Minnesota Senior Health Options

1998 Annual Educational Forum

Building Partnerships for Integration of Acute and Long-Term Care Services

January 22, 1999

Developed by the National Chronic Care Consortium in cooperation with
the Department of Human Services, Minnesota Senior Health Options
under a grant from The Robert Wood Johnson Foundation.

Table of Contents

Welcome 3

Opening Session
MSHO Status Report 4

Plenary Session
Effective Care Management Methods For Dually Eligible Beneficiaries 6

Concurrent Session
Improving Self-Care Capabilities and Adaptive Strategies for Older Adults 9

Concurrent Session
Building Culturally Competent Systems of Care: A Focus on the Hmong Population 11

Concurrent Session
Addressing Polypharmacy and Other Medication Issues 13

Plenary Session
Building Knowledge and Skills for Effective Performance in Managed Care 16

Panel Discussion
From Then to Now: MSHO Successes and Challenges from Physician Perspectives 18

Panel Discussion
The Future Role of Integrated Delivery Systems in Serving Older Adults 20

Speaker Information 22

Welcome

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

Welcome to our 1998 Annual Forum.

This daylong annual forum is designed to explore care delivery and coordination issues to improve care management across settings under the Minnesota Senior Health Options (MSHO) model. The goal of this meeting is to improve care for clients participating in MSHO. We are fortunate to have these educational programs made possible through a grant from the Robert Wood Johnson Foundation. These educational meetings help us keep a focus on the integration of service delivery and care management issues. We know that many other states are interested in this dually eligible program and are looking to Minnesota as an example.

The National Chronic Care Consortium (NCCC) serves as a national resource center for providers and payers in transforming the current chronic care delivery systems to improve quality and reduce costs. The NCCC develops these forums as part of its role in the 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. TEAP activities include clinical integration/care management sessions, annual one-day educational forums such as today's meeting, a series of resource documents on issues that arise from MSHO, and informational resources on topics of interest to key MSHO contacts.

Opening Session

MSHO Status Report

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

Background and Trends

I'd like to begin with a brief look at where the whole Medicaid system is and at some of the trends with seniors. Minnesota has approximately 570,000 seniors in Medicare, of whom 46,000 are eligible for both Medicare and Medicaid. About 26,200 seniors are enrolled in Minnesota's prepaid managed care system for Medicaid beneficiaries—otherwise known as PMAP. The PMAP program has been around since 1985; it began in metro counties and now has extended into rural areas too. Medicaid costs in Minnesota run about $3 billion per year, of which more than $1 billion is spent on services for seniors. Medicaid spends about $850 million per year on nursing home care—about 28,000 seniors on Medicaid live in Minnesota nursing homes.

So with that as a background, where are we with MSHO? MSHO began enrolling seniors in February 1997—we are almost two years old. We currently have 2,777 enrollees. Approximately 21 percent of these enrollees live in the community, and approximately 79 percent live in nursing homes. This is as we expected. Although we had projected it would take the full five years of the project for us to serve 4,000 seniors, we have served nearly 4,000 seniors in less than two years. Therefore we have more than met our target. MSHO has a low voluntary disenrollment rate—most disenrollment has been due to death (given the frailty of the population). No formal complaints have been registered at the state level about MSHO.

MSHO Enrollee Focus Groups

I've got to tell you that I'm excited we finally get to talk about actual MSHO enrollees after all these years of planning. In October 1998 we held two separate focus groups of MSHO beneficiaries. One group was primarily nursing home residents and their family members, and a second group was community-dwelling enrollees and a family member. We had 17 participants in all; they had been in MSHO between six and 19 months. Participants reflected service experience from six health plans, three care systems, six clinics, five nursing homes, and 10 different care coordinators. I'd like to play you a short videotape that includes about seven minutes of comments from the four hours of focus group meetings. This will give you a flavor of some of the discussion.

These folks were very articulate; they were a dynamic group who had insightful comments. Why did the focus group participants say they had enrolled in MSHO? As you saw in the videotape, they were happy because it was just for seniors, their physician supported it, they felt it was a good program given their anticipated future service needs, they liked the idea of less paperwork, and their nursing home supported it.

Some common themes that emerged about the value of MSHO included

- Value of the care coordinator—this is the heart of the whole program
- Personal attention that is paid
- Simplicity of access to a full range of services

- Support for family members
- Enhanced communication with the physician through a nurse practitioner

There were also a few problems cited, some of which were related to MSHO, some of which are problems throughout the healthcare system and are not unique to MSHO. Problems cited included

- Provider confusion about referrals needed for MSHO
- Inaccurate information being given to beneficiaries
- Nursing home issues (e.g., staffing, call light waiting times)
- Billing issues
- The request that more information about MSHO be provided
- Need for more information about particular health plans' procedures relating to such things as referrals

There was also the big question—What if my care coordinator leaves? What happens to me? This highlighted the personal nature of the relationship between the care coordinators and the beneficiaries. And finally, enrollees were concerned about this being a pilot project—What if this ends? We tried to allay their fears.

MSHO From a National Perspective

States are savvy about the shift in dollars between Medicaid and Medicare. There is a growing understanding that the state and federal governments will need to work together to address the needs of people eligible for both programs. Dually eligible seniors comprise 30 percent of Medicare's costs, have more chronic needs, and are growing faster than other Medicare population groups. Some say that solving problems in financing and care delivery for dually eligible seniors will be the key to resolving the current crisis in Medicare financing.

Secondly, MSHO is one of several state projects participating in the Robert Wood Johnson Foundation grant project on Medicare/Medicaid Integration. Minnesota was the first state to receive Medicare waivers; Wisconsin is the second. Also, the Bipartisan Commission on the Future of Medicare visited Minnesota last year and learned more about MSHO during that visit. Finally, the General Accounting Office is conducting a study about dually eligible beneficiaries and will be producing a report about this group. So the interest and activity around dually eligible seniors is high, and Minnesota's experience is a key part of these discussions.

For 1999 and 2000 I see several important issues on the horizon. The first question concerns reimbursement and payment mechanisms. They are changing. For example, the Medicare+Choice risk-adjustment formula as proposed has certain perverse incentives to hospitalize patients and does not seem to adequately support care for frail seniors living in the community. We were worried about this proposed payment scheme and how it would affect MSHO but were successful in getting an exemption from the Health Care Financing Administration (HCFA) for the time being. We will be going to HCFA to encourage them to look at refinements in the payment formula for other projects like ours. I do believe that it will take HCFA more than the five years of this project to make any kind of changes to our payment formula. However, if we ask for an extension of MSHO—and HCFA fully expects us to—then we will have to be very involved in the design of the payment formula for the next several years.

In addition, other Medicare+Choice regulations are coming down the pike—it is unclear what regulations will pertain to MSHO, if any. We are working with HCFA on this.

We need to find ways to continue to expand enrollment. We need to continue to work with health plans and care systems as they evolve, reshape, and reform. We need to do more to respond to the ethnic diversity of our beneficiary population. Finally, we need to more actively and effectively describe what is going on with MSHO, how it is successful. There are many possible sources of information on that—encounter data, satisfaction data, and the evaluation study—but we have to get better at telling our story and increasing public awareness of this program.

It was good to hear from beneficiaries that MSHO really is working for them. I'd like to thank you here today, and your colleagues, for your continued investment in this project. I don't get to tell you very often, but it is very much appreciated. You need to know that it has already made a difference. This project and your efforts are making a contribution to the understanding of how to care for a chronically ill population. We have been a catalyst for change already around the country—you should take some pride in that. I hope that we can continue to learn together and show others the value of this program.

