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Minnesota Senior Health Options  
Clinical Integration and  
Care Management Forum

Sixth in a Series

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**Learnings from  
MSHO Case Experiences**

**September 11, 1998**

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# Welcome

## Speakers

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

*Mary Keith, R.N.C., G.N.P.  
Director of Clinical Operations  
EverCare*

*Jennifer Loeper, R.N., M.S.N.  
Director of Clinical Services  
Optage*

*Stanley Smith, M.D.  
University Affiliated Family Physician  
(UAFP) Clinics  
and  
Assistant Professor  
University of Minnesota  
Department of Family Practice*

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

The National Chronic Care Consortium (NCCC) develops these forums as part of its role in providing the MSHO Technical and Educational Assistance Program (TEAP). Supported by a grant from The Robert Wood Johnson Foundation, TEAP activities include clinical integration/care management sessions such as today's educational forum, an annual one-day educational forum, a series of resource documents on issues that arise from MSHO, and informational resources on topics of interest to key MSHO contacts.

Pam Parker explained that combining the Medicare and Medical Assistance funding streams provides MSHO health plans and care systems with the necessary flexibility and the right incentives to better integrate care for its dually eligible enrollees. It is up to the plans and providers, however, to take action to improve care management and clinical integration. These forums present an opportunity to "keep an eye on the ball" and to share insights and lessons learned in the process of serving MSHO clients under this innovative demonstration.

This clinical forum, "Learnings from MSHO Case Experiences," was designed to discuss client case histories and to examine how integrated financing and the design of MSHO allows providers to do things differently for these beneficiaries. Today's forum also looks at the challenges presented by the MSHO model.

Three providers were invited to share stories from their care systems' MSHO experience and to provide ideas or recommendations for moving forward with the program. Several case studies are provided to illustrate the experience of two MSHO care systems.

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# Learnings from MSHO Case Experiences

*Stanley Smith, M.D.*  
*University Affiliated Family Physician*  
*(UAFFP) Clinics*  
*and*  
*Assistant Professor*  
*University of Minnesota*  
*Department of Family Practice*

*Jennifer Loeper, R.N., M.S.N.*  
*Director of Clinical Services*  
*Optage*

*Mary Keith, R.N.C., G.N.P.*  
*Director of Clinical Operations*  
*EverCare*

## **Stanley Smith**

UCare Minnesota has included several case studies in your packet of materials (see page 6). The client case studies do an excellent job of illustrating how MSHO helps UCare access all needed services—healthcare and support services—in a more coordinated fashion.

As I see it, there are three basic barriers that MSHO must overcome in order to succeed and grow as a program for individuals dually eligible for Medicare and Medicaid in the Twin Cities greater metropolitan area. I will spend a few minutes looking at these issues, including

- Overcoming public and provider perceptions of managed care
- Promoting available services
- Managing patients with chronic conditions

As many of you know, there is a general sentiment that managed care is intended to limit services and that fee-for-service is a better system of care. The issue clients and providers need to recognize is that the current fee-for-service Medicare program already limits access to needed services in many ways. For example, Medicare's definition of homebound limits the equipment that can be made available to beneficiaries, and the two-day hospital stay requirement limits what kinds of services we can make available to our clients. MSHO allows us to overcome these cumbersome regulatory barriers to care. Another issue we need to consider is how well MSHO can open access to

needed services. Many of our MSHO-eligible clients encounter physical and societal barriers to care that may hinder their ability to access needed services. These individuals may be hampered by their own physical limitations or because transportation to services is difficult or unavailable. Societal barriers such as income level, education, and social network also play a role in how and when these individuals access care. The solution seems obvious: many of our frail elders need care and services in the home, but home and community-based services are not as easily accessible under the traditional Medicare program. MSHO provides a coordinated means of improving access to needed care and services as well as a way to train and educate family caregivers.

