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Minnesota Senior Health Options  
Clinical Integration and  
Care Management Forum

Second in a Series

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**Exploring Risk Identification  
as a Process that Supports  
the Care Management Goals  
of the MSHO Project**

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**May 16, 1997  
7:30 – 9:00 a.m.**

Developed by the National Chronic Care Consortium in cooperation with  
the Department of Human Services, Minnesota Senior Health Options Project  
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# Welcome and Introductions

## Speakers

*Pam Parker, Director of the Minnesota Senior Health Options (MSHO) Project*

*Deborah Paone, Vice President, National Chronic Care Consortium*

*Chad Boulton, M.D., M.P.H., Department of Family Practice and Community Health, University of Minnesota Medical School*

*Sally A. Dunn, R.N., M.P.H., Manager, Geriatric Care Resources, Center for Healthy Aging, Medica Health Plans*

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

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

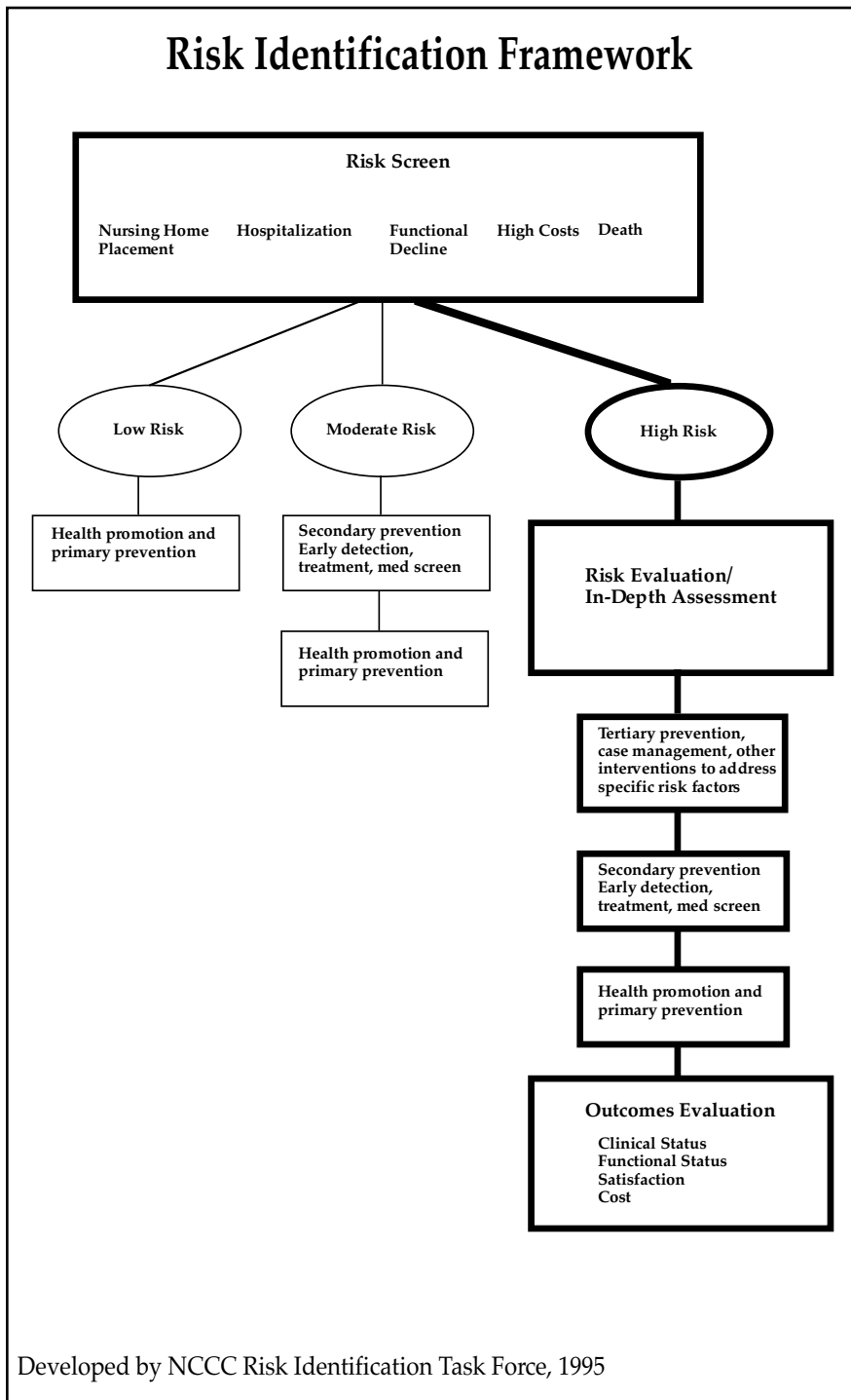
Ms. Parker introduced the three speakers for today's session.

