
Minnesota Senior Health Options

2001 Annual Educational Forum

**Knowledge into Action:
Sharing What Works**

January 18, 2001

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MSHO Status Report

Pamela Parker, M.P.A.

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MSHO Highlights

Pamela Parker provided highlights from MSHO for the year 2000, which included the following:

- Enrollment grew from 3,348 beneficiaries to 3,997.
- The State received Health Care Financing Administration (HCFA) approval to expand to rural areas.
- HCFA changed the Medicaid waiver status of the demonstration.
- The State submitted the Minnesota Disability Health Options (MnDHO) proposal to HCFA in October.
- MSHO appeared to increase the access to home- and community-based services (HCBS) for ethnically diverse seniors.
- MSHO beneficiaries' lengths of stay were shorter (pertains to long stay nursing home use).
- The State commissioned a survey of MSHO providers (nurse practitioners, physicians, and care coordinators) serving MSHO beneficiaries.
- The State commissioned a survey of MSHO nursing home resident satisfaction.

Ms. Parker discussed MSHO enrollment growth by health plan. Currently Medica has 2,476 enrollees; UCare Minnesota has 1,157, and Metropolitan Health Plan has 364. Overall, about 25 percent of MSHO enrollees live in the community; the other 75 percent live in a nursing home. However, this differs by health plan—two health plans have close to 50 percent or more of their MSHO members living in the community.

The MSHO demonstration has attracted a greater proportion of Asian and African-American enrollees. The

current profile of Elderly Waiver (EW) recipients in Minnesota shows that 81 percent are Caucasian, 10 percent are African-American, 5 percent are Asian, and 4 percent are another ethnic origin. However, in MSHO, 56 percent of the enrollees are Caucasian, 20 percent are African-American, and 18 percent are Asian. This may indicate that MSHO is doing a good job of reaching out to typically hard-to-reach population subgroups.

In addition, a look at the average nursing facility length of stay (LOS) of MSHO beneficiaries reveals that the actual LOS is lower than predicted by the pricing methodology established for the demonstration. In 1999 the actual LOS was 62.4 days in the nursing facility, compared to 99.3 days built into the pricing model.

MSHO Provider Survey

In the fall of 2000 the Department of Human Services contracted with the National Chronic Care Consortium (NCCC) to conduct a survey of direct care providers serving MSHO beneficiaries. Twenty-five care coordinators, 34 nurse practitioners, and 28 physicians who serve MSHO enrollees were contacted and asked to complete a mailed survey about their experiences with MSHO in serving their patients/clients. The purpose of the survey was to obtain direct feedback from providers who see and treat MSHO beneficiaries in order to determine what advantages and disadvantages MSHO might be offering to these providers. It was expected that these direct care providers would have a unique perspective on MSHO and its impact on seniors.

MSHO Enrollment January 2001

Total Enrollment: 3,997

25% in the community

75% in nursing homes

Enrollment by Plan

Medica

2,476 enrollees

Metropolitan Health Plan

364 enrollees

UCare Minnesota

1,157 enrollees

MSHO/MnDHO Goals for 2001

- Implement expansion to Wright, Sherburne, and Mille Lacs Counties
- Implement MnDHO
- Continue to collect and analyze data and evaluate impact of MSHO
- Increase public support and awareness of MSHO
- Get HCFA approval for extension of demonstration timelines

The survey was conducted from September to November of 2000. Response rates were good for the care coordinators and nurse practitioners. The physician group was hard to reach; however, 42 percent of the sample target group did participate.

Findings were very positive overall from care coordinators and nurse practitioners. Care coordinators, for example, reported that transitions were better between sites of care (100 percent agreeing), that there were advantages to MSHO that weren't there before (81 percent agreeing), that MSHO made their work simpler (69 percent agreeing), and that MSHO provided greater flexibility to provide "nontraditional" services (82 percent agreeing).

Nurse practitioners said that there was greater flexibility in benefits (79 percent agreeing), that MSHO had allowed them to do things differently (79 percent agreeing), and that there were advantages that weren't there before (70 percent agreeing).

The physician survey results showed that these physicians were either neutral or slightly positive about MSHO, with two physicians being very positive. About half of the 11 responding said that MSHO did offer some advantages that weren't there before. However, most didn't know when they were treating an MSHO patient, and most said that they had not conducted any MSHO-specific studies or quality improvement projects, largely because the small numbers of MSHO patients in their practices did not justify the time or expense.

Ms. Parker concluded her remarks by highlighting several goals for the year 2001. She said that implementing the MnDHO demonstration will be an important next step, as will expanding MSHO to three rural counties. She spoke, too, about increasing public

awareness and support for MSHO and continuing to collect and analyze data and evaluate the impact of MSHO. Finally, it will be important to secure HCFA approval for an extension of the MSHO demonstration.

Satisfaction Survey

Walter Suarez presented information from the most recent nursing facility satisfaction survey of MSHO beneficiaries.

Two previous satisfaction surveys of MSHO beneficiaries have been conducted. In 1998 a face-to-face survey of community and nursing home beneficiaries was conducted. This survey used an instrument developed by the University of Minnesota. Satisfaction results were compared to results from a similar population group—those seniors enrolled in the Prepaid Medical Assistance Program (PMAP). In 1999 a Consumer Assessment of Health Plans (CAHPS) survey of MSHO community beneficiaries was conducted.

In 2000 the State of Minnesota Department of Human Services contracted with the Minnesota Health Data Institute to conduct face-to-face interviews with MSHO and PMAP beneficiaries residing in nursing homes, using a revised version of the 1998 University of Minnesota instrument. Interviews were also conducted with residents' families. The instrument included 39 questions on topics of satisfaction with healthcare; experiences with MSHO, health plan, healthcare providers, and nursing home staff; and use of advance medical directives.

Response options included a yes/no and agree/disagree format and a scale of responses from "poor" to "excellent," as well as other similar scales.

The methodology for the family survey included a mailed protocol

with three waves: first mailing, postcard reminder, and second mailing. Questions pertained to satisfaction issues and to the impact of caring for the older person.

The issue of proxies came up and was debated extensively. It was decided that this survey would not use proxies for the residents' responses. Since the first step in this process of surveying beneficiaries was to determine cognitive ability to complete the interview (using the Mini-Mental Status Exam), individuals unable to comprehend or respond to the questions would not participate—therefore proxies would not be as necessary. This exclusion, not surprisingly, did reduce the sample size significantly. Out of a total of 1,200 people in the initial sample, 699 were excluded due to cognitive impairment, and another 215 were excluded for a variety of reasons (for example, physical limitations, language barriers, deceased, no longer a resident). Another 127 people were excluded at the time of the interview due to several issues (for example, hearing impairment, apparent cognitive confusion, illness, refusal to participate, language barriers).

Only experienced, trained field interviewers were used to conduct the survey. During the interview process, findings about the survey instrument emerged including the following:

- The survey was much too long—many seniors were very fatigued at the end of the interview.
- The structure of the survey questions was too advanced for this population group.
- Respondents were frustrated with numerous questions about the health plan and health plan processes—they did not get at issues they felt were important.
- Questions about personal habits were often considered offensive.
- The agree/disagree response

options were difficult or inadequate.

- The yes/no response questions were the most successful.

Consequently, recommendations were made by the field interviewers for future surveys, including:

- Design the questionnaire to be conducted in 20 minutes or less.
- Use simple and descriptive language.
- Keep personal questions to a minimum.
- Use the yes/no response option.
- Allow some beneficiary questions to be answered by family members.
- Allocate significant resources to preparing the facility for the interviews.
- Train interviewers specifically to work with the frail elderly population.

The final number of completed surveys included 156 MSHO beneficiary surveys and 603 MSHO family surveys. In addition, the same survey and process was used to survey a group of PMAP enrolled seniors. In this group there were 159 PMAP beneficiary surveys completed and 631 PMAP family surveys.

Key findings

With regard to demographics, the MSHO and PMAP beneficiary groups were similar. On the specific issues, MSHO members reported fewer problems with health plan paperwork than PMAP members did. In addition, there were improvements from the 1998 survey results in the number of MSHO beneficiaries and families who had heard of MSHO and who had had interactions with a care coordinator or nurse practitioner. Areas of strength within MSHO included interaction with the health plan, use of the care coordinator, interaction with the healthcare providers, use of advance directives, and nursing home respect for the beneficiaries' cultural beliefs.

However, MSHO beneficiaries reported more problems getting needed help from the nursing home staff than the PMAP beneficiaries—this finding was similar to the results from the 1998 survey. In addition, families and beneficiaries reported wanting to be more involved in healthcare decision-making, and families reported some trouble in getting necessary care for the senior. Another issue raised was the feeling by some that the healthcare provider doesn't spend enough time with the beneficiary.

National and Local Perspectives on Care Coordination

Moderator:

Mary Kennedy

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Commissioner of Health Care, Minnesota
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Minnesota*

Sherry Aliotta, R.N., B.S.N., C.C.M.

*President and CEO, S.A. Squared, Inc.,
Farmington Hills, Michigan*

Sonja Mackey, R.N.

*Medical Services Coordinator,
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*MSHO Field Coordinator, UCare
Minnesota, Minneapolis, Minnesota*

National Perspective

Sherry Aliotta shared information on best practices on care coordination models from research she and others have conducted. Ms. Aliotta began by discussing the term “case management,” noting how that term has fallen out of favor—currently being associated with a utilization review type function. Therefore, she would be using the term “care coordination.”

Current trends in care coordination include the interest to more concretely define and delineate what is in the “black box” of care coordination, the search for solid outcome measures, and the demand for a demonstrated “return on investment,” based on hard data.

Ms. Aliotta has participated in research conducted by Mathematica Policy Research, Inc., and their research examined three functions of care coordination models: (1) assessment of needs and care planning, (2) implementation of the plan and delivery of services, and (3) reassessment and adjustment.

Mathematica submitted its research in a report to HCFA published in March of 2000.

