
Minnesota Senior Health Options

Insights from Beneficiaries: An Examination of the Minnesota Senior Health Options from the Perspective of MSHO Enrollees

**A Report from Two Focus Groups
Held October 30, 1998**

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Background

Description of MSHO

The Minnesota Department of Human Services has implemented a demonstration project called Minnesota Senior Health Options (MSHO) 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 in a seven-county metropolitan area (in and around Minneapolis and St. Paul). The demonstration began in 1997 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 mandatory Medicaid managed care program—as well as Medicare deductibles and coinsurance, medical supplies and equipment, dental care, therapies, prescription drugs, medical transportation and home care services. It also covers services included 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 people who are at risk 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, but end up requiring nursing facility care.

MSHO is offered as a voluntary option to the standard PMAP plan, in which most Medicaid-eligible seniors, including those dually eligible, are required to enroll. 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 enrollees and participate in the enrollment process for current members. Enrollees may disenroll on a monthly basis, but will stay in the same plan’s PMAP program if they do so, until the next PMAP open enrollment period.

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.

Networks of providers—which may include hospitals, clinics, nursing homes, social service agencies, and other organizations—are called “care systems.” These care systems have formed to serve MSHO enrollees. MSHO seeks to encourage these provider networks to work toward coordinating care across settings and over time. In addition to basic Medicare and PMAP requirements, MSHO requires plans to provide access to a care coordinator for each enrollee. This care coordinator 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 and Care Systems

Two health plans began MSHO enrollment in March of 1997—a third plan began participating in MSHO in September of that year. The three health plans and corresponding care system networks participating in MSHO differ from each other in organizational structure and approach. They also differ by financial arrangements with their subcontracted care systems. All three health plans have had previous experience in the Medicaid managed care program (PMAP). One health plan had previously offered a dually-eligible product in the Twin Cities for clients in a nursing home setting who chose to enroll in the plan’s Medicare risk product. Two of the health plans had no previous experience with offering a Medicare risk product, and therefore the Medicare piece contained within MSHO was new for them.

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. For example, one organization has about 1,000 MSHO enrollees who receive services from among its network providers—this organization has contractual relationships with each of the three health plans. Care system networks also differ in many ways, i.e., by number and location of hospitals, clinics, and nursing homes, and by care coordination models. For example, some care coordination models rely heavily on geriatric nurse practitioners (GNPs), while others use social workers, who primarily work in the clinic setting.

The three health plans serve both community enrollees and MSHO enrollees residing in a nursing facility, however, the proportion of enrollees living in nursing homes versus in the community differ by plan. As of March of 1999, MSHO enrollment included 2,811 individuals from 4 counties in the Twin Cities metropolitan area.

Table 1. MSHO Enrollment, by health plan

Health Plan	# Enrollees in nursing homes	# Enrollees in community	Total
A	242	314	556
B	223	151	374
C	1755	126	1881
	2220	591	2811

Enrollee Focus Groups

Rationale

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, this will lead to an improvement in performance (e.g., defined as higher satisfaction of the enrollee, fewer unnecessary hospitalizations or nursing home admissions, smoother transitions between settings, better support to enrollees and their families to maintain health and prevent deterioration, and maintenance of functional independence over time).

Current performance measurement tools are not designed to measure the integration of care across settings—they do not directly examine communication or coordination of care. Similarly, patient satisfaction measurement tools usually address experience at one point in time, at one facility or setting. Therefore, the use of focus groups to obtain the perspective of even a small group of MSHO enrollees was determined to be a quick and relatively inexpensive method of examining the MSHO program from the customer's viewpoint. State personnel believe that by examining the demonstration program from the enrollee's perspective, they gain greater insight into how the experience with this demonstration program is matching expectations, and what areas might need to be enhanced to improve performance. The results of these focus groups can be added to other sources of information about enrollees—e.g., disenrollment surveys, satisfaction surveys, and personal interviews—to form a picture of enrollee experience.

It should be understood that focus groups are not representative samples of a given population group, in this case, of the entire MSHO enrollment. Focus groups can provide insights into what areas may be appropriate for further study, but the findings of this report should not be generalized to the larger population.

Purpose

The goal of the MSHO enrollee focus groups was to obtain enrollee feedback on their experience with MSHO, particularly focusing on beneficiaries' enrollment experience, the type of services provided to them under MSHO, the care coordination aspect of the program, and how their experience under MSHO compared to previous healthcare experience (e.g., under a different managed care plan).

The state wishes to use the results of the focus groups to:

- identify any major gaps or areas of strength within MSHO, as seen from the customer's perspective,
- communicate findings to health plans and care systems to encourage their attention to any key issues or concerns raised,

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- invite focus group participants to consider an ongoing role as a member of the MSHO Advisory Committee—helping to set direction for the MSHO program,
 - educate others (in Minnesota and in other states) about beneficiary issues in this dually eligible demonstration—as seen by these participants at this point in time.

