
Minnesota Senior Health Options
Clinical Integration and
Care Management Forum

First in a Series

**Setting the Stage:
Integrating Care Management**

**March 3, 1997
7:30 – 9:00 a.m.**

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

Welcome and Introductions

Pam Parker, Director of the Minnesota Senior Health Options (MSHO) Project, welcomed all attendees to the program, which is the first in series for MSHO participants to address clinical integration and care management issues. These meetings are a forum for exploring care delivery and coordination issues to improve care management across settings under the MSHO model.

Ms. Parker emphasized that the Minnesota Department of Human Services (DHS) and the National Chronic Care Consortium (NCCC) look to the care systems and health plans participating in the MSHO Project to provide direction for the identification of topics and issues that are explored in future forums. These meetings are intended to be a helpful resource and forum for MSHO Project participants to explore care delivery and coordination issues for the purpose of improving care management across settings under the MSHO model.

The National Chronic Care Consortium (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 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 introduced Deborah Paone. Deborah Paone, M.H.A., is the Vice President of Member Services at the NCCC, where she provides leadership in developing practice-based resources on system integration and on improving delivery of care to people with chronic conditions.

Ms. Paone briefly described the fundamentals for integrating care for people with serious chronic conditions, the fastest-growing, highest-cost, most-complex segment of the population. Integration requires a new infrastructure for chronic care management, including integrated care management, integrated financing, integrated information technology, and integrated network management.

Videotape: A Case Study of Mrs. Dorothy Peterson

As a springboard for discussion on the need for better-integrated care, the program featured this twelve-minute videotape which traces 72-year-old Mrs. Peterson's transitions from home to hospital emergency room to medical/surgical stay to rehab, home health, and nursing home—and illustrates the fragmentation between settings in the current healthcare system.

Framework for Integrating Clinical Care/Care Management Across Settings

Robert Meiches, M.D., Vice President for Medical Affairs, Long-Term and Chronic Care, from Fairview Hospital and Healthcare Services, provided a framework for integrating care management across the continuum with the following characteristics:

- attention to outcomes,
- involvement of a full array of services and settings,
- emphasis on ongoing disability prevention,
- a person-centered care focus,
- use of an interdisciplinary approach, and
- the identification and targeting of clients at high risk.

Interactive Audience Discussion

With the input of panelists Susan Mottaz, Nurse Care Manager/Coordinator, HealthEast Clinics, and Margaret Vogel, RN, MSN, GNP, Director of Gerontological Nurse Practitioner Services, Fairview Clinic, Dr. Meiches facilitated an interactive audience discussion of the care management issues raised by the videotape. The following points were made:

- The importance of prevention (e.g., education on the side effects of medication) and of regular primary care—not just symptom-driven; opportunity for larger role for RN in primary care.
- Healthcare professionals give the procedures and processes (e.g., redundant assessments) more time and emphasis than the patient needs; patients' functional/emotional needs (e.g., loss and sadness) are not addressed.
- There is little to no communication with the family except in crisis; unrealistic assumption by care providers about time and ability of family to assume post-acute caregiving responsibilities.
- An important ingredient to care continuity is missing: a care provider (e.g., case manager) who has a relationship with the chronically ill patient across care settings; advocacy needed for patient.
- An integrated information system is needed; information moves more slowly than the patient across the care settings; portability of advanced directives needed.
- The importance of starting self-management before the chronically ill patient leaves the hospital or nursing home.
- There is a lack of integration within the hospital and between the hospital and other care settings, which reflects turf and trust issues; care providers in the different settings rarely have a chance to actually work together.
- The system is complex and potentially error-prone, so there is some protection in redundancies, especially in a litigious society. Also, regulations may require care providers to ask certain key questions, even when the information is present.

The discussion turned to the question of “who is accountable” for fixing the care system so that it meets the needs of the chronically ill and their families, and “what needs to be done.” Every practitioner and setting plays a part and needs to be accountable. The group clearly felt that integrated information systems will enable care providers to efficiently share important patient data across the continuum and eliminate some of the fragmentation, redundancies, and their associated costs. In a perfect world, case management might not be needed. However, recognizing that these systems will take time and a large investment to develop, case management may be viewed as an important interim method to assure continuity. Case management needs to stretch across settings and systems, and needs to be available around the clock to be truly effective. While case management may play an important role in a fragmented system, all care providers have the choice to take individual responsibility to do what they can to better meet patient needs and to identify needed system changes. Some believe that it is not cost-effective nor desired practice to assign a case manager to every older adult — this also needs to be discussed in future meetings.

In response to a request by Dr. Meiches for possible topics for future forums, the following ideas were proposed:

- **Case management** — different models, definitions, roles, utility, benefits, limitations.
- **Information systems** — ideal attributes, common data set, state-of-the-art, how IS disconnects can be tackled with interim steps, confidentiality issues, addressing different cultures within systems/settings and how this translates to IS.
- **Empowering clients and families** — enhancing communication and education across settings, responding to multiple cultures, ethnicities.
- **Creating teams across the continuum** — teaming in different settings along the continuum and within the hospital, role of social work, role of others, building trust.
- **Barriers** — identifying and recognizing genuine barriers to integration (e.g., regulatory requirements).
- **Lessons learned** from other countries (e.g., personal health data card - France).

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 will facilitate 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 32 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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