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Minnesota Senior Health Options

2000 Annual Educational Forum

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# Exploring Next-Generation Issues

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# Table of Contents

Opening Session

**MSHO Three-Year Update: Are We Making a Difference ..... 3**

Plenary Session

**Focusing on Top Diseases/Conditions through a  
Disease Management Approach: Keys to Successful  
Design, Development, and Implementation ..... 5**

Concurrent Session

**Creating a Database and Decision-Support System  
for Better Care Management ..... 13**

Concurrent Session

**Expanding MSHO to the Disabled Population ..... 17**

Plenary Session

**Opportunities for Improvement through Collaboration  
Minnesota PRO Shares Upcoming Initiatives ..... 25**

Plenary Session

**Results from MSHO Member Satisfaction Surveys ..... 30**

Panel Discussion

**How Do We Know MSHO and Integrated Care  
Are Making a Difference? ..... 34**

**Speaker Information ..... 38**

# MSHO Three-Year Update: Are We Making a Difference?

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Good morning and welcome. I'd like to begin with the original goals of MSHO, which were to:

1. Align fiscal incentives to support clinical practices and reduce cost shifting between acute and long-term care and between Medicare and Medicaid
2. Reorganize delivery systems to reduce administrative duplication and provide a seamless point of access for enrollees
3. Create a single point of accountability for tracking total costs and outcomes of care across a full range of acute and long-term care services

We also expected to impact utilization to some extent, for example, to reduce inappropriate hospital admissions and average length of stay, emergency room (ER) use, and polypharmacy issues. We hoped to increase the use of short-stay visits in a nursing home if that level of care was needed and to increase the use of home care services.

MSHO enrollment began in February of 1997. Since that time we have served 5,670 individuals. Our enrollment figures for January 2000 are 3,420—the difference in those two numbers is due largely to the death rate, given the frailty of this population. We were originally projected to serve a total of 4,000 individuals over the life of this demonstration (five years), so we have more than met that goal in less than three years. About 77.5 percent of current enrollees reside in the nursing home, and about 22.5 percent live in the community.

If you compare us to PMAP, you will find that MSHO has a much older population and more people living in nursing homes. You can also look at the HEDIS (Health Employer Data and Information Set) data and compare MSHO and PMAP, but you won't find a lot of differences. The material we handed out shows the rate of ER visits and outpatient visits of MSHO enrollees compared to PMAP beneficiaries, for example. One real drawback to the HEDIS data set is that it is not risk adjusted—this reduces its usefulness to small demonstrations with more vulnerable or frail populations.

Examining information on the MSHO population by health plan you will see three different profiles. Medica has 2,221 enrollees, and about 94 percent of them reside in the nursing home. Metropolitan Health Plan has 401 enrollees, and about 53 percent of them are nursing home residents. UCare Minnesota has 798 enrollees, with about 45 percent of them residing in the nursing home.

There are differences between plans, for example, in enrollment growth and hospital admission rate, but plan to plan comparisons are probably not valid due to the differences in population profiles, for example, institutional versus community dwelling.

You can also compare MSHO to Medicare statistics for the Twin Cities metro area. We looked at the 1998 data, which is a complete data set, and compared hospital rates. Medicare

MSHO Enrollment by Plan January 2000	
<b>Medica</b>	
	2,221 enrollees 93.7% nursing home residents
<b>Metropolitan Health Plan</b>	
	401 enrollees 52.6% nursing home residents
<b>UCare Minnesota</b>	
	798 enrollees 44.6% nursing home residents

shows an admission rate of 25.5 admits per 100 beneficiaries, whereas MSHO shows an admission rate of 36.6 admits per 100 beneficiaries. Average length of stay (ALOS) in the hospital for Medicare patients in general is 5.8 days, whereas ALOS for MSHO beneficiaries is 6.1 days. So we conclude that, even though we expect the MSHO population is quite a bit more frail, we don't see a huge difference in ALOS and we have, as expected, slightly higher hospital admission rates.

We also were interested in the top diagnoses of MSHO beneficiaries according to the ICD-9 classification of each person's primary diagnosis. Circulatory, respiratory, injuries/poisoning, digestive disorders, and mental disorders are the most common diagnoses for MSHO enrollees in an inpatient setting.

There is a lot of national interest in the MSHO demonstration. Minnesota is still one of only a few states nationwide that has launched a dually eligible demonstration. MSHO is supported by The Robert Wood Johnson Foundation (RWJF) and is part of the RWJF's Medicare/Medicaid Integration Project that includes other states working on similar projects. These projects include the Wisconsin Partnership Program, which you will hear more about in a breakout session today; the Massachusetts project centered around what they are calling "SCOs" or Senior Care Organizations; and the New York project, which will include an extended long-term care product. Also, the Kaiser Commission is doing a study on dually eligibles in managed care, and there is a General Accounting Office study due out in April.

It is important to say where we've been and where we want to go in MSHO. Later today you will be hearing about the Consumer Assessment of Health Plans (CAHP)

survey that looked at satisfaction of beneficiaries in MSHO and PMAP—MSHO looked good on this. The panel discussion at the end of the day will also be a time to think and talk about results and evidence of effectiveness. We need to keep this conversation going even after today's sessions are over.

With regard to where we've been, I've prepared a brief list of MSHO accomplishments. In 1999 MSHO:

- Increased enrollment by 23 percent
- Added enrollees to the Advisory Group
- Scored well on overall rating of healthcare in the CAHP survey
- Expanded to Scott County and added network choices
- Experienced a low voluntary disenrollment rate (2.5 percent)
- Received no formal complaints
- Was exempted from the Medicare+Choice risk adjustment through 2001
- Participated in two quality studies, one on diabetes and another on urinary incontinence
- Successfully avoided long-term nursing home placement (paid for only 34 people who had reached the 180 days of nursing home care covered under MSHO out of 1,037 unduplicated community enrollees since 1997)
- Expanded to the disabled—we issued an RFP and received two responses
- Became part of a Medicare/Medicaid database that will allow for more in-depth analyses

Where do we want to go this year? In 2000 we expect to:

- Expand our marketing to other dually eligibles, not just PMAP beneficiaries
- Learn more about the satisfaction of nursing home residents through a survey
- Conduct a clinician survey and an MSHO plan administrative survey
- Put together or enhance a Medical

Director's Work Group around MSHO clinical and care management issues and outcomes measurement

- Continue to work on a better Medicare risk adjustment
- Document the value of care coordination—exploring a focus group of care coordinators
- Implement MDHO (Minnesota Disabled Health Options) for people with physical disabilities under age 65
- Work on waiver changes under Medicaid
- Participate in a HCFA evaluation

Overall, in 2000 our focus will be on exploring methods to demonstrate clinical results—through data collection, surveys, case studies, quality improvement projects, and other evaluation methods. Case studies are extremely valuable in explaining the benefits of this program to various audiences, especially in the absence of standardized quality indicators for frail seniors.

When we think about how far we've come, I have to say it's significant. The MSHO infrastructure is up and running. Plans and care systems have worked toward coming together around better care management for this population. Our beneficiary focus groups showed enrollees positively responding to the care coordination component of MSHO. Satisfaction surveys show that integrated financing does not harm seniors, and there is modest evidence it can improve care.

Lastly, I want to say a word of thanks. You, the individuals working in MSHO, are making the difference. You are contributing both to the seniors you serve and to the future of chronic care in this country. Whatever the future brings, MSHO has already been successful in so many ways—we and others who come after us can learn from these efforts. A big thank you to everyone!

# Focusing on Top Diseases/Conditions through a Disease Management Approach: Keys to Successful Design, Development, and Implementation

*Mary Jane Osmick, M.D.  
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Crozer-Keystone Health System,  
Pennsylvania*

I want to begin with some background on Crozer-Keystone Health System so you can compare it to what you are working in. Crozer-Keystone is a rather small health system; it is five hospitals, four long-term care facilities, and three home health agencies, with a 65 employed-physician network and 550 physicians in the Delaware County physicians organizations. There is one board over the entire health system.

What we have is much smaller than what MSHO is dealing with. But what we have in a microcosm is the same pieces you are dealing with: physicians who are not necessarily connected to the system. So perhaps some of the things we have been working on in our system will help you to integrate MSHO. That's why I am speaking to you today, to tell you about our work and some of our outcomes and to let you know that it is possible to obtain good clinical, financial, and operational outcomes for a group of patients.

One of my favorite quotations from Albert Einstein is, "If at first an idea is not absurd, then there is no hope for it."

In 1989 one of my patients had a seemingly absurd idea when she said to me, "I'm not going back into the

hospital. I don't care what you say. If it kills me, I am staying home." Well, that seemed pretty absurd to me at that point in time. But the reality was, we had to work with that, and she convinced me that this was not an absurd idea at all. In fact, it was our system that was absurd, and maybe we needed to change our system to support a woman who had an idea about how she wanted to live her life.

Since then Crozer-Keystone has worked on developing and implementing programs—some better integrated into the whole than others—to try to keep people in their homes, to keep them healthy and independent, and to try to address their values and goals. I want to share some of the lessons I have learned over the last ten years as we have tried to change our healthcare system.

## **A Vision of Care**

I am going to start with what I think is a better vision of care. I want to tell you about Jenny Jagger. She is not a real patient but is a compilation of many of our patients. She illustrates the vision I think we need to be striving for.

Jenny is 84 and lives alone in a two-story house. She has lots of problems, one of which is that her daughter—her

only living relative—lives 800 miles away. She also has a cat, Edwin. Edwin is very important to her; he spends a lot of time on her lap. In November Jenny fell on a throw rug in her home and fractured a bone. She had to spend some time in the hospital and the nursing home. It wasn't very long, four or five days, but during her hospital stay, we identified a lot of things that Jenny was at risk for in terms of being at home by herself. The inpatient case manager did the initial geriatric assessment, and when she identified these risks, it put into motion a more extensive geriatric assessment with a geriatric nurse practitioner and a geriatrician.

During her hospital stay, the providers recommended that Jenny go into assisted living. But she adamantly refused. "I am going home. I don't care what you say," was her reaction. Near the end of the hospitalization, she met Sue, an occupational therapist and a coordinator of care for our frail elder program. Sue went to Jenny's house and found all of Jenny's medicines on her refrigerator: 88 bottles of anti-hypertensives, incontinence medications, pain medications, and a number of over-the-counter medications.

At that time we asked Jenny if she would like to be part of our program for senior support. Jenny wasn't so sure, but she said she would consider it. Jenny has a lot of comorbidities: arthritis, hypertension, cardiac disease with some congestive heart failure, type II diabetes, and lots of ambulation problems. Sue went to Jenny's house and performed an extensive assessment using a handheld computer. Then she went back to her office and transferred the data to her computer so it was immediately usable. Sue was able to put together a care plan on her computer and e-mail it to Jenny's primary care provider (PCP) who could edit it and e-mail it back. Now there was a central place

for all of the information.

At that point Sue had to work with Jenny on ways to make things better for her at home. The first thing Sue did was fall-proof Jenny's home. Next the pharmacists reviewed her medicine regimen and bubble-wrapped her medications so Jenny only had to push out that bubble at that time of day, which made it very simple for her. We also hooked her up to a Web TV setup, which Jenny can use to e-mail us and also to stay in touch with her daughter.

Sometimes Sue meets Jenny at Jenny's PCP office to make sure things are going well. So there is some face-to-face communication. Sue also communicates with her via telephone and e-mail regularly. There is also a phone buddy system where volunteers, who themselves are sometimes frail, volunteer to make phone calls to other folks in the community. They hook up with each other and begin to form a network. In fact, one phone buddy became so connected to Jenny that she takes her out to lunch once a month.

If you ask Jenny how she feels about all of this, she says she can't believe it's possible to be so supported in her own home. She also understands that she is not going to be able to stay in her home forever. She has started to have values discussions with Sue and others about what she thinks she would like to do when she can no longer be in her home. She has an advance directive, and she is now working with her daughter to make sure everything in her life is in place, including financials, in case she becomes more ill.

We think Jenny illustrates a vision of where we want to go with a lot of folks: lots of easy communication going back and forth and lots of centralized support systems that help us to take care of the patient. Most importantly, when we ask Jenny how she feels, she says she feels terrific,

even though she hurts here and there and has trouble walking. She feels terrific because she feels she has control over her care. That's the vision we keep trying to create.

So what was the cost of all this? In the first year of her care it cost about \$2,400 to take care of Jenny. Compare that to what it cost the year before with her three hospitalizations—almost \$13,000. We are doing some things that are nontraditional and are supported by systems that take the cost from \$13,000 a year to \$2,000, with happy clients who know how to communicate. It's a pretty good trade-off.

### **A Chronic Care Management Model**

If chronic care management is successful, we are talking about the right care, at the right time, in the right place, by the right provider. It's very simple, but it has to be done with a well-planned methodology. We want to make sure that care is:

- Patient/family centric
- Population centric
- Patient value driven
- Quality-of-life focused
- Collaborative team based
- Continuum based
- Self-management focused
- Preventive/proactive
- Holistic

With that vision, today we want to talk about the individual and population approach to chronic care management, with a focus on process and implementation. I don't have to tell you that care in our country right now is seeing that there is a disease process with high and low costs and a great number of visits across a timeline with disease exacerbations costing us a great deal in the acute care setting. I'd like to suggest that a different and better picture would be one where we manage the disease process and the systems are in control. Then, instead of spending time in the acute care setting,

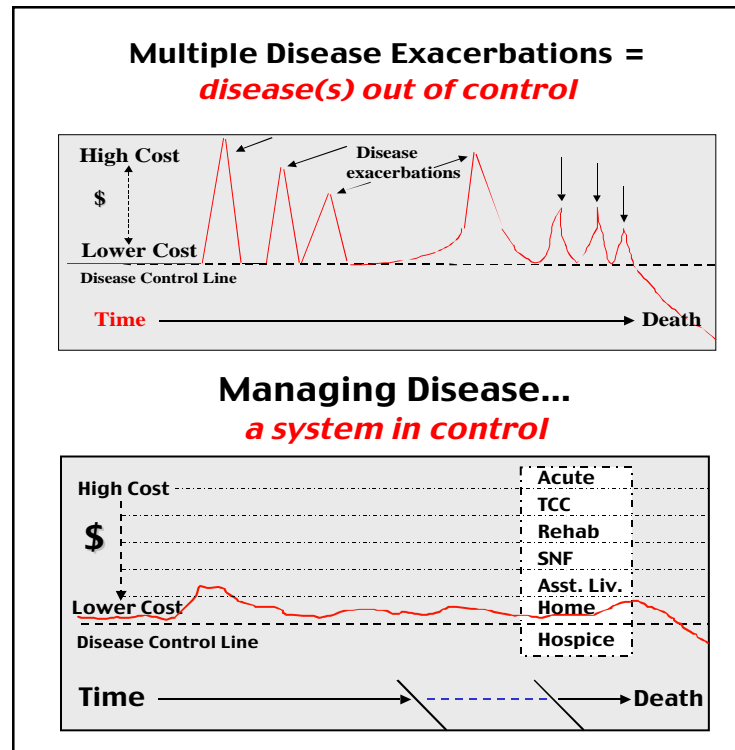
people would spend most of their time at home with just a few bumps to higher acuity areas. There are times when people need to go into acute care settings, but we have to wonder when someone goes into an acute care setting whether there was a failure in the system.

