
Minnesota Senior Health Options (MSHO)
Minnesota Disability Health Options (MnDHO)

2002 Annual Educational Forum

Pushing the Boundaries Beyond Demonstration

January 25, 2002

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Representatives from health plans, care systems, provider organizations, and state and counties participated in the annual MSHO/MnDHO educational forum on January 25, 2002. These proceedings have been written by the National Chronic Care Consortium (NCCC) from the presentation materials and remarks made during that meeting. The NCCC serves as technical educational consultant to the State of Minnesota for the MSHO/MnDHO demonstration.

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Opening Session

MSHO/MnDHO Status Report

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MSHO Enrollment Profile

MSHO enrollment grew 16 percent in 2001, up to 4,620 by January 2002. Enrollment from the community grew by 33 percent, although the majority of participants in the program (68 percent) reside in nursing homes. Of the three health plans involved, Medica accounts for 53 percent of the enrollment, UCare Minnesota accounts for 39 percent of the enrollment, and the other 8 percent is enrolled through Metropolitan Health Plan (MHP). The large majority of the MSHO enrolled population is female (78 percent), and this group is older than the general Medicare population—in fact, 42 percent of the enrolled population is over the age of 85. The MSHO population has a higher proportion of Asian and African-American seniors than dually eligible seniors who are not enrolled in MSHO. This is especially true in the community-dwelling population.

MSHO Quality Improvement and Reporting Efforts

A review of consumer satisfaction of enrollees participating in the MSHO program shows that overall scores are about the same or slightly higher than scores for seniors enrolled in the PrePaid Medical Assistance Program (PMAP), a quality initiative

that was launched in 2000 (and in which local health plans participated) focused on controlling high blood pressure (a HEDIS measure). The percentage of individuals who are controlling their blood pressure following a diagnosis of hypertension was compared across three population groups: commercial, Medicare+Choice, and MSHO enrollees. Unfortunately, the number of patients from the MSHO pool is low. Though the average percentage of patients with diagnosed hypertension who were controlling their blood pressure went up from 1999 to 2000 among many of the plans for commercial and Medicare enrollees, it did not among MSHO participants. Another quality measure looking at diabetes care did not show any significant change between years. A clinical initiative approved by the Centers for Medicare and Medicaid (CMS) for 2002 focuses on polyparmacy issues, with Stratis Health, the federally designated Quality Improvement Organization (formerly PRO) providing consultation.

MSHO Highlights

CMS approved a Medicare waiver extension for MSHO through 2004. MSHO also extended its reach to three new counties, bringing the total number of counties participating in MSHO to ten.

Goals for MSHO

Goals for MSHO in 2002 include: working with plans and care systems on prevention activities for well community enrollees, implementing a waiver service called “Consumer

Directed Community Service,” exploring the impact of a potential Medicare risk adjustment on Minnesota dually eligible seniors, studying the impact of care coordination, and enrolling Medicaid-only seniors in MSHO.

MnDHO Update

Enrollment for the Minnesota Disability Health Options program for younger people with physical disabilities was launched officially in September 2001, as UCare Minnesota began enrolling individuals. The care coordination and clinical management for these enrollees is being provided/organized through AXIS Healthcare, which is sponsored by Courage Center and the Sister Kenny Institute.

There are 42 enrollees as of January 2002, with 64 percent being dually eligible and 36 percent being Medicaid only. Most (74 percent) live in the community.

Goals for MnDHO

Goals for MnDHO in 2002 include: making additional informational materials available to consumers, increasing enrollment, preparing for implementation of the Medicare risk adjustment, implementing an evaluation plan for measuring effectiveness/value, and developing specific clinical initiatives.

Panel Discussion

Consumer-Directed Care: Models and Ideas for Managed Care

Moderator/Speaker:

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National Program Director,
Medicare/Medicaid Integration
Program, Center on Aging,
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Speakers:

*Holly Michaels Fisher, M.P.H.-M.U.P.
Vice President and Executive
Director, VNS CHOICE, Visiting
Nurse Service of New York*

*Bruce Friedman, M.P.H., Ph.D.
Assistant Professor, Department of
Community and Preventive Medicine
Medical Services Coordinator,
Metropolitan Health Plan*

In this session, Dr. Meiners presented information from an exploratory study of the practices in consumer-directed care for managed long-term care. Then, components of two programs were explored, including a Medicare demonstration of consumer-directed care in New York and Virginia and a program developed by VNS CHOICE in New York City.

Study of Consumer-Directed Care Among MCOs

Dr. Meiners discussed a study of the attitudes and practices of managed care organizations (MCOs) concerning consumer-directed care. The study focused on understanding several aspects of consumer direction and used several measures. The definition of consumer direction used was: “a model in which consumers play a major role in determining their own needs, deciding how and by whom these needs should be met, and evaluating the quality of services received.” Client practices included hiring or firing their own personal care worker and/or case manager, having a major say in the selection of the worker, or having input about the worker but not directing or controlling this choice.

The MCOs that were contacted were selected because they provided capitated managed long-term care

benefits to their Medicaid-eligible clients. The response rate to the survey was 70 percent, or 42 MCOs.

Though two-thirds of the MCOs said that consumer-directed care was being discussed in their organizations, few (less than 30 percent) had enough experience with the practice of consumer-directed care to rate it as a good or bad experience.

The primary motivation for exploring consumer-directed care practices was to increase consumer satisfaction, as well as improve the quality and cost-effectiveness of care. Primary concerns among the MCOs was that consumers would make inappropriate choices when directing their own care and that there would be a great administrative and management burden in running the program. Those practicing consumer-directed care were less likely to anticipate client disinterest than those who had not started a program. Overall, it appeared that the decisions about consumer-directed care depended upon balancing the concerns about unprofitability due to impact of consumer-directed care and the perceived level of interest among clients and benefits to clients.

Lessons from the VNS CHOICE Experience

Holly Michaels Fisher discussed lessons in offering consumer-directed care that emanate from the VNS CHOICE experience. VNS

CHOICE is a Medicaid managed long-term care program that serves 2,600 members in the New York City area.

According to Ms. Fisher, the core concepts of consumer-directed care include: (1) clients have more choice and control in meeting their personal care needs; (2) clients can hire, fire, and supervise the work of personal care aides and authorize payment for workers' services; (3) quality of life and client satisfaction will improve; and (4) consumer-directed care is more cost-effective than "traditional" care practices.

One finding is that consumer direction is not a "one-size-fits-all" model; consumers' cognitive abilities, types of services needed, life experiences, personal preferences, and family dynamics vary greatly. Also, the regulatory environments and service delivery models offering consumer-directed care differ. The overall concept, however, is to seek and use consumer input more actively.

There are a range of strategies one can use in designing a consumer-directed care approach. Some organizations have involved representatives from the community (clients/families) actively in the initial program design and include these consumers in ongoing governance and policy making. Offering flexibility and maximizing choices for individuals has involved providing clear and usable information about the range of possible choices and service and provider options, addressing complaint and need to change issues, and outlining the voluntary enrollment and disenrollment requirements. There are also standards for consumer involvement among managed care organizations, including those

arising out of federal regulations and those that have come from state requirements.

