
Minnesota Senior Health Options

**Provider Survey Report:
2000 Survey of
MSHO Care Coordinators,
Nurse Practitioners, and
Physicians**

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About This Report

The Minnesota Department of Human Services contracted with the National Chronic Care Consortium to conduct three surveys of three different types of direct care providers that serve Minnesota Senior Health Options (MSHO) beneficiaries. The surveys—of care coordinators, nurse practitioners, and physicians—were intended to provide insight into the impact and effectiveness of the MSHO demonstration from the perspective of a sample set of direct care providers.

The three surveys were conducted from mid-August through mid-November 2000. Results were tabulated in November and December. The NCCC has written this report that describes results from the three separate surveys.

MSHO Demonstration Background

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 the Prepaid Medical Assistance Program, or PMAP. The PMAP program began in 1985. Medicaid costs in Minnesota are 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.

Description of MSHO

In 1997 the Minnesota Department of Human Services (DHS) implemented a five-year demonstration called Minnesota Senior Health Options (MSHO) that combines Medicare and Medicaid financing and brings together primary care, acute care, long-term care, and community-based services. The demonstration serves people over age 65 who are dually eligible for both Medicare and Medicaid. These seniors may reside in either the community or a nursing facility in the seven-county metropolitan area in and around Minneapolis and St. Paul.

The goals of the MSHO demonstration are to:

- Align fiscal incentives to support sound clinical practice
- Provide a seamless point of access for both acute and long-term care benefits for the older consumer
- Move toward a single point of accountability for care for this population
- Reduce cost shifting between Medicare and Medicaid

DHS obtained federal waivers that allow the state to choose contractors capable of providing a full range of integrated medical and social services on a capitated risk basis. The State manages a combined Medicare and Medicaid contract with health plans that, in turn, subcontract with providers to offer this complete set of services. This includes services traditionally covered under PMAP, as well as Medicare deductibles and coinsurance, medical supplies and equipment, dental care, therapies, prescription drugs, medical transportation, and home care services. It also covers services included under Part A and Part B of Medicare, such as hospitalization and physician office visits. In addition, health plans are able to provide extended home care services to frail elderly people who are at risk for nursing home care (called "Elderly Waiver" services). MSHO requires the health plan to be responsible for the first 180 days of care in a nursing facility for those who enroll in MSHO while residing in the community but end up requiring nursing facility care.

MSHO is offered as a voluntary option to the standard PMAP plan, in which most Medicaid-eligible seniors, including those dually eligible, are required to enroll. A single enrollment process is used for both Medicare and Medicaid, with MSHO enrollment being processed at the state level. Plans may market to their current enrollees and participate in the enrollment process for current members. Enrollees may disenroll on a monthly basis, but will stay in the same plan's PMAP program if they do so, until the next PMAP open enrollment period.

Health plans participating in MSHO have been encouraged to develop new partnerships with primary, acute, and long-term care providers and with county public health departments in order to better serve seniors. One expectation for MSHO is that it would encourage a more integrated service delivery system. A unique feature of MSHO is the care coordination that is expected to occur across settings.

Health Plans and Care Systems

Two health plans began MSHO enrollment in March of 1997—a third plan began participating in MSHO in September of that year. The three health plans and corresponding care systems (provider networks) participating in MSHO differ from each other in organizational structure and approach. They also differ by financial arrangements with their subcontracted care systems. All three health plans have had previous experience in the Medicaid managed care program (PMAP), although two plans had no previous experience with Medicare. The third health plan had previously offered a dually eligible product in the Twin Cities for clients in a nursing home setting who chose to enroll in the plan's Medicare risk product.

The networks of all three health plans overlap to some extent; that is, the same provider could be in all three health plans' care systems. Care system networks also differ in many ways, for example, by number and location of hospitals, clinics, and nursing homes and by care coordination models. For example, some care coordination models rely heavily on geriatric nurse practitioners (G.N.P.s) who work extensively in the nursing home setting, while others use social workers or R.N.s who primarily work in clinic and community settings. The care coordination models and the use of care coordinators differ from health plan to health plan and from care system to care system. The MSHO demonstration did not dictate one model or method for these functions. This allows maximum provider flexibility. It also creates variability that can sometimes lead to confusion or duplication of effort. This issue is alluded to in some of the comments provided by survey respondents.

The three health plans participating in MSHO serve both community enrollees and MSHO enrollees residing in a nursing facility; however, the proportion of enrollees living in nursing homes versus the community differs by plan.

MSHO enrollment began in March of 1997. Enrollment figures for October 2000 were 3,727. The total number of people served since the inception of the demonstration is 6,985. The difference between the total number served and current enrollment is due largely to the death rate, given the frailty of this population. Original projections for MSHO over the life of this demonstration (five years) put the total number of people to be served at 4,000—the demonstration met that goal in less than four years. About 75 percent of current enrollees reside in the nursing home, and about 25 percent live in the community.

MSHO Enrollment by Plan, October 2000

Health Plan A

2,340 enrollees

2,156 enrollees, or 92 percent nursing home residents

184 enrollees, or 8 percent community residents

Health Plan B

379 enrollees

173 enrollees, or 46 percent nursing home residents

206 enrollees, or 54 percent community residents

Health Plan C

1,008 enrollees

476 enrollees, or 47 percent nursing home residents

532 enrollees, or 53 percent community residents

Survey Background and Methodology

Background on Performance Measurement

The MSHO demonstration rests on the premise that elderly enrollees will benefit from greater care coordination efforts and a more integrated care management process across organizations. There is an implicit assumption that by integrating the comprehensive benefit package that extends from primary, preventive, and acute care into long-term and community-based care and that by aligning financial incentives through the payment system offered to the health plans, there will be an improvement in continuity of care. As noted, there is variability in care management methods, provider networks, use of county services, physician involvement, and other aspects of the program from one health plan to another. Therefore, some variability in experience from one care coordinator to another, one nurse practitioner to another, or one physician to another is expected. Nevertheless, it is important to document their experiences in a way that will lead to understanding of common issues or themes regarding MSHO.

Current performance measurement tools used in the healthcare field are not designed to measure the integration of care across settings. They do not directly examine communication or coordination of care across multiple provider settings, nor do they track longitudinal outcomes. Similarly, satisfaction surveys are usually focused on only one setting or patient experience at one point in time.

The MSHO demonstration has employed several methods for evaluating the progress toward more integrated systems of care and the effects of MSHO on the client, the provider networks, and the health plans. For example, the Consumer Assessment of Health Plans Survey (CAHPS) instrument was used to obtain information about MSHO clients' satisfaction with care. Also, DHS funded two focus groups—one examining changes in health plans' and care systems' practices due to MSHO and the other asking beneficiaries and families of beneficiaries about their experiences with MSHO. These focus groups provided rich qualitative information about changes in process and structure of care due to MSHO, as well as benefits perceived by clients themselves.

Purpose

As discussed, information from the MSHO beneficiaries themselves and from administrative personnel at both the health plans and care systems (provider networks) on the impact of MSHO had been collected through satisfaction surveys and focus groups. In the focus groups MSHO beneficiaries had identified the care coordination aspect of MSHO as central to the improvements in the care they received. For this reason and because information from the direct professional caregivers had not been collected in a formal way, the MSHO staff at DHS was interested in hearing directly from care coordinators, nurse practitioners, and physicians who see, serve, and treat MSHO beneficiaries directly. The perspectives of these key "players" are important in understanding whether and how the MSHO demonstration has had an impact in serving these beneficiaries.

Survey Design and Process

State of Minnesota MSHO staff requested that we survey three groups: care coordinators who have MSHO clients in their caseloads, nurse practitioners (NPs) who are serving MSHO clients, and physicians who had at least six MSHO beneficiaries in their practices. Three separate sets of questions were developed. The questions for the care coordinator and nurse practitioner surveys were similar, and the format for the survey was a mail-out questionnaire. The questions for the physicians were significantly different from the other two, and the format for the survey was to be a telephone interview. We asked the physicians fewer questions in order to encourage participation. After trying unsuccessfully to set up interviews by telephone with the physicians, we redesigned the physician survey as a mail-out survey.

A set of potential questions was developed by research staff at the National Chronic Care Consortium (NCCC) in June 2000 for each of the three surveys. These questions were reviewed and modified by staff at the Minnesota Department of Human Services. The modified set of questions was then presented to health plan representatives at a meeting in mid-July, and comments or suggested changes were recommended by early August. The three sets of questions (in the form of a draft questionnaire for the nurse practitioners and care coordinators and in the form of an interview protocol for the physicians), were provided to a group of thirteen physicians for their comment. These physicians are the medical directors for the three MSHO health plans and primary participating care systems.

The survey questionnaires and interview protocol were finalized in mid-August, and questionnaires were mailed out with a return requested by mid-September. A stamped, addressed envelope was provided with the nurse practitioner and care coordinator survey questionnaires. Samples of the care coordinator and nurse practitioner surveys and request letters are provided in the Appendix of this report.

For the physician survey, a cover letter describing the survey was included with the survey instrument and was mailed out in August. The physicians were informed that the NCCC was compiling the information and that the research associate from the NCCC would be conducting the telephone interviews. One week later NCCC administrative support personnel began contacting each physician's office to set up the telephone interviews sometime over the next month (that is, by the end of September). It proved difficult to get through the physicians' schedulers in order to set up these interviews. Most schedulers stated that the physicians were not interested in participating. After these attempts were made, NCCC research staff worked with DHS to redesign the survey as a one-page mailout. In addition, the medical directors of all three participating health plans were asked to co-sign the cover letter describing the survey and its purpose, and they did so willingly.

This second mailout to the physicians was conducted in early October, with a request for response by early November. A stamped, addressed envelope was provided with the survey questionnaire. A sample physician survey and request letter are provided in the Appendix.

Participant Selection and Response

Care coordinators working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses for 25 care coordinators were collected. These 25 care coordinators received mailed surveys; 15 responded initially. Telephone calls to the nonresponders generated another 6 returned surveys. In all, 21 of the care coordinators responded for a response rate of 84 percent. Out of these 21 responses, 4 of the care coordinators had just started their jobs and had only one client and therefore did not complete the survey. Another coordinator had just changed jobs and declined to answer the questions. Ultimately, there were 16 completed questionnaires to review. The final response rate was 16 out of 25 coordinators, or 64 percent.

Nurse practitioners working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses for 34 NPs were collected. These 34 NPs received mailed surveys; 17 responded initially. Telephone calls to the nonresponders generated another 7 returned surveys. In all, 24 of the NPs responded for a response rate of 71 percent. Out of these 24 responses, 4 of the NPs had just started their jobs and could complete only a small portion of the survey. Ultimately, there were 20 completed questionnaires to review. The final response rate was 20 out of 34 NPs, or 59 percent.

Physicians working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses were collected for 26 physicians who had at least six patients—several of them had over 100 MSHO beneficiaries in their practices (mostly nursing home residents). These 26 physicians received the mailed survey; 5 responded initially. Telephone calls to the nonresponders generated another 6 returned surveys. In all, 11 out of 26 physicians responded for a response rate of 42 percent.

Survey Summary and Highlights

Care Coordinators

Overall, the care coordinators' responses to this survey were very positive about MSHO. A sizeable majority of the care coordinators reported that there are real advantages with MSHO over other existing structures for healthcare delivery and payment for their dually eligible clients. Strength areas included greater flexibility in service benefits and in how these care coordinators provided care management services, better communication with other providers, and fewer administrative barriers to service. Areas of difficulty included the need for greater awareness of and support about MSHO in the marketplace—particularly among the county representatives who often have the role of describing this program to seniors and helping them enroll. There was strong interest in having MSHO continue and in increasing the number of MSHO-only or MSHO-predominate clinics or other settings, since it was believed that through higher MSHO client penetration in a given clinic and greater MSHO visibility overall, greater practice change would occur.

Nurse Practitioners

Overall, the NPs responding to this survey were largely positive about MSHO. Most said that MSHO had provided several advantages, particularly around access to benefits and streamlining billing and administration. The MSHO demonstration had not noticeably changed the interaction with physicians or the level of personal involvement these NPs had with their clients or patients. The nurse practitioners indicated that this was positive, since the level of interaction was already high. Nearly all of the MSHO beneficiaries served by these NPs were living in a nursing home—and many of these nursing homes were already part of clinical models that were in place prior to MSHO (for example, the EverCare and Fairview Partners models, which rely heavily on proactive clinical management by an NP). As a positive comment, many of these NPs—those practicing the EverCare model of clinical management—stated that the MSHO demonstration has allowed flexibility in benefits but has not altered their clinical care practices for their patients. This also was seen as a positive, since the NPs view the EverCare model as an effective method of providing care to nursing home residents. MSHO provides the integrated funding that allows these clinical models to continue and grow.

Physicians

The sample size of respondents from the physician group is small; less than half of the targeted physicians responded to the survey. Therefore, it is not possible to make conclusions about the general physician sentiment regarding MSHO, even among this group of physicians who have a higher number of MSHO beneficiaries than many other participating physicians.

Based on these 11 physicians' responses, however, feelings are either neutral or slightly positive, with one or two physicians feeling very positive about the impact of MSHO. The physicians' written comments reveal that, where they have had a chance to work with MSHO NPs and coordinators, they see them as a valuable asset. Unfortunately, many of these physicians have not worked with the NPs or coordinators. In addition, many physicians did not seem to have much information about MSHO or their MSHO patients as a group—in fact 6 out of the 11 responding physicians are not even aware when they are treating an MSHO patient. Some physicians expressed pride in the fact that they do not know when they are treating an MSHO patient: "Irregardless of insurance, we treat all our patients the same." This would, understandably, make it difficult to evaluate any impact of the demonstration. The relatively small percentage of MSHO patients in these physicians' practices also appears to serve as a barrier to more profound delivery system change or program evaluation.