Methodology

The Minnesota Department of Human Services (DHS), Minnesota Senior Health Options project director and staff arranged through contract to have the National Chronic Care Consortium organize and conduct the focus groups, under the direction of MSHO staff.

Beginning in March/April of 1998, MSHO staff informed the health plans' staff about their interest in holding enrollee focus groups and offered the plans an opportunity to comment and provide input. This discussion occurred at several meetings, including the MSHO monthly Quality Assurance meeting attended by the three participating health plans and other local plans. In May, June, and July, MSHO and NCCC staff discussed the design and methods for this focus group, potential discussion questions, and possible criteria for selecting focus group participants.

The state wished to hold two focus group meetings—one for enrollees residing in the community, and one for enrollees residing in a nursing home. NCCC and state staff drafted the criteria for selecting participants of the focus group.

Criteria for Selection

MSHO staff wished to have as many people as possible participate in the focus groups—not to turn many away. Therefore, they established two tiers of criteria for selecting participants: required criteria and preferred criteria, as follows:

Required Characteristics

- At least two members from each of the three participating health plans
- A variety of clinics and care systems should be represented
- At least three ethnic/racial groups should be represented

Additional requirements

- Ability of each person to give his/her opinion
- Ability to tolerate sitting for four hours (two hours in the meeting and up to two hours in transportation)
- A family member may substitute for the MSHO member
- Any family member may attend with the member, at the member's request.

Preferred Characteristics

- At least one person from each of three age groups (65 to 74, 75 to 84, and 85 and over)
- Minimal duplication of assigned care managers/care coordinators
- A variety of nursing homes represented
- A variety of hospitals or home care agencies represented
- Variation in the members' rate cell payment level, reflecting different care needs.

A letter about the focus groups was sent from the Assistant Commissioner of DHS to the three participating health plans, requesting their cooperation (Appendix A). After the health plans submitted names of potential participants, each potential participant received a letter from the Assistant

Commissioner describing the focus group and notifying them that they would be contacted by NCCC to invite them to attend (Appendix B). NCCC staff then contacted each potential focus group participant by phone to describe the details of participation and determine interest. Staff used a script to conduct these calls (Appendix C).

The health plans provided 54 names of potential focus group participants, of which 24 lived in the community, and 30 resided in a nursing home. Telephone discussions with the nursing home residents were arranged through the nursing home social worker or administrator, if needed. Of the 24 community members, ten (41%) agreed to attend the focus group session. Of the 30 nursing home members, six (20%) agreed that either they, or a member of their family would attend. In all, 16 MSHO members agreed to participate.

Transportation needs of each participant was assessed via telephone. Nine individuals required transportation, which was provided via a local taxi service or by specialized van transportation (with wheelchair lift).

Participants were informed that the focus group sessions would be videotaped—this information was also included in a follow-up mailing. Formal permission to be videotaped and to agree to release of information was granted in writing prior to the session (Appendix D). Participants were also informed that they would be offered a light meal and would receive a small stipend for their time. Additional family members who attended with the MSHO enrollee were welcome to contribute to the discussion and eat the meal provided, but did not receive a stipend.

A very brief survey (Appendix E) was mailed with a confirmation letter to each participant prior to the focus group sessions. The survey asked a few questions about the participant’s healthcare history and living arrangement. Fifteen participants returned this form.

NCCC and state staff interviewed several independent professional facilitators in September, and selected one with background in healthcare and experience in working with older adults. This independent communications expert was briefed about MSHO, the intent of the focus groups, the composition of the group, and a desired format for the sessions. State and NCCC staff developed a list of questions for both the community-based enrollees and the enrollees living in a nursing home—this list was reviewed by the facilitator prior to the sessions.

Areas of inquiry included:

- Do you know you’re in the MSHO program—a pilot demonstration?
- How did you enroll in MSHO; what was the enrollment process like?
- Do you notice a difference between your current experience under MSHO and previous healthcare experience under another insurance or managed care plan?
- Have you experienced any problems since you enrolled in MSHO?
- What are the most important aspects of your care?
- What services are you receiving?
- Has MSHO made any kind of difference in the care you receive?
- Are you getting enough information on the MSHO program, your health care issues, and how to obtain services that you need?

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- How could MSHO serve you better? Do you have any suggestions for improvement?
 - What would you tell a friend or relative about MSHO?
 - What would you tell federal or state legislators about MSHO?

At the end of the focus group sessions, participants were given an evaluation form to complete and return via mail—fifteen returned this form; they indicated a high degree of satisfaction with the focus groups (Appendix F). In addition, participants received another form to use if they are interested in becoming a member of the MSHO Advisory Committee. Seven participants indicated that they were interested in this opportunity.