Finally, there is the issue of managing chronic conditions. MSHO is not just about providing healthcare services—we have to teach people how to manage their chronic diseases. We know from research that people with poor coping skills will suffer more disability due to their conditions than people with good coping skills. The influence of patient attitude and behavior is profound. What we need to do is restore older people's sense of control over their own lives. Providers, however, need additional support in working with clients with chronic conditions. Physicians in particular are frustrated by their limited ability to help patients adapt to chronic conditions by promoting behavior and diet modification and assisting with the development of coping skills. Physician education and training in

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managing chronic conditions has lagged behind that of diagnosing and treating acute diseases. The task of improving a provider's comfort level with managing care for chronically ill individuals will take time, but it must be done.

### **Jennifer Lopez**

The mission of Optage is to work in concert with seniors, families, employees, community providers, and payers to continuously improve the health status, independence, and quality of life of the seniors we serve. Optage began with a network of four nursing homes that would also expand into primary and acute care. The Optage provider network is broad based so that enrollees can join without changing residence or physician. Optage has a total of 1,245 MSHO enrollees, approximately 227 of whom are community-dwelling and approximately 1,018 of whom are institutionalized. We use geriatric care managers who are either registered nurses or social workers with extensive experience in senior care and community resources.

In your packet are several client case studies that illustrate our experience with MSHO (see page 7). I see several challenges in participating in MSHO. Although MSHO successfully decreases the paperwork for beneficiaries, we have found paperwork to be a problem for the system. We have encountered individuals who flip "on and off" MSHO due to paperwork problems or changing financial status. This constant turnover causes administrative problems. We have also found that there is often a time lag in notification about an individual's enrollment in the program.

In addition, Optage has seen greater cultural diversity within the enrollee population than expected, and we have experienced difficulty with families who refuse services. As the

case studies show, we have also had limited success in keeping clients in the community, which has subjected us to the financial liability of nursing home admissions. Finally, we are concerned with the length of the preadmission screen.

On the other hand, MSHO has offered us the opportunity to learn more about the marketplace and to build our own network of services. Our clinic providers like the extra resources they can tap for their MSHO patients. Care managers have demonstrated success in managing the care of these frail older people and assisting with transitions from one setting to another. We have a lot of contact with the members, so we are able to understand what is going on with them.

### **Mary Keith**

The EverCare clinical program model, where nurse practitioners promote and manage on-site care for long-stay nursing home clients, was adopted as the model for MSHO nursing home clients. Nurse practitioners usually carry a caseload of 120 clients. The EverCare model consists of a comprehensive assessment, frequent routine visits, urgent visits at the nursing facility as needed, specialty services on-site, inpatient care management, family conferences, and ongoing communication with nursing staff.

We started preparing for MSHO in earnest in 1996. We decided to use the same model of collaborative practice for the MSHO enrollees as we had for Medicare beneficiaries. To be ready for this population, however, we knew we needed to change some of our administrative processes and learn how to take on financial risk. We also discussed the issue of physician involvement. For community-dwelling elders, we selected a small group of community physicians who share the EverCare philosophy, and we thought of these physicians, together with our

nurse case managers, as our partners in serving MSHO enrollees. We have had several success stories—working both with clients in the nursing home who have been managed successfully in that setting, and community-dwelling members whom we've helped stay at home through home adaptations such as hand rails and other equipment to help avoid falls.

I see the following as challenges of MSHO: a small number of community-based enrollees divided among several clinics and too many physicians; high resource utilization by community-dwelling individuals, including surgeries and polypharmacy; disenrollment problems; marketing; and finding the right balance between resource utilization and the common good. These challenges are exactly that—challenges, not barriers.

I also believe that MSHO has had many successes. It allows for an individual contact person, the care manager, to manage care across the continuum. The clinics like having the care manager help with these individuals and keep track of their needs on an ongoing basis. We are also learning more about how to adopt our model of care to meet the needs of people living in the community.

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# MSHO Client Case Studies

## The UCare Experience

### Mr. O

Mr. O, a 75-year-old resident of Ramsey County, joined MSHO seven months ago. Mr. O has diabetes and heart disease. Before joining MSHO, his health began declining because he wasn't able to manage his own care. He also had poor eating habits. Because of his poor health, Mr. O had trouble keeping himself and his home clean. He was hospitalized four times in the year before he joined MSHO.