Survey Highlights

Area of Inquiry	Care Coordinators n=16	Nurse Practitioners n=20	Physicians n=11
Client profile	Split fairly evenly between clients in nursing homes and in community.	Almost all (19 out of 20) had exclusively nursing home residents.	Question not asked.
Client learns about role of care coordinator or nurse practitioner	Through initial marketing/ enrollment process or through personal visit or call by coordinator.	Through initial marketing/ enrollment process or through nursing home staff or personal visit at nursing home.	Question not asked.
Interaction with other providers	Most (88%) have direct interaction with clients' other medical providers, and most said MSHO facilitated this interaction.	All have direct interaction with clients' physicians. Most (14 out of 18) said that MSHO has not affected this interaction. (Note: Many EverCare or Fairview Partners NPs work under a previously established model of team care.)	6 physicians said they had worked with NPs or care coordinators; 4 said they had not.
Transitions in care	All care coordinators who work with clients in the community said transitions were better with MSHO; care coordinators who work with nursing home residents were also largely positive about MSHO's effects on care transitions.	7 NPs said MSHO had positively affected transitions; 6 said there was no effect, and 7 other NPs did not know of any effect on transitions in care due to MSHO.	Though they were not asked directly about transitions, physicians were asked about follow-up in care. Almost half (5) said they were seeing improved follow-up and monitoring under MSHO for their patients. Another 5 said they did not know if the follow-up was better.
Changes as a result of MSHO	11 out of 16 (69%) of the care coordinators said that MSHO has allowed them to do things differently.	15 out of 19 of the NPs (79% of responders) said that MSHO has allowed them to do things differently.	Question not asked.

Survey Highlights

Area of Inquiry	Care Coordinators n=16	Nurse Practitioners n=20	Physicians n=11
Simplification by MSHO	11 (69%) of the care coordinators said that MSHO has made things simpler for them compared to previous work with similar clients.	8 out of 19 NPs responding (42%) said that MSHO has made things simpler for them.	3 physicians said MSHO provided simplified access to acute and long-term care benefits; another 3 said MSHO did this “somewhat.”
Advantages of MSHO	13 (81%) of the care coordinators said there are advantages from MSHO that were not there before.	14 (70%) of the NPs said there were advantages from MSHO.	About half (5) of the physicians said there were advantages from MSHO.
Disadvantages of MSHO	5 (31%) of the care coordinators said that some things were harder for them because of MSHO, though some of the comments were related to aspects of the health plans or counties, not issues that MSHO could influence or impact.	3 (15%) of the NPs said that some things were harder for them because of MSHO, primarily regarding paperwork or eligibility issues.	Only 2 physicians said that there were disadvantages—although their comments referred to the need for greater volume (more patients) in the program in order to make a bigger impact.
Administrative hassles	12 (75%) of the care coordinators said that MSHO had reduced administrative hassles for them, especially in obtaining approval for services.	10 (50%) of the NPs said that MSHO had reduced administrative hassles for them.	2 physicians said that MSHO had reduced administrative conflicts; another 5 did not know, and 3 said that MSHO had not reduced hassles.
Flexibility of benefits	13 (81%) of the care coordinators said that there was greater flexibility of benefits under MSHO.	16 (80%) of the NPs said that there was greater flexibility of benefits under MSHO.	3 physicians said that MSHO provided simplified access to acute and long-term care benefits.
Measuring outcomes	Care coordinators and NPs suggested that outcomes such as hospitalizations, emergency room visits, nursing home admissions and physician office visits be tracked in order to measure the results of MSHO. They also suggested moving away from only looking at healthcare utilization as a measure of success and wanted to see more emphasis on evaluating the quality of the interventions provided, the disability prevention and wellness achieved, and the customer and family satisfaction. NPs were very interested in quality of life measures and provision of comfort care.		The 3 physicians who responded were interested in a variety of measures: healthcare utilization, quality of life, rate of fractures, patient / family satisfaction, and the management of patients across settings.

Survey Results

In this section we provide the responses to each survey question. The responses from the care coordinators appear first, followed by those from the nurse practitioners, and finally those from the physicians. Since the comments provided help to illustrate the responses and did not reveal confidential information, we have included a representative sample of the comments following each survey question.

The reader should be aware that, in several cases, the comments provided did not relate to requirements or aspects of the MSHO demonstration, but rather addressed issues arising from the structures, methods, or requirements of the health plans, counties, or care systems that are participating in MSHO. There seemed to be confusion or lack of awareness in some cases about what the MSHO demonstration put in place and what existed from the activities or policies of these other entities. (For more discussion, see the “Issues to Explore” section on page 33.)

Client Profiles

Care Coordinators

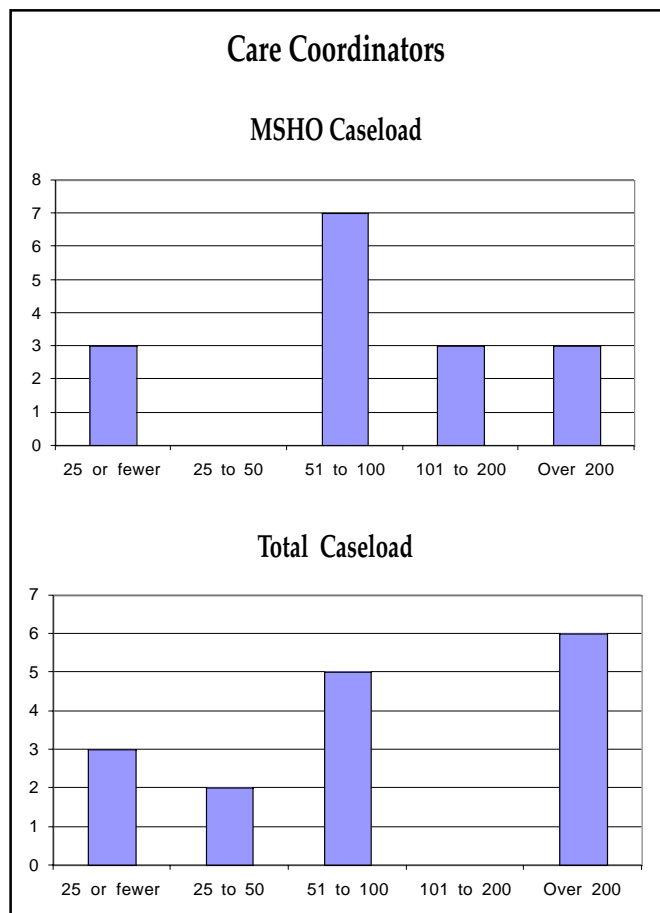
The care coordinators were first asked several questions about the MSHO clients in their caseloads. This group of care coordinators was divided almost evenly between those who had primarily nursing home residents in their MSHO caseload and those who had primarily community-dwelling seniors in their MSHO caseload. Six coordinators (38 percent) reported that 99 to 100 percent of their

MSHO caseload were people living in the nursing home, whereas another 8 coordinators (50 percent) said that 99 to 100 percent of their MSHO caseload were people living in the community. The other 2 coordinators’ clients were either split 50/50 or 60/40 between the community and the nursing home settings, respectively. Given this sharp division, we separated the responses into two groups—those who see primarily community-based clients and those who see primarily nursing home clients.

Three coordinators (19 percent) had 25 MSHO clients or fewer in their caseload—and these MSHO clients were their entire caseloads. Six coordinators had over 100 MSHO clients or more. The total caseload (includes MSHO and non-MSHO clients) of these care coordinators varied as well. Six coordinators had a total caseload of over 200 people. Caseloads of the coordinators with primarily nursing home clients tended to be higher than those of the coordinators with primarily community-based clients. In fact, 3 coordinators (19 percent) had over 450 people in their caseload.

Another set of questions asked the coordinators about the intensity of care coordination services their MSHO clients required and the types of services that the care coordinator typically provided.

Overall, few of the care coordinators’ clients required daily interaction. Three coordinators reported that most of their



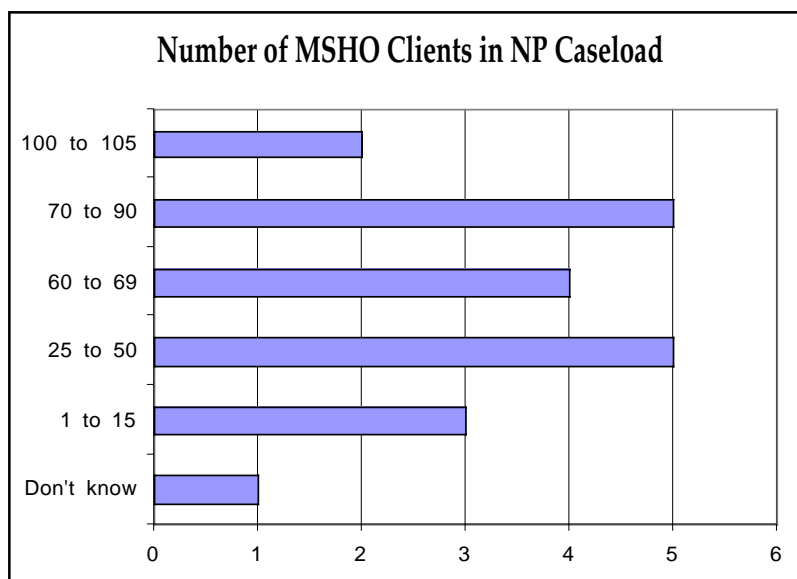
clients required at least weekly interaction. Monthly interaction was more common—some coordinators made sure that all their clients were seen at least once a month. Not surprisingly, those with the highest caseloads (for example, 300+) tended to see and interact with their MSHO clients less often—every three to six months or more.

Of the care coordinators with primarily nursing home clients, 1 was primarily occupied by making personal telephone contacts with his/her clients or client family members; 2 were primarily occupied by making phone calls to vendors or providers, and 2 spent most of their time making visits to their clients in the nursing home. Home visits and telephone calls to clients and their family members were the primary services provided to MSHO clients by the care coordinators of clients living in the community, and for the coordinators who had a split between nursing home and community-based clients.

Nurse Practitioners

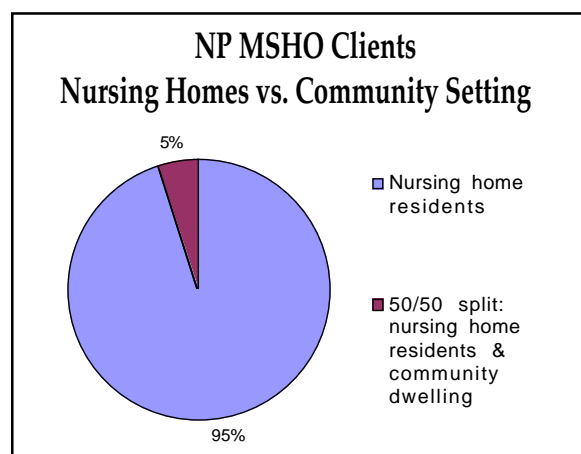
The nurse practitioners were first asked several questions about the MSHO clients in their caseload/practice. Three NPs had 15 or fewer MSHO patients; 2 NPs had 100–105 MSHO patients. One NP had “no idea” how many MSHO patients were in her/his caseload. The accompanying table provides a breakdown.

When examining the number of MSHO patients as a percentage of total caseloads, most NPs (15 out of 20, or 75 percent) had at least 50 percent of their total caseload or practice made up of MSHO patients. Total (all patients—MSHO and non-MSHO) caseloads tended to be fairly high, with 12 NPs having more than 100 patients in their total patient caseloads.



These nurse practitioners were asked what percentage of their MSHO enrollees/patients was living in a nursing home (versus a community setting/private home). Nineteen out of 20, or 95 percent, said that 99 to 100 percent of their MSHO patients were nursing home residents. One person said that she/he had a 50/50 split between MSHO patients in the community and MSHO patients in a nursing home.

Please note that many of the NPs responding to this survey were working within a model of care for serving elderly people in nursing homes that relies on greater NP involvement and authority on site in the nursing home, a team approach for support, intense care management, and active monitoring



of residents/patients. This model of care, known commonly as the “EverCare model,” has been adopted by a number of care systems/providers in the Twin Cities area. Therefore, the responses regarding differences in care management strategies as a result of MSHO may not be as dramatic as they might be in geographic areas where the EverCare model has not been so significantly incorporated into daily care practices. Comments relating to the EverCare model or Fairview Partners model (which is similar) appear in some of the NPs comments.

Identification of and Initial Contact with MSHO Clients

Care Coordinators

When asked how MSHO enrollees initially become aware of the role and services that care coordinators provide, most coordinators with community-dwelling MSHO clients said that enrollees learn about the service either through the initial marketing and enrollment done by the health plan, through an introductory letter, or through the initial home visit conducted by the coordinator. Coordinators with MSHO clients in nursing homes said that the beneficiary learns about coordinators' roles and services through the health plan enrollment process, an introductory letter, or through a personal telephone call made by the coordinator.

