Grant Report on Care Coordination Funding

2008

From 2005-2009, the Health Care Foundation of Greater Kansas City (HCF) committed approximately $2.3 million to support 10 projects that used the Care Coordination approach to health service delivery.[1]

Approximately 13,300 people in HCF's six county service area received over 33,700 direct services, referrals, and outreach or educational services through these projects.

Over 600 regional physicians provided some of this care through 3,000 patient referrals. Physicians' donated time was valued conservatively at $7.8 million. Over $580,000 in donated medications were procured. And, at least 20 regional safety net clinics and hospitals provided services and partnership.

The purpose of this report is to evaluate these 10 projects, which all feature a high degree of Care Coordination, as a distinct cluster of HCF funded projects. Examples from individual grantees are featured in the report only to illustrate certain points.

[1]The ten projects reviewed in this report are a subset of all HCF supported projects that involve some degree of Care Coordination and were selected as representative of these concepts. HCF supported more than one project for three of the local agencies included in this report. Therefore, there are only seven different agencies represented by the ten grants. These grantees do not all define their projects by their health care approach. Instead, most define their projects by their target populations, such as Latino/Hispanic or patients with diabetes.

[2]All numbers reported are estimates for two reasons: (1) Four of the programs included in this report were still in progress when these results were calculated and (2) grantees were not consistent in the way they reported number of services and individuals served during the grant period. Estimates presented here are conservative.

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CARE COORDINATION

Care Coordination is an approach to health service provision rather than a prescribed treatment for a specific condition. It is used most often for patients with complex health issues and/or multiple diagnoses, although the basic tenets can be transferred to individuals with less complex health issues. For the purposes of this report, Care Coordination is defined as follows:

"the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care[3]."

Studies indicate that a Medicare patient typically will see seven different physicians from four different practices in a given year. The care for patients with multiple chronic illnesses is even more fragmented. And these are just average Medicare patients. We can only guess how complex coordination of care would be if we were to consider people who are uninsured, minorities and patients with behavioral health problems just to name a few.

Treatments, tests, results, and appointments must all be well coordinated; providers must share information; and patients must be well-integrated into the system of information sharing and decision-making.

A person with diabetes, for example, may need podiatry and ophthalmology care in addition to primary care and counseling on nutrition, diet and exercise. A person with heart disease and mental illness may need a primary care provider, a cardiac specialist, and a mental health provider. Patients who suffer from an illness and also experience social barriers may require more services and coordination of care. In these cases social services may also be integrated into the Care Coordination model.

Care Coordination is similar to Case Management, and it can be difficult to draw a clear distinction between the two concepts. In general, Case Management tends to feature one Case Manager who is in charge of assessing all of a client's needs (social, health, basic needs such as housing) and working with the set of professionals to provide those services to the client. The Case Manager's agency may provide financial resources for the services.

Care Coordination may also feature a single person or agency that is designated as a Coordinator. Within the Care Coordination model, however, it is the health care providers (i.e. nurse, medical assistants, social workers, community health worker, promotoras, health educators and health navigators) who exchange information about treatments for a single shared patient and make coordinated decisions about the patient's care, including scheduling appointments, tests, sharing results, prescriptions, etc. A Coordinator might facilitate this process and advocate for or educate the patient but is not necessarily in the role of decision-making .

[3]Source: McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft S, McKinnon M, Paguntalan H, Owens DK. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007. p. 41 Accessed online at http://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf on June 16, 2010.

For the purposes of this report, it is not important to make a fine distinction between the two terms or the two approaches. Rather, it is our intent to highlight the successful use of Coordinated Care concepts, which sometimes also integrates Case Management, among some of HCF's grantees. To this end, we focus on the intent of Care Coordination, as described below:

> **"While approaches to coordinating care may vary greatly, the general intent of these strategies is to facilitate delivery of the right health care services in the right order, at the right time, and in the right setting.[4]"**

TARGET POPULATIONS

The grantees identified their target populations in terms of access to care, race/ethnicity and/or Limited English Proficiency (LEP), health status (those with chronic health conditions or more than one diagnosis), specific health condition, and geography. None of the programs targeted children specially, although one program did include children in some of its family-oriented services.

Income and access. All grantees targeted their programs to low-income, uninsured, underinsured populations with limited access to health care in the Greater Kansas City region.

