Minnesota Senior Health Options

1997 Annual Educational Forum

Innovations and Issues in Clinical Integration: Improving Systems for MSHO Clients

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Welcome and Introductions

Speakers

Pamela Parker, M.P.A.
Director of the Minnesota Senior Health Options (MSHO) Project

Pamela Parker, M.P.A., Director of the Minnesota Senior Health Options (MSHO) Project, welcomed speakers and participants to the MSHO 1997 Annual Educational Forum. Ms. Parker provided a special welcome to the representatives from other states exploring dually eligible programs who are attending today's meeting.

This annual forum is designed to explore care delivery and coordination issues to improve care management across settings under the MSHO model. The goal of this meeting is to improve care for clients participating in the MSHO project. "As we say at every one of these forums," said Pamela Parker, "We can put the money together and try to integrate the funding, but that alone does not change the kind of care that people receive. We rely on those of you in this room to use the opportunity we have provided in making the funding more flexible to make a difference in clinical care. We are here today to learn more about how we can do that and to share experiences and information with each other as we work to integrate across the acute and long-term care settings and across the Medicare and Medicaid programs."

Ms. Parker explained the National Chronic Care Consortium's (NCCC) role in this meeting. The NCCC develops these forums as part of its role in the Minnesota Senior Health Options (MSHO) Technical and Educational Assistance Program (TEAP). Funded by the Robert Wood Johnson Foundation, TEAP provides educational support and technical assistance to MSHO health plan contractors and care systems through a contract with the NCCC, a national resource center for providers and payers in transforming the current chronic care delivery systems to improve quality and reduce costs. TEAP activities include clinical integration/care management sessions, such as today's forum; an annual one-day educational forum; a series of resource documents on issues that arise from the MSHO project; and informational resources on topics of interest to key MSHO contacts.

Ms. Parker then provided an overview of the day's sessions and introduced today's first speakers, Richard Bringewatt and Mark Meiners.

Opening Session

What is the Future for the Dually Eligible Client with Chronic Conditions?

Richard Bringewatt
President and CEO
National Chronic Care Consortium
Bloomington, MN

Mark Meiners, Ph.D.
Associate Director, Center on Aging
University of Maryland
College Park, MD

Mr. Bringewatt began by reviewing previous demonstrations that have been important precursors to this MSHO demonstration, including Social HMO, On Lok/PACE, and EverCare. He explained that the Social HMO demonstration had offered important lessons on insurance reform, that the PACE replication had offered important lessons for delivery reform, that the EverCare demonstration offered lessons on nursing home reform, and that MSHO now offers lessons on state managed care and payment reform that affects the delivery system.

In reflecting on the changes in the healthcare industry, Mr. Bringewatt noted the first wave of change has been heralded by the managed care industry and employers who have focused on changing financing to control costs. This has resulted primarily in consolidation of assets and authority. These efforts largely focused on physicians and hospitals, not on long-term care or home care. In the next phase of change, we can expect to see more attention paid to population-based planning and management as well as to the integration of care, information, financing, and management systems. This will need to happen if we are to address the issue of managing care for people with chronic conditions which disproportionately account for the majority of healthcare expenditures—despite less than ideal outcomes.

Mr. Bringewatt described five dimensions of chronic care that are important to keep in mind when changing the delivery system. Chronic conditions are:

1. **Multidimensional**. The multidimensional nature of chronic conditions necessitates a response that encourages the use of interdisciplinary teams and perspectives.

2. **Interpersonal**. The interpersonal nature calls for us to empower people with information and training to be a partner in managing the condition.

3. **Disabling**. The disabling nature calls us to anticipate the next stage of disability progression and to minimize, prevent, or delay the progression.

4. **Interdependent**. The interdependent nature requires us to give up some of our turf and to manage care across settings in coordination with each other.

5. **Ongoing**. The ongoing nature of chronic conditions requires us to manage care over time, to look at the big picture, and to focus on the long-term goals with the patient.

This kind of change requires openness and participation on many levels and by all the players—the government, the payers, the providers, the patients and families, and society at large.

Dr. Meiners described the Medicare/Medicaid Integration Program (MMIP) initiative funded by the Robert Wood Johnson Foundation. He explained that RWJF was providing $8 million for up to ten states. The purpose of this program was to provide technical assistance to states for developing managed care programs that integrate Medicare's acute care with Medicaid's long-term care.

He said that MMIP would recognize different approaches to integrated care. Assumptions include:

- There will be wide variations across states in managed care infrastructure.
- There will be wide differences in goals and target populations among states.
- There are major differences in Medicaid programs.
- States already are in various stages of program development.

MMIP suggests that states include the following components:

- Health plans must manage the entire continuum of acute and long-term care.
- Evidence of true integrated care management should be present.
- Medicaid services must be capitated.
- Quality assurance systems must evaluate quality of care across settings.

Dr. Meiners agreed with Mr. Bringewatt that we need to look at past demonstrations for lessons in dually-eligible programs. He said that the Social HMO demonstration was essentially a Medicare HMO with some long-term care benefits. The majority of people were well or only moderately impaired; the frail were enrolled, but only in proportion to the older community at large. Regarding PACE, he noted that all enrollees or participants were frail; therefore the population is different from the general community. In the EverCare program, all enrollees are nursing home residents, and the care management strategy is Medicare-based.

Why are we interested in dually eligible populations? Why is HCFA interested? Dr. Meiners stated that though only 16 percent of the Medicare population is also eligible for Medicaid, those people account for 30 percent of the costs to Medicare. Similarly, though only 17 percent of the Medicaid population is also eligible for Medicare, they account for 35 percent of the Medicaid costs. Clearly, the dually eligible are worth targeting for better care management and coordination in order to do more with shrinking resources and avoid unintended consequences when the two programs do not work in concert.

Dr. Meiners offered several state examples where integration between Medicare and Medicaid are being tried: Arizona, Oregon, and Minnesota. In Arizona, the state is focused on people who are nursing-home certifiable. This state is trying to capitate the long-term care costs for this population and wrap in Medicare around long-term care. In Oregon, they are taking the opposite approach by mandating Medicaid managed care for primary and acute care, but allowing long-term care to continue on a fee-for-service basis. In Minnesota, as this audience knows, the state is trying to integrate the Medicare and Medicaid financing and address primary, acute, long-term care, and home and community-based services as part of an integrated network.