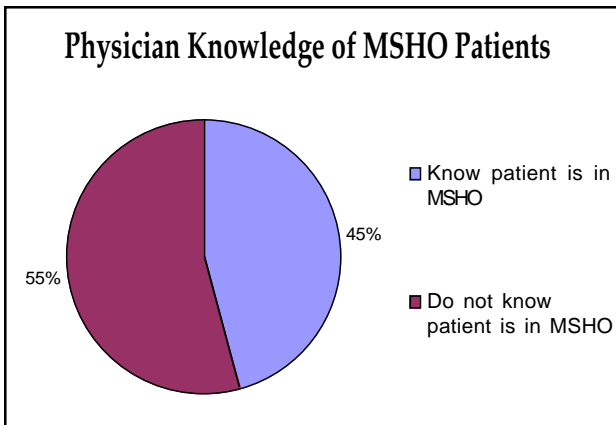
Nurse Practitioners

When NPs were asked how MSHO enrollees initially become aware of the role and services that they provide, many said that enrollees learn about the NP role through health plan marketing and enrollment or through the nursing home staff. NP comments include:

- *A marketing person makes them aware of their healthcare options. I discuss my role as an NP when I meet them.*
- *Through marketing/enrollment [at health plan].*
- *Through the initial contact with the customer service representative [of the health plan].*
- *During the initial visit. Family member and/or enrollees meet with account executive to discuss the program. Word of mouth from nursing home staff and/or other residents. Word of mouth from physician colleagues.*
- *Review role/services with enrollees and their families on my initial visit with the enrollee.*
- *Nursing Home employees, families, other residents.*
- *By physician groups offering the EverCare program to the resident.*
- *Social services, myself, nursing staff.*
- *Through nursing home social worker, our HMO enrollment people, word-of-mouth.*
- *Personal visit to them at the nursing home. Phone call to the families at same time.*
- *Families ask other families or facility staff. I presume there is some explanation by county workers. Then an enrollment specialist talks with enrollees and/or family. Then a letter is sent describing my role. Then I meet the member and talk with the family.*
- *Through the health plan, nursing home staff, social workers.*

Physicians

Physicians were asked if they know when they're treating an MSHO patient and, if so, how they know. Most (6 out of 11) physicians said they did not know when they were treating an MSHO patient. Three said they did, and 2 said sometimes he/she knows. Physician comments include:



- *Yes, office charts are color-coded to distinguish MSHO patients from others. Nursing facility charts are labeled. But evening and weekend telephone encounters do not allow identification of MSHO patients.*
- *Yes, patient is identified by insurance class on chart.*
- *Not a clue.*
- *Sometimes—if I have the nursing home face sheet available.*
- *In general, no. When a patient has special needs that in general are not covered under Medicare, I then look to see what kind of insurance they have and if they have something like MSHO, we can generally be more creative. For example, if a person needs a short-term stay in a nursing home under MSHO I can avoid a 72-hour hospitalization.*
- *Yes, by insurance information.*

Interaction with Other Providers

Care Coordinators

Most of the coordinators (14 out of 16, or 88 percent) said they had direct interaction with their MSHO clients' medical providers. When asked how MSHO has affected this interaction (for example, facilitated it or made it more complicated), most said that it facilitated the interaction, though it appears that it depends on the provider. Care coordinator comments include:

- *Yes, it has affected it a little, but not impacted physician practice that much to date.*
- *Facilitated the process of care planning/intervention.*
- *Varies by physician. Some it facilitates, some complicates, especially when they're unfamiliar with MSHO.*
- *Don't think it makes any difference.*
- *Simplified the process for all parties involved*
- *Easier—seems everyone knows MSHO and what that means from a provider point of view and case managers.*
- *Positively, able to carry through M.D.'s plans, follow up, assist with problem patients, have M.D. make better assessment due to problems with language barriers. I go make home visits and find out a lot more problems and communicate the needs to the M.D. just before the M.D. visit, so problems can be addressed.*

Nurse Practitioners

All of the NPs reported having some level of interaction with physicians on behalf of their MSHO patients. Thirteen of these NPs interacted with 5 or fewer physicians; 6 interacted with 6 to 10 physicians, and 1 person interacted with 11 or more physicians on behalf of their MSHO patients.

When asked how often they interacted with these physicians on behalf of their MSHO patients, 15 out of 20 (75 percent) said at least once a week, and 4 NPs said that they interact with most of these physicians at least every other week. One person said he/she interacts on a monthly basis with most of the physicians on behalf of her MSHO clients/patients.

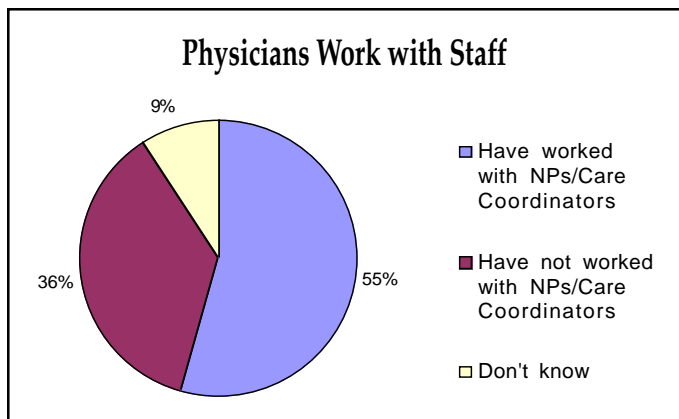
When asked further about how the MSHO demonstration has affected this interaction with the physicians (for example, has it facilitated working together or made it more complicated), most (14 out of 18 responding to this question) said that MSHO had not affected the interaction one way or the other. The other 4 NPs said that it had improved or facilitated the interaction. NP Comments include:

- *Facilitated working together, streamlined benefits, enabled us to work with M.D.s with geriatric experience.*
- *No impact*
- *I believe that it has facilitated a good basis for a collaborative practice.*
- *No negative effect.*
- *Has not had an impact—MSHO has not made it more complicated. I interact with the physicians when there is a need. It is not dependent on insurance coverage.*
- *Facilitated working together.*
- *I don't think MSHO specifically affects this.*
- *Hasn't altered my interaction with the physician.*
- *I treat all my patients the same, including the MSHO M.D. interaction.*
- *MSHO has not really affected the interaction. If anything, it has given more freedom when ordering items (benefit exceptions).*
- *No change.*
- *Has not had an impact either way.*
- *Has not affected interaction. Same interaction with other types of reimbursement.*

Physicians

The physicians were asked about their work with care coordinators or nurse practitioners in serving MSHO patients and, if they had worked with these personnel, had the experience been valuable for them.

Six physicians (over half of respondents) said that they had worked with these personnel, 4 said they had not. One person did not know if he/she had worked with these individuals or not. Physician comments include:



- *NPs have been valuable in providing more point-of-care service.*
- *There are resources for coverage issues, community services, social issues, transportation.*
- *Extremely valuable. The Access Alliance care coordinators are especially helpful. I work with G.N.P.s in all my nursing home care and they are invaluable in timely, cost-effective care.*
- *I believe many of our MSHO patients are in the nursing home. In the nursing home, all of our patients are followed with a team that includes a nurse practitioner and a physician.*

Care Transitions and Follow-Up

Care Coordinators

When asked how MSHO affects transitions in care (for example, discharge from the hospital, entry to the nursing home), the care coordinators working with clients who live in the community all indicated that transitions were better with MSHO. The care coordinators with primarily nursing home clients were also largely positive about the effect of MSHO on transitions—2 people talked about MSHO providing resources and guidelines; 1 person described her/his process of care management under MSHO, and 1 stated there was no difference in transitions compared to what happened prior to MSHO.

- *Streamlines, makes transitions more complete and effective.*
- *Continuity of care, smoother transitions.*
- *It is very smooth, no disruption of care.*
- *My care coordination model is proactive and I follow MSHO members throughout the healthcare delivery system. I serve as bridge for all the settings.*
- *MSHO appears to make the transitions easier, i.e. the care coordinator knows their [enrollees'] history and has worked closely with them.*
- *It offers a resource that is familiar with the member and is usually familiar with all aspects of care so it enhances discharge planning and entry into nursing home.*
- *No difference.*
- *Clear MSHO benefit guidelines eliminate confusion with coverage issues during the transition.*
- *Makes it easier for family. Gives them a point of education and comfort to ask questions and [get] help! Gives me a very good feeling. I am able to help and educate the families so they can make an informed choice.*

Nurse Practitioners

When asked if MSHO has affected transitions in care (for example, discharge from the hospital, entry to the nursing home), NPs were split in their opinions, as shown by their responses below. Seven NPs said MSHO has improved transitions; 6 said MSHO has not, and 7 didn't know.

Of the NPs reporting that MSHO had affected these transitions, comments seemed to indicate that MSHO had a positive or beneficial effect.

- *Able to offer intensive service days, help treat patients at nursing facility, board and care.*
- *To simplify transitions.*
- *I think it is a smoother transition from community to LTC [long-term care]—no interruption of services.*
- *Ability to return patients sooner from the hospital. Also do procedures in the SNF [skilled nursing facility] as hospital.*
- *Unaware of any changes.*
- *Patients allowed into SNF benefits without three-day hospitalization. Have been allowed “in lieu of service days” in the nursing home rather than hospitalization, allowing enrollees to remain in familiar environment (e.g., for IV therapy).*
- *Because of the ability to waive the three-day hospital stay to initiate a SNF benefit period, we are able to utilize transitional care to provide acute care to assisted living patients who don't require hospitalization.*
- *Able to waive three-day hospital stay for benefits. Smoother transition for member. Decreased paperwork for family/member.*
- *Smooth as previously with EverCare patients.*

Physicians

Physicians were not explicitly asked about transitions in care; however, they were asked about follow-up for their patients under MSHO. About half of the physicians (5) said that they were seeing improved follow-up and monitoring for their MSHO patients. Another 5 physicians said they did not know whether the follow-up and monitoring was better. One said no improvement had been seen.

- *Improved monitoring of health maintenance, polypharmacies, advanced directives, and ambulatory clinic visit necessity for nursing facility residents. Increased monitoring of inpatient utilization.*
- *The funds are now available for our care system to employ the care managers and have them work directly with the clinics.*
- *We are able to visit patients as needed and don't feel limited by more limited Medicare guidelines. Care coordinators contact us if other services can be useful or for change in condition.*
- *As I try to answer this question truthfully, I really can't think of anybody that I consider an “MSHO patient.” The type of insurance that patients have is not something that I generally give a lot of consideration. I also think we have very few MSHO clients. The majority of them are in the nursing home and again I rarely pay much attention to what type of insurance they have.*

Changes Resulting from MSHO

Care Coordinators

Eleven out of 16 care coordinators (69 percent) said that MSHO has allowed them to do things differently as they provide case management/care coordination services to their clients. Care coordinator comments include:

- *More creative options.*
- *Flexibility in providing services, equipment without delays.*
- *I can take care of everything, not just home care, MDCR [Medicare], and services in a piecemeal manner as it usually is.*
- *Monitor more closely use of services.*
- *Gave me autonomy to follow from setting to setting. Flexibility with reimbursement allows meeting needs holistically.*
- *We can stay involved with the member across the continuum of care.*
- *It allows personal communication and one person who can have some knowledge of the member across the spectrum of care. Better continuity of care.*
- *More involvement in care coordination.*
- *You can pretty much set up any type of service.*
- *Yes, step up services, processes, etc.*
- *I can provide the services that make sense for each individual, rather than following a set of rules determined for the aggregate.*
- *The numbers must show it! People are staying home, healthier. Hopefully understanding themselves better, better educated.*

One person voiced concern about his/her organization's support of MSHO:

- *I do not have the full support of my current organization to easily do things differently. Without administrative vision and goals, it is too difficult to apply much more than EW [Elderly Waiver] services.*

Nurse Practitioners

Nurse practitioners were asked if MSHO has allowed them to do things differently for their patients. Fifteen out of 19 NPs (79 percent) responding to this question said that the MSHO demonstration has allowed them to do things differently in providing clinical care to their patients. NP comments include:

- *Streamline care, provide additional benefits, increase continuity.*
- *I think it is more efficient at times especially with some specialty services.*
- *Alternative Rx.*
- *It puts all patients on an equal playing field with smoother transition to preventative maintenance care and specialty services as needed.*
- *Provide more care in SNF.*
- *The ability to waive the three-day hospital stay to initiate a SNF benefit period.*
- *Providing items needed that are otherwise not covered.*
- *Has allowed me to provide more extensive service to my one patient in assisted living in order to keep her in the community rather than nursing home, i.e. day care program.*
- *Be more comprehensive and proactive in providing care.*
- *Patients may be allowed services not traditionally covered, e.g. acupuncture.*
- *One payer system. Can do ISD [integrated service delivery] program— not able to do so previously. Smoother coordination of benefits. Greater ability to be more creative, i.e. use of homeopathic/ alternative modalities that Medicare won't cover but MSHO program does—have had some good resident outcomes (pain relief).*
- *The ability to offer the resident intensive service days when ill instead of hospitalization. Some routine services are more fully covered using both.*

-
- *I believe my clinical care is consistent no matter the funding source.*
 - *Provide more counseling. Manage more illnesses in the facility than hospital since med visits are reimbursed.*
 - *Able to provide more services.*
 - *Under Fairview Partners, we can provide benefit exceptions, waive the 3-day hospital stay before allowing SNF days, use in lieu of payments to incent more care in the NH, use combined dollars to pay for items like transfusions not usually covered in the NH.*

Physicians

Physicians were not asked explicitly about changes due to MSHO but were asked whether the MSHO demonstration provided simplified access to both acute and long-term care benefits and about reimbursement issues under MSHO. With regard to simplified access to services, 3 physicians said MSHO simplifies access; 3 said it “somewhat” simplifies access; 3 said MSHO does not simplify access, and 2 did not know.

