Minnesota Senior Health Options

# Synthesis of Early Learnings: An Examination of the Minnesota Senior Health Options Project from the Health Plans' and Providers' Perspectives

## A Report from Three Focus Groups Held October 8 and 9, 1997

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# Table of Contents

Executive Summary ..... 3

The Minnesota Senior Health Options Project Background ..... 5

Focus Groups Background ..... 7

Major Findings ..... 11
- Project Design and Expectations ..... 11
- Communication ..... 12
- Partnerships and Organizational Roles ..... 13
- Marketing ..... 14
- Enrollment ..... 15
- Client and Family Issues ..... 16
- Providers' Roles ..... 17
- Clinical and Social Services ..... 18
- Care Coordination ..... 19
- Operational Changes ..... 20
- Training and Education ..... 21
- Data and Information Systems ..... 22
- Cost and Utilization ..... 23
- Care Outcomes ..... 24

Observations ..... 25

Appendix A: Focus Group Letter and Questionnaire ..... 27

Appendix B: Focus Group Script ..... 29

# Executive Summary

## Background

The Minnesota Department of Human Services implemented a demonstration project called the Minnesota Senior Health Options Project (MSHO) in 1997 that combines Medicare and Medicaid financing, and brings together primary care, acute care, long-term care, and community-based services. The demonstration serves people over age 65 who are dually eligible for both Medicare and Medicaid—both those who live in the community, and those who dwell in a nursing home. Two health plans launched their MSHO product in March of 1997, and another began participating in September of 1997. Three focus groups were held in October 1997—one for each health plan with their respective care system provider partners. This report reflects the comments made during those focus groups and by focus group participants through questionnaires—it represents early learning from the MSHO program, and particularly focuses on areas for further development.

## Major Findings

Considering that these organizations have had only six months or less to serve MSHO enrollees, there has been tremendous commitment of time and energy to get the program up and running. Essential structures have been put into place for managing this project. A communication network across a complex array of organizations has been established. Plans have worked hard on establishing effective methods of marketing for this program, and have explored new ways to attract enrollees. A heavy training effort has been expended, by health plans and by care systems and providers. Organizations have demonstrated their commitment to this demonstration project, and it shows. As the program evolves, additional work may be needed in certain areas.

### Care Management

The program has had a positive impact on some clients, helping them to avoid unnecessary nursing home placement and providing needed home and community-based services. Several focus group participants reported positive anecdotes about improved communication with families and better overall care management. Although each health plan has a different strategy for providing care coordination, these various methods seem to be working.

### Physician Involvement/Changes in Practice

The current healthcare system is fragmented—payment methods, settings, disciplines, regulatory oversight—these are separate and divided from one another. Integrating the providers of care, particularly physicians (who are under great pressure to manage large patient loads efficiently) is difficult at best. Given that, it is not surprising that some of the experience with MSHO clients—particularly with enrollees living in the community—reflects this fragmentation.

Though physicians may have been involved in the design of the care models within the care systems, the current methods and type of communication that plans and care systems have established with the primary or principal physicians do not seem adequate to ensure ongoing physician involvement/continuity—particularly in serving community-based enrollees. In some

cases it is difficult to identify a primary physician; if one is identified, there may be a lack of awareness by the physician about the MSHO program or how care coordinators are being used to navigate the system and support the client. The size of the care system networks, lack of financial incentives for physicians and a very small client base were cited as three reasons why many physicians are not currently engaged in this program. This problem was not discussed when describing management of the MSHO enrollees who are nursing home residents—in fact, management of nursing home residents is reported as being good.

Focus group participants believed more could be done to reduce unnecessary hospital or nursing home admissions; education and involvement of physicians and some nursing home staff would help provide better medical management across settings and result in more preventive behavior.

## Marketing/Enrollment

Marketing MSHO is difficult—there is little name recognition of this program among seniors. The program is seen as both difficult to explain and difficult to differentiate from some Prepaid Medical Assistance Program products (PMAP is Minnesota's Medicaid managed care program). Seniors who did enroll seemed to be attracted to the reduced paperwork burden (for Medicare), and some were also interested in the care coordination. Interestingly, some seniors apparently did not want a care coordinator and therefore did not enroll. Some focus group participants felt that the "early adopters" are now enrolled in MSHO, and that the next wave of enrollees will be much more difficult to attract. Focus group participants felt that the best way enrollment would grow would be through word-of-mouth, arising from the positive experience of current enrollees. Future growth in enrollment is a concern; if the volume of MSHO clients could increase dramatically (e.g., fourfold), many feel that changes would be easier to make. However, given the uncertainty around utilization and cost, such a growth might be financially detrimental to some providers or plans. Nevertheless, plans and care systems articulated a hope that public awareness of MSHO would grow.

## Training

Plans and care systems provided significant training for their staffs about the MSHO program. Getting the program up and running required quite a bit of education and this need continues. Training of providers, vendors, and practitioners is an important, but time-consuming task. Some say that there was a "readiness for learning" issue, where the providers/practitioners did not seem to understand or assimilate the information provided about MSHO until these same practitioners became involved with an enrollee and discovered that they had to do things differently.

## Client Profile

Language and cultural barriers between MSHO clients/families, plans, providers, and care coordinators occurred; this cultural diversity affected the plans and care systems' ability to serve clients appropriately. Also, several providers had experience in managing care for nursing home residents, but community-based enrollees represented new learning. The existing primary care physician network, case management models/methods, enrollment, and marketing information or processes that were set up for managed care products targeted to nursing home residents required some changes to adapt them to community-dwelling seniors, particularly to incorporate the home and community-based services included in MSHO.

## Changing Paradigms

Breaking out of the traditional processes and procedures arising from the Medicare and Medicaid payment methods and regulatory requirements was seen as difficult. These two programs so dominate the processes, practices, and approaches of providers and practitioners that focus group participants said it is difficult to make any kind of change that deviates from this norm.

# Minnesota Senior Health Options Project Background

## Design

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

The goals of this demonstration are to:

- reorganize service delivery systems to support sound clinical incentives, reduce administrative complexity, and create a seamless point of access for all services for clients and providers
- control overall cost growth by providing incentives for lowest cost and most appropriate care by changing utilization patterns and reducing cost shifting between Medicare and Medicaid
- create a single point of accountability for tracking total costs and outcomes of care.

The Department of Human Services obtained federal waivers that allow the state to choose contractors capable of providing a full range of integrated medical and social services on a capitated risk basis. The state manages a combined Medicare and Medicaid contract with health plans, that, in turn, subcontract with providers to offer this complete set of services. This includes services traditionally covered under the Prepaid Medical Assistance Program (PMAP, Minnesota's Medicaid managed care program), such as Medicare deductibles and coinsurance, medical supplies and equipment, dental care, therapies, prescription drugs, medical transportation and home care services, as well as services covered under Part A and Part B of Medicare, such as hospitalization and physician office visits. In addition, health plans provide extended home care services to frail elderly eligible for nursing home care (called "Elderly Waiver" services). A unique feature of MSHO is that it requires the health plan to be responsible for the first 180 days of care in a nursing facility for those who enroll in MSHO while residing in the community.