Dr. Meiners enumerated ingredients for success in these state initiatives:

- The comprehensiveness of the plan.
- Evidence of political will to continue the initiative and stand up to naysayers.
- Presence of consensus among key state agencies.
- An understanding of the technical requirements/regulation.
- Evidence that coordination results in better outcomes.

Plenary Session

The Challenges of Clinical Integration: Lessons Learned

Cheryl Phillips-Harris, M.D.
Clinical Resources Director
Sutter Health, Sacramento, CA

Dr. Phillips-Harris explained that Sutter Health, a member of the NCCC, has been evolving over the past decade into a regional nonprofit healthcare system offering a continuum of services to some of Northern California's largest and smallest communities. By assisting Sutter in its pursuit of creating an integrated healthcare system, Cheryl has learned several lessons which should serve those involved in the MSHO project. She began by affirming the sentiments of Jeff Goldsmith, noted author on healthcare issues who exploded several myths of integration:

- Size does not equal strength.
- Bigger does not equal cheaper.
- Ownership does not equal control.
- Control does not equal trust.
- Security does not equal risk sharing.

Dr. Phillips-Harris advises that organizations step back and consider a framework for supporting population-based care. The goal for effectively managing a chronically ill population (as a portion of the dually-eligible will be) is to focus on relevant outcomes—primarily improving function. To an 88-year-old with arthritis, a relevant goal is to be able to button her own blouse in the morning. The healthcare system needs to find a way to support and promote that goal as a fundamental part of its purpose.

Moving toward an integrated system is a process—admittedly, sometimes one that takes longer than desired. A healthcare system can have all the pieces of a continuum of services, but it is not an integrated system if:

- the multiorganizational system does not invest in R & D initiatives as a single unit: that is, most of the time, separate facilities or pieces of the system continue to pursue their own research or new program initiatives independently;

- the pieces of the system fight over whose patient the person is;

- there is no common database, or very little clinical/demographic information is shared across settings;

- regarding case management, all the facilities or pieces of the system continue to focus on themselves; case management goals are not coordinated for a longitudinal perspective of the patient.

Sutter approached the task of creating an integrated system by focusing on the four aspects of integration that the NCCC espouses: integrated systems management, integrated financing, integrated information, and integrated care management.

Dr. Phillips-Harris provided examples of how Sutter moved ahead in these areas. With regard to integrated governance, Sutter moved from local boards of each hospital or entity to one regional board with advisory groups at the local level. The old system was primarily driven by an acute care orientation; the new structure helps to broaden the perspective toward a system approach. With regard to integrated financing, Sutter created a joint risk-sharing agreement that brought the three medical groups and

the hospitals and healthcare system closer together. Now the medical groups and the healthcare system jointly negotiate managed care contracts and jointly manage utilization review, risk management, and quality oversight. With regard to information systems, Sutter developed a wide area network system-wide and has computerized the medical record in the inpatient settings and physician offices. Yet, Sutter is still struggling, and entities are still separate.

With regard to integrated care management, Sutter worked to create a region-wide system of care management, to implement a risk identification process, and to create pathways that link levels of care. The efforts to create a regional case management system provide lessons for others. The working definition of case management that Sutter used is: "Case management is a collaborative and systematic approach to managing all healthcare services for the people we serve." Expected goals were to:

- Assure efficient and timely use of resources.
- Support appropriate and cost efficient care.
- Promote quality care and improved outcomes by integrating care delivery.
- Encourage education and accountability.

Regionalizing case management allowed for one case manager for a given patient and one point of contact; what was lost, however, was the local expertise. The concept had merit, but implementation was not ideal. Sutter spent a year on the planning process and just a few weeks on training the case managers for their new jobs. Dr. Phillips-Harris felt that more time—six to nine months—should be spent preparing the employees.

Dr. Phillips-Harris then described a successful pilot program conducted at Sutter Health, called the Geriatric Care Coordination Program. This program was developed to assure appropriate risk screening, evaluation, and management occur for Sutter's Medicare risk enrollees. Dr. Phillips-Harris and others recognized that 10 percent of their Medicare risk enrollees accounted for 70 percent of the resources used. Therefore, they created a team of practitioners, including a physician, geriatric nurse practitioner, and social worker, and conducted a simple risk screen at the time a person who enrolled into the Medicare risk product chose a physician/clinic that was part of Sutter medical group or the IPA affiliated with Sutter. The data was entered into the information system at Sutter Health Resource Center; this data was then available to the advice center and nurse triage staff. There were four levels to the risk screen:

1. Level I - No identified risk factors.
2. Level II - Stable, but has a chronic disease.
3. Level III - Chronic disease with social support needs.
4. Level IV - High risk/frail.

They found that 85 percent of those screened were Level I or II; the Level IIIs needed social services primarily and the Level IV enrollees were frail and had functional and medical needs. Following the risk screen, the geri-team conducted an in-home assessment of the Level IV enrollees and some Level III enrollees. They held patient/caregiver conferences and communicated with the primary physician. They provided consults in the hospital, served as the primary care team in the skilled nursing facility, and coordinated services with home healthcare.

In a study of 46 patients who were Level IV and who were receiving services by the geri-team, many improved in such areas as functional abilities, depression, and instrumental activities of daily living and reduced the number of medications they needed to take. The team could not find a difference in the cost of care between the control and experimental group. One issue is the number of patients in the sample—Dr. Phillips-Harris stated she would need about 500 in the study group to really compare to other like patients who did not receive the services of the geri-team. Another issue is collecting the data. Because Sutter does not use a common patient identifier across the system, it is difficult to match records across settings and over time. Dr. Phillips-Harris enumerated the following struggles with this program:

- information sharing
- cost tracking
- operational issues
- patient tracking within the system
- mixed mission
- ongoing funding

Dr. Phillips-Harris concluded with the following issues which, she says, will crop up again and again:

- The issue of who pays for improved service and care management when the benefits are realized downstream (e.g., how do you "count" a hospitalization that never occurred because of the program and who does that benefit?).

- The turf battles and overlapping accountabilities between facilities and practitioners.

- The issue of outcomes—what are these and how are they measured? For example, improved functional ability to perform activities of daily living—this probably matters greatly to the patient and would presumably show up in the patient's higher rating of satisfaction. How important is this to the healthcare system though? There is a heavy emphasis on the cost of care and on utilization and readmissions.