- *Again, I've had very few MSHO clients. However, there was at least one case where we avoided acute care hospitalization and managed to get a person into a long-term care facility for care and rehab.*

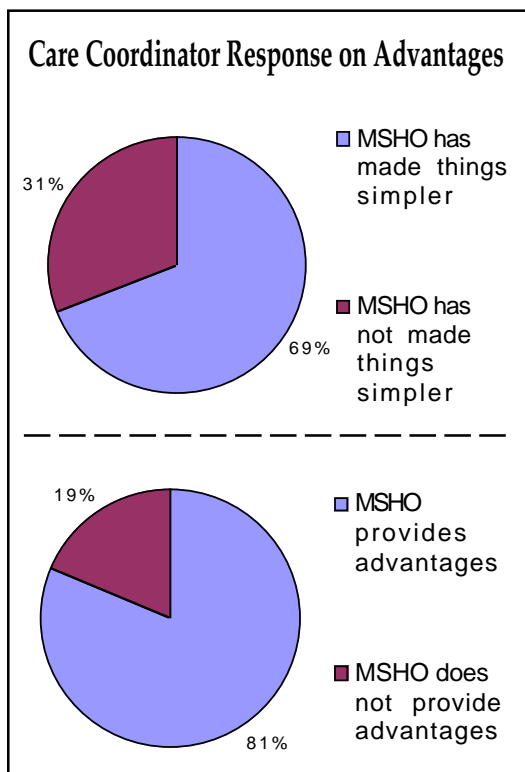
The next question asked whether MSHO had simplified how services were reimbursed—compared to prior experience when, at times, physician-ordering decisions had been complicated by gaps or conflicts in coverage between Medicare and Medicaid. Three physicians said MSHO had simplified reimbursement; 4 said MSHO “somewhat” simplified reimbursement; 1 said MSHO did not simplify reimbursement, and 3 did not know.

- *Again, my experience is limited to a very few patients, but in those patients things were somewhat simpler.*

Advantages of MSHO

Care Coordinators

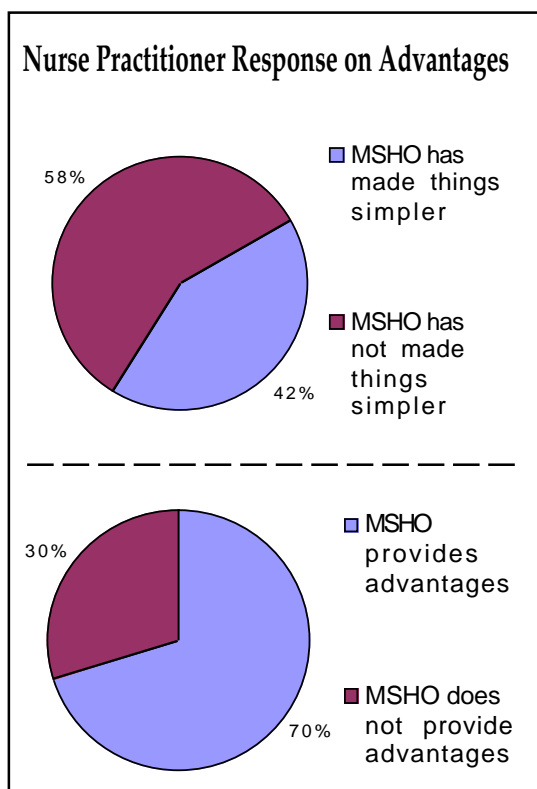
Eleven out of 16 (69 percent) of the care coordinators said that MSHO has made things simpler for them—compared to their previous work with senior clients. Thirteen out of 16 (81 percent) said that there are advantages that were not there before. Comments about what was simpler and the advantages include:



- *Easier to obtain services.*
- *I have better knowledge of the health plans and what's covered; better able to provider a wider range of services.*
- *Only have to deal with one pay source.*
- *The MSHO funding has made service delivery easier (the flexibility).*
- *By following member and their condition monthly, it enhances decisions regarding therapies, DME [durable medical equipment], etc.*
- *Increased communication between the payer and the providers.*
- *Case management built into the system is helpful, one payer, more flexibility in some instances with benefits.*
- *Advantages include continuity of care on continuum as well as preventing fragmentation/lack of service with waivers.*
- *More options as to services that can be provided. Able to get services in place more quickly.*
- *Flexibility, ability to follow them across all settings, increase continuity.*
- *They can be screened and started on EW [elderly waiver] services immediately vs. county waiting lists. They receive very little paperwork.*
- *No bills for clients, health plan care managers who know billing and can assist client as needed. More flexible than county regarding visits.*

Nurse Practitioners

Eight out of 19 of the nurse practitioners (42 percent) said that MSHO has made things simpler for them—compared to their previous work with senior clients. On another question, 14 out of 20 NPs responding (70 percent) said that there are advantages in MSHO that were not there before. Relevant comments are provided here:



- *Able to consolidate care/services, more efficient use of resources/benefits.*
- *Coordination of benefits.*
- *Have only worked with a majority of MSHO patients since starting as a nurse practitioner. Some services are covered that weren't by other insurance coverage.*
- *Nice to have all benefits together. Do not have to write orders just to qualify a resident for Part A benefits.*
- *Less paperwork with referrals.*
- *Decreased paperwork. Better coordination of benefits with less hassle for families/me.*
- *Access to ancillary services. Communication with families.*
- *Same payment system.*

Are there advantages that weren't there before? Explain.

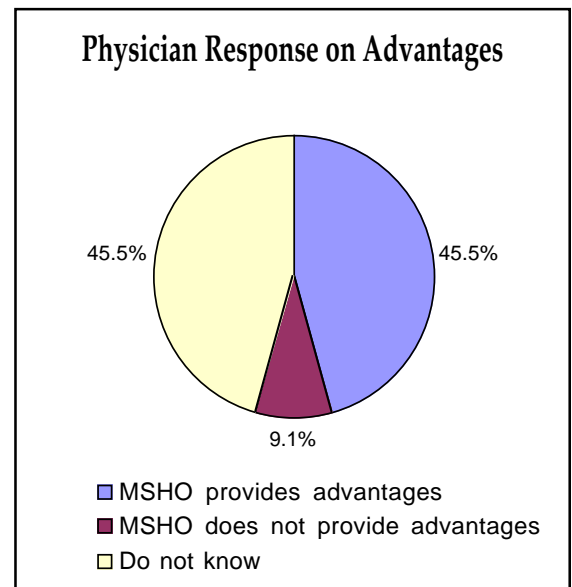
- *More creative use of alternative Rx, acupuncture, chiropractor. Like having one referral source, more efficient from administrative standpoint.*
- *There are benefits to have one system managing both the Medicare and Medicaid benefits.*

- *Single billing.*
- *Especially for the patients who now have only Medicare as a primary insurance and are frantically trying to find coverage.*
- *Intensive service (“in lieu of”) days.*
- *Broader range of benefits.*
- *The ability to offer the resident intensive service days when ill instead of hospitalization. Some routine services are more fully covered using both.*
- *There are some benefits for patients, i.e., services available that private [pay patients] do not receive such as blood transfusions in NH [nursing home]; private need to go to hospital for this service.*
- *Services can be provided more easily. Only bill once for services—simplifies billing, able to provide more services.*
- *Benefit exceptions.*
- *Access to ancillary services. Communication with families.*
- *Coverage is more complete. Services such as family/staff conferences seem easier to bill for.*

Physicians

Physicians were also asked whether MSHO offered advantages that were not there before. About half (5) of the physicians said there were advantages; 5 did not know, and 1 said there were not.

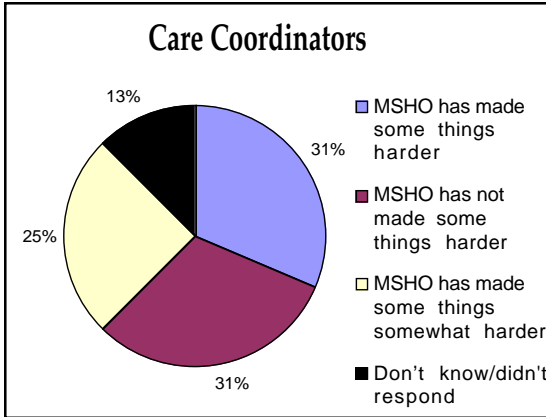
- *While there may be fewer forms for families and other responsible parties, these advantages have not been visible to primary care providers of nursing facility residents.*
- *Closer watch on patients.*
- *Yes, improved flexibility regarding use of nurse practitioners to proactively provide care onsite and prevent hospitalization.*
- *As a managed care product, MSHO does allow us to extend coverage when we see the benefit. For example, Medicare will no longer pay for routine blood draws of a homebound individual for monitoring of Coumadin treatment. Under MSHO, if we believe this to be essential to care, we can cover a home care nurse to go out and draw blood to monitor the INR. If the issue is something like a wheelchair ramp, under MSHO we can choose to spend the funds for something like that, which might improve the quality of life of a patient. Under Medicare, we would never be allowed to do that. Thus, there are some clear advantages to MSHO.*
- *Able to allow better coordination of care.*



Disadvantages of MSHO

Care Coordinators

Five out of 16 coordinators (31 percent) said some things are harder for them because of MSHO—primarily related to more paperwork for them and the need for constant education given the newness of the program. Two coordinators (13 percent) said that there are disadvantages to MSHO. Comments about what is harder and the disadvantages due to MSHO include:



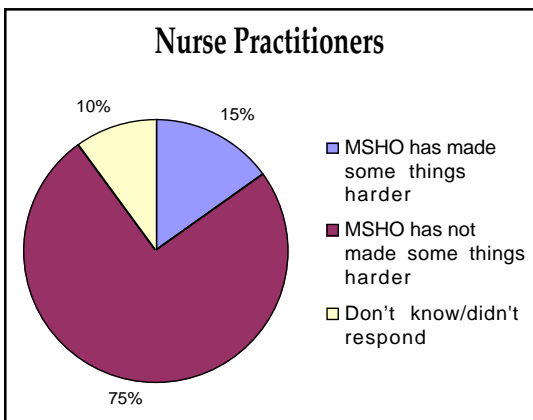
- Paperwork.
- The concept.
- Because MSHO is new and innovative, it requires that I am constantly educating and clarifying what it is and MSHO care systems role.
- They may have to give up relationships with M.D.s/county nurses, etc. when changing to MSHO. They must call for referrals.

Some comments on disadvantages related to issues or policies arising at the county, care system, or health plan levels follow:

- Some of the counties are not accepting of MSHO.
- Interfacing with county case managers in co-case management—duplication, time in scheduling, splitting care plan and client's perspective.
- Large case load, not as much interaction and in-depth case management as I would like.
- Visits to each SNF monthly is something I did not do before.
- Explaining the differences between care systems—all are MSHO, but each operates very differently.
- If they have a provider who does not understand MSHO, they may receive some resistance initially for fear of claims denial.

Nurse Practitioners

Three out of 20 NPs (15 percent) said some things are harder for them because of MSHO—primarily regarding medication coverage and eligibility / paperwork issues for Medicaid that also affect MSHO eligibility status. Fifteen NPs said things are not harder. On a related question, none of the NPs said that there were disadvantages to MSHO. Comments include:



- Occasionally patients or families will not complete paperwork for Medicaid and then there is a short lapse with MSHO.
- I think it's rather smooth. No, I can't think of anything that is a disadvantage over traditional Medicare/Medicaid assistance.
- It is harder when the resident has both Medicare and Medicaid and does not have MSHO.
- Much more time consuming to get benefits approved.

Some NP comments dealt with issues that were not from MSHO but arose at the county, health plan, or provider level, particularly concerning medications:

- The hardest thing for me is the county to county difference in the medication coverage.
- The medication formulary is more stringent than with those patients who pay for own meds or partially pay.
- Some medications are not available that are available to private pay.
- Formularies different for each health plan.
- To select MSHO, patients have to elect a particular care system—being limited to a certain provider group might be seen as a disadvantage.

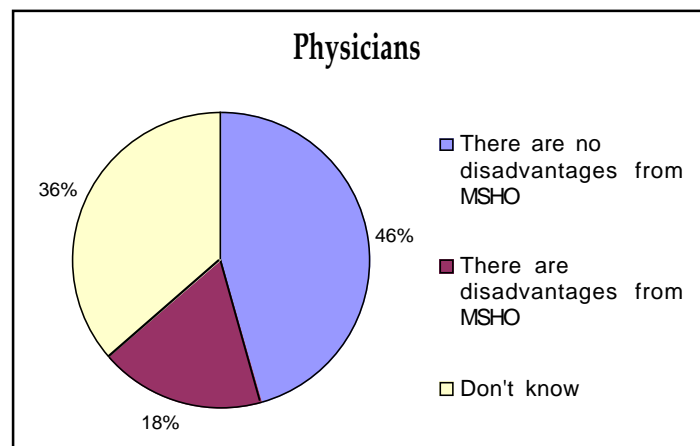
Physicians

Physicians were asked whether there are disadvantages from MSHO. About half (5) said there are no disadvantages; 2 physicians said there are disadvantages, and 4 did not know.

