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Minnesota Senior Health Options  
Clinical Integration and  
Care Management Forum

Eighth in a Series

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**Utilization Benchmarks and  
Techniques in Working with  
Community Frail Elders**

**June 24, 1999**

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# Welcome and Introductions

## Speakers

*Pam Parker, M.P.A.  
Director of Minnesota Senior Health Options (MSHO)  
State of Minnesota Department of Human Services*

*Judith Pinner Baskins, R.N., Vice President of Geriatric Services at Palmetto Richland Memorial Hospital and President, National PACE Association*

*Susan McCarthy, Director of the Technical Assistance Center, Community Care Organization, Inc.*

*Pam Parker, Director of Minnesota Senior Health Options (MSHO), welcomed all attendees to the program, which is the eighth in a series designed to address clinical integration and care management issues for health plans, counties, care systems, and providers participating in MSHO.*

I am happy to welcome you all to the eighth MSHO Clinical Forum this morning. I can't believe we've had eight of these already. I think they are a marvelous part of the Minnesota Senior Health Options. We are fortunate to have funding from The Robert Wood Johnson Foundation to contract with the National Chronic Care Consortium to put on these special forums periodically.

We have tried to get together with some of you to ask what topics you would like covered at these forums. Recently, because we received some utilization data from the plans, we became interested in the issues of utilization and techniques for managing utilization. We thought there was no other place to go than PACE (Program of All-Inclusive Care for the Elderly). The people who run PACE programs are the pioneers in this, particularly in their work with the community elderly. We are happy to have two representatives from PACE sites with us this morning.

Judy Baskins is the National PACE Association president and is the vice president of Geriatric Services at Palmetto Richland Memorial Hospital in South Carolina. She was the director of the PACE site there and also manages senior care programs at that hospital. She is an R.N. and also is on the faculty of the School of Medicine. She has a long history as a national

leader on these issues. We are happy to have her here to share her expertise with us.

Susan McCarthy is from Wisconsin, at the Community Care Organization in Milwaukee. The Community Care Organization sponsors a PACE site, and they are also part of the Wisconsin Partnership Program, which is a sister effort to ours to integrate Medicare and Medicaid. They are also part of the Robert Wood Johnson Foundation Medicare and Medicaid Integration Project that we are a part of. So we have been collaborating with them over the years as they have developed their waivers. They just recently received their Medicare waivers so that they can capitate the Medicare side of the program.

Susan is the director of the Technical Assistance Center at the Community Care Organization where they relate to the PACE sites nationally and consult with them to help them start up. Susan is an expert in medical ethics and the frail elderly and does a lot of speaking around the country as well. We're excited to learn more about the Wisconsin Partnership Program which I always characterize as a PACE program where you can bring your own doctor. I think that their innovations in changing the PACE model are particularly relevant to what we're trying to do here in Minnesota because we have the struggle of not having employed physicians via a staff model. We don't have some of the direct control over the physicians that the PACE sites can exercise, and the Wisconsin people may have some insight into building relationships with physicians who aren't necessarily on your staff.

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# Developing Performance Measures for the Dually Eligible

*Judith Pinner Baskins, R.N., Vice President of Geriatric Services at Palmetto Richland Memorial Hospital and President, National PACE Association*

I am going to focus on how you look at the performance measures that are particularly applicable to the dually eligible population. As you know that's who PACE serves.

## Background on PACE

I am sure all of you are familiar with PACE, but just as a reminder, PACE stands for Program of All-Inclusive Care of the Elderly. It stemmed from the replication of the On Lok long-term care model in San Francisco. It currently operates under research and demonstration waivers, 1115 Medicaid and 222 Medicare. We received provider status as part of the Balanced Budget Act of 1997 and are in the process of transitioning 23 sites that are currently operating under dual waivers. We anticipate that sometime after the publication of the regulations, another 10 to 20 sites will be transitioning into provider status and will be serving the dually eligible in a fully capitated model. Essentially, PACE is a community-based program, fully capitated under Medicare and Medicaid. It provides managed care to a frail elderly population who are qualified as nursing home certifiable based on the state regulations. The program targets individuals who are 55 and older, who live in a defined catchment area, and are certified by the state to meet a nursing home level of care.

What we do is integrate all acute and long-term care services. We provide all Medicare and Medicaid services as defined by the state plans, including all community long-term care services. There are no benefit limitations, no

copayments, and no deductibles. There also is no going outside of our services and providers unless someone disenrolls from the program; otherwise, even if a person is permanently placed in a nursing home, there is no cap on the financial exposure of the PACE site for the cost of nursing home placement.

## Profile of PACE Enrollees

Here is a snapshot of what PACE participants across the country look like according to the most common diagnoses. Hypertension (56 percent) is the most common diagnosis, followed by diseases of the eye (53 percent) and arthritis (50 percent). Dementia (47 percent) varies greatly across sites; the Bronx has a very low number while in South Carolina about 81 percent of our folks have a formal diagnosis of Alzheimer's or multi-infarct dementia. That is unique to where we live in South Carolina; also we have a very high incidence of cardiovascular disease. The next most common diagnoses are depression and anxiety (36 percent), stroke (31 percent), and diabetes (28 percent). I think the diabetes number is interesting considering the volume of money that is spent, especially in managed care and Medicare, on diabetes. Almost 40 percent of the dollars go toward that so it is really interesting that diabetes is such a low number across PACE sites. Coronary artery disease (27 percent), ear diseases (26 percent), and peripheral vascular disease (25 percent) round out the top ten diagnoses (see chart on next page).

The typical person enrolled in the South Carolina PACE site is a 78-year-old, African-American female with cardiovascular disease, diabetes, and hypertension who is teetering on end-stage renal disease.

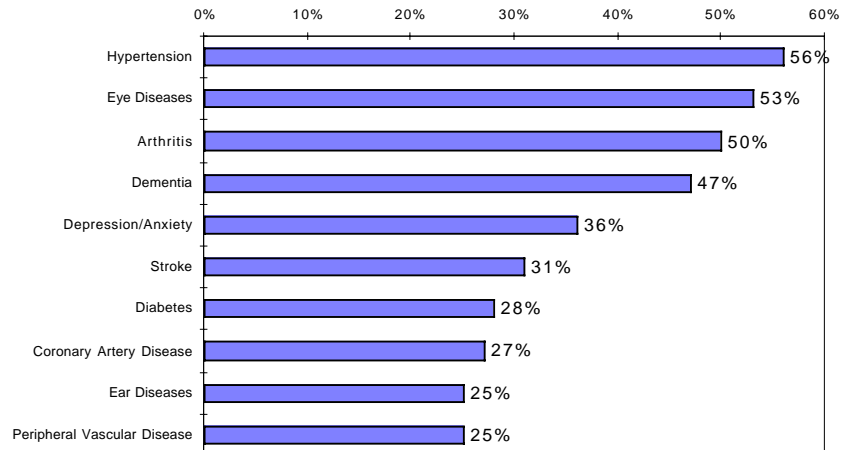
I'd like to share some utilization data with you to give you an idea of what we look like across sites (see chart on this page). In terms of acute hospital days per 1,000 enrollees, per annum, you can see that Detroit's numbers are high. You have to realize that Henry Ford Health System was transitioning into this dually eligible program; they had been operating as a prepaid health plan for a long time and had not been as aggressively managing their days. The Bronx has always been a very high user of acute care days because of the community standard. When you look at PACE's average length of stay of hospital days in 1996, which was 4.1 days, you see that it is lower than Medicare FFS (6.6 days) and Medicare HMO (5.9 days).

If you look at acute hospital use in days per 1,000, per annum, we have done a really good job of controlling this. Remember, FFS Medicare includes all Medicare eligibles, including those that are defined as more well. Their acute hospital use was 2,080 per 1,000 in 1996. Medicare HMO numbers run around 1,629 per 1,000. Across all PACE sites, we run about 1,950; this does vary drastically across our sites.

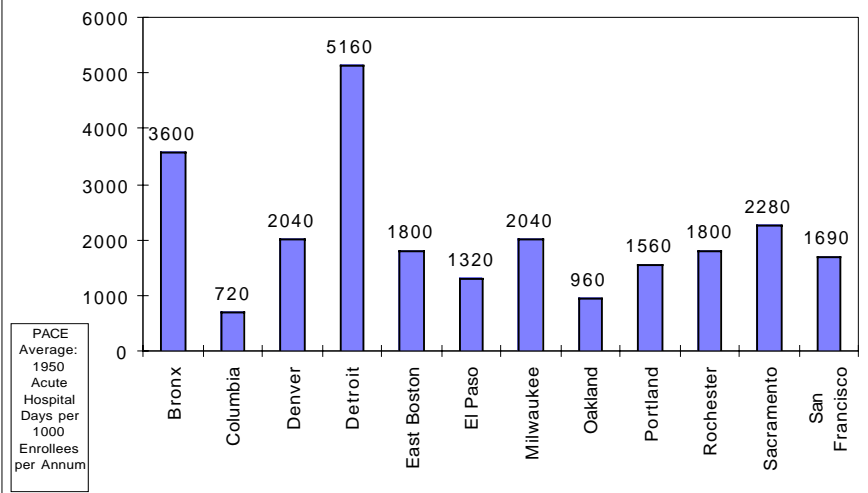
## PACE Accreditation Standards

Next let me run through some of our accreditation standards. The national PACE organization received a grant from The Robert Wood Johnson Foundation to develop accreditation standards for PACE. We put together a panel of national experts to give us feedback. We created work groups at PACE sites and invited provider input

### Ten Most Common Diagnoses Among PACE Enrollees



### PACE Inpatient Utilization



into what we ought to be focusing on. Then we began to realize that it would be a little like the fox guarding the hen house if we did this accreditation stuff ourselves. We decided we needed to find a partner that really understood accreditation and could help us develop a process.