Concurrent Session

Case Study: Establishing a Frail Elder Life Care Management Program

Susan Baseman, R.N., M.S.
Director, Disease Management Programs
Crozer-Keystone Health System
Chester, PA

Crozer-Keystone Health System, which was established in 1990, is comprised of five acute-care hospitals, four long-term care facilities, three subacute facilities, a $40 million Healthplex sports club, a primary care network of practices, a home care and hospice program, and a Medicare Choices demonstration program called Med Care Plus.

Crozer-Keystone's entry into managed care and the growing financial implications of risk-based financing made chronic disease management protocols and target interventions to manage the health of capitated populations imperative to their success.

Chronic Disease Management Program

In developing its chronic disease management programs, Crozer-Keystone was looking to adopt a broader multidisciplinary approach to extend the arms of the primary care physicians to more patients and to improve outcomes. They concentrated their efforts in several areas, such as:

- Educate the primary care physicians and integrated them into the entire system.
- Integrate concepts of rehabilitation medicine, primary care, and behavioral science.
- Develop, implement, and revise protocols as needed.
- Focus on client's function and outcomes.
- Reeducate the entire system to manage care not manage cost.
- Use others, such as the National Chronic Care Consortium, as resources.

Crozer-Keystone has implemented programs for heart disease, diabetes, frail elderly, and asthma. The building blocks that were needed to develop the infrastructure included: a shared vision, a defined clinical and/or cost need, a total care continuum (achieved through partnerships and alliances), and a common commitment to the goal. An administrative "champion" and a formal reporting structure as well as a place in the organization's overall strategic plan and mission are needed.

Frail Elder Care Management Program

The frail elder program does not fit the traditional disease-oriented model. The intent of the frail elderly pathway was to provide continuum-based care under a capitated model that was bio-psycho-social in orientation. Crozer-Keystone is using a definition of "frail elderly" as older than 75 with two or more comorbid conditions or two or more hospital admissions in the past 12 months.

Each enrolled frail elder is assigned a "life care manager" who is in charge of

the continuity of care and controlling resources. The primary care provider offers constant input.

Several tools are used to assess program participants' health and to manage and track their care. The tools used in the frail elderly program include the following:

- Medical history
- Medication inventory (over the counter and prescription)
- Functional Independence Measure (FIM)
- Geriatric Depression Scale (GDS)
- Mini-Mental State Examination (MMSE)
- Baseline family database
- Geriatric assessment
- Pharmacy screening tool
- Psycho-social tool
- Goal-setting by resource team
- Linkage through information system (E-mail, intranet, and ACCESS software)
- Nutrition screening
- Modified SF-12
- Caregiver stress (Zaret scale)
- Home visit (as necessary)
- Advanced directives discussion

The pilot study of the program began in February of 1997. Crozer-Keystone will review the clinical, financial, and operational outcomes measures of this program after one year.

Integrated Healthcare

- Stage 1: Competition on price; event-driven through acute care use; primary care networks.
- Stage 2: Control resource intensity; redesign system-patient interface; value-driven; CQI; clinical practice guidelines; outcomes management.
- Stage 3: Population based; a healthy community; pooled capitation risk; targeted interventions.

Source: Jeff Goldsmith

Pathway for the Frail Elderly

- Create and record the concepts in a blueprint.
- Implement within a continuum-based care model.
- Develop as part of a capitated model.
- Create a program that has a bio-psycho-social orientation.
- Structure so that family is the unit of care.
- Integrate the clinical, operational, and financial.
- Develop outcome measures.
- Define what resources are needed.
- Create a small scale model of the concepts.
- Test the model.
- Evaluate, revise, and learn.

Outcomes Measurement

Clinical	Financial	Operational
Weight changes	Hospital costs	Patient and family satisfaction data
Zaret scores	LOS (acute care)	SF12 data
FIM scores	Emergency department utilization	Primary Care Provider perspective of value
GDS scores		
Drug number and Adverse Drug Reactions		

Closing Messages

- Tailor needs: elders AND systems differ.
- Listen to elders.
- Listen to primary care providers.
- BE SPECIFIC.
- Do it! Then, evaluate and reassess.

Concurrent Session

Integrated Information Systems: Patient Care and Quality Improvement

Howard Lai, M.A.
Special Projects Manager,
PACE Development Specialist
On Lok Senior Health Services
San Francisco, CA

John Shen
Director of Special Projects
On Lok, Inc.
San Francisco, CA

John Shen provided a brief overview of On Lok/PACE, explaining that PACE stands for Program of All-Inclusive Care for the Elderly and is a replication of the managed care system for the frail elderly pioneered by On Lok Senior Health Services in San Francisco, California. The On Lok-PACE model is characterized by: a focus on the significantly impaired elderly living in the community; integration of a comprehensive package of primary, acute and long-term health services (usually through adult day centers); and capitation financing from pooling Medicare and Medicaid funds.

Mr. Shen stated that On Lok has been developing an integrated information system for patient care and quality improvement, starting with the centers/clinics located in San Francisco and testing at other PACE centers around the country. On Lok is developing this information system, called the Integrated Chronic Care Information System (ICCIS), in house. The objectives of ICCIS were to:

- create a common, accessible medical record and database;
- facilitate communication and the care management process among the interdisciplinary team members serving a clinic/center;
- enhance quality assurance capability; and
- create database for utilization and actuarial analyses and for subcontracts.

Factors driving the development of ICCIS included the need for better scheduling and communication between practitioners and the interest in improving quality assurance. On Lok embarked upon this journey of finding or creating a software program about four to five years ago. After a review of existing software programs on the market, they determined they would need to develop their own system. Once they developed this system for On Lok, there was interest in expanding this system for others. System development milestones included:

1992-1993
Most clinicians are not linked to each other by computer; work to create electronic medical record begins at On Lok.

September 1995
The computerized medical information system (electronic medical record) is fully operational at all On Lok centers.

November 1996
On Lok receives $1.08 million from The John A. Hartford Foundation to expand architecture and create software to support care management activities across a network of providers.

January 1997
ICCIS architecture developed.

July 1997
ICCIS tested at the PACE site in Milwaukee, WI.

There are four components of the system:

1. **Launcher**—allows the software to be tailored to local sites and has a security layer.

2. **Administrator**—contains quality assurance and export functions.

3. **Intake/Enrollment**—contains prospective client information.

4. **Centralized Medical Information**—contains all the patient-level medical and other records.

Howard Lai demonstrated the software, using a fictitious patient, and scrolled through numerous screens.