- *From a care provision perspective, there appear to be no disadvantages.*
- *There are many needy seniors who don't qualify for MSHO. It is difficult to deal with two sets of rules about what we can cover for these patient populations.*
- *None that I am aware of.*
- *One of the main problems is that we have very few MSHO clients. Thus, there is little impetus for change in the system of care.*

One of the physicians' comments referred to issues that were not part of MSHO but may be occurring in the setting where they practice.

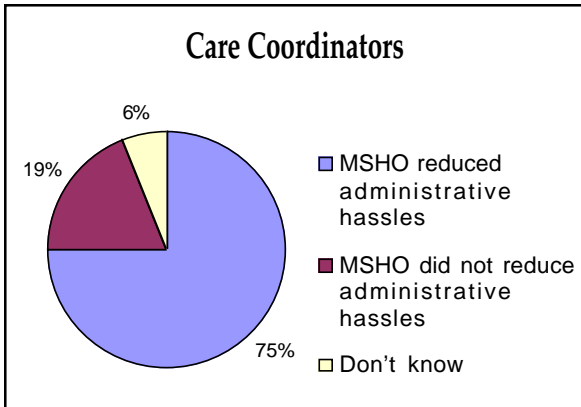
- *Over-testing and treatment.*



Administrative Requirements

Care Coordinators

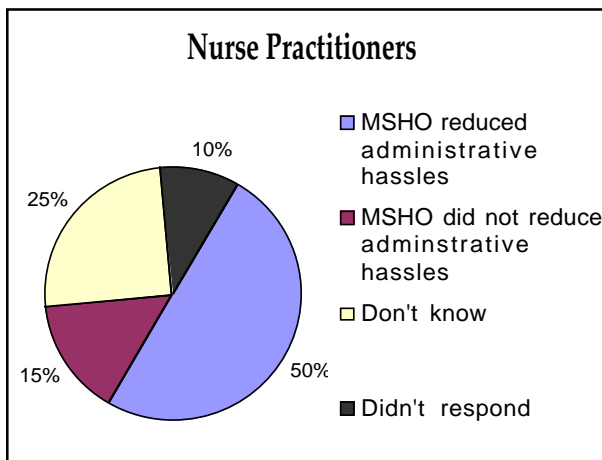
Twelve out of 16 (75 percent) of the care coordinators said that MSHO has reduced the administrative hassles they face in obtaining approval for services. Three coordinators said it has not reduced hassles, and 1 coordinator did not know. Comments include:



- *Under our care system, we have instituted an understood referral system. In theory, this reduces "administrative hassles."*
- *CM [case manager] is person authorizing most of services.*
- *I don't need to go to another source for authorization. However, there are still hoops to jump through within care systems.*
- *I do the authorizing for most services.*
- *I represent the payer and have control of authorizations.*
- *Yes, have been able to put in many community-based services.*
- *We have the authority to make decisions.*
- *Easier to make decisions when I know about the member.*
- *Because of MSHO, they are able to enroll with EverCare. Obtaining approval is streamlined and effective. We don't have to make multiple phone calls.*
- *Our care system is non-gate keeper. We do not require referrals/prior authorizations. This allows the M.D./NP to use professional judgement.*
- *I just talk with my peers and have case review. Then do it!*

Nurse Practitioners

Ten of the nurse practitioners said that MSHO has reduced the administrative hassles they face in obtaining approval for services; 3 said it has not reduced hassles, and 5 (25 percent) didn't know. Two people did not respond. Comments include:

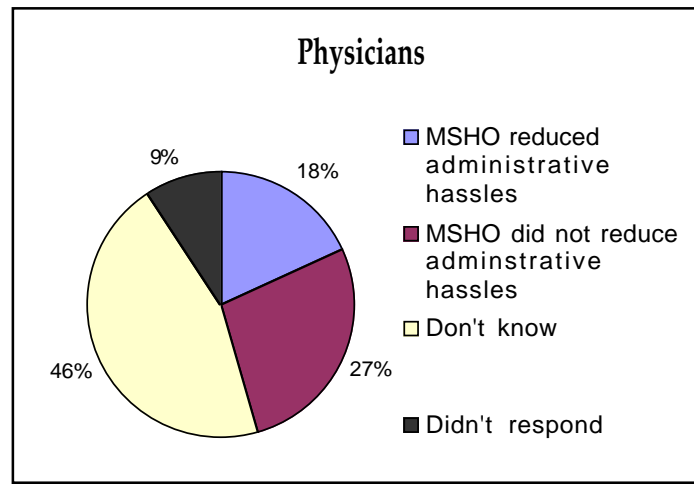


- *Streamlined care/benefits.*
- *Less paperwork.*
- *Decreased paperwork. Better coordination of benefits with less hassle for families/me.*
- *EverCare handled previously.*
- *The office staff handle all paperwork and referrals.*
- *Occasionally patients or families will not complete paperwork for Medicaid, and then there is a short lapse with MSHO.*
- *Less people involved in the administration of benefits.*
- *Health services coordinator is who may be most involved. I request services and she determines from that point.*
- *Single billing system.*
- *Makes it easier for families, nursing home staff. Don't need to request authorizations from multiple places.*
- *Because I am an HMO provider, the red tape is already reduced.*
- *The paperwork for Part A benefit is less.*
- *No hassles with referrals.*
- *Service substitution is easier. Dealing with various health plans (UCare, Medica) increases administrative work.*
- *It has reduced these for people who do the billing.*
- *Somewhat less "justifying" of needed services.*

Physicians

Physicians were asked whether MSHO has reduced administrative requirements and conflicts between the Medicare and Medicaid programs. About half of the physicians (5) did not know—they indicated that others deal with these types of administrative issues. Two physicians said that MSHO has reduced conflicts; another 3 said it has not, and 1 did not respond.

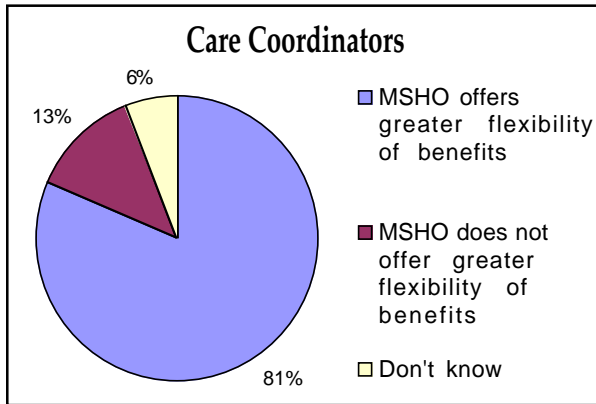
- *Since the care manager handles this, I can't really comment.*
- *I'm not sure quite how to answer this question. As a physician, I generally don't deal with these "administrative requirements and conflicts between the Medicare and Medicaid programs."*



Flexibility of Benefits

Care Coordinators

Thirteen out of 16 (81 percent) said there was greater flexibility of benefits under MSHO, allowing for service substitution of “nontraditional” services to their clients. Comments include:



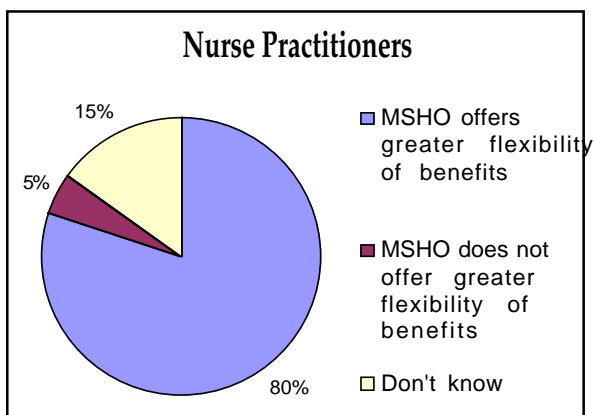
- *I think there is a myth or misinterpretation of MSHO where people claim you can get more benefits, but I think under MSHO there is less regulatory restriction to pull from another pot of benefits to pay for a covered benefit.*
- *We are able to provide ACG type services as well to NHC [nursing home certifiable] clients, rather than just EW. And we are not limited—care systems can choose to pay for additional items.*
- *Apply AC [alternative care] benefits to EW clients. Can put EW services in place for non-NH certifiable members who remain in community as non-NH-certifiable.*
- *Yes, but “services” is still vague. Would like more definitions, i.e., can alternative meds be used, shaman ceremony, reimburse for herbal remedies?*
- *The ability of MSHO to waive 3-day stays for medical skilled days and waive medical bed if care can be safely provided.*

- *Again, it's what makes sense. If light therapy works better than an expensive antidepressant, we can do that.*
- *Easier to do benefit exception.*
- *Yes, for example, I put a “door” on a chain link fence to stop an Alzheimer’s client from wandering at night. Great solution to an at-risk client.*
- *Clients are able to enroll in programs such as EverCare, FV partners, etc.*

One person discussed his/her opinion on how home health care services are provided in the system:

- *Home health is extremely limited with narrow focus primarily on tasks.*

Nurse Practitioners



Most (80 percent) of the nurse practitioners said there was greater flexibility of benefits under MSHO, allowing for service substitution of “nontraditional” services to their clients. Comments include:

- *Intensive service days, equipment, special services, i.e. acupuncture, manage prior to procedures.*
- *Dental, eye care—good!!*
- *Provide more counseling. Manage more illnesses in the facility than hospital since med visits are reimbursed.*
- *Can provide services in SNF that Medicare does not cover in SNF, i.e., transfusions, ET [enterostomal therapy] nurse visits. Better coverage on nonmedical care items and services.*
- *Patients may be allowed services not traditionally covered, e.g. acupuncture.*
- *It seems the same for me, but I haven't needed “nontraditional” services.*
- *Medications, special beds, w/c's [wheelchairs], etc.*
- *Use of acupuncture for chronic low back pain—very effective for residents. Regular Medicare wouldn't cover, MSHO does.*
- *Under Fairview Partners, we can provide benefit exceptions, waive the 3-day hospital stay before allowing SNF days, use in lieu of payments to incent more care in the NH, use combined dollars to pay for items like transfusions not usually covered in the NH.*

Physicians

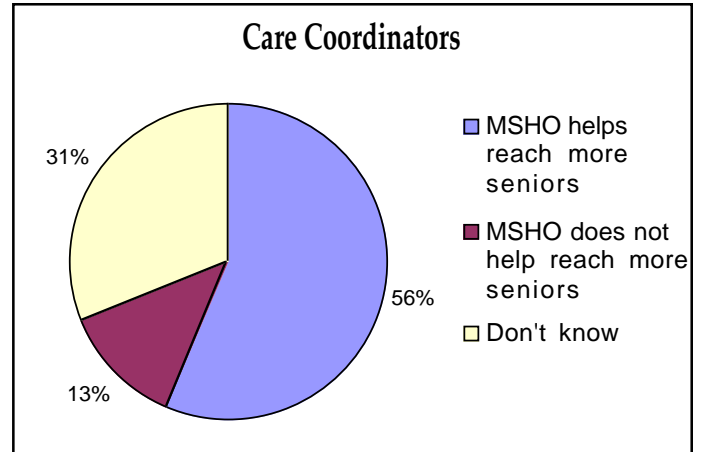
Physicians were not asked about flexibility of benefits.

Reaching Seniors

Care Coordinators

Seven out of 16 of the care coordinators said that, under MSHO, they were able to reach seniors and provide case management to those whom they do not usually reach; 2 coordinators said they were able to reach seniors better to some extent (somewhat). Five said they did not know or could not say whether this was better under MSHO, and 2 said that was not the case. Comments include:

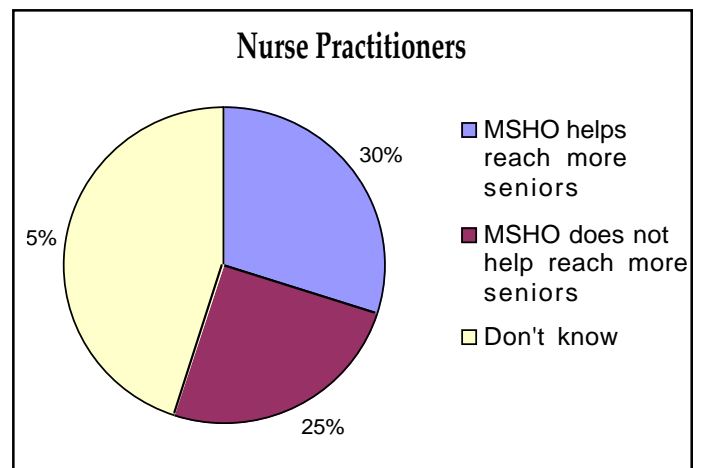
- *This is the area I'm most interested in and the best thing to come out of community MSHO. With clients who recognize the value, much can be done to prevent decline in health.*
- *I find many seniors on my initial visit that need services and don't have a clue about what's available and how to access it.*
- *Members are fairly easy to access.*
- *Time and energy is spent on seeking out MSHO members. Not the same effort is applied to PMAP non-MSHO seniors.*
- *For the population that I work with, going into the home makes a big difference. Face-to-face contact is so important.*



Nurse Practitioners

A handful (5 out of 20, or 25 percent) of the NPs said that, under MSHO, they were able to reach seniors whom they do not usually reach; 1 said he/she was able to reach seniors better to some extent (somewhat). Nine NPs said they did not know or could not say whether this was better under MSHO, and 5 NPs (25 percent) said there was no difference in reaching seniors. Comments include:

- *I think these patients/families are looking for care delivery systems which use NPs.*
- *Often. I will pick up new patients who are just now qualifying for Medical Assistance/MSHO and they and their families choose to work with NP/M.D. teams.*
- *Community-dwelling elders.*
- *With health plans changing, can keep members that otherwise would have had to leave us (i.e., Medica changes recently).*
- *Sicker patients can be managed at nursing facility.*



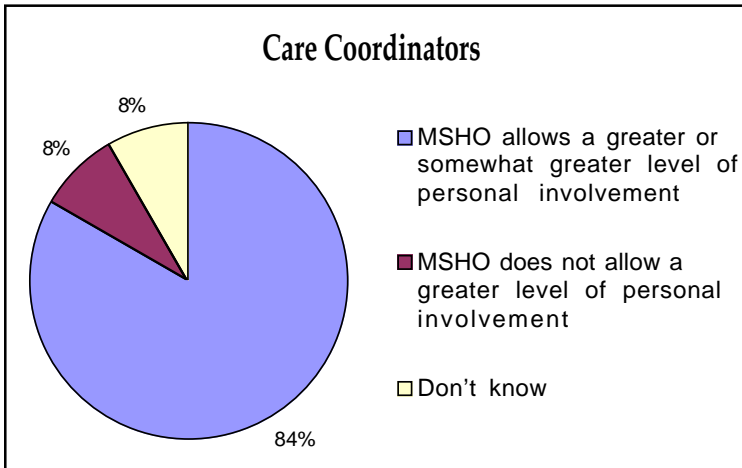
Physicians

Physicians were not asked about their ability to reach seniors under MSHO.