Assessment and Planning

Researchers found that successful programs do the following:

- Uncover all of the client’s important problems.
- Address all important problems and goals.
- Draw from a comprehensive arsenal of proven interventions.

- Produce a clear, practical plan of care.

Implementation and Delivery

Researchers found that successful programs do the following:

- Build ongoing relationships with the primary care providers (a key success factor) and other providers.
- Develop ongoing relationships with patients/clients and families.
- Provide excellent patient education.
- Ensure that the planned interventions get done.

Reassessment and Adjustment

Researchers found that successful programs do the following:

- Perform periodic reassessments.
- Remain accessible to clients.
- Nurture PCP relationships and those with other providers.
- Nurture relationships with clients and families.
- Make prompt adjustments to the plan of care as needed.

Ms. Aliotta discussed the limitations of the study as well, stating that the study relied on data and information provided by the programs themselves, did not use a random sampling or census method to identify the programs, and did not look at the financial aspects of the programs. She also noted the following strengths:

- The study included only programs with reported impacts.
- The study incorporated a breadth of program types—those programs

An executive summary of the research report, *Best Practices in Coordinated Care*, submitted to HCFA by Mathematica Policy Research, Inc. can be downloaded at <http://www.hcfa.gov/ord/fr-essta.pdf>.

that were contained within a disease management program and those that were strictly “stand alone” care coordination programs.

- The study followed an empirical approach without predefined conceptions about care coordination practices.

Common characteristics of **successful programs** included the following:

1. They had longevity.
2. Care coordinators were nurses.
3. They completed all three steps: assessment/ planning, implementation/ delivery, and reassessment/ adjustment.
4. Disease management programs used evidence-based guidelines for that particular disease.
5. They were proactive—they dealt with potential problems and risk factors before adverse events occurred.

As a caution, however, these characteristics by themselves are not a prescription for success.

Care Coordination Models

The *utilization model* program is primarily concerned with the utilization of healthcare services. Much of the planning, assessment, and service organization has to do with avoiding high-cost services and being cautious about expensive benefits. Many managed care organizations that employ this model of case management are recognizing the need to transform their programs into true care coordination models.

The *critical path model* focuses on the management of care along a predetermined pathway or continuum. This model is designed to reduce variations in practice and minimize delays while improving the quality of care and outcomes. The most recognized critical path model is the New England Medical Center program.

The *indemnity model* is one of the earliest case management models that was first implemented in traditional indemnity type insurance programs. It

is highly individualized and intensive and is usually directed at high-cost, complex illnesses. This type of care coordination tends to be reactive. It is very intensive, as the coordinator works to control adverse situations once

they have already occurred.

The *disease focus model* includes those care coordination programs that are focused on the management of elements of disease progression or chronic illness—people with a moderate to severe burden of illness. This type of care coordination is sometimes included as part of a comprehensive population-based disease management program, but it can also be freestanding.

Another way to understand care coordination programs is based on the following categorizations: proactive versus reactive, population based versus episodic, and community/ social versus medical. The *proactive model* of care coordination seeks to

identify individuals prior to decline and to intervene to prevent decline. Some of the program models described above are proactive. The *population-based model* collects information about a defined population and stratifies the population according to need. Interventions are staged according to level of need. The *community model* focuses on maintaining function and independence in the least restrictive environment. Intense medical monitoring is not as important as ensuring that activities of daily living are supported.

Few programs are “pure” models. All programs should provide the three key functions of care coordination, and many methods are effective in doing so. There are clearly at least two types of needs in the senior population—those with complex medical needs and those with heavy psychosocial and environmental needs. The hope is that the “black box” of care coordination will be opened a bit and that it will be seen as an important part of good care for older people.

Local Perspective

Metropolitan Health Plan

Sonja Mackey discussed the importance of attending to the needs of the low-risk members as well as people at high risk. Out of the more than 200 community MSHO members at Metropolitan Health Plan (MHP), 145 of them are at low risk according to the risk screening conducted by MHP. Many are largely healthy, have controlled medical conditions, and joined MSHO because they believed they may need services in the future. These low-risk members offer value because:

- They provide a foundation for the future of MSHO.
- They add opportunities for prevention and early intervention.
- They add a new disability prevention dimension to senior care.

- They can dispel stereotypes and can change attitudes.

Two issues arose in working with these low-risk MSHO enrollees: (1) enrollees did not know how a care coordinator worked or how this person would help them in the future, and (2) enrollees had no sense of “belonging” to the MSHO program—it was invisible to them.

MHP responded with innovative programs including “teas” where staff and beneficiaries could attend and become familiar with MSHO; an MSHO newsletter that featured stories about MSHO members; and public “coffee hours” that were community based, provided health information, and were open to all seniors.

In addition, MHP made several quality enhancements to its MSHO beneficiary service. It implemented several preventive programs including primary care health maintenance, screenings, and immunization initiatives. There is development around disease states, for example, a support group and a foot care program for diabetes. Also, MHP seeks to involve family members early on and has switched the care coordinator assessment from a telephone assessment process to face-to-face interviews. Visits are done at the members’ homes. The care coordinator also meets members at the clinic.

Finally, Ms. Mackey suggested using words a senior can understand to describe the functions of a care coordinator.

UCare Minnesota

May Hang provided another local perspective about care coordination, drawing upon her experience at UCare Minnesota as a coordinator for MSHO clients—especially the Hmong elders enrolled in the program. Ms. Hang described care coordination as, “a process that links MSHO members and

their families with healthcare needs, to services and resources in a coordinated effort to maximize the potential of the member and provide them with optimal healthcare.”

Early in the MSHO demonstration, UCare Minnesota established a collaborative partnership with two local independent family physicians from the Hmong community. Both clinics had substantial numbers of dually eligible seniors who could participate in MSHO if they desired. The clinics would be provided with care coordination services for any senior enrolled in UCare’s MSHO product. UCare sought out qualified care coordinators from the Hmong community and now has two bilingual coordinators, both registered nurses.

The following care coordination activities are provided:

- Patient education
- Planning of service and treatment strategies (with the PCP)
- Monitoring of outcomes and resources
- Coordination of specialist visits
- Coordination of home care needs
- Organization of care to avoid duplication of services
- Bridging of communication among healthcare professionals, community services, and family members
- Facilitation of service access
- Collaboration with hospital discharge planners
- Consultation on cultural issues
- Reassessment and refinement of the care plan

The intended goals of care coordination are disability prevention, better education of clients/patients, enhancement of patient autonomy and shared decision-making, facilitation of system integration, and better service use.

Ms. Hang listed several programs developed by UCare Minnesota,

including disease management programs in asthma, congestive heart failure (CHF), and diabetes. UCare has also organized a flu clinic in a primary care setting. Through MSHO, more Hmong seniors are receiving Elderly Waiver (EW) services.

Some of the barriers that arise in serving her clients include language issues, transportation, lack of culturally responsive community services, lack of independent living skills, the breakdown of the extended family system, and fear of medication and treatment.

Several strategies can address these barriers, including the use of trained interpreters, identification of family members and the decision-making process, better (and more appropriate) transportation services, greater capacity within the Hmong community to provide community services, assistance with things like bill paying and errands, and education and communication to build bridges between professional health beliefs and culturally accepted folk beliefs through education and communication.

Strategies for proactive care coordination include making telephone calls to members, providing home and post-hospital discharge visits, and accompanying the senior to visits to specialists or PCPs. She advised coordinators in the audience to be prepared to negotiate with providers to allow the Hmong patient to use traditional approaches to care or have care occur in the most culturally appropriate manner. Above all, be respectful, since culture is an important part of health and healing.

Concurrent Session

Accessing Resources in the Community: Mini-Resource Fair, Networking, and Facilitated Discussion

Catholic Charities
St. Paul, Minnesota
(651) 222-3001
www.cccspm.org

DARTS
West St. Paul, Minnesota
(651) 455-1560
www.darts1.org

Minnesota Board on Aging
St. Paul, Minnesota
(651) 296-2770
(800) 882-6262
www.mnaging.org

Nokomis Healthy Seniors
Living at Home/Block Nurse Program
Minneapolis, Minnesota
(612) 729-5499
www.mtn.org/~nhs
www.elderberry.org

Nutrition Education Programs
University of MN Extension Service
Minneapolis, Minnesota
(612) 374-8451
<http://ftw.che.umn.edu/eating.html>

Senior Linkage Line
Metropolitan Area Agency on Aging
St. Paul, Minnesota
(800) 333-2433
www.tcaging.org/senior.htm

STAR Program
State of Minnesota Department of
Administration
St. Paul, Minnesota
(651) 296-2771
www.admin.state.mn.us/assistivetechology

Vision Loss Resources
St. Paul, Minnesota
(651) 224-7662
www.visionlossresources.com

Volunteers of America
Minneapolis, Minnesota
(763) 546-3242
www.voamn.org

This Resource Fair featured representatives from nine different service organizations in the Twin Cities metropolitan area. Care coordinators and others attending the Annual Forum were invited to visit each of the displays and then come together to discuss current issues/interests they have in serving their senior clients.

During this group interactive portion of the session, the following questions were posed to facilitate discussion:

Questions for Case Managers/Care Coordinators

- Are there big issues that arise as you seek out or arrange for services for your senior clients? Are there different issues that arise for your younger disabled clients?
- What services are difficult for you to find?
- When arranging services, do you typically get all the information you need? What information is often lacking? Are there methods that could improve this information gathering process?
- Do you typically get follow-up or feedback from your clients about services rendered? Are there any common issues that arise?
- Do you encounter geographic barriers (that is, certain areas of the Twin Cities metropolitan area where services are hard to find)?
- Do you encounter other barriers?
- How could these organizations here, or others like them, interface more

effectively with case managers such as yourselves?

- Could service provision be streamlined, enhanced, or changed to better meet your needs or the needs of your clients?
- What enhancements would you as case managers appreciate in securing services for your clients or in providing them with needed information?