Plenary Session

Effective Care Management Methods for Dually Eligible Beneficiaries

Sharon Christenson, R.N.
Exceptional Needs Care Coordinator,
Oregon Health Plan
Kaiser Permanente
Portland, Oregon

Background

I'm here today to share some of the program experience relating to our Medicaid managed care program—focusing on people with exceptional care needs. First, I'd like to introduce you to our newly elected governor, John Kitzhaber, M.D. Governor Kitzhaber is an appropriate place to start because he was instrumental in shaping the legislation that founded the Oregon Health Plan (OHP). OHP is the statewide, mandatory Medicaid managed care program that began in 1994. Governor Kitzhaber is a physician by profession, and in the early 1990s he started collecting evidence and information around the state about what happened to people who had high care needs and did not have private health insurance. What he found led to legislation to change the way care was organized and paid for. In 1995, older people, the blind and disabled, and medically frail children were added to the program, and thus the Exceptional Needs Care Coordinators (ENCCs) were born.

OHP covers all primary and acute care services—long-term care services are not part of the program but are provided on a fee-for-service or sometimes a fee-waived basis. You will see how we make adjustments for those with special care needs through case studies that I'll present. Dually eligible beneficiaries who are enrolled in a health plan that also has an OHP contract, like Kaiser Permanente, can receive both their Medicaid and Medicare services through this single health plan. Otherwise they need to receive their Medicare benefits on a fee-for-service basis from their Medicaid health plan (similar to Minnesota's PMAP).

In 1998 there were 360,000 people enrolled in OHP, with 22,000 of them choosing Kaiser as their health plan. Of the 22,000 members, 2,300 (about 10 percent) were eligible for exceptional needs services. I am the only ENCC for all of Kaiser—therefore I have a caseload of 2,300 people. How can I do this? I can't. I rely on several methods to identify and provide service to these people at given points in time. I will describe how people are enrolled and then discharged from the exceptional needs care service.

When this program first started, we brought together key players from many service and government sectors, including the state caseworkers, the health plans, the clients, and the care coordinators. There was much distrust—especially of health plans. People were very territorial about this population and wanted to keep things the way they had always been. The state legislation designated the ENCCs as a single point of entry to the health plan. The ENCCs became the bridge between social services (traditionally the state caseworkers' domain) and medical services (traditionally the health plans' domain). We had to work long and hard to bring the very different viewpoints closer together. We went through a kind of boot camp training on all the Medicaid rules, on vendors, on service providers and agencies—the ENCCs were expected

to know and understand these things as necessary tools for doing their jobs.

When we began the exceptional needs service, we needed to have a way for the caseworkers to access ENCCs. The state devised the continuity of care referral forms that you see in your handout materials to gather some information about people who have exceptional needs. The ENCC receives the form, determines the service need or other required response, and then contacts the client and the caseworker. Most of the referrals come by phone, not by mail. We have an open referral policy, and I get referrals from all types of sources. I've had referrals from the fire department, from mail carriers, from state ombudsmen, and of course from family members, physicians, and clients themselves.

When I receive a person's name, I send that person a letter briefly explaining the ENCC service and a health status questionnaire (enclosed in your handout material). When the questionnaire is returned to me, I send a copy of it to the individual's primary care physician for their chart.

Case Studies

Let me describe a few clients I've had to illustrate the kind of needs we see. Many of these cases also illustrate the need to make coverage decisions which see the big picture and focus on preventing disability.

Karen

Karen is a retired nurse who has diabetes and cellulitis and who is obese. Karen lives at home and has a disabled spouse who is not able to care for her. Karen was told to keep her legs elevated to decrease edema, but she did not have a recliner and therefore used a stool. Unfortunately, because of her weakness and body weight she could not get up without assistance once she sat down and acquired an infection and skin breakdown. This resulted in a hospitalization and home health nursing care for IV antibiotics. Karen wanted a lift chair for her home, but it was not a covered item through the OHP. Medicare might cover the item if she met the criteria, but Karen did not have the money for the Medicare copayment. Working with the caseworker, we agreed that if Medicare covered the cost of the lift chair than the state would pay the remainder. After weeks of negotiation this scheme was approved and Karen got her recliner/lift chair. That was in 1996, and Karen has not been hospitalized or needed home health care since that time.

Norris

Norris is an 84-year old living at home with a mildly demented spouse. He is on oxygen and has congestive heart failure (CHF). Recently he had requested and received a prescription for a walker in order to help him ambulate at home and especially get to medical appointments. The request was denied by a Kaiser customer service representative. As the ENCC, I contacted the primary care physician and received an order for a home health physical therapist to assess his needs. The therapist found that Norris was trying to care not only for himself but for his wife as well. Review of his medical history showed many recent hospitalizations for CHF and complications. Following the home assessment we provided a walker with an oxygen holder, home adaptive equipment, transportation to all clinic visits, and home-delivered medications. In addition, we arranged for a paid caregiver five days per week for Norris and his wife.

These cases provide some understanding of the importance of good home support and of the benefits structures of the client's insurance packages. Some of these people have been beaten down by the system, and they need to be listened to and educated about how to speak for their own needs. I see my job as an advocate for the client. If something I think they need is denied, I do not let it end there. I ask the client to send me a letter, and I attach the letter to a member complaint and, if necessary, request an administrative hearing. I have gotten quite effective at getting the services needed for these clients.

I follow people to and from nursing facilities as well, to be sure I know what their needs are going to be. I get a list of people who are going from the hospital to the skilled nursing facility. I send this information to the county caseworker and let the caseworker know what the client's needs are going to be. Kaiser will pay up to 20 days of skilled care; after 20 days, if the person is on a Medicare-risk plan with Kaiser, then Kaiser will cover up to 100 days at 80 percent and Medicaid picks up the 20 percent copay. If they go to the intermediate care facility level, Kaiser is responsible for the medications, and the state Medicaid program is responsible for the board and nursing care. Often these things are a shared responsibility, and that is where I can come in and be helpful—I have to know the rules and regulations and can run interference between the state, Medicare, and Kaiser. Agencies, caseworkers, and clients have expressed their sincere thanks for having just one person to call to provide this coordination. We have come a long way in building bridges of understanding between the state and health plans and other agencies—we have monthly meetings where we share information and receive continuing education.

Challenges

Cultural Differences

I understand you have a range of ethnic groups enrolled in MSHO. I have found that knowing how to effectively use interpreter services is

very important in serving clients from other ethnic and cultural backgrounds. Kaiser has an excellent interpreter service that I have learned to use well. We do three-way meetings and three-way calls, and I have learned to ask the right questions to understand the client's needs and arrange for appropriate services. In our computer system, we have a flag that indicates the individual needs interpreter services.

Pharmacy

Medication issues are very important for these folks. There are potential barriers to consider. For example, OHP members can only have their prescriptions refilled every 30 days—therefore this needs to be taken into account when prescribing a course of medication for treatment. In addition, certain medications are not covered. The ENCC needs to be aware of all these rules and regulations. Medication abuse is also flagged on our medical information system.

Confidentiality

When you have a client, you need to get approval for sharing information with specific organizations and agencies—get the confidentiality form signed right up front.

Homeless People

We are required to provide case management services to homeless people. This is often a challenge because we can have trouble locating the client. Followup is extremely difficult.

Diagnoses Not Covered by Medicaid

We also have contractual issues with the state in terms of their not covering a procedure that may be needed, but is not on the list of approved procedures, i.e., is "below the line," or is not in the capitation rate. You probably know that Oregon has a list of diagnoses for which the state has agreed to provide care under Medicaid. Certain diagnoses are not on that list and that is what I mean by "below the line." In these cases we try to find a comorbidity that is covered.

Aid to the Dying

The good news with regard to our physician-assisted suicide regulation is that it has gotten people to look at how we treat terminally ill people and how we manage certain long-term chronic diseases and control things like pain. The bad news is that it may send the wrong message, i.e. the state will not pay for your heart/lung transplant, but it will pay for your physician-assisted suicide.