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

Chad Boulton, M.D., M.P.H., is an associate professor at the University of Minnesota Medical School. His recent work has focused on three related initiatives: identification and healthcare of high-risk older people; care management of elderly enrollees in managed care organizations; and projections of the number of functionally disabled elderly Americans that can be expected in the first half of the 21st century. He is the research director of the University of Minnesota Center on Aging.

Sally A. Dunn, R.N., M.P.H., is Manager, Geriatric Care Resources, Center for Healthy Aging, which is the division of Medica Health Plans of Allina that is dedicated to comprehensively meeting the medical-social needs of its Medicare membership through a specialized team of geriatric, member service, and sales staff. Ms. Dunn is responsible for the activities of the geriatric care team that provides case management services and information and referral for senior members of the health plan.

# A Brief Introduction to Risk Identification



*Deborah Paone, Vice President of the National Chronic Care Consortium, briefly described the NCCC's risk identification process.*

After examining a number of risk screening tools and processes, a 1994-1995 NCCC member task force developed both a framework for establishing a risk identification process in a healthcare system and a template for a risk screening tool. Risk identification, as defined by the task force, is an ongoing process aimed at enabling healthcare providers to identify and manage the health risks of consumers and prevent disability or delay further deterioration.

Risk screening processes are designed to determine if individuals are at low, moderate, or high risk for adverse outcomes. The most significant adverse outcomes, according to the task force, are nursing home placement, hospitalization, functional decline, high cumulative costs, and death. The task force identified disability prevention as the major goal of risk identification. To prevent disability, it is essential not only to identify those at risk, but also to intervene at some point early in the care process. Secondary and tertiary prevention are most important, particularly for the chronically ill.

An ongoing, systems-approach to risk identification that is part of an overall care management process is the most effective approach. Because the risk identification should result in better care management, it is important to track and evaluate outcomes.

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# Identifying and Managing High-Risk Seniors

*Chad Boulton, M.D., M.P.H., Department of Family Practice and Community Health, University of Minnesota Medical School, shared his research related to the development of a validated risk screening instrument that is used to predict risk of hospitalization for older adults. He also examined the process of risk identification and offered his advice to health systems developing a risk identification process for purposes of earlier intervention to avoid or delay disability progression and other adverse events.*

Older populations are different not only in their age, but also in their concentration of morbidity. Older populations have a higher concentration of chronic disease than younger populations.

In the older population, about 10 percent of the people have chronic conditions which frequently result in crisis situations that bring these individuals to the emergency room or hospital. What that means, according to Health Care Financing Administration (HCFA) data from the fee-for-service sector, is that 10 percent of this population accounts for 70 percent of this population's healthcare costs. At the individual level, the average cost of care for one of the people in this high cost group is about \$28,000 per year; the average cost for each individual in the other 90 percent of the population is approximately \$4,000 per year. It is this concentration of morbidity that distinguishes older populations from younger ones.

