

King County Care Partners (Chronic Care Management)

Partners: Aging and Disability Services, Harborview Medical Center, and four community health centers; Sea Mar Community Health Center, HealthPoint, Neighborcare Health and Harborview.

Client Population: Top 20% of State identified Medicaid patients who have at least one chronic medical condition along with a mental health and/or substance abuse problem. Risk factors are present in the client population served, including illicit drug and alcohol use (especially current intoxication), history of criminal behavior, and a history of childhood abuse.

- Individuals who, due to mental health problems, have sudden deterioration or changes in behavior which put them at risk of hospitalization
- Reclusive individuals, who need, but refuse to access medical or mental health services
- Individuals, who are not eligible for mental health services, but have mental illness or personality disorders
- Individuals who are at risk in areas of personal safety, nutrition, survival and self-neglect
- Chronic medical conditions that include diabetes, high blood pressure, heart problems and pain control

Care Management Team:



Lara

Jeanette

Tia

Samantha

Flor

Caroline

A team-based approach to care management helps patients develop self-management skills and encourages them to take personal responsibility for their health care. Each RN care manager works with 50 high risk patients a month for up to twelve months.

The team has three ADS RN care managers, two social workers and a half time social worker for engagement/outreach:

- High Risk assessments are done to identify: health status, self-management skills, assistance with adherence to provider's treatment plan and prescribed medications
- Development of a care plan specific to identified risks, including goal setting to help manage his/her condition, address barriers to using the health care system
- RN attends one or more primary care provider visit/s with the patient
- Social workers refer and connect patient to services available in the community

Medical Home: Four Community Health Clinics

- One Clinical Care Coordinator per clinic
- Work closely with the ADS care managers to provide coordination of medical services within the clinic system as well as education and assistance
- Follow KCCP clients for 3 months after transition from care management