Following the focus group sessions, NCCC and MSHO staff reviewed their notes and the four hours of videotape and selected highlights from the tape reflecting the major themes of the sessions. Comments were transcribed and analyzed, and then put into one of six categories as follows:

1. Enrollment experience
2. How MSHO has made a difference
3. What is important to enrollees
4. Problems experienced with the healthcare system
5. Care coordination
6. What others should know about MSHO

The NCCC developed a composite videotape that contains approximately 45 minutes of selected quotes, using a professional editor/videographer. In addition, NCCC developed a Viewer's Guide as a companion to the videotape, and this report to capture the sentiment of the focus groups and describe major themes.

Description of Participants

Seventeen people participated in one of the two focus group sessions that were held on Friday, October 30, 1998. The morning session included twelve people, including ten MSHO members, one family member representing her mother who lived in a nursing home, and one family member who was observing with her mother. The afternoon session included five people, including four MSHO members who were currently residing in a nursing home or in a board and care facility, and one family member who was representing her spouse, who lived in a nursing home.

Table 2. Focus Group Participants, by Living Arrangement

Description of Participant	AM Focus Group	PM Focus Group
MSHO member in Community	10	0
MSHO member in nursing home	0	4
Family member of nursing home resident	1	1
Family member observing focus group (also contributed to discussion)	1	0
Total	12	5

Eleven of the attendees were women; six were men. The ethnic and racial mix of the group included: three African-American participants, 13 Caucasian (of which two people were Russian immigrants), and one Hispanic. The age distribution of the MSHO enrollees ranged across the three age categories highlighted in the selection criteria—including eight people between the ages of 65 and 74, six people between the ages of 75 and 84, and two people who were over age 85.

All three health plans were represented by these focus group participants—that is, at least two people had chosen each plan's MSHO product. A variety of healthcare facilities were used by these 16 MSHO enrollees. Across all participants, six different clinics were used within 3 different care systems. Five different nursing homes were used by the MSHO enrollees residing in a nursing home. Most MSHO members had a care coordinator assigned to follow their care—a total of ten different care coordinators were represented by the participants.

The participants had been enrolled in MSHO from six to nineteen months. Five people had been enrolled from six to eleven months, and eleven people had been in MSHO for over one year. Most of the MSHO enrollees participating in the focus groups (fifteen people or 94%) had been eligible for Medical Assistance for at least one year (range was from one to seven years). Many (fourteen people or 88%) of the participants had been enrolled in PMAP prior to joining MSHO. The length of time that participants had been enrolled in PMAP ranged from one month to five years. Only two people were new to managed care and had not been enrolled in PMAP.

The pre-meeting survey results revealed a relatively high degree of healthcare utilization. Out of the fifteen survey forms received, six people had been hospitalized in the past year, four had used the emergency room at least once, and seven had seen their physician or nurse practitioner at least five times in the last year. The results on living arrangements showed that three participants lived alone, six lived with others, and six lived in a nursing home.

Major Findings

Enrollment Experience

Participants had very positive enrollment experiences. They discussed how they heard about the program—through marketing material or letters received in the mail, through presentations at their nursing home, through their doctor, nurse practitioner or family/friends. Several participants who had been enrolled in PMAP recalled receiving a letter about a new plan that they could choose—MSHO. All of the focus group participants living in the community, and most of the nursing home residents remembered receiving some information about some type of change in their health plan coverage. A few participants seemed confused about when and how enrollment had occurred. Only two of the nursing home residents/family members seemed to have no idea how they were enrolled in MSHO. Most of the participants were aware that they were in a new insurance plan. A few participants recalled the name “Minnesota Senior Health Options.”

Several participants reported discussing the new plan (MSHO) with their physician or other trusted advisor, and felt that these individuals had encouraged them to join. In fact, an important factor in considering enrollment was whether the person’s physician or regular hospital was part of the MSHO care system network offered by the health plan.

Some expressed an interest in the array of social supportive and long-term care services that could be available to them in the future, even though they did not feel a need for such services when they enrolled. Others were attracted to this program because it was for seniors only—indicating that this program would be tailored to seniors’ specific needs. Another appealing feature of MSHO seemed to be the reduction in paperwork and a coordinated billing process. Finally, MSHO was discussed more as a health insurance product than of a government program that provides services to seniors.

Focus group participants commented:

“I got the booklet in the mail—first the letter that said would I be interested. I said yes. I got the booklet and took it down to our doctor, which I’ve had for ten years. She said ‘I think it’s a marvelous thing. You should join.’ So I did.”

“I got the letter. There were three different health plans that I could join. I looked through them to see where the doctors were . . . I looked to see where my doctor was. She was with Hennepin County, [part of the care system network] so that did it.”

“I was in Medical Assistance [PMAP]. They sent me a letter saying I was being changed to UCare.”