Currently, we are in discussions with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to have them look at our standards. They are looking at developing some

core standards that will work across all healthcare providers and then taking what PACE has developed and creating what we call "wraparound" standards. They have developed an internal business plan looking at this approach. We had sought some grant funding to continue to do this, but right now we have developed this partnership with the Joint Commission that we hope will result in a survey process.

PACE's accreditation standards are the

same kinds of things you would see in most accreditation standards. These standards include:

- **Organizational structure**  
The relationships of PACE providers are very unique. About 42 percent of our programs are sponsored by health programs and smaller numbers by community health providers. Some are freestanding agencies such as those in Milwaukee and El Paso.
- **Enrollment, disenrollment, and marketing**
- **Participants' rights and responsibilities**
- **Administration, program management, and human resources**
- **Finance**
- **Quality improvement**
- **Physical environment**
- **Service delivery**
- **Medical records.**

## PACE Performance Indicators

PACE performance indicators are the kinds of data that we need to be tracking over time. What I am presenting to you is very much in a draft format.

- **Timeliness of enrollment**  
How long does it take to enroll someone in our PACE programs? That's a bit of a problem given the level of care process that has to go to the state for authorization. Then there is the issue of effective enrollment starting on the first day of the calendar month. How do you serve that person in the interim?

How do you stagger enrollments? We need better definitions of what this means.

- **Enrollment rate**  
Of those folks who qualify for the program, how many actually enroll? This helps us understand market penetration and expansion. It helps us look at a community with a certain number of people who meet level of care, age, pension, and major income eligibility and project how many might enroll in a PACE program. Could a PACE program develop in this community and be a viable financial organization to care for this population?
- **Disenrollments due to death**  
How does this stack up against traditional long-term care systems?
- **Disenrollments due to reasons other than death**  
Why are people exiting our program? Is it because they're not happy with the service or the physicians? These questions can lead to quality assurance indicators. So once again, capturing this data and understanding what is happening with the people you serve is important in terms of quality assurance.
- **Enrollee/caregiver complaints**  
I'm sure you've all heard about QISMC. A lot of these things are in those components. These are things I think we're all going to be expected to look at, track, and monitor as part of managed-care plans.
- **Enrollee/caregiver grievances**  
We had a hard time defining the difference between a complaint and a grievance, so within our system, we put a timeframe on it. A complaint is something that gets resolved within 24 hours. If it does not resolve within that timeframe, it kicks into what we call a grievance process. Then we have an internal

process for resolution and an external process both through our Medicaid agencies and, in theory, Medicare, though I'm not sure we'd get anything through our Medicare folks right now as far as grievances, but technically these are avenues for seeking resolution of concerns and complaints. QISMC addresses this information. I think there are important components in there and a lot of good information that you can glean from that document to incorporate into internal grievance and complaint systems.

- **Access to primary care**  
This is one that we think is very, very important and is one of the major things that we like to query as part of our satisfaction survey. Our state Medicaid agency in South Carolina does a satisfaction survey in great detail. They interview, very objectively, a large percentage of our enrollment every other year, and one of the things we like to include in that questionnaire is access to primary care—do people feel that their physicians are available, that they have input into their care planning process, and that they get to specialists as they feel they need to. Those are important performance measures for us from a satisfaction perspective, and we have consistently ranked high in them.
- **Access to needed services**  
This is another area where, once again, only upon surveying do you get the information. We want to know if people feel like they are getting the care they need. We recognize that need is a very subjective term, so knowing your patients and their families, understanding what is of value and importance to them, is really critical.
- **Involvement in care decisions**  
We just added this, in a succinct way, to our survey process which we just got back about a week ago. It

was really nice to see that 92 percent of our folks felt that they had involvement in their care planning process. I'm not sure that you're ever going to find a number that high in the fee-for-service system. So that was really good feedback for us, one in which we could say, "Yes, we're there." But we also want to make sure we don't lose that momentum, that we continue to create opportunities for dialogue, trust, and relationship building between our team process and the people we take care of in our program.

- **Satisfaction with services provided**

Our major criticisms were that we don't have enough activities, they don't like the food, and, while they love our transportation providers, we need to be on time more regularly. The services that we know often take the most aggressive amount of attention are the ones that seem to be more important. We started out with a very naive perspective about 10 years ago thinking that what people would value the most is clinically competent geriatricians and physicians. No, they expect those people to be there. So it's really important to establish your performance indicators based on the perspective of the people you're taking care of, i.e., your consumer, not on your own values or expectations. It was real eye opening; over the years we've learned a lot from these people by just listening.

- **Quality of care**

That's a real catch-all phrase; how are you going to determine that?

- **Acute care utilization-hospital discharges**

- **Acute care utilization-LOS**

- **Acute care utilization-inpatient**

**days per 1,000 per annum**

- **Acute care utilization-re-admission** (within two weeks rather than the 30-day intervals that are looked at traditionally )

- **Nursing home utilization—LOS for short-term stays**

- **Nursing home utilization—long-term discharges**

- **Nursing home utilization—LOS for long-term care stays**

- **Inpatient psychiatric services**

- **Inpatient rehabilitative services**

- **Use of prescription drugs**

Polypharmacy is a huge issue for this population. Anytime you get more than five drugs you're automatically going to have some kind of drug interaction. So controlling the volume of drugs that people are on in a way that effectively targets what their needs are, without over medicating, is really important. The close supervision that we are able to have within a PACE environment really helps us with that. Those numbers are in your PACE profile. In South Carolina we run a little bit over three drugs per person. Now, it varies across PACE sites whether that data includes over-the-counter drugs or just prescription drugs. That's one of the flaws in our data set. Also, it depends on your cycle fills. Sometimes, if you're on a two-week cycle fill, that data will show up. We track very specifically in South Carolina because we use Pharm.D.'s aggressively as part of our team process. We look at psychotropic medication, cardiovascular medication, beta-blockers, things like that. We look at their effectiveness and at generic versus name brands. We closely track that information. We run a little over 2.8

prescription drugs including those over-the-counter (OTC) drugs that are prescribed by the physician, e.g., Tylenol or Dulcalax. If you include all OTC drugs, we run around 3.6–3.8 drugs per member, per month. We begin to track this upon enrollment, and they are enrolling with an average of eight to ten medications. Then we look at what we can cut down and track drug use at three and six month intervals to see how much we're having to add back and what we're able to do so we don't have to add back. It's been a good learning experience for us. We have also created as part of our system a drug utilization review committee that meets regularly with our primary care committee. We look at and study the latest things on the market. Out of that group comes things like protocols for anticoagulant therapy. We're also focusing on how we're managing our diabetics, the latest medications, their cost effectiveness, and if they bring about better outcomes.

A lot of the other PACE sites are beginning to add Pharm.D.'s as part of their process. Initially it seemed like an extravagance, and we sort of fell into it by sheer luck in South Carolina. The school of pharmacy needed an FTE on their faculty and a place to rotate. We were able to put up half the dollars and get a full-time doctorate pharmacy faculty member who helped establish this program. The university has done away with the baccalaureate pharmacy degree and now only has the doctorate in pharmacy program available. They were mandated as part of the curriculum to have a community rotation, and we were the ideal setting. So, not only have we had students for the last eight years, but we've also culled the best of those as employees. Now we have three full-time Pharm.D.'s in addition to our part-time faculty. Student rotation has worked real

well for us. It's an administrative cost for a preventative measure that really has a major impact on quality of care provided later.

- **Use of psychotropic drugs**

We watch very carefully how we are effectively doing this. We have very little inpatient psych stays in our program. And even across PACE, I don't think we have a lot of inpatient psych stays. Those can blow you out of the water financially as you probably well know. Unless you have some really major kinds of behavioral problems, a lot of this can be managed in nontraditional ways like assisted-living, subacute, or SNF.

- **Use of in-home personal care/chore services, community-based**

How many hours are folks getting? What percentage of your population is using these services?

- **Use of in-home personal care/chore services, specialized housing**

This gets a little complicated in the definition. If you think about it, Oregon has a PACE program, and they contract with the adult foster care models. Often there is some service delivery component that is part of that contract process, and then the PACE program brings in more services on top of that. You contract with assisted-living; there's some component of room and board. PACE programs may also bring other services in on top of that. So that's what we're talking about, in-home use of personal care services and specialized kinds of housing settings.

- **PACE center attendance**

That's been one of our major controversial points with PACE, drawing a lot of criticism. No, you're not required to attend day health. That's not a prerequisite when you enroll in a PACE program. On the other hand, I think what you will

find is that it is a very effective substitute for a lot of things such as hospital stays, skilled nursing placements, even home- and community-based services. It's also a substitute for skilled home care, and frankly, in South Carolina, I think we have the highest utilization of adult day care of any program across the country. That doesn't mean that we don't have a subset of folks who don't come. I think the Bronx has the lowest level of adult day health use and yet the highest level of home care use, so you can see the swap-off. But they also have the highest reimbursement rates. There's an ability to "swap out" on those issues in the Bronx, given the payment there. Sometimes the adult day health center is a barrier for enrollment across PACE programs along with the fact that this is a staff-physician model and you have to give up your own physician. But actually, it's not necessarily an impediment in the long run when folks begin to understand and appreciate the value of it. We also find in South Carolina that it is the breaking point for nursing home placement if families have to work and they don't have someplace for their parent to go during the day. Then they often feel that their choices are institutional placement versus community-based care. It's a double-edged sword.