We are making the jump from an individual patient approach, where there are interventions and outcomes of the single patient that are completely separate from other patients, to a population approach. You still have to take care of individuals well, making sure they get what they need. But you also have to look at how that care affects the entire population. In a population approach, we:

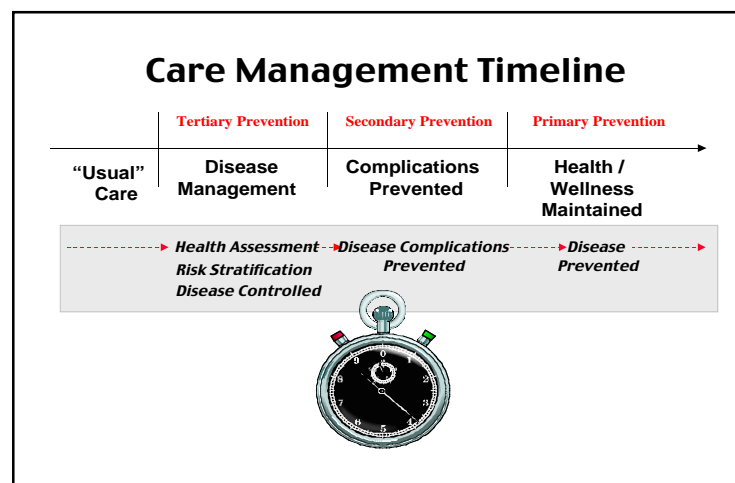
- Screen the larger population
- Identify potential cohorts
- Risk-assess cohorts
- Stratify individuals
- Enroll/“engage” patients
- Have “controlled” interventions
- Track outcomes over time

There are real challenges to a population approach. A population approach requires an infrastructure that often needs to be built. You have to find the patients, usually from a database somewhere. You have to risk assess those patients, intervene proactively, manage the continuum, and manage the data. We are talking about a care management timeline.

We are doing usual care at one end of the timeline, moving toward tertiary prevention of the disease—these are the people who have the disease and in whom we are trying to prevent exacerbation. Then there is secondary prevention, preventing the complications of the disease. Finally, there is primary prevention to prevent the disease from occurring. What we are doing with chronic care management is moving down that timeline.



Our chronic care management goals are straightforward: you need clinical, operational, and financial goals when you do this kind of work. If you do one without the others, you will not have support from all the people who have to be part of the plan.



Implementation is everything. We recognized that we needed a consistent model for program development, implementation, and renewal. We created and documented a six-phase

model for chronic care management, based on the human “natural learning cycle.” There is a similar infrastructure for all the programs so that when one program has gone through a phase, the lessons learned are available for the next program. We use a template to allow us to go through all the steps within each phase. There is rigorous documentation of individual program progress and results. Cross-continuum care planning teams promote integration across the system, and upper level administration is always kept in the loop for resource needs.

Chronic care management is a multiple team process. This model incorporates multiple teams throughout the six phases: a Core Work Team, a Governance or Oversight Group, a Program Work Group, a Patient Care Team, and a Resource Team.

In Phase One the Core Work Group is assisted by the Oversight Group. In Phase Two we bring together the Program Work Group, which is a larger group made up of all the customers for that program. Phase Three, the Preimplementation Phase, is the workhorse of all the phases, where we do the patient education materials, protocols, guidelines—all the really intensive things. In Phase Four we add a Patient Care Group and Resource Group for the Pilot Phase. We have a team of caregivers who are focused on the patient and family, and we have a life care manager who connects all the parts. All the work is based on expert guidelines and protocols, and usually we have an expert seated at the table.

At the point of program realization—Phase Five—we move from 50 patients to 500 patients. Lastly, in Phase Six, which we call Renewal, the whole model is working in concert, and we are able to do a never-ending improvement cycle with the whole process. Again, everything is documented as we go along, and each group is reporting back to the

Oversight Group so they know what is happening.

One of the most important things in Phase 6 is systemizing the program. We call this “The Beer Truck Test.” If you were a major coordinator of a program and you got hit by a beer truck, what would happen to your program? You want to make sure that a program is not dependent on one individual. Systematization increases care and program consistency over time because standards of care, assessment, stratification, intervention, language, information transfer, communication, and outcomes reporting are all systematized.

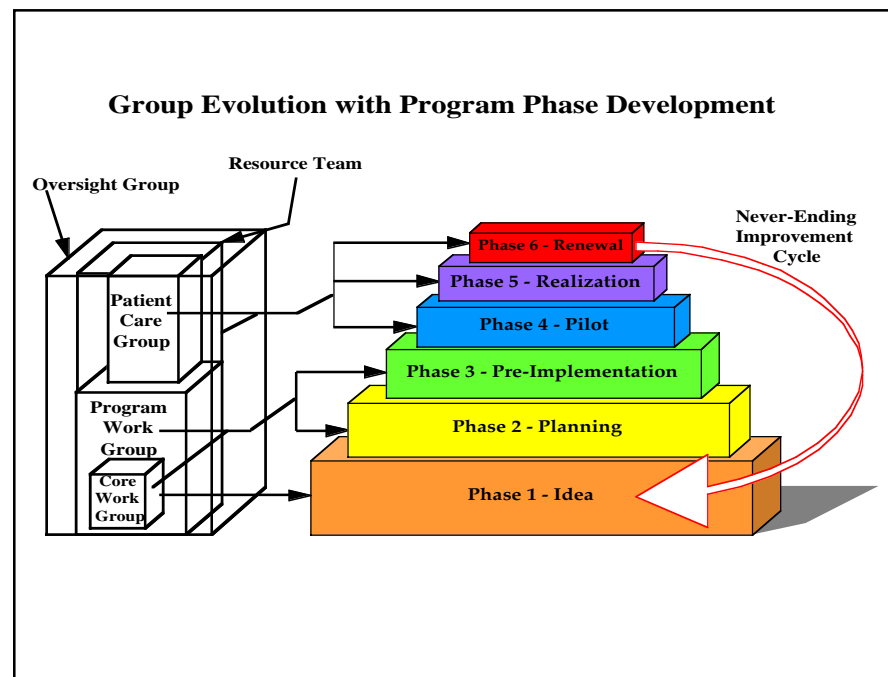
We documented our experience in creating this chronic care management model in a book we published in October 1999, *Chronic Care Management: A Toolbox for Action*, published by the National Chronic Care Consortium.

I want to give you the results from two of our programs: the Frail Older Adult Management program and the Heart Success program.

## Frail Older Adult Management (FOAM) Program

Our Frail Older Adult Management program takes the sickest of the sick older adults, those who are aging in place and those whom we expect have a high mortality rate. Our program includes people over age 65, though most are in their eighties. Other inclusion criteria are three or more comorbidities and an ambulatory, mental health, or psychosocial dysfunction so that they are at risk for several problems. We use a patient-focused problem list. Instead of the physician or geriatric nurse practitioner deciding what the problems of the patient are, the patient tells us what his or her problems are. We ask them, “What do you want to do about that problem; what is your goal?” Then that is the goal we set for the program. So if somebody wants to be able to visit a daughter in North Carolina twice a year, that’s our goal. We have to do a lot of things to make that happen. One goal might be to be able to walk across the room without so much pain.

Our goal is to maintain independence with quality of life, which, of course,



we have to measure consistently and reassess. We do intense case management with geriatric nurse practitioners, resource teams, and geriatricians. We “front-end” load resources to try to prevent complications from occurring.

We formalize all of our risk assessment methodology so that every person is stratified by risk factors including social, medical, functional, mental health, and resource utilization. Those things are scored on a regular basis, and each person is reassessed every six months so that we have a timeline for each person. We have, then, three risk levels from this methodology.

Our financial model is one that can be accepted by both the Chief Financial Officer as well as the people working in the program.

We did a pilot project with 92 patients. Our outcomes data showed that we were able to save \$242,750 in reduced acute care costs the first year—that includes everything we spent on the patient in front-end loaded resources. We also discovered that the mental component of those 92 patients improved significantly, but the physical component fell significantly. These people were aging in place and getting sicker, yet they perceived themselves as better. Ninety-five percent of patients say they are very satisfied with FOAM. The provider perception has been very positive; physicians are asking that their patients be in this program.

## FOAM Risk Assessment

Risk Parameters	Stratification of Risk	
<b>Social risk factors:</b>	<b>Low</b>	<b>High</b>
Age	65 - 79	80 and over
Self Perceived Level of Health	Excellent to Good	Fair to Poor
Financial (Dual Eligibility)	no	yes
Living Arrangements	Lives with others	Lives alone ( <b>score = 2</b> ) *
Caregiver Burden (Zarit Score)	0 to 25	26 and over
Advance Directive in place	yes	no
Potential for non-adherence to health care plan	no	yes
Inadequate support system	no	yes
Functional Illiteracy (less than 5th grade education)	no	yes
<b>Medical risk factors:</b>	<b>Low</b>	<b>High</b>
<i>CO-morbidities -Number of the following: 1. CHF 2. Diabetes 3. COPD/Asthma 4. CVA 5. PVD 6. Parkinson's or other degenerative neurologic disease 7. Hx of Fracture</i>	0-1	2 or more
# of Medications	0 to 4	5 or more
Pharmacy Screen Score	0 to 9	10 or more
Nutritional Screen Score	0 to 5	11 to 14
Frequency of contact with PCP relative to severity of illness	yes	no
<b>Functional Risk Factors</b>	<b>Low</b>	<b>High</b>
ADLs and IADLs (Sutter Score)	0-10	11 or more
Hx of Fall, Trip, or Stumble	not within past yr.	within past yr.
Cognitive Status ( MMSE score)	25-30	24 or less
Vision or hearing loss that impacts on functional performance	no	yes
Appropriate use of assistive devices	yes	no
Incontinence	no	yes
<b>Mental health/Addiction risks :</b>	<b>Low</b>	<b>High</b>
Depression ( Geriatric Depression Scale Score)	0 to 10	11 or more
Suspected Substance Abuse (Drugs, ETOH)	no	yes
Nicotine Use	no	yes
Current Acute or Chronic Mental Health Diagnosis	no	yes
<b>Resource Utilization risk factors:</b>	<b>Low</b>	<b>High</b>
ER visit with D/C within past 6 months	no	yes
Hospital admission within past 6 months	no	yes (Score = 2) **
Nursing home use in past year	no	yes
	<b>Number of high risk parameters:</b>	
	Level I = less than 5	
<i>Nbte * Lives alone (Score = 2)</i>	Level II = 5-9	

## Heart Success Program Risk Assessment

<input type="checkbox"/> New Patient				CMC
<input type="checkbox"/> Re admission to Program				DCMH TAYLOR
<b>HEART SUCCESS PROGRAM RISK ASSESSMENT</b>				
Patient Name: _____		Date: _____		
Patient Weight _____ lbs				
Patient/Caregiver able/willing to participate in Program?		YES _____	NO _____	
Reason: _____				
Check appropriate level for each:	<b>LEVEL I</b>	<b>LEVEL II</b>	<b>LEVEL III</b>	<b>LEVEL IV</b>
<b>NYHA CLASSIFICATION</b>	No symptoms with ordinary activity	Comfortable at rest	< Ordinary activity causes symptoms	Symptoms at rest
<b>FUNCTIONAL STATUS</b>	Independent	Independent or minimal assistance	Needs frequent rest or assistance	Needs assistance for all activities
<b>PHYSICAL FINDINGS</b>	Feels well	"Normal" baseline	Actively causes symptoms	Symptoms with minimal exertion
<b>CO-MORBID CONDITIONS</b>	None or stable	Stable or with little effect	Increases overall debilitation	Significantly affect patient status
<b>MEDICATION</b>	Stable	Changing meds	Chronic high level	Complex regimen
<b>HOSPITAL ADMISSIONS</b>	0 - 1 CHF Admits/yr	> 1 CHF Admits/yr	> 2 CHF Admits/yr	> 2 CHF Admits/yr
<b>ER VISITS</b>	No ER activity	> 1 ER visits/yr	> 2 ER visits/yr	> 2 ER visits/yr
<b>PSYCHOSOCIAL</b>	Ready to learn	May need reinforcement	Limited ability to learn	Needs extensive and repetitive teaching
<b>RECOMMENDED HEART SUCCESS PROGRAM LEVEL:</b>			<b>LEVEL I</b>	
			<b>LEVEL II</b>	
			<b>LEVEL III</b>	
			<b>LEVEL IV</b>	
<b>SERVICES INDICATED:</b>				

### Heart Success Program

I also want to mention Heart Success, a program where we focus on a specific disease process. I don't particularly like disease management; I don't even like to use the term. The reality is these people don't have a disease, they have multiple diseases. We know that, but there are certain circumstances where a person may have most of his or her care driven by a specific disease and may need some special intervention. For that reason we have these types of programs.

We have to case-find the congestive heart failure (CHF) patients, which may sound like an easy thing, but it is not. We find clients through claims systems, which is challenging because coding is so imperfect. We use specialty-trained home care nurses with cardiology/PCP backup, home education/home care interventions, and a computerized telemanagement calling system. About 30 percent of the people are on telemanagement.

We have a risk assessment methodology, also based on leveling. We assess New York Hospital Association classifications, functional status, physical findings, comorbid conditions, medication, hospital assessment, ER visits, and psychosocial issues. For each one of those categories, we have the guidelines for each risk level, recommended visit pattern, telemanagement calling system, and estimated costs for care. So we can look at what we expect a patient to cost us and then look at the actual cost.

We have served over 700 patients since the program inception. There was an average 11 percent readmission rate for 1998; the national rate is 22 to 42 percent. Our average savings were \$2,604 per patient per year. We also have improved quality of life and patient satisfaction scores.

## Special Considerations

Whenever you are developing a program, you need to pay attention to these special considerations:

- **Individual Patient Values**

Base your programs on patient values. If you try to have something happen in the program that a patient doesn't value, it's a waste of your time.

- **Literacy**

The reality is that literacy can have a huge effect on what people choose or don't choose. There is an enormous problem with literacy in our country—44 million U.S. citizens are functionally illiterate, and another 50 million are marginally literate. This means that one in three citizens will have difficulty performing personal functions which require reading, including health-related tasks. Minorities and seniors represent a higher percentage of the low literacy population.

- **Learning Styles**

Assessing people's learning styles will help you determine the best way to transfer information back and forth. Do they get information best by reading it, by hearing it, or by doing something kinesthetically that will help them understand?

- **Cultural Competency**

In Delaware County there are 59 languages spoken. We have learned through difficult lessons that people may have very different cultural expectations of their care. When you are building your program, be aware of these potential cultural issues.

- **Pharmacy Continuity**

We have a pharmacy continuity of care program where we screen all patients in the hospital to review their pharmacy regimens and put them in risk categories. If they are in a high-risk category, we do a

predischarge visit and then a home visit to make sure that there is continuity from the hospital to the home. One of the biggest challenges is that hospital formularies are different from those used in outpatient settings. Other challenges include rising pharmaceutical costs, population-based contraindications, polypharmacy, medication errors, and multiple prescribers. Identifying the teachable moment for the patient is also important; trying to teach patients in the hospital is not optimum.