Turnover

Members can change plans every six months. Disenrollment is being looked at by a group right now, but the state feels that even if someone disenrolls, they will probably be back sometime in the near future. The state encourages plans to provide preventive services in spite of the turnover problem.

Here is an interesting set of statistics that underscores the significance of community-based care and good case management across the board. Because of Oregon's focus on community-based care, foster care, and assisted living, we have demonstrated cost savings and, we hope, improved satisfaction of clients. The average cost per month for nursing facility care in Oregon was approximately $3,000 in 1997, while community-based care cost an estimated $560 per month. This means that Oregon saves more than $650,000 per week in state and federal dollars for an estimated savings of more than $69 million in the period between 1995 and 1997.

Thank you for your interest in our experience in Oregon.

Concurrent Session

Improving Self-Care Capabilities and Adaptive Strategies of Older Adults

Mary Gruenewald, R.N. (retired)
Member, Executive Committee for Senior Caucus
Group Health Cooperative of Puget Sound
Seattle, Washington

Background

My name is Mary Gruenewald. I worked as a nurse at Group Health Cooperative of Puget Sound for 23 years, and I am an active member of Group Health's Senior Caucus. Group Health is a consumer-governed cooperative health maintenance organization (HMO) with approximately 656,000 members; 55,000 of these members are 65 years of age and older. The Senior Caucus, a special interest group that reports to the board, has 5,000 active members.

Group Health has a number of programs and strategies designed to assist older adults in improving their self-care capabilities.

Group Health Resource Line

Beginning in 1985, the Senior Caucus recommended to the system that there be a free information service for consumers—the Group Health Resource Line. The Resource Line is a free information and referral service available to all Group Health members. The Resource Line staff provide up-to-date pamphlets about health topics as well as referrals to Group Health and community health resources and senior services. They assist with patient education information, classes, forums, and support groups, and services for seniors. The Resource Line staff specialize in helping improve quality of life for seniors and their caregivers. There is information on home care, transportation resources, and fitness classes. They also offer one-on-one consultations with a community specialist to help seniors discuss living wills and other advance directives.

Healthwise Handbooks

In 1995, Group Health mailed a *Healthwise* self-care book to each of the 180,000 Group Health households—at a cost of approximately $900,000. It takes about $175,000 annually to maintain this program. The *Healthwise Handbook* is sent to households where people are 65 years of age and younger. *Healthwise for Life* is sent to those 65 years of age and older. Before mailing these books, Group Health offered extensive orientation to providers on what the books contain and how they should use them with patients to reinforce self care. Group Health has found high satisfaction with these handbooks among consumers and providers. In 1997 they completed a study of the effect of using the handbooks with their clients; they estimated that using the handbooks resulted in cost savings of $10 million.

Senior Health Improvement Plan Questionnaire

In 1997, Group Health codeveloped with Pfizer Health Solutions a questionnaire tailor-made for the Group Health senior population. They spent between $8,000 and $10,000 to refine the tool. They mailed this tool to 10,000 seniors throughout the system, selecting 5,000 randomly and sending the other 5,000 to seniors from the clinic with the largest senior population. This questionnaire allows for self-assessment of health status and builds the self-awareness of seniors.

For more information

For more information on some of the self-care strategies referenced in this session, contact:

Healthwise Knowledgebase™
www.hcp.org

The Chronic Disease Self-Management Program
Stanford Patient Education Research Center
1000 Welch Road
Suite 204
Palo Alto, CA 94304
(650) 723-7935

Publications

Group Health regularly includes self-care information in their system publication, *Northwest Health*, and in their publication for seniors, *Senior Outlook*.

The Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program through Stanford University is an extremely valuable patient education program that Group Health uses with its seniors and chronically ill populations. This program has been shown to be an effective, low-cost treatment for patients with chronic health problems. It is designed to be an adjunct to regular treatment and to disease-specific education. It teaches the skills needed for the day-to-day management of treatment and for maintaining and/or increasing life activities.

This program is a seven-week class provided at no charge to the consumer. Trained seniors who have one or more chronic conditions facilitate the sessions. Group Health has a nurse health educator who serves as the central coordinator for this program; she divides her time between all Group Health clinics and trains the facilitators.

One of the real benefits of this program is that people attending these classes offer expertise to each other. They can demonstrate that they still have something to contribute to another's life, which is good for their self esteem. Socialization is an important part of this class.

Group Health has seen good results with this program. There is reduced dependence on providers, greater satisfaction among members, and greater confidence among members about their ability to handle their conditions.

Clinic Services in a Retirement Center

We have several retirement centers where many Group Health clients reside in the assisted living areas. In one of these retirement homes Group Health established a clinic that is staffed a couple of days a week by a physician, a geriatrician, and a nurse practitioner. Group Health found a high level of satisfaction with this clinic among the patients. This clinic reduced drug usage because the staff could monitor drugs better. The clinic also increased the number of flu immunizations. The clinic was so successful in improving care and reducing costs that Group Health is considering replicating this clinic in another retirement center.

What Do Older Consumers Want?

In thinking about improving self-care strategies, it is important to understand what we older consumers want and need.

- We want to be healthy and active as long as possible.
- If we become ill or injured or have exacerbations of chronic conditions, we want to know where to get help.
- We want to have relief from the limitations of chronic diseases.
- We want easy access to a stable relationship with our providers.
- We want you to help motivate us by finding out what is meaningful to us. We will make our changes when the time is right for us.
- We need you to tell us what to do and how to do it, over and over until we know how to do it. Demonstrate, demonstrate, demonstrate.
- We want you to listen to us. Remember the letters in the word "listen" are the same letters as in the word "silent."
- We want and need respect and inclusion in the discussions and decisions that affect our death and dying. Be comfortable talking to us about the direction of our lives.

Concurrent Session

Building Culturally Competent Systems of Care: A Focus on the Hmong Population

Foung Lo, M.D.
Resident
Department of Family Practice
Regions Hospital
St. Paul, Minnesota

Sia Lo
Attorney at Law
Bannigan & Kelly, P.A.
St. Paul, Minnesota

Mike Moua
President
Moua International Communications
St. Paul, Minnesota

Foung Lo

I will begin with a brief introduction to the Hmong people's history. Until the Vietnam War, the Hmong lived relatively unknown to the outside world in China, Laos, Thailand, and Vietnam. During the Vietnam War they played a crucial role in aiding the United States and South Vietnam by exposing the Ho Chi Minh Trail and assisting pilots who were shot down. When the war ended in 1975 most Hmong spent about two years in refugee camps in Thailand before being sponsored for citizenship by people in the United States, Canada, France, and Australia. Today there are seven million Hmong people in China, one million in Laos, 87,000 in Thailand, 40,000 in France, 25,000 in Australia, and upwards of 100,000 in the United States. The largest concentrations of Hmong people in the United States are in California, North Carolina, Minnesota, and Wisconsin. The Twin Cities metro area has the largest concentration of all—between 60,000 and 70,000 Hmong people.

Fundamental Hmong Beliefs

- The family is the most important unit in Hmong culture, much more important than the individual.
- There is a traditional belief in an intersection of the worlds of living and dead. The souls of the dead are sustained by the lives of children in this world, and every birth is really a rebirth. The living have continuing obligations to their ancestors.
- It is the duty of the father or the eldest son to take care of the family, both those who are still living and those in the spirit world. In traditional Hmong culture, to give up the care of one's parents is seen as a failure. Nursing home placement for elders is not considered a valid option; children who do resort to placement can be viewed as traitors to their family.

