
Minnesota Senior Health Options
Clinical Integration and
Care Management Forum

Third in a Series

**Care Coordination Across
the Continuum:
Examining Approaches to
Case Management
for the MSHO Client**

**September 8, 1997
7:30 – 9:30 a.m.**

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Welcome and Introductions

Speakers

*Deborah Paone, M.H.A.
Vice President, National Chronic
Care Consortium*

*Pam Parker, M.P.A.
Director of the Minnesota Senior
Health Options (MSHO) Project*

*Jernell Walker, R.N.
Coordinator, MSHO
Metropolitan Health Plan*

*Maryon Kellar, B.S.N., P.H.N.
Supervisor, Hennepin County
Coordinated Homes Services*

*Linda Kramer, L.S.W.
Care Coordinator, University
Affiliated Family Physicians Clinic*

*Diane Dahl, M.D.
Medical Director, University Affiliated
Family Physicians Clinic*

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

Pam Parker, M.P.A., Director of the Minnesota Senior Health Options (MSHO) Project, welcomed attendees to the program, which is the third in series for MSHO participants to address clinical integration and care management issues. These meetings are a forum for exploring care delivery and coordination issues to improve care management across settings under the MSHO model. The goal of these forums is to improve care for clients participating in the MSHO project. "As we say at every one of these forums," said Pam Parker, "We can put the money together and try to integrate the funding, but that alone does not change the kind of care that

people receive. We rely on those of you in this room to use the opportunity we have provided in making the funding more flexible to make a difference in clinical care. We are here today to learn more about how we can do that and to share experiences and information with each other as we work to integrate across the acute and long-term care settings and across the Medicare and Medicaid programs."

Ms. Parker then introduced the four panelists for today's session.

Jernell Walker, R.N., B.S.N., is medical services coordinator and MSHO point person for the Medical Administration Department of Metropolitan Health Plan (MHP). As the MSHO point person, Ms. Walker is responsible for facilitating collaborative activities between case management sites, coordinating the internal case management processes and activities, reporting activities, and performing provider education. Her responsibilities include benefit coordination with a focus on long-term care and transitional care case management and durable medical equipment coordination. She has also worked as a utilization reviewer for MHP.

Ms. Walker's nursing experience includes four years of medical/surgical, hospice, and oncology nursing. She worked for six years as a hemodialysis nurse on a renal ICU unit for the Regional Kidney Dialysis Program and for two years as a clinical educator for a renal specialty unit at Hennepin County Medical Center. Ms. Walker received her Bachelor's of Science in Nursing from St. Olaf College in Northfield, Minnesota.

Maryon Kellar, B.S.N, P.H.N., works at Hennepin County Coordinated Home Services as a Nursing Supervisor, with direct responsibility for the Elderly Waiver program in Hennepin County. She also has been responsible for creating and coordinating alternative living sites for clients, such as assisted living, residential care, and shared housing in Hennepin County.

Ms. Kellar serves on several seven-county committees for MSHO and housing. She has great enthusiasm for using computer technology to share case management documents and is presently involved in committee work to update Hennepin County's Assessment to be able to electronically share it with their MSHO partners. Ms. Kellar's work with MSHO started last year with Metropolitan Health Plan, which officially began its project in the Spring of 1997.

A graduate of the College of St. Catherine, Ms. Kellar has twenty-seven years of experience in the field of aging. Her experience includes the elderly who are residing in nursing homes, home care, and hospitals.

Linda Kramer, L.S.W., is the MSHO Care Coordinator for University Affiliated Family Physicians (UAFP) Clinics. She has been employed by UAFP since February. Ms. Kramer has a social work background and is a Licensed Social Worker. She has past social work experience in home care, hospital, nursing home, and assisted living settings. Ms. Kramer worked with Carver County for thirteen years coordinating Preadmission Screening, Alternative Care, and Waivered Services for the disabled and elderly.