Once Mr. O joined MSHO, his health and life began to improve. His care coordinator made sure that Mr. O had regular appointments with his primary care clinic. She arranged for Meals on Wheels to bring healthy meals each day. She also arranged for a skilled nurse to visit every other week. The coordinator also had a home health aide come in three times a week to help him with personal care such as bathing, grooming, and dressing. In addition, the coordinator arranged for a service to help with homemaking and weekly chores.

Once Mr. O's health and home life improved, so did his outlook on life. He told the care coordinator that she is his "ray of sunshine" because of the help she has given him. In the seven months since joining MSHO, Mr. O has not been hospitalized once.

### Mrs. Y

Mrs. Y is a 76-year-old Hmong MSHO member in Ramsey County. On a visit to Mrs. Y's home, the care coordinator noticed that Mrs. Y relied heavily on walls and furniture to support herself as she walked through the house. She arranged for a home visit by a physical therapist to expertly evaluate Mrs. Y's ambulatory needs. After the evaluation, the care coordinator arranged for grab bars in key places around Mrs. Y's home and for safety equipment in the bathroom to prevent falls and make personal care easier. The care coordinator also secured a wheelchair and a walker so that Mrs. Y could be more mobile both inside and outside her home.

The care coordinator suggested that Mrs. Y consider joining a Hmong women's group to socialize with other Hmong women. Through the coordinated care and special attention provided by the MSHO program, Mrs. Y now lives in a safer environment, and with her wheelchair, she is able to enjoy sitting outside with greater comfort.

### Mrs. V

Mrs. V is a 78-year-old diabetic who has high blood pressure, arthritis, low back and knee pain, and incontinence. She was living in a nursing home, but her health had stabilized enough that she could return to more independent living. Mrs. V worked with her MSHO care coordinator to move into an assisted living apartment. Her care coordinator helped her locate furniture from community agencies and other sources.

The care coordinator arranged for weekly skilled nursing visits, weekly visits from a home health aide to help her with foot care (important as she is diabetic), and Meals on Wheels—the diabetic meal plan. Mrs. V's care coordinator also arranged for Mrs. V to go to adult day care, where she socializes and participates in activities. UCare MSHO pays for transportation to and from the adult day care facility, and Mrs. V is happy to have regained her independence while obtaining the special care she needs.

### Mrs. K

Mrs. K, a 73-year-old who has diabetes, lives in her own apartment in an assisted living facility. She reported a decrease in her ability to prepare meals and shop for groceries. Through MSHO, she is able to get Meals on Wheels services during the week and a care package over the weekend, which is a service not available through regular elderly waiver services.

Mrs. K's care coordinator also arranged for three hours of homemaking services every other week. A skilled nurse visits two times per week to help Mrs. K with medication management, diabetes management, nutritional teaching, and personal care such as bathing and grooming. Although Mrs. K was at first reluctant to ask for help, she now looks forward to the visits from the nurse and says that they have reduced her feelings of anxiety and stress. She says that just talking to the nurse has made her feel better.

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## The Optage Experience

### Mrs. S

Mrs. S, 84, became a member of MSHO in May 1998. A preadmission screening was performed in May to determine eligibility for elderly-waiver services. Mrs. S was recovering from hip surgery following a fracture in January 1998 and had lost 30 pounds since January. Mrs. S ambulated with the aid of a walker, could do most chores independently, and had an elderly neighbor assist on a daily basis with bathing and instrumental activities of daily living. It was determined that she was nursing-home certifiable. The care manager secured transportation for clinic visits, a hand-held shower nozzle, and Ensure to counter the weight loss. Home health services were implemented, including home health care three hours per week and a nurse visit every month. Meals on Wheels were also delivered five days a week.

Services were provided through June 1998 at which time the client requested that the home health care be canceled because she was feeling better and her physician wanted her to be more independent and do things for herself. Her mobility was improving and the home health care was reduced to one day per week to assist with bathing, cleaning, and laundry. Ensure was continued to supplement her diet. The nurse visits were discontinued but the care manager continued to monitor Mrs. S's status. A custom inlay for her shoe was provided to assist with ambulation. Currently Mrs. S is independent, thriving, and being monitored by the care manager.