Mr. Lai and Mr. Shen provided some advice about developing an electronic medical record, based on their experience:

- Ideally the system should be developed by programmers working closely with clinicians.

- There must be an institutional commitment to changing from paper-based records to an electronic record.

- The system's user interface must be easy to learn, intuitive, and accessible.

- The plan should be that all clinic staff will be using the system.

Session participants had the following questions:

Q: What do you do when the system crashes?

A: We have a backup system (paper-based); the maximum downtime is two hours.

Q: Are individual assessment tools used by various disciplines in the database?

A: Yes.

Q: How do you get people to make this kind of switch?

A: You provide a lot of training. You find the early adopters and use them to demonstrate the usefulness to their colleagues. You keep up the organizational commitment to making this kind of change.

Concurrent Session

Care Management and Clinical Decisions Across Settings: Measuring Outcomes and Cost

June Buckle, Sc.D.
Senior Director, Care Management and Outcomes Evaluation
Johns Hopkins Bayview Medical Center
Baltimore, MD

Structure for Quality Improvement

In January 1995 Johns Hopkins Bayview Medical Center (JHBMC) adopted a new performance improvement structure which is governed by the executive quality management council. Seven service-specific interdisciplinary joint practice committees—each headed by a physician and a nurse leader—report to the council and prepare annual written objectives related to care management, cost management, and satisfaction. Clinical practice improvement teams carry out the annual objectives across the medical center.

At JHBMC, they developed a new and different definition of care management in order to foster a common understanding and create a vision for the future:

> *Johns Hopkins Care Management is a program of care delivery and coordination that promotes preventive health and patients' self care; appropriate and efficient use of resources; and the provision of high quality, most appropriate, least-intensive, least-costly services. Johns Hopkins Care Management will be applied to groups of patients and individual patients across the health care continuum. Care management involves Care Coordination and Case Management.*

This definition clarified JHBMC's intent to focus on prevention and health rather than on acute care and to establish processes that enable the organization to achieve its goal of taking care of people across their life-spans.

In 1995 JHBMC formed the Care Management and Outcomes Evaluation Division to support the organization's vision and goals for implementing and measuring outcomes-oriented care management. This division is empowered to make patient-focused changes that support JHBMC strategic imperatives and departments' objectives and that are integrated into the operations of the Medical Center. The division uses a performance improvement process to bring about change.

The case management quality improvement team defines the quality-related problem that is to be addressed and then follows a process which includes diagnostic and remedial phases, with lessons learned as an important by-product. The team is patient-focused and involves consumers of case management in the improvement process. Eliminating inefficiencies and duplication of effort is a key objective. Functions, rather than roles, are the focus of the systems-thinking used by the team.

Dr. Buckle shared some key learnings from her experience with team-based performance improvement:

- the team must be interdisciplinary;
- there should be guiding principles in place;
- the team must be product-oriented;
- the team's work must be concluded within a specified timeframe; and
- facilitators are essential to keeping the team focused and transcending any turf issues.

The division's case management team is a tightly integrated group which includes social work, utilization management, and case management. Social work team members serve as patient advocates, address complex psychosocial needs, and undertake discharge planning. Utilization management staff are the payer/ finance advocates who explore alternative settings for care management and coordinate care across settings. Case managers serve as the patient advocates with a population-management focus and work to ensure continuity of care. However, rather than "policing" clinical units and staff, their role is to serve as information brokers—especially as the responsibility for patient care is transferred from provider to provider over the total episode of care.

Tools for Performance Improvement and Seamless Care

Dr. Buckle described case management team tools including risk screening, social work leveling used to determine social work case complexity, and value-added measures which focus on clinical outcomes evaluation, patient and payer satisfaction, productivity gains, cost savings, loss avoidance, and revenue enhancement, both short and long term. Case managers need to address the clinical and business issues. Deal with quality first, Dr. Buckle advised, and the cost savings will follow.

Dr. Buckle also discussed JHBMC's approach to clinical guidelines which is under an initiative called Clinical Quality Improvement. This interdisciplinary effort to coordinate care among all providers addresses medical conditions as well as care system issues that may impede effective and efficient care delivery. Key guideline elements include: a disease-specific problem list, discharge outcomes, an interdisciplinary pathway, a teaching-learning flow sheet, a variance scanning form, and a variance documentation form. The guideline packet contains a family and patient education guide, an interdisciplinary plan of care, standardized physician orders, and a patient education flow sheet. Guidelines are either opinion-based, evidence-based, or analytically-derived; guideline results are automated and linked to other databases, such as the financial database, so that clinical and financial data may be analyzed together in order to arrive at value-based results.

Extended care pathways (ECPs)—pathways that cross settings—are important tools for creating seamless care. In order to successfully design ECPs and put them in place, it is necessary to create cross-functional, interdisciplinary teams that span the services that are involved in the process of care for an entire episode. Teams need to examine and collaboratively tackle care system issues in the process of developing ECPs.

JHBMC has developed a model for developing ECPs which contains the following components:

- the compilation of a common problem list for guidelines in all areas;
- the specification of common condition-specific outcome measures in addition to "cost" and "satisfaction," required generic measures;
- the use of common measurement tools;
- the application of specific process measures that are appropriate to each care setting; and
- communication links.

Demonstrating Value-based Results

JHBMC's Division of Care Management and Outcomes Evaluation demonstrates value-based results for every performance improvement initiative. As a result of redesigning its performance improvement structure and implementing case management, clinical guidelines, and extended care pathways, JHBMC has measurably improved patient outcomes and satisfaction while reducing length of stay and charges for specific conditions and increasing the volume of business. Specifically, through the use of case managers and clinical guidelines, the division has been able to define standards of care, identify outcomes measures, foster population management, and determine best practices. After only one year of activity, the division's leadership efforts related to performance improvement have shown a seven to one return on investment, Dr. Buckle reported.

The keys to success are:

- supporting automation which makes it possible to measure and track outcomes and to aggregate data for population management;
- creating structures for performance improvement accountability;
- encouraging creativity and learning;
- identifying process owners; and
- finding resources.