Questions for Service Organizations

- When you work with case managers/care coordinators, are there common issues that arise in providing information to them or service to the clients they are working with?
- Do you get all the information you need to provide service to seniors requesting service? If not, are there better ways to get the information you need?
- What issues are you seeing “out there” with regard to serving seniors? Are there different issues you face in serving younger people with physical disabilities?
- Are you planning on expanding any services?

Interactive Discussion

STAR Program

We use technology to achieve results, and our purpose is to ensure assistive technology for all Minnesotans with disabilities—all ages, all disabilities, across all life situations. We are also a public policy agency as well as a patient referral. We do a lot of public education involving technology because technology offers solutions for many people.

I am often asked where to find these things (the items on display at the STAR table). The low-tech kinds of things I have displayed today are from Wal-Mart, Target, Kmart, Radio Shack, or the local hardware store. They range in price from \$5 to \$10. Radio Shack

has a lot of electronic devices for less than \$20 including memo monitors. Target has terrific voice activated things—talking clocks, talking video—again for less than \$20. If you buy from the specialty catalogs be aware that you can often find comparable items at these stores if you know what features to look for. That is part of challenge—knowing what features to look for and seeing beyond the obvious uses for an item. Particularly with elders, who often are not familiar with technological language, low-tech solutions like these can work very well.

Another question I am asked is where to find a technology specialist. We put together a list and tried to objectify the criteria. This information is available on our Web site at www.admin.state.mn.us/assistivetechology. We list the skills you should expect to find, and a grid shows the education a specialist should have. People enter the field of technology in different ways. Some have formal theory background like artificial therapists, speech therapists, and physical therapists. Others, like engineers or social workers have an interest in it and have developed skills in that area. We divided the service areas into high-risk and moderate-risk areas and made recommendations for experience and training for each category.

Technology changes so quickly. Currently a technology is being developed using brain waves to drive the cursor on a computer. This technology has been used with a woman in California who had been in

a persistent vegetative state. The woman responded and was able to drive the cursor and communicate. She is not vegetative; new technologies are allowing more function. But how do

you know who can provide that service? Call us. (The STAR Program can be reached at 651-296-2771).

Who pays for services is another concern we hear, particularly when Medicare won't cover a service.

The STAR Program has a directory of funding resources for the purchase of assistive technology, which is defined as any piece of equipment that is used to increase, maintain, or improve the functional abilities of a person with a disability. The directory identifies over 50 funding resources from the public and private sector that provide funding or loans for assistive technology purchases.

Awareness is still a very big problem particularly for minority communities, which includes elderly and rural people. The STAR Program reaches out to these communities by partnering with organizations such as the Urban League, Council on Black Minnesotans, Council on Asian/Pacific Minnesotans, and Chicano/Latino Affairs Council. We educate them about new technology so they can provide that information to their clients. Some materials have been translated into other languages.

I'm very appreciative of the opportunity for dialogue because we are a system change agency and I am eager to hear from you about things that can be done differently and other ways that technology can help.

***Assistive Technology. . .
any piece of equipment
that is used to increase,
maintain, or improve
the functional abilities
of a person with a
disability.***

Nutrition Education Programs

I am very thankful for the opportunity to have our program here. I told a couple of you that we are a well-kept secret. Our program started over 30 years ago, and at that time we were only funded for families with children. However, for the last seven or eight years, through the food stamp plan, we have been able to work with the elderly population. Most of our work has been done on county sites and limited housing sites in Minneapolis. But I have a strong feeling that the ones who need us the most are the ones we are not reaching. Many seniors are living independently in their own homes. So, referrals, referrals, referrals...

As I listened this morning to some of the other conference speakers, I realized what a great opportunity it is for us to connect with nursing homes as people are being discharged to go home. I had never thought of that. It is a prime time to connect with people and work with them on meal planning if their diets have been changed, on stretching their food dollars, and on cooking healthier in general. We are a free service. We are federally funded, and we do have paperwork to do. Some of that is demographic information.

We use an assessment tool, a 24-hour dial-in recall to check on an individual. We put that information into our computer and get a printout of that day, the diet they had, the treats they had, what might be lacking, and what we can help them with. Usually that is interesting to people; they like to see that. We also have a list of about 18 different topics from which our clients choose what they want to learn about. All of our teaching is very much hands on. We do some cooking each time to get people to try new recipes, new ways of cooking. It's fun for them and fun for us too!

Comment by Facilitator (staff person from DHS/MSHO):

This is one program that I didn't know anything about, and I think it is a perfect example of programs and resources that are out there that can be readily used by MSHO or other case managers. I think it also illustrates the challenge of connecting with the services that are out there. This small forum was an attempt to facilitate that connection.

Senior Linkage Line

The Senior Linkage Line is an information center. We have three social workers and two other people who answer phones. There are a variety of areas that our clients can qualify for assistance in such as nutrition, telephone, transportation, and energy. We connect care managers, social workers, and clients with the people and agencies who can help in these areas. If they call, they will get help. We are not an informational medical line, if people call for information on doctors, we can't help with that.

It used to be that when one of our care coordinators identified a resource that was really helpful or learned that someone had moved, that information would be added or pulled from a resource file. When we became more computer literate we used word processors or software card files on a shared drive that everyone could access.

I also want to suggest that for some of those one-time needs, people could try connecting with the Honeywell Retiree Group or the 3M Retiree Group. Those retirees do things like build technology for kids in school and adapt toys or appliances for other people.

Block Nurse Program

I am with Nokomis Health and Care Nurse Block Program, one of several Block Nurse Programs in the Twin Cities. We have a Senior Help Line that

you can call if you have a question or if you have a client, for instance, who lives in our area and needs a little maintenance task done or a lighter TV moved. We will try to find someone to do that. We make it our mission to see if a volunteer can help that senior with whatever tasks he or she has. You can always call and ask. If we can't do it, we always find someone else who can. Our service is free, and we are limited to our own geographical area.

DARTS

I work at DARTS, a transportation service. It occurred to me that a lot of what is most affordable and, in some cases, the best services available to your clients are provided by agencies that have next to no marketing capacity. We want you to know about us, but we have not figured out how to do the marketing. So I want to use this opportunity to ask you if there are particular networks or avenues that we should use to keep you updated about what we have to offer. And when there is turnover in your jobs, how do we ensure that information gets passed on to your successors?

Case managers are sharing info via e-mail. I would like to echo that you can contact the Case Management Society of America for good information and networking. The national telephone number is (501) 225-2229, and the e-mail address is cmsa@cmsa.org. You can contact them and ask for the Minneapolis Chapter, and they will give you a name and number. Many chapters now have newsletters on their Web sites. Somewhere down the road the smaller entities will have a chance to get their names on the Web site. Seniors don't use the site, but case managers and people who help seniors do.

High-Tech and Low-Tech Solutions at Home

Margaret Christenson, M.P.H., O.T.R., F.A.O.T.A.

President, Lifease, Inc., New Brighton, Minnesota

Tim Bowman

Project Director, Advanced Rehabilitative Technologies, Sister Kenny Institute, Minneapolis, Minnesota

Linda Savard

Physical Therapist, Sister Kenny Institute

Matt White

Occupational Therapist, Sister Kenny Institute

Low-Tech Solutions

Margaret Christenson began with a brief overview of her company, a software company, started about ten years ago, that helps people identify low-tech technology and match them to individual needs. The software identifies over 6,000 products and over 1,000 ideas.

Ms. Christenson discussed the frustration that occupational therapists and others who work with people with functional issues may have when they try to find the right product or solution for a person with a unique need or set of circumstances. Many possibilities exist for adapting the environment itself to enable function. The environment is a “hidden” modality that can be used to the advantage of the older or disabled person.

There are three main areas of focus for adapting the environment: (1) making physical changes, (2) addressing sensory changes/needs, and (3) addressing cognitive changes in the person.

Physical Changes

These refer to changes that address stability and mobility—climbing stairs, sitting and rising, bending and reaching, and grasping and pinching. Grab bars are a common item that many people use to adapt the environment for older people. However, problems often arise when the area where you need the bar does not have studs or reinforcements to ensure that the bar will not slip or fall

off. Where you place the bar is almost as important as the bar itself.

Aesthetics are important. People do not want to have something put in their living environment that is ugly or that “smacks of disability.” As an example, grab bars do not have to be chrome or cumbersome. They are now made of different materials and in different colors, as well as brass. The adaptation can be functional and attractive.

Mobility is an important consideration. An individual may be ambulating but not very well, or someone might be in a wheelchair. Ramps are one idea, but they can take up a lot of space. And ramps can only be pitched so far—every foot it goes up, there are many feet that it needs to go out so that the angle is not too steep. Ms. Christenson provided an illustration of a device called an easy ramp that will reduce the need for a long ramp. There are other ramp pieces that come in larger sections. These can be particularly helpful in getting over small obstacles like a doorjamb or a small step up. Another low-tech solution is to berm or slope the entryway to bring the ground up to the door.

Other small devices can address problems. For example, many people confront the problem of having a too-small doorway that will not allow a wheelchair to fit through. Removing the door or widening the doorway are not the only way to address this problem. A swing-away hinge can be used to add another 2 inches to the width of the opening. This way a 34-

inch door allows a 36-inch wheelchair to enter. Another example is the baskets or other attachments to walkers that allow people to carry something as they go from place to place. By adding these things, you can eliminate the dependency on other people to move things around. A third example is the motion detector light. These can be added to any room so that when a person walks into a room, a light comes on without having to reach up for a switch or fumble around in the dark and lose balance.

There is a misconception that older people or those with functional disabilities related to mobility must have a one-story house. This is not the case when there are adaptations such as gliders and elevators. A multistory house with closets on two levels stacked on top of each other provides a convenient space in which to add an elevator if the need arises.

Another important area is seating. The lesson here is to match the person (height and weight) with the chair. The geriatric lounge chairs normally seen in nursing homes do not allow people to rise easily from the chair—there is no place to put ones feet. The chair needs to have the right kind of arms on it, a seat that's comfortable but not too big for the person, and space for the feet, so when a person begins to get up, his or her center of gravity is in line.