Ms. Kramer also worked at the Department of Human Services as Assistant Coordinator of Preadmission Screening and Alternative Care Programs. She was appointed to serve on the Department of Human Services Advisory Committee for PAS and

Waivered Services from 1991 to 1995. She currently is a member of the Seniors Agenda for Independent Living (SAIL) Long Term Care Strategy Team.

Diane Dahl, M.D., a family physician, serves as the Medical Director of the management corporation, University Affiliated Family Physicians, for all the Family Practice Residents and as full-time faculty at the Department of Family Practice and Community Health, University of Minnesota.

Dr. Dahl served as Unit Director at the Family Practice Residency at Methodist Hospital from 1990 to 1996. Dr. Dahl has had a strong interest in geriatrics for the past thirty years. She also serves as Medical Director for the Good Samaritan Ambassador Health Care Center. While practicing in Wisconsin, she served on the Governor's Commission for rights of the elderly. She also served on the Minnesota Governor's Commission in the 1980s for medical issues of the elderly.

Overview of Case Management Approaches

MHP MSHO Case Management Goals

- to provide coordinated, cost-effective, comprehensive, quality healthcare for seniors who are in the Medicaid dual eligible group.
- to provide care coordination services that link medical services to the psychosocial services that are available in our network.
- to provide a wide range of alternative care services to reduce the need for institutionalization.
- to improve the quality of care by detecting problems early and by monitoring and adjusting care plans as the members' needs change.

MHP MSHO Case Management Components

- Assessment of health status
- Case manager determination
- Coordinator of services
- Monitoring
- Reassessment of health status

Metropolitan Health Plan

Jernell Walker, R.N., Coordinator, MSHO Metropolitan Health Plan (MHP) provided an overview of how MHP approaches case management for MSHO clients.

At MHP case management and care coordination of the MSHO member are part of a health wellness continuum. This continuum integrates all available resources and services within our network and through our supported sites. We want to maintain and enhance each individual's personal level of wellness.

MHP's eight care coordinators and case managers coordinate care over the telephone. When a person is in the hospital, we have a health plan inpatient case manager on site. We have a contract with Coordinated Home Services of Hennepin County to provide services on site in the community and a contract with Optage to provide on-site case management of members in skilled nursing facilities.

Our main goal is to help seniors make informed decisions, enabling them to stay in the community. To help seniors problem solve and to connect seniors who have no support systems to resources in the community.

Our case management model has five components:

1. Assessment of health status
2. Case manager determination
3. Coordination of services
4. Monitoring
5. Reassessment of health status

The assessment of health status includes an initial health risk assessment survey. During this assessment, we gather as much information as we can to determine who will be the case manager.

MHP case manages, by telephone, those who are low risk. Coordinated Home Services manages those at moderate risk who need hands-on community-based services. Optage manages those at high risk .

Monitoring involves comparing our initial database with current utilization data.

Reassessment is done on a timetable. Sentinel events require weekly reassessment until resolution. For people living in the community, we reassess health status and care plans every three to six months. We also complete an annual MSHO screen for members who are deemed nursing-home certifiable and who are living in the community.

Hennepin County Community-based Long-Term Care

Philosophy and Definition of Case Management

Case management is a client-centered service which respects the individuals' dignity, rights, values, and preferences. Case managers strive to promote enhanced quality of life and highest level of independence and autonomy consistent with the individual's capacity.

Case management incorporates the following core functions:

- completion of a comprehensive and standardized assessment and periodic reassessment of a client's needs and strengths
- identification of client-centered goals
- development of a high-quality and cost-conscious care plan
- coordination of formal and informal resources
- ongoing management and monitoring of client status and service delivery to ensure appropriateness of care and the optimal use of public and private resources.

Case managers are public health nurses and social workers who provide information and advocacy while coordinating the formal care network with the client's informal support system. Case managers strive for flexibility and innovation to obtain the most appropriate, highest quality, and cost-effective long-term care services available.