Healthcare systems, especially those at financial risk for care delivered, need to predict who these high-risk individuals are and give them proactive services to keep them healthy. The challenge is to find them—find them early—and invest in systems that can maximize the quality of care. Give these high-risk, high-cost individuals special care to keep them healthy, out of crisis situations, and out of expensive care situations. This is good for the health system because it ultimately can result in lower costs for services for this population.

Some systems are concerned that they will waste money by identifying these individuals and providing them

special care, only to have them disenroll from the plan. This is not the experience in older populations. Less than 10 percent of seniors disenroll; in well-managed plans, the disenrollment rate is as low as four percent. For those who do disenroll, the number one reason for disenrollment is dissatisfaction with their primary care physician.

Success in MSHO is going to equate with your ability to provide extra value in the care of your entire enrolled population, but particularly of those at high risk for adverse outcomes. MSHO will be successful to the extent that you develop systems of care that find these people and deliver them effective, proactive, preventive services. MSHO will not be successful to the extent that it is viewed primarily as a financing mechanism.

There is a difference between risk screening and assessment as I am using these terms. Screening is gathering a little bit of information about a lot of people to determine who is at risk. Assessment is gathering a lot of information about the few people identified as at risk to determine what their health needs are and what should be done for them to make their lives better and keep them out of expensive, crisis situations. Identifying high-risk people is a science and an art. Three sources of information about high-risk individuals include risk screening, referrals, and data from existing information systems.

Screening can be done in a number of ways. The P<sub>ra</sub> screening instrument that was developed at the University of Minnesota is a tool that is used to identify high-risk, older people. It is mailed out to people, or it is completed

### **P<sub>ra</sub> Screening Instrument Questions**

- 1. In general, would you say your health is: excellent, very good, good, fair, or poor?**
- 2. In the previous 12 months, have you stayed overnight as a patient in a hospital?**
- 3. In the previous 12 months, how many times did you visit a physician or clinic?**
- 4. In the previous 12 months, did you have diabetes?**
- 5. Have you ever had coronary artery disease, angina pectoris, a myocardial infarction, or any other heart attack?**
- 6. Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?**
- 7. Are you male or female?**
- 8. What is your date of birth?**

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over the phone. This instrument consists of eight simple questions (see sidebar). Many people think this tool is too simple to work; they think it does not provide enough information to predict the future.

We did four studies on the predictive accuracy of this tool. The populations studied included a national Medicare population, a local Medicaid population, a California HMO, and a Washington HMO. In each of these studies, we gathered the answers to these eight questions from a population of older people and put the answers into a formula that provides a risk rating between zero and one. Everyone in the population was classified as high risk or low risk. We then followed those four populations and their use of health services for one to four years. We looked to see if the high-risk people, according to this screening, used more services than the low-risk people. We discovered that, regardless of the population, the groups classified as high risk used services and incurred costs at a ratio twice that of those identified as low risk. This tool should not be the sole means of identifying and monitoring a population. It is better used along with a system that includes referrals to healthcare professionals and the use of information systems.

After you have screened a population and identified those at high risk, you need to complete comprehensive assessments on those high-risk people. An assessment is a detailed process that involves the following domains: personal, medical, functional, emotional, cognitive, social, nutritional, environmental, caregiver, and preferences. It may take a team of professionals several hours to gather and synthesize all this information. From this information, you develop a broad, integrated care plan that addresses all the major risks to this person's health.

## **Innovative Interventions**

I am going to give you a brief tour of five innovative interventions that you can put into place after you identify and assess high-risk individuals.

### **Case Management**

Case management is the most widely used intervention; most managed care organizations do some type of case management. There are two types, based on the intensity of the relationship between the case manager and the client. The first type is "high-intensity, low-volume" where the case manager carries a relatively small caseload—50 to 100 people. The case manager sees the clients face-to-face fairly frequently, gives them personal guidance, arranges for services, and sometimes even provides services such as counseling or education. The second type of case management, "low intensity, high volume," is more like utilization review. The case manager carries a caseload of one hundred to several hundred people, typically monitoring them through the computer and doing most of the interventions by telephone.