Barriers

Some of the barriers healthcare providers face with elderly Hmong clients are

- Language
- Cultural beliefs. The traditional belief in Hmong culture is that illness is an imbalance between the body and the spirit. The spirit can leave the body of its own accord because it is sad or troubled, or it can be captivated into leaving by ancestors who are angry.
- Providers' own preconceptions. It is important for providers not to assume that clients of other cultures have the same common body of knowledge about medical science.

Let me give you an example of some issues that can arise in caring for elderly Hmong clients. An elderly Hmong woman with throat cancer was intubated at my hospital. She begged to be extubated, explaining that she was ill because her deceased husband was angry with her and that only his acceptance of her apology would make her well. The hospital ethics committee ruled this patient competent to make decisions about her care. She was extubated, and she did well.

Providers can feel frustrated when a client refuses care because they do not understand why the client thinks the care is not appropriate. Providers can bridge the gap by keeping an open mind, making an effort to integrate patient beliefs into care, making sure fear and lack of information are not creating a barrier to care, and improving their explanations of what treatment they want to provide and why.

Sensitive Issues for Hmong Clients

Some things providers can be sensitive to with Hmong clients in nursing home settings:

- Privacy. Exposure of the body is a painful experience for elderly Hmong people.
- Respect. Hmong elderly are regarded as special sources of knowledge and are accustomed to being treated very respectfully.
- Diet. The traditional Hmong diet is very different from the food served in most nursing homes and inpatient settings. If possible, encourage the client's family to help provide food.
- Isolation. There are rarely more than two elderly Hmong people in one nursing home. This lack of social life is one of the reasons older Hmong people are so resistant to living in a nursing home. Encourage as much visitation as possible.

Sia Lo

Some other things providers can keep in mind when dealing with elderly Hmong clients:

- "No means yes." A refusal of help is often not a true refusal. Offer again.
- Hmong people are accustomed to making decisions as a family, a clan, or a community. An elderly Hmong person may not be capable of answering when you ask him or her to make a choice, even one that seems straightforward to you.
- In Hmong culture the dead are not treated as dead, but as living in the spirit world. Old people are believed to be very close to the spirit world, and many elderly people are fearful of being left alone for fear of seeing spirits. Being alone at death is especially frightening; it is traditional for a person's family to be with the person at the moment of death and for at least 24 hours afterward to ease the spirit's fear and keep it from getting lost on its journey to the spirit world. Children can be afraid that giving up care will cause their deceased parents to be angry with them for the loneliness they experienced in the time before death. The whole family's fear can be eased somewhat by having Hmong-speaking nursing home staff. Also, most Hmong people living in nursing homes would prefer to have a roommate.
- Building trust is essential. Many elderly Hmong people feel lost in American culture and have memories of the Vietnam War that make them feel betrayed by Americans.
- It is helpful to make contact with Hmong community resources.
- Make a point of asking frequently about the Hmong client's family and including them in care.
- Allow a shaman to visit the elderly person in the nursing home if possible to help them feel protected.
- Remember that elders are accustomed to extreme respect; no disagreement or raising of voices is appropriate in their presence.
- Elderly Hmong people love it when people around them can speak even a few words or phrases of Hmong; learning to say something as simple as hello or goodbye can make a big difference.

Mike Moua

I would like to provide you with a few central facts to bear in mind about the Hmong people.

- The Hmong are socially isolated. They have a 4,000-year history of resisting assimilation, and this history has continued in the U.S.
- The Hmong are economically disadvantaged, with an unemployment rate of 60 percent, the highest of any demographic in the United States. Unemployment hits the generation of Hmong people currently age 40 to 60 the hardest.
- The Hmong are "medically misinformed." They do not have the common knowledge about medical science that many healthcare providers take for granted.
  In addition, some older Hmong people believe that white doctors experiment on Hmong people. Autopsies and invasive therapies in particular may arouse suspicions about experimentation.
- The Hmong are a spiritually centered community. Traditional Hmong spiritual beliefs are animistic; there is also a growing number of Hmong who practice Christianity.

Areas of Concern

- Trust
- Communication. Interpreting is not regulated in the state of Minnesota. Bilingual staff are more and more important.
- Treatment regimens. Many elderly Hmong people refuse to comply with a treatment if they are not told it is 100 percent effective; American doctors almost never say anything is 100 percent effective. Hmong view invasive therapies as desecration.
- Strong family/clan consciousness. Decisions are made by groups.
- Many elderly Hmong people have more faith in herbal remedies than in the medical sciences.

Bridging Cultural Barriers

- Ongoing community education
- More Hmong health professionals
- Convenient, affordable, licensed language services

Concurrent Session

Addressing Polypharmacy and Other Medication Issues

Bruce Scott, M.S.
Vice President, Pharmacy Operations
Allina Health System
St. Paul, Minnesota

Deborah Klein, Pharm D.
Clinical Pharmacist
Allina Health System
Minneapolis, Minnesota

Bruce Scott

I am Bruce Scott from Allina Health System. Deborah and I are both pharmacists. I want to begin by going over key trends that have affected medication costs and use over the last few years. Then Deborah will focus on hands-on clinical issues and how we have been working with seniors at one clinic.

The first chart I want to show you demonstrates the growth in prescription drug sales. We can't talk about medications without talking about medication costs, and medication costs are going in one direction—up. In this first overhead you see that between 1987 and 1991 drug sales growth (that is the rise in drug costs due to inflation and the costs of new products) was fairly constant. Then in 1992 Clinton's healthcare reform activities got underway in earnest, and this had a significant dampening effect on drug costs in 1992 and 1993. Once it seemed that the healthcare reform efforts would not succeed, drug costs began to rise again. You can see that since 1994 inflation has held very steady at about 2 percent. Therefore, the reason for the significant rise in drug sales overall is the price of new products.

We are also seeing a significant number of new drugs being brought to market. When I say new products, I mean new chemical entities that the FDA has approved—not existing products that have been repackaged or put together in some way. Every year since 1995, we have had many new drugs coming to market, because the FDA approval time for new drugs was shortened, largely due to pressures put on the FDA by key constituency groups and the pharmaceutical industry.

Let's look at some of these new products. Viagra is perhaps the most famous. There are also other new classes of drugs coming online for diseases such as arthritis, obesity, incontinence, memory loss, depression, and migraine headaches. One important thing to note about these drugs is that the population of potential users is enormous, and the projected annual sales due to these drugs is extremely large—we're talking billions or tens of billions of dollars. You should know that most products are priced based on what the market will bear, not on the cost of bringing the drug to market.

The pharmaceutical companies have also been aggressive in bringing information about these new products directly to the consumer. For example, they are adept at getting scientific and other information about their "breakthrough" drugs to news agencies in the hope that they will be reported on the national news. As an example, what did Pfizer pay in advertising costs to market its newest drug, Viagra, last year? Very little. And yet everyone knows about Viagra—information about this drug was reported on every major newscast and in most major periodicals. The company could not have purchased better exposure.

So in answer to your question—Will drug costs continue to rise, and will they represent an increasing proportion of the healthcare dollar? The answer is very definitely yes.

I want you to know that I am very supportive of the research and work being done by pharmaceutical companies to bring new drugs to market that provide new treatments to address diseases in our population, but I do have an issue with the cost of these drugs and how they are priced.

I also want to talk with you about what the literature tells us about medications and the elderly. We know that noncompliance and adverse drug reactions play a big role in hospitalizations of the elderly. One study of 315 elderly patients found that 28 percent of them experienced drug-related hospital admissions. We also know that medications play a role in ER visits. Another study of more than 10,000 ER visits over four months showed that about three percent resulted from a drug-related illness. Another study of drug-related hospital admissions showed that 4.2 percent of admissions resulted from adverse drug reactions. The cost of drug-related morbidity and mortality is huge—one estimate puts the cost at about $76 billion in the ambulatory setting.