Other helpful items include: tension poles, grab bars and toilet seat adaptations in the bathroom, and lever door handles versus knobs. Raising wall electrical outlets so that a person does not have to bend over to plug something in is another adaptation. The ideal height is 24 inches for outlets and between 28 and 48 inches for drawers and cabinet handles. Raising the kitchen dishwasher to reduce bending is also helpful.

Sensory Adaptations

Examples of sensory adaptations include telephones with large numbers; better (non-glare) lighting in the home; lighting in places that are usually dark, such as closets and the top and bottom of stairs; having a contrast between light and dark areas (for example, light walls, dark floors); and putting a strip on the first and last steps of a stairwell to make the edge distinct. Signage in facilities or housing units should be at about 35 inches—not 6 feet. Signs should have dark lettering on light backgrounds. Water temperature should be no more than 120 degrees because the sense of touch is less responsive. Because an older person's grip may not be as strong as it once was, look for lightweight drinking glasses with ridges on them. More herbs and spices can be used in meal preparation to compensate for the diminished sense of taste and smell. Background noise and static can be reduced through the use of acoustical tile, carpets, or other products that absorb sound. There are also a variety of devices, such as "pocket talkers" and ear microphones that can be useful, particularly in place of hearing aids, if they have not worked for the older person.

Cognitive Changes

It is important to create a calm, simplified environment. Reduce clutter and store items not used by the person out of sight. Provide a secure area for the person to pace/walk. Ms. Christenson also suggested the following: photo (picture) phones, with the face of each person next to a button; timers for outlets/stoves so that they shut off after a certain amount of time; heat guards that shut off the stove if it senses a pan has run dry, and special locks for drawers or doors. Another useful device is a pill dispenser that beeps if the required day's pills have not been taken—with some devices even hooked up to a telephone monitoring system so a family member or nurse can telephone

For information on these and other low-tech solutions for the home, contact Lifease, Inc. at:

2451 15th Street NW, Suite D
New Brighton, MN 55112
(651) 636-6869
(651) 636-7075 fax
mclifease@aol.com
www.lifease.com

the senior to check whether medications were taken. Finally, recorded reminders can provide verbal cues that can help an older person get through the day.

High-Tech Solutions

Tim Bowman and two of his colleagues, **Matt White** and **Lynda Savard**, discussed “high-tech” programs that can serve people with physical disabilities. Sister Kenny Institute was founded over 50 years ago during the polio epidemic, and the Institute pioneered innovative techniques to help people adapt to functional loss and improve functional abilities. Continuing in that tradition, Sister Kenny created the Advanced Rehabilitative Technologies Center that has a number of active projects including: a bio-rehab device, a virtual reality driving simulation, a virtual reality wheelchair platform, and telerehabilitation.

A few years ago, the National Institute for Disability, Rehabilitation, and Research (NIDRR) issued a request for proposals to develop a rehab education and research center to identify or develop technologies capable of supporting rehab services for individuals who do not have access to comprehensive outpatient rehab services. This is one application for telerehabilitation, defined as the application of computer, communication, and information technologies to improve access to rehabilitation services and to support independent living. There were three partners who responded to the request and are collaborating in this effort—the National Rehabilitation Hospital,

Sister Kenny Institute, and Catholic University of America.

Selecting Technology

Matt White, an occupational therapist who works with video technology, said that one of the first questions the Rehab Technologies Center addressed is, “How do you select the technology to provide telerehabilitation services?” There are three components to addressing this question: (1) identifying the needed services and desirable features, (2) balancing the real-world trade-offs, and (3) choosing the simplest and least expensive technology that best meets the needs today.

Desirable technological features

include: a high-quality video image, high-speed data transmission, a large bandwidth, reliability, portability, low cost, and security. The image is important for obvious reasons. High

speed is needed to transfer data quickly so that neither the client nor the staff is spending time waiting around for things to happen. The bandwidth allows for more data to be transferred—akin to a bigger freeway allowing more cars to travel. Reliability is important so that the system doesn’t shut down at inopportune moments. Portability is key if you are putting the unit in people’s homes. Low cost speaks for itself—but the cheapest option is not always the best. Security is especially important since these data are personal and private.

Two other features are interoperability

and POTS. Interoperability means that one videoconferencing system can work with another, and POTS stands for “plain old telephone system”—versus a cellular system. The advantage of POTS is that almost everyone has a telephone, so that the technology can be plugged in at home without new lines or other equipment. Mr. White also described important features of videoconferencing units, for example the ability to remotely control the camera to allow for zooming in on a subject, panning a room, or tilting the camera at an angle.

Home telephones work with analog communication where the sound of the voice is converted into electronic signals. With digital communication information is converted into a digital format. Digital communication is more efficient and therefore faster. Mr. White briefly explained the capacity of each type of connection, including: POTS, ISDN, digital cable modem, digital subscriber line, and a T1 through T4 line. Each type of connection has a different capacity for transmitting images. The goal is to have a smooth image, where there are no delays in motion or jerkiness. The eye generally cannot detect delays when there are more than 12 frames per second.

As a reference point, television usually has 30 frames per second. POTS has the capacity for only five frames per second, so that would not be sufficient if you wanted to see how stable a person was trying to stand or how smoothly he or she walks at home. ISDN, or integrated service digital networks give you about 15 frames per second but cost about \$120 a month and have a limited range. Digital cable modems offer up to 25 frames per second and also cost only about \$40 per month, but the client must have cable. Digital subscriber lines run about \$40-\$50 per month and have good video images (25 frames per second), but they have limited range. T1 lines are wonderfully fast and

Telerehabilitation—the application of computer, communication, and information technologies to improve access to rehabilitation services and to support independent living.

provide a very high quality image, but they are very expensive—up to \$2000 per month.

There are four types of wireless communication: cellular, microwave, radio, and satellite. And there are various options for camera equipment, including inexpensive personal computer cameras that can be obtained at places such as Best Buy or Radio Shack.

Long Distance Applications for Technology

Lynda Savard is a physical therapist who has been working with this technology with her clients. Since she is a PT and Mr. White is an OT, Ms. Savard remarked that most of the applications they have explored for telerehabilitation have been in these two fields—however other applications are certainly possible.

Sister Kenny Institute has many therapists who specialize in the various areas of rehabilitation, therefore they can serve as resources to each other and can provide a wide range of consultation services that target a specific patient need. This is not the case in many smaller institutions or for therapists working in rural Minnesota without the luxury of a large institution to provide support resources. This issue is another area that telerehabilitation can address. Ms. Savard provided several examples of therapists in outstate Minnesota receiving consultation support from therapists at Sister Kenny via telerehabilitation technology. This technology is also useful for conducting in-service education and continuing education classes.

Mr. Bowman discussed a long-distance application of telerehabilitation with islands in the Pacific Rim, including Guam and American Samoa. These islands typically have few resources and, in

most cases, no trained therapists. Through a grant project, the team from Sister Kenny / Allina has been able to provide training and consultation.

To effectively extend resources into the community, more policy and payment support from federal and state governments is needed. Professional associations like physicians and nurses must also view telemedicine as a way to improve patient care.

Privacy and security are additional issues. HIPPA legislation, which looks at privacy and the process for transmitting electronic patient-specific data, has been passed. If interpreted broadly, it could serve as a barrier to telemedicine/ telerehab. So this is another area for education. Finally, Mr. Bowman pointed to the Internet as a tool that could advance telerehabilitation in many ways.

For more information on Advanced Rehabilitative Technologies, visit the Sister Kenny Institute Web site at www.sisterkennyinstitute.com or the Rehabilitation Engineering Research Center on TeleRehabilitation Web site at www.hctr.be.cua.edu/RERC/.

Improving Transitions between Settings

Mary Parish Gavinski, M.D.
Medical Director, Community Care for the Elderly, Milwaukee, Wisconsin

Mary Parish Gavinski, discussed improving the transitions in care across settings, drawing on her experience as a geriatrician, nursing home medical director, and PACE medical director.

PACE and the Wisconsin Partnership Program

Dr. Gavinski began by describing the typical PACE program participant: 83 years old, female, 3-4 dependencies in Activities of Daily Living (ADLs), 8-9 conditions, and 5-6 daily medications.

The PACE program is based on an integrated care model, bringing acute, primary, and long-term care services together under the direction of an interdisciplinary team. In addition, PACE combines Medicare and Medicaid financing.

When the PACE program began in Wisconsin, there was 1 day care center, 1 provider team, and 49 program participants. As of January 2001, there are 5 day health centers, 8 provider teams, and 670 program participants. This includes the individuals in the Wisconsin Partnership Program (WPP), which takes components of the PACE model but uses contracted physicians (not staff) and collaborative practice agreements with those physicians in terms of their role, the role of the interdisciplinary team, and that of the nurse practitioner (NP).

In the early days of PACE there was a belief that every senior participant needed to come into the day health center on a regular basis to get care and to participate in socialization activities. The State of Wisconsin did not want to mandate participation in a day health center and encouraged the development of an alternative. State representatives were also interested in broadening the provider network beyond an employed or staff model and in working with community physicians under contract. The WPP was designed to offer this kind of

flexibility. It began with 6 physicians in the community and has expanded to 24 physicians and 3 residency programs.

The interdisciplinary team includes a nurse, social worker, NP, and facilitator, as well as the community

physician(s). The NP works with the physician at his or her office at least once or twice a week. The NP also follows the participant into the hospital if the senior is admitted. The Primary Care Triad (the team) maintains control of medical decisions across settings. When a senior is admitted to the hospital, the NP will bring along the information that the participant's physician will need (because rarely is that information available). The NP becomes the "eyes and ears" of the physician at the hospital—he or she can help the hospital staff understand the plan of care following the admission and

Communication is a key aspect of improving transitions, and it is vital that the providers within the team all buy into the team concept and processes.

communicate with the primary care physician about how things are going.

Communication is a key aspect of improving transitions, and it is vital that the providers within the team all buy into the team concept and processes.