Hennepin County Coordinated Home Services

*Maryon Kellar, B.S.N., P.H.N.,
Supervisor, Hennepin County Coordinated
Homes Services described how her
organization provides case management
services to moderate-risk, community-
dwelling MSHO clients.*

Hennepin County Coordinated Home Services began working with Metropolitan Health Plan in March of 1997, but we spent a lot of time the year before that preparing for this effort. In June of 1997, we started with UCare. We are now beginning talks with Medica.

We have a lot of experience—we have been at this for 14 years. We have approximately 55 case managers who work for us; over 35 of those work with clients who are on the Alternative Care and the Elderly Waiver program. We just recently started a program in collaboration with Services to Seniors in our county.

In Hennepin County most of our case managers are public health nurses, although we do have five social workers on staff. With the addition of Services to Seniors, we added 12 more case managers who are social workers. So we are getting a broad perspective on case management for our clients.

We began by forming teams. We have five to seven members on each MSHO team. We divided them geographically because one of the goals for our whole organization is to do geographic location of case managers. We followed this same perspective when we looked at how to do this for MSHO, and this seems to be working quite well.

We've had regular meetings with the managed care organizations and with case managers. In that way, the case managers have had a lot of input on how this will work. I think this is why

it has been successful as it has. They have been involved in developing the policies and the procedures. They are modifying these as they go, smoothing out the rough spots.

We have a large case management manual that we put together. Sue Bulger, another of our nursing supervisors, can take great credit for this. She has worked with a group of case managers from our county to develop this. That committee continues to define what case management is for us, using this model and integrating with MSHO.

One of our challenges for case management is getting information on the client. It is difficult to get information, especially when you are working with Hennepin County which is a teaching hospital, because people tend to have about six different doctors when they are in the hospital. When you try to call and get information, no one knows the comprehensive picture of the client.

An advantage we have within the county system is our e-mail system that allows us a fast way to transfer information between settings electronically. We always follow this up with a paper copy.

Being able to coordinate care with Optage at the nursing home has allowed us to really plan well for the client. Those of you who work in home care know that you have to do a little planning. Knowing that the client is going to be leaving and being able to plan for those services is very important.

UCare/University Affiliated Family Practice Clinics

Linda Kramer, L.S.W., Care Coordinator, University Affiliated Family Physicians (UAFP) Clinic, described her role as a clinic-based MSHO care coordinator.

University Affiliated Family Physicians (UAFP) is a group of family practice clinics affiliated with the University of Minnesota Medical School. Physicians who staff the clinics are University faculty and residents.

I am the care coordinator for patients from these clinics who sign up for

MSHO. Our approach with MSHO is clinic driven. Clinics differ in the way I work with them, depending on factors like staff turnover, staff job descriptions, and level of assistance needed at each clinic.

As UAFP's only care coordinator, I make an initial visit to their home to introduce myself and explain my role. Then I do a risk assessment to determine each person's risk status for home care and for nursing home placement and what referrals may need to be made. I may set up services for assistance in their home or may provide education, resources, and information to them. If the patient has not been seen recently at the clinic or is new to the clinic, I would encourage her to make an appointment and see a physician. After I do the home visit, I consult with the physician, especially if I have questions or concerns about the patient.

After I visit a client, the team initiates a care plan and evaluates risk status. I classify the patient as low, moderate, or high risk. For someone who is considered low risk, I would make a follow-up phone call in three to six months. People at moderate risk need more assistance from the care coordinator to help coordinate their care. High-risk individuals need further intervention for them to stay in the community. Interventions might include home care services/PCA, alternative housing, therapy, adaptive equipment, or nutritional consultation. Risk identification is an important component of what we do, but I want to stress that when you identify risk, it needs to result in intervention, not just a classification.

A unique feature of our model is that the care coordinator follows each client to each healthcare setting.