- **End-of-Life Care**

End-of-life care is an extremely important piece that you have to build in from the beginning.

## Information Services

I want to take a moment to talk about information services because when you have this whole program, you have to figure out how you are going to support it from an information services perspective. There are some specific needs:

- Patient demographics
- Patient-specific clinical "snapshots"
- Centralized, editable patient "care plans"
- Fast communication methods among practitioners
- Work task "flags" for life-care managers
- A sortable database to produce clinical, financial, and operational outcome reports

As we are building our information services, we are looking at:

- Web-based technology
- Data warehouses
- Computer links to home care and the employed physician network
- Telemanagement
- "Seniors On-Line" where 150 frail seniors will have Web TV in their homes.

## Physician Involvement Strategies

How do you get physicians to be part of this? It is a challenge. The most important strategy is internal marketing. You need to market internally through the entire process of developing your program. Other useful strategies are to:

- Identify the "most connected" physicians
- Find champions
- Show physicians your available data
- Consider payment for time for the "very involved"
- Add "value" to patient care
- Use physician time carefully
- Consider incentives

Excellent chronic care management is about successful relationships.

## Payer-Provider Relationships

What would a "true" payer-provider partnership look like? What if the payer and the provider were really linked in a collaborative way so that the care that was being delivered was not just the provider's care, but the linkage of those two entities?

In a true payer-provider relationship there would be:

- Clear partner role delineation
- Timely exchange of relevant data
- Case management collaboration
- Built-in incentives (not always money for clinical, operational, and financial success)
- Conflict resolution methods defined at the onset
- Common language development
- Service in each other's governance

## Elements of a Fully Developed Program

A fully developed chronic care management program has:

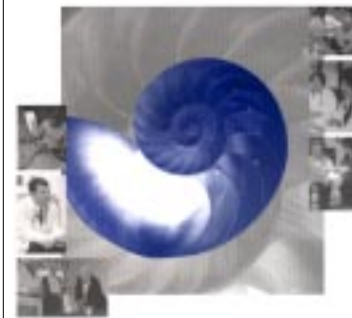
- Patient needs at the core
- A care integrated cross-continuum
- A psychosocial/medical focus
- Literacy/cultural sensitivity
- Consistent language
- Collaborative patient care teams
- Resource Team support
- Positive payer-provider relationships
- Planned communication
- Inpatient recognition
- Adequate IS support
- Community connections
- Clinical, operational, and financial outcomes

## Barriers

There are many barriers to making excellent chronic care management a reality:

- Payment systems
- Lack of awareness of problems of aging
- “Magic bullet” versus prevention focus
- Lack of wider focused health system integration
- Payer-provider relationships

### Chronic Care Management: A Toolbox for Action



by Mary Jane Osmick, M.D.  
with Linnea Varney, R.N., M.S.N.

*Chronic Care Management—A Toolbox for Action*, written and developed by Mary Jane Osmick, M.D., Medical Director at Crozer-Keystone Health System, documents a health system’s five-year journey in developing and implementing cross-continuum chronic care management programs.

The 581-page book presents three introductory chapters about chronic care management, followed by a practical six-phase model designed to help others improve their chances for success. Supporting chapters discuss “drivers” of success or failure including functional health literacy, end-of-life concerns, learning styles, cultural competency, and optimal team functioning. Reporting templates, checklists, and measurement tools to assist practitioners in program development are included in the book.

This book will become the practitioner’s step-by-step guide for chronic care management programs—from the first meeting of the planning committee, through years of successful ongoing patient care.

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# Creating a Database and Decision-Support System for Better Care Management

*Sue Walker, M.S.N.  
Vice President  
Connecticut Community Care, Inc.  
Bristol, Connecticut*

I am pleased to share with you what Connecticut Community Care, Inc. (CCCI) has experienced while developing a conceptual framework to support the development of an information management system that facilitates the delivery of care management services.

Before I begin, I want to take a moment to applaud your state's vision and pioneering efforts in caring for the dually eligible population. Even though MSHO's efforts are more advanced than in Connecticut, I hope to share with you lessons learned through CCCI's more than 20-year history of caring for the dually eligible, frail elderly in the community setting. During my presentation, I will discuss CCCI's background, key trends driving change, challenges surrounding the development of an information management system, and the critical issues to consider when creating communication links with providers.

## **Background**

CCCI is a statewide, private, not-for-profit, independent care management organization. We have served over 50,000 clients and their families since 1974. CCCI administers both public and private programs and varied small research projects. The core of our business stems from the Connecticut Home Care Program for Elders (CHCPE), a publicly funded Medicaid waiver program that helps to keep the frail elderly in a community-based setting. CCCI is currently supporting approximately 5,500 clients per month in the community and leverages

approximately \$2.4 million of home- and community-based services monthly. The care managers (nurses and social workers) work in an interdisciplinary team approach. CCCI manages a formal provider network of approximately 300 providers statewide.

CHCPE eligibility is based on age and financial and functional status; there are three levels of care within the program. The levels of care are based on both the financial and functional status of the client and serve to delineate the maximum amount of service dollars (caps) that can be authorized by the care manager on a monthly basis per client. The spending cap for each level is determined based upon a percentage of the state's average nursing home cost.

- **Level 1** cap is 25 percent of the state average SNF cost (\$953.82/month).
- **Level 2** cap is 50 percent of the state average SNF cost (\$1,907.65/month).
- **Level 3** cap is 100 percent of the state average SNF cost (\$3,815.31/month).

Level 1 and level 2 are purely state funded, while level 3 mandates that the client be on Medicaid (Title 19) and is a 50/50 match of federal and state funding. The care managers rarely reach the spending caps, so the program is very cost-effective for the state.

Two other divisions of CCCI are the Case Management Institute (CMI) and

Care Management Associates (CMA). CMI provides consultation and training services nationally, and CMA provides care management services on a privately-funded basis within the state of Connecticut.

## Key Trends Driving Change

### Health-Related Outcome Measures,

defined as the study of the end results of the structures and processes of healthcare on the health and well-being of patients and populations, are the largest trend we explored in developing the conceptual framework for our information management system. A study completed by the Institute of Medicine, *Health Outcomes for Older People, Questions for the Coming Decade*, spells out the key issues to be addressed in relation to outcome measurement. This study concluded that the most important area on which to focus attention is health-related quality of life, including functional status. They specifically noted, "For most older individuals, health-related quality of life—with its focus on an individual's perceptions and judgments about his or her life—is perhaps the most important outcome to consider."

Barriers that limit access to care are another troubling trend that requires attention. The Agency for Health Care Policy and Research funded a study entitled, *80+ Project*, conducted by John Watson, M.D. The study gathered essential data on barriers to care for the growing elderly population with the goal of informing both payers and service providers of the unique needs and perceptions of care for this population. The study concluded that the presence of contacts with the healthcare system does not assure sufficient access to effective care among the very old.

"...having health insurance, a regular source of care, and a generalist physician as a

primary provider were necessary, but improving the health outcomes in very old adults will require interventions to reduce financial and structural barriers to care and to assure that providers have the requisite knowledge and skills to address their special needs."

### Consumer Health Informatics,

defined as the union of healthcare content with the speed and ease of technology, is a rapidly growing trend. Congressional Research Services reported that the Internet is the fastest-growing communication medium in history. The rapid technological advances are contributing to the shifting evolution of healthcare delivery in the information age. The consumer is becoming a partner in healthcare decision making, therefore, gradually inverting the medical management power pyramid. Health service organizations must address the evolution from utilization management to disease management to the goal of individualized health management.

### Information Technology Issues to Consider

Faced with the rapidly changing healthcare system, we explored our information technology (IT) capabilities. An excellent resource was *The CEO's Guide to Health Care Information Systems*, by Joseph M. DeLuca, FACHE, with Rebecca Enmark Cagan (1996, American Hospital Publishing, ISBN1-55648-158-6). The following seven myths of IT are outlined in the book:

**Myth 1:** We do not need an IT plan. Actually, to be effective, organizations must have a plan that is a continuous and revolving process.

**Myth 2:** IT is a peripheral investment. Actually, to remain competitive, organizations must invest in necessary technology as a tool to streamline operations, improve communication, and inform practice.

**Myth 3:** Detailed benefit analysis is prohibitively expensive. Actually, unless a technology is so leading edge, providers can strategically seek out and examine "best practices" from others already using the technology.

**Myth 4:** Any technology investment must be "the best." Actually, there are numerous stable technologies that can provide significant economic and strategic benefits.

**Myth 5:** Information technology equals data systems. Actually, IT comprises data/clinical information systems, voice and video systems, networks, LAN, WAN, CHIN, MAN.

**Myth 6:** IT is used primarily for administrative and financial purposes. Actually, IT helps make the care process more efficient and avoids duplication.

**Myth 7:** We can just extend our current technology for whatever new needs we may have. Actually, the belief that current systems can adapt to new requirements can lead to wasted money on system modifications.

## Keys to Successful Implementation of Information Technology

Having taken on the challenge to develop an information management system, I can recommend an excellent article by Lance E. Dublin entitled, "Why Some Organizations are Successful with New Learning and Performance Technologies While Others Aren't" (*CBT Solutions*, January/February 1997). The article addresses the key challenges confronted while implementing new technologies. The top ten success factors are:

10. **Solve the Right Problem from the Start**—It's critical to understand the whole business process to ensure that application of the learning and performance technologies will solve the problem identified.
9. **Manage the Entire Change Journey**—People react 30 percent on logic and 70 percent on emotion.
8. **Understand Both the Technology and the Technologist**—A solid understanding of technology is necessary to ensure that current technical issues are resolved in the context of long-term, organizational technical architecture. Effective communication with the technologist is critical and challenging, yet when mastered, very rewarding.
7. **Shift the Mental Models**—What is known can limit thinking about what is possible.
6. **Think Globally but Act Locally**—Early learning must be captured and applied immediately, and early success must be shared to continually build the momentum.
5. **Pull, Don't Push**—People do not like to be changed; involve them with identifying the compelling

vision and need for change, linked clearly to business objectives.

4. **Realize it's More than the Technology**—The technology must be used properly and effectively in order to achieve the real business impact.
3. **Work from Right to Left**—Implementation planning must also focus on the results. Planning must start early, be iterative, and integrate all aspects of the project.
2. **Get Ready, Get Crazy, Get Real, and Have Fun**—The learning must be fun and keep humor as an active outlet for change management.
1. **Remember, it's About People!**

### Overview of CCCI's Conceptual Framework

After a review of the trends and research on the multiple issues, several steps were followed internally. These included a thorough evaluation of the current assessment/documentation process as well as challenging ourselves to determine the clinical essence of our service intervention and how to best design the data collection to enable effective measurement of outcomes.

We formed an interdisciplinary and cross-functional project team, defined our clinical and business system requirements, identified external information technology consultants to assist with the technical development, and made the organizational commitment to computerize.

The clinical team established essential requirements for the system:

- A simple user friendly format supporting a natural thought process
- A SOAP (subjective, objective, analysis, plan) documentation format

## Enabling Technologies

### Networking and Networking Technology

This allows efficient, complete data storage and communication, new ways to capture and store raw data, and the ability to communicate raw data across geography and separate facilities.

#### Examples

Data Warehouse, Clinical Data Repository, Enterprise and Wide Area Networks, Electronic Data Interchange, and Interface Engine

### Data Access and Analysis Tools

These are technologies that broaden the potential IT user base through more visual, intuitive presentation and interpretation of data.

#### Examples

Clinical Workstation, Data Mining and Visualization, 3-D and Multimedia, Graphical User Interface, and Advanced "ad hoc" Report Writers

### Enterprise Applications

In support of integrated healthcare delivery, these applications work to integrate information with associated improvement in care quality and efficiency, cost maintenance, and control.

#### Examples

Scheduling, Case Management, Product Management, Community Master Patient Index Member Health Record, and Uniform Eligibility Database

### Development Tool Sets

These technologies ease financial and risk barriers to new development and shorten application development timetables.

#### Examples

Relational Databases, Interface Tools, Structured Query Languages, Graphical User Interfaces, Object-Oriented Programming, Open Systems, and Client/Server

- A holistic approach to care
- A comprehensive assessment capability
- The need to enter data only once
- A client-centered approach
- A service utilization driven by a mutually agreed upon goal

The system technical requirements include:

- Easy customization
- Adaptability to multiple funding streams and reporting requirements
- Easy access to data for multidimensional analysis and outcome measurement
- Evidence-based protocol development
- Inter-organizational communication and data sharing

The clinical conceptual framework of the information management system centers on seven core domains:

1. Health
2. Function
3. Support system
4. Cognition
5. Psychosocial
6. Environmental
7. Financial

The client's response guides the care manager through a question/answer format. The care manager:

- Collects both subjective and objective information
- Identifies an analysis statement for each domain supported by contributing factors
- Identifies the needs and client-desired action
- Negotiates domain-specific measurable goals
- Establishes the total service plan of care
- Monitors and reevaluates as needed

## Communication Challenges with Providers

CCCI care managers have experienced multiple challenges with various segments of the healthcare provider network. Within the various providers and settings, the care managers identified a need for increased awareness of proactive discharge planning and a need to include the support system in the planning immediately.

Institutional-based staff could benefit from an increased understanding of a team approach to care planning, patient teaching focusing on needs postdischarge, and effectively documenting learning needs to the home care provider before the client is discharged. The care managers have identified gaps with the institutional-based staff's understanding of and confidence with home- and community-based services and the infrastructure to support care at home.

The communication loop with the primary care physician (PCP) has been challenging. The care managers rely heavily on developing a close relationship with the PCP office staff to enable communication in a timely manner. Family/caregiver concerns identified by the care managers have centered on a general lack of understanding of Medicare coverage and the role of home care as a bridge between the facility and independence.

# Expanding MSHO to the Disabled Population

*Kathleen Schuler, M.P.H.  
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Minnesota Department of Human Services  
St. Paul, Minnesota*

*Chris Duff, M.Div.  
President and CEO  
AXIS Healthcare  
St. Paul, Minnesota*

*Steven Landkamer  
Program Manager, Wisconsin Partnership Program  
Wisconsin Department of Health and Family Services  
Madison, Wisconsin*

## **Kathleen Schuler**

Obviously people with disabilities are different than older people though some of the care needs are similar. The presentation today by Mary Jane Osmick was excellent; a lot of what she said that applies to the care of older people also applies to the care of people with disabilities.

I'll begin today by giving you a profile of people with disabilities in Minnesota. In 1996 there were over 93,000 people eligible for Medicaid and who met the diagnosis of a disability. At any point in time there are about 65,000 people with disabilities who are eligible. Fifteen to 16 percent have a spend down. This is a big issue for people with disabilities, much bigger than it is for the senior population. There aren't too many seniors in the community who have spend downs. Nursing home spend downs have been handled through MSHO. But it is problematic to enroll people with spend downs, and we've developed some policies for that.