- **TB screening**

That's part of our admission criteria. We look at thresholds for this kind of indicator at 100 percent. You want everybody enrolled to be screened.

- **Influenza immunizations**

100 percent flu shots.

- **Pneumonia immunizations**

100 percent pneumonia shots.

- **Use of physical restraints**

We've had a lot of discussion about this one. As we refine our

performance indicators within PACE, we really want to look at the long-term care definition of physical restraint. It can be anything from a reminder belt to a lot of other things. And if you think of PACE as a kind of nursing home without walls, you're looking at how that definition applies across all those settings—how it is used in the home, what part it plays in the care planning process, and how it affects discussions with and education of the family. We really need to refine this. I think it is an important piece of information to look at especially when you're dealing with a long-term care population.

- **Weight loss**

Once again we had to look at different parameters below a certain percentile and a certain timeframe since we're really clinically focusing on appropriate indicators for the population that we were serving.

Just to let you know that we're not the only ones looking at this, currently HCFA has Peter Shaughessy, a researcher at the University of Colorado, under contract to develop continuing quality outcome-based indicators for PACE. For those of you who don't know him, Dr. Shaughessy developed OASIS. They have convened an aggressive panel of experts, with input from PACE providers, and have created something like 50 draft outcome indicators. The definition that Dr. Shaughessy uses looks at improvement stabilization or decline in a lot of areas.

Some of these indicators include improvement stabilization, decline in ambulation or locomotion, pain interfering with daily activities, hospital utilization, number of participants residing in a nursing home at any given point in time, and hospital readmissions within 30 days. Actually, when we started looking at some of this in South Carolina we

found that we needed to push the bar back to two weeks and track it out from there. The number of medications, caregiver satisfaction in PACE programs overall, participant care consistent with performance about end-of-life decisions—these are a lot more clinical kinds of things and it gives you a little snapshot. These are still in discussion and refinement, and we will be testing these performance indicators sometime soon.

We're not real clear where PACE is going as it relates to quality expectations from HCFA's perspective. They tell us the regulations for PACE providers are going to be out in August. It's not clear now whether or how the components of QISM will apply to PACE. We know that they have invested a lot of money in this, but this is almost two years away, and provider status is looming on the horizon for us. The last conversation I had with HCFA on this related to the fact that they won't work together with us in this transitional phase. They believe there will be a lot of issues that will resolve as we move into provider status. In other words, they're not going to have the answers when the regulations are published.

Twenty-five to thirty years of experience in healthcare has provided me with the following information about health and medical service distribution:

Nonessential Services	15 percent
Services Controlled by the Physician	35 percent
Essential Medical Services	50 percent

Nonessential services are services or the duplication of services that are repeated simply because there is no consistent system of care—physicians see patients in their office during the day; they make changes, but the patient is still running a temperature

and doesn't have an on-call system, so they go to the emergency room, and the same procedures and tests are done in that environment. Not that the initial part of that testing component wasn't right, but without the communication and coordination of different service delivery components, it is difficult to manage the needs of these folks in a comprehensive way.

Another 35 percent of utilization is directly controlled by the physician's pen. That varies from practice style to practice style. We started out with a physician in our program who kept referring people to cardiologists to adjust their lasix, and we suggested that he could do that himself. It depends on their practice style and comfort level. Over time, I think we have found that a type of physician gravitates to PACE, one who is open to our concept of care, is willing to work within our team environment, and is willing to take chances if he or she is sure that caring for someone in a different way is going to result in the same kind of outcome as traditional systems, i.e., the community standard of practice.

The ability to take risks and to develop those alternative services varies greatly across PACE sites. I am not suggesting that you change the practice patterns of your physicians; I am saying that you need to understand what's important to them in caring for their patients, and you develop mechanisms or ways to get those needs met.

## Top Inpatient Categories

People from the Milwaukee site came to see us a couple months ago and gave us some of their inpatient utilization information. We were trying to understand why South Carolina's hospital rate is so low. What are we doing here that we're not doing at other PACE programs? Pam was also

kind enough to send me some of your information for Minnesota. Let me put this in perspective.

Our fiscal year started in October, and our inpatient utilization so far this year is 318 days per thousand, per annum. That's with the frailest patient population in the country. So you can manage these folks in a different environment and be very effective. We like to say that the hospital is the last place you want to be. We use a lot of one-day observation stays. So when you look at our length of stays which average around 2.5 days, it includes those one-day inpatient stays. Our total number of enrollees was 380.

Let's look at our admitting diagnoses.

- **Dehydration**

Given our level of dementia, we manage it as best we can. Getting them to drink and remain hydrated in the community environment is pretty tough even though we do it in the day health center, and they come very frequently. This is for our calendar year of last fiscal year; we had seven admissions for dehydration.

- **Hip fractures, falls**

These are difficult to prevent. You can try to teach a 95-year-old to fall right, but they're still going to break something. We had six admissions for hip fractures.

- **ESRD**

We had five admissions for ESRD. Some PACE sites serve ESRD's, some don't. ESRD is the only current stop loss diagnosis that we have. In South Carolina, if we didn't serve ESRDs it would be a problem for us. Unlike most, we have been able to negotiate with HCFA an allowance to enroll ESRD's. We just don't know how the payment mechanisms are going to continue. The stop loss will go away. We do have a much higher AAPCC reimbursement that comes

## Top Five Inpatient Categories

PSC—South Carolina	CCE—Milwaukee	MSHO
1. Dehydration (7)	1. Pneumonia (19)	1. Circulatory System Diseases (263)
2. Hip Fracture (6)	2. GI Hemorrhage (16)	2. Respiratory System Diseases (241)
3. ESRD (5)	3. Esophagitis, Gastrointestinal & misc. digestive disorders (14)	3. Injury and Poisoning (199)
4. Pneumonia (5)	4. Cardiovascular disorders (10)	4. Digestive Disorders and Diseases (115)
5. CHF (4)		5. Mental Disorders (79)
LOS: 2.5 Days	LOS: 4.9 Days	LOS: 6.1 Days
Acute Care: 387 (per 1000 per annum)	Acute Care: 2500 (per 1000 per annum)	Acute Care: 2232 (per 1000 per annum)

and the quality of care provided. We don't put them in subacute or the SNF and leave them alone. We very aggressively manage that care. Our physician is the same physician across all levels of care. I recognize that a lot of these things are not what you have the ability to do because you contract with community physicians. Having control of all the system components does give you the ability to manipulate the system. But I understand that obstacle for you, and maybe there are things that you can apply to your community setting.

## Acute Care Utilization

When you focus on acute care utilization, one of the first things to do is look at your statistics. It's good to see that you are able to get your hands on this kind of data. You need to understand what is happening to the people who are in your plan. Why are they going in, what kind of resources are utilized, who are the physicians that link back to certain practice styles? Do you have patients who are grouped within one practice so that you have better ability to leverage numbers and effect change? What are your reasons for admission, and why are they staying so long? Look at your length of stay, and see if you can relate it to certain diagnostic groupings.

Then you can ask additional questions. What do you have to do to help shorten that length of stay? Ask your physicians and your primary care providers, "We could send this person home earlier if we had what in place? What would make you comfortable shortening that discharge?" Sometimes it's as simple as guaranteeing that they will show up in the physician's office the next morning so their congestive heart failure can be monitored. Is that an issue of transportation or case management? What are the issues that are going to lead that physician to look at providing care in a different way than normal fee-for-service? Working

off of a state number; it's not adjusted. I tried to negotiate our taking the adjustment on the ESRD AAPCC; that would give us almost \$8,000 a month. I don't think they're going to let us do that.

- **Pneumonias and congestive heart failure**

These are ones that we have not been effectively managing in the day health although we try often to do. When you think about the profile of our patients, to only have four CHF admissions for unmanageable pulmonary edema and related problems is pretty remarkable.

We have put together a simple medical record review form to collect information and see how we managed GI hemorrhage differently, because it never hit hospitalization. Interestingly enough, what we found is that technically, the medical management may not have been a lot different. Ours is so good because we use subacute. We admit them directly into a subacute care environment, and they have better clinical outcomes.

One of the obstacles we found in

Milwaukee, is that they require a guardian to be appointed. So they can't effectively use this substitution for acute care without going through a lengthy court process. All you want is a short-term stay managed care. We're not talking about SNF placement as a long-term commitment; we're talking about short-term stay. For us, it was a real eye opener. This had nothing to do with medical management, it had to do with the availability of resources. This is not adequate utilization, and it is costing taxpayers more money.

In South Carolina, we pay to hold an empty bed because we have a really high occupancy in our nursing home environments. There are a limited number of Medicaid beds. If we have a patient at 5:00 on Friday afternoon that we want to move out of the hospital, we have a bed to put him or her in. We also stole bits and pieces of the Evercare model and looked at bringing in our nurse practitioners and physicians to work very aggressively with our nursing home staff. We have created strong relationships there. If we have a unique procedure or expect special nursing, our nurse practitioners will go in and train all three shifts and monitor their ability

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with your clinical staff in understanding this is really key to thinking about how to manage care differently, along with providing the resources.