MSHO is offered as a voluntary option to the standard PMAP plan. Working with the county as part of PMAP enrollment, a single enrollment process is used for both Medicare and Medicaid, with MSHO enrollment being processed at the state level. Plans may market to their current PMAP enrollees and participate in the enrollment process for their current PMAP members. Enrollees may disenroll on a monthly basis, but will stay in the same plan's PMAP program if they do so.

Health plans participating in MSHO have been encouraged to develop new partnerships with primary, acute, and long-term care providers and counties in order to better serve seniors. MSHO seeks to encourage these provider networks to work toward coordinating care across settings and over time. In addition to basic PMAP requirements, MSHO requires plans to provide access to a care manager for each enrollee. This care manager conducts or arranges for appropriate assessments, coordinates care, and enhances cross-site communication on behalf of the client. Plans must also ensure that the enrollee and family will be involved in care planning and treatment decisions.

## Health Plans Structures

In March 1997, two plans began enrollment in MSHO in the state's two largest metropolitan counties. In September 1997, a third health plan began enrollment in these two counties, plus two additional metro area counties. At the time the focus groups were held, approximately 2,000 people were enrolled in the MSHO program. MSHO enrollment is projected to peak at 4,000 members.

The three health plans and corresponding sub-contracted care system networks participating in the MSHO program in 1997 differed from each other in organizational structure and approach to the MSHO program. They also differed by financial arrangements with their subcontracted care systems and providers from full risk sharing to discounted fee-for-service. All three health plans had previous experience in the Medicaid managed care program, known as the PMAP program. One health plan also had experience in offering a dually-eligible product in the Twin Cities for clients in a nursing home setting. Two of the health plans did not have a Medicare risk product, and therefore the Medicare piece contained within the MSHO program was new for them.

A care system is a network of hospitals, clinics, nursing homes, and other providers that have come together in order to create a more integrated care delivery continuum. The networks of all three health plans overlap to some extent, that is the same provider could be in all three health plans' care systems. This has occurred in some cases; for example, one long-term care group has almost 1,000 enrollees as part of its network—some proportion of which come from each of the three health plans. The following table describes the plans' networks at the time of these focus groups.

| Health Plan | # hospitals | # clinics/doctors | # nrsg homes | # counties |
|---|---|---|---|---|
| A | 1 | 28 clinics/348 docs | 28 | 1 |
| B | 10 | 48 clinics | 89 | 2 |
| C | 20 | 532 physicians | 115 | 4 |

In terms of the care coordination mechanisms established for MSHO clients, one health plan chose to ask the care systems to perform this function, while the other two plans created processes for providing care management services that involved their own health plan staff. One health plan, with nurse care managers on staff, trained its care managers about the MSHO program and uses these care managers to coordinate with its care system providers for each MSHO enrollee. This health plan conducts a risk screen and a record review for each enrollee, determines a risk level, and then provides information to care managers in the community, clinic, or nursing home setting for those enrollees who require services. Health plan care managers provide case management for clients at the first, or lowest, risk level. For clients at higher risk levels, the plan works in concert with other case managers in the care system. Another health plan works with a clinic-based care coordinator to conduct an in-home evaluation of each enrollee and provides the case management services on an ongoing basis, throughout the course of the enrollee's experience.

At the time of the focus groups, the three health plans also differed in the proportion of enrollees living in nursing homes versus in the community:

| Health Plan | # enrollees in nursing homes | # enrollees in community | Total |
|---|---|---|---|
| A | 199 | 117 | 316 |
| B | 173 | 108 | 281 |
| C | 1419 | 1 | 1420 |

# Focus Groups Background

## Rationale

The State of Minnesota has an obligation—both to MSHO enrollees and to health plans that have contracted with the state to provide services to these individuals—to monitor the progress of health plans and care systems toward "ensuring communication and coordination of an enrollee's care across the network of providers and settings and to ensure smooth transitions for enrollees who move among various settings over time." (Section 7.02 of the MSHO Model Contract). The state has reviewed the state-of-the-art performance measurement tools and believes that these tools do not explicitly provide a vehicle for external evaluation of the performance of health plans and provider systems in terms of the communication and coordination of care capabilities across organizations.

The MSHO demonstration rests on the premise that elderly enrollees will benefit from greater care coordination efforts and a more integrated care management process across organizations. There is an implicit assumption that by integrating the comprehensive benefit package that extends from primary and prevention into long-term and community-based care, and by aligning financial incentives through the payment system offered to the health plans, care will be provided in the most appropriate setting, transitions between settings will be smoother, and there will be better support to enrollees and their families. Examining system integration issues from the health plan and providers' perspectives provides insight into what key operational and clinical issues serve as barriers to this goal and into what methods or strategies plans and providers are using to achieve this goal.

## Purpose

The goal of the MSHO focus groups was to record and summarize the structural and process changes that the health plans and care systems made prior to the start date for service and during the first few months of enrollment as well as ongoing problems that have prevented optimal service or served as roadblocks in developing this program. The focus groups would capture information about programmatic or operational changes made, communication and partnership issues, clinical and care coordination issues, and client, enrollment, and marketing issues across several time periods: at the early planning stages, just prior to launching the product, and in the first few months of experience with the program. The groups would particularly focus on care management and care coordination issues.

The state wished to use the results of the focus groups to understand salient issues and possible best practice methods for putting such a program together and for building an integrated network—from the perspective of health plans and care systems. The state would also move closer to understanding how to assess care management capabilities of a healthcare network that has substantial subcontracted services and providers.

Focus groups are a snapshot in time. They provide qualitative information and represent the opinions of individuals who reflect their own views as well as those of their organizations at a given point in time.

# Methodology

## Overview of Methodology

**July 1997**

- The State of Minnesota informs the three health plans participating in MSHO that focus group meetings will be held.
- Health plans provide input on the individuals to invite including representatives from the care systems.
- The state and the NCCC review lists to ensure appropriate focus group composition and representation of different disciplines.
- The state and the NCCC develop a questionnaire for participants to complete prior to focus group meeting.

**August 1997**

- The NCCC sends letters to twenty-nine individuals inviting them to participate in focus groups.
- The NCCC sends questionnaires to the twenty-three confirmed participants.
- Seventeen participants return questionnaires. These responses are reviewed and used to help shape the focus group script; they are also incorporated into the focus group final report.

**September 1997**

- The NCCC and the state prepares a comprehensive script for facilitating the focus group meetings.
- The NCCC and the state meet twice with a professional communicator who has been hired to facilitate the focus group meetings.

**October 8 and 9, 1997**

- Three focus group meetings are held, one for each health plan with its respective care plan partners.

## Participants/Questionnaire Development

As of September, 1997, three health plans had signed contracts with the State of Minnesota to participate in the MSHO demonstration, and had begun serving enrollees. The state invited these three health plans, each with a set of subcontracted provider or care systems, to participate in a focus group meeting. Each plan and respective care system would have its own two-hour focus group in which to share early learnings about the MSHO program.

Approximately three months prior to the scheduled focus group meetings, a representative from the state contacted each health plan to generate a list of plan and care system representatives who should be invited to the focus group meeting. The state and the NCCC reviewed this initial list and added additional names to ensure that there was a good distribution of individuals from key settings and disciplines, e.g., representing the clinic setting, nursing home setting, hospital, community, and health plan, and that the list included a practicing physician serving MSHO clients, nurse managers in the clinic, care coordinators in the community, health plan marketing and quality assurance representatives, county representatives, and others.