About 30 percent of people with disabilities have dual Medicare/Medicaid eligibility. What distinguishes Minnesota Disability Health Options (MDHO) from MSHO is that MSHO only includes those eligible for both Medicare and Medicaid. Because 75 percent of the MDHO population does not have Medicare eligibility, we wanted the opportunity to enroll people in managed care and, for people who have dual eligibility, we are looking at Medicare plus a Medicaid capitation.

Twenty-eight percent of people with disabilities are under age 18. About 16 percent of the disabled population have developmental disabilities, 40 percent have mental illness, and the remaining portion of the population, about 43 percent, have physical disabilities. For the MDHO project, we're only seeking to enroll adults with physical disabilities. Obviously there is a diversity of diagnoses, of care needs, and of support systems within this disabled population, but we're trying to hone in on one subset of the disabled population.

## **Profile of People with Physical Disabilities**

As I said, about 43 percent of the population with disabilities have physical disabilities. That's about 18,400 adults in the seven-county metro area. We're trying to implement MDHO in the seven-county metro area because that is the service area for MSHO for which we already have contracts with health plans. Of the 18,000, about 20 percent have dual diagnoses. This means that they have a primary physical disability, and they may also have a mental illness or a developmental disability (DD). The care systems may be designed to meet physical disabilities, but they also have to address the mental health and DD needs and services that go with them. The proportion with dual eligibility is a bit lower in the physically disabled group—25 percent instead of 30 percent.

## **History in Minnesota**

In Minnesota, we actually have a

history of enrolling people with disabilities. It just didn't last very long. When we implemented the PMAP program in 1985, we enrolled people with disabilities. They were enrolled for only one year. That was in the demonstration counties of Dakota, Hennepin, and Itasca—one urban, one suburban, and one rural site. We never did get people with DD enrolled because the county was responsible for managing care for people with DD and also responsible for a lot of the services. We also never figured out how the health plans in the counties were going to coordinate those things. We lost a major contractor in Blue Cross Blue Shield, which has over 50 percent of people with disabilities enrolled in their plan. When Blue Cross dropped out as a contractor, the state had to reassess and decide whether or not to leave people with disabilities in, mainstreaming them into a program that was geared more for the average healthcare consumer rather than specifically to meet their needs. We determined that we needed a disability focus so we actually pulled everyone out. They went back to fee-for-service, and they have been there ever since.

Another difference is that we don't have a mandatory program as a base. MDHO is completely voluntary. All are on fee-for-service unless they have private coverage. We also have a demonstration in the works called the Demonstration Project for People With Disabilities (DPPD) which the state has been working on for several years now. We have potential contractors in the SMHI, the Southern Minnesota Health Initiative, which is Blue Earth, Sherburne, and Sibley Counties. Right now that project is being reassessed, and I think its future will be determined fairly quickly. But MDHO is a separate initiative; it's not affiliated with the DPPD project.

### Why Managed Care?

Why managed care for people with

disabilities? They are currently excluded from participation in managed care. There are very few HMOs that enroll people with disabilities in their Medicare+Choice contracts. We believe that people with disabilities should have the same options that other people do, but not by mainstreaming. There needs to be a system designed specifically to meet their needs.

Right now in the physical disabilities population, about 10 percent are on waivers. We're planning to include the Community Alternatives for Disabled Individuals (CADI) waiver and the Traumatic Brain Injury (TBI) waiver. About 19 percent receive a high level of home care. They get PCA or they get a home health aide or skilled nursing. Yet even the people with home care don't have comprehensive care coordination. They have a piecemeal care coordination. The people on waivers have more care coordination, but as I said, it only applies to 10 percent of the population. The vast majority of people with physical

disabilities don't have service coordination, so the services are fragmented. Another challenge is a lack of primary care providers interested and experienced in serving people with disabilities.

### What is Needed?

To address the needs of people with disabilities, we began by identifying what is needed (see box below). These are the things we asked for in the RFP that we issued in November. We also emphasized the importance of:

- **A service coordinator role**—Like MSHO the service coordinator role is key to the success of this model.
- **Systematic health assessment**—Instead of people becoming eligible for Medicaid and then seeking care wherever they can, we assess everyone, find out what the needs are, and create a care plan.
- **Partnership with the enrollee.**
- **Assistive technology**—This is an issue for people with disabilities and can be expensive, but it is also important to help people stay in the

### What is Needed?

- **Holistic focus**—look at people in their lives, where they live, and what they want.
- **Self-determination**—meaning that you get a pot of money and can purchase your own services or meaning that you can decide for yourself what you want in you life and be supported in that.
- **Integrated service coordination**—this is key, it is what this workshop is about.
- **Supports for independent living.**
- **Choice and flexibility in home care**—this is important because the home care program, especially the PCA program, has some inflexibilities, and under managed care we're going to be able to change that and do some innovative things.
- **ADA accessibility**—of course everyone needs to comply with the ADA, which is a particular issue for physical accessibility and other kinds of accessibilities when you have a large number of people with disabilities enrolled.

- community and live independently.
- **Benefits exceptions**—One of the unique requirements that we don't have in our other contracts is a benefits exception process. It allows some flexibility. If you have a person with particular needs, it is cost effective to look at low-cost alternatives that the person can use for those needs. If you can provide those alternatives, you may avoid a costly hospitalization.
  - **Specialty services**—Obviously this is important, not only the need for primary care but the need to access necessary specialty services. One unique requirement is going to be a standing referral so that if people have specialists they see a lot, the health plan would authorize standing referrals so they could see the specialists over the course of the particular conditions. This would include referrals for rare and low prevalence conditions.

### MDHO Implementation

We issued our RFP in November, and responses were due the end of December. Because we have an existing waiver program (MSHO) and we're just altering it to include a new population, we are on a fast track. We need to have the same waivers that we have for MSHO, which allow us to expand to people with disabilities. We hope to begin enrollment in June or July.

We're working on our capitation rates. Because we don't have a lot of systems money and we don't have a lot of time to develop a whole new rate setting methodology, we're using a methodology similar to MSHO in the sense that we have the same four categories:

1. Other people in the community
2. Nursing home-certifiable people in the community
3. Conversions (people who were previously in a nursing home who were served in the community)

### 4. The nursing facility resident

The mix of people among the disabled population is going to be very different than it is for seniors. A majority of people in MDHO will probably be in this nursing home-certifiable community group because those are the people who need care management and will be attracted to a voluntary model like this.

Medicare payments are going to be pretty much the same. It's going to be the disabled AAPCC, and people who are nursing home-certifiable in the community will receive the PACE adjuster. What is different is that with Medicaid, we're going to combine acute and long-term care. We'll be able to see what the acute versus the long-term care costs are, but we're going to combine them into one capitation. Then we're going to have categories for CADI eligible, TBI eligible, or nursing home certifiable-level home care-eligible. We may have cost categories broken out within those three because for TBI there are people who are hospital-level care who have a neurobehavioral problem. Those people cost more than the nursing home-certifiable level.

Our potential contractors are UCare, Axis, Partnership, and possibly Hennepin county. So, with that I will turn this presentation over to Chris.

### Chris Duff

I'd like to begin with a couple of examples of the challenges people with physical disabilities face.

There is a person who works for a home health agency who needed a seat cushion. He was told by the home health agency's health plan internal case manager, "We'll get you a real good cushion; just call the DME that we use." The gentleman responded, "No, I don't need a real good cushion, I need a roho cushion, a specialized

cushion." He called the DME who said that they don't have roho cushions, but he would get him a real good cushion. This man is a quad and had to explain that it isn't a matter of comfort.

Another example is a gentleman who just turned 65, has polio, has been on a ventilator for years, moved into PMAP, and has enrolled in a health plan. The health plan has a contract with a DME provider. He chose the health plan based on where his doctor was. He's not happy now because the DME provider sent out the vent that they use. This person has been using a different vent for 20 years. They literally expected to take away his vent and replace it with a new vent, never thinking that there might need to be a trial period, that there might need to be some caregiver training. He was frightened to death. I can't blame him.

The message is not only do you need to get the right DME providers at the table, but that probably the key provider group that we need to pay attention to with this population is the DME. That's where the issues are.

### Axis Healthcare

Axis is a joint venture of Sister Kenney Institute, Courage Center, and Becklund Home Health—three providers who have expertise with this population of people with physical disabilities. We're focusing on physical disabilities only, not mental illness or developmental disabilities. I know many people carry multiple diagnoses, but we're looking at primary diagnoses with this population. What we're trying to do is offer our managed care knowledge to improve the system.

Our medical director is Jim Rohde, a primary care physician with Edina Family Physicians. He was also the medical director at Courage Residence for 20 years. He has hundreds of people with severe physical disabilities who he follows out of his clinic in

### Characteristics of People with Physical Disabilities

- **Mobility and access issues.**
- **Multiple services and providers.**
- **Extensive utilization of supplies and DME**—One project in Boston found that over 40 percent of their capitation was going into DME. That's very high, and they were able to bring that down with tighter management. They used the concept of an open network for DME when they first started operations, and they realized that wasn't real fruitful. With DME it isn't as easy as having a couple of good DME providers. There are one or two who are really good with electric wheelchairs and may have 24-hour repair, which is really important if your chair breaks down. And there are probably a couple that are really good with urinary equipment. So just having a couple general ones is not adequate. There needs to be a range.
- **Expectation of close involvement in healthcare decisions and service delivery planning**—The disability community is just coming into its civil rights era in this country, where we were with racial issues maybe 20 or 30 years ago and 10 years ago with gay rights. The disability community is just coming forward. One woman said to me, "I just realized that I don't have to apologize for being in that chair." If you have been disabled for quite a while, you tend to have that attitude. With the "I'm okay" attitude, there comes an expectation of participation and a consumerism that is really healthy and productive. But you need to work with it. If you don't it will be counterproductive and dysfunctional for everyone involved.
- **Active lives**—This requires interface with work and school settings and social activities.
- **All Medicaid recipients are currently fee-for-service**—In this state they're all in a fee-for-service. So the big issue is whether those people currently in a fee-for-service system will be willing to sign over their benefits to a manage entity. Why would they do it?

Edina. There is no one in the metro area or probably in the state that we've been able to identify who has a better foundation of knowledge in primary care with this population. Most people with physical disabilities don't have primary care. They can't find it. If they can find it, they can't get in. If they can get in, they can't get onto the table. It isn't accessible for a variety of reasons.

The issues are different for people with physical disabilities. There is a lot of comparability with the geriatric population, but there are important differences (see sidebar).

Axis Healthcare has been operational for about a year, developing our infrastructure and various work groups and working with consumers. We were told about six or nine months ago to stop talking and planning and just start delivering our services. So we did. We opened the doors, and within a couple of months, we had 20 to 25 people come through and say they wanted us to help them with health coordination. So not only do we have the work groups, not only are we doing a lot with education, but we have 20 ongoing individual clients who we are working with and learning from. Together we're developing this model.

#### What Consumers Say About Their Healthcare

Consumers actually say that there is good healthcare, especially in systems like Hennepin County. The problem is it's islands of healthcare and the interaction and the communication between those islands (see sidebar).

#### What Consumers Say They Need

Consumers are looking to have their needs met through a comprehensive flexible healthcare system (see sidebar).

There is a model to improve healthcare that incorporates a care team of a health coordinator, a primary care

physician, and the consumer along with any support people accompanying the consumer. That team will access the full range of services available and the benefit set.

In Minnesota we have a broad and generous set of benefit services and a good provider community. Axis brings health coordination and a specialty network of providers. Courage Center, Sister Kenney Institute, and Becklund Home Health Care started Axis out of a sense of mission and also because managed care is happening. They felt it would be irresponsible to wait and see what happened because the traditional managed care system doesn't work for this population. So the boards of the organizations were clear in saying that this was a time to come forward and put a model on the table, test that model, share our information, and learn from other systems.

The network is much broader than Courage, Kenny, and Becklund. I like to say that if a person has a personal care assistant who is available, alive, and shows up, why would we ever discontinue that relationship in this healthcare market? We wouldn't. The key is that we can't contract with 75 different home care agencies in town; so there is some give and take to be worked through. We want to make sure that we have access to the right providers while still getting that buy-in.

Several years ago we approached all the health plans. UCare was the most interested and eager to develop a pilot project with us, so we have developed a relationship with them. They respect the knowledge that we bring, which is different than the knowledge base that they have. They're doing a good job of training us in all the systems that they have developed. So we're coming together to build a partnership to develop and provide a pilot. This pilot includes a primary care component, a

## What Consumers Say about Their Healthcare

- *“People who don’t know me or my disability are telling me what I need.”* Even though people are already in a fee-for-service system, all those individual systems are being managed. I was talking with a physician group the other day, and they were complaining about the number of forms they fill out and the letters they write to get authorizations for chairs when it should be obvious that these people need chairs. Even though they are in a fee-for-service system, many consumers, especially the heavy users, say that it is a managed system. But it’s managed in all these islands.
- *“I’m tired of training new providers about my disability.”* My favorite story here involves a woman who had very spastic cerebral palsy whose dentist kept telling her to calm down. And she has been going to the him for years. She is so frustrated.
- *“My doctors and therapists don’t know what each other are doing, so my care is fragmented and important pieces get lost.”*
- *“I have to spend hours talking to numerous people before I get authorization for the things I need.”*
- *“I can’t find a primary care physician who knows my disability, will see a new client, and has an accessible office.”*
- *“My providers only focus on the services they provide. No one treats me as a whole person.”* This is the concept that when you go to urologists, they see you as urinary tracts and don’t understand how their treatments will affect all the other pieces.

## What Consumers Say They Need

- *“Someone knowledgeable and experienced to help me navigate the healthcare system.”* Another thing we hear is, *“All I want you to do is open the doors; I’ll go through them.”* Then we have other people, the woman in her seventies who says, *“I’ve been fighting this for 50 years. I’m too tired, I can’t do it anymore. I want you to tell me where to go.”* We need to be prepared for both ends.
- *“One doctor who will coordinate all the rest of my doctors, therapists, and medications.”*
- *“Access to the best providers.”* Or even just the right providers.
- *“Competent services provided in my home and local community.”*
- *“Access to what I need without having to justify every single service.”*
- *“Respect from all of my caregivers, so I can maintain my dignity.”*

medical specialist component, and a home- and community-based services component.

### Primary Care Component

- Choice of an experienced primary care doctor from a small primary care network
- Close communication between the consumer, his or her primary care doctor, a health coordinator, and all other involved parties
- Primary care focus on prevention, early intervention, and health education
- Four member clinics

We’re looking at a small primary care network. The rationale is that there isn’t primary care for the most part in this population. They don’t really see the need for primary care or appreciate it, but they can access it—just make sure it doesn’t get in their way. There is a whole piece around educating consumers about the benefits and the opportunities of primary care. Most of the people we have worked with have not had flu shots or annual exams in years. They don’t understand the concept of primary care.

### Medical Specialist Component

- Broad network for consumer access to his or her specialist for continuity of care
- Selection of physicians and therapists in each specialty area with demonstrated expertise in working with physical disabilities
- Health coordinator to ensure communication with primary care and specialty network for comprehensive and integrated services

We’re creating a broad, open network with a foundation in the relationships that are most important to people with physical disabilities. We want to build on those key, long-time relationships already established and maintain that access.