New York State has a managed long-term care program that integrates all long-term care services in a flexible service delivery model. These programs are regulated as HMOs in the state of New York. Covered services include all Medicaid long-term care benefits and care coordination for all services (acute and long-term care). Eligibility for the managed long-term care (MLTC) program includes:

- Being age 21 or older and Medicaid eligible
- Meeting the New York State standard for requiring a nursing home level of care
- Living in the community at time of enrollment
- Expecting to require extended (>120 days) long-term care service
- Residing within the service area of the MLTC program

The target population is frail and disabled adults with complex long-term care needs and who are at risk for hospitalization or nursing home placement.

VNS CHOICE is a home care based program using a nurse care management model, multidisciplinary team, and a community-based network of providers. The following characteristics are typical of a VNS CHOICE participant:

- Is an 80-year-old woman living alone with multiple ADL and IADL needs
- Is incontinent
- Has some confusion

- Uses a walker or cane
- Has vision and/or hearing losses and five or more medical diagnoses
- Takes seven or more medications
- Has been hospitalized at least once in the past year

VNS CHOICE strategies for consumer involvement are to create a member-centered model that uses a member resource consultant, a consumer advisory committee, member surveys and focus groups, and a multilingual staff. VNS CHOICE uses a negotiation approach to care planning with clients and family members as part of the team. The client is part of a larger team that includes the member (client), a nurse consultant, a home health aide, a member service representative, and others such as family members, physicians, social workers, nutritionists, therapists, community service representatives, pharmacists, and nurse practitioners.

VNS CHOICE prepares staff and client for the negotiation approach to care planning/service choice process. The purpose of the services is to maximize independence and autonomy. They do collaborative care planning across settings, services, and payers with the members, family, and physician and other providers. All staff participate in skill-building sessions to think and act cooperatively, balance concerns, focus on common interests (not independent "positions"), and creatively seek options.

The member resource consultant is a resource person for both staff and clients/family members. For staff, the consultant focuses on helping with complex interpersonal situations and problem resolution during the negotiation process. For clients

and family members, the consultant focuses on identifying underlying issues that may be going on and finding a good solution to problems that balances the desires of the client/member with the goals and constraints of the VNS CHOICE program.

The Consumer Advisory Committee has a charge to increase the understanding of consumer preferences and perspectives within the VNS CHOICE enrolled membership, to identify best practices, to assure sensitivity to culturally specific values, and to improve enrollee satisfaction.

VNS CHOICE also does member surveys and analyzes member complaints and grievances. Interestingly, 75 percent of complaints are from family members, not the clients themselves—managing the expectations of families has been one challenge that the program has faced.

Translating the lessons learned from VNS CHOICE to the MSHO program, Ms. Fisher offered the following advice:

- There are many options for consumer involvement; do not create a “one-size-fits-all” program.
- The strategies an organization employs must fit with the population; younger adults with disabilities may want a different level of involvement and self-direction than older adults.
- Make sure the strategy you choose aligns with the program/service model and the organizational culture.
- Use multiple strategies to involve consumers and their representatives.

- Put muscle into the measures of effectiveness and satisfaction.
- Remember that innovations will need resources and support.

The Medicare Primary and Consumer-Directed Care Demonstration

Dr. Bruce Friedman presented information from a randomized controlled trial of primary and consumer-directed care for people with chronic illnesses that is being conducted in two sites—8 counties in upstate New York and 11 counties in West Virginia and Ohio.

Dr. Friedman described the key principles of consumer-directed care as involving: (1) choices about service cost, quality, location, and delivery of care; (2) a right to choose and control one’s own healthcare goods and services; (3) personal responsibility to actively participate in behaviors that maximize health; and (4) services that are decentralized and responsive to people’s individual needs. Consumer-directed care is about an active partnership between the consumer and provider.

The theoretical framework for this study is that chronic illness has a negative effect on functional status and lowers self-efficacy and a sense of control/mastery. It also leads to a decrease in quality of life and health status and an increase in Medicare and other healthcare costs. The purpose for the demonstration is to test the acceptability and effectiveness of three models of consumer-directed care. The models would also be compared for their ability to reduce the rate of decline of health status, functional status, and quality of life and minimize hospital, Medicare, and total healthcare use and expenditures.

The eligibility criteria to participate in the study included: Medicare beneficiary status, significant functional impairment, and recent significant healthcare utilization.

The total number of participants is 1,609. The first participant enrolled in July 1998 and the last participant will finish the program in June 2002. A profile of the characteristics of the participants in the study reveals that:

- The mean age is 78.
- Ninety-six percent are Caucasian.
- Thirty-seven percent are living alone.
- Fifty-nine percent are not married.
- Twenty-nine percent are under age 85.
- Sixty-nine percent are female.
- Eleven percent are also on Medicaid.
- Sixty-nine percent have a Medigap policy.
- Twelve percent belong to an HMO.
- Twenty-six percent have incomes below \$10,000.
- Sixty-two percent have incomes below \$20,000.

Many participants in this study have multiple chronic conditions. Diagnosed conditions/diseases include: hypertension (65 percent of sample), hip/knee arthritis (60 percent), coronary artery disease (36 percent), chronic obstructive pulmonary disease (28 percent), heart failure (28 percent), stroke (28 percent), cancer (21 percent), and bowel disease (13 percent).

SF-36 mean scores for the participants is low, indicating depleted physical and emotional health. In

fact, health status indicators show 59 percent impaired in one or more ADL functions, 96 percent impaired in one or more IADL functions, 45 percent with at least mild depression, and 68 percent with at least borderline cognitive impairment.

The randomized controlled trial design involved three intervention groups and a control group. Each participant was eligible for intervention for 24 months.

The three models of consumer-directed care that are being tested include:

- *Voucher*—provides 80 percent reimbursement up to \$250 per month for in-home services not normally covered by Medicare, with a “consumer choice benefit specialist” who assists the consumer with managing the voucher
- *Health promotion nurse*—provides at least monthly home visits by a nurse, a self-management handbook (*Healthwise for Life*), a computerized comprehensive assessment of needs, coaching by the nurse around self-management concepts and practices, and physician-patient-caregiver-nurse conferences
- *Combination of nurse and voucher*—provides the voucher and home visit nurse intervention, with joint orientation visits of the consumer choice benefit specialist and the home visit nurse and shared consumer information from selected computerized assessment items

Preliminary results from the first 348 participants who have finished the study provide useful information. From the group that used only the voucher (with 92 percent of the group actually using the vouchers for

services), 77 percent of the vouchers were used for adaptive and assistive equipment, 54 percent for consumable care goods, 29 percent for environmental modifications, 26 percent for agency in-home workers, 16 percent for transportation, 15 percent for privately hired in-home workers, 12 percent for durable medical equipment, 5 percent for medical supplies, and 2 percent for private respite care. The average voucher charge per month was \$138.62.