Panel Discussion

Healthcare Leadership: Charting New Waters

Facilitator:

Maria Gomez
Assistant Commissioner
Aging and Adult Services
Minnesota Department of Human Services, St. Paul, MN

Panelists:

Senator Linda Berglin
Minnesota Senate, St. Paul, MN

Joan Delich
Director, Administrative Services
Metropolitan Health Plan
Minneapolis, MN

Nancy Feldman
Chief Executive Officer
UCare Minnesota, St. Paul, MN

Jan Malcolm
Vice President, Community Affairs
Allina Health System, Minneapolis, MN

Maria Gomez served as the facilitator for series of presentations by a panel of healthcare leaders from participating health plans and the State Senate on the realities, challenges, and opportunities of serving the frail elderly and the chronically ill.

Metropolitan Health Plan

Founded in 1984 by Hennepin County, Metropolitan Health Plan (MHP) serves approximately 29,000 enrollees. MSHO enrollees total 316. Thirty five percent are African-American or Southeast Asian. Community-based elderly represent 37 percent of MHP's MSHO enrollment with the balance residing in nursing facilities.

MSHO participation has enabled MHP to establish partnerships with Optage and Hennepin County Coordinated Home Services to jointly coordinate care for dually eligible clients. The first six months of MSHO experience also has acquainted MHP with several important realities:

- the complexities of Medicare rules and regulations;
- the need for individual and group advocacy;
- the recognition that assessment represents only a single snapshot in time for high-risk individuals whose health status can change rapidly;
- the benefits of collaboration; and
- the knowledge that there is room for improvement, especially in terms of installing information technology that will enable MHP and its partners to share data and measure quality of care.

Ms. Delich identified key challenges for the future related to payment issues including:

- the need to ensure adequate payments to health plans;
- the need for risk-adjusted rates;
- the importance of rewarding quality;
- the rising costs for public programs;
- the impact of different purchasing models, such as county-based purchasing; and
- the importance of defining success in the context of care for dually eligible clients.

UCare Minnesota

Ms. Feldman began her presentation with an overview of UCare Minnesota, a thirteen-year old network model health plan that serves low-income, ethnically diverse, special needs groups. Through contracts with DHS, UCare currently serves 60,000 enrollees who are eligible for Medical Assistance, General Assistance Medical Care, or MinnesotaCare; approximately 280 are MSHO clients.

Multiple development challenges faced UCare including:

- inadequate network/provider qualifications;
- the substantial time investment needed to develop collaborations;
- relationship-building with counties—especially around Elderly Waiver (EW) services;
- low Medicare/Medicaid payment levels;
- unreimbursed administrative costs;
- the large up-front resource commitment; and
- financial risk, especially adverse selection.

Ms. Feldman highlighted the following lessons learned based on UCare's MSHO experience to date.

- UCare underestimated the MSHO marketing challenges; the product is difficult to sell to consumers and families; differentiation of services by care systems is not easy to explain; and there is not enough DHS support for operations.

- Unexpectedly low enrollment led to major budgetary problems and Board scrutiny of UCare's participation in MSHO. Health plan boards will need results to prove the value of the sizable investment in this dually eligible program.

- Small enrollment numbers across many providers also make it difficult to effect system changes.

- Counties are not prepared to take on risk relative to providing EW services.

- More DHS support is needed for non-English speaking members.

There are important reasons for participating in MSHO and, on the plus side, UCare has found collaboration to be a positive experience and the expertise gained through its involvement in the demonstration to be valuable and applicable to other senior products.

Ms. Feldman concluded her presentation with the following cautionary notes about MSHO:

- Don't overpromise and oversell.
- Numerous complex operational issues must be resolved before success is claimed.
- Due to the high capitation, MSHO financial impacts are much greater than enrollment.
- Providers as well as members must be sold on MSHO; cooperation from the care system management to the frontline practitioner is essential.

Allina Health System

Allina has served Medicare beneficiaries for nearly 15 years and Medical Assistance clients since the inception of the Prepaid Medical Assistance Program in 1984. Medica's Medicare enrollment totals 76,000; 42,000 belong to the Medicare risk program "SeniorCare."

Jan Malcolm reviewed the rationale for Medica's dual eligible product, which predated the actual implementation of the MSHO project. Medica's product goals center around reorganizing the delivery system, controlling cost growth, and creating accountability for total costs and outcomes of care.

Ms. Malcolm described Medica's dual eligible model, which serves approximately 5,600 MSHO clients. Medica has created a unique network of providers to serve the members. Providers are paid on a fee-for-service basis with a merit program or, alternatively, on a capitation basis. In order for Medica to contract with care systems to carry out the plan's model for geriatric care management, they must have the following required features:

- sufficient geriatric expertise and capacity;
- integrated healthcare services: prevention and primary care, acute care, post-acute, and certain long-term care services;
- a program designed and in place to identify, assess, and treat high risk and multiproblem patients; and
- a program designed and in place to monitor long-term care and to provide home healthcare, if applicable.

The benefits of Medica's dually eligible program include care coordination, a geriatric-focused care team, a single point of contact for patients and families, the services of Medica's Center for Healthy Aging, and little to no Medicare paperwork.

State Policy

Senator Linda Berglin identified the following key trends that are likely to influence state policy decisions relative to public expenditures for healthcare for the aged:

- high medical inflation;
- the current antitax sentiment among voters;
- the Republican administration which is not adverse to reducing state Medicaid spending;
- a large projected increase in the number of aged in Minnesota; and
- the wonders of new and expensive medical technology.

The MSHO project is currently serving a small number of the total pool of 18,000 dually eligible in the five county Twin Cities metropolitan area. Senator Berglin commented that the small size of the project affects its ability to make a difference in the healthcare system. Senator Berglin proposed that the MSHO pool be expanded to include individuals age 65 and older who are not yet Medicaid-eligible. She explained that this group of low-to-moderate income elderly cannot afford prescription drugs and that the legislature is struggling with how to address their needs.

Discussion

Discussion centered on:

- Preconditions for the extension of MSHO beyond the Twin Cities metropolitan area, such as the development of a rural provider infrastructure with geriatrics expertise and managed care sophistication; as a next step, MSHO expansion to Duluth or Rochester could be considered.
- How health plans will ensure that their data systems address the issues and needs of communities of color.
- Given overlapping care systems, how MSHO health plans differentiate their products to MSHO eligibles.