Personal Involvement

Care Coordinators

Ten out of 16 of the care coordinators said that they were able to have a greater level of personal involvement with their clients and family members in the MSHO demonstration; another 4 felt this was somewhat the case.



- *The long-term nature of MSHO case management allows you to establish a relationship and maintain it, gaining trust and providing education to clients and families.*
- *The program creates the effort to seek out needs assessment. With non-MSHO we wait until an issue comes to us.*
- *Yes, being assigned specifically to one member allows a relationship to develop. Family and member have a key person to be point of contact. MSHO has facilitated communication and trust. Allows for care coordinator to be their advocate.*
- *Because we stay involved with them in various settings, we get to know the member and family quite well. One member said, "You are all I have. I have no family."*
- *Personal visits to nursing homes each month.*
- *Family members more likely to call with questions or concerns.*

- *Family and the client rely on case manager to answer questions/arrange services.*
- *Because care and service approval is streamlined, we contact families frequently to discuss benefit structure, coverage rationale, etc.*
- *I spend a great deal of time getting to know seniors and families, attending care conferences.*
- *I talk with family members more! I do a lot of unrequired home visits to get to know the client.*

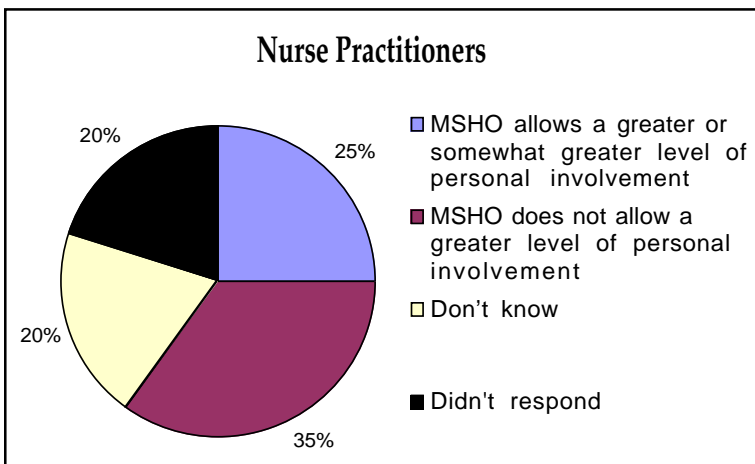
Some issues regarding personal involvement seemed to depend on the county or health plan involvement in case management:

- *Varies depending on whether I am sole CM or co-CM.*
- *Large case load, large amount of paperwork. County and other case managers become very territorial.*

Nurse Practitioners

Only 2 of the 16 NPs responding to this question said that they were able to have a greater level of personal involvement with their patients and family members in the MSHO demonstration; another 3 NPs felt this was somewhat the case. Seven NPs said that MSHO did not make a difference with

regard to personal involvement—they are able to work on a close level with all of their patients.



- *Same as all my patients.*
- *I always work closely with families and patients.*
- *In the EverCare program we try to provide personal involvement to a greater degree with all of our patients and family members. This is a core value of our organization.*
- *We try to have a great deal of personal involvement with all our patients and families.*
- *I treat all my patients the same. I have a great level of involvement with all my patients and family members. The most time being spent with those individuals who are going through change—transitions between hospitals and nursing homes, experiencing decline/end of life, or personal/health problems or issues.*
- *Already a part of our model before MSHO.*

- *Because of the EverCare program, I am able to see residents as often as I feel I need to instead of according to a regulation. I can check things while they are small problems.*
- *I have the same involvement regardless of their financial resource.*
- *I have much personal contact with all my patients and their family members.*
- *Family conferences, health care directives, educating/ counseling families and staff.*
- *Under Fairview Partners, we emphasize family contact. In so far as, MSHO makes Fairview Partners possible, I guess it promotes this.*

Physicians

Physicians were not asked about personal involvement.

Outcome Measures and Quality Improvement Projects

Care Coordinators

Care coordinators were asked what kind of outcome measures they would suggest tracking as MSHO moves into its “second generation.” Coordinators varied in their responses—several suggested that utilization such as hospitalizations, nursing home admissions, and physician office visits (particularly wellness visits) be tracked. Others suggested moving away from only looking at healthcare utilization to a better examination of preventive activities and the quality of the interventions provided. Customer and family satisfaction and cost of care were two other suggested areas for measurement. Comments include:

- *Look at hospitalizations before and after case management.*
- *Yes! Less emphasis on cost outcomes and hospital utilization, move emphasis to evaluating the quality of interventions and their role in preventing acute episodes. Prevention is hard to measure, especially in terms of causation. But there are ways!*
- *Inadequacy in addressing cultural aspects of caregiving in tools of assessment and delivery of services.*
- *Clients’ perceptions of their health and well-being. Client satisfaction with care system.*
- *Hospitalizations, appropriate use of services.*
- *Number of NH stays less than 30 days and less than 6 months, number of months members who are RCB are maintained, number of ED [emergency department] visits, number of IP [inpatient] stays, program costs.*
- *Number of well visits for annual preventative measures, flu/pneumonia shots, decreased hospitalization and ER use.*
- *Measure customer satisfaction, how members perceive their health status and the impact MSHO has had on them.*
- *Inpatient hospital admissions, quality of life for members, number of admits from community to SNF and vice versa, satisfaction of members, compare PMAP senior cost to MSHO senior costs/admits/ satisfaction.*
- *Cost savings, quality of care.*
- *Client/Family/Provider satisfaction survey.*
- *Types and amounts of nontraditional services delivered, average age, primary diagnosis and number of comorbidities (I believe it’s the frail elderly).*
- *Our care system has a comprehensive assessment conducted every 6 months with 52 elements. A senior should be evaluated with a holistic tool that looks at health maintenance, as defined by that senior’s individual health status.*

Nurse Practitioners

Nurse practitioners were asked what kind of outcome measures they would suggest tracking as MSHO moves into its “second generation.” Several suggested utilization measures, such as decreased hospitalizations or ER visits. Many others noted that quality of life and satisfaction measures for both the patients and family members were important. Comments include:

- *Quality of life, length of time in community-assisted living, board and care.*
- *Comfort at time of death.*
- *Provide service for elders/seniors who need them. Case managers in our office facilitate care with community and long-term care patients.*
- *Less hospitalization, less ER visits.*
- *Patient/family satisfaction with the program.*
- *Patient/family wishes were followed.*
- *Patient/family communication with providers of care.*
- *Patient/family satisfaction.*
- *Cost to system, overall.*
- *LOS [length of stay] in acute care settings (compared with those who aren't in MSHO).*
- *Advance directive planning and follow through.*
- *Perhaps specific management issues—i.e. pneumonia.*
- *Length of time people are able to remain at home after nursing-home certifiable.*
- *Ability to provide care in non-hospital settings and the outcomes of that care (i.e., LTC, transitional care).*
- *Decreased hospitalizations.*
- *Patient/family satisfaction.*
- *Hospitalizations.*
- *Evidence of discussions with family about health care directives.*
- *Patient/family satisfaction.*
- *The psychological effects to elderly institutionalized clients (who have lived most of their lives in a culturally homogenous setting), when faced with care givers from a rich background of cultural and racial diversity (in short, do long-standing prejudices affect perceived happiness?)*
- *The degree to which unwanted ER trips/ hospitalizations occur.*
- *Decreased hospitalization with more care delivered in nursing home.*

Physicians

Physicians were asked what outcome indicators they would suggest that MSHO focus on for future study or quality improvement, as MSHO moves into its “second generation.”

Six physicians had no ideas or did not answer; 5 responded with the following ideas:

- *The impact of advance directives—presence/absence—on the quality of end-of-life existence and the cost of end-of-life care.*
- *Quality of life from patient perspective.*
- *Hospitalization rates for CHF, hip fractures.*
- *Discharge to lower skill level facility/home.*
- *Patient/family satisfaction.*
- *I would suggest that you focus on whether MSHO has made any significant impact on how care is truly delivered versus simply a change in how things are paid for. What is the level of communication between these case managers and the physician? How are patients managed across the different settings as they enter the hospital, transitional care unit, nursing home, and assisted living or home?*
- *Meet regularly with the physicians regarding patient care.*

Physicians were also asked if their clinics or care systems had done any quality improvement projects where MSHO patients had been specifically evaluated as a group. They were also asked a follow-up question about whether they had factored the impact of the MSHO program into any other outcome measures/projects they were studying.

Improvements or Enhancements to MSHO

Care Coordinators

Care coordinators were asked about specific things that could be done to improve the MSHO demonstration. The entire set of comments received is included below.

- *Training for new coordinators—I have had to learn “on the job.”*
- *Develop a quantitative tool that measures risk for an acute episode and track risk over time to see whether it increases or decreases for MSHO clients.*
- *Don’t just look at hospital utilization data when evaluating success or failure of a program.*
- *Focus on care systems and health systems that have a significant amount of MSHO members grouped in [one] clinic. This is where we will see impact on physician practice influenced by care systems. The approach of having many clinics with clients spread out across many physicians puts many communication and logistical barriers in the way of establishing a good partnership with the physician. I am most effective in partnering with clinics that have a higher concentration of members. They begin to recognize who I am and the types of resources and value I can bring to the problems.*
- *More resources must be devoted and re-devoted to showing, explaining, convincing, cajoling, and selling MSHO’s value to the counties, especially on the direct service level. There is a huge negative perception that this managed care program is not or potentially will not be an added value for dual eligible seniors. This attitude is not universal, but is pervasive with metro area county human service works, adult service workers, and economic assistance workers. Combined with the national anti-managed care sentiment, this makes the current environment a difficult one for MSHO to thrive in. MSHO must get leadership from the state to educate and continue the debate about MSHO’s value.*
- *Establish MSHO-only clinics. Increased dollars for medical care. The high costs of medical care take dollars away from creativity of services. More stress on the importance of maintaining the rate cell A people, who are the MSHO of tomorrow. Much verbiage is used to talk about the frail elderly and their needs. As important are the MSHO members who are independent who will be frail and elderly. Now is the time to educate on alternatives to NH placement and remaining in the community. Consistently, the healthcare system applies a NH (nursing home) stay as the first answer. Only when a patient can direct his own care and make informed choices will MSHO be truly successful.*
- *All clients have PAS [preadmission screening] on the initial evaluation; then determine cell rate.*
- *It would be nice if there were separate category (payment-wise also) for persons who require really extensive care at home—should go to nursing home—but never will. Hmong persons and some other Asians in particular will not go to nursing homes and families won’t place them. But they require huge amounts of both time and money to keep them at home.*
- *Decrease paperwork. Improve understanding of what MSHO is with the county case managers and providers in community.*
- *It seems that people are still unaware of the MSHO program. Needs more publicity.*
- *Make it mandatory for all MA [medicaid] people. Increase communication with families to promote awareness of program. Devise system to decrease the number of clients with lapse in coverage.*
- *More communication between the care systems and DHS. The health plans are conduits—which are often blocked.*
- *Redo county contracts, more informative meetings for vendors about MSHO!*

Nurse Practitioners

Nurse practitioners were asked about specific things that could be done to improve the MSHO demonstration. The entire set of comments received is included below.

- *I feel the current program meets patient needs.*
- *If no hospitalization, then cover comfort measures.*
- *Keep it going!*
- *Spread into other counties.*
- *One formulary, information about what is/is not covered such as wound care supplies, therapies, meds, equipment.*

Some NPs needed more background and education on MSHO:

- *As a fairly new NP (two years) I would appreciate more of the history behind MSHO—goals, outcomes, etc.—attained to date. Would help me as a core provider understand more of the underpinnings.*
- *To my knowledge have never received information regarding what to expect differently.*

Some mistook rules arising from their care system or health plan as coming from MSHO:

- *I think that care delivery systems for institutional and community dwellers are very different—people should be allowed to specialize in one or the other and not forced to do visits in order to participate in MSHO.*

Key Learning from MSHO

Nurse Practitioners

NPs were asked if there were other issues or key learning that they wished to share with regard to the MSHO demonstration. They said:

- *Provide a good service/access for elders in healthcare.*
- *I have the client understanding of what is allowed/not allowed for my MSHO patients—“the rules” are clear.*
- *Critical mass is a serious issue. Very small numbers of patients make it difficult to change patterns of care.*

Physicians

Physicians were asked if there were any other issues or key learning to come from the MSHO demonstration that they wished to share. The entire set of comments received is included below.