Then you build the infrastructure. Over the years when we ran into major obstacles, we would look at our data. Who was running the highest length of stay? What were those problems? How could we have done it differently? We would take those cases back to our team and play them out. This case analysis has been helpful to us over time to change our decision making and to understand from an administrative perspective what kind of resources have to be in place to make major changes in utilization of service, without compromising quality of care and outcomes.

## Pharmacy Utilization

This is another cost issue and certainly impacts quality. What kinds of drugs are people using? Are there generic substitutes? What kind of purchasing contracts do you have? What is the availability? Don't underestimate the role of clinical intervention. That can help your bottom line. It's one of those proactive, preventive kinds of measures that can really make a difference in quality. Look at other preventive measures and mechanisms to improve compliance. When we see these people coming in on eight or ten medications, we find they organize their medications in shoe boxes, by physician. And there are multiple medications, sometimes three doses of one drug. No wonder they're going in for toxicity. It's important to understand who they're seeing and how they're accessing these medications, and then bring back that good old nursing or teaching role. We can get reminders, medi-paks, simple basic things that make a difference in compliance. If they adhere to their prescriptions, you can better manage their needs.

## Where to Begin

Sometimes it's difficult to choose where to start. First, you need to understand your system. It's important to understand what service components you have in place. How do they work? What kind of utilization do you have? Acknowledge your limitations. Don't say we can't do it; you have to start somewhere. And you can make a difference. We're very good at saying, "Well, plan A didn't work, let's try plan B. How can we figure out how to get around this particular obstacle. There has to be some way to overcome it." But just don't acknowledge it or accept it without really thinking it through. There are some finite things you cannot change. Those are the ones you figure out how to get around. But you can make a difference.

Ask yourselves: What are the things that are important for you to change within your system, your access, or your service provision that are going to make a difference in quality, cost and outcomes? Then determine what those are. If it's access, should you restructure the service delivery system? Can you build something over here that can substitute for what you're doing over there that is a better product? Sometimes it's the quality; sometimes you're paying less over here but you need better quality and you're going to have to put more money over there. But in the long run your outcomes are better, and your quality of care is better. So don't always use cost as your first indicator. I don't think that necessarily plays out in the long run. Think more proactively, more preventatively on care. What can you do to eliminate problems up front? "Just do it." Develop a plan, try it, don't hesitate to go back to plan B, and start again if that didn't work. We use the analogy in PACE that you can take swimming lessons on dry land, but at some point

in time you have to jump in the water. That's part of the process of developing any kind of healthcare infrastructure. Until you get in there and know where the rocks and tree stumps are, you're not going to know what changes you really need to make. Start out with something that you feel you have control of. Collect your data, evaluate, and go forward.

As you go through the process of developing performance measures it is important to recognize the following factors.

- **System issues**  
The example of Wisconsin and nursing homes and utilization is a really good example of a system issue. Sometimes within your own acute care system there are system issues.
- **Primary care has functioned as the Lone Ranger**  
They have been out there charging on this horse forever. Sometimes they think that they are the only ones who are advocates for patient care. That is important to cultivate, but we all are invested in quality of outcomes and care. That is why we develop these programs. We're trying to look at a different way to provide care that achieves those objectives. Capitalize on the philosophy and approach of the physician. But again, understand that their reason and rationale for being in control is one in which they feel like they are the sole controller. Sit down and talk to them. Ask them what needs to be different. If you have any kind of volume, any one particular practice where you can leverage change, maybe you can begin to look at interventions and incentives that change how you provide care across your system.
- **Don't legislate change, but build partnerships**

This is important. Look at ways of building partnerships and objectives. Build incentives where everyone benefits. The incentive is quality patient care and outcomes. Capitalize on that; that's wonderful.

- **The goal is better patient care**

How are we going to do it better and differently? That's what we're all about, not necessarily cost containment, but better outcomes.

One of our doctors said to end with this one:

*A grook on finding a form commensurate with one's subject: It may be observed in a general way that life would be better distinctly, if more of the people with nothing to say were able to say it succinctly.*

And he says that what that means is "just do it!"

## Questions

**Q:** What have you seen in terms of Palmetto taking learnings from PACE and mainstreaming them within other parts of the health system?

**A:** We've done a lot of that. We built our whole geriatric service line with lessons from PACE. We've opened a senior primary care practice on campus that we staff with geriatricians with a Medicare-only practice that takes the case management concepts of primary care and the things we've learned with PACE. We have a hospitalist that now manages our geriatric patients on the inpatient side that uses the concepts of how we manage with primary care. We hopefully will break ground on our own skilled nursing facility that, if I can consolidate all my PACE patients there, should be up in two years. We have also developed a program in conjunction with our state Medicaid agency for medically fragile children using the concepts of PACE in a medical home that has been very successful, considering what I went through to get it started. We started out with a foster care population because it was the only one the state had guardianship of and could mandate and get around this freedom of choice issue under Medicaid. So the state, having custody of these kids, mandates their enrollment in our program. That has worked so successfully that it is going statewide, and we are partnering with the Children's Hospital systems to sponsor it. I honestly think the concepts of PACE have applicability across any kind of high-cost, high-user group.

Even within your own enrollment, I think that you're going to have a segment of people for whom you can pretty much predict cost and care. When you can do that, you have the ability to make effective change.

Whether those fall out on diagnostic related grouping like diabetics or hip fractures, you can begin to look at some homogeneity there and begin to build systems that are more effective across larger numbers. PACE has a lot of applicability. We have also opened a geriatric fellowship program in response to our difficulty in finding geriatric physicians. We just got our certification for five years for a ten-year-program. This is a major development that we're real excited about. We also looked at building research on top of service. We've opened assisted living programs that are operating for community-based populations. A lot of things have evolved out of the lessons learned from PACE.

**Q:** Judy, I think a difference between MSHO and your program is that your state requirements for the threshold of frailty are different. Maybe it would be worthwhile to get a thumbnail sketch of your criteria so we can get an idea of the kind of people you're talking about for home care versus the kind we have.

**A:** Those do vary. In South Carolina we like to say that if you don't have one foot amputated or in the grave, you don't qualify, and that's pretty much what it is. We have some of the strictest levels of care criteria in the country. It has to do with the state's approach which is to keep raising (or lowering depending on how you look at it) the bar of how frail people have to be which, in theory, reduces your numbers. Well, no. If you limit the number of nursing home slots and the number of home and community-based waiver slots and people can't get in the door, then, in theory, no care is cheaper than care. So recognize that that's the approach of our state legislature. We have very high frailty standards, something like 4 out of 5 ADL dependencies. They do now look at cognitive impairment, and ability of cueing is required. Sites vary; there's

even different criteria between the Bronx and Rochester, New York sites. Bronx actually has the least frail population of any program. Rochester, interestingly enough, in theory is supposed to have the same criteria, but Rochester has a frailty population that looks more like South Carolina's. Milwaukee is relatively frail. California has less frail criteria. Actually they look at some IADL dependencies as the minimum threshold for qualification, like dependency in medication instruction. It does vary drastically across states. Tennessee, for example, has very high thresholds. They require a 24-hour caregiver in the home in order to get into their home and community waiver programs. We had to figure a way around that one when we started the PACE program, so there is some verbiage in there about having to have a 24-hour lifeline or something like that if someone does lives alone. So it's interesting how states have interpreted the level of care criteria.

**Q:** Judy, your PACE site in particular and most of them, actually, are sponsored by hospitals. Is there a tension between being sponsored by the hospital and trying to keep people out of the hospital?

**A:** Our system is so big—it's about 1,000 beds. These people get lost in it. We have a nursing shortage, a bed shortage; it's not a good acute care environment for our geographical region right now. But no, I don't think hospital systems put pressure on their PACE programs to admit.

**Q:** Could you tell us a little more about the adult day health center (ADHC)? Is it a medical model?

**A:** Very much a medical model. You put it in the community where these people are. It's the focal point for care. It is the office space for your team and the physician's office. It's your rehab

facility. Then it also serves a social component sometimes with people. There's a mini-clinic that goes on all the time. Our mini-clinic within the ADHC looks like a little emergency room with IVs, tube feedings, and other procedures going on. You can do a lot of medical care there that becomes a substitute for a skilled home care visit which can run around \$100, whereas it takes about \$45 a day to run day health. We have six centers. Two are focused on dementia because we have such a high volume. Then we also have one center that is open on the weekends so we can provide respite if families need a break. We also have one telephone number, available 24 hours a day, seven days a week, by which our patients can access physicians. It isn't triage through a nurse; they talk to a doctor. That has been one of the most valuable things we ever did. Sometimes they call just to see if they will get an answer. We have an administrator on call, but we also have the physicians. That has been very important for us. Our geriatric fellows don't substitute, but they expand our primary care. Our patient/physician ratio is about 1 to 100. When you add nurse practitioners it comes to about 1 to 45. Now you see why we can make this kind of change. You're really bringing them back home to the bedside, having them focus on taking care, sitting down with a family conference, working out issues, creating communication channels, and building trust.

**Q:** I was interested in your top five inpatient categories, and I'm wondering how much of the difference between your numbers and Milwaukee's and ours can be attributed to the criteria you have in place to even get into the program. You said that yours seems more stringent.

**A:** I'm not sure it's a whole lot different. Across our populations our diagnoses were pretty consistent. But the ability to care for them in different

settings is a little different for us. These numbers are typical of long-term care across most PACE programs. But the complications of those, the dementia for example, directly impacts why we have so many dehydrations going in. Normally we think about that as something we can prevent. But when you see that 81 percent of our enrollment has dementia, only having seven hospitalizations for dehydration is pretty good. So I think it has a lot to do with the community, the environment, and the problems.