If a patient is admitted to the hospital, a UCare healthcare management nurse would be notified of the admission

UCare Minnesota MSHO Care Coordination

- Team approach to care delivery facilitated by a care coordinator who is either a nurse practitioner, nurse, or social worker. Other team members include the physician and additional members as needed such as a pharmacist, a rehabilitation therapist, and a psychologist.
- The goal is to deliver health services to the individual, whether he or she is residing at home, in an assisted living facility, or in a nursing home rather than the individual having to move to the health service. One intent of MSHO is to assist the member to reside in the most favorable environment, given their health status.
- Upon enrollment into the program, the member receives a risk assessment, which is arranged by the care coordinator to identify any significant issues. This assessment has an emphasis on disability prevention and a goal of decreasing the potential for health crisis.
- The care coordinator reviews the risk assessment and develops a care plan with the member, involved family members, and the care delivery team. The care coordinator also coordinates care with other current providers. The member is involved in determining his or her health goals, including advance directive details, activity levels, and goals for quality of life.
- Any prior authorizations or referrals are made by the care delivery team with the member and are facilitated by the care coordinator.
- The care coordinator is in regular contact with the member, and the member or family can contact the care coordinator with any questions or concerns.
- The care coordinator provides health education to the member and facilitates the coordination of health and social services, removing some of the complexity around accessing care and services.

and would share information on the patient's status with me. I would work with the hospital discharge planner on their discharge planning, finding out what's needed at home.

If a patient went into a nursing home, I would coordinate the care for the first six months. Optage would take over case management after the resident had been there six months. In our system, Optage also case manages enrollees who sign up for MSHO while they are in the nursing home.

I would work with the physician and nursing home to implement discharge plans with the resident. Because I've been following the resident through the continuum of care, appropriate services would be in place at the time of the discharge.

I do work with Hennepin and Ramsey counties, and what they are contracted to do varies in regard to preadmission screenings. Hennepin County does the full screening, and then they do the care plan and assign a case manager to follow up. Ramsey County would just do the screening and then I would take over and do the care plan and the case management. So where the person lives is important in our plan because we do have the variation in what the county has contracted to do.

Our enrollment started June 1. Now we have 65 people from the community enrolled in MSHO. MSHO members have been enthusiastic about the addition of a care coordinator. They appreciate the fact that there will no longer be the Medicare paperwork.

We are moving beyond the role of discharge planning to integrated care management, that incorporates the concepts of disability prevention into the plan of care across the continuum. It's a coordinated system that links management of care across time, place, and profession throughout the progression of a chronic condition.

UCare/University Affiliated Family Practice Clinics

Diane Dahl, M.D., Medical Director, UAFP offered her perspective on case management of MSHO clients.

The Department of Family Practice Community Health at the University of Minnesota saw back in the early eighties the need for having enough patients to train our family physicians in our residency program here in the Twin Cities. Out of that came the idea of developing an HMO, which would give the residents managed care experience as well as a mandated group of patients.

UCare, the HMO of the Department of Family Practice, is going statewide now. As we look ahead, this HMO has brought us a patient population in the ambulatory clinics; this population flows into hospitals, nursing homes, hospice, and all healthcare settings, which allows us to teach family practice residents how to manage care across the continuum as part of a team.

When I left private practice to go into teaching, I felt the most important thing the family practice doctors needed to learn was how to be a part of a team. This is essential for effective case management. Physicians need to be part of a team, especially in geriatrics and pediatrics where clients are more vulnerable. My mission has been to make sure that physicians understand what it takes to be a doctor in this realm. Residents come to us with the medical training, but not necessarily the communication skills they need to be effective physicians as part of today's healthcare continuum.

As we see where we are going now with MSHO, I see us reaching for the future, but also returning to the past. What I mean by that we have an opportunity to take care of patients in the best way with resources given to us to manage care most effectively.

MSHO Client Case Study

Jernell Walker, R.N., Coordinator, MSHO, Metropolitan Health Plan (MHP) described how MHP provided case management for a MSHO client.