Before a final agreement is made to work with a particular physician, the WPP medical director (Dr. Gavinski) meets with that physician and goes over the program, its philosophy of managing care, the role of the team members, the services that are provided, and so on. Each physician receives a physician handbook that outlines processes and policies. Not all physicians are willing to work within this model. This is a true partnership, and it requires a different way of working with each other and with the client, patient, participant, and family. This requires time because a relationship is being built. Communication is the key ingredient for this to succeed.

One thing they have learned in their work with community physicians is that doctors' records are often not up to date, and the hospital's records are often incomplete as well. There are omission problems, transcription problems (for example, something goes on the discharge summary that is not true), duplication problems, and other mistakes. The WPP has agreements with each hospital it works with that allow the NP to record his or her assessment in the hospital record, though not write orders. Education is provided to accustom the hospital staff to the WPP processes. They work in a similar way with the community physicians.

Characteristics of a Functional Integration Model

According to Dr. Gavinski, hallmarks of a "functional integration model in action" include:

- More care occurs in the community setting, yielding fewer iatrogenic institutional effects.
- The functional statuses of patients are maintained as a priority.
- Disease prevention and management is targeted at an earlier stage of progression.
- Care providers know the patient/family very well.
- A high degree of trust exists between the patient/family and the care providers.
- Members of the interdisciplinary

Key Roles of Interdisciplinary Team

Physician:

1. Provides primary care of patient with NP
2. Provides acute care of patient with NP
3. Is involved in all complex medical issues
4. Oversees (best if is the primary attending) all inpatient admissions
5. Uses medical specialists as consultants not primary providers
6. Is involved in discussions of Health Care Wishes and Advance Directives

Nurse Practitioner:

1. Provides primary care of patient with collaborating physician (essential in the care of frail SNF patients)
2. Provides episodic care of acute problems—collaborating with physician per practice agreement
3. Is team leader in bringing primary care perspective to case management team
4. Monitors complex chronic conditions
5. Is involved with physician and patient in all healthcare wishes discussions
6. Is liaison with community physician
7. Educates patient and family about complex medical issues

Nurse:

1. Provides close monitoring of chronic conditions
2. Assumes the role of liaison with physician in some cases
3. Oversees personal care needs of patient
4. Monitors patient and family needs
5. Educates patient and family

Social Worker:

1. Advocates for patient and family
2. Monitors caregiver
3. Counsels participants and caregivers
4. Refers participants and caregivers to appropriate community resources
5. Provides team with knowledge of psychosocial and financial issues

Rehabilitation Services (OT, PT, Speech, Recreation):

1. Does initial assessment of function and development of POC
2. Reassesses at time of transitions and acute changes
3. Understands/believes in community-based care philosophy

team trust each other and rely on each other's perspectives about care. These are the characteristics that will result in better outcomes for this population and improve transitions in care when they need to occur.

Hospitalization is pursued when necessary, but the WPP also uses subacute care and nursing facility care for short-term stays. Medication usage is a big issue, and they have been working with a consultant pharmacist and have established a small list of medications that need special attention when used in the senior population (these medications need to be controlled). Educating the community physicians about prescribing is key.

Quality of care reviews are conducted on an annual basis with each of the physicians. For some physicians, undergoing this type of performance review is a new experience. The reviews include: team feedback, client/patient feedback, family feedback, and a review of utilization patterns and care issues.

The key components of a working model for this population include:

- Trust and effective communication between care providers
- An effective care management team that is interdisciplinary
- A fluid plan of care that integrates the interdisciplinary recommendations
- Patient and family access to appropriate coverage of issues on a 24/7 basis
- Decision-making at the level of the provider
- Access by all care providers to the necessary information for good decision-making
- Excellent and complete medical and case management records (one repository)

Dr. Gavinski briefly discussed the roles of each of the providers—the

physician, nurse practitioner, nurse, and social worker, as well as the rehabilitation services professionals, and the facilitator. Characteristics of a good team member include: being an excellent clinician, having confidence without being overbearing, being a good listener, having a desire to work in teams, being trustful and respectful of others, and having flexibility and creativity.

Characteristics of an effective organization include the following:

- Staff are given the necessary tools to succeed—there are appropriate staffing, education, and financing.
- Administration offers ready support when needed.
- The organization responds quickly to staff-identified issues surrounding patient care.

Obstacles commonly experienced within the team management model include: one provider thinking he or she "knows best," poor internal systems (cannot share pertinent information among providers), inadequate education for staff, and no feedback mechanism for providers to report on how the system is working.

In summary, to improve transitions, you have to believe that this is an important goal—develop your organization's understanding about the significance of this. Dr. Gavinski recommends, too, that organizations develop the internal systems that address the issues she has highlighted. Finally, it is important to point out where the system fails and offer ideas for improvement and to go the extra mile—do more than your part.

Disability Prevention in the Senior Population

Susan Snyder, M.S.

Director, Senior Wellness Project, Senior Services of Seattle/King County, Seattle, Washington

Joelyn Malone

Consultant, Malone Consulting, St. Louis Park, Minnesota

Susan Snyder presented information on the Senior Wellness Project, a health promotion/ disease management program that provides a package of programs for seniors to choose from to manage their health behaviors. There are four main research-based wellness programs: (1) a Health Enhancement Program, which includes (2) a Health Mentors program; (3) a Lifetime Fitness Program; and (4) a Living a Healthy Life Workshop.

Health Enhancement Program

HEP Research Study

This approach to disability prevention and chronic illness self-management was researched by the University of Washington in a randomized control study called the Health Enhancement Project (HEP) research study. The study included senior members from two health plans—Group Health Cooperative of Puget Sound and PacifiCare and was based in one of the Senior Services senior centers. However, the participants recruited for the study had previously not been attendees of a senior center. Study subjects were aged 70 and older, were recruited through their physicians' offices, had at least one chronic condition (typically two or three), did not have dementia or a terminal illness, and were able to get to the senior center on a regular basis (were ambulatory). The goals of the research study were to:

- Enhance the quality of life of seniors.

- Support the primary care physicians.
- Reduce hospital stay and ER use.
- Be self-sustaining and replicable.

All of these goals were met. Results from the study showed that study participants had the following:

- Fewer hospital days than the control group
- A decrease in use of psychoactive medications
- Higher levels of physical activity
- Better functioning in ADLs

The Health Mentor component of the program uses peer volunteers who act as role models and extend the work of the healthcare professional—seniors helping seniors. The study looked at mentor outcomes and found positive health outcomes there as well. Mentors experienced improvements in their physical function scores, their levels of exercise, their levels of social activity, and their self-management techniques.

A Participant-Centered Approach

The Health Enhancement Program uses a participant-centered approach. The participant (senior) assumes responsibility for his or her own health and behaviors. Participants set their goals and actively participate in the program. The emphasis is on behavior and how participants' behaviors either contribute to or take away from their goals.

In designing the approach, researchers looked at behavior change models and stages of readiness to change theories.

The book *Health Behavior Change* was used as a reference. The approach uses these theories and models, working with participants wherever they are on the continuum of readiness to change (from pre-contemplation to action). Participants choose the activities they are most comfortable with, are encouraged to take part in senior center activities and use community resources, and receive social support and encouragement through the peer mentors. Nurses talk with participants about the barriers to change the participants may be facing. It is a one-year program.

Health Enhancement Program Team Member Roles

Other roles that nurses play as members of the Health Enhancement Program team are to conduct comprehensive health reviews and functional assessments at baseline, 6 months, and 12 months; to develop an action plans with the participants; and to provide ongoing monitoring, problem-solving, and support. The assessment includes an 11-page questionnaire that the participant completes and brings back to the team. This is the starting point—what the participant sees as important. The nurses have to learn to let go of some of their “professional judgement” and be good listeners. Once participants have identified their goals, the program nurses help them develop action plans, and then those action plans are shared with the physicians. The team then provides ongoing monitoring, support, and referrals over the course of the year. Most of the seniors “graduate” from the program after one year.

The role of the social worker is to provide individual and family counseling, to facilitate support groups, and to build skills (for example, communication, management of grief or depression). The health mentors or peer volunteers are based in the senior center.

Outcome Measures

The outcome measures that have been studied include:

- Physical function and performance measures
- Self-rating of health
- Utilization of hospital, ER, office visits
- Performance of certain behaviors, such as exercise, use of medications, social activities, mood management, health management behaviors, and nutritional health management

These measures are included in the questionnaire that participants complete at home. Utilization statistics are self-reported.

Software (WellWare©) developed by the Senior Wellness Project allows team members to create electronic health action plans; enter encounter notes; and generate reports such as medical care utilization, encounter summaries, and participant lists by physician, network, or mentor.

Lifetime Fitness Program

The Lifetime Fitness Program was developed by researchers at the University of Washington and has been tested in randomized controlled trials conducted by the School of Public Health and Group Health Center for Health Studies. The program has been shown to improve physical and social functioning and reduce incidence of pain, fatigue, and depression. Trained fitness instructors who have been certified by a national fitness certification organization receive an additional four-hour project-specific training course. The program includes strength training using soft wrist and ankle weights, flexibility exercises, aerobics, and balance exercises. It involves a one-hour, three-times-a-week class. There is a charge of \$25 for a 15-week session. It is safe for physically unfit

seniors and can be tailored to the levels of fitness of the participants in the class. The health plans have provided this class as a benefit for their members. A User’s Guide is available for purchase by the seniors so they can do their fitness activities at home; however, most people find the socialization of the class environment to be an added benefit. Fitness instructors have an Instructor’s Manual, are connected via an electronic mailing list, and are encouraged to participate in an annual workshop.

Living a Healthy Life Workshop

The chronic disease self-management program, Living a Healthy Life Workshop, was developed by Dr. Kate Lorig and colleagues at Stanford University. Trained lay facilitators conduct the program over a six-week time period, with each class lasting 2 1/2 hours. In this workshop/program, seniors learn how to take care of the symptoms of their illnesses, learn techniques to help them carry out their normal day-to-day activities, and learn to manage the emotional changes that can arise as a result of their conditions/diseases. The class sets goals every week as a group and reports on how they met those goals. Class participants learn from each other as much as they do from the curriculum, and often members of the class will continue getting together informally, even after the class has been completed.