Working closely with the state, the NCCC developed a brief questionnaire for participants to complete prior to attending the focus group meeting.

In August 1997, the NCCC sent letters to twenty-nine individuals inviting them to participate in the focus groups. Individuals were asked to respond via fax to confirm their participation. The NCCC then sent the twenty-three confirmed participants a questionnaire to complete prior to attending the focus group. A sample copy of the letter of invitation and questionnaire appear in Appendix A.

The NCCC received seventeen responses to the questionnaire; they reviewed and summarized these responses.

## Facilitation/Script Development

To conduct the focus groups, the NCCC hired a professional communications expert, independent from either the State of Minnesota Department of Human Services or the NCCC. The NCCC and the state used the responses from the questionnaire to create a script for the facilitator to use during the focus groups, and met twice with this facilitator to prepare her for the meetings.

One focus group meeting with one of the health plans (and respective care system representatives) was held on October 8 and the other two focus group meetings were held on October 9, 1997 at a market research facility located in Bloomington, MN. Twenty-three individuals participated in these three focus group meetings; one individual from a metro area county attended all three meetings, given the role of that county in working with all three health plans.

The focus groups were audiotaped and videotaped, with the permission of the participants. An NCCC staff member and DHS staff member greeted the participants and then retired to view the focus group from behind a two-way mirror.

When creating the script for these focus groups, DHS and NCCC organized questions into four time phases: the design phase, the preparation phase, the early implementation ("going live") phase, and the future phase. Questions posed to these health plan and provider representatives related to operations, care models, care coordination, communication, marketing, clinical issues, client issues, data, program evaluation, and general lessons learned. A copy of this script appears in Appendix B.

In reviewing the focus group comments, we grouped comments into 14 categories as follows:

**Project Design & Expectations:** comments about the concept and design of the MSHO program and the participants' expectations about aspects of the program before it started, e.g., the type of clients who would enroll, how fast enrollment would grow, what would attract clients to this program/ product, etc.

**Communication:** comments about communication among partners, practitioners, or between organizations and about the methods or channels of communication that have been established for this program (both internally and externally).

**Partnerships and Organizational Roles:** comments about how partnerships with other organizations were developed and how organizational roles were defined.

**Marketing:** comments about the process and methods used to market the MSHO program, experience with describing the program to seniors, and any other marketing issues which arose.

**Enrollment:** comments about the enrollment process and the rate of increase in MSHO enrollment as compared to expectations.

**Client/Family Issues:** comments about the type of clients expected and those who actually enrolled, e.g., in terms of the nursing home vs. community-dwelling proportions, the ethnicity and cultural characteristics of enrollees, and about family involvement in the MSHO program.

**Providers' Roles:** comments made about expected and actual roles and duties of various practitioners, e.g., the county case manager, the health plan nurse care manager, the physician, etc.

**Clinical and Social Services:** comments about the set of medical and social services provided, the care delivery model, and any other issues related to the type of care provided.

**Care Coordination:** comments about care coordination, case management, and how care managers work together or work in various settings.

**Operational Changes:** comments about the administrative and operational activities performed to prepare for and/or administer the MSHO program, including staffing changes.

**Training & Education:** comments about training or education performed for the MSHO program, either internally to an organization's staff or externally to others in the network who would be serving MSHO enrollees.

**Data/Information:** comments about the process or methods used to transfer information from one organization to another or within an organization to ensure accurate and timely data sharing to support effective continuity and good decision making.

**Cost/Utilization:** comments about risk sharing between partners, projected cost compared to payment for a particular organization, and early utilization experience (after about six months).

**Care Outcomes:** comments about quality management methods, expected outcomes, and methods for evaluation of the program.

# Major Findings

The questionnaire responses and focus group comments provided important early learnings about the MSHO program from the perspectives of the health plan, the counties, and the participating provider and care systems. The following is a summary of these early learnings and experiences.

## Project Design and Expectations

Expectations for this program were high and participants continue to be hopeful that the stated goals for the program will be met. Participants spoke about the following:

- A hope that this demonstration would bring Medicare and Medicaid together, reducing the fragmentation in the system.
- A belief that this program represented innovation at the state level and held a promise for better care management for these seniors over time.
- A desire to use this program to help people stay in their own homes, and that it would help balance the need for medical and social services.

There were also concerns about:

- the financial risk that providers or health plans would be exposed to—given that they would be liable for some portion of nursing home costs if an MSHO client was admitted from the community,
- the growth in enrollment and the type of client that might enroll (e.g., slow growth and adverse selection),
- how different the community-dwelling client might be from the nursing home resident.

Participants' comments included:

> *"Medicare and Medicaid are two distinct programs. MSHO had the potential to bring them together and reduce fragmentation—this was a big attraction. Previously, we would manage only one of the funds, so we would constantly need to examine what would be covered under which program and then refer accordingly. You would find yourself needing to deny services because they are not covered under the plan and then switch to the role of advocate, sometimes needing to plead your case to another case manager to get the services or care you felt your client needed. In MSHO, the case manager has authority over both the member's Medicare and medical assistance benefits."*

> *"I come with an insurance background. . . and I know about adverse selection and the most costly patients. So I did some gasping when I heard that we would be taking on the seniors , especially the ones that could be possibly nursing home certifiable or in the nursing home!"*

> *"There is an upside and a downside to this program. The upside is that this a new program, it's innovative and will help prepare for the future. The downside is that no one knows the risks involved; you don't know what you can achieve in terms of market share or enrollment."*

## Communication

Focus group participants agreed that establishing communication channels between organizations and key personnel is extremely important in getting this program up and running. The first MSHO clients who required clinical or case management services helped to illuminate where better communication was needed and where the processes for communication needed fine tuning. For example, in one primary care clinic, certain practitioners were not being informed when an MSHO client was seen; a system was set up to ensure earlier and more thorough communication throughout the clinic after this experience with the first MSHO client.

There has been good communication between the county, some clinics and nursing homes, and with care coordinators at the plan level, through regular meetings, e-mail, voice mail, and via fax machines. However, several focus participants, including physicians working in a clinic setting, felt that physicians are not currently part of the regular channels of communication. The case managers, nurses, social workers, know how to "work around" the physician in order to manage the care of a client; this practice has developed over many years and is difficult to change, even in the MSHO program where at least a few physicians envisioned themselves as more integral to the program.

One health plan reported that some opportunities for earlier intervention are not being capitalized upon because of lack of awareness or readiness on the part of some nursing home staff or clinic physicians. Part of the reason for this may be lack of regular communication to and with these individuals. Participants seem to feel that the counties, the health plans, and certain clinics and nursing homes are on board, but they are unsure about other clinics, nursing homes, and hospitals.