Race/Ethnicity and LEP. Three projects targeted Latino and Hispanic populations exclusively, particularly those with Limited English Proficiency (LEP). And, a fourth project included Latino/Hispanic populations as a significant subset of its clients.

Health condition and health status. Diabetes, heart failure, smoking, and mental illness were the most common health conditions targeted by the grantees. One grantee targeted clients with chronic conditions who were considered non-compliant or who had not achieved adequate disease management.

Homeless and hard-to-serve marginalized individuals. A significant portion of one project's target population was homeless. Additionally, conventional health delivery systems had not worked for many of its clients. This program addressed the needs of people with both mental health issues and physical health issues.

Geography. The grantees' services appear to be highly concentrated geographically in the Kansas City Metropolitan area, Jackson County (MO) and Johnson County (KS). One project focused only on Lafayette County (MO), and the majority of clients from another project were from Wyandotte County (KS). A small number of Cass County (MO) residents were served by one of the grantees, but Cass was not the primary target. Allen County (KS) appears to be the only county that was not specifically served by one of the grantees.

[4]Ibid.

APPROACHES TO CARE COORDINATION

All grantees focused on ensuring that the health needs of their clients were met and that health services were well coordinated and integrated. Some grantees focused on ensuring that health services were well coordinated with other types of non-health services (such as social services) for targeted populations. Others coordinated different types of medical treatments across different providers for clients with chronic conditions or multiple health conditions.

Latino/Hispanic populations with Limited English Proficiency.

Three projects that coordinated social and medical services also targeted Latino and Hispanic populations, typically with Limited English Proficiency. One project targeted the 500 migrant farm workers and families that come to Lafayette County each year in the fall to harvest the apple crops. This population is mostly Spanish-speaking, with limited access to transportation or telephones. Families typically live in one of several housing camps.

The key component of this program is the Medical Care Case Management, through which trained advocates helped families navigate the health care system and worked with families to assess medical needs, arrange appointments, provide transportation, translation and assistance with follow-up. Other components of the program included legal assistance for immigration issues, educational services for children and parents, emergency food, and assurance of basic resources. This program also helped pregnant women access prenatal care.

A second program used Patient Navigators to assist Latino and Hispanic clients find medical homes, access emergency and urgent care, set up prenatal care and obtain prescriptions. The third program used the health promoter ("promotores de salud") model to promote smoking cessation among Latino/Hispanic clients. This involved culturally appropriate education about the effects of smoking and tobacco use, working one-on-one with families to help them adopt home smoking restrictions, and assistance / translation to enable clients to access already existing services such as KAN-STOP, a telephone counseling program.

Chronic conditions – General

Three projects focused on uninsured, low-income adults with chronic conditions of all kinds. One of the three projects managed a large referral system of over 600 volunteer physicians (primarily specialty care) who donated times slots and services free of charge. This grantee worked with more than 20 local safety net providers who identified specialty care needs among clients. The grantee then arranged the specialty care, from making the appointment, to arranging transportation, to making sure follow-up instructions were understood by the client and communicated back to the primary care providers. The top five specialty referrals during the grant period were: cardiology, gastroenterology, general surgery, orthopedics, and gynecology.

Two of the projects provided free medical services on-site at clinics for patients with chronic diseases. The most common conditions mentioned were hypertension, diabetes, and high cholesterol. Services were tailored to each individual person and included direct specialty medical services, primary care services, screenings, educational materials, classes and one-on-one coaching. Project personnel also assisted clients with transportation, provided culturally appropriate care and translation services, arranged appointments and assisted clients in obtaining prescriptions. One of the project specifically targeted patients considered non-compliant, whose conditions were not well managed.

Chronic Conditions – Specific

One project targeted adults with diabetes and provided a range of diabetes-related services directly on-site at a clinic. Through this project, clients were able to access primary services through walk-in and after hours appointments. They were provided with ophthalmologic and podiatrist screenings, free medications through pharmaceutical programs, individual counseling by pharmacy students and a diabetes educator, smoking cessation support, and dental services.

Another project targeted clients with heart failure. The goal of this project was to develop a "Guided Chronic Care Model" that integrated social assessment with interventions to remove barriers from care.