Looking at the health status indicators and other measures of change for the three intervention groups compared to the control group (based on the first 348 people who have finished the study), it appears that all three interventions were more efficacious than the control in avoiding nursing home days and in positively affecting the mental health scores as obtained through the SF-36 instrument. However, hospital days were lower only in the health promotion nurse intervention (compared to the control group). This health promotion nurse intervention group also scored best in improving the physical summary scores of the participants, using the SF-36 instrument. Dr. Friedman cautioned that these are only preliminary results and that final results should be available before the end of the year.

Elders at High Risk for Adverse Drug Reactions: Practice Innovations and Research

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Studies show that the elderly are at risk for adverse drug events (ADEs) due to medication misuse, polypharmacy, and fragmented prescribing practices where multiple prescribers are unaware of the older person's complete medication regimen. This session explored medication-related problems in the elderly population. Dr. Hanlon discussed research on identifying high-risk elders—and suggested interventions that could be effective in avoiding such events. Mr. Miller described a pharmacy care pilot program that targets individuals with medication management issues who are being seen in Fairview clinics.

An Overview of ADEs in the Elderly

Dr. Hanlon identified positive outcomes associated with drug therapy, including:

- Curing disease
- Eliminating or reducing symptomatology
- Arresting or slowing disease processes
- Preventing disease or the symptomatology of disease

By contrast, bad outcomes associated with drug therapy include:

- Therapeutic failure

- Adverse drug reactions
- Adverse drug withdrawal events

Studies of adverse drug events (ADEs) in the elderly provide guidance on what to address when trying to reduce such events. First, work by Grymonpre and others (*Journal of the American Geriatrics Society* 1988, 36:1092) revealed that up to 25 percent of all hospital admissions among the elderly are related to drug issues. Common causes of drug-related hospitalizations include: ADRs (37 percent), intentional noncompliance (21 percent), treatment failure (15 percent), medication error (8 percent), and other reasons (19 percent). Studies of elderly outpatients experiencing ADEs (not many studies exist for this population) showed that such events occur in approximately 10-35 percent of ambulatory elderly patients. The most common drugs implicated in these events include cardiac, musculoskeletal, and central nervous system agents. In home health care, a study of recently discharged elderly found that 20 percent had an ADE within a month of discharge. A recent 18-month study of elderly nursing home patients (almost 3,000 people in study) showed that the rate of ADE was 1.89 events per 100 patient-months and that 50 percent of the ADEs were preventable. The

most common drugs implicated included psychotropics, antibiotics, and anticoagulants.

Studies show a variety of factors may contribute to ADEs, including: polypharmacy (the risk of adverse events increases with increased numbers of medication), advanced age, drug interactions, altered pharmacokinetics (the older body absorbs drugs differently), altered pharmacodynamics (there is evidence of enhanced drug response to certain drugs and decreased response to other drugs), problems with medication compliance, and medical errors. With regard to pharmacokinetics and pharmacodynamics, unfortunately, less than 20 percent of the 3,000 drugs prescribed have been tested in an elderly population. Therefore physicians may not really know the correct dosage or regimen for a given older person.

With regard to medical errors, this includes prescribing, dispensing, and administration errors. In the ambulatory elderly population, there is evidence to suggest that prescribing errors occur in up to 100 percent of elderly patients and may involve up to 74 percent of medications used. Dr. Hanlon believes that one of the most important factors in the frequency of medical errors is the fragmentation of the medical care system—though he is not aware of any conclusive studies to demonstrate this hypothesis. In hospital settings, 70 percent of elderly have a new medication upon discharge and have a previous medication discontinued, yet patient education is lacking.

In terms of detecting and assessing ADEs, Dr. Hanlon presented several approaches. Strategies include identification through telephone questionnaires and self-reports,

through a review of medication orders, through a review of lab test results, through chart review, and other methods. Dr. Hanlon and colleagues looked at all of these methods for cost-effectiveness. He pointed to the strategy of soliciting self-reports of ADEs as being less time consuming as other methods and having evidence of reliability.

Once an ADE has been identified, there is the issue of linking the event to its cause. There are formal causality assessment algorithms that can be used to rank the event as definitely, probably, possibly, or unlikely to be linked to a specific cause. This method by Naranjo (*Journal of Clinical Pharmacology* 1992, 32:897–904) has been used for over 20 years and is simple and reliable.

The World Health Organization definition of adverse drug reaction is: “an effect produced by a drug that is noxious and unintended and which occurs in doses normally used in man for the prophylaxis, diagnosis, or therapy of disease.”

There are two types of ADRs: Type A, which are common, predictable, dose-related extensions of the usual pharmaceutical effect, and Type B, which are uncommon, unpredictable, potentially serious, non-dose-related events. Most (95 percent) ADRs are Type A, predictable and common.

To prevent ADRs, Dr. Hanlon offered the following:

- A systems approach using such methods as: electronic prescribing, computer screening for drug interaction and dosage problems, unit dose packaging and automated dispensing, bar coded medications and scanning before administration, enhanced pharmacist drug monitoring, and better

ADR reporting. Make sure previous drug history records, including ADRs and medication regimens are complete and electronic. Dr. Hanlon suggests that the “do not use” lists are not very helpful in avoiding ADRs.

- A targeting approach targets high-risk patients for drug regimen review, such as those taking nine or more medications or 12 or more doses per day, those taking specific high-risk drugs (for example, sedative/hypnotics, antipsychotics, anticholinergics, narcotic analgesics), those with characteristics such as low body weight or age greater than 85, those taking drugs with a narrow therapeutic range (such as digoxin, warfarin, or lithium), those with a prior history of ADRs, and those who have 6 or more illnesses/diseases/conditions.
- A medication compliance approach simplifies medication regimens, involves patient in medication decisions, help patients develop a medication routine that fits their lives, uses generic substitutes for lower cost alternatives to address the issue of out-of-pocket costs, provides verbal and written information about medications, involves family members for support, and provides memory aids like calendars

When conducting a drug regimen review, Dr. Hanlon suggests asking the following questions:

- Is there (still) an indication for the drug?
- Is the medication effective (particularly for the specific patient)?
- Is the dosage correct (taking into

consideration things such as age, diet, renal function)?

- Are the directions correct, and does the patient/family understand them?
- Are the directions practical?
- Are there significant drug-to-drug interactions (or the potential for such—though few ADRs are due to drug interactions)?
- Are there significant drug-to-disease interactions (or the potential for such)?
- Is there unnecessary therapeutic duplication?
- Is the duration of therapy acceptable, and when is the anticipated endpoint?
- Is the medication cost-effective?

Additional factors to consider include: allergies, undertreatment, drug-food interactions, medication storage problems, therapeutic monitoring, and endpoints.

In summary, Dr. Hanlon espouses the following principles for optimal drug use in the elderly:

- Consider whether drug therapy is necessary (alternatives).
- Promote the use of a small number of drugs to treat common problems.
- Adjust doses and/or dosage intervals for medications.
- Establish reasonable therapeutic endpoints, and monitor for desired outcomes.
- Monitor for ADRs.
- Encourage compliance.
- Regularly review the need for ongoing (“chronic”) medications.

Fairview Case Study

David Miller provided a case study experience from Fairview clinics of their pharmaceutical care collaborative practice program. The program is in six Fairview Physician Associates clinics and involves five pharmaceutical care practitioners. The pharmacists are in the clinics anywhere from one to four days per week, working hand-in-hand with the physicians.