Focus group participants commented:

> *"There were a lot of communication pieces around the clinic that we needed to get into place once MSHO got started. Some we really hadn't thought about until we suddenly had clients who were MSHO members. We have built in some things to make sure that communication occurs; a lot of it is a paper trail of making sure that memos got to the right people about new members."*

> *"Communication is a problem. With the one or two MSHO patients that I have, I don't seem to be a part of the communication system. As a physician I get a note in the mail that something is going to happen, like some service, and I just sign off on it."*

> *"There are weekly meetings between certain team members, practitioners, and providers from certain organizations."*

> *"When we were trying to figure out 'How are we going to do this?' (manage care for MSHO enrollees and work in tandem with care system partners), we began setting up channels of communication. It came down to tracking one piece of paper and seeing how it would flow to members of the care team."*

# Partnerships and Organizational Roles

The relationships being developed between organizations and key people within those organizations are seen as very important for MSHO and for future programs seeking a coordinated approach to care delivery for seniors. Focus group participants say that it was a challenge, at times, to clearly delineate organizational roles at the beginning of the program. Some organizational roles are changing; for example, one organization that was primarily associated with nursing home care is evolving to take on care management for community-dwelling seniors as well. The counties, too, had a shift in roles, from an oversight body to a provider of services under contract. One important catalyst for moving ahead and reconciling differences was having a champion—one easily identified person—who was a champion for working things out and for MSHO.

One health plan had some concern about how to bring people together who never talked to each other. For example, MSHO provided the health plan with a unique opportunity to connect with the nursing home sector. However, even existing relationships have had to evolve differently over time. A plan representative offered this:

> *"Basically, with MSHO we now have to offer all the services—but different folks have been doing different things, and now there is a need to bring them all to the table. I have learned that folks are talking the same language, but at the same time they may never have talked to each other before. Or now they are talking from a very different perspective because the roles have changed."*

One of the participants from the clinic setting explained:

> *"Being a social worker who has worked in long-term care for a number of years, MSHO meant getting involved in the healthcare system in a much bigger way than I have ever been involved before. This has meant having to make some real shifts in the way I think. There has been different language, a lot of changes, new systems that I have had to learn—integrating all of this and the paperwork has been a real challenge. It doesn't affect the members so much, it is more of an internal issue."*

There was also a feeling that the large networks of some of the plans may be counterproductive—that is, the few MSHO enrollees are spread over such a large number of clinics and hospitals. One participant observed:

> *"This is real life, everyone is out there contracting with everyone else, competing for the few enrollees."*

Others comments included:

> *"This project represents a foot in the door for developing partnerships between organizations and, in some cases, for changing the roles of certain providers or organizations. We are working on how the community-based piece, the nursing home, the clinic or physician piece, and the hospital piece all fit together."*

> *"Being part of a capitated contract—this role was new for the county."*

> *"A champion at each organization is needed to make these partnerships work well."*

# Marketing

Focus group participants felt that it was difficult to explain this program to seniors and their families; lay people did not understand the role or duties of a care coordinator. They felt it was hard to differentiate this program from PMAP programs that offered care coordination and a "managed Medicare" component, and that there was little name recognition of MSHO among clients.

Why did people enroll? Focus group participants said that some seniors who enrolled seemed most interested in the reduction in paperwork from Medicare. Some seniors were interested in the care coordinator, seeing this person as an advocate. Some potential enrollees, however, were put-off by the care coordinator piece—perhaps feeling that this was too prescriptive, intrusive, or that it would impair their relationship with their physician.

Plans that did not have a Medicare product needed to modify marketing materials, processes, and techniques to fit the older client. Marketing techniques used by plans included telemarketing, posting information on kiosks or in clinics, hosting information sessions for seniors, conducting a media campaign with a press release that attracted some press coverage, and direct mailing to current PMAP enrollees who were with the health plan.

County workers also played a part in explaining this program to Medicaid enrollees as an option to PMAP. There was a question initially by counties as to what their role should be in convincing a potential enrollee that this is a good thing—they needed to remain impartial.

One focus group participant said that it is likely all the "early adopters" (people who like to participate in new things) have now enrolled and that the next set of clients would be more difficult to enroll unless these seniors hear there are tangible benefits which match their needs.

Other participants said:

> *"One of the biggest hurdles for us in introducing this and continues to be is that it just doesn't have name recognition and people don't know what it is. Physicians don't know, the members don't know, even internally it took a lot to teach our own staff what it meant and I think we continue to fight that when we go out in public and say 'Have you heard of Minnesota Senior Health Options?' Nobody knows what it is."*

> *"To be honest, it is very difficult to explain this program to people. From an administrative standpoint and from a provider and plan perspective it is a really good idea. Try to explain MSHO to somebody who currently gets case managed—especially since they don't care if the person is from the county or home health agency. For them there is somewhat of a seamless system that has already been developed. Further, what does [MSHO] really mean for somebody, especially for people who are in the nursing homes."*

> *"Marketing and enrollment for MSHO is an intensely educational process."*

## Enrollment

Actual client enrollment for MSHO did not match expectations in a number of ways for two of the health plans. For one health plan, the growth in enrollment was higher than expected; for another it was much lower than projected. One health plan found it easier to enroll the community-based senior; another felt it was easier to enroll the institutionalized seniors (already living in a nursing home). The enrollment process, like the marketing process, was difficult; even after enrollment, some seniors did not understand what they had signed up for and were confused. A case coordinator who conducts home visits to complete an assessment of MSHO clients described a few cases where the client did not believe they had signed up for MSHO—the coordinator had to produce the signed documentation as proof:

> *"I explained that there was a great deal of flexibility in the MSHO program and that I would not violate their privacy—which seemed to be a concern."*

Another health plan, having a dual eligible product for seniors in nursing homes already in place, found the enrollment process more straightforward. However, the addition of community-based seniors in MSHO may present some challenges.

Participants agreed that the bigger the enrollment, the greater the impact. Larger volumes of clients would help make the mental and operational shifts that are needed. One county said that it could also expand its role in care management if the volume was there to support this change.

Several focus group participants stated that they were initially concerned about adverse selection; that is, more frail and medically complex seniors would be attracted to this program and the payment rates would not support the cost of care.

Focus group participants felt that the best way enrollment would grow would be through word-of-mouth advertising" or if there was additional metro-wide television coverage of the MSHO program, highlighting success stories.

A nurse case manager said:

> *"I was told to expect maybe 10 people at the beginning of the program—I started paddling upstream pretty fast when the first 100 walked in, and they were almost all people living in the community."*

Other participants commented:

> *"We've enrolled primarily nursing home residents and do not see that many more institutionalized elderly will come into the program—if enrollment is to grow it will have to come from the community side."*
>
> *"Bigger enrollment would help make this program more visible and therefore make our jobs easier."*
>
> (If the enrollment increased fourfold)*"it would in many ways simplify the system because MSHO becomes more part of what everyone is doing everyday, instead of the exception."*

# Client and Family Issues

Clients were more diverse ethnically and culturally than initially expected. Several groups were mentioned—Hmong, Korean, others of Southeast Asian descent and Russian-born—where the language and cultural norms (even health beliefs) served as initial barriers/challenges to providing service or to working with the clients and families. The particular challenge is to provide the home and community-based services—included within the MSHO benefits—in a culturally competent way.

One health plan reported that a large majority (81 percent) of their institutional enrollees have some type of cognitive deficit, which makes the role of the family members even more important.

Some focus group participants said the enrollees they have treated are more frail and medically complex than expected; other participants said the opposite—that the more active, younger seniors have signed up for MSHO. Either way, many of the enrollees are familiar to the plans and care systems, having been enrolled in another product previously.

Families have been involved in the program; they are often the decision-makers or are very influential and therefore are an important group for the care coordinators to work with as services are provided.