**Q:** I'm curious about your enrollment process. Right up front do you say that this is a different care delivery method and that this is what you're going to have to do? And what is your disenrollment rate because of dissatisfaction?

**A:** Very much so. It's less than one percent of disenrollments. Overall, it's about four percent for us in South Carolina. But the majority of that has to do with moving out of the service area. A lot of people have multiple children, and they move from daughter to daughter to daughter. That's the biggest reason. And, yes, we're very specific during the enrollment process. Part of our learning was that less than six percent of the entire population of South Carolina is enrolled even in a commercial HMO. We only have one Medicare HMO. Managed care has not hit us in South Carolina like it has in other environments. Certainly not like Minnesota. So it is difficult for people to even understand the concepts of managed care. The other difference for us is the fact that the majority of our people are dually eligible. Finding a physician that will take Medicaid is difficult in our state because the reimbursement is so low.

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# Working with Community Physicians

*Susan McCarthy, Director of the Technical Assistance Center, Community Care Organization, Inc.*

Let me tell you a little about the Community Care Organization which is the sponsor of our PACE in Partnership Programs. It's a private, nonprofit organization that was founded in 1977 with the goal of doing a research and demonstration project aimed at enabling people to receive their care at home rather than in institutional settings. This was an amazing idea in the 1970s. Over the years, Community Care Organization has developed and tested over a dozen different programs. By far our largest is PACE and Partnership Initiative. We've been operating PACE since 1988 and Partnership for the last couple years. So, since Judy did such an admirable job talking about PACE, I'll really be focusing on the differences between the two and talking more about the Partnership program.

I'm the director of the Technical Assistance Center. We started doing technical assistance in 1994. Prior to that time, On Lok Senior Health Services of San Francisco, the original model upon which all the PACE programs are based, had always done the technical assistance, worked with developing programs, did site visits, helped them develop their feasibility studies and decide whether to go forward with development or not, and worked with them through the first several years of operation.

In 1994, it became clear to On Lok that they were no longer going to be able to do that all over the United States. So they identified three mature PACE sites: the one in South Carolina where Judy works, the one in Rochester, New York, and ours in Milwaukee. They decided that South Carolina and Rochester could take care of the East Coast, On Lok would keep the West

Coast, and we could take care of the middle. We have done technical assistance in eight states. We work with all sorts of entities: community-based organizations, big hospital systems, smaller systems, etc. We've also worked in two Canadian provinces which has been a really interesting experience. We worked in Edmonton, Alberta where there are now three programs. In Canada they're called Choice. Financing is a bit different of course, because financing is different in the Canadian system. But their outcomes are fabulous and they are so pleased with what they have been able to do in terms of reducing acute care utilization and keeping people out of permanent long-term care. We've also worked in British Columbia, helping them assess feasibility, and we are hoping that they will also do a Choice program one day.

We recently were awarded a state technical assistance contract by the state of Wisconsin. You may have heard about Wisconsin's newest initiative, Family Care. Counties have been identified as care management organizations to develop this totally new program. We applied for and were awarded the technical assistance program with the state to work with the counties that are going to be the demonstration sites for Family Care. We just started working on that last week.

## The Traditional Acute Care Model

Why doesn't this work? Why don't any of us want to provide care in this way? Well, it's cure or fix oriented, and for the frail elderly population, it's just not realistic. The scope of services is

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limited to medical care. If someone has surgery, for example, and is going to need someone to come home with them and prepare a meal that day, that just may not be within the purview of what an acute institution is able to arrange. It's an institutional focus, i.e., if someone can't go home from the hospital, they need to go into a nursing home. We have learned that the best elderly care is not provided in an institutional setting, that it's not always what people need; these are the reasons we're trying to work beyond the acute care model with MSHO, PACE, and Partnership.

## Social-Health Models

Like yours and ours, these models are not necessarily focused on cure. The integration of all care components — acute and long-term care needs, primary care needs, social needs, and recreational needs—must be addressed for this population. The emphasis is on personal and social adjustment and meeting the needs of the whole person. One of what we consider our most important QI studies this year is on integrating participant (we call our enrollees participants) wishes into the plan of care, integrating their goals. We found that we weren't as good at that as we had thought prior to measuring it. So, we're working at getting better at that.

Our goal is to minimize further deterioration. That sounds so negative, but when cure is not possible, this is often the best we can do. Keeping people from deteriorating further is often the difference between someone needing or not needing full-time care. If we can keep people at the point where they can do a pivot transfer and their spouses can help them, then we can keep them at home.

Maintaining community living is so central to what we do. The people who enroll in both of our programs, PACE and Partnership, usually list that as

their primary goal. They want to stay at home as long as they possibly can.

We're trying to emphasize consumer choice, involvement, and self-direction to the greatest extent possible.

## Limitations of PACE

What the state of Wisconsin was concerned about with PACE was some of the limitations that are evident in any program, such as the limited choice of providers, particularly primary care physicians. In some markets this has actually caused a difficulty with referrals because physicians don't want to give up their patients. In other instances that's not the case, because if someone really is at the nursing home door, which is the point at which we tend to get enrollees, (people don't generally come in before they need it), then, at least in our market, if they go into a nursing home, their physician is probably not going to follow them. But in some markets it really was making a difference, people not wanting to give up their primary care providers. Madison, Wisconsin was one of the areas where this was a major issue.

Regarding the emphasis on the adult day care model, attendance at the PACE day center is not required. However, so many of the services are delivered there that attendance becomes, practically speaking, necessary to keep many people healthy and functioning as best as possible in the community. Many PACE services are provided in the center. We are finding, however, contrary to what I think the state of Wisconsin expected with the Partnership model, that we are having utilization of our day health centers by Partnership enrollees, and about 20 percent of them attend the day health center on a regular basis, with others attending from time to time. We are glad to have those PACE centers there for when the enrollees need it.

Another limitation of PACE from the state's perspective is that it only services the elderly. Fifty-five years of age, of course, is not elderly, but that is the minimum age cutoff for enrollment in this program.

## Partnership Programs

Let me give you an idea about the census. Currently in Milwaukee, we have the second largest combined census of all the replication sites. We're right after Bronx at about 540 enrollees. About 125 of those are Partnership. We actually have operated both of these programs under our PACE waivers for the last couple of years. Pam mentioned that we had just recently received our waivers for Medicare for the Partnership program. That's true, we have been operating effectively under the current waivers that we had. We have been at financial risk for this since the beginning.

There are four Partnership sites, two that are serving just elderly, one that serves young disabled, and one that's serving both. Madison Elder Care has an elderly program. They also have both PACE and Partnership. They have about 190 people in their Partnership program. CLA, which is Community Living Alliance, serves a young disabled population, and they have 102 enrollees. In Eau Claire, Community Health Partnership has both elderly and disabled, 98 elderly and 37 disabled so far.

Evidence of the importance of making this available to younger disabled people is the percentage of people living in the community with a chronic condition. Only one in four of them are elderly. So far, our program does not reach children. But as you can see when you combine a Partnership Program for both elderly and disabled people, you're covering a vast number of people who are trying to live in the community with chronic conditions.

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## Goals of Partnership

- Improve healthcare
- Provide more cost effective care
- Assure consumer choice
- Strive to maintain community residence

The first two goals as well as the last one we share with PACE. Certainly PACE is interested in assuring consumer choice, but in the areas of choice, we've added a couple more—the physician and additional services in the home.

## Similarities Between PACE and Partnership

- Capitated per person financing, both Medicare and Medicaid.
- Nursing home certifiable people, using state criteria at the time of entry.
- Coverage of all Medicare and Medicaid services. Other services are covered as well, basically whatever the interdisciplinary team decides can keep this person functioning in the community as well as possible.
- No incentive for cost-shifting. There's absolutely nothing to be gained by moving someone from the hospital to the nursing home to some other center. We have to pay for it all.
- Provider assumption of risk. I would add the word eventually which applies to most of the Partnership sites. They are under a risk-sharing arrangement now with the state. Because we had already been bearing full risk for this program for a couple of years there was really no reason for us to enter a risk-sharing arrangement when we did finally get our Partnership waivers, so we did not. But the other sites all do have an arrangement like that.

## Differences Between PACE and Partnership

With PACE we have an employed

physician. They are staff physicians. We have a medical director and four primary care physicians caring for around 400 people. In Partnership we have a community M.D. and a staff Nurse Practitioner. The N.P. is a vital link between our program and that physician in the community. She is the one (all of our N.P.s are female) who is at that physician's office, who is attending office visits with the enrollee, who is going back to the team and reporting on things, and who provides that constant link. She is also in the enrollee's home a great deal and can report that back to the physician. She goes along on specialty visits and can report that back to the primary care physician too. They have a very central role in this model.

In PACE, day care, nursing, and social work components are largely conducted at the PACE center. Some of it, of course, happens at home. But a great deal of it can happen at the PACE center. With Partnership, some services are available or are used at the PACE center or some other center. We actually contract with other adult day care centers, so we don't bring everyone into a PACE center. If there is a question of dementia and they need some sort of custodial watching during the day and there is a day center that specializes in that sort of care, it may not be a day health center, but if their health needs are stable, we don't need to have them at our very expensive PACE day health center, we can use one of the other ones in the community. It may be closer to their home. They may have a relative who works there. There are a lot of reasons that we might want to be flexible on something like that. Many services are provided in the member's home. So the team and the ratios of care do look different but the team is smaller.