“My mother was paying her own way and had medical insurance through my Dad’s pension plan. When she ran out of funds, she had to apply for Medical Assistance. Medical Assistance wanted her on one of their plans, not a private insurance plan. I was given a folder by Human Services, where we applied for Medical Assistance—with all the options. My main objective was to keep her with the same physician and same hospitals that we were both used to. This [MSHO] was the only plan that included the physician we were seeing at that time. The switch over from her prior insurance plan to this one was very easy.”

“One of the reasons I joined up was it was for seniors, seniors only. I had had trouble with other programs. When I saw seniors, seniors only, I thought, well, they care.”

“There I was, just out of the hospital. I came home to my house all alone. . . . At the clinic they said, ‘Do you need somebody to cook? Do you need household help?’ Well, I really didn’t. But, I thought—I’m going to be older and sicker in the coming years—I sure would. To me, it was like a gift from God.”

“We first heard about this program last Spring sometime. The administrator at the nursing home at a monthly meeting introduced the program. It would be available through two options, EverCare or Fairview Southdale Hospital. We were given a sheet explaining the basic fundamentals of the program. We took it home, read it over, and inquired about it. A few days later, a representative from the one we picked came and visited and explained the whole program to us.”

“Laura [a nurse practitioner] came to see me. She explained the benefits of the program. The bills, for instance, Medicare and my insurance company, will coordinate and take care of everything. I understood it was going to be easier for me not to have to deal with the insurance company and Medicare. They were going to do it for me. That was a decisive factor.”

How MSHO Has Made a Difference

In general, focus group participants reported that their experience was better in MSHO as compared to previous experience.

Several community-residing enrollees seemed to especially appreciate the range of services that had been provided to them that they never knew were available—items such as hand rails in the bathroom, and services such as transportation to and from the doctor’s office. Even if the range of services were not currently needed, the participants clearly voiced comfort in having the security of home-based and long-term care services available for future needs.

One family member present emphasized how much that MSHO had reduced her mother’s and her own stress levels, by having the MSHO care coordinator solve problems as they arose. The one-to-one relationship and communication between the enrollee and the care coordinator or nurse practitioner was also especially valuable, reducing stress on the enrollee and his/her family. Several participants also indicated that the follow-up by healthcare practitioners was better—more proactive in managing the enrollee’s condition.

At least two nursing home residents said that they had never had a nurse practitioner before and appreciated the personal attention and enhanced communication that this person brought to their care. Another difference discussed was the reduction in paperwork and billing problems.

Focus group participants commented:

“I like it because Norman and I—we have family, but not too close. When he had his stroke, if he had to go to a nursing home, I’ve had no experience with that before. Now it’s all taken care of for me. I don’t have to worry about that any more. They’ll help me pick out a nursing home and one that’s close where I can visit. It’s just like having a big brother. They really take an interest and care.”

“I’ve been on blood pressure medicine for 40 years. The only time I’d see the doctor was when the pharmacist told me the doctor wants to see you. That would be after I had my prescription filled many times. When I went on Medical Assistance, I was assigned a doctor and had to change my dentist and eye doctor. Before, I went whenever I felt like it. Now, it’s every 6 months. If I don’t call and make an appointment, they call. I think that’s good. Then they call the day before the appointment and remind me I have an appointment tomorrow.”

“I remember a lot of changes. Before I got into this program, I couldn’t get nothing. You know—no help.”

“I can tell they care. Somebody will call me—Sonja [care coordinator’s name]. ‘How are you doing?’ She’ll come out to the house. She advises us. It’s been just great. Before that, I’d have to worry about how to do it. Now I can just call Sonja. I can rest.”

“The difference is that the nurse practitioner is there for at least 3-4 times a week. Somebody to talk to about your problems. [Facilitator asks: “You didn’t have that before?”] No, no nurse practitioner before.”

“I do like it because when she [the nurse practitioner] comes to our room, she sits and talks and visits. It’s not like in a doctor’s office. . . . [In a doctor’s office] you tell him your problem and he checks you a little bit. . . . He’s very good, but they don’t give you the time this nurse practitioner does.”

“It’s a very good program. It took a lot of stress off of me and my siblings. Basically, my mother doesn’t have to worry about anything when she has a problem—they solve it. When she has a problem with medications, [or] she has a problem with transportation—they took care of all of it. [Before], it stressed her out.”

“I do not receive reams of paper in the mail anymore from Medicare and from Blue Cross/Blue Shield telling me whether they’re going to pay it or they’re not and the copayments and things. The paperwork has gone down dramatically. . . It also cuts down on the amount of time that I have to make phone calls to straighten out referrals and coordinate appointments because Julie [her mother’s care coordinator] does this for me. She takes care of it. I check with her periodically to see that we’re current on having the referrals for the repeat visits and things. She checks when she visits my mother to see what’s coming up and takes care of it.”

What is Important to Enrollees

Participants especially valued good communication and information when and in the form they wanted it. They appreciated honest, open communication from their doctor, in words they could understand. They were looking for healthcare personnel to treat them as a “whole person,” and someone with good listening skills. A person who took the time “to chat” was seen as someone who had their best interests in mind.