Participants said:

> *"I was surprised by the number of non-English speaking enrollees, and particularly by the number of Asian enrollees, since I did not know that this large of a group had immigrated early enough to be eligible for Medicare benefits."*
>
> *"Clients and families appreciate the care coordinator, in having a name and face and telephone number to contact in case they need it."*
>
> *"Many of these MSHO enrollees were known to us."*

## Providers' Roles

Defining each person's role and level of accountability for certain functions or for the overall care management of MSHO clients was an issue that many focus group participants raised. Especially in the planning phase or start of the program, people asked themselves and each other "Who is in charge?" There was some tension in discerning people's roles; this corresponded to the tension in defining organizational roles.

Among the many types of providers and practitioners, physicians were often discussed as needing better role definition. To effect greater change in medical management and avoid unnecessary admissions from the emergency room to the hospital or from the community to the nursing home, focus group participants (especially the physician participants) stated that the care models would need to increase the role of the primary care physician. One physician felt that several things are needed to increase physician involvement:

- select a smaller, core group of physicians that are actively engaged in and significantly part of the communication channels,
- increase the patient volume to attract attention to MSHO, and
- redesign financial incentives to provide support for behaving differently.

One provider reported:

> *"We tried to find a way to make MSHO a value-added component to physicians' practices— not just another 'add-on' program to the list of things they're supposed to pay attention to."*

A physician stated:

> *"I can't provide good geriatric care if I am not a member of the team; MSHO is our chance to align incentives and get everything and everyone on board."*

Other participants commented:

> *"They can't manage without the physician integration piece. It's not going to be possible. Whether the physician group can rally to reconstruct itself to change behaviors, to start to reward things like continuity, like integration, like coordination of services, like teamwork— can the physician group do that? Can we find a model to cast that? Can we find the people to fill those roles? ...I hope so."*

> *"The ability to differentiate care systems from each other in terms of the potential enrollee perspective has been somewhat constrained by need to define consistency in new program development from both the state and the health plan perspectives."*

# Clinical and Social Services

In preparing for MSHO, providers who had extensive experience with managing the care of nursing home residents reexamined their care models and methods for adaptation to the community-dwelling senior. Those who were already based in a primary care clinic setting, serving many older adults, did not feel they had to make many changes in their model to prepare for MSHO.

Focus group participants talked about creating the right teams of providers; one county selected a public health nurse and social worker to be trained in the aspects of MSHO; this team provides service to other organizations that the county works with around the MSHO program. Another focus group participant noted a lack of physician involvement in the team. The composition and methods of "the team" were set by each organization as it created its care model.

On the other hand, some vested parties in the MSHO project worried that the integration of the programs and the single funding stream might lead to too much medicalization of the psychosocial issues faced by seniors. The counties, for example, were concerned about how to maintain the:

> *". . . social work component that has always been in our long-term care services. We were happy to participate and be part of a project [but wanted them] to at least keep in mind some of those [social and public health] needs the elderly have, as well as their medical care needs."*

Participants spoke about risk assessment and risk screening methods—two of the health plans are involved in the risk screening process, the other health plan has delegated this to its care system partners. Focus groups participants talked about how they defined "risk," and how they created or selected a risk screening instrument. Each organization conducting risk screening seems to do so in a little different way, but all MSHO enrollees are assessed according to some established criteria. One focus group participant cautioned about placing too much emphasis on that risk screen.

> *"The results of the risk screen should be seen as a snapshot, only a point in time. In this population, especially, they may be level one today and have a stroke tonight."*

A care manager serving nursing home residents said:

> *"This was not necessarily 'business as usual'—we had to look at our care model and see if it would fit these (community-based) enrollees."*

Other participants commented:

> *"Risk screening is now our responsibility as the care provider. We must now deal with Elderly Waiver services, which is new to us. Previously we only had responsibility for the institutional population, so we are still learning about the community population."*

> *"There are many differences in the ways in which dually eligible seniors are served between those enrolled in MSHO and those who are not, especially for the community-residing members. Prior to MSHO, community-residing seniors received their clinic services with coordination of care provided through the county only if they were found to be eligible for the Elderly Waiver. Now all community-residing enrollees at the clinic receive care coordination services. These services include risk screening, assessment and case management, and interdisciplinary team review. Enrollees in long-term care facilities are managed in much the same way as they had been prior to MSHO."*

## Care Coordination

One health plan uses its care system partners to perform the care coordination function for MSHO enrollees; the other two health plans are more directly involved in care coordination. All three plan approaches differ. Clearly, the presence and functions of the care manager are seen as a crucial component to the MSHO program, regardless of the system established for care coordination. One health plan has nurses on staff who serve as care managers for the enrollees at the lowest risk levels, requiring only monitoring. The challenge is to communicate effectively with care system case managers for the MSHO enrollees who are at higher risk levels and require services. In another health plan there is reliance on a clinic-based care coordinator; here, growth is a challenge; if the program grows the volume may outstretch the coordinator's capacity to manage effectively.

Focus group participants support the care coordination aspect of MSHO strongly; however, arriving at the most effective and efficient methods for providing care coordination has been an evolving process. Where more than one care manager is involved in an enrollee's case there can be confusion about roles and responsibilities—this problem was discussed especially with clients living in the community. There is a belief that this problem may diminish with experience.

For one focus group, the community-dwelling clients represented the most unknowns to the care coordinators; many were familiar primarily with nursing home residents and are unsure how to effectively "follow" the client in the community. For all three focus groups, an important issue raised is how the care coordinator can identify who the client's primary care physician is and how to contact him/her. Comments included:

> "(In our plan) *all MSHO members have a care coordinator assigned to them who will help them get the care they need. For community-based members, the care coordinator is conducting an in-home risk assessment of the member. The care coordinator is working as a team with the primary care clinic and the county."*

> *"I think the MSHO model fits nicely into the model we had been using to coordinate care for our managed care seniors in the past. One difference with this group is that the case manager is informed as new members enroll so risk can be assessed and needs can be met early—relatively small numbers of new enrollees make this possible. Traditionally, case managers became involved only after the member accessed care at the clinic or in an acute facility."*

> *"Client need for case management seems to follow the old 80/20 rule; 20 percent of the clients need 80 percent of the services (which are coordinated through the care managers)."*

> *"We are still working on the hand-offs from one case manager to another, from one setting to another."*

A care coordinator said:

> *"In one case, for example, it was very important for me to be part of the care conference. I had visited the client in the home, knew the heavy family involvement and support, and could describe what services we could offer, things like adult day care and respite care. The family involvement, and their understanding of what we could do, made return to home possible—given the person's extensive needs, he/she might not have been able to return home otherwise."*

For some individuals there was a lot of appeal in having the benefit of better coordinated services, and having a designated person to coordinate for them. MSHO has made it possible for one person to follow

> *". . . the client in the hospital and nursing home . . . a real advantage to the family is that there is one person that they can count on, one contact that they know will continue to follow them no matter where they're living or what part of the care continuum they are at. One care manager has found that the frailer they are, the more needy they are, the more they appreciate the care coordinator. The active 70 year olds don't want the care management piece of MSHO."*

# Operational Changes

There was significant work completed to prepare for MSHO, including creating new networks of providers, negotiating contracts between health plans and care systems and counties, making staffing changes and training staff on MSHO, establishing new enrollment or claims processing procedures, creating new communication mechanisms between organizations, developing processes for transferring important clinical and demographic data, and modifying customer service methods.