**Home- and Community-Based Services Component**

- Home- and community-based services, including home care/PCA, DME, adult day, independent living skills, behavior management, respite care, and others
- Transitional, residential, and independent living settings
- Coordination with social, vocational, and educational services
- Mental health and chemical health services
- Bundling of services to minimize redundancy and increase coordination

This is the traditional waiver services. What we're looking at, again, is trying to capture the kind of modalities that are available through waivers for this population.

**Axis Healthcare Case Studies**

**Consumer:** Tom, 36-year-old college graduate, engineering major. Both parents and a sibling live out of state. Traumatic Brain Injury in 1986 while on a graduation trip to Europe.

**His needs:** "I need someone who gives a damn." His parents are upset because his medical providers don't talk to each other, resulting in fragmented care and because no one follows up on the problems that are really disabling him such as tremors and diplopia.

**Situation:** Tom depends on his physiatrist for primary care—she is very resistant to this and demands he find a primary care physician. The recommended primary care physician refuses to see him because he already is serving a lot of complex Medicaid clients. None of his doctors know who else is working with him. He has seen multiple rehabilitation therapists in different settings, many consecutive physiatrists and neuropsychologists, and multiple mental health therapists. Though he has seen many specialists, he forgets who he has seen and what they said. He has been repeatedly evicted from residential settings due to his behavior and hasn't stayed in one living setting for more than 12 months in the last decade. He is on MA waiver, but his case manager doesn't address his medical issues. His current living setting is inaccessible, and he has had two fractures from falls this year. There is constant conflict with housing staff and housemates, and he is only out of the home one day each week for structured activity.

**UCare/Axis Intervention:**

- Establish relationship with Tom so he uses Axis as a resource
- Facilitate communication between all community-based providers to discuss goals with Tom and coordinate his care
- Contact all medical providers and attend appointments with specialists as needed to get baseline and communicate medical needs
- Arrange and follow through on recommendations of medical providers, for example, surgery or equipment (Someone from Axis went with him to an eye appointment, and, as it turned out, he had seen this doctor nine months ago. A recommendation for surgery was made at that time, but there was no follow through.
- Establish primary care physician relationship and attend appointment with Tom to discuss medical and community care
- Maintain regular communication with Tom, his family, and providers
- Arrange for new housing and prepare staff to work with him
- Arrange for neuropsychological testing, development of a behavior plan, and caregiving training

**Consumer:** 38-year-old man with quadriplegia, 20 years post injury.

**Situation:** Roho wheelchair cushion goes flat on way to work.

**System Response and Result:**

- Difficult to contact health plan case manager
- Case manager authorized foam cushion in response to perceived need for comfort
- Health plan DME provider did not stock the needed cushion
- Eight hours before situation was addressed satisfactorily, resulting in skin breakdown requiring three-week hospitalization, 12 weeks off work, five months before return to full-time employment, total cost over \$100,000

**Axis Intervention:** DME provider under contract to deliver or repair the needed cushion within two hours.

**Consumer:** 43-year-old woman with multiple sclerosis, diagnosed in early twenties.

**Situation:** Progression of illness requires regular reassessment and medical, rehabilitative, and home care plans. Experiences repeated UTIs, respiratory complications, and skin breakdown. Becomes increasingly depressed, family and caregivers burned out. Followed solely by neurologist.

**System Response and Result:**

- Treated progressed UTIs, pneumonia, and decubiti through inpatient care, resulting in numerous hospitalizations
- All medical care provided in ER in response to an acute situation, resulting in premature progression of illness and physical dependence
- MS exacerbations treated in lengthy sub-acute or SNF stays
- Provider burnout resulted in multiple providers with poor reliability

**Axis Intervention:**

- Primary care/health coordination for comprehensive management
- Minimize placements through risk management and early intervention and treatment
- Prevent caregiver burnout through consumer education and counseling, monitoring relationships, and respite care

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## Steve Landkamer

I'm the project manager for the Wisconsin Partnership Program. The Partnership Program is a fully integrated managed care program. The idea of partnership is to provide good primary and long-term care services upfront so we can minimize the need for an individual to access institutional or acute care settings. The program combines Medicare and Medicaid benefits to members via small community-based organizations in the form of a capitation. For people with disabilities, it's roughly \$3,000 a month for Medicaid and about \$1,000 a month for Medicare.

The program serves people who are frail elderly, aged 55 years and older, similar to the PACE model. It also serves people with physical disabilities aged 18 and over. The models that are serving people with physical disabilities cannot enroll someone who is over 65 years of age. But people who are in the model who turn 65 can remain in the program.

To be eligible for Partnership, people must be Medicaid eligible, meet nursing home level of care, live in the designated catchment areas (currently five counties), and have a desire to remain in the community. This is a small program; it services about 750 people at this time. Currently ten are in nursing homes.

### Partnership Contractors

Currently four contractors are part of the Partnership Program. I work for the state, and we contract with small community-based, nonprofit organizations. They don't provide any other Medicare or Medicaid services, though some do personal care on separate contracts with counties.

Elder Care of Dane County (Madison) is the oldest of the Partnership organizations. It is both a PACE and a Partnership organization.

Community Care for the Elderly is also both a PACE and a Partnership organization serving people in Milwaukee County. What distinguishes between PACE and Partnership enrollment is whether people have an existing relationship with a primary care provider. If so, they go into Partnership; if not, they go into PACE. That is the main factor. Partnership is not a designated group of doctors; we will do whatever we can to enroll a primary care provider with whom an enrollee has a relationship.

Community Living Alliance (CLA) in Dane County enrolls people exclusively who are between the ages of 18 and 65 and who have a physical disability.

The fourth organization is Community Health Partnership (CHP) located in Eau Claire. They serve a three-county area, Dunn, Chippewa, and Eau Claire Counties, primarily a rural setting. They serve both people with physical disabilities and older adults.

What is the difference between the model that serves elderly people and the model that serves people with physical disabilities? CHP did a study of 150 people that they were serving as of January 1, 1999. They looked at what happened in the lives of those 150 people six months before they were enrolled and the six months from July 1998 to January 1999. In those last six months of 1998, they cut the amount of nursing home days applied to those same 150 people by over 4,000 days, a considerable savings. They cut in half the number of inpatient hospitalizations or admissions. They cut in half the length of stay in the hospital, and they also nearly doubled the number of primary care visits. All of these are things we had hoped for.

There are lots of reasons why those numbers are not "scientific." For instance, they relocate a lot of people

out of nursing homes so, of course, there is going to be a vast reduction in the number of days. Many of those people have physical disabilities and, except for the fact that they didn't have ready access to providers, shouldn't have been in nursing homes at all. Access is one of the primary things that Partnership has been successful in providing—access to specialty services, which was somewhat limited due to the Medicaid certification, and access to such routine things as dental care, which is just horrendous under the Medicaid system in Wisconsin. Over 60 percent of the people who are served had two routine dental visits last year.

### Issues Related to Serving People with Disabilities

What are the three or four primary differences between serving people with disabilities and serving older adults? Our models that serve people with disabilities grew out of independent living centers (ILCs). Eventually the ILCs spun them off because the independent living movement is basically an advocacy movement. They saw a real conflict between being in advocacy and also being a provider because sometimes they had to advocate against themselves. Their roots are in the independent living movement, and they try to incorporate a great deal of that philosophy, mostly in their choice and consumer self-direction, in their business operations, and in how they provide services.

### Consumer Participation

Consumer participation is on the programmatic level as well as on the individual level. I am told that there is an incredible amount of distrust of managed care on the part of the disabilities community. (I understand that people are individuals; I don't want to over generalize, but overall this is the impression.) Managed care is something that is out there, that is the enemy, because managed care

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traditionally says, “no.”

It is important to involve consumers in program design, ongoing advisory roles, and representation on boards. For each of the Partnership organizations, 25 percent of the boards of directors must be consumers. That means they actually have to be enrollees, receiving services from that organization. This sets up some conflict issues, but nevertheless, it is the way to gain trust and begin to demonstrate that people have the capacity for self-direction, not only in the care and services they receive, but also in the organization that is delivering those services. For the groups that were independent living centers, it was no big deal; most of the boards of directors were consumers anyway.

Individually, there has to be choice in the services received and in who provides them. There has to be consumer direction where the consumer has an equal or greater voice in the development of an individual care plan than the other people on the care management team. But that introduces the issue of utilization management. So this is something that we have had to debate, and it is a fine line to walk. You want to empower consumers to make choices that they see as being in their best interests. You need to support people in those choices.

Last night I happened to speak to the board of directors at CHP. The chairman of the board is in a wheelchair, and he told me that when people make bad choices, you have to learn how to support them in those bad choices. He’s right. Otherwise, you set up an adversarial position and will get nowhere. He also said that then you try to bring them around.

### **Comorbidity**

Another big issue is comorbidity of chronic conditions. We are seeing in

one organization a 60 percent overlap of AODA/CMI. CLA in Madison found that over 60 percent of the people with physical disabilities that they serve also have major alcohol or drug abuse problems or major mental illnesses. I don’t mean to imply that that situation doesn’t exist in older adults; I think it is probably underdiagnosed in both populations. But because of the level of activity, it seems to have larger financial ramifications as it is reported to me.

A story that one of the medical officers told me regards a young man they have who has serious multiple conditions and is on a lot of medications. This young man goes out on a drinking spree once a month and ends up in the ER with his medications all messed up. He gets admitted for a three-day hospitalization during which time he is detoxed and then brought back. The organization is going broke on this person. How long can they permit this to continue? We’re working on a couple things. One is an effort to look at the whole person, not just a primary diagnosis. Partnership has some nonenrollment protocols. There are specific groups that are included in calculating the capitation. People with primary diagnoses of major mental health or alcohol or drug abuse are not included in the calculation of capitation. How do you weed out what is a primary diagnosis of major mental illness over some kind of physical disabling condition?

What we have had to do is not weed out the primary conditions. We’re trying to build a capacity to serve the whole person. In Wisconsin there has been this situation between what has been the Department of Social Services and what has been Community Boards (the mental health and developmental disabled sections). When somebody comes in who happens to have two diagnoses, there is a ping pong match, and it’s not people saying, “I’ll serve them.” We’re trying to keep that from

happening.

### **Vocational Services**

There is a lot of documentation that would suggest that work is therapeutic and important to overall well being. In this program, the capitation is supposed to cover long-term care services, standard Medicaid services, and Medicare services. Vocational services comes in under the home- and community-based waivers. This can be done in Partnership because there is nothing they can’t provide. There are things they have to provide, but there is nothing they cannot provide. So, if a magazine subscription would be beneficial for someone, they can buy the subscription. If they decide a power wheelchair is warranted, they can get that. The consumer is the center of the team.

I think most people are familiar with supportive employment in the developmental disabilities world. We do that for people with physical disabilities, and it works very well. In this case, instead of providing hand-over-hand assistance in learning the job, a job coach may work to find out what kind of adaptations are needed.

Before I finish, I want to talk about Pathways to Independence. It isn’t meant to be a program that links with Partnership, but it does. Pathways proactively helps people with disabilities to engage in meaningful, substantial employment while eliminating the cliffs of Medicaid eligibility and Social Security. There is a Medicaid purchase plan that, while not finally approved, is now in the offing, and it is working.

# Opportunities for Improvement through Collaboration: Minnesota PRO Shares Upcoming Initiatives

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I'm Jane Pederson, director of medical affairs at Stratis Health. Presenting with me today is Susan Severson, one of our project managers. Susan is in charge of our immunization and mammography initiatives. I wanted Sue to present with me today because when you think of the work we do at the Peer Review Organization (PRO), it's our project managers who do the bulk of it. It's good for people to meet them.

I have a couple of goals for my presentation today. First, I want to help you understand what the PRO does and how it might complement what you are doing. Our objective is not to create our vision of what quality improvement should be or what kind of quality improvement efforts you should pursue. We're here to support the work that you are already doing. My second goal is to describe some of the collaborative relationships we have in place. Our hope is that we can start to collaborate with more people who are working on similar projects so we can all use our resources effectively and come out with better results. We'll be working with many of the hospitals, clinics, long-term care facilities and providers that you interact with. Finally, I'd like to give you some idea of what people want in quality improvement.

I'll begin with an overview of the Health Care Quality Improvement Program, some history of the PROs,

and some examples of the kind of work we do. I'm going to use our immunization initiative as an example, giving you a sense of how we tie the various tasks we work on for HCFA into a whole initiative around a clinical topic such as immunization. We're also going to give you some tangible examples of things we've created that are available to people to use in their quality improvement efforts.

## **Health Care Quality Improvement Program**

The Health Care Quality Improvement Program (HCQIP) began in 1993 and is a HCFA-funded initiative to support healthcare quality improvement. There has always been some type of oversight for the Medicare programs. Initially it was more utilization. But when the DRG was passed, the PROs came into play. Many of you probably remember when the PROs did random chart review of 25 percent of hospital discharges, looked for potential cases of poor quality, and then sent letters to the hospital and doctors telling them to improve their care. It wasn't a very effective way to foster quality improvement; so in 1993 this new approach emerged where the goal was to work more collaboratively with providers to help initiate and support quality improvement activities. This is the contract we currently work under today. Our newest contract for Stratis Health began November 1, and it is focused on collaboration and coordination, trying to pull together

everyone in the state who is working on various topics to increase our effectiveness.

### **Stratis Health**

Stratis Health is a private, nonprofit organization, and we contract with HCFA to serve as a Peer Review Organization for Minnesota. This has been our role for a number of years. We used to be the Foundation for Healthcare Evaluation. We have about 45 employees with a variety of skills. With only 45 people, trying to impact the whole state without collaborating with other groups is a big charge. As I mentioned, our whole approach to HCQIP is to collaborate and coordinate to support the implementation of evidence-based quality improvement strategies throughout Minnesota and, of course, to achieve some measurable results.

Our contract with HCFA is divided into three areas.

1. National Health Care Quality Improvement Initiatives
2. Minnesota Quality Improvement Projects
3. Quality Improvement Systems in Managed Care (QISMC)

Our goal is to have all of these tasks interrelate in initiatives that will be useful to the work that you do.

### **National Health Care Quality Improvement Initiatives**

HCFA has identified seven national clinical priorities:

1. Acute myocardial infarction
2. Pneumonia
3. Heart failure
4. Stroke/ TIA, atrial fibrillation
5. Immunization
6. Diabetes
7. Breast cancer / mammography

All states are required to work on each of these topics. HCFA has chosen standards on which to measure

performance. These are minimum performance standards. For example, with heart failure they're looking at the number of patients discharged from hospitals for whom ACE inhibitors are appropriate and who are actually on ACE inhibitors. When we go out and work with hospitals, we work on more than just that issue, but that is the issue on which HCFA will be measuring the state of Minnesota and our performance as a PRO.

There is a baseline measure for each of these topics, and I have some of the data to share with you. Some of it is provisional, and there will be a follow-up at 28 months.