- *My MSHO population has an extreme degree of lifelong psychiatric primary illness. Many have been residing in nursing facilities for many years as a consequence of psychiatric illness. This population appears to be a different cohort from the “usual” elderly person needing nursing facility care and should be intensively studied/composed with respect to comorbidities and care management concerns.*
- *I think the care manager component of the program is perhaps the most critical. For many of the patients, this is the one stable, dependable person in their lives!*
- *I hope we can expand the program and make it a more desirable asset for the frail elderly.*
- *It is my opinion that MSHO may have eliminated some payment barriers primarily in regard to Medicare rules. It has done very little to promote true integration of care at least as far as our clinic is concerned. The major reason for this is the small numbers. In general I am very supportive of the concept. I am currently working on a project where we hope to build low income housing for seniors that will not only provide housing but also health care services. Having the capacity to enroll patients in the MSHO product will be crucial to the success of such a program.*
- *I recommend a team approach for complicated patients. I have not met with MSHO care coordinators regarding MSHO patients.*
- *A list to the physicians of the MSHO patients and of the phone numbers of care coordinators would help.*

Issues to Explore

There are a number of recurring themes arising from the comments provided by these three types of direct care providers serving MSHO beneficiaries. These themes are: issues of patient volume, ongoing education for staff, county support for the demonstration, differences across health plans and providers, and MSHO as a special program. Each of these issues is explored briefly in this section, and several suggestions are offered for addressing these issues.

Perception of Low Patient Volume Impedes Innovation

The need for more MSHO beneficiaries in the demonstration overall, as well as in one service setting, comes up repeatedly—especially among the physicians who responded. There is a perceived lack of concentration of MSHO clients in any one setting or clinic. Providers talked about having too few MSHO patients to change systems or practice methods. There is also a belief that many/most of the MSHO clients are in the nursing home setting. The EverCare and Fairview Partners model of care for nursing home residents has been widely adopted in this marketplace, and providers believe this has resulted in improved management of care for the nursing home residents. Therefore, providers may not see a need to change methods for MSHO residents—MSHO then, is seen only as a financing vehicle that supports the EverCare and Fairview Partners model of care.

Comments from the survey related to this issue include:

- *Critical mass is a serious issue. Very small numbers of patients make it difficult to change patterns of care.*
- *One of the main problems is that we have very few MSHO clients. Thus, there is little impetus for change in the system of care.*
- *Again, I've had very few MSHO clients.*
- *MSHO has not impacted physician practice that much to date.*
- *I think we have very few MSHO clients.*
- *I believe many of our MSHO patients are in the nursing home.*
- *Focus on care systems and health systems that have a significant amount of MSHO members grouped in [one] clinic. This is where we will see impact on physician practice influenced by care systems. The approach of having many clinics with clients spread out across many physicians puts many communication and logistical barriers in the way of establishing a good partnership with the physician. I am most effective in partnering with clinics that have a higher concentration of members. They begin to recognize who I am and the types of resources and value I can bring to the problems.*
- *Establish MSHO-only clinics.*

The smaller number of community-dwelling seniors enrolled in MSHO may be the target group to focus on for improved clinical care and care management. However, these 900+ individuals are scattered throughout the Twin Cities area and few primary care clinics have a heavy concentration of these beneficiaries. A notable exception is in the Hmong community, where one or two physicians serve a significant number of MSHO beneficiaries, and most of these beneficiaries live in the community. In this case, the care coordinator(s) and the physician(s) are also Hmong and are very involved in the community.

Another telling response is that most of the physicians (7 out of 10) said that no quality improvement projects on MSHO had been done, primarily, it seems, because there are too few patients in their practice to support this.

Sample comments from the survey:

- *We have not treated them as a separate group.*
- *No studies.*
- *Not yet.*
- *No, again the number of MSHO patients is insufficient to justify something of this nature.*

Suggestions for Further Work

- ✓ Study what has made the demonstration successful among the Hmong community. Identify key components or factors leading to the success, and put together a model for replication into other communities where there is a close-knit group—either a community with a concentration of individuals from a specific minority group or another type of natural community.
- ✓ Explore whether there is interest by a senior-oriented physician practice with some MSHO clients to work with one of the three health plans participating in MSHO to encourage greater senior participation in MSHO—with the senior-oriented clinic as the “Center of Excellence” in MSHO senior care. Several providers suggested this as well.
- ✓ Identify the interest among providers serving MSHO beneficiaries to participate in a quality-enhancement project around MSHO beneficiaries—across organizational lines. With shared goals and measures and joint funding, a collaborative project might offer the patient volume needed to do enhancement/improvement pilots.

Educational Needs Continue

There is an ongoing need for orientation, education, and training about the MSHO demonstration for healthcare professional staff coming in contact with this demonstration. Because there are potentially many people who come in contact with the MSHO beneficiary, this is no small task. There are staff members involved at the county level in at least two counties, at the health plan level in three health plans, at the clinic level in dozens of clinics in the Twin Cities, at the nursing home level in many area nursing homes, at the acute care level at many hospitals, and at the community level within the community-based service organizations. In addition, there are the vendors who work with these organizations. In each type of organization, there will be individuals who need to understand the goals of the demonstration, State of Minnesota rules and procedures, their own organizations’ policies around MSHO, and the policies and practices of other organizations who serve MSHO clients and with whom the staff will need to coordinate care.

Add to this complexity the issue of staff turnover and the fact that, for many organizations, MSHO will be a very small percentage of their total clients served, and it is easy to see that misunderstandings about MSHO might arise.

Comments from the survey related to this issue include:

- *As a fairly new NP (two years) I would appreciate more of the history behind MSHO—goals, outcomes, etc.—attained to date. This would help me as a core provider understand more of the underpinnings.*
- *To my knowledge I have never received information regarding what to expect differently [as a result of MSHO].*
- *Training for new coordinators—I have had to learn “on the job.”*
- *It seems that people are still unaware of the MSHO program. Needs more publicity.*

Suggestions for Further Work

- ✓ Host regular orientation sessions for any new MSHO staff, and include a training or orientation manual that can be referred to on an ongoing basis.
- ✓ Widely publicize an information line that allows healthcare professionals to reach a knowledgeable person at the State offices.

-
- ✓ Encourage the three health plans to cosponsor a session on policies and practices around MSHO.
 - ✓ Put information about MSHO on an easy-to-access Web site, and publicize the Web address.

County Issues

A number of responses to several different questions brought up the issue of county acceptance and support of MSHO. Though there may be only a few people at the county(ies) who are perceived as unsupportive, the frequency of the comment warrants further examination. The comments reflect a perceived lack of support for MSHO by some county workers; the complexity arising from duplicate care management functions, which some plans have chosen to include in their model but which is not required of MSHO; and the assumed county to county differences in medication coverage (although this comment may reveal the need for further education for providers).

Comments from the survey related to this issue include:

- *My personal involvement varies depending on whether I am sole CM [case manager] or co-CM.*
- *County and other case managers become very territorial.*
- *Some of the counties are not accepting of MSHO.*
- *Interfacing with county case managers in co-case management—duplication, time in scheduling, splitting care plan and client's perspective.*
- *More resources must be devoted and re-devoted to showing, explaining, convincing, cajoling, and selling MSHO's value to the counties, especially on the direct service level. There is a huge negative perception that this managed care program is not or potentially will not be an added value for dual eligible seniors. This attitude is not universal, but is pervasive with metro area county human service works, adult service workers, and economic assistance workers. Combined with the national anti-managed care sentiment, this makes the current environment a difficult one for MSHO to thrive in. MSHO must get leadership from the state to educate and continue the debate about MSHO's value.*

Suggestions for Further Work

- ✓ Host a special meeting for counties' workers who are involved in explaining this program to seniors—provide written information on the program and play the videotape showing MSHO beneficiaries commenting on the program via a focus group (conducted in 1998).
- ✓ Conduct a simple mail survey of county representatives to understand their issues with and perceptions of MSHO more fully.
- ✓ Invite county workers to participate in a focus group about MSHO, and offer suggestions for changes.

Plan and Provider Differences

Providers encounter differences in policies and processes between health plans and among care systems and other providers. These differences add to the complexity of organizing services for their MSHO clients and in managing care. MSHO may not seem like one program but rather like many different programs (depending on which health plan the senior enrolled in to access MSHO and on which care system or provider network the senior is using). It is worth noting that many of these issues of complexity apply to the healthcare system at large and are not unique to MSHO.

- *The hardest thing for me is the county to county difference in the medication coverage.*
- *The differences between care systems—all are MSHO, but each operate very differently.*
- *Formularies different for each health plan.*
- *The medication formulary is more stringent than with those patients who pay for own meds or partially pay.*
- *Some medications are not available that are available to private pay.*

In addition, a few care coordinators feel a lack of support from their organizations, and one physician talked about a patient care issue that may be occurring in the setting where he/she practices.

- *I do not have the full support of my current organization to easily do things differently. Without administrative vision and goals, it is too difficult to apply much more than EW services.*
- *Large case load, not as much interaction and in-depth case management as I would like.*
- *Over-testing and treatment.*

Suggestions for Further Work

- ✓ Encourage organizations to explore common areas where each of their processes could be modified to reduce complexity for the care coordinator and client and increase providers' adherence to the process.
- ✓ Explore the issue of formularies across health plans and care systems—discuss exception request policies, and consider streamlining these policies for MSHO.

MSHO as a Special Program

Since MSHO is a demonstration, providers must follow certain processes to serve MSHO clients. Some survey respondents wrote that MSHO represents another set of administrative rules and requirements to remember (even though it simplifies some processes). Seniors who qualify and enroll in MSHO have one set; those who enroll in PMAP have another set. Those who are part of a Medicare product have another set, and those who are under Medicare fee-for-service have yet another set.

- *There are many needy seniors who don't qualify for MSHO. It is difficult to deal with two sets of rules about what we can cover for these patient populations.*
- *If they [MSHO beneficiaries] have a provider who does not understand MSHO, they may receive some resistance initially for fear of claims denial.*

Suggestions for Further Work

- ✓ Explore ways that MSHO can be expanded to other senior populations, with the goal of eventually mainstreaming the demonstration.

Appendix—Cover Letters and Survey Instruments

Care Coordinator Letter



Minnesota Department of **Human Services**

August 11, 2000

«FirstName» «LastName»
«Company»
«Address1»
«City», «State» «PostalCode»

Dear «Drms» «LastName»:

The Minnesota Senior Health Options (MSHO) demonstration combines Medicare and Medicaid financing and brings together primary, acute, and long-term care services. All beneficiaries in MSHO are participating in both the Medicare and Medicaid programs. The demonstration began serving seniors in 1997 and is expected to continue at least through 2001.

The primary goals of MSHO are to:

1. align fiscal incentives to support sound clinical practice,
2. provide a seamless point of access for both acute and long-term care benefits for the older consumer and improve care coordination,
3. move toward a single point of accountability for care for this population,
4. reduce cost shifting between Medicare and Medicaid.

We are currently surveying selected care coordinators who serve a number of MSHO patients. Individuals from a cross section of health plans and care systems are being asked to participate. Your participation will be important to us to be sure that we have an accurate picture of the impact of MSHO. We would like to determine if we are taking full advantage of the opportunities that MSHO offers us in improving care to this population.

As a care coordinator who sees MSHO patients, we would like to have your opinion of how this MSHO demonstration has been working and to obtain a better understanding of your experience in serving these patients. We have developed a survey questionnaire (enclosed) that we hope gets at the right issues. Health plans participating in the MSHO demonstration and medical directors from health plans and care systems have been informed about this survey and have had an opportunity to see the questions.

We estimate that the questionnaire will take no longer than 20–30 minutes to complete, depending on how much you would like to share with us in the comment sections.

The questionnaires should be returned by **September 15, 2000**. Each participating care coordinator will receive a copy of our summary report, which will be completed by early December. No responses will be identified as connected to any person; findings will be displayed in the aggregate.

If you have any questions about this initiative, please call Deborah Paone, Senior Research Associate of the National Chronic Care Consortium at (952) 814-2646, or Sue Kvendru of the Minnesota Department of Human Services at (651) 215-1828. We greatly appreciate your participation.

Sincerely,

Pamela J. Parker, Director
Minnesota Senior Health Options
Minnesota Department of Human Services

Appendix—Cover Letters and Survey Instruments

Care Coordinator Survey—Page 1

Respondent # _____

MSHO Care Coordinator Survey

One key component of the Minnesota Senior Health Options demonstration is the care coordination that helps integrate primary, acute, and long-term care services, including home- and community-based services. This survey is being sent to care coordinators who serve MSHO clients. Please complete it and return it to **Deborah Paone** of the National Chronic Care Consortium in the enclosed envelope. We would appreciate receiving your completed questionnaire by **September 15, 2000**. Questions may be directed to Deborah at (952) 814-2646 or Sue Kvendru, Minnesota Department of Human Services at (651) 215-1828.