Mr. J.K. is a 72-year-old male who enrolled in MSHO in March, 1997. Following enrollment, the health plan reviewed existing information about Mr. J.K. that they gathered from a claims audit and from the medical information system for prior clinic visits he had made.

March 14, 1997

The health plan conducted an initial telephone health survey. Mr. J.K. stated that, compared to others his age, his health was fair. In the past year he had no hospitalizations. He took twelve pills per day (vitamins, eye drops, heart pills, and a pill for diabetes). He said that he didn't have any trouble knowing which pills to take. He told the reviewer that he had heart disease (CHF), diabetes, and arthritis. He was able to get around inside his home without the use of assistive equipment. He had a son who could take care of him for a few days if he needed someone. He also stated that he had some stress in his life. He was independent and did his own driving. He kept his clinic appointments and was able to identify his physician. He lived in a senior high-rise and had some friends there.

The prior information the health plan had gathered substantiated Mr. J.K.'s telephone assessment. Mr. J.K. scored in the "low risk" category for people living in the community. The health plan determined that no services were needed at this time, and that he would get a follow-up phone call in three to six months. The health plan would do the case management.

March 26, 1997

Mr. J.K. was admitted to Hennepin County Medical Center with a diagnosis of CHF secondary to ischemic cardio myopathy and later cardiogenic shock. A percutaneous angioplasty (PCA) was done on the day of admission. He was placed in the ICU with acute pulmonary edema and required mechanical ventilation. He was followed by an inpatient case manager. The case manager worked with the healthcare team and Mr. J.K. to assess discharge needs. In collaboration with the hospital social worker, the case manager initiated an MSHO screen. It was determined by the healthcare team that Mr. J.K. would require a short-term stay at a skilled nursing facility (SNF) for further rehabilitation due to his slow recovery and poor endurance.

April 7, 1997

Mr. J.K. was discharged from the hospital and admitted to skilled nursing facility. The inpatient case manager communicated with the nursing home case manager. The nursing home case manager coordinated plans for Mr. J.K.'s return to the community with the SNF care team and with the physician assigned to Mr. J.K.

The county case manager was identified and went on-site to the SNF. She and the nursing home case manager shared information. She participated in the care conference. A partial MSHO screen was done at the facility to set up initial services for Mr. J.K.'s return to his home.

April 26, 1997

Mr. J.K. was discharged from the SNF. As planned, the county case manager met him at his home and completed the remainder of the MSHO screen at that time. Mr. J.K. was classified as a case mix "E", meaning that he required assistance for a number of ADLs. Services needed were: skilled nursing visits once a week and a homemaker for two hours two days per week. The timeframe for services was not specified because a follow-up visit was to be conducted. Monthly updates were to be done by the nurse visiting on-site, with information transferred to the county case manager.

May 15, 1997

Mr. J.K. contacted the county case manager. He stated that he no longer needed the home services. The county case manager conducted a telephone visit to determine Mr. J.K.'s status. He clearly understood where to go or to call if he needed help.

May 31, 1997

All home services were discontinued. Case management services for Mr. J.K. then became the health plan's responsibility. Mr. J.K. was given the phone number and name of his health plan case manager for further needs.

July 2, 1997

The health plan case manager made a follow-up phone call to Mr. J.K. At that time Mr. J.K. stated that he had no new health problems. He understood the MSHO care coordination services. He did not have a cardiology appointment for six months. He had the same primary care physician, and he was glad to get the phone call.

Questions and Answers

Q: This is a question for Jernell. We have talked at these clinical forums about the role of care coordination and the need for it to integrate the services, because the system is not integrated. When I hear about your system, I hear there is a case manager in MHP, and the hospital, and the nursing home, and the community. I am wondering who integrates your care coordinators?