Each of these seven initiatives has a project manager assigned to it. Additionally, project managers are assigned regionally so that the various hospitals and clinics throughout the state will have one contact as opposed to a different contact for each clinical topic. Our approach has changed. In the past there were focused clinical projects. A group of hospitals or clinics would work on a specific initiative, do a pre- and postmeasure, and see if the intervention worked. We still support these focused projects to some degree. But now we're looking at a statewide improvement and a more customized consultation approach, where we work with hospitals and clinics, ask what they are doing, and determine how we can support those activities.

### **Minnesota Quality Improvement Projects**

The Minnesota Quality Improvement Projects are the local projects. We have to do one that is in an alternative setting, meaning we have to look at one of the national topics in a setting that we haven't previously worked in. One of the alternate setting areas we've been chosen for in Minnesota is standing orders (SO) for vaccinations in long-term care. Another is to look for areas of disparity in care, that is,

various populations that may have lower measures in the various topics that HCFA is looking at.

In Minnesota our largest disadvantaged population, according to HCFA's terminology, is the dually eligible population. From preliminary data, it looks like immunization rates are lower in the dually eligible population. We don't have a lot of specifics for this project yet. We're working closely with the Department of Human Services to study the immunization rates and further define this population. Then we will be coming to some of you to learn how we can get to people who aren't getting immunized through the clinics or other sources available to them. We want to know what the barriers are and how we can help.

### **Quality Improvement Systems in Managed Care (QISMC)**

As many of the health plans know, quality improvement projects must be initiated annually. The annual topic for 1999 was diabetes, for 2000 it is community-acquired pneumonia, and in 2001 it may be heart failure. The PROs are required to provide technical assistance to these QISMC activities. So one of the things we are planning to do is proactively go to plans and ask, "What can we do? How can we help?"

### **Inpatient Pneumococcal Immunization Project**

How do we start an initiative? To answer that, I'd like to talk about a project that we have completed.

From the state baseline that we have for immunization it looks like our pneumococcal vaccination rate is 48.3 percent, and influenza is 69 percent. This is based on the Behavioral Risk Factor Surveillance System (BRFSS). There isn't a perfect measure to get at this, but BRFSS looks at community-dwelling Medicare beneficiaries, both fee-for-service and some of the

managed care beneficiaries. It does not capture beneficiaries in long-term care. People waffle back and forth as to what to use for the measure for this because claims tend to underestimate and BRFSS tends to overestimate. The truth is probably somewhere in between, but they chose to go with BRFSS.

Some of the history we have for immunization comes from our Inpatient Pneumococcal Immunization Project, which we finished just last fall. We worked with 26 hospitals throughout the state to put in a standardized assessment procedure. Patients came in and were assessed to determine their vaccination status. Based on that assessment they had some type of vaccine ordering policy:

- **A Preprinted Order (PPO)**  
By our definition, a PPO is a situation where the nursing staff can do the assessment and conclude that the person is eligible for a vaccination, but the physician has to sign the order before the person can get vaccinated.
- **A Standing Order (SO)**  
With a SO, the nurse can assess and vaccinate without a physician order
- **An Individual Physician Order (IPO)** With an IPO, a nurse can assess and put the information on the chart, but it is up to the physician to write the order.

The project included both staff and patient education. What we learned from that project is not surprising. PPOs (53 percent of those assessed were immunized) and SOs (40 percent of those assessed were vaccinated) worked the best. With IPOs, 12 percent of those assessed were vaccinated. This data suggests that PPOs are better than SOs, but, there isn't a statistically significant difference between the two. A smaller number of hospitals chose PPOs so most likely they are similar in their effect. But there is definitely a statistically significant difference

between PPOs and IPOs and between SOs and IPOs.

So, that was really good—put an SO in place and everyone will get vaccinated. However, we learned that that isn't necessarily the case. We did a sampling of the discharges of the 26 hospitals that participated. We found that at baseline the vaccination rate was zero, and after this intervention, the vaccination rate was 28 percent. That's good, but when you start looking at where patients fall through, you realize it's the process that is really important. Even if you put an SO in place, there are places where it can break down. Of the patients who were found to be appropriate for assessment, 44 percent just didn't get assessed for whatever reason. Of those who were assessed and found to be eligible, 72 percent did not get vaccinated for whatever reason. So there are still definite barriers that we need to address. We thought this was important to build on as we started to go on to our other initiatives.

### **The Minnesota Department of Health Model**

The first partnership that came out of our collaborative work in immunization was working with the Minnesota Department of Health (MDH). MDH had a CDC-funded demonstration program to increase pneumococcal vaccination rates in a three-county area. Specifically, the demonstration was to look at the effectiveness of putting a toolkit in place in the clinic and long-term care settings. I was fortunate to be on their advisory committee, and as they were planning their project and we were starting to plan our work, we realized that we had similar goals. MDH has a strong background in education and population health. Our background is in process improvement. This realization led to a collaborative effort that resulted in joint development of

materials for both the clinic and long-term care settings, a model for working with clinics and long-term care facilities to improve immunization rates, and also a plan for working initially with the metro-area clinics and then taking the model statewide.

In the clinic setting, the MDH model consisted of one-on-one consultations. The project manager would go out to the clinic, walk the staff through the intervention materials, help them decide what intervention would be best for their clinic, and encourage system changes such as the SO or previsit planning. They also provided implementation support at the clinics by having someone available to call with questions and support for ongoing, sustained change.

In long-term care, the approach was a little different. Invitations were sent out to the infection control nurses within a long-term care facility inviting them to come in for training. We had excellent response. We brought them together, provided training on immunization programs and implementation strategies, and had them break into small groups where the representatives from various long-term care facilities could actually create a quality improvement plan that they could take back to their facilities and implement if it was appropriate. We also provided ongoing support to those long-term care facilities.

At this time I'm going to turn it over to Susan Severson who will present some of our intervention strategies.

## Intervention Strategies

The MDH tools and trainings were based on evidence-based strategies. We did a literature search, met with experts in the field of immunization, and, in addition, HCFA contracted with the Oklahoma PRO for recommendations that were to be used nationwide by all the PROs. These are the recommendations that they came up with and that are integrated into a toolkit:

- Standing orders
- Patient reminder/recall
- Multi-component education interventions—for all levels of staff and patients
- Provider reminder/recall (only from provider)
- Provider feedback—letting providers know what their actual immunization rates are (Often, if you ask providers what their rates are, they'll say they're great. But if rates are actually measured, there is some incentive to improve.)

The following interventions were not considered as part of the strategy. In the case of the last three, there was a lack of sufficient evidence of effectiveness.

- Expanding access by expanding hours or location
- Adding immunization to home visits
- Community-wide education only
- Clinic-based education only
- Client or family incentive (financial or otherwise)

## Resource Kit Materials

We included the following materials in our resource kits:

- Quik Planner—this was key to implementation. With this, clinics and long-term care facilities could assess their current systems and select the most likely interventions.
- Policies—examples of SOs, PPOs

- Guidelines—ACIP, AMA, and Alert guidelines, CDC guidelines, and MDH immunization schedules
- Assessment tools
- Pocket guides—algorithms, patient communication, counter indications, Minnesota hotline for immunization questions
- Education materials—posters, brochures
- Articles and references for staff education

We didn't want to overload the kit with materials that wouldn't be used. The kit is streamlined and looks workable.

## Results So Far . . .

Here's the exciting part. Twenty-six clinics participated in the MDH demonstration phase of the project. Stratis Health visited four of the 26 clinics and found that all four implemented standing orders and did so within one to three weeks of receiving the kit. Most clinics self reported good increases in immunization rates. One clinic went from 0 to 300 immunizations in just two weeks. Many of the clinics added pneumococcal vaccinations to their flu clinics. The clinics reported that they were pleased with the materials and that they were easy to use.

Jane will now provide some additional examples of our collaborative efforts.

## Health Plan Coordination Goals

As I mentioned at the beginning, we're starting to work with some of the health plans. This will be a great collaborative effort, and I want to thank DHS—and specifically Robert Lloyd—for helping us get started.

To begin, we looked at what health plans want to improve and what the PRO wants to improve, and we established the following goals:

- Improve immunization rates and decrease variation in care (For example, we want Medicare beneficiaries to be able to go to any clinic and have the same chance of getting vaccinated.)
- Decrease the burden on clinics due to multiple interventions
- Provide good stewardship in the use of healthcare resources (We all know there aren't a lot of extra dollars, so we need to work together.)
- Meet QISMC requirements

## Standing Orders in Long-Term Care

This is an initiative with an interesting history. HCFA and the CDC came together to talk about the area of immunization. We were fortunate to be one of the PROs represented in this discussion. When they heard about some of the work that had been done here and elsewhere, they decided to look at this issue of standing orders in the long-term care area. They realized that many people are already doing standing orders, but just because there is a standing order in place doesn't mean that it is effective. There are various barriers to implementation. So HCFA and the CDC selected 11 PROs, including Minnesota, to work on this project. This is a good opportunity for us to feed back information to HCFA and the CDC about the long-term care area, the needs, issues, and approaches.

This is a project that I hope we can work on with some of the care systems. In some respects it is patterned on MDH and Stratis Health collaborative efforts. We began developing a resource kit with materials similar to those we developed here, and we'll do training aimed at long-term care facilities similar to our MDH model but now doing it statewide. We'll have a mandate to try to work with all the long-term care facilities and provide ongoing support. So again, this may be an opportunity to collaborate.

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## Diabetes

Now, so you don't think we're completely unidimensional in the area of immunization, I want to just touch on what we're doing in diabetes. We have some preliminary rates back on the measures that HCFA has selected, and I'll go over those. These are provisional measures. Overall, Minnesota was the highest of all the states, which means we're doing a good job. So for us, trying to improve these measures is a bigger challenge. Eighty-two percent of patients receive an annual HbA1c, 75 percent receive a biennial eye exam, and 58.9 percent receive biennial lipid profiles. This last one might be a little deceiving because HCFA looked at whole lipid profiles as opposed to just an LDL. I suspect if we looked at how many received specific components of the lipid profile it would probably be higher. Some of the things we are planning to do with this information are to look for pockets of opportunity by doing some age analysis and some county-level analysis. Even though we're the best overall, we need to look at where the challenge areas are here in Minnesota.

We've been working closely with the MDH Diabetes Control Program and using some training materials similar to what we developed for the immunization initiative. Some excellent quality improvement guides have been developed through projects such as IDEAL as well as good implementation packages. If you aren't familiar with them, call us, and we will point you in the right direction or try to get them for you. We're also starting to talk with health plans to try to do some collaborative work in diabetes and to do some work with the clinics—again, with the goal of trying to eliminate the number of mixed messages that go out and trying to help the clinics be more streamlined in their quality improvement efforts.

## Mammography

The other initiative I want to touch on is mammography. Overall, the mammography rate in Medicare fee-for-service beneficiaries was 45 percent. Again, this is provisional data based on claims. One of the roles we see for ourselves in mammography is to convene many of the interested parties. There is not a coalition for breast cancer and mammography like the Minnesota Coalition for Adult Immunization. We also want to provide resource kits based on evidence-based strategies to help organizations build on what they currently have. And we're looking at some other options such as media coverage to try to increase mammography rates.

In conclusion, I want to stress that our goal is to coordinate and collaborate, not to dictate what you should do for quality improvement. This is an instance where the phrase, "We're from the government, and we're here to help" is true. We're getting paid to do this. So please use us.

We have, as I mentioned, many active collaborative relationships already in place with MDH, DHS, HCFA and the CDC, health plans, and hospitals. We would love to add the care systems to this list. We know there is already a lot of good work happening in Minnesota, and we want to support that. But there is still room for improvement. Together we can impact the health of Minnesotans.

# Results from MSHO Member Satisfaction Surveys

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## **Walter Suarez**

The Minnesota Health Data Institute is a public/private partnership, nonprofit organization. We have three roles. The first role is to gather and disseminate community wide information about performance of organizations that deliver care. The second role is to improve the efficiency of the healthcare system by facilitating and promoting the use of electronic information between healthcare providers and health plans. The third role is to work on data privacy standards. So, if you have to use one word to describe the Institute it is standards.

The Minnesota Health Data Institute conducted consumer surveys in 1999 under contract for a project that had two components representing different populations: (1) the state employees and employees of member companies of the Buyer's Health Care Action Group and (2) beneficiaries under state programs, such as Medicaid, MinnesotaCare, MSHO, and the Demonstration Project for People with Disabilities. I will be reporting on the second population, focusing on the results for MSHO beneficiaries.

The sampling methods used were to extract files from the Department of Human Services (DHS) database, look only at MSHO beneficiaries currently enrolled in the program and who had been enrolled for at least five out of the last six months of the 1998 reporting year. From a random sample of 856 such cases, we targeted a response of 300 usable cases.

The survey instrument used was the Consumer Assessment of Health Plans Survey (CAHPS) 2.0H for all individuals in managed care and the CAHPS 2.0 FFS for individuals in fee-for-service Medicaid. Both instruments include the SF-12. The CAHPS instrument is a result of a five-year effort by the Agency for Health Care Policy and Research (AHCPR) to develop a standardized questionnaire that assess health plans and healthcare services from a consumer perspective. The tool has been extensively tested for psychometric and internal consistency. The instrument has 63 questions covering such things as: overall ratings, utilization, enrollment/coverage, access, provider relationships, communication, plan administration, health status, and demographics.

We used the standard CAHPS methodology in conducting this survey—a three-wave mail out (a letter, postcard reminder, and another letter to nonresponders) with a follow-up phone call. We used the standard timeframe and season, which is a ten-week field period from mid-March to the end of May. The MSHO response rate was 58 percent.

The data collection process began in March and ended in May/early June. We selected an independent data collection and analysis vendor via an RFP process. The data were submitted to the National Committee for Quality Assurance (NCQA) in June, and the data analysis was conducted from July through September of 1999. We prepared a report from that analysis

that has been shared with you today. The data analysis involves program aggregate comparisons and plan-specific comparisons. We case-mix adjust by age and health status in our analysis. We looked at two overall satisfaction scores: the overall rating of health plan and the overall rating of healthcare. We also looked at five composite scores for the following issues:

1. Getting the care the person needs
2. Getting care without long waits
3. Doctors who communicate well with patients
4. Courtesy, respect, helpfulness of office staff
5. Health plan customer service

Let me say a word about the importance of having a standardized, validated instrument that has been used to build a national database. The AHCPR established the National CAHPS Benchmark Database to facilitate comparisons of survey results among different organizations, including Medicaid agencies, Medicare, and public and private employers. Because of that, we are able to compare Minnesota's results with a national average, and we did that. We found that Minnesota's Medicaid health plans scored significantly higher than national averages in most of the overall ratings and composites.

Now let's look at overall survey findings from this project. By program, Medicaid FFS showed higher scores than other programs, followed by MSHO, PMAP, and MinnesotaCare. By age group, we found that seniors were more satisfied than younger adults across programs and plans. We also found that non-metro groups were more satisfied than metro populations across programs and plans.

With a rating scale of 10 being the best, and 0 being the worst score, MSHO respondents came out with an average of 8.4 for evaluating overall health

plan satisfaction, and a score of 8.8 for evaluating overall healthcare. Nationally, Medicaid programs (for all ages) rank at 7.9 and 8.1, respectively for the same components. So this shows higher satisfaction than national averages.