Mental illness and health conditions

Two projects targeted clients with mental illness and chronic health conditions. One of the projects was a collaboration with safety net providers to divert people with psychiatric and addiction disorders from hospitals to other services. It linked psychiatric, addiction, hospital and ancillary services. Clients were often homeless and frequent users of emergency departments and inpatient services.

The other program addressed the needs of clients with mental illness and physical health issues, especially clients with co-morbid health conditions. It co-located mental and physical health services at three locations in the Kansas City area, so that clients could access all (or most) of their services and treatments in one place so that coordination among the providers was easier to achieve.

BUDGET [5]

The 10 grantees depended heavily on HCF to pay for staff positions. Approximately $1.6 million or 67 percent of all HCF funds for this group of projects was budgeted to pay for salary and benefits. Although this is a high proportion of the funding allocations, it is lower than other HCF funding clusters. An assessment of 11 2008 HCF domestic violence grantees, for example, showed that over 80 percent of HCF funding was budgeted for staffing.

The grantees spent $548,000 (23 percent) on "Other Direct Expenses." Some grantees classified direct payments for health services in this category. "Other Direct Expenses" also covered items such as contracted services for partner organizations, evaluation services, some professional travel and training, patient transportation, etc.

[5] These estimates are based on grantees projected budgets.

ADDRESSING FUNDAMENTAL NEEDS

In order for Care Coordination to be possible, networks among providers and communication systems need to in place and the fundamental needs of the targeted population need to be met, or at least addressed. Most of the projects addressed these fundamental issues as a prerequisite to ensuring coordinated health care for their target population.

Partnerships with clinics, physicians, hospitals are imperative.

Grantees collaborated with over 120 different regional health care providers (including safety net clinics and hospitals), social service agencies and community agencies. In addition, they partnered with over 600 individual physicians (including many specialists). Because Care Coordination by definition requires that different health care professionals share information and collaborate, it was imperative for all grantees to establish good networks and partnerships to accomplish goals.

Bringing individuals into the health system.

Half of the projects noted that before Care Coordination could occur, clients needed to be identified and brought into the health system. For those working with the Latino/Hispanic population, language and lack of information about the regional health system were barriers. For example, for the Lafayette County Project (which addressed the needs of Latino/Hispanic migrant farm workers), the first step was to identify farm workers with significant health needs, educate them about the health services available and help them get access to the services. Once the farm workers (or their family members) were in the system, coordination across different health care providers could begin. The project that addressed the needs of those with mental illness and more than one health condition found that many of its clients were homeless and that conventional treatments were not appropriate for some of its clients. This project also had to find creative ways to bring clients into the health system before Care Coordination could begin.

Information sharing systems.

Three projects identified developing electronic health records or shared electronic patient information as a component of their programs. This can be a key resource to sharing information accurately and in a timely manner across providers.

Addressing basic needs.

Basic needs such as housing, food, transportation, access to telephones, and financial concerns were issues faced by nearly all of the grantees. For example, the project that focused on diabetes found that difficult economic times had caused their clients to lose their telephones and means of transportation; had made it harder for them to afford appropriate, low sugar food; and had increased their stress overall. This played out in missed appointments and less well controlled diabetes among some clients over time.

The project that focused on diverting those with mental illness from hospitalization to community-based support found that intensive case management was a necessary prerequisite. Some clients needed to find housing and meet other basic needs first. Only then could a non-hospital alternative for treatment be considered appropriate.

GOALS

Care Coordination grantees were able to achieve and exceed most of their program goals in terms of amount of clients reached, services provided, training, and outreach. For example, the Patient Navigation project had a goal of serving 200 clients and had served over 250 clients with 400 services before the end of the project. The migrant farm worker project in Lafayette County coordinated over 850 services for its population and accomplished specific goals with very targeted clients. They successfully identified and assisted 17 pregnant women with prenatal care and were in the delivery room for 6 new babies, born healthy. They were able to follow-up on care coordination and also securing social security cards and Medicaid for the new babies. A free clinic had a goal of 7,200 patient encounters with non-compliant patients with chronic health conditions. They succeeded with over 13,826 patient encounters and 5,964 unduplicated patients. This clinic also reached its goals in terms of numbers of clients with positive blood pressure, cholesterol and blood sugar readings. Another grantee coordinated 3,000 patient referrals from 20 safety net clinics to over 600 volunteer physicians in 28 specialties. And, yet another assisted clients to obtain 17,483 free medications.