Of the managed care organizations we surveyed, only six could answer our question about whether there were any cost savings associated with their case management program. Five of the six felt, intuitively, that they were saving money; none of them could provide any data to support this. Yet all of the organizations surveyed were planning to continue or expand their case management efforts. There is a lack of evidence about the cost-effectiveness of case management, but there is a strong belief that it is working.

### **Chronic Care Clinics**

Chronic care clinics, which provide a modified or improved version of primary care, are another interesting innovation. Group Health Cooperative of Puget Sound is experimenting with

**Design systems to:**

- Monitor Risk Status**
- Identify High-Risk Persons**
- Assess Specific Needs and Resources**
- Provide Tailored, Integrated Interventions**

**Quality-Enhancing Services for Most Enrollees**

- Prevention:** vaccinations, mammograms
- Wellness:** exercise, information
- Education/Demand Management:** for enrollees, families
- Advance Directives**
- Primary Care:** expertise in geriatrics, guidelines, appropriate time allotment
- Integration of Services**

chronic care clinics. They identify people who are high risk and bring them into their clinic as a group for a half day every three to four months. The clients meet individually with the nurse, the pharmacist, and the physician. Then they all come together for an educational support group on a topic that they as a group have chosen at the previous session. Finally, clients have an opportunity to visit further with the physician if they need individual time. Nurses call individuals in between these group visits to follow up with them on their care. The idea here is to reorganize primary care using evidence-based guidelines to ensure that patients' fundamental healthcare needs are being met.

**Cooperative Healthcare Clinics**

Another primary care innovation is cooperative healthcare clinics, being tested now at Kaiser Colorado. They use their information systems to identify people with chronic illnesses who have been high utilizers in the previous year and bring these people in monthly for a group visit. These half-day visits begin with a presentation on a health-related topic, followed by an informal session where the healthcare professionals follow up with the clients on health maintenance issues such as blood pressure checks, medication refills, and inquiries about mammograms and flu shots. Next the group has a session where they ask questions of their primary physician. Finally, some patients may have brief individual physician visits. These clinics are extremely popular with the clients, because they feel like they have more time with their nurse and physician. These clinics also reduce the use of emergency rooms and hospitals.

**Home Care**

Home care has a variety of purposes, but, in our society, we typically use home care as a form of long-term care. Initially, the Medicare program wanted home care to be used to avert or

shorten hospitalizations; it has not worked out that way, but it could. There is a study from Israel about a home hospitalization program that is now being tested in the United States. In this program people with acute illnesses such as urinary tract infections or pneumonia are evaluated at home and, if they meet certain criteria, are managed at home by daily care and monitoring by nursing professionals and by frequent visits by physicians. The program's savings were six times greater than its costs.