With regard to getting care that is needed, 79 percent of MSHO respondents and 92 percent of Medicaid FFS respondents said that this was no problem. Another 14 percent of MSHO respondents said this was a small problem. MSHO scores were the same as MinnesotaCare scores on this question.

With regard to getting care without long waits, 54 percent of MSHO respondents said they always get care without long waits, and another 31 percent said they usually get care without long waits. Of Medicaid FFS respondents, 62 percent said they always get care without long waits, and another 30 percent said they usually get care without long waits.

On the issue of how well doctors communicate, MSHO scored as well as Medicaid FFS, with 65 percent of the respondents saying their doctors always communicated well. These scores were comparable to Medicaid FFS and PMAP and slightly better than those for MinnesotaCare.

With regard to courtesy, respect, and helpfulness, 78 percent of MSHO respondents said that the staff is always courteous and respectful, and another 16 percent said that the staff is usually courteous. These scores were comparable to those from Medicaid FFS respondents and better than those for MinnesotaCare and PMAP.

With regard to the health plan's customer service, 68 percent of MSHO respondents said they had no problem with the service, with another 27 percent saying they had a small problem. This was slightly better than

the other programs surveyed. Though the scores across the programs were not vastly different, it is useful to take a look specifically at the MSHO scores and examine where MSHO respondents were most positive and where they were most negative. The areas with the most positive responses for MSHO were:

- How well the doctors communicate—that the provider usually or always listened carefully (93 percent), that he or she explained things in an understandable way (87 percent), that he or she showed respect (92 percent), and that the beneficiary spent as much time with the provider as wanted (89 percent).
- Courtesy, respect and helpfulness of office staff—that the beneficiary was treated with respect (94 percent) and that the staff were as helpful as wanted (95 percent).

The areas with the most negative responses for MSHO were:

- Getting care that is needed—trying to get a doctor or nurse they were happy with (26 percent said this is a big or small problem), getting a referral to a specialist (21 percent said this is a big or small problem), getting necessary care (23 percent said this is a big or small problem), and having problems with delays while waiting for approval (14 percent said this is a big or small problem).
- Getting care without long waits—getting help or advice by phone (15 percent said this was a big or small problem), getting regular or routine care when wanted (16 percent said this was a big or small problem), getting illness or injury care as soon as wanted (8 percent said this was a big or small problem), and waiting more than 15 minutes past their appointment time (21 percent said this was a big or small problem).

- Program customer service—finding or understanding written information (31 percent said this was a big or small problem), getting help from customer service (34 percent said this was a big or small problem), and dealing with program paperwork (32 percent said this was a big or small problem).

These data can be useful as a tool to identify priority areas for action in a quality improvement effort. We conduct an analysis of the problem scores to relate the magnitude of the problem score and its correlation to overall health plan/program satisfaction. Four priority areas are then constructed: top priority, high priority, medium priority, and low priority. We create a matrix with four quartiles—each representing one of these priority categories. The top priorities are those that reflect a high problem score (for example, > 15 percent) with a high correlation score (> .40). These are where patients report having unfavorable experiences and are issues that are very important to them, what they care most about. For MSHO the top priorities for action are: program customer service, getting care that is needed, and getting care without long waits.

### **Patty Homyak**

I am here to talk to you about the multi-state dual eligible demonstration evaluation that is being conducted by Robert Kane at the University of Minnesota under contract with the Health Care Financing Administration. I should caution you that the results are still preliminary—the evaluation is supposed to extend from October 1997 through September 2002.

The three states that we are evaluating are: Minnesota, Minnesota Senior Health Options demonstration; Wisconsin, Wisconsin Partnership

Program; and New York, Continuing Care Network. Our evaluation approach is to conduct a prospective, meta-analysis, handling each site as a separate study. The instruments and methodology we use will be as comparable as possible across the sites. We will do cross site summaries of findings.

The focus of our analyses is on the following:

- Coordination of care and benefits
- Outcomes
- Utilization of healthcare services
- Net costs and/or allocation of costs across payers

We are using the following sources of data:

- Client and family surveys
- Encounter/utilization data
- Site visits
- Provider surveys

Today I will only be talking about the results from the client and family surveys, and I will focus on the MSHO evaluation.

The survey was developed, as much as possible, using tried and tested questions in other published surveys. The types of questions on the client and family survey include questions about the person's general health, activities of daily living, special equipment needs and use, pain and discomfort, evaluation of MSHO, satisfaction, caregiver burden, medical history, mental status, and demographics. We are using a quasi-experimental design. We will be using pre-MSHO utilization data back to 1996 and current utilization and survey data on MSHO to try to compare pre- and post-MSHO implementation.

The survey takes approximately one hour to complete. We send an interviewer out to talk with the

beneficiary and his or her family. We first attempt to interview the beneficiary and then use a family proxy if necessary. We use a staff proxy for nursing home residents if the beneficiary cannot answer the questions and no family member is available.

We are surveying three groups of people:

1. MSHO beneficiary group (the experimental group)
2. In-area PMAP control group
3. Out-of-area PMAP control group

We matched the control groups to the experimental group on these indices: age, gender, previous nursing home residence, and Medicare managed care enrollment status prior to MSHO enrollment. We have separated the responses from the nursing home residents and those of the community dwelling beneficiaries.

Your handouts provide several graphics showing how the control groups compare to the MSHO experimental group. The populations, as expected, were largely female. General health status was similar for community-dwelling groups, with most answering that they had good or excellent health, followed by fair and poor. The in-area MSHO group and the out-of-area control group were more evenly matched on this question of general health status than the in-area control group.

Regarding medical history, we looked at the total number of diagnosed conditions, and again, the answers were similar, with three, four, or five conditions reported. On depression, the control group reported a little bit higher level of depression than the MSHO study group.

We had a few questions related to MSHO specifically—for example, what health plan or program they were

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enrolled in—and found that many people did not know what they were enrolled in. The families didn't do much better. This does cause one to question some of the answers on satisfaction with their health plan and healthcare.

Overall, though, the control groups and the experimental group are very comparable.

When we conducted our analysis of variables related to satisfaction, we found the following:

- African-Americans living in the community were more likely to agree positively with the items; that is, they were more positive in their response and more satisfied.
- Depression was not a significant predictor of satisfaction for nursing home residents but was negatively associated with satisfaction for community respondents.
- Functional status did not play a strong role in determining family member satisfaction, though functional disability was negatively associated with satisfaction for the community respondents. Greater disability was negatively associated with satisfaction.
- The people with the higher number of health problems were more likely to be satisfied with their care.
- Nursing home residents and family members in the out-of-area group were positively associated with satisfaction; that is, they were more positive than those in the MSHO study group. However, the family members of the in-area control group were negatively associated with satisfaction; that is, they were more negative than those in the MSHO study group.

- The frequency of family member visiting the beneficiary affected their levels of satisfaction. We found a strong positive correlation with satisfaction among the family members who frequently visited the community-dwelling beneficiary. On the other hand, for the nursing home residents, we found that the more the family members visited the nursing home resident, the more they were negatively associated with satisfaction.

So far, we find that there are some correlations of satisfaction related to the variables we studied. However, these correlations do not demonstrate a clear or consistent pattern of positive or negative satisfaction. Overall, then, that data seem to suggest that there is not much difference between the experimental and control groups in terms of the components of satisfaction that we studied.

Our next steps include:

- Refining the model
- Comparing patterns of service utilization to satisfaction
- Looking at informal care—including the amount of care provided and the caregiver burden.

We have started to get data from DHS regarding MSHO and PMAP utilization. We want to look at the patterns of utilization as outcomes, for example, preventable hospitalizations, emergency room visits, nursing home admissions for community-dwelling beneficiaries, deaths, disenrollments, functional status changes, and use of other services such as physician office visits, PT/OT services, home health, and personal care services. We also plan to conduct cost analyses to determine the net cost of the demonstration and the allocation of costs over providers and plans.

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Panel Discussion

# How Do We Know MSHO and Integrated Care Are Making a Difference?

*Moderator: Tom Moss  
Deputy Commissioner  
Minnesota Department of Human  
Services  
St. Paul, Minnesota*

*Panelists:  
Richard Bringewatt  
President and CEO  
National Chronic Care Consortium  
Bloomington, Minnesota*

*Julie Conrad, R.N.,  
Administrative Director  
Fairview Partners  
Minneapolis, Minnesota*

*Stan Smith, M.D.,  
UAFP Clinics,  
Assistant Professor  
Department of Family Practice and  
Community Health  
University of Minnesota  
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## **Tom Moss**

I am happy to be with you today because this group is made up of believers in integrated care. To understand the present we can look ahead to the year 2030 when our grandchildren will look back and see such things as cigarette smoking, cars that ran on fossil fuel, garbage collection during a time when we didn't recycle, and eye glasses or contact lenses instead of surgery to correct eyesight. And they'll ask us, "What were you thinking of then?" Similarly, people then will look back at how we did things in healthcare and will wonder how we thought we could do the job when we had separated Medicare and Medicaid funding and had few mechanisms to bring the right financial incentives or care segments together. Today's session will involve us asking these important questions.

## **Stan Smith**

I'm going to talk about our clinic experience. It's a 100 percent senior clinic, representing the heaviest users of the healthcare system. I plan to use one case to help illustrate the effectiveness of an integrated approach. In this case you will see that communication is key to integrating care—cell phones, pagers, faxes, and electronic medical records.

One afternoon we got a call about an MSHO member. We were lucky that in this case the dispatcher called us saying they couldn't take the person to St. Joseph's Hospital and wanting to know where to take her. This gave us

the opportunity to dispatch our house call team. We sent our physician and social worker to the person's home, and they determined that the she didn't need to go to the hospital but did need a higher level of care. So we had her go to a nursing home that had the capacity to serve her. We didn't have to call someone else and ask if we could do this. In this case, we were the case manager. This patient spent one to two weeks in the skilled nursing facility. She improved and went back home. We achieved our clinical goals as well as cost savings. So how do we know it's working? We know through anecdotal stories like this.

I'd like to draw on the work of Ed Wagner, M.D., at Group Health Cooperative in Seattle who talks about reorganizing primary care. We need to do more inpatient education. We need to organize around care teams. We need to do a better job in information management. Wagner and others used these ideas to try to reorganize chronic care in group visits. They looked at self-report of urinary incontinence, frequency of falls, depressive symptoms, and satisfaction. Unfortunately, they didn't find cost of care or the other clinical indicators were improved. They did find improvement in patient satisfaction.

We were involved in a geriatric assessment and management pilot, and we didn't find any difference either, except for satisfaction. So what happened, and how do we convince the skeptics? Wagner didn't have sufficient power in his study. Secondly,

only 53 percent of the patients participated in two or more of the specialty clinics, and 30 percent of the group didn't participate in any of the clinics. Also, the results are probably highly dependent on the physician and nurse involved as team members.

If we're going to redesign medical care, we need to:

- Identify and modify the risk factors
- Collaboratively identify goals with the patient
- Provide patient education and support for self-management
- Empower patients to participate in their own care

One example of self-management that did seem to work is the Chronic Disease Self-Management Course developed by Kate Lorig and her colleagues at Stanford.

I'll leave you with this—physicians need to be at the table, as do nurses, social workers, case managers, and the patient and family in order to reorganize healthcare effectively.

### **Julie Conrad**

When we look at MSHO, we want to focus on the outcomes of care and how an integrated care system can work. Some of the components of an integrated model are:

- A disability prevention orientation
- Medication management
- Coordination of care
- A systematic way of managing chronic conditions—perhaps through disease management pathways or other mechanisms

Providing case studies is a useful tool to examine the success of any program. I would like to present a Fairview Partners case study on an 82-year-old woman who is a permanent resident in the nursing home. In 1996

when she enrolled in MSHO, our nurse practitioner went to the facility to perform an initial health assessment.

The nursing staff said the patient was not doing well. She continued to have a fever, even though she was on oral antibiotics ordered by her previous physician. After a thorough examination and chest x-ray at the nursing home, the nurse practitioner confirmed her suspicion that the patient had pneumonia.

This patient was very restless, had dementia, and did not want to stay in bed. IV antibiotics would not work in this situation. The decision by the care team was to treat the patient with IM antibiotics. It was also decided to have a nursing assistant stay with the patient during the first few days of treatment to keep her calm and safely in bed. The patient responded to the treatment and recovered quickly.

So, what does this prove? Because of the MSHO program, we are able to use our healthcare dollars wisely. With traditional Medicare payment, this woman would not have been eligible for one-to-one care. She was able to receive the treatment she required in her own room in the nursing home.

In nursing home facilities, we are now able to provide many specialty services that used to be done only in the hospital. MSHO allows us to coordinate care more effectively and efficiently. For example, if a resident falls and sustains a minor fracture, can we get a specialist to come to the nursing home to provide treatment? Why not? Why should we be constrained by a benefit structure that doesn't meet the needs of the individual?

As we continue to provide services for the frail elderly in our society, we need to keep our goals clear. What is best for

the patient or resident is our key focus. Focusing on disability prevention, medication management, coordinated care, and a systematic way of managing chronic conditions will produce good outcomes. To produce excellent results, a program must have accountable practitioners, a financial structure that keeps the program viable, and outcomes management to assure that we are making a quality of care difference.

At Fairview Partners we have evaluated our success. As part of a Robert Wood Johnson Foundation project, we compared data from enrolled versus non-enrolled residents at our nursing homes. We found:

1. Fewer Fairview Partners-enrolled residents died during the study period compared to their matched control group.
2. The non-enrolled residents had higher hospitalizations (2.4 times higher). They also had 2.5 times more hospital days, and SNF days were 2.5 times higher.

How do patients and residents respond to this program? Satisfaction surveys on our enrollees show good results as well. Ninety-five percent of those polled said they were pleased with the way they were treated by the physician/gerontological nurse practitioner team. Ninety-five percent said they felt unnecessary hospitalizations were avoided because of the care they received. With regard to concerns of underuse of services, 98 percent of the families of residents said the physician/gerontological nurse practitioner team had not kept their loved ones unnecessarily out of the hospital.

In conclusion, when asked by the skeptics, "Does this type of integrated care really work?" I would have to reply a resounding, "Yes!"

## Richard Bringewatt

I want to address the following three questions:

1. Why integrate?
2. How do you know a good integrated system when you see one?
3. For the leaders in integration, what do we need to do next?

I'm going to take the perspective of health system executives. I also want to begin with the assumption that integration has not been tried yet—we have not yet seen an integrated system.

In understanding where we are in all of this, we need to understand that we are talking about integration in a disintegrated world. In the last year as I have traveled around the country and observed, I can assure you that health systems are disintegrating—literally. They're splitting off health plans, and they're spinning off home health agencies and other, what is termed, "non-core" business. They are going back to what they used to do, what they consider to be their "core businesses." Where there are still connections between organizations, it's more about connecting the pieces, not about integrating them. Most organizations are moving back to a fee-for-service world.