The program did not start out focusing on the elderly—it serves people of all ages—but 52 percent of the patients referred to the program are age 65 or older. Fairview has had four years of experience with the program, and the program has served over 1,900 patients. Most of the referrals come from physicians. Other referral sources include nurse case managers, hospital discharge planners, retail pharmacists, and sponsored studies (for example, with Blue Cross/Blue Shield).

The pharmaceutical care collaborative practice program provides a new approach to medication management. The definition of appropriate pharmaceutical care that Fairview employs is as follows: “a practice in which the practitioner takes responsibility for a patient’s drug-related needs and is held accountable for this commitment.” The process involves a pharmacist who spends time with the patient on medication management issues and is held responsible for drug-related outcomes for that patient. This is not a stand-alone approach—the approach involves collaborative practice with the physician(s).

This approach sets a new standard of care that includes the following:

- Access to necessary medication(s)

- Appropriate indication for medication
- Use of the most effective product
- Use of an effective and safe dosage regimen
- Avoidance of adverse effects
- Manageable and understandable instructions

The first thing the pharmacist does is look at every medication the patient is taking, reviewing the indications for them and the diagnosed diseases/conditions. All drugs are reviewed, including prescription medications, supplements, herbal medications, over-the-counter drugs, foods, other substances (alcohol, caffeine), and immunizations. Patients bring in everything they have—even those things they take only occasionally. The pharmacist will then go through the steps outlined above, particularly looking at effectiveness, safety, convenience, and patient adherence issues. The pharmacist goes through the regimen to be sure the patient understands what a medication is for and how/when it should be taken. The visit takes anywhere from 15 minutes to an hour.

The pharmaceutical care process involves three steps. First is the assessment to ensure that all drug therapy is indicated, effective, safe, and convenient. Second is the care plan that is developed to resolve drug therapy problems, establish therapeutic goals, and prevent drug therapy problems. Third is the evaluation step, which involves recording actual patient outcomes and evaluating progress in meeting therapeutic goals. If problems have arisen, then a reassessment and follow-up occurs.

Some patients have been in the program for four years, and a

therapeutic relationship has been established so that they see the value of the pharmacist and the collaborative practice approach. Patients have an improved understanding of drug therapies and their purpose. They are better able to monitor their own response to medications and to inform their physicians about effects.

Reports go to both the patient and the physician and show the full set of patient conditions and all the medications and supplements that the patient is taking. There is a list of physicians who are prescribing the medications. The report also shows allergies, any adverse reactions that have been experienced in the past, and a number for the patient to call.

From August 1998 through September 2001 over 1,900 patients were served. The top ten conditions in the population served include: hypertension, hyperlipidemia, peptic ulcer disease, arthritis, osteoporosis, diabetes, depression, allergic rhinitis, hypothyroidism, and menopause. The program has had 4,159 patients encounters; 12,480 conditions have been evaluated, and 4,270 problems resolved.

The types of drug therapy problems that have been revealed with the more than 1,900 patients served include: need for additional drug therapy (28 percent) dosage too low (23 percent), ADR (12 percent), inappropriate compliance (17 percent), unnecessary drug therapy (7 percent), wrong drug (7 percent), and dosage too high (6 percent).

The results have been positive. There has been a dramatic increase in the type of problems identified and resolved. The benefits to the prescriber have included: a useful adjunct to their medical practice, help with patient education, assis-

tance to improve/encourage patient adherence, improved drug therapy quality monitoring, and the ability to provide the prescriber with a comprehensive list of all medications their patients are on.

The financial impact has been analyzed using “soft” data. The program practitioner (pharmacist) makes a determination on what adverse outcomes were avoided, such as hospital admissions, emergency room visits, and office visits. An independent pharmaceutical care practitioner has been used to evaluate/validate these assumptions of the program pharmaceutical care practitioner, by reviewing the records. Based on this type of analysis, the program has achieved the following:

- Hospital admissions were avoided 26 times.
- Emergency room visits were avoided 109 times.
- Urgent care visits were avoided 65 times.
- Long-term care (nursing home) was avoided nine times.
- Office visits were avoided 1,834 times.
- Drug costs were reduced 737 times.

Overall direct cost savings, then, are estimated at \$583,094. Indirect savings due to prevention have been estimated at \$414,205. The costs of the program are basically the costs of the pharmacist time—which is expensive. These practitioners are seeing less than ten patients per day.

Patients are asked to respond to the statement: “I feel that my overall health and well-being has improved because of my pharmaceutical care visit.” Satisfaction surveys show

that, among patients, satisfaction increased from 73 percent to 90 percent. The 25 physicians who have referred to the program have also been asked about their satisfaction, and 91 percent have found this program valuable—especially noting that it is a time-saver for them.

The challenges include: Fairview is fully funding this program—there is no payer providing support. A study underway by the University of Minnesota and Blue Cross/Blue Shield will allow for “hard data” to show the costs and benefits of this program. The hope is that payers will eventually fund this type of service.

Care Management Needs of the Younger Physically Disabled: Selected Experiences and Issues

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The Minnesota Disability Health Options (MnDHO) program began operating in September 2001. Prior to enrollment, AXIS Healthcare conducted a small, two-year pilot to get ready for the program. Mr. Duff described the unique characteristics of the younger physically disabled population and offered insights into how these characteristics influence service preferences. Experiences with the pilot program revealed important lessons about intake and marketing the program to consumers, successful care management methods, provider relations, and measuring results.

AXIS Healthcare is a partnership of Courage Center and Sister Kenny Institute. These organizations bring a knowledge of the disability community and the needs of the disabled to the managed care industry. AXIS operates under contract with UCare Minnesota to manage the healthcare of MnDHO members. It is staffed to provide health coordination, provider relations, member support services, and a link to the disability community. The Robert Wood Johnson Foundation is providing support, particularly for a unique evaluation that has been designed with this population in mind.

The project started in the mid-1990s as policy makers were looking toward the managed care industry to

help manage the costs of care for the disabled. AXIS worked with members of the disability community to create a program designed around their needs.

Comparing MSHO with MnDHO

MnDHO is different from MSHO in a number of ways.

<u>MSHO</u>	<u>MnDHO</u>
For 65+ years old	For 18–64 years old
Has been duals only, though changing	Dually eligible and Medicaid only
Mostly medically frail	Physically disabled
Nursing home residents–69%, community living–31%	Nursing home residents–25%, community living–75%
Primary care model with extensive use of nurse practitioner	Primary care provider with health coordinator
Three health plans, many care systems	One health plan, one care system
Operating in seven metro counties	Operating in four metro counties
Began in 2/1997	Began in 9/2001
Voluntary program	Voluntary program

Demographic statistics show that there are roughly 24,000 eligible

disabled individuals in the four county metro area in Minnesota. Most (85 percent) are living independently with minimal medical utilization. About 11 percent are nursing home certifiable, and 38 percent are dually eligible. All these individuals are currently in fee-for-service (FFS) Medicaid, with a very generous benefit package. Prior experience among the disability community with a proposed managed care project in Hennepin County that did not become operational was unfavorable—the AXIS program had to work hard to overcome the negative image of managed care that exists in the disabled community.