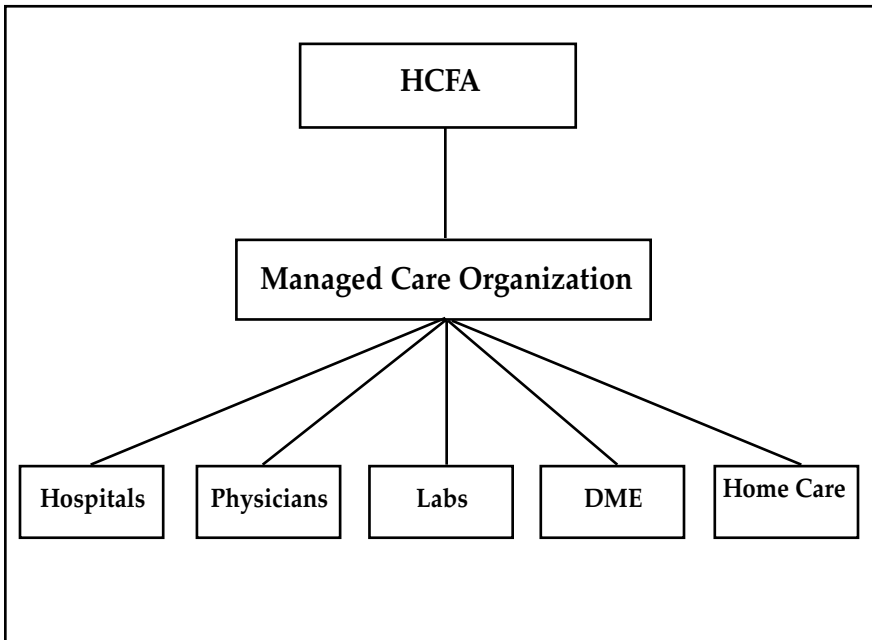
**Geriatric Evaluation and Management**

Geriatric Evaluation and Management (GEM) is another intervention for high-risk people. In this program, a geriatric team—typically a physician, nurse, and social worker—completes the comprehensive assessment, designs a care plan, and delivers the care. This team takes care of an individual's total healthcare needs for a period of three to six months to get the client as healthy as they can and on the right track before sending them back to their primary care physician. We just completed a study of 522 people who were identified as high risk; half of this group received usual care, the other half GEM. Patient satisfaction with GEM is extremely high, and early results suggest that GEM leads to improved quality of life and lower utilization rates.

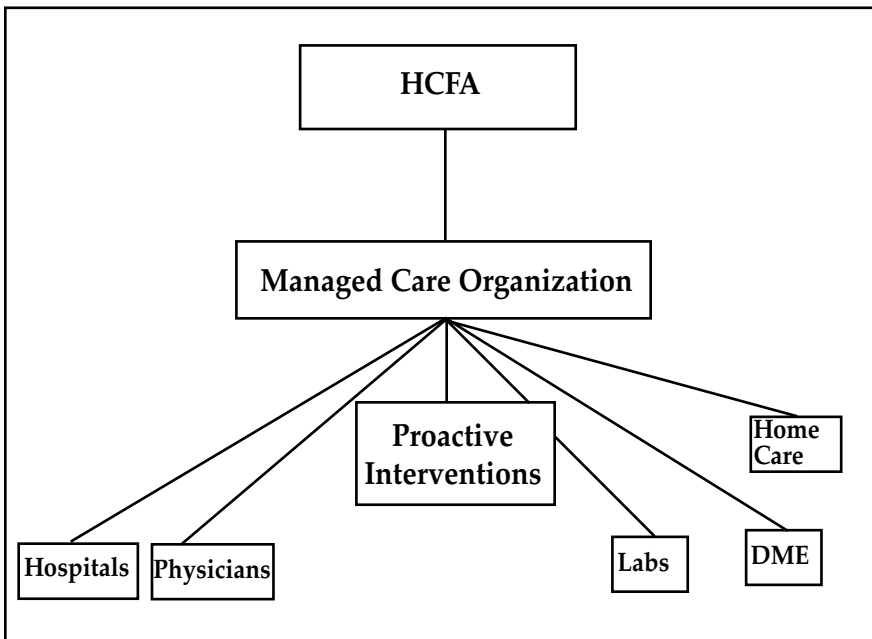
These are five innovations that systems can use to approach care for individuals who have been identified as high risk. To successfully provide care for those at risk, managed care organizations need systems that continually:

- monitor the risk status of older populations
- identify high-risk individuals
- assess specific needs and resources
- provide tailored, integrated interventions

## The way money flows now in Medicare HMOs



## The way money should flow in Medicare HMOs



## Financing

The money flows from HCFA—with MSHO there is an additional entity with the state—to the managed care organization. The way it works now is the managed care organization sees its role as purchasing services from a number of providers, including hospitals, physicians, labs, DME suppliers, and home care agencies. This is a standard operating model.