Most organizations did not add staff or added only minimal staff to prepare for MSHO. Most did internal training of some sort, and several organizations also reviewed the capabilities and experience of existing staff in order to create the right complement of staff that would be assigned to MSHO—often choosing those who had experience with seniors.

One or two focus group participants alluded to the fact that some providers are in all three of the health plans' networks of care, which results in a heavy administrative burden for them.

Focus group participants raised several administrative issues, especially noting their increased paperwork burden and that of the care system partners. In one focus group there were several concerns related to the health plan's payment of claims, the process for obtaining current enrollment lists and assessment information, and the delays in authorizations for service.

> *"It's always a question, do you hire first and then wait for the patients? Or do you wait to get up and running and then hire to meet need?"*

> *"A separate phone line was established for our senior members. This line is answered by a representative who has had experience and training dealing with the elderly. The representative identifies the reason for the contact, handles the appropriate inquiries, and connects the caller with the member's case manager if necessary."*

> *"My job is in Member Services and we explain how the plan works and what the benefits are. Initially it was "this is Medicare* ***and*** *Medicaid." We're familiar with PMAP; we've been doing that for a million years! Did we have to know Medicare and where to start from? I think that was scary and it raised some flags because we had been so segmented."*

> *"We all had to create processes to manage these enrollees. . . . so things are in duplicate or triplicate form."*

> *"I'm worried about those nursing homes who are in all the networks—I'm worried we're going to overwhelm them with three separate sets of procedures. . . . Because MSHO is new and there are not many members in one location, like a nursing home for example, training that nursing home to do everything different for a particular person is very difficult."*

> *"Challenges thus far include implementing new procedures and coordinating care with the health plan. The administrative piece has posed more problems than anything."*

> *"The biggest problems we have had has been in getting the paperwork components to work: There are delays in getting enrollment lists and forms from the health plan in a timely manner, and the referral/certification process isn't smooth."*

# Training and Education

Focus group participants state that MSHO has required extensive training and education, but that their efforts have not always been successful.

Internal and external training needs (within an organization and to others the organization works with) were great and at times overwhelming. Several participants stated that training of providers, vendors, and practitioners is an important and time-consuming task. Some also say that there is a "readiness for learning" issue where the providers/practitioners did not seem to understand or assimilate the information provided about MSHO until these same practitioners became involved with an enrollee and discovered that they had to do things differently. One-to-one training is most effective, but also most costly.

Health plans took a lead in conducting training for all types of provider groups and the counties; presentations and written materials were well received, but needs for this information continue.

One health plan said, since the Medicare program was new to it, training on Medicare codes, processes, etc., would have been useful prior to the launching of MSHO. Also, training on how to communicate with seniors would have been helpful.

One health plan trained all of its care manager nurses in MSHO to get them exposed to the program. They are all now familiar with the risk screening process, which the health plan does itself, and have used the protocol for follow-up telephone contact with the client/enrollee.

Two groups who were identified as needing more education about MSHO are physicians and nursing home staff.

A long-term care group reported:

> *"One of the challenges has been to educate the nursing home staff as to the role of the nurse coordinator and the added value of her involvement."*

Other participants said:

> *"It was a question for us—do we do provider education for everyone early on or later? Do we focus on specific clinics or practices? Should this happen on a case-by-case basis?. . .This issue of timing is critical; people get so confused."*

> *"Training remains a huge challenge."*

# Data and Information Systems

Important information about MSHO enrollees is collected at many levels, including the health plan, the clinic, and the nursing home; sharing this information across organizations remains a cumbersome process. Much of the information or data transfer is still in paper form. As organizations work to upgrade their computer technology, they had needed to establish new paper trails. The feedback loops after "hand-offs" from one organization or person to another are not as smooth as needed for good continuity of care, but most participants say that this is evolving. Since information sharing problems are so systemic to the healthcare industry, the problem is not only one of the MSHO program; therefore, participants believe that the short-term solutions achieved for MSHO are stopgap measures that will be improved upon as information technology capabilities grow.

Participants said:

> *"Computer upgrades, in our case switching to Windows 95, were not happening fast enough, and our usual paper forms were not adequate, so we had to start over in even creating the paper forms that would work for MSHO."*
>
> *"We had to go back to the nuts and bolts and trace one piece of paper through the system."*
>
> *"We have to upgrade our computer technology so that we can be real-time between all the participants. I think it's going to be a lot easier to engage the physicians when we have information in front of them instead of promises of information."*
>
> *"At the dreaming stage, we wanted an electronic system where everyone could talk with each other—that is still a long way away."*

## Cost and Utilization

It is very early to examine any kind of cost or utilization results. The program is only six months old (even younger for the latest health plan to participate). However, in "eye-balling" some initial data, one health plan stated that from a utilization standpoint, there has not been the anticipated reduction in emergency room admissions to the hospital or in nursing home admissions for the MSHO enrollee group. Therefore, the plan will be working with its care system partners to examine the factors that led to these admissions and see if there are changes that are needed.

Risk sharing between the health plans and care systems did not always occur. Clearly, these arrangements can affect the behavior of the plan and its care system partners—as the program grows or evolves, new risk sharing arrangements may be possible/desireable.

One area for review may be the extent to which physicians arenow engaged financially in the MSHO program. Focus group participants alluded to one option for change: to create a smaller group of physicians as a network for MSHO enrollees that might receive a different payment rate.

Other comments included:

> *"We were disappointed not to be able to do more extensive risk sharing across the network, but hope that will come as we gain experience with the program."*
>
> *"Physicians, to date, have not been willing to accept financial risk for MSHO clients. This is understandable because the numbers are so small for a given physician."*
>
> *"We will want to look at the data and the patterns of service and cause and effects (now after six months of experience)."*
>
> *"We're still afraid of adverse selection with this program."*

## Care Outcomes

Outcome measures and evaluation mechanisms for the MSHO program seem to be evolving. Focus group participants mentioned several goals for the program, including:

- reorganize service delivery,
- improve care coordination,
- reduce unnecessary admissions, and
- improve the quality of enrollees lives.

These could be evaluated, they said, although comments at the focus group meetings focused on tracking more traditional outcome measures such as cost, utilization, and client satisfaction. The health plans say they will use the state-administered client satisfaction survey to assess enrollees' satisfaction with the program.

One health plan representative stated that he would like to see the development of best practices or extended care pathways that arise as a result of MSHO, where care systems would begin to adopt a standard of practice voluntarily.

Other participants said:

> *"From a quality management perspective, the goals of the program were to reorganize delivery systems and increase accountability. But embedded in there is improving the quality of these peoples lives, improving the quality of the healthcare they get. Figuring out how to monitor the quality and measure the outcomes remains a huge challenge."*

> *"The real question is: How do you tell if what has been done has made a difference?"*

# Observations

A great deal has been accomplished in this first phase of MSHO implementation. Through the entire planning period and the first six months of experience, health plans and care systems have remained engaged in this project and committed to its goals. Plans, care systems, and providers have put essential communication and management structures in place for operating the program. Enrollees are befitting from the additional case management services—there are success stories and evidence of positive outcomes on a case-by-case basis. The program is having an even larger impact on the marketplace and on healthcare organizations in the Twin Cities metropolitan area. The program is affecting how plans and provider systems are thinking about and planning for future programs/products for seniors.