PACE is for frail elderly, nursing home eligible people. The federal legislation does allow private pay. If someone doesn't qualify for Medicaid, they can

private pay that portion. The state of Wisconsin has decided that Partnership will only be for Title 19 people; it's not possible to private pay. It's our exemption with the Office of the Commissioner of Insurance that specifies that we cannot take private pay people into the Partnership program. The fact is that most PACE sites serve a vast majority of dually eligible people. Rochester, New York has a 15–16 percentage of private pay. For most of the rest of us, it's a couple of people. There is such a great need among people who are dually eligible that most of us haven't really put any effort into marketing this to the private pay constituents.

PACE is a permanent provider type as allowed for in the Balanced Budget Act of 1997. Initially, we were expecting the regulations in May or June of last year. They were going to come out for comment. Then they said they were going to put them out in interim final form and maybe the end of summer. Well, we're still waiting. So, we have permanent provider status, but we don't have regulations. We're all still operating under our demonstration authority, waiting for those regulations to come out so that we can apply for provider status.

Partnership is a waived demonstration, both 1115 and 222 waivers. PACE programs are at full financial risk; the sponsors of them are at full risk for any expenses that they occur. There is reinsurance available for PACE programs, and I know a lot of sites including our own have decided to purchase reinsurance for acute care. We went with a high deductible, \$75,000. It is quite reasonable per member per month, and that will protect us from very costly cases. We did a three-year analysis and found that we come out about even doing that given one or two very expensive cases a year so we decided to try it and see how it works out. Reinsurance is available through

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private insurance companies. The only caution with reinsurance is that they have daily caps of up to \$3,000. So be sure you know what you're getting into. There isn't a really sophisticated long-term care reinsurance product out there yet.

## Differences in the Teams

PACE has the following positions on staff: physician, nurse practitioner, R.N., L.P.N./medical assistant, social worker, occupational/physical/recreational therapist, dietitian, transportation, and team facilitator. Partnership has a shorter list: the community physician, not really on staff but certainly part of the team; the nurse practitioner who is more or less the representative of that community physician on the team (occasionally the physicians will attend a team meeting, certainly not on a daily basis); an R.N. who is doing a lot of home care or arranging and supervising home care that is performed by home care staff; a social worker or, for the younger disabled population, an independent living coordinator; and a team facilitator. In a couple of our sites, we have both Partnership and PACE teams operating in the same place, and the team facilitator may actually work with both of them.

Rehab services and assessments for the Wisconsin Partnership are done in the PACE center. So if someone needs physical or occupational therapy, 99 times out of 100 we're bringing them into our PACE center to have that done. That represents part of the 20 percent of Partnership people who are attending day centers at one time or another. The day care at PACE can be done either at PACE or at another center by contract so there's some element of consumer choice there. We recruit the Partnership doctors. We are doing this a little bit differently than Madison. When Madison started their program, they weren't at risk for Medicare services so it was different from us. They were still under fee-for-

service for Medicare so it was much less risk for them. Anyone who was interested in the program was asked who their doctor was and that doctor was called and asked if they were interested in being on the Partnership panel. To this day, they have perhaps three times as many doctors as we do. They are generally physicians with whom we've had some sort of working relationship with in the past either through the Geriatrics Institute or some other sort of teaching arrangement or clinics that are affiliated with the hospitals that we are under contract with.

Many times they have noticed one of our centers and wondered what it is. That's an opportunity for us to market to those physicians. Our centers tend to be in the central parts of the city, so if they're practicing in those areas, they tend to have a lot of Title 19 patients. Groups have been a referral source for good partnership doctors because those doctors are already familiar with PACE and think it is a great model of care. They have referred patients to us in the past and appreciate the opportunity to keep their patients and still have us do a lot of the care management with an N.P. to help them.

Up to this point, because of the care with which we selected these 22 primary care physicians, there hasn't been a lot of behavior modification needed. They have been willing to work with nurse practitioners. They sign collaborative practice agreements, and when they become providers for us, they have a thorough orientation with our medical director and the nurse practitioner if they're going to be assigned one.

We reimburse them 100 percent of the Medicare allowable for fee-for-service and \$10 per member, per month for case consultation. Now we're looking at alternative ways of reimbursement based on utilization and other things.

But at this point, two years into operation, this is how we are doing it.

We expect our Partnership physicians to market to their current patients, and we receive many referrals from our Partnership physicians. They also market the program to other physicians in the community. We expect them to work very closely with our medical director, for example, with difficult medical cases, nursing home utilization, hospital utilization, etc. They're not so much out there on their own—not so much the "lone ranger" anymore. We have physician accessibility standards to which they are held. For example, they can't just write orders for things over \$1000 without approval. Also they need approval for out-of-network care and nursing home admissions. Our medical director also oversees the nurse practitioners. If there are issues between the community physician and the N.P., our medical director is the arbitrator.

Our Partnership Medical Director's other role is to conduct primary care reviews (performance reviews) with these doctors using data from utilization review and QA, member and team feedback, etc. So she's in something of a supervisory role. We have established guidelines for preventative health and screening test procedures. Those are based on the PACE protocol and other standard geriatric expectations.

We have had a few challenges in working with community physicians. One of them is that the Partnership doctors don't always want to follow cases into the nursing home. It isn't typically what has been done in Milwaukee. We contract with only a few nursing homes since our employed positions with PACE, of course, have to follow people if they end up in the nursing home long or short term. So you can't have one doctor going to 30 nursing homes.

We do continue to have lifetime responsibility for that person, but there has been some reluctance on the part of Partnership doctors to follow them there. Given that the Partnership is only a couple of years old, our nursing home utilization is still quite low. People haven't aged in place. It's not nearly as high as with the PACE program which has been operating for 10 years. But we anticipate that in years to come it will increase. Some Partnership sites have reported some physician reluctance to participate because they say they don't want to be Medicaid magnets. We haven't heard that, maybe because of how we're recruiting our doctors. But some of the other sites in Wisconsin have said that there are whole groups that say they don't want to be known as the Medicaid doctors.

The Team Facilitator needs to be a part of the interdisciplinary team but not a part of the team that has care responsibilities. It's how we've set up the model in PACE, and it seems to work so well that we carried it over into the Partnership Program. You could have nurses sitting there taking notes, but then they can't really focus entirely on their nursing responsibilities, so we've always used a separate team facilitator. It's not a full-time position. If you were only doing Partnership you would probably want to identify one of these people or maybe rotate it or have someone from the administrative staff serve that function.

## Consumer Choice in Partnership

We have physician choice—but not unlimited physician choice. Because of our financial vulnerability, we can't just open this up to every comer. So we fairly carefully selected the physicians. We're constantly expanding the pool.

We have 25 percent consumer representation on our governing

board. We implemented this last year, and it has been challenging. We have similarly high dementia rates as South Carolina. The people who serve on the board need to have some ability to understand financial statements and the functioning of the entire agency, not just the part of the program they're involved in. We have recruited some wonderful people to serve on the governing board, but then someone will become ill, and we have a vacancy again. This is one of the things that our state is requiring of us, and we're taking it very seriously as an obligation that we want very much to fulfill. But it has been a challenge. There are practical considerations to work through. For example, our board of directors meets for lunch Tuesdays of alternate months. Some of the people who are in the program are wheelchair bound, so we can't do a lunch buffet anymore. Someone has to come into the board meeting and get those people who need to be toileted right after lunch. We talked about changing the time of day and not having lunch, but they so look forward to having lunch. Our CFO, like most CFOs, has taken these three participants under his "financial wing" and has worked with them small step by small step on interpreting financial statements. Then they will say, "My daughter does my check book so I think I'll just show it to her." We also are going to have participants on our grievance committee.

## Levels of Care

Once again, Partnership has only operated for a couple of years and hasn't had the same aging. With PACE we have about 55 percent Skilled Nursing Facility identified by our state level of care determination. Partnership is about 10 percent lower. There are fewer medications on PACE but again they've been under our management for some time. Partnership has a lot more medications. We're working on that.

About 3 ADL deficits is the average in PACE, with 1.5 in Partnership; 7.7 IADL deficiencies is average in PACE, 5.8 in Partnership. These folks do tend to be a little younger; they tend to be living in the community. We have alcohol problems with the Partnership enrollees and more mental health issues. We used to say that these were the people that the doctors were referring to us, ones they didn't want in their offices creating a scene.

## Partnership Census Growth by Site

For the current year our number is 117. For Eldercare it is 190; they are the ones with the 69 physicians out of 31 different clinics. CLA is 102, and CHP is 136.

The community is very different in Madison than in Milwaukee, with higher levels of education. I've been to their center many times. People are doing pen pals, they read, they write. That isn't the case with our participants. It's difficult to draw a comparison. It's much more likely in Madison that they have had a relationship with a physician. But it is much more likely in Milwaukee, as in South Carolina, that they have been getting their primary care in the Emergency room.

## The Enrollment Process

One of the services that we do share at both PACE and Partnership is our intake department, although there are intake workers that are specified for the two different programs. When the intake staff members get a referral, they look at who the referral is from. If it is someone from the community, they ask who their physician is. If it is someone who is one of our Partnership physicians, then they can talk to them about both programs and see what will best suit their needs. If it's a physician who we think we might like to have as part of our Partnership program, then that's an inquiry that

can be made. If they have no primary care physician or say, they're getting their primary care from a cardiologist, which isn't uncommon, then they're a candidate for the PACE program. So, it's a balancing act when determining which of these programs will best suit their needs. Some people really need five-day-a-week day care, and that is one of the main reasons they're not interested in the program. Then they are likely to be someone who would be best served by PACE. For some people, particularly those I talked about earlier with the long-term mental health diagnosis, the last thing they want is come to a PACE center. It's just not part of how they want to receive their services. So if they don't have a doctor, we may suggest to them that they sign up with one of our Partnership doctors and be in the Partnership program.