Deborah Klein

I am going to talk to you about medication issues affecting seniors.

Polypharmacy

I should start by defining polypharmacy. We consider polypharmacy to be between five and eight medications per day. The average senior takes about four medications per day. The average Medicare enrollee takes between 12 and 17 prescriptions per year. This is much higher than the rate in younger adults. As a frame of reference, though seniors make up only about 11 percent or 12 percent of the population, they represent about 34 percent of pharmaceutical expenditures.

The causes of polypharmacy are many, including multiple physicians, lack of current patient information, and patient resistance to giving up medications they have been taking. Polypharmacy is not always bad—sometimes a person legitimately needs to be on eight or 10 different medications at the same time.

I currently work at a senior health clinic. The average age of the patients at our clinic is 85. We are a primary care clinic, and we try to manage all of their care through our clinic. I work as part of a team with the nurse and the primary care physician. We try to be sure we know all the medications that our patients are on—we encourage the patients to bring in all their medications (including nonprescription medications) when they join our clinic. Then we can go over the set of medications they have and those that they're supposed to be currently taking, and we can talk about making adjustments. I can work with a patient for as long as it takes—I've spent as much as one hour with a patient, going over medications.

Potential solutions we've identified for polypharmacy include

- Conducting a brown bag session during the primary care office visit
- Reviewing the clinical indication for each drug
- Avoiding treating a medication side effect with another medication
- Finding an optimal dose of one medication before adding a second medication for the same indication

Medication Selection and Dosing

Medication selection is another issue. There is a published list, called the Beers list, that shows the effect of medications on the elderly. This list shows the medications that should be avoided in the elderly and those that

should be given at a different dose. It also provides information about frequency of administration. Frequency of dosing is an important issue. It will affect patient compliance and satisfaction with the medication prescribed. It will also play a part in cost.

Cost is a big issue for seniors. Between 80 percent and 85 percent of the seniors seen at my clinic do not have any coverage other than Medicare—they pay for medications out of their own pockets. Older consumers have been influenced by direct advertising about medications as much as younger people. Many patients come into the physician's office asking for a specific drug. Even as recently as a decade ago, pharmaceutical companies did not advertise to anyone except physicians. A few years ago the regulations about advertising drugs were relaxed and now we have seen a proliferation of ads directed at consumers. To help make people aware of costs, I have a chart that the patients can look at posted in the physician's office. The chart is arranged by class of drug, lists medications by their common name, and shows the cost per dosage and the frequency of dosage needed. This is a way that the physician and patient can discuss costs—maybe there is a drug in the same class that costs less per dosage, but needs to be taken twice a day versus once a day for another drug. By switching to once a day, the person may save $20 per month.

With regard to medication dosing, we recommend the following.

- Prescribe an age-appropriate initial dose.
- Reduce doses for decreased renal/hepatic function.
- Consider frequency of administration.
- Consider cost of medication.

When a patient comes into the clinic following a hospitalization, I take a look at what they're taking and when they're supposed to take it. I often find that they are on the same regimen they had in the hospital—which doesn't always work. In the hospital there is a nurse to come in and give you your meds four times a day, but at home it is hard to keep up with that schedule.

Medication Monitoring

With regard to medication monitoring, we look at adverse side effects, effectiveness of medications, adherence to the medication regimen, and over-the-counter medication usage. It is difficult to monitor medication use—we will not pester the patient about their meds or count pills to be sure they've taken what they should.

A Case Study

To move to the next part of our presentation, please refer to the cases discussed in the handout.

Let's begin with Jack, an 80 year old man who was taking only aspirin, no other meds, until he was hospitalized with congestive heart failure. He left the hospital with six medications. When we saw him in the clinic a week later, he said he felt "like a sick old man who is all drugged up with no money to spare." What are some of the things we should do to work with him?

- Decrease the frequency of medications; try to get it down from four times per day to twice per day or even once per day.
- Show him that this medication regimen will not last forever.
- Write a medication schedule for him.
- Help him figure out the costs of medications, and see if he qualifies for free medications.
- Look at the drugs he is taking: is he able to comply with the regimen where the level of medication in his body is at a therapeutic range? With Jack, some of the meds were not at a therapeutic level because he refused to take them regularly.

Senior Health Clinic

I want to tell you now about the senior health clinic. It is different from many of the other Allina physician clinics. In our clinic, pharmacists are part of the primary care team. We use a pharmacist to focus on the patient's medication use. We provide education for the patient and family and education for the healthcare team.

We recently conducted a study of 167 patients at two clinics. We targeted CHF patients. People were enrolled in our project if they had congestive heart failure, hyperlipidemia, or polypharmacy. After reviewing each patient's case, we made recommendations to physicians. Of the 320 suggested changes made, 62 percent were accepted, and 10 percent were not accepted, and 28 percent are under review. Overall cost savings from this small pilot were $1,120 per month or $13,500 per year. We are collecting data on an ongoing basis about our work, how we are making a difference, and what kind of impact that has on costs.

Plenary Session

Building Knowledge and Skills for Effective Performance in Managed Care

John Wisniewski, M.D., M.H.S.A.
Director, Managed Care College
Henry Ford Health System
Detroit, Michigan

Today I would like to tell you about two examples of education programs for clinicians. Both employ a technique called rapid-cycle continuous quality improvement (CQI), which is a CQI technique very much in vogue at the moment. The advantage of rapid-cycle CQI is that, unlike a traditional controlled study approach, it is a "quick and dirty" technique that allows us to learn by doing, rather than by studying, and to test and implement improvements as they occur to us.

The HFHS Managed Care College

Now in its fifth year of operation, the Managed Care College is an organizational, educational, and training program. Designed to improve clinical care at HFHS, the college also helps align professional development with organizational needs and improve the performance capabilities of the professional staff.

We hold some fundamental premises pertaining to adult learning as a philosophical basis for the college. Learning should be grounded in daily work experience, it should be interdisciplinary, and it should contribute directly to improved professional performance.

The purpose of the college is best articulated by a staff internist who said:

> *There ought to be advantages to practicing in a managed care organization other than mere economies of scale realized through the pooling of personnel and material resources. There should be economies of knowledge and clinical skills as well—a means for shifting the practice paradigm to levels of effectiveness not as easily achieved in independent medical practice.*

Enrollment in the Managed Care College is voluntary. We begin with classroom-based plenary sessions in which we discuss the professional roles and teamwork concepts students will practice in their time at the managed care college. Our principal vehicle for adult learning is a concept we call Integrated Work Projects (IWPs). To begin the IWPs, the teams choose from a list of defined populations. Past lists have included people with diabetes mellitus, chronic congestive heart failure, bronchial asthma, and chronic low back pain. By having teams select specific diagnoses and real situations, we encourage the use of explicit approaches to improving care.

After they select a defined population, the teams are combined into cross-regional learning circles for that population. They spend time in the classroom, and the faculty provide coaching, instruction, and homework assignments. After they acquire a more thorough understanding of the target population, the team sets goals for improving that population's care. The teams return to the clinical setting and recruit others from their department or from throughout the system to help them achieve their care goals. Using these work groups, they analyze current care processes and generate ideas for improving these processes.

Returning to the classroom setting, the teams join the other participants in their target population learning circles to receive formal instruction and dialogue with teams from other regions. Once again, homework assignments are made. The teams then return to the clinic setting where they bring new information and skills back to the clinic work groups they have recruited. The clinic then implements some or all of the team's recommended changes. After an appropriate time, the teams see whether the changes are in fact improvements. When they return to the classroom, they share what they have learned with their learning circles to continue improving the care. The cycle continues for 10 months.