A: **Jernell Walker:** We coordinate in several ways. We have regular meetings to communicate. I oversee and facilitate a lot of the communication between sites. At the beginning of this MSHO work—and in an ongoing way—we had to define what is our role versus what is the community case worker’s role. The health plan is the umbrella over everything. We are the storehouse for that information. It may sound as though communication is a challenge, because we have several different case managers in different sites, but there is a hand off of information between each site. We continue to grow and learn, but we are doing it well.

Q: I am in the process of trying to develop a case management system for different populations. I am wondering about the thinking of having one person cross all settings versus having someone in each setting and how did you come to that decision?

A: **Jernell Walker:** When you have the three settings that we have, you look at who does what and how they do it and do they do it well. We know that Community Home Services does their role well, so why would we try to assume that role? Optage knows the skilled facility environment well. We would never try to impose upon that, but we do want to assume there is coordination and a team approach to the case management.

Pam Parker: When a person is temporarily going into a nursing home, don’t you assign your case management based on how long they will be in the nursing home? Or do you automatically switch case managers when the patient moves?

Jernell Walker: The health plan case manager always stays involved. But if someone is in a facility where there is a case manager, the health plan case manager allows the on site case manager to do her job. When the client moves back into the community, the health plan case manager is still involved, but the community case manager will do the hands-on management. The health plan case manager is the one to whom the other case managers communicate their information.

Q: When the county has responsibility for managing the MSHO client, does the case manager have the authority to set up arranged services?

A: **Maryon Kellar:** Once the case manager has gone out to screen the client, she develops a care plan in her head and talks with the MHP care coordinator and gets the go ahead to set up services. So we do need to get permission, but we do it in an informal, verbal way.

Q: Does the county always case manage in the community?

A: **Maryon Kellar:** In Hennepin County, the county manages moderate to high risk in the community. MHP manages the low risk in the community.

Q: We have not yet talked about the client's perspective on the care coordinator. Individual MSHO members may not understand the role of the care coordinator. What do the panelists think about this?

A: **Linda Kramer:** What is helpful about seeing them in person is that you get to explain your role. Most people understand the role and like the fact that care coordination is available if they need it. Some people do not want to have anything to do with care coordination. The higher risk people seem to really want the care coordination. I have a patient with COPD who calls me his guardian angel. There is quite a difference in each client's perception and what they want from care coordination.

Maryon Kellar: I have seen a trust relationship building between clients and care coordinators. So when the care coordinator refers them to services, they are more likely to accept them. We would not be able to approach many clients who need services without first building this trust relationship.

Diane Dahl: I'd like to bring another perspective in that our patients are often already enrolled and have a relationship with a physician at one of our clinics. With the care coordinator, we are adding another person. We have to make it clear that that's okay. We have to respond to the concerns that this person might get in the way of the client/physician relationship. It depends on the person making that contact.

Q: What is the role of the primary care physician and how they might work differently with MSHO clients?

A: **Diane Dahl:** In each of our primary care clinics, we have marked each patient's chart at each clinic with big orange covers so that all the staff who may interface with that patient know they are MSHO clients. We picked orange because it shows up.

Our family practice residents are assigned a case load, so they have the same patients for up to three years. Continuity is really important, so we make sure the resident knows about any communication about the client. Their faculty supervisor will be communicated with as well. The physician is becoming part of this team, and I think it's working. But it's nice to start out slowly and have a number of healthy people involved in MSHO.

Q: Have you had any specific positives or negatives experiences with coordinating with different care settings?

A: **Linda Kramer:** It is harder when you are not on site. You have to make a point of communicating, scheduling meetings, and doing more things over the phone.

Jernell Walker: One of the bigger challenges is to make sure people are educated about MSHO. For each of our sites we have learned to communicate using different methods. Until there is actually a member in the setting, especially in the hospital setting, that's when you need to do a lot of education. Right now, it's more getting everyone to embrace the idea that we have a program that's going to work for our seniors. We need everyone's teamwork, and we need to alleviate people's fears that we are treading on their territories. We have worked very hard to communicate with our inpatient settings, to give them the understanding that we are not here to threaten them, but to enhance communication.