Panel Discussion

Innovations in Disability Prevention and Care Delivery for the Frail Elderly

Facilitator:

Cheryl Phillips-Harris, M.D.
Clinical Resources Director
Sutter Health, Sacramento, CA

Panelists:

Kathleen Kraynack, R.N.
Cooperative Health Care Clinic Nurse
Kaiser Permanente–Westminster Clinic
Westminster, CO

John Mach, M.D.
Medical Director, EverCare
Minneapolis, MN

Stanley Smith, M.D.
Department of Family Practice
University of Minnesota
Minneapolis, MN

Identification of high-risk individuals and the ability to provide effective, early interventions is key to improving care for the frail elderly. This session looked at innovation in primary care, nursing homes, and home care that enhance early risk identification, improve satisfaction, reduce healthcare costs, and delay or even prevent disability and functional loss.

Primary Care

Kaiser Permanente's Cooperative Health Care Clinics offer a group approach to individual patients, where a multidisciplinary team facilitates, rather than directs, an interactive process of care delivery. As explained by Kathleen Kraynack, the clinics were started to provide better care to high utilizers of healthcare services by providing them with an innovative, ongoing care concept that allows groups of patients (mostly seniors with multiple complex, chronic health problems) to meet on a regular basis, to participate in educational exchange, and, as needed, to receive other care services.

The patients are empowered by the team and supported by information, allowing them to make better informed healthcare decisions. The cooperative clinic concept allows health maintenance to be conducted more efficiently and for utilization to be managed more effectively by involving the appropriate provider in the care of the patient on an ongoing basis.

Cheryl Phillips-Harris, M.D. presented background information about the Program of All Inclusive Care for the Elderly (PACE), which is an innovative total-care program for the frail elderly modeled after On Lok in San Francisco. PACE puts all medical, restorative, social, and supportive care together in one organization, where most care is provided in an adult day health center and the home, preserving the client's community residence, family relationship, and life style. PACE's multidisciplinary team is made up of physicians, nurses, social workers, therapists, drivers, health aids, and others as determined by the care plan. PACE services exceed traditional Medicare and Medicaid benefits and reimbursed on a fixed rate.

Currently, there are 11 PACE programs in eight states. Congress has recently passed legislation that would increase the number of PACE sites in future years.

The PACE program has demonstrated important results such as:

- Despite PACE enrollees' level of frailty, their hospital utilization rate is better (2,476 days/1,000/annum) than for the general Medicare population (2,512 days/1,000/annum).
- The average length of stay in the hospital for PACE enrollees is 5.4 days, versus 8.1 days for the Medicare population.

- Although all PACE enrollees are certified eligible for nursing home care, an average of just 5.3 percent of enrollees actually reside in a nursing home.

- HCFA estimates PACE savings to be between 14 and 39 percent of Medicare fee-for-service expenditures.

Nursing Home

John Mach, M.D., discussed the EverCare program, which is a Health Care Financing Administration (HCFA) demonstration that capitates Medicare for long-stay nursing facility residents. The model utilizes a team-based approach of a physician and nurse practitioners to promote on-site care for residents. The program increases the amount of preventive care that is provided, improves care continuity, and reduces unnecessary emergency room and hospital visits, which can be very disruptive for frail and demented elders.

The EverCare clinical program model consists of a comprehensive assessment, frequent routine visits, urgent visits at the nursing facility as needed, specialty services on-site, inpatient care management, family conferences, and ongoing communication with nursing staff.

Currently, there are seven EverCare sites nationally, and there is some interest in moving this concept beyond the nursing home to assisted living. Preliminary data has shown that the EverCare model reduces hospital utilization and that consumer satisfaction is high. The program is currently undergoing an in-depth, three-year evaluation to measure its effectiveness.

Home Healthcare

Stanley Smith, M.D., explained that home care services are becoming more mainstream in our healthcare delivery system, with nearly 44 percent of all patients discharged from the hospital requiring post-hospital medical or nursing care that can not be provided by the family or friends and nearly 20 percent of people over the age of 65 having functional impairments with related health needs.

For the elderly, barriers to healthcare are complicated. The elderly are often times homebound and have difficulty accessing transportation. There are also social and health belief barriers that limit their access to services. For example, the elderly often believe that a health complaint "is just normal" or that they "would just be complaining" and therefore are less likely to recognize a true health situation. Home care provides a way to provide care to these individuals. Home care provides:

- Greater access to other health professions and services.

- Greater efficiency through coordination and integration of services.

- Availability of a broad range of knowledge, skills, and services.

- Increased communication and support among providers.

- Opportunity to practice at highest level of skill and training.

The team approach to home care, however, does not coincide with current healthcare delivery models. Even though home care provides many other advantages, physicians are not trained in the team model of home care.

Speaker Information

Susan Baseman, R.N., M.S.
Director, Disease Management Programs
Crozer-Keystone Health System, Chester, PA
Susan Baseman has 17 years of experience in acute care and critical care nursing, in staff, education, and administrative positions in a variety of settings from small community hospitals to large university-affiliate teaching centers. She has extensive experience in program development, evaluation and reengineering of care delivery models, and working with cross-disciplinary, intra and interdepartmental work teams, and system-wide integration efforts. Currently, Dr. Baseman is leading Crozer-Keystone Health System's efforts to develop and implement comprehensive, cost-effective Disease Management programs for delivery to the growing population of capitated risk-insured patients of the system's Medicare Choices Demonstration Project product, as well as other risk and managed care insured patients.

Senator Linda Berglin
Minnesota Senate, St. Paul, MN
State Senator Linda Berglin has represented Minnesota for over 20 years. She was first elected in 1972, to the House of Representatives and served there until 1981. In 1982, Senator Berglin was elected to the State Senate and was appointed chair of the Senate Health and Human Services Committee, becoming the first woman to chair a full committee in the history of Minnesota. Currently, Senator Berglin is Chair of the Senate Human Resources Finance Committee and sits on over ten legislative committees and commissions including the Senate Judiciary, Health and Family Security, Health and Family Security Funding Division, Crime Prevention, and Rules and Legislative Administration. She is the cochair of the Legislative Oversight Commission on Health Care Access and also serves on the Commission on the Economic Status of Women.

Senator Berglin has received over 30 awards for her dedication. Her most recent achievement, the passage of the MinnesotaCare legislation, was the culmination of many years of hard work and research.

Richard Bringewatt, President and CEO
National Chronic Care Consortium,
Bloomington, MN
Richard Bringewatt is President and CEO of the National Chronic Care Consortium (NCCC), a national nonprofit organization comprised of thirty three of the nation's leading healthcare providers collaborating to develop practical, innovative methods for integrating care. Mr. Bringewatt developed the "chronic care network" strategy that is central to the Consortium's work.