What I am talking about is a change where HMOs or provider groups that are taking risk add services to enhance quality of life and to reduce their need to purchase services for their clients. The money still comes from HCFA to the managed care organization, but instead of using most of that money to buy services, the organization at risk develops and implements proactive interventions. These interventions include both screening, identifying, and monitoring risk status and providing or working with providers to offer care interventions. This is a different model for managed care organizations; there is a lot of debate about how much these organizations should be involved in these interventions and how much this should be done by the provider organizations with which they contract.

In the future managed care organizations will need to have the vision to see the importance of this approach, the courage to go for it and stay the course, and the administrative skill and persistence to make it happen. They will need electronic data systems that are much superior to what we have today; they will need to have access to basic clinical information about individuals in real time. They will need to have aligned incentives so that when the whole system works, everybody benefits, and when the whole system doesn't work, everybody pays.

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## Recommendations for MSHO Participants

### **1. Develop a system for monitoring risk in your populations.**

If you are going to be in the business of Medicare managed care, you need to have a way to know who is at high risk and follow those individuals so that you can give them special services.

### **2. Develop a system that provides special care for those high-risk people.**

If we don't develop better systems, we are going to be wasting our time in experiments like MSHO. MSHO is a great start toward integrated funding; now we have to do something with the advantage of having that pooled capital. We have to develop something that is better than what we have now. This includes new and improved information systems, aligned incentives, and better geriatric education for our primary care physicians.

### **3. Have geriatrics expertise within the system.**

I am not advocating trying to have geriatricians take care of all your old people, because there will never be anywhere near enough geriatricians to do that. But you need to have geriatrics expertise—whether it's a geriatric nurse practitioner or a geriatrician—in your system to help develop systems that make sense and to provide consultation to your primary care physicians.

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# Case Study on Risk Screening: Experience from Medica

*Ms. Dunn shared her learning from over 20 months of working with a risk screening process for senior members of Medica Health Plans.*

At Medica we began using a risk screening tool—the P<sub>ra</sub> tool—in August 1995 for members who enrolled in our new TEFRA risk plan that July. Currently, we have about 5,000 members, mainly in Hennepin and Ramsey counties. About 50 percent of these members are individual enrollees and about 50 percent are enrolled through company retirement plans.

We use a care advisor model which involves having either a nurse or a social worker with geriatric expertise assigned to every member enrolled in the plan. These care advisors call new members within a month of enrollment to welcome them and to explain the specifics of the risk plan, including making sure they have a physician and that they understand they need to go to Medica providers.

When the care advisor receives the risk survey results back—currently this occurs within two months of enrollment—they identify the high-risk members to follow more closely. Our 5,000 members break out into the following risk levels:

2-3 % high risk

15-16 % moderate risk

81-82 % low risk

Care advisors do home visits and complete a comprehensive assessment of members at high risk. We also have a multidisciplinary team conference for every member who has a home visit or for members who appear to have complicated care needs. Members of this team include the nurses and

social workers who are care advisors as well as a geriatrician.

In explaining our risk screening and care follow-up process, I will review our initial plan, the modifications we have made since implementation, and the future revisions we have planned.

## Initial Plan

1. Survey all new enrollees and, in the future, survey only those who initially scored low-risk (because we thought we would be following everyone else).
2. Send *Healthwise for Life* to all who returned the survey so they knew they would be receiving something in exchange for completing the survey.
3. Send members who scored at moderate risk a second survey with questions on functional status and other health problems.
4. Have care advisors make home visits and complete a comprehensive assessment for all who scored at high risk.

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## Modifications Since Implementation

1. We had trouble getting the initial survey results back, so we decided that to try to send out a second survey to those at moderate risk would be impossible. In July 1996 (one year after we started), we decided to use one longer survey and send it to everybody. We still used the eight questions on the P<sup>ra</sup> but we added ten questions. This eighteen-question survey is four pages long. Although I thought we would have more trouble asking people to complete the longer survey, we had a return rate of 84 percent in the first month using the new survey, up from the 74 percent response rate from the initial survey.
2. We send a different gift—with a health improvement message—every year to those who complete and return their surveys.
3. We decided that all those at high risk do not need home visits. We had been doing that automatically and what we found was that the younger people—65 to 70 year olds—who are at high risk, generally had good medical management and did not have need for community resources. Now care advisors do phone screenings to determine who needs a home visit.
4. We made major revisions in our information systems and scanning process for the surveys. We now use an outside company to do our scanning.
5. We developed an internal system where we can pull information from our mainframe database for our reporting.