Many were interested in information on what they could do to prevent or address particular health problems. Several mentioned that they had learned to be assertive in order to get the information they needed.

In addition, the activities and follow-up of the care coordinator were mentioned many times—clearly each participant’s coordinator was seen as a person who could be counted on to make arrangements, and work through the system on the MSHO enrollee’s behalf. Participants agreed that having an advocate was important—the coordinator served this role for many in the focus groups.

Participants valued having a wide range of services easily available to them. Features noted included the easy access to services through their care coordinators. The coordinators served as “one-stop” to go for easy links to all services that might be needed. Home support services, were especially important.

In addition, the nursing home residents talked about the need for better continuity of nursing staff, or better information sharing between nurses/nurses’ aides—so that important information was transferred from shift to shift.

Other services that were mentioned as being important to these participants included:

- reminder letters and phone calls about appointments
- transportation to medical appointments
- equipment to help stay more independent

Focus group participants commented:

“I like the idea of having a doctor wherever I go let me know what is wrong with me, what I can do about it. Nor just tell me: ‘You’ve got this’ or ‘You’ve got that.’ What caused it and why? That’s important to me.”

“What I like about it, he [the doctor] comes down to earth to explain every little thing. They don’t use those great big words or nothing. This guy comes down to earth. I like that.”

“It sounds to me like they’re talking about their doctor looks at them, deals with their problem and goes on. Whereas, the nurse practitioner has a chance to sit down and talk to them and chat. I suspect that more things come out in those little chats. My mother is fortunate to have a physician that does take the time to chat and talk with her. It’s the talking to and dealing with the whole problem or whole condition that’s important.”

“Well, I get more now than I got before. I get it by asking. I keep digging until they give me an answer. If they’re just going to say: ‘Well, it’s this or that, and in time you’ll get worse.’ I want to know why it’s getting worse. I want to know what I’m doing wrong. Now the doctors tell me.”

"They take very good care of me. That's important. They're always making my appointments. If I miss an appointment, they arrange to set it up for another day and stuff like that. They always set my appointments always a week or so in advance. Then the day before I go to the appointment, I get a letter in the mail. They're very good."

"I think now we have a care manager. I think it's an important thing that we can call when we don't know what we have to do. We have a primary doctor but sometimes if we have some problem, we can call (the care manager). I think it's important."

"I think older people have grown up with doctors and stuff. You've got a gut feeling when you know you got a doctor you can depend on or trust or you like. And communicate. . . [Also] Older people like to know what's available in an emergency. What kind of help is available in case of emergency, like a stroke, a heart attack, at two in the morning. What do you do? What's available for you? This business is about communication."

"They provided me a bed, the wheelchair, anything and everything that was needed, which we didn't even expect—a bench for the bathtub, the shower, the railing—You name it."

Participants were also asked what additional information they would like. They asked for the following:

- updates on new procedures and treatments
- coverage for alternative medicine
- more information on MSHO itself, because it is a pilot project
- legal resources, such as a living will

"I would like it if they would update me on new procedures. For instance, I've had this wart for over 20 some years. . . I haven't had anything done for 8-10 years. I'd like to know if they have some new procedure to help me get rid of it."

"I think we need information about alternative medicine. We need to connect conventional medicine to alternative medicine. There are a lot of very helpful things."

"Well, if this is a pilot project, then I wasn't aware that it was. It would have been nice to know that. If it is a pilot and it ends, where do we go?"

Problems Experienced with the Healthcare System

Participants reported some problems that seem to be imbedded in the healthcare system—not necessarily specific to MSHO. Other problems or needs could possibly be met by changes to the way MSHO enrollees are served.

Participants said they had problems with having to deal with referrals. They also noted that some of the providers did not seem to understand the process for serving seniors enrolled in MSHO. One couple was sent back and forth to different optical departments, with each provider telling the clients that the other department was supposed to cover their services, the issue was resolved when the couple's care coordinator intervened.

A few community-based participants reported that they still occasionally received bills for services. Some of the enrollees were unsure about their responsibility for paying for services. Several focus group participants discussed this issue of receiving confusing bills or bills in error and offered each other different strategies for how to deal with this problem. Some did not pay, and said that eventually, their insurance kicked in and took care of it. Another referred the bills to her care coordinators to take care of the bill. One person had paid half of a bill, but was advised by the other participants that she didn't need to, and should get her money back (this was later resolved by the individual's care coordinator).

In addition, participants wanted more information about their coverage, and wanted timely response to their needs for information from the health plan. For example, a daughter—who was taking her mother out of the nursing home occasionally to go to a clinic—wanted an additional identification card to show proof of insurance via MSHO. Again, the care coordinator helped resolve this issue.