In the first four months of operation (since September 1, 2001), 42 individuals have enrolled. Of these individuals, 64 percent are dually eligible for Medicare and Medicaid, 55 percent are male, the average age is mid-40s, most are single, many are functionally quadriplegic. The per-member-per-month (PMPM) costs for this group average over \$5,000 per month and in some cases up to \$18,000 per month. Other characteristics of this group include:

- Mobility and access issues
- Multiple service providers (for example, 5–6 different medical providers alone)
- Extensive utilization of durable medical equipment and supplies
- Active lives requiring interface with work and school settings and social activities
- Disabled since birth or before mid-life

These members expect to be actively involved in healthcare decision making and care delivery issues. They have an ingrained

distrust of managed care and of many providers. They reject the medical model of care—believing that the medical model portrays disability as a deficiency and that curing is the focus of care. The model they espouse is an interactional model that sees disability as a neutral difference, a normal part of the human experience. The disability is derived from the interaction with society (for example, environmental and social barriers come from the external environment). The current healthcare delivery system is not configured to support the disabled in the way they need/want. They see “islands of care” that are not connected. The person who needs services from different islands must sink or swim on their own, bringing along whatever information they can.

In putting together and rolling out the AXIS model, the program designers looked to other experiences for lessons learned. The Community Medical Alliance (CMA) program in Boston is one example where experienced case managers have been able to minimize delays in receiving services, reduce fragmentation in care, and improve communication. The

program has an excellent reputation. CMA is capitated for Medicaid acute care and primary care only. There is only one primary care clinic (PCC) and a broad specialty network. Nurse practitioners provide direct primary care and care coordination. The single PCC model limits enrollment into the program somewhat, and the large specialty network creates challenges with coordination and efficiency.

Another project, the Wisconsin Partnership Project, has six sites throughout Wisconsin, operating collaboratively under the direction of the State of Wisconsin Department of Health and Human Services. All sites serve the elderly; two of the sites also serve enrollees who are under age 65 and have physical disabilities. They have an integrated Medicare and Medicaid capitation payment with a PACE adjuster. Lessons learned from this program include the following: (1) enrollment is slow and sporadic and involves multiple visits/calls, (2) it is difficult for staff to learn to incorporate cost considerations into clinical decisions, and (3) it is hard to consistently listen to member preferences and ensure them the freedom they want to make decisions.

Joe presents with	AXIS intervention
<ul style="list-style-type: none"> • Recently diagnosed cancer • Skin breakdown subsequent to bedrest during hospital treatment • Conflicting recommendations between oncology and plastic surgery • Subsequently readmitted, demonstrated disorientation 	<ul style="list-style-type: none"> • Facilitated communication between specialists • Established interim plan, with supports and equipment • Evaluated cognitive status and medication effects with spinal cord injury • Arranged referral to hospice and discharge home

Case Study 1: “Joe” is a 45-year-old man with spinal cord injury experienced in his teens.

These are two very good models of care. Unfortunately, there are many more managed care models that are not so good—that have not been designed with the disability community in mind, nor with their input.

The AXIS Model

The uniqueness of the AXIS model is that it is a partnership between a specialty provider and a health plan. AXIS provides a choice of primary care providers (within a limited network) and provides a full set of benefits across the entire continuum of healthcare and social support services. There are two community clinics, an independent private practice clinic, a health plan women’s clinic, and a medical center clinic (four to six clinics in all) being used at this time for primary care. These clinics are very receptive to serving these members and have been flexible in adapting to the purpose and mission of this program.

There is a broader specialty network that supports the often long-term clinical relationships that consumers/ members have had with their specialists. The program did not want to have members change their specialty physicians if they did not want to. The health plan (UCare Minnesota) worked hard to be sure that these specialty providers were part of the network.

The program was designed with extensive consumer and advocate involvement; these consumer and advocacy groups will also be involved in ongoing refinement and evaluation. The program integrates Medicare and Medicaid benefits, and employs a risk adjustment methodology that is sensitive to physical disability.

The service that AXIS itself provides is care coordination, not primary

Keith presents with	AXIS intervention
<ul style="list-style-type: none"> • Currently receiving only personal care attendant (PCA) services • History of two flap surgeries for pressure sores • Broke leg, resulting in lengthy ER wait with subsequent skin breakdown with phlebitis a few days later 	<ul style="list-style-type: none"> • Assessment of skin, temporarily increased PCA time • Assessed ER wait times and arranged for same-day PCP appointment

Case Study 2: “Keith” is a 50-year-old man with quadriplegia, living independently.

care or specialty care. A health coordinator works with the member and the primary care provider (PCP) to coordinate the entire spectrum of services from acute care to mental health to primary care to community-based services. In addition, the coordinators work with the member on related services such as vocational, educational, housing, and recreational. The program uses carefully selected, experienced providers in its referral base. Consumers are expected to share in the responsibility for changes in health status and take part through self-care and health practices. The program utilizes prevention and risk management strategies to prevent further decline and avoid additional illness. AXIS is available 24/7 to triage emergency issues.

The AXIS model has clearly delineated roles for the member, health coordinator, primary care physician, other providers, and the support network (family and friends).

A two-year pilot project was conducted by AXIS for this model of care for people who are physically disabled. The Robert Wood Johnson Foundation helped to fund the pilot while the program awaited federal approval for waivers under Medicaid

and Medicare. The pilot served 40–50 people. The purpose of the pilot was to:

- Develop, apply, and refine the AXIS model
- Build stakeholder understanding and involvement in the project
- Build relationships with potential members and participating providers
- Develop and test internal communications and management policies and procedures

This pilot got the name “AXIS” out in the community. Through this pilot the AXIS team learned about some operational and communication issues and worked out the bugs in the program. The key learning from the pilot was that: (1) the system is *more* dysfunctional than originally perceived, (2) roles and responsibilities need to be developed and defined, and (3) *all* stakeholders are fearful and resistant to change.

Some key challenges that AXIS has faced include: issues in partnering with a health plan, low enrollment, struggle to gain PCP interest and commitment, and the complexities and challenges of payment arising from the rate-setting methodology.

With regard to partnering with a health plan, it is important to clarify roles, responsibilities, and communication channels, both internally and with other stakeholders. It has been difficult for the plan to work with this new provider entity (AXIS) as a partner, as they originally saw AXIS as working for the health plan, while AXIS saw itself as an equal partner to the plan with regard to this disability project. It has been a dance. The Robert Wood Johnson Foundation is interested in the partnership since there are chances that such a partnership could be replicated in other communities.

With regard to enrollment, limited avenues and a slow process for marketing have stunted growth. Enrollment volume is lower than projected and requires extensive consumer education. The assessment process is lengthy—it takes about eight hours. There is great distrust of managed care among people in the disability community. The idea of “signing away” their ability to go to any provider at any time (as in FFS Medicaid) is very scary for these people. There has been more interest among the disabled who are living in nursing homes, as these individuals need AXIS to help them get out of the nursing home and into an appropriate community living environment.