During his 24-year career, Bringewatt has worked extensively with the spectrum of acute and long-term care providers, think-tank" organizations, and foundations, as well as the nation's leading healthcare provider and professional associations on issues of integration, managed care and chronic disease management. He has also provided leadership in health systems policy development at the county, state, and federal levels, including Congressional testimony and serving on policy commissions. He has consulted with many of the nation's leading reform demonstrations in chronic care, including the Social HMOs, On Lok and the PACE replication, the National Channeling Demonstration, HCFA's Medicare Alzheimer's Demonstration, and various other public and foundation supported programs. He has provided leadership in establishing a multidisciplinary clinic and a senior HMO.

June Buckle, Sc.D.
Senior Director, Care Management and Outcomes Evaluation, Johns Hopkins Bayview Medical Center, Baltimore, MD
As senior director for Care Management and Outcomes Evaluation at the Johns Hopkins Bayview Medical Center, Dr. June Buckle directs strategic planning for care management, quality management and guideline development and evaluation. Previous high-level quality-management positions include a national directorship for CIGNA and a GMIS directorship in health information research and development. She was also the accreditation reviewer for the National Committee for Quality Assurance and held senior research positions with the Robert Wood Johnson Foundation Faculty Fellowships and the Center for Hospital Finance and Management for Johns Hopkins University.

Dr. Buckle is a member of the Maryland Hospital Association Council on Clinical and Quality Issues and is on the board of directors for Roland Park Place, a continuing care community in Baltimore. Extensively published, Dr. Buckle holds faculty appointments at the George Washington University in Washington, D.C., and at The Johns Hopkins University's School of Hygiene and Public Health and the School of Nursing.

Joan Delich
Director, Administrative Services
Metropolitan Health Plan, Minneapolis, MN
Joan Delich is the Director for Administrative Services for Metropolitan Health Plan (MHP), a nonprofit HMO operating under the auspices of Hennepin County. Ms. Delich cofounded MHP and was responsible for developing the MSHO product for MHP. Ms. Delich has also been involved in health policy development at the county and state levels. She has consulted with local counties on developing county-based managed care plans for Medical Assistance recipients and with Aetna Health Plans in New Jersey for their prepaid public assistance programs. Ms. Delich serves on the Minnesota Department of Human Services MSHO Advisory Committee and, within the past year, was instrumental in founding the Hennepin County Gerontology Alliance; she serves as the chairperson for this Alliance.

Nancy Feldman
Chief Executive Officer, UCare Minnesota
St. Paul, MN
Nancy Feldman is CEO of UCare Minnesota, a 60,000 member nonprofit health maintenance organization serving low-income and special needs individuals. Before assuming this position in September of 1995, she was Director of State Public Programs for Medica, a 700,000 member HMO with a low-income enrollment of 50,000.

Before beginning work in the private sector, Ms. Feldman worked for Minnesota state government in a variety of management and health-related positions. She served as Assistant Commissioner of the Minnesota Department of Health for three years where she was responsible for a variety of programs including long term care and managed care policy and regulation, community health services, and maternal and child health. Prior to that, she was in charge of budget development and oversight for the state's health and human services agencies at the Minnesota Department of Finance. She also worked for ten years at the Minnesota Department of Human Services where she had responsibility for many aspects of the state's Medical Assistance Program including development of the state's Medicaid managed care program.

Maria Gomez
Assistant Commissioner, Aging and Adult Services, Minnesota Department of Human Services, St. Paul, MN
As assistant commissioner for the Minnesota Department of Human Services, Maria R. Gomez heads the Aging Initiative, which includes management of Project 2030, a special project to prepare Minnesota's response to the long-term care needs of the large baby boom generation in the future; community support services; continuing care for the elderly; and the Minnesota Senior Health Options.

Ms. Gomez's career reflects a lifelong commitment to human services, beginning in Florida as a social worker in the early 1970s. She has held several top policy positions at the Minnesota Department of Human Services, including assistant commissioner for Health Care and Residential Programs and commissioner of the department. She has also worked for the Minnesota Department of Employee Relations, most recently as director of Integrated Health Care Purchasing.

Kathleen Kraynack, R.N.
Cooperative Health Care Clinic Nurse
Kaiser Permanente-Westminster Clinic
Westminster, CO
Kathleen Spisak Kraynak, R.N., B.S.N., is a registered nurse in Kaiser Permanente's Colorado region. She has facilitated a cooperative healthcare clinic (CHCC) group made up of elderly high utilizing patients since April of 1995. Her CHCC group was funded by the Robert Wood Johnson Foundation's study on alternative methods of healthcare delivery for two years.

Ms. Kraynak is an expert-level clinician with 20 years experience caring for the chronic needs patient in both the inpatient and ambulatory care setting. During her career, Ms. Kraynak has authored the nursing care plan and nursing standards for the patient with AIDS. She is preceptor for B.S.N. nursing students a Colorado University and the University of Northern

Colorado. Ms. Kraynak had dedicated her practice to Jean Watson's Nursing Theory of Care and incorporates complementary medicine into her healthcare delivery.

Howard Lai, M.A.
Special Projects Manager, PACE Development Specialist, On Lok Senior Health Services
San Francisco, CA
On Lok Senior Health Services is a private, nonprofit organization created in 1972 to provide comprehensive health care for the frail elderly of San Francisco. On Lok's goal is to help the frail elderly live independently in their own home and home community. Today, it is a nationally recognized leader in long-term care and assists Programs of All-Inclusive Care for the Elderly (PACE) sites across the country in replicating its model of care.

Mr. Lai joined the On Lok staff 15 years ago, initially providing direct services as a Social Worker and the Intake/Outreach Coordinator. Over the years, he has assumed increasing responsibilities in the overall operations of the program. As a Program Administrator, he coordinated and facilitated the work of an interdisciplinary team in developing and implementing comprehensive Participant care plans. Currently, he continues to work with developing PACE projects across the country and locally by providing technical assistance and manages special projects that support the primary work of On Lok SeniorHealth. Most recently, he has been involved in orienting the staff at On Lok to their newly developed Integrated Chronic Care Information System.