Senior Wellness Project Replication

This is a relatively low-cost intervention for disability prevention that can have a big payoff. In 2001, 46 replication sites will be up and running in four states. Having leadership at the site level that believes in this person-centered model is an important first step for replication.

Implementation tasks center around getting each of the components in place, and the technical assistance and training manuals are an important part of this effort.

Challenges include: staff selection and retention, marketing, stable funding, appropriate space and equipment, and participant recruitment. For funding, Ms. Snyder suggested partnering with other organizations, for example, area agencies on aging, hospitals, governments, public health departments, foundations, universities, housing centers, senior centers, and civic organizations. Future funding is going to be needed from stable payer sources—hopefully Medicare will eventually fund this kind of disability prevention effort.

Keys to success for this program include:

- Finding start-up funding/ mobilizing resources
- Developing a volunteer base
- Securing adequate/ appropriate space and equipment
- Obtaining long-term commitment for funding that will not be based on “soft money”
- Learning how to work in teams
- Developing a strong base of project advocates and disseminating information about success

CalPERS Health Matters

Joelyn Malone discussed a specific project initiative in Sacramento, California, that is replicating the Senior Wellness Project model. This initiative is a partnership of CalPERS (the California Public Employee Retirement System); the Long-Term Care Group, Inc.; Kaiser Permanente; PacifiCare; and HealthNet. CalPERS provides coverage for 1.8 million state, city, and county employees and their dependents and covers acute and long-term care services. They have a unique long-term care insurance product that

is self-funded as a trust fund through individual enrollee contributions. The Long-Term Care Group is the third party administrator of that long-term care insurance program.

The opportunity to launch a replication of the Senior Wellness Project was a golden opportunity to involve a significant payer of both acute and long-term care services in a disability prevention/wellness initiative. Initial funding for this replication came from the California HealthCare Foundation.

CalPERS had been looking for a way to involve the HMOs and focus on disability prevention for seniors who were not already frail or requiring case management services. The partners were interested in seeing if this type of program would work in a different setting, through a different structure. They wanted a strong evaluation component as well. Consequently, they will be using a randomized controlled trial study design methodology for their initiative.

The target population for the study is people aged 65 and older who live in the Sacramento area. Individuals must have at least one chronic condition and be enrolled in one of the health plans. The CalPERS representatives working on implementing this study wanted to see if this model would work for a group of seniors that is spread out across a fairly wide geographic area, which is the case with CalPERS enrollees. Sacramento has the highest concentration of CalPERS employees, but they are still dispersed somewhat throughout the state.

The program will recruit seniors to volunteer for this study through letters of invitation and a nurse who contacts seniors by telephone to explain the program. About 500 will be recruited, with 250 in the intervention group and 250 in the control group. The nurses will be called “nurse coaches.” This is

clearly NOT a care management program but is a program to encourage individuals to take charge of their own health.

There will also be a small subpilot program for frail individuals, since some of the CalPERS enrollees are already receiving services under the long-term care benefit.

Eskaton has been contracted to serve as the lead agency—the nurses and social workers are employees of Eskaton. Eskaton already provides case management, outreach, and other services to CalPERS enrollees.

The enrollment is taking place as a “rolling enrollment” beginning in January 2001, and the intervention will be applied for one year. In November of 2000 the pilot site began serving individuals on a “test case” basis in order to familiarize staff with processes, etc.

Four senior centers are participating. All of the Senior Wellness Project components are being offered. The project team includes: 1 FTE project manager, .75 FTE social workers, 1.5 FTE nurse health coaches.

Bob Newcomer of the University of California at San Francisco will be the evaluator. The outcome measures used will be those that Susan Snyder has already described, in addition to tools to measure changes in self-efficacy.

Ms. Malone described one person’s experience with the program and discussed the importance of exercise, nutrition, and socialization in this person’s life. The important thing about this, she said, is that the program focuses on helping the person change his or her health behaviors and habits. The challenge is to support sustained long-term behavior change and to help the healthcare professional serve as coach rather than someone who “does things” for the person. The program is all about empowerment.

Sharing Insights for Effecting Change: Group Discussion & Panel

Moderator:

Pamela Parker, M.P.A.
Director, Minnesota Senior Health Options, Minnesota Department of Human Services, St. Paul, Minnesota

Reporters/Commentators:

Marcia Anderson, R.N.
Director of Operations, The Access Alliance, St. Paul, Minnesota

Sue Bulger, R.N., M.A.
Director of Health Coordination, AXIS Healthcare, St. Paul, Minnesota

Mary Keith, G.N.P., M.S.N.
Director of Health Services, EverCare Minnesota, Golden Valley, Minnesota

Sally Dunn, M.S.N.
Executive Director, North Country Aging Services, Edina, Minnesota

Response Panelists:

R. Craig Christianson, M.D.
Medical Director, UCare Minnesota, Minneapolis, Minnesota

Susan Crutchfield, M.D.
Medical Director, Metropolitan Health Plan, Minneapolis, Minnesota

Gregory Gilmet, M.D., M.P.H.
Medical Director, Medica Health Plans, Minneapolis, Minnesota

Four of the morning sessions were highlighted by the Reporters/Commentators.

National and Local Perspectives on Care Coordination

Marcia Anderson presented highlights from the “National and Local Perspectives on Care Coordination” session. She noted that while many different types of case management/care coordination methods still exist, the field has moved from a traditional “case management,” utilization-review type process, to a “care coordination” model where services provided are more comprehensive. Sherry Aliotta, who gave the national perspective on care coordination has participated in a study of programs on a national basis and found three core components: assessment and planning, implementation and delivery, and reassessment and adjustment. In any model, communication is key. Another important element of successful programs is to develop a relationship with the primary care provider. The local care coordinators who presented the local perspective put a “human face” on the methods that Ms. Aliotta had talked about. One strategy being pursued is to look not only at the high-risk MSHO member, but also at those currently at low risk of adverse health events but who offer an opportunity for some disability prevention and education/wellness. Ms. Anderson observed that the coordinators are also, in effect, serving as interpreters of the healthcare system for the seniors—especially those with diverse ethnic backgrounds who are not familiar with

Western medicine or the Twin Cities healthcare market.

Improving Transitions between Care

Mary Keith reported on the “Improving Transitions between Care” session. She observed that Presenter Dr. Gavinski had emphasized several important points in her presentation. First, that better care is provided by healthcare professionals who enjoy working with the elderly. Second, that communication is key to continuity of care. Third, that good care requires a team approach—often that is a new experience for staff. Trust is important so that team members are willing to learn from one another and see each discipline as bringing important skills and knowledge to the management of the seniors’ care. Other messages Ms. Keith took away from this session include: the need for 24/7 coverage for the client, the need for a smaller network of physicians to make a bigger impact in changing care delivery, the usefulness of doing home visits and home assessments, and the effective use of a pharmacy consultant as a member of the team to assist in better medication management.

High-Tech and Low-Tech Solutions at Home

Sue Bulger reported on the “High-Tech and Low-Tech Solutions at Home” session. Low-technology adaptations for seniors and people with physical disabilities include three areas: (1) physical needs, (2) sensory issues, and (3) cognitive issues. A key message for any adaptation or device or intervention is to take into account

function/purpose for the device and *esthetics*. A number of ideas were offered relating to physical needs, including door hinges, baskets on walkers for carrying items, raising outlets and appliances, and many others. Ideas for sensory needs included color contrasts for chairs and between walls and floors, non-glare lighting, large print signs, and large number telephones. Cognitive needs can be met through the use of computered medication systems, phones with photographs and pre-programmed numbers, and magnet locks to name a few.

The high-technology portion of the presentation focused on various programs at the Sister Kenny Institute. One, Advanced Rehab Technologies, includes a bio-rehab device, a virtual reality driving simulation, and a virtual reality wheelchair for power wheelchairs. Other telerehab programs bring therapy to distant locations. Ms. Bulger said that there are lessons to take away for MSHO and MnDHO—particularly that there is no “gold standard” for doing a technology assessment or deciding which devices or therapy should be provided for particular cases. It is still a case-by-case, learn on the job type of skill, though many professionals, for example, occupational therapists, have honed their skills for matching technology to the needs. There is value in learning more about high-tech developments and keeping abreast of innovation. Other issues that are worth advocacy and investigation are how to pay for these technologies and privacy/confidentiality—with such things as monitoring devices in the homes.

Disability Prevention in the Senior Population

Sally Dunn reported on the “Disability Prevention in the Senior Population” session, which included lessons learned from the Health Enhancement Program intervention

conducted at the senior center setting. She said that the results of this program—a decrease in hospitalizations and psychoactive drug use—are very promising. An important point is that these programs seek to improve self-efficacy—new ground for many perhaps. An important lesson and idea for MSHO from this experience is that more could be done with the MSHO beneficiary’s primary care physician or other provider to ensure that seniors are getting the exercise they need—for example through an annual fitness assessment and an exercise prescription. A standard assessment using the “Get Up and Go” process could be used.

There may also be warning signs regarding mobility/fitness, for example, falls. There are a number of programs around the state dealing with falls prevention and with exercise and wellness activities for seniors. The primary care providers and care coordinators could be made more aware of these programs and could encourage their patients/clients to participate in them. Ms. Dunn said that she would like to see coverage for strength training—there have been a number of carefully designed studies that show that strength training helps in falls reduction. This could be both for ambulatory seniors and nursing home residents. Finally, Ms. Dunn suggested that health plans could cover fitness memberships at local clubs and work with senior centers to offer some classes especially designed for seniors.

Response

A panel of three medical directors was asked to react and respond to information presented and discuss how these programs and lessons might help further shape the MSHO and MnDHO demonstrations.