### Mr. D

Mr. D, 70, became an MSHO enrollee in November 1998. He is diagnosed with Alzheimer's disease, anxiety, depression, and macular degeneration. He was rescreened for elderly waiver services and determined to be nursing-home certifiable and elderly waiver eligible. His wife was caring for him with increasing difficulty. His behavior was compounded by a long history of alcohol abuse. He needed cueing with dressing and eating and was confused and tearful. His medications were adjusted to address his behavior.

The care manager arranged for adult day care in January. His behavior was initially disruptive at day care but subsided as time progressed. His wife was finding him difficult to manage when he returned from day care as he was restless, glassy-eyed, and angry. The question became one of medication reaction or sundowning. The care manager kept in touch with his wife and his behavior subsided with a decrease of Haldol.

In February, Mrs. D was hospitalized on an emergency basis. The county home care staff called needing emergency placement for Mr. D. At this point the elderly waiver services were managed by the county, and some confusion occurred as to who would arrange transportation and placement for respite care. Home care was authorized to stay with Mr. D until placement could be made. At this time, the family also indicated that they wished permanent placement because Mrs. D could no longer care for her husband. During the month of February, Mrs. D was admitted twice to the hospital and alternatives to nursing home placement were explored. Permanent placement occurred in March 1998. Optage's six-month nursing home liability began upon permanent placement. Mr. D's behavior continues to deteriorate and requires increasing environmental and medication interventions.

### Mr. B

Mr. B, 77, enrolled in December 1997. The member is a chronic alcoholic, has had multiple hospitalizations, cataracts, and glaucoma and is resistant to interventions. A preadmission screening was done, and Mr. B was determined to be nursing-home certifiable and elderly waiver eligible. Adaptive equipment was secured, and Meals on Wheels was initiated along with lifeline and a homemaker. Mr. B declined help with personal care. He was concerned about his scheduled eye surgery and did not want to proceed. The care manager followed up with Mr. B because he had canceled surgery earlier. Mr. B uses a wheelchair continuously and has an unsteady gait and poor grooming habits. The care manager continued to work with community resources to monitor his progress at home.

Mr. B's condition continued to decline even with added services and a neighbor who helped on a limited basis. He continued to defer eye surgery. Nursing services were added. Falls were frequent and grooming declined.

In July, Mr. B was hospitalized after a fall at home. This prompted his primary care provider to admit him to a nursing facility for permanent placement and monitoring by the care manager. Mr. B continues to reside at the nursing facility.

## Speaker Information

Pam Parker, M.P.A.  
Director, Minnesota Senior  
Health Options  
State of Minnesota  
Department of Human Services  
444 Lafayette Road  
St. Paul, MN 55155-3854  
(651) 296-2140  
Fax (651) 297-3230  
pam.parker@state.mn.us

Mary Keith, R.N.C, G.N.P  
Director of Clinical Operations  
EverCare  
2550 University Avenue West  
Suite 4015  
St. Paul, MN 55114  
(651) 603-8415  
Fax (651) 603-8525

Jennifer Loeper, R.N., M.S.N.  
Director of Clinical Services  
Optage  
2550 University Avenue West  
Suite 440S  
St. Paul, MN 55114  
(651) 646-0880  
Fax (651) 646-1686

Stanley Smith, M.D.  
University Affiliated Family Physician  
(UAFP) Clinics  
and  
Assistant Professor  
University of Minnesota  
Department of Family Practice  
Stadium Village Mall  
Suite 201  
Minneapolis, MN 55414-3034  
(612) 627-4945  
Fax (612) 627-4314  
Ssmith@famprac.umn.edu

## 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 will be implemented in the seven-country metropolitan area for a five-year period.

The Robert Wood Johnson Foundation (RWJ), 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.

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National Chronic Care Consortium  
National Resource Center on Chronic Care Integration  
8100 26th Avenue South, Suite 120  
Bloomington, MN 55425  
Office: (612) 858-8999 Fax: (612) 858-8982  
www.nccconline.org