Cumberland Valley Health Network Program

Now I would like to tell you about a ground-breaking patient-centered physician education program at the Cumberland Valley Health Network (CVHN) in Pennsylvania. This program originally developed in response to the medical condition known as post-polio syndrome (PPS). PPS is a recently-identified illness that causes weakness and pain in people who survived polio years earlier. PPS is not yet commonly known, and its diagnosis is complicated by the fact that, while it mimics some of the symptoms of polio, many doctors practicing in the United States today have never seen polio and do not know which of their patients have had polio in the past. PPS sufferers often undergo extensive batteries of tests and imaging before anyone makes the connection.

PPS sufferers in the Cumberland Valley region experienced typically inefficient care until one of the members of a PPS support group happened to encounter a member of senior management at CVHN and suggest that the network increase physician awareness of PPS. The result of this chance suggestion was a symposium about PPS targeted to physicians treating members of the support group. 20 physicians received invitations both in writing from the network and verbally from their patients; 19 physicians attended the symposium. This new patient-physician dialogue revolutionized PPS care in CVHN. In fact patients were so satisfied with the improved level of care that they began to spread the word, and CVHN has since become a magnet for PPS care in the greater Philadelphia area.

Encouraged by the success of this first effort, CVHN next approached the local schools and asked which student health problems would most benefit from targeted attention. The schools suggested teen pregnancy, and CVHN initiated a similar physician-education effort. CVHN also coordinated with the local Boy Scouts to target risk of falling in the elderly. The Boy Scouts performed fall-risk assessments in the homes of elderly network members. This new fall-risk program resulted in a 75 percent reduction in hip fractures in the targeted population.

The beauty of this example from CVHN is how well it illustrates what we believe about education at the Managed Care College, that the best way to learn is by working and doing together.

Panel Discussion

From Then to Now: MSHO Successes and Challenges from a Physician Perspective

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

Jane Pederson, M.D., M.S.
Medical Director
Optage
St. Paul, Minnesota

Sharon Marx, M.D.
Medical Director
EverCare
St. Paul, Minnesota

Data Summary

Acute Care	Admits/ 1,000	Days/ 1,000	ALOS
MHP MSHO (350 Members)	507	2,677	5.3
Optage MSHO (1, 000 Members)	437	2,490	5.02
EverCare MSHO (779 Members)	220	932	4.2
Evercare Medicare (879 Members)	222	896	4.0
Hennepin County Medicare (Population: 118,206)	193	977	5.06

SNF/ NH	Admits/ 1,000	Days/ 1,000	ALOS
MHP MSHO (350 Members)	196	4,536	23.2
Optage MSHO (1, 300 Members)	321	3,729	21.0
EverCare MSHO (779 Members)	257	4,110	16.0
Evercare Medicare (879 Members)	259	4,011	15.5

Susan Crutchfield

Metropolitan Health Plan (MHP) is a 30,000-member HMO affiliated with Hennepin County Medical Center and the Hennepin Faculty Associate physicians. We currently have 350 members enrolled in MSHO, which is just over one percent of our population. But on a per member per month basis they are definitely our most costly group.

Our case management process is organized around three segments: the community-dwelling members who are managed by MHP case mangers, the complex community members who need lots of services are are managed by our partner CHS, another Hennepin county organization, and the nursing home residents who are managed by Optage.

Cost Issues

Let's look at our cost issues.

MSHO Expense Breakdown

Hospital Inpatient	35 percent
Outpatient Rx	11 percent
Administrative	10 percent
Hospital Outpatient	8 percent

MHP Utilization Data

	Admits/ 1,000	Days/ 1,000	ALOS
Acute Care	507	2,677	5.3
SNF/NH	196	4,536	23.2

The numbers I am sharing are from a small number of people, so the data may not be actuarially sound. I wanted some numbers to benchmark against so I called Stratis Health to obtain data for people age 65 and older living in Hennepin County; this is an entirely different group of people from MSHO. You can see that they have a population of 118,206 with total admissions of 22,796.

Utilization Data for Medicare Beneficiaries in Hennepin County

	Admits/ 1,000	Days/ 1,000	ALOS
Acute Care	193	977	5.06

Source: Stratis Health, July 1998. Total Population 118,206.

Challenges

Besides our cost challenges, I see three major challenges.

1. **Provider Involvement.** We have a handful of committed doctors, but I wish we had more. We are going to work with our doctors to find ways to get them more involved.
2. **Community Members Participation** These members are not signing up in the same numbers as nursing home members.
3. **Communication.** As patients move across the continuum, we have to pass the information along at each juncture.

Successes

Our successes are the human stories, the fact that we have advocates there for these people, someone they can call who will accompany them across the continuum. We are proud of the patient-case manager collaboration across the care process.

Jane Pederson

All of the enrollees in the Optage care system are in MSHO. We have approximately 1,100 nursing home enrollees and approximately 200 community-dwelling enrollees. Our physician network consists of 250 physicians in the nursing home network and 500 physicians in the community program. We have institutional care managers who are RNs with experience in long-term care and a special interest in geriatrics. We also have community care managers, some of whom are RNs, some of whom are medical social workers, both with an expertise in care management and in geriatrics.

Cost Issues

I want to give the caveat that we have had some large numbers and some changes in our enrollment over the past year, but these numbers will give you an idea where we are.

Optage Utilization Data (1/98-12/98)

	Admits/ 1,000	Days/ 1,000	ALOS
Acute Care	437	2,490	5.02
SNF/NH	321	3,729	21.0

Challenges

We have a list of challenges, but we don't see these as negative—they are obstacles to overcome.

1. **Physician buy-in and participation**. It is difficult to fit the program into the systems and processes with which physicians work, and there are turf issues to negotiate.
2. **Success does not occur in a reliable fashion**. Case managers are not routinely consulted or included in physician decisionmaking.
3. **Our MSHO population is small and broad**. It is difficult to do focused disease-specific management and to assess outcomes.
4. **Financial incentives are not adequate to change physician practice**.

Successes

This is not an exhaustive list, but it illustrates outcomes unique to the program. In the nursing home, we

1. Learned some new roles for the case manager, such as risk screening.
2. Provided resources to staff and coordinated a wound management process through consultants.
3. Supported services coming into the facilities.
4. Improved communication with families.

In the community, we

1. Provided earlier screening to determine need for services.
2. Provided information to the physician regarding what is happening in the home.
3. Intervened to direct care to the least costly place of service.

Sharon Marx

I want to begin with an overview of our service delivery model and case management model for our MSHO population. For our institutionalized elderly, we were able to use the model that had been in our system for 10 years. We have between 1,600 and 1,700 members in Evercare, and almost all of those are institutionalized. About half are in MSHO. Physician-nurse practitioner (NP) teams provide primary care, and the NP acts as the primary case manager. Unique features of EverCare include comprehensive assessment on admission, onsite illness care, intensive service day reimbursement to nursing facilities, advance care planning, and regular communication with the family. Our community-dwelling elderly receive their primary care in the clinics, with a central office-based RN serving as the case manager. Our community-based enrollment is 12.

Cost Issues

I'd like to share with you a little bit about our utilization data.

EverCare Utilization Data, 1998 (779 MSHO Members)

	Admits/ 1,000	Days/ 1,000	ALOS
Acute Care	220	932	4.2
SNF/NH	257	4,110	16.0

EverCare Utilization Data , 1998 (879 Medicare-only Members)

	Admits/ 1,000	Days/ 1,000	ALOS
Acute Care	222	896	4.0
SNF/NH	259	4,011	15.5

Challenges

The challenges we have faced have been almost exclusively associated with trying to develop this community-based model.

1. **Achieving collaborative, functional relationships** between case managers and physician/clinic staff for community-based elders
2. **Getting good clinical information** on community-based elderly
3. **Determining the optimal skill set** for case managers working with community elderly
4. **Identifying and more aggressively managing potential problems**
5. **Optimizing the primary care provider network for the community elderly**

Successes

1. **The EverCare Nursing Home Model was readily adaptable** to the MSHO nursing facility population.
2. **"Repersonalization" of healthcare**. Our clients can turn to the NP and case manager for assistance in navigating healthcare.
3. **Case reports**. The individual stories are our successes.