The process itself is fairly simple. The referral comes in, and the intake department sends information if that's appropriate or goes out and does a home visit. The intake worker will then briefly present the person to the team. The team, within a very short period of time, will do the assessment of the person. Partnership assessments take place in the home, largely. PACE assessments take place in the center. They then make a decision very quickly as to whether the person is appropriate. Then a decision still needs to be made by the state regarding the level of care. We, of course, do need to meet the level of care criteria for everyone. It's pretty rare for us to miss. Generally the team can tell if somebody's not frail enough and will offer to go ahead and submit a plan of care to the state but will also suggest some alternative services. Because of the size of our agency and the other programs that we have, we can often link them into other things.

People only need to qualify at the time of enrollment. The idea was that they didn't want sites to be penalized if they were able to actually improve

people's functioning to the point where they would no longer qualify. That may change under the provider regulations. People may need to be recertified on a regular basis, perhaps annually. That's not particularly worrisome to us given the years of experience. Our average enrollee is about 82-years-old, and we're able to maintain them. People are not getting a lot better. And truly, both of these programs probably appeal a lot more to providers than they do to the public. This isn't a dream for somebody out there in the community; they would rather not need any services at all. So they are often, literally, at the nursing home door when they come to our program. They have come to the top of their home- and community-based waiver allowance for services that they can receive, or they've been on the waiting list for so long that they have deteriorated further and need a lot more services than they needed before. We do a "tune-up" when they come in (podiatry, dental care, prosthesis, medication management, etc.) and can usually bring about improvements, but the major conditions that people come in with are usually still there.

## Encounter Data

There is something called DataPACE that all the PACE programs have been using. Part of our demonstration requirement was that we all had to keep DataPACE, using the same dataset for comparison and measurement. When we started doing Partnership, we asked the state of Wisconsin if we could collect DataPACE on our Partnership enrollees as well. So, it's everything from individual encounters with the social worker to group encounters with recreational therapy. Our acute care utilization for PACE is about 2,000, if you break it down by PACE and Partnership. Now again, we're keeping DataPACE for everyone so it looks like our utilization has really gone up in the last two years, and it has, but not for PACE. It's the

Partnership utilization, that is higher—3,000 days per 1,000, per year.

It was very interesting for me to actually take our seven sites, break them out individually, and calculate those utilization numbers. It's not something that we often do. But we aren't quite managing the acute care utilization as well with the community physician. We're certainly working on it, and it is only a two-year-old program so there's no cause for alarm yet. It's a matter of practice, and if physicians in the community aren't used to thinking of alternative care settings for people, then they haven't necessarily done it as well as they could. It's developing that relationship with the family, the trust, which comes sometimes not until after years of caring for someone, that will let them feel comfortable with delivering care in an alternative setting. When someone comes into the program with a particular condition and everyone they know with that condition gets treated in the hospital, if you say we're going to put them in a nursing home, it's not going to go over very well until they are able to trust you.

Looking at alternative care settings and having those things available, as Judy said, in the state of Wisconsin and putting someone in the nursing home even for a short-term stay, requires that they must have had at least a three-day hospital stay or someone has to have guardianship and sign them in which defeats the purpose. This is all very well intentioned to keep people from being "dumped" into the nursing home after the hospital, people who couldn't make that decision and couldn't sign themselves in. But those are barriers to our being able to use alternative care settings most effectively.

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# Interactive Discussion

## Participants

*Pam Parker, M.P.A.*

*Director of Minnesota Senior Health*

*Options (MSHO)*

*State of Minnesota Department of Human Services*

*Judith Pinner Baskins, R.N., Vice*

*President of Geriatric Services at Palmetto*

*Richland Memorial Hospital and*

*President, National PACE Association*

*Susan McCarthy, Director of the Technical*

*Assistance Center, Community Care*

*Organization, Inc.*

**Q:** How are you making the housing part of that work, given the Medicaid eligibility standards?

**Judy:** Fortunately, our state has recognized that once people are enrolled in a PACE program, they meet level of care for long-term care, period. Then, anytime institutional placement applies, we look at the least restrictive level of care that safely meets their needs within licensing requirements. If they need assisted living or SNF level of care, there is some shared cost for room and board unless spousal impoverishment applies. It varies depending on their resources. For example, if you have a contract in place for \$1,000 per member, per month with an assisted living and they only have the ability to contribute \$300, you're paying \$700. The next person may have more money, and they're paying more toward their room and board.

**Q:** So in other words, you're subsidizing some of that housing because it is cost effective for you to avoid the nursing home cost?

**Judy:** Essentially.

**Susan:** Housing isn't part of the PACE model, but all of us that have been operating PACE for very long, have realized that at the very least, access to safe, affordable housing is absolutely necessary in order to prevent these long-term placements. We have approached it a little differently from the safety issues. We have an Alzheimer's unit in each of our centers. While we have high percentages of dementia, only about 15 to 20 percent of our enrollees are really at risk for wandering or agitation such that, if they're in the day center, they

really need a much different environment. So we have those dementia centers right there at the PACE centers, co-located with the clinic and therapy and so on. That's been real effective for us. We also developed our own group home in 1994. It's not the sort of four bedroom mom and pop thing. It's bigger. It was licensed for about 70, but we use some space for offices, conference space, and so on, so we really only have about 40 people living there. One of the floors though can accommodate 24 people, and it is dedicated to dementia. Day center services take place there. Meals are there. The clinic staff runs up one flight of stairs and takes care of people right in that environment as much as possible. As for people still living at home though, there are many interventions that we can do to help the family keep the person safer. We use alarm systems, for example, pretty routinely. We have some people who are fairly placid during the day and then escalate at night. We are opening a dementia resource center in conjunction with the Alzheimer's Association in our city. It will be at one of the hospitals. That will have much longer hours so if caregivers need to get some rest, we're actually talking about doing a night care program, although that hasn't been developed yet. It is an idea from Edmonton. They do night care for persons with dementia so their caregivers can sleep during the night. It's a quiet, calm environment. When people go there for the night, there are drawers that they can rummage around in, there's a wandering circle, and it's really been quite effective in Edmonton.

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**Q:** Would you say something about how you went about implementing this with your contract providers?

**Judy:** Well, very specifically, with our nursing home, I put the checkbook down and asked how much it would cost to get a bed. If you put enough dollars on the table, you get their attention. We pay about \$150 a day, essentially for the room, board, and skill component. Then we bring in drugs, rehab, DME supplements on top of that. That is prime for our market. On the other hand, an average Medicaid bed runs around \$85 a day, and reimbursement costs for these people are running somewhere around \$113. Private pay starts somewhere around \$120 or \$130, depending on the facility. But, up front, we said we're going to bring in a little higher level of acuity than you may be used to seeing, and we're willing to pay for that. In addition, we're willing to support you in your staff development and your training. We also want medical staff privileges for all of our physicians. We want to be able to bring our rehab staff into your environment. We don't want you using your OT/PT. So we've had some negotiation. But I knew the first thing that was going to get their interest was the money. That's how you open the door.

I mentioned earlier that we pay to hold a vacant bed. We pay that at the Medicaid rate. That gives us access. That costs me \$85 a day for something that I don't occupy, but it was a way, in the long run, to cut acute care utilization. People have commonality in need; if you can sit down and figure out what buttons to push to get there without totally compromising what you're trying to do then you can open some doors and build that infrastructure.

We started with our physicians, asserting that they are the quarterbacks of our team. I clearly know that we cannot be successful

without them as a key part of the decision making process. So we sit down and listen to them. They tell us their needs, for example, that a patient needs IV therapy. We say, "No, they don't need that in a hospital; we could do that here, but this is the level of credentialing we want for the nursing staff. We want this level of skill. GI bleeds, blood transfusions, why can't we do those in the subacute care environment?" we ask. "What kind of training needs to happen?" Then we bring those resources to play.

Now, I'm not saying we haven't had problems with some of our SNF providers. We have. And we have gone so far as to report them to the licensing agency for substandard care when we've had problems. We try to leverage it with money. We've made threats; we've pulled contracts. Interestingly enough, care varies drastically depending on the administrator in charge. You can have the same direct care staff, and when you change the administrator, it turns around. That has been an interesting lesson. We found we needed to keep those communication channels going with that administrator. Build peer relationships with your DONs, your nurse practitioners, and your staff so they know the head nurses and the nurses on the floor, and ultimately, you're going to be able to keep your fingers on what's going on with quality of care. Our physicians are expected to round on these folks just as they would on the inpatient facilities. So on the weekends, our on-call physicians are seeing these people in the nursing home, and they're able to monitor care very aggressively.

**Q:** Do you think it would work not using nurse practitioners, and instead, using what we often use, R.N.s or social work care coordinators as we call them? We use nurse practitioners here too, but I think we're using a lot of the other as well. Do you think you

can get the same level of communications with the doctor or enough of a level? Have you considered using those at all?

**Susan:** We haven't tried it. The protocol for Partnership is this N.P. model, so that's what we're doing. But we're very interested in watching what you're doing here.

**Q:** Do you see any evidence that the aging of the baby boomers is impacting medicine in terms of their awareness of the future and the need for a chronic care model?