1. How many MSHO enrollees do you have in your case load (on average)?

Average monthly MSHO case load: _____

2. What proportion of these MSHO enrollees are living in the community: _____ %

3. What proportion of these MSHO enrollees are living in a nursing home: _____ %

4. What is your total caseload (all clients, even if they are not in MSHO)?

Total monthly case load: _____

5. We would like to understand the range of intensity of care coordination that your **MSHO clients** require. Please provide an **estimate** of your MSHO caseload that usually require daily, weekly, monthly, or infrequent case management. (Case management could be in the form of a home visit; a call to the client or family; a call to providers, vendors, or the health plan on behalf of a client; or other similar activity performed for an MSHO client.)

Frequency of Case Management Required by MSHO Clients in Caseload

	<i>Daily</i>	<i>Weekly</i>	<i>Every 1-2 months</i>	<i>Every 3-6 months</i>	<i>Infrequent > 6 months</i>
# of MSHO clients					
% of total MSHO caseload					

6. Estimate the proportion of time you spend doing each of the following—thinking about your time on behalf of MSHO clients only—(total should equal 100%).

<i>Type of case management provided</i>	<i>% of time on behalf of MSHO clients</i>
Personal telephone contact with clients or phone calls to families	
Home visits to clients or nursing home visits to clients	
Phone calls to providers or vendors	
Phone calls to the health plans	
Phone calls to Minnesota Department of Human Services, to other State agencies, or to counties	
Other (describe)	

Appendix—Cover Letters and Survey Instruments

7 How do MSHO enrollees initially become aware of your role/the service you provide to them?

8 Do you have direct interaction with enrollees' medical providers? *Yes No Don't Know*
If so, how has MSHO affected this interaction (e.g., has it facilitated working together or made it more complicated)?

9 How does MSHO affect transitions of care for you and your clients (e.g., discharge from hospital, entry to nursing home care)?

Please answer the following questions by circling the most appropriate response (yes, no, somewhat or don't know), and then provide comments below each question, as requested.

10. Has MSHO made anything simpler for you compared to your previous work with senior clients? *Yes No Some what Don't Know*

11. Are there advantages that weren't there before? Explain. *Yes No Some what Don't Know*

12. Is anything harder for you because of MSHO? Explain. *Yes No Some what Don't Know*

13. Are there disadvantages to clients who are in MSHO? If so, explain. *Yes No Some what Don't Know*

14. Do you feel that the MSHO demonstration has allowed you to do things differently in providing care coordination/case management to your clients? If so, how? *Yes No Some what Don't Know*

Appendix—Cover Letters and Survey Instruments

Care Coordinator Survey—Page 3

15. Has MSHO reduced the administrative hassles you face in obtaining approval for services? Explain. Yes No *Some what* *Don't Know*

16. Do you find that there is greater flexibility of benefits under MSHO, allowing for service substitution of “nontraditional” services to your clients? Explain. Yes No *Some what* *Don't Know*

17. Are you able to reach seniors and provide case management to those whom you don't usually reach? Explain. Yes No *Some what* *Don't Know*

18. Are you able to have a greater level of personal involvement with the client and family members in the MSHO demonstration? Explain. Yes No *Some what* *Don't Know*

19. As MSHO moves into its “second generation,” policymakers, planners, and healthcare leaders will begin to study outcomes of care. What kind of care outcomes would you expect to be measured? Are there specific indicators or measures that you would suggest the evaluators of MSHO target?

20. Are there specific things you would suggest that could be done to improve the MSHO demonstration?

Thank you for your participation. Completed forms should be mailed to the NCCC at: 8100 26th Avenue South, Suite 120, Bloomington, MN 55425.

Appendix—Cover Letters and Survey Instruments

Nurse Practitioner
Letter



Minnesota Department of **Human Services**

August 11, 2000

«FirstName» «LastName» «Cred»

«Company»

«Address1»

«City», «State» «PostalCode»

Dear «Drms» «LastName»:

The Minnesota Senior Health Options (MSHO) demonstration combines Medicare and Medicaid financing and brings together primary, acute, and long-term care services. All beneficiaries in MSHO are participating in both the Medicare and Medicaid programs. The demonstration began serving seniors in 1997 and is expected to continue at least through 2001.

The primary goals of MSHO are to:

1. align fiscal incentives to support sound clinical practice,
2. provide a seamless point of access for both acute and long-term care benefits for the older consumer and improve care coordination,
3. move toward a single point of accountability for care for this population,
4. reduce cost shifting between Medicare and Medicaid.

We are currently surveying selected nurse practitioners who serve a number of MSHO patients. Individuals from a cross section of health plans and care systems are being asked to participate. Your participation will be important to us to be sure that we have an accurate picture of the impact of MSHO. We would like to determine if we are taking full advantage of the opportunities that MSHO offers us in improving care to this population.

As a nurse practitioner who sees MSHO patients, we would like to have your opinion of how this MSHO demonstration has been working and to obtain a better understanding of your experience in serving these patients. We have developed a survey questionnaire (enclosed) that we hope gets at the right issues. Health plans participating in the MSHO demonstration and medical directors from health plans and care systems have been informed about this survey and have had an opportunity to see the questions.

We estimate that the questionnaire will take no longer than 20–30 minutes to complete, depending on how much you would like to share with us in the comment sections.

The questionnaires should be returned by **September 15, 2000**. Each participating nurse practitioner will receive a copy of our summary report, which will be completed by early December. No responses will be identified as connected to any person; findings will be displayed in the aggregate.

If you have any questions about this initiative, please call Deborah Paone, Senior Research Associate of the National Chronic Care Consortium at (952) 814-2646, or Sue Kvendru of the Minnesota Department of Human Services at (651) 215-1828. We greatly appreciate your participation.

Sincerely,

Pamela J. Parker, Director
Minnesota Senior Health Options
Minnesota Department of Human Services

Appendix—Cover Letters and Survey Instruments

Nurse Practitioner
Survey—Page 1

Respondent # _____

MSHO Nurse Practitioner Survey

One key component of the Minnesota Senior Health Options (MSHO) demonstration is the care coordination and medical management that helps integrate primary, acute, and long-term care services, including home- and community-based services. This survey is being sent to nurse practitioners who serve MSHO clients. Please complete it and return it to **Deborah Paone** of the National Chronic Care Consortium in the enclosed envelope. We would appreciate receiving your completed questionnaire by **September 15, 2000**. Questions may be directed to Deborah at (952) 814-2646 or Sue Kvendru, Minnesota Department of Human Services at (651) 215-1828.

1. How many MSHO patients do you have in your practice (on average in a typical month)?

Average # of MSHO patients: _____

2. What proportion of these MSHO enrollees are living in the community: _____%

3. What proportion of these MSHO enrollees are living in a nursing home: _____%

4. What is your total patient caseload (including all patients, even if they are not in MSHO)?

Total patient case load: _____

5. How do MSHO enrollees initially become aware of your role/the service you provide to them?

6. How many physicians do you interact with on behalf of your MSHO patients? _____

7. How frequently do you interact with these physicians on behalf of your MSHO patients?
(circle most accurate answer below)

interact with most
physicians at least
once a week

interact with most
physicians at least
every other week

interact with most
physicians at least
once a month

interact with most
physicians less than
once a month

time with
physicians
varies widely

8. How has MSHO affected this interaction (e.g., has it facilitated working together or made it more complicated)?

Appendix—Cover Letters and Survey Instruments

Please answer the following questions by circling the most appropriate response (yes, no, somewhat, or don't know), and then provide comments below each question, as requested.

- | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------------|---------------|
| 9. Has MSHO affected the transitions of care (e.g., discharge from hospital, entry to nursing home care) for you and your patients? Describe how this has changed as a result of MSHO. | Yes | No | Some
what | Don't
Know |
| 10. Has MSHO made anything simpler for you compared to your previous work with senior patients? | Yes | No | Some
what | Don't
Know |
| 11. Are there advantages that weren't there before? Explain. | Yes | No | Some
what | Don't
Know |
| 12. Is anything harder for you because of MSHO? Explain. | Yes | No | Some
what | Don't
Know |
| 13. Are there disadvantages to patients who are in MSHO? If so, explain. | Yes | No | Some
what | Don't
Know |
| 14. Do you feel that the MSHO demonstration has allowed you to do things differently in providing clinical care to your clients? If so, how? | Yes | No | Some
what | Don't
Know |
| 15. Has MSHO reduced the administrative hassles you face? Explain. | Yes | No | Some
what | Don't
Know |
| 16. Do you find that there is greater flexibility of benefits under MSHO, allowing for service substitution of "nontraditional" services to your patients? Explain. | Yes | No | Some
what | Don't
Know |

Appendix—Cover Letters and Survey Instruments

Nurse Practitioner Survey—Page 3

17. Are you able to work with patients whom you wouldn't usually reach/have in your practice? Explain. Yes No *Some what Don't Know*

18. Are you able to have a greater level of personal involvement with the MSHO patient and family members in the MSHO demonstration? Explain. Yes No *Some what Don't Know*

19. As MSHO moves into its "second generation," policymakers, planners, and healthcare leaders will begin to study outcomes of care. What kind of care outcomes would you expect to be measured? Are there specific indicators or measures that you would suggest the evaluators of MSHO target?

20. Are there specific things you would suggest that could be done to improve the MSHO demonstration?

21. Are there other issues or key learnings you would like to share with regard to the MSHO demonstration?

Thank you for your participation. Completed forms should be mailed to the NCCC at: 8100 26th Avenue South, Suite 120, Bloomington, MN 55425.

Appendix—Cover Letters and Survey Instruments

Physician Letter



Minnesota Department of **Human Services**

October 2000

Dear Dr:

We are asking for your help in understanding physicians' experiences in serving older people who are enrolled in the Minnesota Senior Health Options (MSHO) demonstration—a unique national demonstration focusing on people dually eligible for Medicare and Medicaid. One of the goals of this demonstration is to reduce the “hassle factor” for physicians who have to navigate between separate Medicare and Medicaid policies. Minnesota is the first state in the nation that has been allowed to combine funding and receive higher Medicare payments for some enrollees. We are anxious to continue the demonstration, but this will depend on how it is evaluated.

You are one of only a few physicians selected to participate in this survey. You were chosen because you are listed as the primary physician for a number of MSHO patients—both those living in the community and nursing home residents. Local health plans and provider systems participating in the MSHO demonstration listed you as a physician who had at least 8–10 patients enrolled in the program. Would you take a few minutes and fill out the enclosed?

Each participating physician will receive a copy of our summary report. No responses will be identified as connected to any person; findings will be displayed in the aggregate.

If you have any questions about this initiative, or are unable to participate, please call me (Pam) at (651) 296-2140, or Sue Kvendru at (651) 215-1828. The staff of the National Chronic Care Consortium, our contractor, is conducting the survey for us—questionnaires may be returned to them in the enclosed envelope. We are hoping to have all the questionnaires returned by the end of the month.

We greatly appreciate your assistance in helping us understand the physician perspective with regard to this demonstration.

Sincerely,

Pamela Parker
Director, Minnesota Senior Health Options
Minnesota Department of Human Services

Craig Christianson, M.D.
Medical Director
UCare Minnesota

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

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

Appendix—Cover Letters and Survey Instruments

Physician Survey—Page 1

Survey of Selected Physicians Serving MSHO Patients

Yes No Somewhat

1. Do you know when you're treating an MSHO patient? How?
2. Have you worked with care coordinators or nurse practitioners in serving MSHO patients? Has this been valuable for you? How?
3. Based on your experience, does MSHO provide simplified access to both acute and long-term care benefits?
4. Prior to MSHO, physicians complained that, at times, their decisions about ordering certain services were complicated by gaps or conflicts in coverage between Medicare and Medicaid. Has MSHO simplified how services are reimbursed?
5. In your experience, has MSHO reduced administrative requirements and conflicts between the Medicare and Medicaid programs?
6. Are you seeing improved monitoring and follow-up for your MSHO patients? Can you give examples?
7. Are there advantages MSHO offers that weren't there before? Explain.
8. Are there disadvantages that weren't there before? Explain.
9. Do you have any case examples of how MSHO has worked for you and your patients?

Appendix—Cover Letters and Survey Instruments

Physician
Survey—Page 2

10. Has your clinic or care system done any quality improvement measurements where MSHO patients have been specifically evaluated as a group? Have you factored the MSHO program impact into any other outcome measures you are studying?

11. As MSHO moves toward its “second generation,” policy makers, planners, and clinical leaders will begin to study clinical outcomes of care. What kind of care outcomes or clinical indicators would you suggest that the MSHO program focus on for study and/or quality improvement?

12. Are there other issues or key learning you would like to share with regard to the MSHO demonstration?

Minnesota Senior Health Options

The Minnesota Department of Human Services has developed a demonstration called Minnesota Senior Health Options (MSHO) that combines Medicare and Medicaid financing and acute and long-term care delivery systems. This demonstration facilitates the integration of primary, acute, and long-term care services for people ages 65 and older who are eligible for both Medicare and Medicaid. Minnesota has received federal Medicare 222 and Medicaid 1115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The waivers allow the State of Minnesota to combine the purchase of both Medicare and Medicaid services into one contract managed by the State. Minnesota is the first state ever to be granted such a combination of waivers.

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

National Chronic Care Consortium National Resource Center on Chronic Care Integration

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

Provider Survey Report was written by Deborah Paone and edited by Mary Almen Goehle.

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