Dr. R. Craig Christianson noted that patient empowerment is a strong theme in the remarks he heard and is a

phenomenon that is here to stay. While he is seeing that more physicians are responding to this “movement” at the practice level, it is probably an area for future growth. Another observation is that, while the PACE model that uses a tightly organized team of providers has been shown to be so successful, it is still hard to see how to translate that to the MSHO demonstration where the primary care base is so spread out and the networks so large. Also, particularly on the physician side, it might be helpful to explore ways for physicians to learn how to manage in teams—participatory management. These are some of the main directions that he sees.

Pam Parker asked whether the State of Minnesota, Department of Human Services should be asking health plans to go further with their clinics to do some things differently for their MSHO patients—and to put some of this in their subcontracts.

Dr. Christianson said that the willingness to customize on the part of clinics/care systems is what they have depended on to take care of their MSHO beneficiaries. That has been on a fairly small scale—a larger scale effort would take more resources to organize a structured response.

Dr. Susan Crutchfield noted that the process of having care coordinators make visits to the physicians’ offices has made a difference in having the clinic staff and the physician become more aware of MSHO and the care coordinator’s role. The person-to-person contact is more valuable than the telephone contact for the initial relationship-building process. The care coordinators also accompany the senior to the primary care clinic and participate in the office visit—this seems to be welcomed by the doctor, she said, and helps the care coordinator to find those “teachable moments” and clarify things both with the senior and the physician. Another

innovative idea that seems to work well is to do short talks for seniors as part of promoting their own health awareness and empowerment—one clinic has been especially interested in this, she said. During these sessions, called the “Health Keepers Club,” seniors socialize, network with each other, and come to feel more empowered.

Dr. Gregory Gilmet discussed the paradigm shift that will be needed to go from the acute care model to the chronic care model—adopting more of a public health framework that is population based and works toward prevention. Another technique he is interested in is predictive modeling where the methodology helps to identify the person today who might become the patient of tomorrow. MSHO seems to be building toward this chronic care model that incorporates better practices for older people.

Pam Parker responded by saying that having a person-centered mission and values that embrace a long-term perspective seems to be an important component of advancing toward this better model. In MSHO many of the plans and providers seem to have embraced this mission of better care, but she asked how the evaluation of MSHO can capture this component. The current measurement methods do not seem to document this difference in mission.

Dr. Gilmet agreed that the measurement piece is critically important and stressed that it needs to be built in from the beginning of the program. Right now, for example, most of Medica Health Plan’s MSHO beneficiaries reside in a nursing home—many nursing homes are in their network of providers. So what are the right metrics to use in evaluating the success of the care in that setting for the MSHO beneficiaries?

Dr. Christianson remarked that crude measures, such as hospitalization, will not be adequate for measuring MSHO. For example, an appropriate short-term hospital stay will be counted the same as a could-have-been avoided hospital stay that is extended in length. The crude utilization data will not differentiate between the two. The goodness is there, he said, but it is often very subtle.

An **audience participant** said that she has had experiences in various research projects that involved talking with seniors about their care coordinators. Very few knew the term “care coordinator” or “case manager,” but they did know the individual by name (“Oh, you mean Sonya”). They learned to always have the name of the care coordinator ready in talking with the senior and would ask, “How do you like working with Sonya—what kinds of things does she do?” instead of asking about a generic “care coordinator.” The message here is to ask meaningful, relevant questions of the senior when evaluating service—maybe even have the seniors who are the target group help design the questions to be asked.

Another participant suggested that the MSHO demonstration look at the length of time that seniors are maintained in the community and compare the MSHO beneficiaries’ data to those in PMAP who are at a similar level of disability. Another point made by an audience member was that with this population, quality-of-life issues become more important and also that qualitative research methods may be just as important as quantitative methods.

Dr. Crutchfield remarked that we should celebrate some of the successes around MSHO, for example, that MSHO enrollment reached 4,000 seniors a year earlier than projected and that MSHO is being rolled out to younger people with disabilities.

Pam Parker explained that they have been working with a consultant who is able to do predictive modeling on an integrated database of matched Medicare and Medicaid data. Under the direction of the State, this consultant is doing analyses on the data and beginning to query the data in different ways to see how people are currently utilizing services.

Ms. Parker then asked the three medical directors to discuss what they see as key local concerns and talk about what they see as the value of the MSHO program to their health plans. **Dr. Christianson** said that one of his concerns is the staff shortages in the marketplace and the need to ensure seniors are being treated or served by people with the right skill set. With regard to MSHO’s value, it provides a framework for expanding the reach of care coordination for these individuals. It is a good model that should be sustained. **Dr. Gilmet** said that, similarly, Medica sees this as a good model and a successful project. **Dr. Crutchfield** agreed and said that Metropolitan Health Plan looks forward to continuing the program as well.

Speaker Information

**Sherry Aliotta, R.N., B.S.N., C.C.M.
President and CEO
S.A.Squared, Inc.**

Ms. Aliotta has had a number of years of experience in the area of care/case management/coordination. In 1997 she founded S.A. Squared, located in Michigan, a consulting company that provides consultation in the areas of utilization, case, and disease management to HMOs, physician groups, independent practice associations, hospitals, home health agencies, and other managed care entities. Her prior experience includes: National Director of Case Management and Director of Health Care Management at Prudential Healthcare, where she was responsible for Utilization Management and Case Management throughout the western states, as well as key national initiatives; Manager and Director roles in Patient Care Management at FHP Health Care; and several years of nursing experience.

Among her many professional achievements are: core team member "Medicare Best Practices in Coordinated Care Study," 1999-2000; National Board of Directors for CMSA; CMSA "1996 Distinguished Case Manager of the Year;" member Clinishare Senior Case Management Advisory Board; and Council for Case Management Accountability Core Task Force Chairperson. Ms. Aliotta has given numerous presentations some of which include: a case management training video used by Visiting Nurse Association Affiliates of Indiana; Group Health Association of America, "Best Practice in Case Management"; "Medicare: Managed Care at the Crossroad" Case Management and Quality Outcomes for Seniors; "Screening for High Risk Seniors in HMO's," American Society on Aging International Case Management Conference; and Blue Cross Blue Shield Medicare and Medicaid Forum.

**Marcia Anderson, R.N.
Director of Operations
The Access Alliance**

Ms. Anderson is currently the Director of Operations for the Access Alliance, located in St. Paul, a joint venture between the Benedictine Health Systems and the Evangelical Lutheran Good Samaritan Society. In this capacity she developed a program for participation in Minnesota Senior Health Options (MSHO), and she is responsible for contracting with network providers and operational development of

the program with Medica, the administrator for the program. In addition, she has participated in the development of clinical assessment tools to track clinical quality health measures of member Ms. Anderson has previous experience as a clinic manager at Aspen Medical Group, a mid-size, multi-specialty clinic, where she was responsible for all operations and staffing, as well as several years of nursing experience at various locations. Other educational experience includes the Managing Diversity Profile at Blue Cross, Blue Shield, Minnesota (1994) and Clinical Quality and Total Quality Improvement at the Juran Institute (1994).

**Tim Bowman, Project Director
Advanced Rehabilitative Technologies
Sister Kenny Institute**

As a Project Director at the Sister Kenny Institute of Abbott Northwestern Hospital in Minneapolis, Mr. Bowman developed the Advanced Rehabilitative Technologies Center, integrating innovative rehabilitation devices and technology into the delivery of rehabilitation. He secured over two million dollars for the development of the project through private donation, corporate sponsorship, and federal grants. He established Sister Kenny Institute as the Rehabilitation Engineering Research Center on Telerehabilitation. As a Product Manager at Abbott Northwestern Hospital, Mr. Bowman was responsible for overall planning and business development of 15 Allina Medical Group clinics, developing strategies and implementing plans to expand the reach and profitability of clinics. He has led hospital-based business development including the development of TransOne, a small for-profit business specializing in lasers. Currently Mr. Bowman is working on an M.B.A. degree from the University of St. Thomas.

**Susan Bulger, R.N., M.A.
Director of Health Coordination
AXIS Healthcare**

Ms. Bulger is the Director of Health Coordination at AXIS Healthcare in St. Paul, Minnesota. She has worked in the areas of case management/care coordination/health coordination since 1982. She has assisted in development of case management standards for community-based long-term care programs in Hennepin County and for the national case management certification program. In

addition, she has published an article about developing standards and quality measures for case management in the fall 1999 issue of the Journal of Case Management. Ms. Bulger received her masters degree in health and human services administration from St. Mary's University in Minneapolis.

**Margaret Christenson, M.P.H., O.T.R.,
F.A.O.T.A.
President
Lifease, Inc.**

In 1991 Ms. Christenson founded Lifease, Inc., a software company located in New Brighton, Minnesota, that develops computerized decision support systems for health care professionals, designs software that generates customized reports using scannable questionnaires or internet access, provides consultation to businesses on assistive products and information to consumers on assistive products and universal design, and conducts seminars on these issues. She has worked in and consulted in the area of occupational therapy for over 40 years, including membership on the adjunct faculty of the University of Minnesota. Ms. Christenson's publications include two books, five book chapters, and numerous articles. In the course of her career Ms. Christenson has given hundreds of presentations on adaptations to compensate for age-related changes and the incorporation of universal design principles to professional organizations, colleges, and universities.

**R. Craig Christianson, M.D., M.P.H.
Medical Director
UCare Minnesota**

Currently Dr. Christianson is the Medical Director of UCare Minnesota, a health plan serving over 10,000 enrollees in the Twin Cities area. He has been practicing medicine since 1973. During this time he has also had a number of administrative roles, including Hospital Chief of Staff, Geriatric Assessment Unit Program Consultant, Utilization Review Coordinator, Director for Quality Assurance, and Medical Director. He is certified by the American Board of Family Practice and has an additional certification in Geriatrics. In addition, he is a member of the graduate faculty of the University of Minnesota. Dr. Christianson has presented nationally to the Gerontological Society of America, Group Health Association of America, New York State Department of

Health, and Alpha Center. He has served on task forces and advisory committees for the Minnesota Departments of Health and of Human Services.