**Judy:** I see it in our senior primary care practice site, where we have a more healthy and affluent population. They are much more consumer savvy, seeking out qualified geriatricians that they feel can better meet their needs. I think as the baby boomers age they will bring a lot more private pay to the market, and they're going to demand a different level of care. The other thing I think is interesting is that frailty creates a lot of commonality. In other words, the frailer you get the more willing you are to do things like give up your physician. You begin to compromise in your decision making to meet your increasingly complex needs. I don't mean to suggest that compromise is necessarily a bad thing. I think providers still need to provide quality products and services and recognize that if people feel like they are being compromised, they will feel at a disadvantage. If you provide a product that is as good as or better than what they feel they are compromising for, then everyone is going to win in the long run.

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**Q:** Judy, there's quite a range of reimbursements at the various PACE sites across the nation. Could you explain some of that?

**Judy:** Well, as with Medicare, we're all based off the AAPCC which has this whole urban/rural basis. So your thresholds vary drastically. South Carolina is the lowest pay under the Medicare side. We average, within our AAPCC and the 2.39 adjuster, about \$960. Across PACE sites it averages about \$1,200 per member, per month on Medicare. Medicaid averages around \$2,100 per member, per month. Some sites like Oregon and Colorado are as low as \$1,600, others like the Bronx are as high as \$4,000 or \$5,000 per member, per month for Medicaid alone. (Remember, this is for the frail and includes the nursing home component.) Medicare mandates the methodology or formula for reimbursement for PACE. Then you plug in your own numbers. States are all over the place in looking at an actuarial perspective of what it is costing to care for that population. Generally this is anywhere from a 5 to 15 percent savings on the Medicaid side of the fence. Some do purely institutional basis, looking at what it costs them to pay for institutional care copays and crossover claims for the dually eligibles and then looking at shared cost and those sorts of things. Others have done combinations of home- and community-based waiver programs. Others have just done, I believe, a dartboard. There aren't a lot of actuarial firms out there that really understand this carve out. This is not your typical managed care, so they have to understand that. The state of Virginia can tell you who not to use for actuarials because they have been through all of them and finally came back to say, "Why don't we just pay you this." And it works.

**Q:** There must be some elderly serviced by PACE who might want to stay in the hospital. But as you have gone around the country, have you seen any movement, either on a microlevel or by advocates for the frail elderly, to mandate longer hospital stays?

**Susan:** I would say not. The care is so continuous. The discharge planning starts right at admission, so we're not sending somebody home and letting them figure out how they're going to get dinner that night. It is very planned and organized. The elderly in our program and the other programs I've worked with don't want to be in the hospital. Think of yourself and your elderly relatives; it's like a broken record that they want to go home. We really haven't had reluctance to be discharged, especially since they get discharged to our center. They go back, they see their friends, they see the staff, and they go home with a comprehensive plan that addresses what will happen to them in the future. So I really haven't seen that.

**Judy:** If it became very prevalent, maybe that would happen. Part of this is an educational process. If you take a well 65-year-old person and put him in bed, for every day he spends in bed, it takes another week to return to baseline. If you take a frail, chronically ill patient and put him in bed for a day, it will take two or three weeks to get him back to baseline. These people struggle to achieve very minimal things that for them are hallmarks and goals. They see the length of time it takes them to get better after they've been in the hospital. I'm not saying that if it is important for the patient and the family to have another day or two that we won't do that. Perhaps it buys them emotional security. We're not going to compromise that to push it. But we have been able to globally control our numbers enough so that an occasional exception is okay.

**Q:** Do you have problems with "refusers" of service? How do you manage that?

**Susan:** People may not necessarily agree with their care plan. Maybe they want the physical therapist to come to their house, but it just isn't possible for us to do that on a regular basis. So we need to negotiate. When people do come into this program, they or their families are very well informed about what it has to offer and what the limitations are. One of the reasons we see for disenrollment, aside from moving out of the service area, is not wanting to use a particular nursing facility. Not because it was a surprise to them, they knew it ahead of time and maybe hoped to avoid it altogether.

**Judy:** Interestingly enough, sometimes people do things like refuse amputations. It creates an ethical dilemma for the team, knowing that they can fix it, but having to choose not to intervene. So it can actually go both ways. I think the ethics committees that function as part of our model at PACE have been a great resource for those kinds of issues. Then we have had those families with very unrealistic expectations; that can be the other end of the spectrum. Usually it goes back to Susan's point about trust and communication. Once those channels are established, a lot of those problems go away, and you can begin to have what we call "healthcare wishes." Our populations traditionally don't sign formal, advance directives. Some of that is cultural. There's a good article that you can read about advance directives across the diverse ethnicity of PACE which plays out the cultural issues. In South Carolina, we are predominantly African-American which is reflected in a lot of our chronic conditions. There is just a cultural barrier that prescribes that they will not sign a piece of paper. It has to do with the fact that they think care will be withheld instead of

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provided. So we aggressively do what we call healthcare wishes. Sometimes deciding who the spokesperson is for that family, who the decision-maker is, is an issue. They have 13 children, and they all have an idea about what needs to happen to this parent. We look to our adult consent laws to establish the hierarchy, and we talk from day one of enrollment about how that is going to work. Then we try to take what they value, where they perceive their quality of life to be, and integrate that into our team and team process so that we understand their perspective toward care. That is a good foundation for building relationships and trust and understanding. You hope that you are being proactive in dealing with those issues of refusing services. We've had some of Susan's problems. We contract with four nursing homes in our area. It's not that we wouldn't contract with all of them. It's just geographically not feasible because you can't spread your staff out like that. If we have problems with substandard care, we'll pull the contract or work to get those problems resolved. But we can't always be everything people need us to be. So if they want a place somewhere else, that's their choice, and they can disenroll at any time.

**Pam:** I wanted to talk about how PACE fought very hard as did MSHO to be exempt from the new DCG reimbursement system because it was so inappropriate for this population. Are you involved in discussions with HCFA as to what that new system is going to look like? We are trying to get them to talk to us about that. We know they are collecting information. They haven't collected it from us yet. That is on the horizon, and we're talking to them about it. They're coming here to do a site visit with us next month, so we will probably talk more then. But we're a little concerned because I think that PACE will drive a lot of the conversation with HCFA, and that might be okay. But on the other hand,

we have this huge institutional population as well, and we're concerned about having a fair reimbursement for that. Do you have any sense of what is going on nationally with that conversation?

**Judy:** I met with HCFA last Thursday. This is certainly an issue we've kept on the table. We are submitting data. The impression I got was that they are going to be so consumed with dealing with this from a much more global perspective that getting down to the nursing home viable population, or being able to look at that frailty adjuster, is so far off their radar screen that we're probably going to get some stays (exemptions) beyond 2000. That's my gut feeling. But they did discuss their request for HCFA 1500 information on the outpatient and ambulatory care side which they expect to start collecting as of October, and they intend to get information out to the managed care plans as to what they will have to submit.

**Pam:** Are they talking about using any of the other functional information that you have in your database system? Are they talking about putting that together with any of the other DCG type of information?

**Judy:** There is such a level of suspicion about our DataPACE information. We want to say, "Listen, there is a lot of information here, longitudinal studies if nothing else, so look at that." Part of that is speaking a common language. One of the things that we have done from PACE's perspective is taken some alpha software that we have been testing. It develops seven different provider types that actually define who we take care of and links back to cognitive impairment and burden of care. So it's a much better scale for defining what these people look like. Hopefully that will lead us somewhere down the trail. The other thing is that HCFA has

agreed that the frail population may need a different kind of survey tool and may be developing that. They have some on the radar screen, and this is such a subset that MedPAC has come out with a recommendation that we should have a unique reimbursement.

**Pam:** MedPAC's June report comes out saying PACE and projects with special populations like ours should be treated differently.

**Judy:** But they won't apply it across all managed care. I think when all of managed care recognizes that there is some reimbursement link for caring for these folks, they're going to put their weight behind pursuing it. Whether that is good or bad, I don't know. But more numbers are going to be out there pushing this than the small numbers we have enrolled in PACE. We're only five to six thousand nationally. When we add your numbers, we're still just incrementally getting toward where this whole subset of dually eligibles really is.

**Pam:** But the dually eligible are 30 percent of Medicare costs, and that is probably understated. Medicare doesn't track dually eligibles the same way; they track them by the buy-in status, and Minnesota isn't a buy-in state. We don't pay the Medicare premium for everybody, and there are other states like us, so that's probably understated. I think that dually eligibles are 35 or close to 40 percent of Medicare, and they have to start paying attention to that.

**Judy:** It will eventually pop up on the radar screen, but they're so consumed with Y2k, reorganization, and other things right now. We're just fortunate that our little agendas are getting enough attention to move them forward right now.

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## Minnesota Senior Health Options

The Minnesota Department of Human Services has developed Minnesota Senior Health Options (MSHO), which combines Medicare and Medicaid financing and acute and long-term care delivery systems. This demonstration facilitates the integration of primary, acute, and long-term care services for people ages 65 and older who are eligible for both Medicare and Medicaid. Minnesota has received federal Medicare 222 and Medicaid 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. This demonstration began serving seniors in the metropolitan area in 1997 and is expected to continue through 2001.

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

## National Chronic Care Consortium

### National Resource Center on Chronic Care Integration

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

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

*Utilization Benchmarks and Techniques in Working with Community Frail Elders* proceedings were written by Mary Almen Goehle, Deborah Paone, and Barbara Vaughan.

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