So the question is, why integrate? It's expensive; it's hard to do; and people are currently running the other way. First, it's important to understand that when people are in crisis, they go back to what they did before—what they did well. As Roger Mark has said, "The most exasperating thing about companies in crisis is they go back to what made them successful." They want that strategy to work again even though the environment has changed. The makers of the future are not necessarily the leaders of today.

Second, integration isn't what people think it is. People talk about integration as managed care, as mergers, or as geriatric medicine. It may not be any of those, or it may be some of those. There is an article about Allegheny Health System losing \$1.3 billion dollars—they are in bankruptcy. People see that headline and say, "Integration is bad for business." But if you read the details, you'll see that the system did not integrate. They made merger decisions and other financial decisions. That's not integration.

What is important to understand is that integration is about linking different parts, services, and functions of the delivery system as the different parts of a person's problem evolve across time and settings. As the nature of healthcare problems change, and a person's health declines, the delivery system is connected and works together in a dynamic way. It is not static. It is about chronic disease and disability. You don't need to integrate if you have a singular problem. If you have something that one person at one point in time can solve, then you don't need integration.

How do you sell this? I can't emphasize enough that people who are in executive roles still make decisions around profit, cost-containment, or market share. They believe in other issues, but that's what drives most healthcare decisions today. Again, I'd like to suggest that most "integration" studies are about geriatric care, managed care, or mergers. The problem is that most integration efforts stop there. But true integration is much more—it is about connecting the dots so that the clinical and other efforts at one setting are done in a complementary way in the next setting or for the next service need.

Are we monitoring an integrated delivery system here? Or, are we monitoring a point in time when there is an integrated delivery system emerging—a piece of a system? For those in leadership the question is, what do we do to make this move forward? The first important factor is to recognize that we have a critical mass problem. MSHO is only a small piece of a larger system. It is hard to effect change when you're only a small piece of a larger system.

The real thing to focus on is chronic disease and disabilities. This is of fundamental importance. This is the way you may have to explain it to others—as a program that focuses on the fastest-growing, highest-cost segment of the population. Most people don't realize how important the population that you're dealing with is. It's about one-third of the expenditures for Medicaid and one-third of the costs of Medicare. That's a huge number of dollars. The problems that you're addressing have direct implications for these national programs.

Here are some recommendations. We may have to drop the integration language for now; we may have to talk about such things as coordination, continuums, quality performance—language that people are comfortable with. And we need to:

- **Focus on clinical outcomes**—We have some emerging studies that show some promise of an integrated approach, but these need to go further.
- **Increase consumer control**—We need to take a complex system and make it simpler.
- **Reduce cost accumulation**—We need to show dollar savings longitudinally.

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- **Document cost savings**—If you cannot show people you're saving money or improving outcomes for the same dollar amount, no one will listen to you.
  - **Develop integration competencies**—We get rewarded in a disintegrated world right now, but we have to build a bridge to that new world. We have to develop competencies for working in integrated ways, and therefore demonstrate their effectiveness.
  - **Focus on high-leverage change initiatives**—Look at information exchange. Look at management competencies.

This is important work. We need to rally together and show that we can make a difference in the lives of elderly people. You can do it; this is important work. You are on the right track.

# Speaker Information

**Tim Beebe, Ph.D.**  
**Manager of Health Program Research and Evaluation**  
**Minnesota Department of Human Services**

Tim Beebe is currently Co-Manager of the Health Program Research and Evaluation Unit in the Performance Measurement and Quality Improvement Division at the Department of Human Services (DHS). He has been involved in the conduct of many surveys undertaken by DHS, including the administration of multiple CAHPS surveys. Tim holds a Masters degree in Applied Social Research from the University of Michigan and a Doctorate in Sociology from the University of Minnesota.

**Richard Bringewatt**  
**President and CEO**  
**National Chronic Care Consortium**

Richard J. Bringewatt is President and CEO of the National Chronic Care Consortium (NCCC), a national nonprofit alliance of the nation's leading healthcare providers collaborating to develop practical, innovative methods for integrating care. Mr. Bringewatt developed the "chronic care network" strategy that is central to the NCCC's work and assumed the lead role in developing the NCCC. During his 27-year career, Mr. Bringewatt has worked extensively with the spectrum of acute and long-term care providers, think-tank organizations, and foundations, as well as with the nation's leading healthcare provider and professional associations on issues of integration, managed care, and chronic disease management. He has also provided leadership in health systems policy development at the county, state, and federal levels, including Congressional testimony and service on policy commissions. He has consulted with many of the nation's leading reform demonstrations in chronic care, including the Social HMOs, On Lok and PACE replication, HCFA's Medicare Alzheimer's Disease Demonstration, and various other public and foundation-supported programs. A chronic care expert, he speaks and writes extensively on integrating the care continuum.

**Julie Conrad, R.N.**  
**Administrative Director**  
**Fairview Partners**

Julie Conrad has ten years of experience in professional nursing. Her areas of expertise

include Med/Surg, oncology, emergency room, rehabilitation, and home care. She has eight years of experience in managed care, specifically Medicare managed care products. Ms. Conrad also has five years of experience in program development and implementation. In her current position, she is responsible for orchestrating all operational components including care delivery, financial, enrollment, administrative, and contracting to ensure success of the Fairview Partners integrated health network.

**Chris Duff, M.Div.**  
**President and CEO**  
**AXIS Healthcare**

Chris Duff is president and CEO of AXIS Healthcare, a joint venture of Becklund Home Health Care, Courage Center, and Sister Kenny Institute established to provide specialty care management and a provider network to serve people with physical disabilities. Prior to that, he served as director of Consumer Relations at Courage Center; program director for Community Support Services, Residential Services at Courage Center; and program director of Residential Services at Courage Center. He is also a cofounder of New Beginnings for Brain Injury. Mr. Duff has written numerous publications and frequently gives presentations to healthcare audiences. He received a bachelor of arts from the University of Minnesota and a master of divinity from United Theological Seminary.

**Patricia Homyak, M.H.A.**  
**Project Coordinator**  
**Division of Health Services Research and Policy, University of Minnesota**

Patricia Homyak serves as project administrator for a number of studies under the direction of Dr. Robert Kane in the Division for Health Services Research and Policy, School of Public Health, University of Minnesota including the Multi-Site Evaluation of the Dual Eligible Demonstrations. Her training is as a long-term care administrator. Ms. Homyak has direct experience with both institutional and community based long-term care services. For the past nine years she has managed several large research projects including the Post Hospitalization Outcomes Studies.

**Steven Landkamer**  
**Program Manager, Wisconsin Partnership Program**  
**Wisconsin Department of Health and Family Services**

Steve Landkamer serves as the Wisconsin Partnership Program Manager. In this role he supervises staff, guides and coordinates all aspects of the program, and manages program operations. Under Partnership Program dual waiver status, Mr. Landkamer plans and negotiates with HCFA on operational issues and designs advanced methods for improving systems. He received a bachelor of arts in psychology, with a minor in philosophy.

**Mary Jane Osmick, M.D.**  
**Medical Director, Disease Management Programs**  
**Crozer-Keystone Health System**

Mary Jane Osmick, a board certified general internal medicine physician, began developing chronic care management strategies as early as 1989 in her own patient care practice. She has served in medical directorships for both area managed care organizations and Crozer-Keystone Health System (CKHS), a five hospital, not-for-profit, fully integrated health system in Delaware County, Pennsylvania. Since 1995 Dr. Osmick has served as the Clinical Director of Chronic Disease Management for CKHS, successfully leading a system-wide effort for integrating the care needs of chronically ill people. Working with the CKHS employed physician network and a county-wide physician organization, Dr. Osmick applies chronic care management strategies to support and promote quality care in the primary and specialty care settings. Dr. Osmick received her medical training at Temple University in Philadelphia. She speaks regionally and nationally about chronic care management strategies and programs, working to refocus national efforts on preventive strategies versus "rescue." Dr. Osmick's efforts have led to the establishment of multiple successful chronic care programs in CKHS. Working collaboratively with interdisciplinary teams, she has developed and documented a model for planning, implementation, maintenance, and marketing of chronic care programs for diverse patient populations.

**Pamela Parker, M.P.A.**

**Director, MSHO**

**Minnesota Department of Human Services**

Pamela J. Parker is director of Minnesota Senior Health Options, a demonstration funded by The Robert Wood Johnson Foundation that integrates primary, acute, and long-term care and Medicaid and Medicare services through managed care for dually eligible elderly. From 1987 to 1992 Ms. Parker was the director of the Long-Term Care Division at the Minnesota Department of Human Services, and, prior to that, she was responsible for design and implementation of the state's nursing home case mix system. She has 25 years of experience in health and managed and long-term care and has held a number of positions in state and local government including state Long-Term Care Ombudsman. Ms. Parker has a masters degree in public administration from Harvard's Kennedy School of Government and was a 1982 Bush Foundation Leadership Fellowship recipient.

**Jane Pederson, M.D., M.S.**

**Medical Director**

**Stratis Health**

Jane Pederson joined Stratis Health in September 1996. She is responsible for providing clinical input to the design and implementation of state-wide quality improvement initiatives, specifically in the areas of heart failure, anticoagulation management, pneumonia, and adult immunization. She also functions as a liaison to the provider community. In addition to her work at Stratis Health, Dr. Pederson is a medical director for EverCare, focusing mainly on clinical quality improvement initiatives. She previously served as the medical director for Optage. Dr. Pederson received her medical degree from the University of Minnesota in 1987 and completed residency training in internal medicine, also at the University of Minnesota, in 1990. She completed a fellowship in ambulatory care at the Veterans Administration Medical Center in Minneapolis and obtained a masters of science in health services research and policy from the University of Minnesota. Dr. Pederson is board certified in internal medicine and geriatrics and is licensed to practice in Minnesota.

**Kathleen Schuler, M.P.H.**

**Coordinator, Minnesota Disability Health Options**

**Minnesota Department of Human Services**

Kathleen Schuler serves as the coordinator of Minnesota Disability Health Options at the Minnesota Department of Human Services. Prior to that she participated in

the Bush Leadership Fellowship, Self Study Program in Environmental Links to Cancer. Ms. Schuler also was the manager of the Demonstration Project for People with Disabilities at the Minnesota Department of Human Services. She has held several positions managing Medicaid managed care demonstration projects which included development, implementation and operations involving rate setting, enrollment, consumer safeguards and advocacy, contracts, rule-making, and legislation. Ms. Schuler received a master of public health degree from the University of Minnesota in 1983.

**Stanley Smith, M.D., M.S.**

**University Affiliated Family Practice Clinics**

**Assistant Professor, Department of Family Practice and Community Health University of Minnesota**

Stanley L. Smith is an assistant professor at the University of Minnesota at the Department of Family Practice and Community Health in the Geriatrics Program and is director of the Geriatric Fellowship Program. He is fellowship trained and board certified in geriatrics. He received his undergraduate degree from Emory University and his medical degree from the Medical College of Georgia, Augusta. During his Geriatric Fellowship at Bowman Gray School of Medicine, Dr. Smith obtained a masters degree in epidemiology from Wake Forest University. His activities at the University of Minnesota include research, education, and clinical care in the nursing home, Wilder Senior Clinic, and individual homes. His research interests include geriatric interdisciplinary team training, caregiver education, and the influence of mental health on healthcare utilization.

**Walter Suarez, M.D., M.P.H.**

**Executive Director**

**Minnesota Health Data Institute**

Walter G. Suarez is a physician and a public health and medical information systems specialist and is the executive director of the Minnesota Health Data Institute (MHDI). The Institute is a nonprofit, public-private partnership established by the Minnesota legislature in 1993 to support the information needs of consumers, purchasers, providers, plans, and policymakers in measuring and improving the quality and cost-efficiency of healthcare in Minnesota. Prior to his current position Dr. Suarez was MHDI's director of Information Systems and Operations, overseeing the Institute's Electronic Commerce Program. Before joining the Institute Dr. Suarez worked for the Minnesota Department of Health directing the Health Care Cost Information System, the statewide hospital and surgical

center data system. Dr. Suarez is a member of the National Association of Health Data Organizations, the American National Standards Institute, the National Uniform Claims Committee, the Minnesota Population Health Assessment Workgroup, and the Minnesota Administrative Uniformity Committee. Dr. Suarez received his medical degree from the Colombian School of Medicine in 1985 and his masters in public health from Tulane University in 1986. Dr. Suarez practiced medicine in his native Colombia for several years before coming to the United States. He has worked in the fields of community and preventive medicine and general pediatrics, with special emphasis on management information systems and computer applications in primary healthcare.

**Sue Walker, M.S.W.**

**Vice President**

**Connecticut Community Care, Inc.**

Sue Walker is the vice president of Connecticut Community Care, Inc. (CCCI), an independent care management organization currently serving over 5,000 older adults throughout the state. Ms. Walker brings a wealth of knowledge and experience through her more than 20 years of nursing experience, which includes critical care nursing, home and hospice care, home health aide program coordination, discharge planning, case management, and program administration. Ms. Walker received her bachelor of science in nursing from California State University, Chico in 1978, and, under full scholarship, received a master of science degree in community health nursing from Yale University School of Nursing in 1992. Her master's thesis focused on the current provision and future planning for home- and community-based long-term care service delivery within the state of Connecticut. Ms. Walker was inducted into Sigma Theta Tau, the International Honor Society of Nursing, in 1992. Ms. Walker has presented both nationally and internationally on care management in both the public and private markets and information technology—*Building a Future Vision*, at conferences sponsored by the American Society on Aging, the National Council on the Aging, the American Association of Homes and Services for the Aging, and national HMOs.

## **Minnesota Senior Health Options**

The Minnesota Department of Human Services has developed a program called Minnesota Senior Health Options (MSHO) that combines Medicare and Medicaid financing and acute and long-term care delivery systems. This demonstration facilitates the integration of primary, acute, and long-term care services for people ages 65 and older who are eligible for both Medicare and Medicaid. Minnesota has received federal Medicare 222 and Medicaid 115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The waivers allow the State of Minnesota to combine the purchase of both Medicare and Medicaid services into one contract managed by the State. Minnesota is the first state ever to be granted such a combination of waivers. This demonstration will be implemented in the seven-county metropolitan area over a five-year period.

The Robert Wood Johnson Foundation (RWJF), which supported the planning stages for this demonstration, has provided a grant to cover the initial administration and implementation of the demonstration.

## **National Chronic Care Consortium National Resource Center on Chronic Care Integration**

The National Resource Center (NRC), a subsidiary of the National Chronic Care Consortium (NCCC), is the nation's premier resource for obtaining best practice information, consultation, and tools on chronic care integration. NRC products and services are designed to help emerging health networks restructure their primary, acute, and long-term care relationships under risk-based Medicare and Medicaid financing. These practice-based resources enable health networks to move beyond the merger of assets and authority toward integrating the ongoing management of governance, programs, information, financing, and care for people with chronic diseases and disabilities. This service is provided in response to the emergence of people with chronic conditions as the fastest-growing and highest-cost user segment in healthcare and the need to restructure how we finance, administer, and deliver care to contain cost accumulation and maintain quality.

The NRC is sponsored by the NCCC, a strategic alliance of leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

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