Only one project appeared to be behind schedule in achieving its goals. The start-up period for this project was prolonged because of difficulty finding and hiring appropriate health care staff.

CHALLENGES, BARRIERS AND LESSONS LEARNED

Grantees identified several challenges, barriers and lessons learned. Most had already identified strategies for addressing the challenges and barriers that were within their control. It is worth noting the wide diversity of issues that arose among grantees. This is due in part to the extremely diverse types of programs and services they provided. It makes it more challenging, however, to prioritize the issues and to address them as a unified group.

<u>Patient education.</u>

Patient education appeared to be a significant issue for most projects. Some projects focused on one-to-one education and counseling, particularly the three projects that targeted Latino/Hispanic populations. Others integrated one-on-one counseling with support groups or group classes. One project felt that its educational groups had not been as effective as possible because they were isolated from the coordinated health services. This project was reviewing its program to ensure better integration in the future.

<u>Unanticipated client/staff needs</u>.

Several projects encountered client needs that were unanticipated or greater than anticipated. A few examples are provided here:

- Outstanding medical bills were an issue for one grantee, who addressed it by re-assigning one of its grant-supported staff people to work full-time on outstanding bills.
- Another project underestimated the number of clients with serious dental issues including dental emergencies, pain management and tooth extraction.
- The third found that 85 percent its clients lacked medical homes. It can take 6-8 weeks to establish a medical home. So, this project worked with an area provider to see the patients in a more timely fashion.
- Another project did not anticipate the amount of time necessary to work in crisis intervention mode and then to help clients obtain basic needs. This meant that it took longer to establish well coordinated care for the health issues targeted.

Three projects mentioned unanticipated staff and volunteer staff issues:

- One project found that its corps of health promoters ("promotores de salud") needed to have child care in order to attend weekly meetings, but their space and resources for child care provision was limited.
- One project found that volunteer health care providers preferred to remain anonymous in the beginning, perhaps fearing that they would attract more uninsured patients than they could serve. This was changing by the end of the project.
- Another project did not anticipate the difficulty of finding appropriate staff. This project re-designed its staffing configuration and budget to accommodate hiring fewer, more highly qualified, and more expensive health care providers than anticipated.

Hospital support.
Only one grantee specifically noted the importance of hospital support in its report. It is clear, however, that the grantees had established good relationships with the area hospitals and other safety net providers, and they were crucial to the success of the projects.

Basic needs and economic distress.
As discussed earlier in the report, several grantees found their clients in need of basic requirements such as housing, telephones, transportation, food and financial security. Five of the projects identified the need to pay to help clients purchase prescriptions as significant. One grantee noted that economic distress seemed to correspond directly to patients' ability to manage their disease, in this case diabetes. If clients were unable to afford appropriate foods, unable to travel to all appointments and unable to manage stress, they seemed to lose ground in disease management.

Cancer.
Cancer was identified by only two grantees as significant. The two grantees found that clients sometimes had advanced and/or undiagnosed cancer and that cancer treatment was very difficult for uninsured or underinsured clients to access. One of the two grantees scheduled 29 women for breast cancer screenings and felt that breast cancer, in particular, was an emerging issue with its target population.

APPENDIX

In this report, ten projects funded by the Health Care Foundation of Greater Kansas City are reviewed as a comprehensive funding cluster because of their shared approach to service delivery: Care Coordination. These projects were implemented from 2005 to 2009 and are listed below:

- El Centro, Inc: Patient Navigation Initiative
- El Centro Inc: Promotores Health Outreach-Smoking Cessation in Medically Underserved Latinos
- Kansas City Free Health Clinic: General Medicine Services for Uninsured
- Kansas City Free Health Clinic: Improving Access to Care
- Rediscover: Hospital Diversion Initiative
- ReDiscover: Integrating Services for Persons with Mental Illness and Co-Morbid Medical Conditions
- Legal Aid of Western MO: Migrant Farmworkers Medical Case Management Project
- Jackson County Free Health Clinic: Expanded Diabetes Grant
- Metrocare of Greater Kansas City: Northland CARE/MetroCARE &Wy/Jo Care
- Truman Medical Center Charitable Foundation: Guided Chronic Care