Some participants expressed a desire for more complete coverage of certain services, for example, alternative medicine, and more physical therapy in the nursing home setting.

Participants were not always sure what process they were supposed to follow and what services they were entitled to receive—for example how to work with the care coordinator and the nurse practitioner versus the doctor or the nursing home staff.

Several participants who reside in nursing homes discussed quality of care and staffing issues in the nursing facility at length. They seemed to agree that advocacy in the nursing home is important—someone to speak on behalf of the resident. Participants reported that the care coordinator or nurse practitioner often helped them deal with the issues that arose in the nursing home.

Focus group participants commented:

“From the beginning, we needed a referral if we need to go to some doctor. It's not a big problem, but it takes our time and makes us nervous. It's a restriction.”

“The doctor prescribed glasses. When we went to the Optical department, they turned us down, saying they could not get payment. We called our care manager and she said to go back to the optical department. She said the optical department doesn't know exactly what is happening and need to be educated. They should educate before they enroll us. Therefore, our trouble educates people.”

"I had a bunch of bills. Every time, I called them and explained that I have insurance. They said they would take care of it. Next month, I received the same bill. I received the same bill ten times. They have my insurance, but they don't use this insurance."

"My problem is now I got a bill for these tests that they say are not covered. I got it two times. I paid half this bill. What should I have done? [Another participant responds] You can't let that bother you. They'll get around to it. I don't pay it. I know the insurance company doesn't always pay the bills on time. Sometimes, they are 3-4 months late."

"I needed an ID card for my mother. I was told that the facility had notified that she was a participant and didn't need a card . . . I think it's only reasonable to expect that I get the proper paperwork so that when I take her to the doctor's office, I can show what insurance plan she is in."

"I would like to have more therapy given. Physical therapy. For instance, I've got a brace for my leg. I can't walk with this brace. I would like enough therapy that I'd be able to walk with my brace."

"I didn't really know what the [administrative] procedures were [for using the care coordinator]. I kind of had to feel my way along. I've worked well with Julie so that's been nice. If Julie were to leave and someone else come along, I'm still not sure exactly what the limits are of what they're supposed to do for my Mom."

Care Coordination

Participants were very complimentary about their care coordinators. Clearly these enrollees felt that the coordinators were their advocates, and were very attentive to the clients' needs—even anticipating needs that the clients themselves didn't think about. There seemed to be a good one-on-one relationship between each client and his/her care coordinator. In story after story, focus group participants described situations where a problem arose and their care coordinator took care of it. These stories were told with almost audible relief at not having to navigate the system themselves.

The participants reported that the care coordinators provided the following services:

- arranged home service for them when needed, such as home care nurses - to help the individual avoid institutionalization
- provided information on new procedures or new treatments
- visited them at home or in their room at the nursing home
- provided home safety equipment, such as tub chairs, toilet seats, grab bars
- checked on them after hospitalizations
- arranged coverage for items that were initially denied coverage
- arranged for preventive services at home (e.g., flu shot)

The care coordinators kept communication open with the MSHO member and ensured continuity of care. The care coordinators in nursing homes were reported as checking into any problems and taking action to prevent further difficulties.

Some did not fully understand the role and expectations for care coordinators—they were not sure of the limits of the role. For those who were nursing home residents, they wanted to know a schedule of when the care manager could be expected at the home. The community-residing residents were not always sure just when the care manager should be called. Some called for any reasons; others only when they were experiencing some difficulty that they could not resolve on their own.

Focus group participants commented:

“She [my Mom] got things that I didn't really think she could get. Some of the meds, she always had to pay for and like the high seat for the toilets and stuff like that. We never knew that. It helped out to get [hand] railings. Her coordinator told her about how to get handrails and all these type things. It was very shocking. . . much more than we imagined. It took a lot of stress off her. [Mother would say] ‘How am I going to get this?’ You call your coordinator and she'll take care of it.”

“When I talk to the coordinator, they come over to the house. They ask me about everything I need. I said I didn't need anything. They said I needed a railing for my tub, a shower holder and shower chair. All that stuff. Things that I didn't know I needed. Now I am using it. I'm very glad that this program is there for the seniors.”

“If I have any problems, why I call Sonja [the care coordinator]. She corrects them for me. Before that, I'd have to worry about how to do it. Now I can just call Sonja. I can rest.”

“Sonja called. She wanted to come over and talk to us. I said my doctor has been threatening to put me in a nursing home. . . She [the care coordinator, Sonja] says: ‘No, no, you call me. I want to check and see what you need around here since your stroke.’ And she did and she got it. The transition was easy going from [hospital to home]. Before, I didn't have anybody to call and find out. Now I've got someone. It's great.”

“Laurel Rose always calls me when she has new information about anything. She calls me and tells me some such thing.”