## Future Revisions

1. One of the things we have not done early enough is to let our physicians know about this survey process. We have recently begun going to the clinics to talk to the physicians about this risk screening process and to explain what the survey results mean and how the care advisors can help them manage the care of these complex members. Our plan is to get out to all the clinics to educate physicians about the process.
2. We want to monitor certain ICD-9 codes for “trigger” diagnoses. This information is difficult to obtain in our system. We can get claims data on diagnoses, but we want it linked to a care advisor so they can follow up on patients who may need more care. We currently cannot get this data in real time for our clients.
3. We also have begun reviewing high-cost cases (over \$20,000) to see what the patterns are: How many of these people are high risk? How many are moderate? Were the care advisors involved? Were the clients hospitalized? We recently received this information, but have not yet begun analyzing it.
4. One other thing we are trying with a different plan is to use the survey with one additional page devoted to health education topics. When people complete the survey, they check which topics they are interested in, and we send them information along with their gift.

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## Recommendations for MSHO Participants

**1. Make sure you have a system in place to handle the information you are going to get from the survey, before you even think about using a survey**

**2. Consider the cost-effectiveness of the system you put in place**

It is important to have a risk screening and monitoring process in place, but it is expensive to set it up. We paid for a number of consultants to set up our system and it wasn't linked to our database; it cost over \$100,000 to set up the one that was linked to our database. You need to think about the costs involved with the system you have and what it's going to cost you to set up something new. After it is set up, you have to maintain the system.

**3. Know how you are going to use the survey information**

It is important to use and follow up on the information you request from members.

**4. Design a system that is flexible**

We have made a number of changes in the system that we have. There are probably more updates to be made.

**5. Make sure your system has appropriate reporting capabilities**

Reporting capabilities are extremely important. Currently, we can obtain lists of care advisors and their members; care advisors use these to track their caseloads. We also receive a one-page report by member that provides the responses people made to the survey questions.

**6. Have other sources of information about your members**

You need to have some ways members or family members can call you when they have problems. You need to know if they are hospitalized or if they are placed in a nursing home.

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# Questions and Answers

**Q:** How accurate is the P<sub>ra</sub> screening instrument? How many does it miss? How many does it incorrectly classify?

**A:** **Dr. Chad Boulton:** The P<sub>ra</sub> instrument is 60 percent specific and sensitive, which means that it picks up only 60 percent of the high-risk people. Forty percent of the people who are going to be high-users are missed by this instrument. That's why I recommend it not be the only way you identify people at risk. Its main advantage is that you can get it out to the whole population, and you can correctly classify at least 60 percent of those people. You really need to have a system to incorporate referrals from physicians to pick up the others. It isn't perfect, but it's better than waiting for people to show up in the hospital or nursing home.

**Q:** What about confidentiality?

**A:** **Dr. Chad Boulton:** People worry that we are going to put their medical information on some kind of a server and then allow administrators and clinicians access to it. Is that going to violate confidentiality? These are issues that are going to have to be worked through. Keep in mind the kind of information that is put on these systems is not terribly sensitive information. It is not information that is protected now. I think the sensible thing is to include only the information that is really important and use appropriate security to protect the information. I would encourage us all to pursue procedures that are as secure as possible and still meet the needs of integrated care.

**Q:** Does HCFA need to approve the survey tool?

**A:** **Sally Dunn:** HCFA needs to approve anything that is sent out to the members. We did send them the tool and there were no issues.