With regard to primary care providers, it is hard to find a primary care clinic that is interested in this community and that remains committed to it. There is a lack of disability competency in primary care in the region. Those primary care providers who are skilled and knowledgeable about issues in care for the disabled are overwhelmed by the number of people trying to get into their clinics.

With regard to rate setting, AXIS suffers from being too small and too new for other providers to be comfortable in sharing risk. The Department of Human Services created the most sensitive rate setting methodology in existence in the country. Therefore the program operations have to be very responsive. There is still the question as to whether the rate cell definitions are adequately identifying and assigning rates to the subpopulation of the eligible individuals who choose to enroll in this program.

The AXIS model has tried to bring a coordinated, comprehensive approach to the islands of healthcare that exist in the community, with the members and their support people at the center of the model.

Serving Frail Elders in the Community: Lessons from the VNS CHOICE Experience

*Holly Michaels Fisher, M.P.H.-M.U.P.
Vice President and Executive
Director, VNS CHOICE, Visiting
Nurse Service of New York*

VNS CHOICE is a comprehensive, managed long-term care plan for older adults (age 65 and up) who wish to live at home but need assistance with day-to-day activities. To be eligible for VNS CHOICE, a person must be: at least 65 years old, Medicaid eligible, eligible for nursing home care (but electing to remain at home with assistance), and in need of long-term care services for at least four months. VNS CHOICE has an enrollment of 2,800 seniors in the community and over two years of experience with working with providers in the New York City area to meet the needs of these frail elders.

Ms. Fisher focused on successful methods for communication with primary care physicians and practitioners and specialists. She described challenges and success factors for working with this diverse client population being served by multiple providers and spoke about how these lessons can be applied to MSHO/MnDHO.

VNS CHOICE, as described earlier, is a managed Medicaid program for people age 65 and older living in the five boroughs of New York City. The focus of this program is on prevention and rehabilitation, and it seeks to maximize function and independence among members. The VNS CHOICE service delivery

network is large; it includes: home care, adult day care and community services, physician services, hospital care, and nursing home services. The community care network includes:

- A certified home health agency
- Fifteen social day care sites
- Nine specialized day care sites
- Six medical day care sites
- Seventeen providers of home delivered meals
- Nine providers of housekeeping service
- Forty-three transportation service companies
- Twenty nursing facilities
- Podiatry, audiology, dental, optometry, and pharmacy services

New York State provides the following definition for the process and responsibility of care coordination for managed long-term care providers:

Care management is a process which assists enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist enrollees [to] obtain needed medical, social,

educational, psychological, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement. (New York State Managed Long Term Care Contract, January 2001)

Coordinating Care— Strategies

The VNS CHOICE multidisciplinary team consists of a nurse consultant, home health aide, social worker, rehab consultant, nurse practitioner, and member services representative. Coordination strategies include the use of a single care manager (nurse consultant) who moves between all settings and all types of providers. The nurse consultant provides feedback to physicians who are involved in the program. Nurse practitioners and VNS home care clinical specialists are used to consult on complex cases and provide medically complex care. Clinical protocols and guidelines have been developed which are used by all staff to ensure consistent levels of practice (several examples of VNS CHOICE clinical visit guides were distributed at this meeting). The multidisciplinary team connects with the physician through visits and telephone calls.

A core principle of VNS CHOICE is that members are involved in their care planning and that an individualized care plan is created based on needs and preferences (where feasible). Physicians participate in the care planning at initial enrollment into the program and are updated every 60 days and sooner, if care plans need to change. If a community provider is going to be involved in the care, VNS CHOICE staff will confer with that provider

prior to referral to assess provider capacity, ability to meet member needs, and agreement with the plan of care.

When a member is hospitalized, the care coordination practices continue. The care manager will conduct an in-facility visit, review the reason for admission and the planned interventions, and discuss the anticipated length of stay with the medical team at the hospital. When discharge planning is begun, a hospital utilization management specialist is available to provide guidance and direction to the nurse consultant. Care coordination in the nursing home also includes a review of the admission and a plan that is worked out with the member, family, and relevant physicians. The care manager also serves as an advocate for the member on care issues (for example, plan of treatment, care and condition management, and member preferences). The care manager monitors the member's status while in the nursing facility and works to ensure that the care plan keeps pace with changes in health status. The care manager also is involved in discharge planning if the member can return home.

With experience from the program, some changes and enhancements were made. These enhancements included:

- Additional staff training and development
- Specialized support roles
- Mental health services
- Consulting geriatricians
- Physician clinical education
- New tools and forms and improvements to existing ones
- Physician office visits

Lessons learned include:

- Building relationships takes time and is done one physician at a time.
- Stakeholder perspectives shape all interactions.
- Training is essential.
- Each stakeholder believes that he or she understands and is trying to do the right thing.
- Good communication takes skill, practice, and patience.

A Collaborative MSHO Quality Improvement Project in Heart Failure

*Jane C. Pederson, M.D., M.S.
Medical Director, Stratis Health*

*Lois Renae Sipprell, M.A., R.N.C., A.N.P.
Clinical Nurse Practitioner,
Evercare*

Metropolitan Health Plan, UCare Minnesota, and Medica Health Plan, together with Stratis Health, have been working together to improve the identification and treatment of heart failure patients in the MSHO population. Through this collaborative, the participating organizations hoped to raise awareness in the provider community of the prevalence of heart failure and its manifestations in the elderly.

Dr. Pederson and Ms. Sipprell provided case study examples of heart failure patients and offered practical information for care managers as they identify patients at risk, assess needs, and offer opportunities for improved management.

Heart failure was chosen as a point of focus by Stratis Health and the three health plans because it affects many people (five million Americans with heart failure and 500,000 new diagnoses per year). It is the underlying reason for 12–15 million office visits per year, and 300,000 patients die from heart failure annually. Approximately 6–10 percent of people over age 65 have heart failure.

Patients with heart failure who are treated by a specialist or even a general practitioner represent only the tip of the iceberg—there are many more people with unrecognized signs and symptoms of heart

failure and even more with asymptomatic left ventricle dysfunction. Heart failure has a variety of etiologies. Heart failure may be due to ischemic heart disease, hypertension, valvular disease, alcohol, viral issues, postpartum complications, amyloidosis, or thyroid disease. Signs and symptoms include shortness of breath, rales, jugular venous distention, edema, inadequate tissue perfusion, fatigue, and poor exercise tolerance. The disease presents itself a little differently in men versus women. Coronary artery disease alone is present in approximately 19 percent of men and 8 percent of women with heart failure.

The role of the care coordinator is to improve awareness and help assess the etiology of the disease. The care coordinator: identifies people with signs and symptoms of the disease and those that are at high risk for developing heart failure based on other risk factors. The assessment requires an understanding of the differences between left heart failure and right heart failure. The systolic and diastolic functions of the heart can be examined and will help determine treatment. The treatment goals are to:

- Relieve symptoms
- Improve quality of life
- Reduce hospitalization

- Improve left ventricular function (for left ventricular dysfunction)
- Prolong life

Different treatment options, such as the use of ACE inhibitors, angiotensin II receptor blockers, beta blockers, aldosterone antagonists, diuretics, and Digoxin, were reviewed by Dr. Pederson. The coordinator has a role in supporting the pharmaceutical care regimen and working with the patient and family to understand the drug regimen and monitor it.