Panel Discussion

The Future Role of Integrated Delivery Systems in Serving Older Adults

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

Nellie Johnson
CEO
Optage
St. Paul, Minnesota

Ghita Worcester
Vice President of Public Affairs & Development
UCare Minnesota
St. Paul, Minnesota

Richard Bringewatt

Healthcare systems are under major pressures right now—this has accelerated even over the last six months. What are healthcare organizations to do in the face of these strong pressures to cuts costs and do more with less? There are certain factors that remain constant which we would do well to recall.

- First, problems of chronic disease and disability will not go away—people with chronic conditions are currently the biggest population group we see in our healthcare organizations. This population segment will continue to be our biggest challenge for many years to come.
- Second, there has been growing recognition by states, the federal government, and providers and plans that the dually eligible population requires a great deal of service given their health and socioeconomic status. We know that a large subset of people who are dually eligible for Medicare and Medicaid have one or more chronic condition.
- Third, we know the nature of chronic diseases and disabilities hasn't changed; therefore, the needs should be well known to us. We should already have some idea of how to address these needs.
- Fourth, though we have seen many healthcare organizations going about consolidating their assets through mergers and affiliations, we know that this is not true integration. Integration, as a service delivery method and as an approach to care, has not been widely tested in mainstream healthcare. Integration is about bringing together the set of people (healthcare professionals, social service staff) who serve the same client, either concurrently or at different points in time, in different service sectors.

I like to compare the situation in healthcare to a sailboat that must sail against the wind. What are the techniques to remember when trying to move forward against a strong wind? In sailing, you need to have points that you can sail toward, going back and forth diagonally, but making headway. You need to know where you ultimately want to land. You need to be aware of factors that will require you to make adjustments, but this does not change your ultimate destination.

In healthcare, we need to look at the outcomes we want. The right outcome measures will help us keep a focus on the right things (our ultimate destination). We also need to look at the top issues—the key problems our community and our patients are facing. This will help us to pick our battles appropriately—we will identify those things that are truly worth fighting for. We also need to look at the relationships between organizations. We must think about true partnerships that get us where we're going. These do not have to be formal mergers—think more in term of virtual integration, with a commitment to common objectives and goals.

Nellie Johnson

Let's look at some of the factors influencing the healthcare industry today.

- Consumers are more demanding.
- Any "cost savings" have been squeezed from the system already—current decisions to cut costs are much more difficult because we're cutting programs that have value to patients/clients.
- In Minnesota there is the inherent unfairness in current Medicare payments to healthcare providers and plans—reform is needed.
- The uncertainty about changes in healthcare rules and in the healthcare industry in general makes it very hard to do solid strategic planning. One is lucky to be able to plan six months in advance, never mind five or 10 years.
- The increase in federal and state mandates and in regulations affecting how we provide service place a burden on providers and plans.

There are significant challenges to improving care delivery through integrated systems. First, physician incentives are often not aligned with those of other provider segments or with health plans. In some clinics or groups, the patient's method of insurance may be hidden from the individual physician in order to ensure equality in treatment. Second, healthcare insurance is viewed as conferring entitlement to medical care—patients believe they have a right to any type of care that has been developed, even if the efficacy is questionable. We need to think in terms of medical care for what purpose, for what end? Third, there is the issue of competency and availability of staff—we know that nursing homes, for example, have increasing difficulty filling positions. The lack of consistent staff impedes the implementation of clinical protocols.

Another barrier is the federal regulations around Medicare that issue denial notices and termination notices to beneficiaries and that restrict transfers to sites of care within the same system. These are designed to ensure "due process" and open access, but they are confusing or alarming to seniors. There is also the issue of physician practice patterns and training. Most physicians are not trained to work in a managed care environment. Finally, there is the issue of lack of affordable housing with supportive services for seniors. The Twin Cities has a real shortage of low-income senior housing.

What are some catalysts for improvement?

- The demographics will continue to push providers and payers to focus on the needs of seniors.
- Cost pressures will force decisionmaking, and eventually we will have to do a better job of prioritizing.
- Consumers want change, they are becoming more informed, and they are demanding more of us. Those who respond first will reap the benefits.
- Finally, the attempts at true disease management, with a holistic approach to care needs and good data tracking on outcomes, are yielding positive results that others can learn from.

In terms of predicting a future scenario for healthcare in the Twin Cities, I see a more limited set of provider networks and consolidation of providers.

Ghita Worcester

In 1992, UCare began working on MSHO with Wilder and HealthEast. Over a three-year period, we developed our concept of a care system and established how we would serve members as a partnership. As a small health plan we had to be flexible in our models of care. We hoped to include smaller physician groups as well as the larger care delivery systems that have formed. Our core philosophy with MSHO was that we didn't want people to have to change their primary care provider if they joined MSHO. Therefore, we did not do marketing in those clinics where they did not have the staff to support the case management services that MSHO requires. Only about one-third of our clinics in the metropolitan area participate.

Currently, we have 530 members in MSHO. Our attrition rate is 1.9 percent; many of the people who sign up for MSHO are the frailest of the frail seniors. Unlike some of the other plans, our MSHO members are approximately 50 percent community dwelling and 50 percent nursing home residents. In fact a few more reside in the community than live in the nursing home. We determined early on that we would work with the counties to provide elderly waiver services. Every county has its own way of providing elderly waiver services. That has been both a struggle and a benefit—they are much more integrated now with the primary care physician than they were when MSHO started. It is also important to note that there are quite a few rural counties who would like to participate in MSHO; where there are smaller numbers of people it is hard to figure out how to do that.

We think that MSHO has been challenging and fulfilling for us.

Speaker Information

Richard Bringewatt
President and CEO
National Chronic Care Consortium
Bloomington, Minnesota
Richard J. Bringewatt is President and CEO of the National Chronic Care Consortium (NCCC), a national nonprofit alliance of the nation's leading healthcare providers collaborating to develop practical, innovative methods for integrating care. Mr. Bringewatt developed the "chronic care network" strategy that is central to the NCCC's work and assumed the lead role in developing the NCCC. During his 26-year career, Mr. Bringewatt has worked extensively with the spectrum of acute and long-term care providers, think-tank organizations, and foundations, as well as with the nation's leading healthcare provider and professional associations on issues of integration, managed care, and chronic disease management. He has also provided leadership in health systems policy development at the county, state, and federal levels, including Congressional testimony and service on policy commissions. He has consulted with many of the nation's leading reform demonstrations in chronic care, including the Social HMOs, On Lok and PACE replication, HCFA's Medicare Alzheimer's Disease Demonstration, and various other public and foundation-supported programs. A chronic care expert, he speaks and writes extensively on integrating the care continuum.

Sharon Christenson, R.N.
Exceptional Needs Care Coordinator
Oregon Health Plan, Kaiser Permanente
Portland, Oregon
Sharon Christenson works as an Exceptional Needs Care Coordinator and Referral Nurse for Home Health/Hospice Agency for Kaiser Permanente. Prior to that, she worked as a case manager, community health nurse, assistant nurse manager, and clinical consultant. She received her B.S.N. from Linfield College in Oregon.

Susan Crutchfield, M.D.
Medical Director
Metropolitan Health Plan
Minneapolis, Minnesota
Dr. Crutchfield joined Metropolitan Health Plan as associate medical director and director of medical administration in 1997. A family practice physician, Crutchfield is board certified and has practiced in the Twin Cities for more than 25 years. She is currently a member of the Family Practice department of Hennepin Faculty Associates and serves as a 10-year member of the board of Southside Community Clinic. She was vice president of medical services at Prudential Insurance Company for 12 years prior to joining MHP. She has served on the boards of the American Heart Association and the University of Minnesota Alumni Association and as Board Chairman of Minneapolis Children's Medical Center. She is a native of Minnesota and graduated from the University of Minnesota Medical School.