“The only concern I had at the time [of enrollment] was having the care coordinator help-having someone else supposedly coordinating her care when I had been the one watching her care and seeing that she got to the right doctors and things. I was concerned about someone else coming in and maybe not doing things the way we knew they ought to go, but that wasn't a problem. It worked out just fine.”

“Similar feelings were expressed about the nurse practitioners in the nursing home setting who served these MSHO enrollees. The nurse practitioners were described as more available and sometimes more responsive than the clients' physicians.”

[Facilitator asks: Do you have a nurse practitioner?] *“Yes, her name is Laura. . . She stays on top of my problems all the time. She consults with me if I have any improvement and stuff like that.”*

“I asked my dietitian to put me on lower calories because I've gained a lot of weight. She [the dietitian] said she'd called my doctor and was waiting for a call back. I happened to see Laura. I said [to the dietitian] 'There's Laura. You don't have to wait for the doctor to call you back; just ask Laura.' Laura wrote out permission for the dietitian to put me on a low calorie diet.”

“Well, I mentioned that our staff, the nursing staff in our building think the program is great because it takes a lot of pressure off of them by having this nurse practitioner come.”

“What the practitioner does, you might say that she's the frosting on the cake. She gives us that personal attention. She'll sit and visit with us for 20 minutes and answer questions that the doctor doesn't have time for.”

What Others Should Know about MSHO

Overall, these 17 focus group participants were very positive about MSHO, and felt that more seniors should know about the program.

Participants reported being very pleased with the care they received through MSHO; they felt well cared for and cared about. When they needed something, they generally received it. The care coordinators and nurse practitioners were the heart of the MSHO program, being seen as advocates for the client/resident and family. For the community-residing enrollees, care coordinators were critical to bringing services into the home that helped them stay independent and out of the nursing home. For the nursing home enrollees, care coordinators and nurse practitioners worked together to ensure proper care and to troubleshoot if problems arose with nursing home procedures.

The participants recommended that more information about MSHO be provided both to them and to other seniors who are eligible to join. One participant suggested that everyone should be eligible for the services provided in the program, not just those who qualify financially. One family member present voiced a wish for this program to be extended to younger people with similar care needs. Participants recommended that other states try this program.

Focus group participants commented:

“I think it makes senior citizens, gives them a comfortable feeling—that they’re still important. It makes you feel independent, more independent. Do things for themselves. Not like they’re the next step into a nursing home. This is to help yourself.”

“It’s so easy to understand. Not a lot of hassles. They’re right there to help you—your coordinator.”

“I guess my comments would be positive that they would have someone in the system to help, whether it’s a nurse practitioner or care coordinator. They do help when you get stuck and you’re not getting a response. She knew where to go to and who to ask. She handled the prescription problem, to get the administration of medications straightened out. She does see my mother. She did call me to ask about things she was not aware of about my mother. For me, it’s been a lot of help and a lot of moral support. I really do appreciate that. It did cut down on all the paperwork with the private insurance system.”

“It gives you peace of mind. I think that’s what it boils down to. I didn’t know what would happen to me. It was a gift.”

“I knew a little bit about it, but I didn’t know it was going to be as good as it was.”

“I want them to know that my generation is coming up, and I think we need to know about this—this senior program. A lot of people really don’t know about it. My generation is coming up and I want to be able to get that help from MSHO. . . It’s going to be a lot cheaper in the long run.”

“My interpretation is that it’s a program of the state and federal [government] to help senior citizens get better healthcare overall. . . I think it gives us more options and makes us feel a little bit more important than maybe we thought we were.”

“I would say it would be needful, very needful. I think that as the population ages and insurance to take care of people who are older—they need the advocacy that this is supplying right now.”

“If I were a millionaire, I couldn’t have better healthcare. . . with MSHO it seems that somebody cares about seniors. They don’t just care at voting time. They care all year long. It makes you feel much better. I couldn’t get any better.”

Observations and Conclusions

Being a member of Minnesota Senior Health Options has been a positive experience for the participants in these two focus groups.

The heart of the MSHO demonstration seems to be the care coordinators and nurse practitioners who provide personal attention and who have developed one-on-one relationships with their clients. Care coordinators are clearly readily available to assist the members with various problems and to provide advocacy and continuity. Community-based participants especially appreciate receiving home visits by care coordinators and adaptive equipment to help keep them independent.

The additional advocacy provided by the care coordinators in the nursing home environment has helped to resolve care issues, and seems to have enhanced communication with other healthcare workers (e.g., nursing home staff, physicians). Though MSHO cannot solve all the issues that might arise, it appeared that the program can help address some of these issues.

The requirement for a care coordinator is a key feature of the MSHO program and one that differentiates this program from Minnesota's managed care program, the Prepaid Medical Assistance Program (PMAP). The MSHO care coordinators are involved on an ongoing basis, not just for episodes of care. Members can, and do, call their care coordinator at any time.