These plans and care systems should be recognized for the tremendous energy and effort they have expended to prepare for MSHO—beyond even that which could be supported by the financing incentives or the projected enrollment. This is strong evidence that these organizations are committed to an improved care delivery model across the continuum for seniors. As with any new demonstration, there are aspects of program development that we can learn from. We provide several observations here for others to consider.

## For plans and providers already participating in MSHO

### Improve the cultural competency of providers and of health plan staff.

The cultural diversity of older clients/families requires additional resources to train providers about these cultures in order to effectively provide case management services and treatment. This is an area in which health plans and care systems could work together to create a higher level of competence, especially in those organizations that serve many MSHO clients or who serve a high concentration of people from diverse cultural backgrounds.

### Fine-tune and include physicians in care management models as they evolve.

Despite the different methods for care coordination and case management, several aspects of the plans and care systems' methods were working well. However, there were some areas that could be reexamined. Tying case management activities to the physicians was one gap. Others felt that there was room for improvement in the clinical management of nursing home patients. One group felt the care coordination method that requires home visits was labor-intensive and might not work over time.

### Establish outcome measures.

Quality monitoring and outcome measures are sure to play a role in the future. Identify and share "best practices" as they evolve, and encourage adoption of practices that are demonstrated to be sound. Select several key indices or outcome measures to track over time. Again, there is an opportunity for all three plans to work together to move toward some standardization in quality/outcome reporting measures for their care systems or providers.

### Improve communication between care systems and health plans.

More than one care system commented on glitches they have experienced with the health plan billing systems and claims processing (e.g, enrollment lists are delayed in reaching the care systems, or claims are slow in being processed. Health plans are encouraged to review the timeliness and comprehensiveness of the information it gives to care system partners and the efficiency of processing requests from providers and systems.

### Use clients in future development of the MSHO product.

As the health plas and providers become more experienced in serving clients in a more coordinated network, MSHO clients could provide valuable input into evolving the product design (e.g., through identifying service preferences and better ways to educate clients and families).

## For new organizations getting involved in MSHO or other states working on similar projects

### Create the provider network carefully.

The "catch-22" of network development is that a larger network can attract more enrollees but result in less practice change or clinical integration, while a smaller network allows for higher concentration of clients among fewer providers—thereby offering the potential for greater clinical coordination—but may result in fewer people enrolling in the product in the first place.

We see here that the networks of all three health plans overlap to some extent; that is, the same provider could be in all three health plans' care systems, and these networks are large. This could be a problem for at least three reasons. First, it makes it more difficult for the potential enrollee to differentiate between the plans/care systems. Second, it can be very difficult and costly for the provider to conform to three different ways of providing care management services and tracking and reporting—e.g., for three MSHO clients who each selected an MSHO product, but enrolled in a different plan. Third, and perhaps most important, a large network may make it impossible to instill changes in practice behavior that would be required to achieve some of the prevention, care outcomes, and cost goals of this program. On the other hand, restricting enrollee access to one care system could disrupt existing patient-provider relationships.

### Identify a few key physicians who will serve dually-eligible clients and maintain their involvement.

Physicians need to play an active role in care system networks' for dually-eligible clients that are part of this type of demonstration. Physician commitment and leadership is needed to keep the programs on track clinically. This might involve forming a smaller, subgroup of primary care physicians or even specialists who would serve as the core providers to enrollees. In addition, the payment arrangements offered to physicians should be examined in order to identify options that would create better financial incentives for physicians involved.

### Examine risk-sharing arrangements throughout the network of plans, care systems, and providers.

Each health plan had different and a multitude of payment arrangements with its care system partners and provider organizations. These care systems, in turn, had various arrangements with subcontracted providers—from discounted fee-for-service to some level of risk sharing. Though the MSHO enrollee volume may currently represent too small a population group for some practitioners, plans and providers are encouraged to be innovative and proactive about aligning the financial incentives—particularly with key providers. This is important even at the subcontracted level with individual practitioners.

### Carefully project enrollment growth, and don't underestimate training and marketing needs.

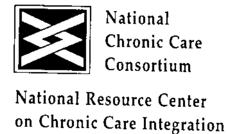
Projections of enrollment growth should be made conservatively. A new program such as this is hard for consumers to understand. Plan and budget for ongoing internal and external communication and training for staff and partners, as well as for marketing for attracting new enrollees. To build the program over time and ensure enrollment growth, the program should be easily identified by seniors and should be of tangible benefit to seniors from their perspective. Without this product differentiation in the market, organizations will need to invest greater resources to build this momentum. Health plans and states may wish to work together to create an ongoing public relations and marketing strategy.

### Work to develop long-term relationships.

There are many challenges to creating a new program, especially where the delivery model changes organizational or personal roles and responsibilities. Be prepared for differences of opinion. If the relationship is to work over the course of the program, however, trust needs to be established—which means some flexibility in who does what or how it is done. There are many entrenched assumptions or misperceptions that people in one organization may hold about another; these perceptions can be changed over time with open dialogue and through early successes in working through problems.

# Appendix A: Focus Group Letter and Questionnaire

## Focus Group Letter




National Resource Center
on Chronic Care Integration

August 18, 1997

Dear

In early October, the State of Minnesota Department of Human Services is conducting a series of focus groups in with each health plan and representatives from care systems participating in the Minnesota Senior Health Options (MSHO) project. We invite you to serve as a focus group participant. The purpose of these focus groups is three-fold:

1. to identify and record, in a qualitative way, the changes health plans have made in serving MSHO clients to date in such areas as care coordination, transitions planning, information transfer, and case management;

2. to identify and describe common challenges in coordinating care across settings and over time for MSHO clients and develop a sense of how these organizations will be moving ahead;

3. to serve as a resource to plans and care systems in continuing their MSHO program development and help guide NCCC technical assistance in the future.

We are pleased to be working with you on this endeavor—the information you share during these focus group sessions will provide us with an early "snapshot" of the impact of the MSHO project on care coordination. We have asked our technical and educational consultant, the National Chronic Care Consortium (NCCC), to work with us in conducting these focus group sessions and to take the lead in developing four reports—a report that is specific to each of the three health plans and one that provides a composite picture of the strategies and challenges overall.

One copy of this consolidated report, a 20-minute videotape composite of the three focus groups, and the individual health plan report will be provided to each health plan. Every participant of the focus groups will receive a copy of the consolidated report. The public may purchase the consolidated report and videotape at the cost of production. The health plan's MSHO representative to the State will preview the videotape before it is made available to the general public, to ensure it does not contain proprietary information. No information about clients discussed by name will be included in the edited videotape. The individual health plan reports will not be released to the public.

The NCCC is under contract with the State, and, as such, is considered an agent of the State. Participants may be assured that any proprietary information provided will be kept confidential.

The focus group for ______________________ and its care system partners will be held on **October 8 from 8:30 to 10:30 am**. We will be using a special facility in Bloomington, called Quality Controlled Services, located at 2051 Killebrew Drive, Suite 680 (the building is next to *T.G.I. Friday's* across from the south side of the Mall of America). Participants will be asked to sign a permission slip to allow for videotaping.