John Mach, M.D.
Medical Director, EverCare, Minneapolis, MN
John R. Mach, Jr., M.D., joined the EverCare Corporate staff as Medical Director in March 1996. Prior to joining EverCare full-time, Dr. Mach served nine years as a consultant to EverCare and Linkage, both divisions of United HealthCare. Previously, he held a position at the Minneapolis VA Geriatric Research Education and Clinical Center (GRECC) for ten years, five as Medical Director and two as Acting Director of the program. He received a Certificate of Added Qualifications in Geriatrics in 1988. Dr. Mach practiced as a primary care internist prior to joining the GRECC. As an Assistant Professor of Medicine at the University of Minnesota during his tenure with the GRECC, Dr. Mach was involved in a variety of research and educational endeavors. His primary research interest was investigating the pathophysiology of delirium for which he was presented an American Geriatric Society New Investigator Award in 1990. Dr. Mach served as Chairman for several national educational programs while at the GRECC and served as faculty and planning committee member on two VA National Training Programs on geriatric topics.

As part of the EverCare Corporate staff, Dr. Mach is charged with implementing the EverCare model, developed in 1987 in Minnesota, across six new HCFA demonstration program sites. The first demonstration site became operational mid-1995. EverCare currently has over 7500 patients in more than 250 nursing homes spread across seven states. To date, more than 120 primary physicians and 100 nurse practitioners are working with the EverCare clinical model. Dr. Mach's role is to develop and implement clinical programs, information systems, care networks, and infrastructure to support this model over very diverse settings.

Jan Malcolm
Vice President, Community Affairs
Allina Health System, Minneapolis, MN
Jan Malcolm is system vice president of public affairs for Allina Health System. She is responsible for development of public policy positions, government relations, corporate communications and public relations. Prior to joining Allina in 1994, Malcolm was senior vice president for government relations and public programs at HealthPartners. Malcolm has served in similar roles at MedCenters and Partners National Health Plan. She began her health policy career at Interstudy.

She is a member of the board of directors for the Living at Home/Block Nurse Program and the Courage Center. She has served as an appointed member of the Governor's Commission on Health Plan Regulatory Reform and as an alternate member of the Minnesota Health Care Commission. She is former chair and current president-elect of the Minnesota Council of Health Plans.

Mark Meiners, Ph.D.
Associate Director, Center on Aging
University of Maryland, College Park, MD
Mark R. Meiners, Ph.D. is Associate Professor and Associate Director for the University of Maryland Center on Aging in College Park. He is the originator of the Robert Wood Johnson Foundation (RWJF) Partnership for Long-Term Care and has served as the National Program Director for this initiative since its beginning in 1987. He is also Director of the Robert Wood Johnson Foundation Medicare-Medicaid Integration Program, designed to help states develop new systems of care that better coordinate acute, post-acute, and long-term care.

Dr. Meiners specializes in the areas of aging and health with emphasis on financing and reimbursement issues. He has written numerous publications including articles on nursing home costs, long-term care insurance, and cost of illness analysis. Dr. Meiners is nationally recognized as one of the leading experts on financing and program development in long-term care. His research on long-term care insurance has been a major catalyst to the current interest in this topic. He was recently voted one of the 100 most influential people in long-term care by McKnight's Long-Term Care News Editorial Advisory Board.

Pamela Parker
Director, Minnesota Senior Health Options
Minnesota Department of Human Services
St. Paul, MN
Pamela J. Parker is director of Minnesota Senior Health Options, a demonstration funded by the Robert Wood Johnson Foundation, which integrates primary, acute and long term care and Medicaid and Medicare services through managed care for dually eligible elderly. From 1987 to 1992, Ms. Parker was the director of the Long Term Care Division at the Minnesota Department of Human Services, and prior to that she was responsible for design and implementation of the state's nursing home case mix system. She has 25 years of experience in health, 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 was a 1982 Bush Foundation Leadership Fellowship recipient.

Cheryl Phillips-Harris, M.D.
Clinical Resources Director
Sutter Health, Sacramento, CA
Cheryl Phillips-Harris is the Clinical Resource Director for the Sutter Health Transitional and Long Term Care Services. In this capacity, she is the regional medical director for the five Sutter Oaks skilled nursing facilities, including Sutter's hospital-based subacute unit and an Alzheimer's special care facility. She has developed a geriatric risk screening and care coordination program for high risk and frail elders enrolled in Sutter's Medicare HMO plans. She is also the Medical Director for Sutter SeniorCare, one of 16 national PACE replication sites. She is currently the Vice President of the American Medical Directors Association (AMDA) and services on the national Board of Directors for the National Chronic Care Consortium, AMDA, and the chairs the AMDA Education Committee. She serves as the geriatric education coordinator for the Sutter Family Practice residency program. She completed her family practice residency and geriatric fellowship at the University of California, Davis, where she currently holds a faculty appointment as Assistant Professor in the Department of Family Practice.

John Shen
Director of Special Projects, On Lok, Inc.,
San Francisco, CA
John Shen is the Director of Special Projects; responsible for the strategic planning of On Lok, Inc. From 1995-97, he was the Director for Geriatric Planning at the Mount Sinai Hospital coordinating the infrastructure development for the Medicare Managed Care Plan, as well as developing a chronic care management strategy for the Mount Sinai Health System. Mr. Shen was the Director of PACE, On Lok, Inc., where he led the national replication of the On Lok/PACE model, demonstrating a fully integrated, full risk approach to care for the frail elderly. He has been involved with managed care since 1982 and has focused on the development of delivery systems for the frail elderly, capitation, and risk sharing arrangements with HCFA, state governments, hospitals and other providers.

Stanley Smith, M.D.
Department of Family Practice
University of Minnesota, Minneapolis, MN
Dr. Stanley Smith is currently an assistant professor in the Department of Family Practice and Community Health at the University of Minnesota. Dr. Smith completed a three year fellowship in Geriatrics at Bowman Gray School of Medicine, Winston-Salem, NC and has obtained the certificate of added qualification in Geriatrics. As a fellow, he obtained a Master's Degree in Epidemiology. He has 10 years of experience working with the elderly in various health care settings. Dr. Smith has published articles on anxiety, depression and health care utilization in the elderly. Most recently, he has been working on the Geriatric Interdisciplinary Team Training program sponsored by the Hartford Foundation. For the past year, he has been developing a program to bring physician services on-site to clients of the Adult Day Care Center associated with Catholic Eldercare.

Minnesota Senior Health Options Project

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

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

National Chronic Care Consortium
National Resource Center on Chronic Care Integration

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

The NRC is sponsored by the National Chronic Care Consortium (NCCC), a strategic alliance of 33 leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

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