Q: What size case load do you think you can handle?

A: **Linda Kramer:** That really hasn't been decided yet. You have to look at how many high risk and low risk people you have. There have been more of the lower risk than I thought would sign up for MSHO. I thought it would be more of the frail elderly, but there have been more people in the 65 to 70 age range who have signed up who really don't need care coordination at this point, but they appreciate that it will be available to them later. I had one woman who did not want anything to do with a care coordinator. I asked her why she signed up for MSHO if she didn't want a care coordinator. She had a very simple answer that I think is legitimate. She doesn't want to deal with the Medicare paperwork. So people really do vary. In answer to your question, we have to look at how much time the people we are supporting need.

Q: What are the issues and strategies for communications that you want to emphasize?

A: **Linda Kramer:** In our medical charts, there is an orange sheet, in addition to the cover, that designates them as an MSHO patient. We like to have listed up front who their primary care physician is. We also have a shingle that goes in the chart that contains the notes from my contacts with patients. This goes right into the chart for physicians to see. Also, we do lots of phone calls. I would like to implement having noon meetings at the clinics with the physicians to discuss MSHO patients.

Pam Parker: Do you have enough concentration of MSHO clients with any group of physicians or are they spread out across the physicians?

Linda Kramer: They are spread out among our physicians, so we need to do constant education. I do call the physicians initially, and I try to remind them that I am the care coordinator and would like to be involved in any issues that may come up with this client.

Diane Dahl: The senior health clinic has a group of MSHO clients. The faculty in each of the other five clinics is small so we feel like we have a handle on those patients. We work in teams with residents. We try to work so we are reviewing those things on a regular basis.

Maryon Kellar: One of the tools that Optage uses is contact with both the doctors and the nurse practitioners.

Q: What challenges or opportunities has MSHO provided for you?

A: **Maryon Kellar:** I've got one coming up with Medica. Evercare, Optage and Fairview are their all vendors. One of the things Medica has asked us to do is to have their coordinator from any one of those organizations go out on the initial site visit in the community. This is going to be a challenge to set up. Someone will be coordinating that from our end, trying to get people from different organizations out at the same appointment, with the same client, at the same time.

Linda Kramer: I have a lot of foreign-speaking enrollees who have signed up for MSHO. The challenge comes in working with interpreters for visits and phone calls. There are cultural considerations as well. I use different resources for different populations. An example with the Hmong population is I have learned that their culture includes a male-dominated family system. So instead of calling a daughter, whom I would normally call, I need to call the son-in-law.

Q: What do you want to address in terms of your case management systems as you move forward with MSHO? How will you address the efficiency and effectiveness of what you already have in place?

A: **Maryon Kellar:** My hope is that all of our case managers will be trained in this MSHO system, and they can all do this, once we get the bumps in the road ironed out.

Jernell Walker: For so long we have been doing our care coordination and case management from the telephone. As we build our skills, we want to start going out into the community to see first hand what is going on. This offers a great deal of learning as we look at fine tuning what we have now.

Diane Dahl: We need to look at the social outcomes and the purpose of MSHO, which is to help the elderly stay in the best possible situation for the longest period of time. This is going to be a hard one to measure. I don't think we have a handle on how we are going to do this yet. As far as medical outcomes, we can put these into existing paradigms of disease process and disease management. Out of that comes, in the HMO model, the cost containment. We already have some access to that information. We probably will try to see what happens with those in these elderly as they enroll.

Linda Kramer: I appreciate the flexibility of MSHO. I like the fact that there is the flexibility in service delivery, without needing to look at the funding source. There is less paperwork. There are fewer policies and procedures. I can focus on getting the patients what they need.

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Minnesota Senior Health Options Project

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

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

National Chronic Care Consortium National Resource Center on Chronic Care Integration

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

The NRC is sponsored by the National Chronic Care Consortium (NCCC), a strategic alliance of 32 leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

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