We will need confirmation of your participation by **August 29th** (see enclosed confirmation form). Questions may be directed to Deborah at 814-2646 or to her assistant, Carol Sumerfelt at 814-2650, or to Paul (DHS) at 282-5263. Enclosed is a map & directions, as well as a brief questionnaire for you to complete prior to the focus group meeting. We look forward to working with you on this important project.

Sincerely,

Paul Zenner
Performance Measurement & Quality Improvement
Minnesota Senior Health Options
Minnesota Dept. of Human Services

Deborah Paone
Vice President for Member Services
National Chronic Care Consortium

Focus Group Questionnaire

# MSHO Focus Group Questionnaire

This questionnaire should be completed and returned by September 15 to the NCCC offices by fax (612) 858-8982) or mail to: 8100 26th Avenue South, Suite 120, Bloomington, MN 55425. To the attention of Deborah Paone.

Your name: ______________________________

1. What is your role in supporting and/or providing services to MSHO members?

2. Discuss/describe the methods, processes, or activities that are being handled differently for MSHO enrollees than they were handled in 1996 for seniors/dually eligible clients. (Processes could include risk screening, case management, information transfer, assessment processes, working in teams, quality tracking, etc.)

3. Please describe how these activities may evolve in 1998.

4. What are some of the challenges you've faced thus far in implementing MSHO and serving MSHO clients?

5. As you look ahead, how might you refine your approach in serving the dually eligible client in the future? Will your approach to MSHO members be different than PMAP members? How?

Other comments:

# Appendix B: Focus Group Script

## MSHO Focus Groups

### Part I. "A Walk Through MSHO History" 15 minutes

Reflect on your organization's deliberations some year or two ago, as MSHO was still a twinkle in the eye of the state.

1. Share with me some of the upside and downside of MSHO, as you and your organization perceived the program.

2. What were the biggest hurdles about MSHO and your organization's participation in it that you saw at that time?

3. What did you think the role of your organization would be in MSHO?

4. What did you think you (your organization) would get out of this?

### Part II. "Preparation for the Start Date" 25-30 minutes

1. {*Open-ended* question} As you began preparing for your start date for MSHO "going live," what kind of activities were you/your organization working on?

2. Relationships: What new relationships had to be built, both formal and informal to deliver the MSHO product?

3. Care Coordination: Describe the components of the care coordination system that required cooperation and integration with other agencies and organizations.

4. Structure/processes for Internal Management Communication about MSHO: What kind of structure and process was set up to promote ongoing communication within your organizations regarding MSHO?

5. Case Management: Describe the preparations that were made to implement or modify a system of case management within your organizations?

6. What about preparations for other aspects of this program, for example:

   - Marketing: How did your marketing plan evolve and how were the MSHO marketing plan and efforts similar or different from other new senior products that your health plan or care system has been involved in?

   - Enrollment: What were your main concerns with respect to enrollment? What did you expect your enrollment profile to look like?

   - Staffing: What were your staffing issues to gear up for this program? Did you need to hire staff?

   - Training: What kind of education and training was done within your organizations to orient staff to the MSHO product and program?

   - Provider Education: How were participating providers educated on what MSHO is and what potential impact MSHO would have on care decisions?

   - Information System Support: What changes were made in the information systems to support MSHO? (e.g., hardware, software, training, etc.) What new ideas and processes were generated due to MSHO?

## Part III. Moving Into Action - "The Deeper Middle" 50-55 minutes

Think for a minute about some actual client experiences/enrollees that you've served. Chances are there have been some "realities" of serving clients that have been different from the expectations; the testing of the system with real clients may have revealed some of these realities.

1. {*Open-ended question*} Describe some of your realities, as your systems were tested by MSHO clients—what happened and how did processes or activities need to be changed?

2. Operations: What was the biggest gap between preparations and actual needs? What things did you do that really worked?

3. Operations: What impact has this MSHO program had on your operations? What changes have you made, since enrollment began, because of this program?

4. Describe for a moment some real scenarios that you have had with MSHO enrollees (without using their real names) that illustrate how your health plan and/or care systems work to provide the health screenings and the integrated services necessary to address enrollee needs. The scenarios should include things like:

   - nursing home, hospital, and clinic issues
   - issues in/ description of risk screening and assessments
   - how the communication of important enrollee information within and outside of the organization has been handled
   - issues in/ description of care planning, including accountability and follow-up
   - issues in family involvement
   - tracking the client across the system

   << SCENARIOS SHARED >>

5. With respect to the scenarios just shared, what gaps or problems existed or still exist in the system? How did you handle the gaps or problems? What still needs to be done to make it all work better?

6. One of the main features of MSHO is the integration of care services and the care coordination required to provide an integrated product. What has really worked well in care coordination, and the sharing of clinical and administrative data across the care system and health plan and what have been major hurdles?

7. How has the enrollee/family been involved in and/or benefitted from the care management and integrated service approach of MSHO? What has been enrollee reaction to the care coordinator, in particular? How could care coordination be even more effective, from the enrollees' perspective?

8. What about other client/family issues, for example:

   - To what extent are you finding that clients and family members wish to be and are involved in care management and treatment?
   - Have enrollees endured some negative consequences of being in MSHO? If so, how have they reacted to those consequences and what should be done about this issue?

9. Have we talked enough about specific aspects of the program, such as enrollment, marketing, risk assessment, transfer issues? For example:

   - Enrollment: Did the efforts made in preparation for MSHO meet the requirements for handling actual enrollees?
   - Enrollment: Was the volume and demographic profile of enrollees different from what you expected? How/Why?
   - Marketing: What marketing issues surfaced once enrollment began?
   - Risk Identification and Assessment: What have you learned about the risk screening process/ risk tool that you've employed? How has the information from the risk screen been used? Could this be more effective? How?
   - Transfer: From your experience, as an MSHO enrollee needed a transfer to a hospital or nursing home, what were the main issues in coordinating that transfer successfully? Could this be done more effectively? How?

10. Let’s be sure we have perspectives from the various settings or sites of care where MSHO clients can be served, and from specific disciplines. Have we heard from:

    • nursing home
    • clinic/physician office
    • hospital
    •community agencies/home care
    •health plan
    •and from: physicians, care managers, management/operations staff, and administrators

11. How do your processes/activities with MSHO clients compare with those for PMAP clients?

12. Was the MSHO program a catalyst for any new processes/systems, etc. that are now in place for others? Describe this.

## Part IV. “Looking Toward the Future” 15 minutes

1. Would you do anything differently, if you were to do this over, knowing what you know today?

2. Overall, would you say your participation in MSHO has been “worth it”?

   Let’s imagine that it is sometime in the future and you have 5 times as many MSHO enrollees/clients that you expect to have by the close of this year. . . .

3. What changes/modifications would you need to make from what you do today?

4. What kind of markers or trigger points would you set for your organization regarding evaluating the efficiency and effectiveness of your operations? In other words, how will you know your particular way of doing things is “the best?”

5. What outcome measures would you use to evaluate the MSHO program and your organization’s role in it? Are there measures and systems to consistently measure your progress over time? What more would you need to do this?

6. Are there major opportunities or challenges that you see over the horizon, say in the next year? What are these?

7. Are there any other issues important to the successful operation of your MSHO programs have we not spoken about yet today?

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