Susan Crutchfield, M.D.
Medical Director
Metropolitan Health Plan

Dr. Crutchfield is the Medical Director at Metropolitan Health Plan in Minneapolis. She is board certified in Family Practice, Insurance Medicine and QA/UR. She was recertified in 1998 in family practice. She oversees the Medical Department Policy, Health Plan Benefit Administration, quality assurance, and utilization management. Dr. Crutchfield serves on the Hennepin County Medical Center (HCMC) Quality Council and chairs the MHP QM committee. She is a member of the Hennepin Faculty Association. Her postgraduate coursework includes geriatrics, general endocrinology, infectious disease, and disease management. She teaches residents and medical students at HCMC and the University of Minnesota Medical School in managed care and healthcare financing. Dr. Crutchfield received her medical degree from the University of Minnesota.

Sally Dunn, M.P.H.
Executive Director

North Country Aging Services
Ms. Dunn is the Executive Director of North Country Aging Services located in Edina, Minnesota. She has ten years experience in geriatric healthcare including seven years with Seniors Plus, the local social health maintenance organization. She has co-authored three articles on the topic of social health maintenance organizations for the *Journal of Case Management, HMO Practice, and Generations*. She has also been a speaker at conferences sponsored by the following organizations: National Chronic Care Consortium, Minnesota Health & Housing Alliance, Second International Conference on Long-Term Care Management, Gerontological Society of America, Minnesota Gerontological Society. Ms. Dunn received her masters of public health from the University of Minnesota.

Mary Parish Gavinski, M.D.
Medical Director

Community Care Organization, Inc.
Dr. Gavinski has been Medical Director and Primary Care Physician with the Milwaukee PACE program since its inception in 1990. The Milwaukee PACE program was one of the first four On-Lok replication sites in the nation. She also helped in the development and

implementation of the Wisconsin Partnership Program. Board certifications include Internal Medicine, completed in 1986 and Geriatrics in 1990. Professional memberships include: American Association of Medical Directors, American Geriatrics Society, American College of Physicians (Associate member), Gerontological Society of American, Milwaukee County Medical Society (including Needs of the Aging Committee), PACE Primary Care Group, Wisconsin State Medical Society, Wisconsin Association of Medical Directors.

Over the past 10 years, Dr. Gavinski has had the opportunity to present at a number of national, state, and local conferences including: Gerontological Society of America, American Geriatric Society, National PACE Association Conferences, Wisconsin Geriatric Education Center. Presentations include: *Primary Care in the PACE Project, The PACE Model of Community-Based Long-Term Care, Breaking Ground within the Managed Care System: Emerging Collaborative Practice Patterns in Geriatric Care, Outpatient Care of the Vulnerable Elderly, Nontraditional Approach to Primary Care, Changing Practice Patterns in the Delivery of Primary Care, and Expanding the Model of PACE: The Wisconsin Partnership Program.*

Gregory Gilmet, M.D., M.P.H.
Medical Director
Medica Health Plans

Dr. Gilmet is a board certified specialist in allergy, immunology, and pediatrics. He is the medical director of Medica Health Plan, a 1.2 million member health plan based in the Twin Cities and part of Allina Health System. In addition to his medical training, Dr. Gilmet has also received a masters of public health degree. He is a Certified Managed Care Executive from the American Association of Health Plans. In addition, he is a Fellow of the American Academy of Allergy, Asthma, and Immunology, and the American Academy of Pediatrics, and a member of the American College of Physician Executives. Dr. Gilmet is a former Chair of the Immunization Task Force and a member of the Quality of Care Committee of the American Association of Health Plans and a former Liaison Member of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Prior to joining Medica, Dr. Gilmet served in several roles, including 10 years as a practicing physician, director of clinical research for Solvay Pharmaceuticals, corporate medical director for quality and clinical outcomes research for Blue Cross

and Blue Shield of Michigan, and vice president and chief medical officer for Diversified Pharmaceutical Services in Minneapolis. A contributor to the medical and administrative literature, he has been a featured speaker at national and international conferences on a diversity of topics of scientific, clinical, and administrative interest.

May Hang, R.N., B.S.N.
MSHO Field Care Coordinator
UCare Minnesota

Ms. Hang has had six years of cross-cultural nursing experience. At UCare she developed and implemented the Minnesota Senior Health Options (MSHO) program, and she case manages over 75 cases coordinating medical, social, and activities of daily living needs across the healthcare delivery system. In addition, Ms. Hang has a consulting practice where she consults on cross cultural teaching, evaluation and research, health policy, and educational materials; conducts focus groups, workshops, and training; and provides oral and written medical translation. In 1999 she was the recipient of the MSHO care Coordinator of the Year award and in 2000, the State of Minnesota's Governor's Commendation Award. Currently she is working towards a masters level nursing degree.

Mary Keith, G.N.P., M.S.N.
Director of Health Services
EverCare Minnesota

Ms. Keith has been employed by EverCare since 1995 as a geriatric nurse practitioner working with dually eligible geriatric residents of long-term care facilities. Her position as the Director of Health Services at the Minnesota EverCare enables her to work with both the institutional and the community population served by Minnesota Senior Health Options (MSHO). Before her work at EverCare, Ms. Keith was employed at the Minneapolis Veterans' Medical Center for over 15 years. Her last five years at the MVAMC were as a geriatric nurse practitioner in the general medicine clinic.

Sonja Mackey, R.N.
Medical Services Coordinator
Metropolitan Health Plan

Ms. Mackey is a Registered Nurse and a Medical Services Coordinator with Metropolitan Health Plan (MHP) in Minneapolis. She has worked at MHP for 14 years in the areas of utilization review, women's health, and behavioral health services. She has been a Minnesota Senior Health Options (MSHO) Community Care Coordinator since MSHO began in 1997.

Prior to MHP, Ms. Mackey worked at Hennepin County Medical Center and Abbott Hospitals in Med-Surg, Orthopedics, Ambulatory Care, Chemical Dependency, and Mental Health. In 1998 she was named MSHO Care Coordinator of the Year.

Joelyn K. Malone
Independent Consultant
Malone Consulting

Joelyn K. Malone of Malone Consulting has had 22 years of experience in developing, managing, and evaluating health and human service programs for special needs populations. Her work has focused primarily in development and funding of community alternatives for care of persons with special support needs including frail elderly individuals. Prior to becoming an independent consultant in 1999, Ms. Malone was Director of Claims and Care Management at Long Term Care Group Inc., a third-party administrator providing services for companies offering long term care insurance. At United HealthCare's Managed Care for the Aged Division she was responsible for creative work in the development of innovative services for elderly persons, financial analysis of proposed service delivery products, and the development and implementation of evaluation tools. As Executive Director of Seniors Plus, one of four sites of the National Social/HMO Demonstration Project, she was responsible for the management and delivery of a broad array of health care and supportive services for over 3,000 older persons. The Social/HMO is a national Medicare and Medicaid demonstration. The Twin Cities demonstration site, was developed as a joint partnership between Group Health Inc. (now Health Partners) and Ebenezer Society.

Pamela Parker, M.P.A.
Director, Minnesota Senior Health Options
Minnesota Department of Human Services

Ms. Parker is director of the Minnesota Senior Health Options and Minnesota Disability Health Options. MSHO is 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 she was the director of the Long-Term Care Division at the Minnesota Department of Human Services. Prior to that she was responsible for the design and implementation of the state's nursing home case mix system. She has had 25 years of experience in health,

managed care, and long-term care and has held a number of positions in state and local government, including state Long-Term Care Ombudsman. Ms. Parker received her master's degree from the Harvard Kennedy School of Government.

Susan Snyder, M.S.
Director, Senior Wellness Project
Senior Services of Seattle/King County

Ms. Snyder has managed the Senior Wellness Project since completion in 1997 of the research study on which it was based. The project has received national awards—the APHA Archstone Foundation Award for Excellence in Program Innovation in 1999 and the 2000 National Institute on Senior Centers Research award. The Wellness Project is currently in 35 sites in the Puget Sound region and four sites in Sacramento, California. It has received Robert Wood Johnson Foundation funding for replicating the program in low-income public housing buildings and for a research project based in a senior center providing services to Medicaid/Medicare dual eligible diabetics. Ms. Snyder has coauthored an abstract entitled, “Outcomes of a Community-Based Replication of the Senior Health Enhancement Program.” She received a masters of science degree in organizational development from Central Washington University.

Walter Suarez, M.D., M.P.H.
Executive Director
Minnesota Health Data Institute
Dr. Suarez is a physician and public health and medical information systems specialist and is the Executive Director and Chief Executive Officer of the Minnesota Health Data Institute, a nonprofit, public-private partnership established by the Minnesota Legislature in 1993 to support the information needs of consumers, purchaser, providers, plans, and policymakers. Prior to work at the Institute, he directed the Health Care Cost Information System, the statewide hospital and surgical center data system, for the Minnesota Department of Health. Dr. Suarez is a member of the Association for Health Services Research, 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. Before coming to the United States, Dr. Suarez practiced medicine for a number of years in his native Colombia where he received his medical degree. He received his master of public health degree from Tulane University.

Minnesota Senior Health Options

The Minnesota Department of Human Services has developed a demonstration 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 1115 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.

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) is a subsidiary of the National Chronic Care Consortium (NCCC). The National Chronic Care Consortium is a strategic alliance of leading nonprofit health systems in the United States and Canada that share a vision for better care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death. The NCCC is working under a contractual agreement with the State of Minnesota to provide technical assistance, best practice tools, and other resources to health plans and provider systems in support of the MSHO demonstration. The NCCC serves as the Technical and Educational Assistance Program (TEAP) provider to the MSHO demonstration. TEAP activities focus on clinical issues, service enhancement, care management, and coordination of services across providers and plans, as well as on the experience of the health plans, care systems, and beneficiaries of this demonstration.

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