Frequent errors in the management of heart failure include:

- ACE inhibitors are not used.
- An inadequate dosage of diuretic is used.
- The deleterious effects of certain drugs (for example, NSAIDS, calcium channel blockers) are not fully appreciated.
- The education of the patient and family is inadequate.

In the study with Medica, UCare Minnesota, and Metropolitan Health Plan, Stratis Health conducted a medical record review on 131 MSHO members with heart failure (111 lived in nursing homes, and 20 lived in the community). These were MSHO members who met a strict definition of heart failure (they were hospitalized at least once for heart failure or had three outpatient visits due to heart failure). The table below shows some of the findings from the 2000 data.

Measure	Total result	Result for institutionalized members	Result for community-dwelling members
Documentation of left ventricular function found in records	48% (63/131)	40% (45/111)	90% (18/20)
Results of left ventricular function assessments	40% (25/63) had left ventricular systolic dysfunction so up to 60% may have diastolic dysfunction		
Documentation of left ventricular function found in records	75% (19/25)	69% (11/16)	89% (8/9)
Documentation of left ventricular function found in records	47% (9/19)	55% (6/11)	38% (3/8)
Documentation of left ventricular function found in records	<1% (1/131)		

Future Directions in Medicare and Medicaid

*Susan L. Roberts, M.A.
Senior Vice President, Business
Development, Evercare, Minnesota*

Ms. Roberts provided an update on the current activities and likely future directions for the Medicare and Medicaid programs and how they come together to serve the dually eligible beneficiary.

Medicare and Medicaid issues are in the news—funding shortfalls, payment reform, alternatives to nursing home placement, quality improvement in service delivery, and the need for better coordination between the two programs—these are items we read about and may deal with on a daily basis. We know that the population of interest (the dually eligible) accounts for only 26 percent of the population, but represents 70 percent of Medicare and Medicaid expenditures.

On the state level, the biggest issue is tight budgets due to revenue shortfalls that are leading to cutbacks in payment to providers. A recent analysis shows that more than 35 states are experiencing revenue shortfalls—and that in ten states this shortfall is more than \$1 billion (for example, Minnesota, Florida, New York, California, Michigan, Ohio). Healthcare cost inflation is also impacting Medicaid budgets, and enrollment is increasing due to the rising number of older people who have spent down their assets. At the same time, there are pressures on states to increase spending on long-term care and to create better options for community-based care. A recent analysis of state budgets and spend-

ing shows that Medicaid spending has been higher than anticipated in more than 30 states, with some states (for example, Texas, New Mexico, and Washington) being more than 10 percent over projections.

The states' obligations are to pay for and provide access to healthcare services for low income and vulnerable population groups within the state and to meet federal and state regulatory requirements for oversight and administration of the program.

At the federal level, fewer and fewer health plans are participating in the Medicare+Choice (M+C) program, due to inadequate payment rates. Those plans that are continuing are reducing benefits or raising premiums (or both). The payment updates have been 2 percent over the last few years, and this rate does not even keep up with healthcare cost inflation. These are tough budget times for the nation as well as the states. The federal budget surplus is gone, and deficit spending has begun again. Congress is unlikely to act on comprehensive Medicare reform or to increase provider payments, given the budget scenario. A drug benefit, while it has support, is unlikely to be comprehensive, given the cost.

Both Congress and the administration, however, are looking for health plans and providers to come up with new demonstration ideas to serve the chronically ill, dually eligible population. The Centers for Medi-

care and Medicaid Services (CMS) will be issuing three request for proposals (RFPs) this Spring focusing on:

1. Preferred provider options (PPOs) within a Medicare managed care product
2. Disease management
3. End-stage renal disease (ESRD)

Representative Nancy Johnson (R-CT) has introduced H.R. 3584 that would reform M+C payments and change reporting, lock-in, and other provisions. The bill would also create specialized M+C plans for special need beneficiaries.

Meanwhile CMS has been exploring risk adjustment methods for M+C plans to provide better incentives for serving the chronically ill, higher cost beneficiary. The risk adjustment model under review would take into account diagnoses from both inpatient and outpatient settings. A recent meeting called by CMS focused almost exclusively on M+C payments for the average beneficiary—it did not focus on special populations nor on any kind of methodology for calculating an adjustment for specialized M+C plans, Ms. Roberts stated.

The regulatory environment also offers challenges, particularly with regard to HIPAA requirements and Olmstead compliance.

Evercare's experience has been to pursue demonstration initiatives that build on existing competencies to improve the care for people with a serious burden of illness. This is where the promise of M+C programs to reduce costs and improve quality can be realized. However, this effort depends on appropriate, sound risk adjustment. The model used needs to realize some savings, be replicated

by other plans or organizations, and be somewhat "scalable," that is, able to be enlarged or reduced, depending on what the needs of the population and host organization are.

Some of the demonstrations, such as PACE, SHMOs, and MSHO are creative solutions that should be tapped for successful components. These efforts are still moving slowly, but both states and the federal government seem to be making some progress toward expanding or building upon these programs. In the long term, the vision of integrated care—that includes the full continuum of primary, acute, and long-term care services and allows providers to purchase the most efficient package of care for their clients—has to become a reality.

In summary, we see that the dually eligible population represents a diverse set of population subgroups with a wide variety of health and long-term care needs. There is no single model of Medicare and Medicaid integration that meets all the needs of all subpopulation groups. Over the last several years, various approaches have emerged that should be encouraged and fostered. The big issues that still remain are:

- Maintaining budget neutrality in an environment of scarce resources and rising demographic need
- Finding an appropriate risk adjustment mechanism
- Creating better incentives within the M+C payment methods
- Moving from episodic, institutionally-oriented healthcare delivery systems to multidimensional, ongoing, person-oriented service networks

Speaker Information

Christopher Duff, M.Div.
Chief Executive Officer, AXIS
Healthcare

Mr. Duff is President and CEO of AXIS Healthcare, which was established to provide specialty care management and a provider network to serve people with physical disabilities. He has over 20 years of experience in the field of rehabilitation, working with people with physical disabilities as both a provider and administrator. Through participation on community boards and advisory committees, he has focused on addressing systemic issues involved with the delivery of healthcare services for people with disabilities. Past professional involvement includes membership on the boards of the National Head Injury Foundation, the Minnesota Head Injury Association, and the Youth Emergency Service. Mr. Duff holds a master of divinity degree from United Theological Seminary.

Bruce Friedman, M.P.H., Ph.D.
Assistant Professor, Department of
Community and Preventive
Medicine, University of Rochester

Dr. Friedman is the course director or instructor for several courses at the University of Rochester School of Medicine and Dentistry. These include a seminar series on the Health and Healthcare of the Elderly, Conducting Research with Older Persons: Methods and Applications, and Assessing Health Status of Older Adults. In addition he is the Associate Director of the Monroe County Long Term Care Program, Inc. Among his professional and academic memberships are the American Public Health Association and the Association for Health Services Research/Academy for Health Services Research and Health Policy. Dr. Friedman received his academic training at SUNY Binghamton, the University of Michigan, and the University of Minnesota. He has authored or co-authored a number of journal articles,

books, book chapters, abstracts, and other publications.