**Dr. Chad Boulton:** A note of caution, you cannot send this out to people before they are officially enrolled, because it could be seen as an effort to screen out high-risk people.

**Sally Dunn:** We do say in our cover letter that the information is confidential and that their responses will in no way affect their continued enrollment, because there have been some concerns expressed about that.

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**Q:** Under the MSHO program, is the screening tool going to be defined by the state or are care systems allowed to define our own screening tool?

**A:** **Pam Parker:** MSHO has not dictated any particular risk screening mechanism for any of the HMOs or care systems. We do have the preadmission screening form which is a different process used just for determining nursing home certifiability. This whole process does have to be followed in a standard format.

Not having defined methods and tools has been the subject of some debate. We have been criticized by some on our advisory committee and others for not having dictated a specific clinical model for MSHO in our contracts. If you look around the country and see other states that are trying to do the same thing we are doing, many of them are going to dictate specific processes. We have not done that because we felt that this would not be successful. We understand that the climates and philosophies of the various medical practices and care systems can vary. Something that might work for one might not work for another. This is going to make it more difficult to evaluate our program and to see if the plans and care systems are actually doing something in this area that does make a difference. We really need you all to go forward and develop some innovations in this area, to find things that work for you, and to be really vigilant about implementing them and making them work.

**Q:** We are using the NCCC screening tool. It is working for community-dwelling seniors, but it doesn't seem to be working for nursing home residents. Given the risk assessment that you have been doing, do you feel there has to be a different approach for determining the long-term care risk? Or are acute care and long-term care risks so linked that you can use the same process for both?

**A:** **Dr. Chad Boulton:** The P<sub>ra</sub> instrument does predict long-term care risk. It wasn't designed specifically to do this, but it was designed to identify chronically ill people who use a lot of hospital services. We have looked to see what the outcomes are for people who are identified as high risk in terms of their long-term care use. It shows the high-risk people in a managed care organization have 3.5 times the number of home care visits and 3.6 times the number of nursing home admissions as the people who are classified as low risk. You wouldn't want to rely on this tool as your only method for identifying people who are at risk for long-term care, but it would be a good place to start. As Sally pointed out, you can increase your questionnaire a bit and not hurt your response rate. I agree with that, as long as you don't go too far. For some reason, eight pages seems to be the limit, with 14 point bold type and lots of white space. So you can end up with a questionnaire around 20 questions. It makes sense for the MSHO programs to add functional questions to the P<sub>ra</sub> questions.

**Sally Dunn:** At SeniorsPlus (the social HMO) the survey we used was designed to pick up people who are at risk of nursing home placement. One thing we have talked about doing for the survey we are using now is adding a question at the end about whether the person needed help completing the survey. We felt that would be predictive of whether there was a possibility of dementia.

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# Resources on Risk Identification

Boult, Chad, Boult, Lisa & Pacala, James. "Clinical Innovations for Older Populations of the Future." *Gerontologist* (1997)

*Chronic Care Initiatives in HMOs—Identifying High-Risk Medicare HMO Members: A Report from the HMO Workgroup on Care Management.* (April 1996) Group Health Foundation, Washington, D.C.

"Reduce Risk by Screening, Managing Frail Elderly." *Public Sector Contracting Report.* (January 1997)

*Risk Identification: Exploring A Conceptual Framework and Identifying Implementation Issues.* National Chronic Care Consortium, Bloomington, MN

Wagner, Edward. "Organizing Care for Patients with Chronic Illness." *The Milbank Quarterly.* 74, no. 4 (1996).

Wagner, Edward H. "The Promise and Performance of HMOS in Improving Outcomes in Older Adults." *Journal of the American Geriatrics Society.* 44 no. 10 (October 1996) 1251-1257.

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## Minnesota Senior Health Options Project

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

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

## National Chronic Care Consortium National Resource Center on Chronic Care Integration

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

The NRC is sponsored by the National Chronic Care Consortium (NCCC), a strategic alliance of 30 leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

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