Maria Gomez
Assistant Commissioner, Aging and Adult Services
State of Minnesota Department of Human Services
St. Paul, Minnesota
As assistant commissioner for the Minnesota Department of Human Services, Maria 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 baby boom generation; community support services; continuing care for the elderly; and MSHO. 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.

Mary Gruenewald, R.N. (retired)
Member, Executive Committee for Senior Caucus
Group Health Cooperative of Puget Sound
Seattle, Washington
Mary Gruenewald serves as a member of the Executive Committee of the Senior Caucus, a special-interest consumer group of Group Health Cooperative of Puget Sound. In addition she is a member of Northgate/Northwest Senior Caucus chapter, Northgate Medical Center Council, Wellness Circle (a consumer group), the Group Health/Kaiser Community Foundation Endowment campaign Committee, and the Chair of the North Region Senior Caucus chapter. Prior to retirement, Gruenewald served as a Training and Development Specialist, the Manager of the Emergency Department of Central Hospital, an Assistant Night Supervisor, and a staff nurse.

Nellie Johnson
CEO
Optage
St. Paul, Minnesota
Nellie Johnson is CEO of Optage. Prior to that she served as senior vice president of operations for Walker Methodist Inc., where she managed nursing homes and retirement communities. In addition, she served as Minnesota State Budget Director for six years, specializing in healthcare financing. Johnson received a bachelor's degree in social work from the University of Minnesota-Duluth and an M.S.W. from the University of Wisconsin-Madison.

Deborah Klein, Pharm D.
Clinical Pharmacist
Allina Health System
Minneapolis, Minnesota
Deborah Klein serves as a clinical pharmacist for Allina Health System. Klein received her Bachelor of Science in Pharmacy from South Dakota State University, her Doctor of Pharmacy from North Dakota State University, and her ASHP Accredited Pharmacy Practice Residency at Mayo Medical Center in Rochester, Minnesota. Klein has given numerous presentations and is a member of the Heart-Lung Design Team and Code 99. She is also involved in the American Society of Health-System Pharmacists and the Minnesota Society of Health-System Pharmacists.

Foung Lo, M.D.
Resident
Department of Family Practice, Regions Hospital
St. Paul, Minnesota
Born in Laos, Dr. Lo completed his undergraduate training at Bethel College and attended the University of Minnesota Medical School. He is currently working on his residency in Family Practice at Regions Hospital in St. Paul.

Sia Lo
Attorney at Law
Bannigan & Kelly, P.A.
St. Paul, Minnesota
Mr. Lo works as an attorney in St. Paul

Sharon Marx, M.D.
Medical Director
EverCare
St. Paul, Minnesota
Sharon Marx is an internist/geriatrician who has spent the last 10 years working on case management strategies for providing health and human services to the elderly. Her background experience includes clinical geriatrics (primary care and consultation), medical direction of senior health services for a large clinic and a Medicare HMO, consultation to the Department of Health regarding issues in long-term care facilities, and nursing facility medical direction.

Mike Moua
President
Moua International Communications
St. Paul, Minnesota
Mr. Moua is a communications consultant in St. Paul, Minnesota

Pamela Parker
Director, Minnesota Senior Health Options
State of Minnesota Department of Human Services
St. Paul, Minnesota
Pamela 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 elders. From 1987 to 1992, 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 has a Masters of Public Administration degree from Harvard's Kennedy School of Government and was a 1982 Bush Foundation Leadership Fellowship recipient.

Jane Pederson, M.D., M.S.
Medical Director
Optage
St. Paul, Minnesota
Jane Pederson is a Medical Director for Optage in St. Paul.

Patricia Riley
Vice President of Government Programs
Medica Health Plans
Minnetonka, Minnesota
Patricia Riley is vice president of government programs for Medica Health Plans, a part of Allina Health System. She is responsible for all of Medica's government programs and products and serves as part of Medica Health Plans' senior management. Prior to joining Allina, Riley served as director of Medicare Programs for United HealthCare Corporation and for Aetna Health Plans. She also worked with several nonprofit, aging-related organizations and helped develop the Prepaid Medical Assistance Programs in Minnesota. Riley serves on the Medicare and Medicaid advisory panels for the American Association of Health Plans and on the Minnesota Council of Health Plans Government Programs Committee. She is a member of the Minnesota Gerontological Society and the Gerontological Society of America. She has served on the board of directors for the Humphrey Institute of Public Affairs, the University of Minnesota Center for Biomedical Ethics, Children's Theatre, and Northland College. She received a bachelor's degree in intercultural communications and a master's degree in gerontology and public policy from the University of Minnesota.

Bruce Scott, M.S.
Vice President, Pharmacy Operations
Allina Health System
St. Paul, Minnesota
Bruce Scott is Vice President of Pharmacy Operations for Allina Metro Hospitals. He obtained his B.S. degree from the University of Wisconsin and his M.S. degree from the University of Kansas where he also completed his residency. Scott serves on the board of directors of the American Society of Health-System Pharmacists (ASHP), is recognized as a Fellow in the ASHP, and has served as president of the Minnesota Society of Hospital Pharmacists. He has a special interest in issues regarding the integration of pharmacy practice into healthcare delivery systems and has served on several national committees addressing pharmacy practice and educational issues.

John Wisniewski, M.D., M.H.S.A.
Director, Managed Care College
Henry Ford Health System
Detroit, Michigan
John J. Wisniewski, M.D., M.H.S.A. is the founder and Director of the Managed Care College at the Henry Ford Health System in Detroit, Michigan. He is also the Director of Continuing Medical Education and Associate Medical Director for Managed Care Services within the Henry Ford Medical Group. He is a practicing general internist with over 17 years of experience in managed healthcare and healthcare administration. Dr. Wisniewski earned his doctorate at Wayne State University in Detroit, Michigan and his Master of Health Services Administration degree at the University of Michigan in Ann Arbor.

Ghita Worcester
Vice President of Public Affairs & Development
UCare Minnesota
St. Paul, Minnesota
Ghita Worcester is Vice President of Public Affairs and Development for UCare Minnesota, a state-licensed HMO serving 60,000 members. She directs the administration of new product development and policy design specific to state and federal changes in healthcare delivery, marketing, and provider network expansion and has been instrumental in the development and implementation of the HMO strategic and operational plans.

Ms. Worcester oversees the departments of Government Programs and Legislative Affairs, Business Development, Provider Relations, and Public and Preventive Health. She is responsible for compliance with regulatory agencies and contract vendors related to areas of contracts, procedures, and protocols. Ms. Worcester has more than 25 years experience in healthcare management and possesses a broad business perspective with expertise in programs for low-income and high-need populations, including the Prepaid Medical Assistance Program (PMAP). Her background encompasses clinic management, management information systems, preventive health program coordination and product management.

Minnesota Senior Health Options

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

The Robert Wood Johnson Foundation (RWJ), 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 NCCC, a strategic alliance of leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

Building Partnerships for Integration of Acute and Long-Term Care Services proceedings were written by Laura Cashore, Deborah Paone, John Selstad, Barbara Vaughan, and Joyce Anne Wainio.

Copyright © 1999 by the National Chronic Care Consortium.
All rights reserved.

National Chronic Care Consortium
National Resource Center on Chronic Care Integration
8100 26th Avenue South, Suite 120
Bloomington, MN 55425
Office: (612) 858-8999   Fax: (612) 858-8982
www.nccconline.org