closely with clinic coordinators to ensure that clients received the support they needed when they transitioned out of KCCP and back to the clinics for care. Providers and care managers stayed informed about client needs and operational issues through regular in-person, multidisciplinary meetings.

Financing: KCCP was originally created in 2007 as a pilot intervention, funded through a grant from Washington state's Medicaid agency. In 2009, the pilot was modified in collaboration with the state Medicaid agency, and it received additional support and funding from the Center for Health Care Strategies' *Rethinking Care Program* to enhance and rigorously evaluate the program over a two-year period.

KEYS TO SUCCESS

Among KCCP's many lessons, the following address particularly critical strategies for integrating systems to improve care:

1. **Develop a common perspective on how to interact with patients**, which incorporates the 'spirit of motivational interviewing,' suspends judgment, and extends across care teams, clinics, and all partners.
2. **Utilize information technology infrastructure** to integrate and communicate important information across systems.

*KCCP is now phasing out, as Washington is moving all Medicaid-only beneficiaries with disabilities into managed care plans – all of which must offer state-certified care management based on findings from KCCP and other care management demonstrations in the state.

Spotlight: Motivational Interviewing

"I walk side-by-side with my clients," became a mantra of KCCP care managers. Extensive training in motivational interviewing was initially provided to the core KCCP team of nurses, social workers, and outreach workers, but proved to be so successful that it was extended into the clinics and across the partnership. Motivational interviewing was one of the most integral aspects of the KCCP philosophy, and Dr. Lessler credits much of the program's success to it.

All KCCP staff received ongoing training in this technique, which involves listening actively, respectfully, and non-judgmentally to what clients want; asking open-ended questions; and helping clients balance decisions. Care managers used motivational interviewing techniques during provider visits, with both the client *and* clinician.

High client satisfaction was a natural result of this type of person-centered interaction. More than 90 percent of clients 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.

Dr. Lessler sees the success of the KCCP model as a result of coupling the 'spirit' of motivational interviewing with the specific skills of this technique. KCCP nurses and social workers truly internalized the values of motivational interviewing, and mastered the skills on top of that, in order to really engage with clients. "After some time, I would be amazed to see how care managers had connected with clients," he says, "and there was this element of trust – and frankly, warmth – in these relationships."