Holly Michaels Fisher, M.P.H.-M.U.P.
Vice President and Executive Director
VNS CHOICE, Visiting Nurse Service
of New York

Ms. Fisher is responsible for the management, operation, and expansion of VNS CHOICE, a managed long-term care program currently serving 2,600 dually eligible nursing home qualified seniors throughout New York City. VNS CHOICE is partially capitated under Medicaid for home, community, and institutional long-term care services; an array of community-based services such as dentistry, podiatry, optometry, audiology, and prescriptions; and for the coordination of non-capitated medical and hospital care. Ms. Fisher joined VNS of New York Home Care in 1995 as the Director of Long-Term Care Programs Development. She has worked for many years throughout the healthcare industry in New York State in health policy, advocacy, and program development. She has worked for the New York Academy of Medicine, the New York County Medical Society, the Greater New York Hospital Association, Empire Blue Cross and Blue Shield, and St. Lukes Roosevelt Hospital Center. Ms. Fisher received a bachelor of science degree in nursing as well as her masters degrees from Columbia University.

Joseph T. Hanlon, Pharm.D., M.S.
Professor Pharmacotherapy for the
Elderly, and Director, Institute for
the Study of Geriatric
Pharmacotherapy, University of
Minnesota

Dr. Hanlon has held professorships and directorships in the field of pharmacy at Duke University, the University of North Carolina, and University of Minnesota. Currently he is the Director of the Institute for the Study of Geriatric Pharmacotherapy and Professor, VFW Endowed Chair-Pharmacotherapy for

the Elderly at the College of Pharmacy, University of Minnesota. In addition Dr. Hanlon is a Professor of Experimental and Clinical Pharmacology at the College of Pharmacy and an Adjunct Professor of Health Services Research and Policy at the School of Public Health, University of Minnesota. He received his Pharm.D. from the University of North Carolina and postdoctoral training from Duke University. Dr. Hanlon serves on the editorial boards of the Journal of Geriatric Drug Therapy, the Annals of Pharmacotherapy, and the Gerontologist. He has been published numerous times on the subject of pharmacy

Mark R. Meiners, Ph.D.
National Program Director,
Medicare/Medicaid Integration
Program, Center on Aging,
University of Maryland

Dr. Meiners is Associate Professor and Associate Director for the University of Maryland Center on Aging in College Park. He is the Director of The Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration Program, an initiative designed to help states develop new systems of care that better coordinate acute, post-acute, and long-term care. He is also the Director of the RWJF Partnership for Long-Term Care, an innovative state-based long-term care insurance program and has led this initiative since its beginning in 1987. He holds a Ph.D. in economics from Georgetown University. Dr. Meiners is nationally recognized as one of the leading experts on financing and program development in long-term care. His path-breaking research on long-term care insurance has been a major catalyst to the current interest in this topic. He has been voted one of the 100 most influential people in long-term care by McKnight's Long-Term Care News Editorial Advisory Board.

David B. Miller, R.Ph.
Director of Retail Pharmacy
Operations, Fairview Pharmacy
Services, Fairview Healthcare
Services

Mr. Miller has been a pharmacist for 28 years, with a focus on community/retail practice. For the last 10 years he has held administrative positions, including his current position of Director of Retail Pharmacy Operations for Fairview Pharmacy Services. Mr. Miller was involved with the original Pharmaceutical Care pilot program in 1994 and has managed the development of Fairview's Pharmaceutical Care Program from its inception four years ago. He retains a passion for making this practice concept a reality. As a member of the Minnesota Pharmacists Association, Mr. Miller has chaired and served on various committees over the years. He holds a Clinical Assistant Professor appointment from the Department of Pharmaceutical Care and Health Systems at the College of Pharmacy, University of Minnesota.

Pamela Parker, M.P.A.
Director, Integrated Purchasing
Demonstrations, Minnesota
Department of Human Services

Ms. Parker is the 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.

Jane C. Pederson, M.D., M.S.
Medical Director, Stratis Health

Dr. Pederson is the Medical Director for Stratis Health, a private, nonprofit healthcare quality improvement organization. Under a contract with the Centers for Medicare and Medicaid Services (CMS), Stratis Health serves as the Medicare Peer Review Organization/Quality Improvement Organization (PRO/QIO) for Minnesota. As Medical Director, Dr. Pederson is involved in a number of quality review activities and studies, including a review of pneumococcal vaccination procedures and an examination of best practices in diabetes care. Dr. Pederson received her medical degree and her masters degree (health services research) from the University of Minnesota.

Susan L. Roberts, M.A.
Senior Vice President, Business
Development, Evercare

Ms. Roberts' diverse experience in the healthcare industry spans over 20 years. Her "hands-on" management experience includes financial, operational, and product oversight of HMO's, PPO's, and other managed care products. She has a depth of experience in operational planning, development and re-engineering, public and private policy analysis/development, and community healthcare strategy and strategic planning. Previous industry experience includes five years as the Executive for Government Programs for two major HMOs offering Medicare Risk and Medicaid products. Additionally, she served as the Product Officer and also as the Director for Member and Provider Services for a major HMO. Prior to joining Evercare, Ms. Roberts was a principal in the national full service healthcare consulting firm of The Pace Group, Inc. in Dallas, Texas. Ms. Roberts has maintained a national speaking presence on topics around strategic planning for Medicaid and Medicare initiatives. She has two bachelor of science degrees, one each from the University of Florida and the University of Kentucky. In addition, she has a masters of psychology from Nova University.

Lois Renae (Lowie) Sipprell, M.A., R.N.C., A.N.P.
Clinical Nurse Practitioner, Evercare
Ms. Sipprell is a masters-prepared board certified Adult Nurse Practitioner and is a Clinical Nurse Practitioner at Evercare, where she is clinically responsible for total patient management of the frail elderly, including their families, within the nursing home setting. Previously she was the Director of Nursing at the St. Paul Heart Clinic. Her extensive background includes clinical assessment and treatment, organizational team building, staffing models, program development, budget preparation, pharmaceutical and device research, and investigational review board applications. Ms. Sipprell received her adult nurse practitioner training and a master of arts in nursing from the College of St. Catherine.

John Tschida, M.P.P.
Senior Director of Public Affairs and Research, Courage Center
John Tschida, Director of Public Affairs and Research at Courage Center, spent two years as a research fellow at the National Rehabilitation Hospital-Research Center—now the NRH Center for Health and Disability Research. There he worked on the RTC on Managed Health Care and Disability, specifically the project: Evaluating State-Sponsored Health Care Reform Initiatives in Managed Care for People with Disabilities. This project explored consumer involvement in the development of programs in Texas and New Mexico. Preliminary findings were presented at the American Public Health Association Annual Conference in November 1998 and the Society for Disability Studies Annual Meeting in May 1999. Mr. Tschida also spent seven years as a writer and editor working for the Minnesota House of Representatives. He holds a masters of public policy from Georgetown 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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