Other MSHO features that participants feel add value to them include the enrollee's ability to access a full range of acute, long-term care, and community based services. Even if these services are not presently needed, their availability brings a sense of security about the future. Security was a re-occurring theme in these focus group discussions—MSHO provided these participants with the mental comfort that services would be there when they need them.

Participants also voice appreciation for additional attention received from the clinics or care systems, including reminders for appointments and improved communication. The reduction in paperwork was also seen as a plus. Finally, this program was seen as special because it was designed especially for seniors.

Several of the issues mentioned by these participants had been mentioned by participants in previous focus groups conducted by the Department of Human Services with PMAP beneficiaries (McGee, et. al, 1996). Factors that were important to the PMAP beneficiaries that were also important to the MSHO enrollees include:

- keeping the same doctor
- doctors who explain things in understandable terms
- personal and caring treatment by healthcare personnel
- continuity of care

Enrollment into the MSHO program appeared to be an easy process for the participants. Participants who had been on Medical Assistance had differing levels of awareness that some change had occurred when they enrolled in MSHO. For people newly applying for Medical Assistance, who were also eligible for Medicare, the process was explained through materials prepared by the state's Human Services Department at their county of residence. MSHO was also selected when recommended by someone the enrollee trusted. Some participants chose a particular health plan's MSHO product based on whether their physician was included in that plan. Others were attracted to the reduction in paperwork. Most changed from the PMAP program into MSHO.

Only two were newly enrolled in MSHO. In either situation, however, it was an easy transition.

It is interesting to note that participants related to MSHO as a form of healthcare insurance—not as a government program that provides services to seniors. This seems to be a positive, perhaps distinguishing MSHO in their minds from other programs.

A few concerns were also raised, such as the need for obtaining more information about MSHO and how their health plan operates, and some nursing home staffing or quality issues.

Participant responses indicated that MSHO name recognition could be improved. Participants generally knew the name of their health plan; only a few identified MSHO by name.

The state and NCCC had previously conducted focus groups of health plans and providers who were involved in the MSHO program. In those focus groups, which occurred in 1997, the providers also reported their observations that beneficiaries were interested in the plan because of the potential for reduced paperwork. Likewise it was reported at the earlier focus groups of plans/providers that there was little name recognition of MSHO and that marketing the program was difficult (NCCC, 1998).

At least one enrollee mentioned that prior to enrollment she had a concern about the requirement to have a care coordinator, but after working with the care coordinator, her concern proved to not be relevant. Again, health plans and providers had reported in previous focus groups that a few seniors they had approached to consider joining MSHO were not interested in the program because of the requirement for a care coordinator (NCCC, 1998).

Although there were problems mentioned by the participants during the enrollee focus groups, most issues related to typical problems or issues experienced in health plans, care systems or nursing homes, not to the design of MSHO. Some of the participants had not been in a managed care plan before and did not know about or understand the requirement for a referral to see specialists, even though all plans provide members with this information. Similarly, some participants did not seem to know what to do if they wished to make a formal complaint, even though this process is outlined in member materials provided by the plans and by the state. Most participants called their care coordinators to understand more about these issues.

Even though plans had conducted provider training and education about MSHO, participants in these focus groups indicated that some providers were still confused, or that education had not reached all staff. The previous plan/provider focus groups similarly mentioned the difficulty of training providers about MSHO (NCCC, 1998). The earlier PMAP focus group participants also were unhappy about the requirement for referrals to see specialists (McGee, et al., 1996).

The members of these enrollee focus groups were generally quite an assertive group, willing to ask questions of their health plan or providers in order to get needed information. When they experienced problems, most would call their care coordinator to determine what to do. Even for those willing to call their care coordinator, however, the boundaries for the care coordinator were not always clear. There was a bit of uncertainty about expectations and limitations in the care coordinator's role.

Participants were happy with their physicians, and very pleased with their care coordinators and nurse practitioners. Unfortunately, the focus group discussions did not reveal much about how the care coordinators and physicians worked together. Participants of the previous plan/provider focus group had mentioned that the involvement of the primary care physician needed to increase (NCCC, 1998). Since such physician interaction is an important part of care management activities, MSHO members' need for further understanding of the role the care coordinators (e.g., how they work with physicians) may be important.

The group of participants from nursing homes (including family members participating on behalf of an MSHO enrollee in a nursing home) discussed quality of care issues in the nursing facility environment at length. There may be need for additional advocacy for clients and family members, given the issues that surface in providing nursing facility care.

The following activities may also be helpful in refining the program:

- Promotional efforts about MSHO could be improved—perhaps by targeting information to community leaders or others that seniors trust.
- Given that there are a variety of care coordination models, health plans and care systems could work to better define the process for using the care coordinator and the role of care coordinators—clarifying expectations and limitations, including how the coordinators work with physicians.
- Health plans and providers could review billing procedures for improvement.
- The process for educating new MSHO enrollees (or re-educating those already in the program) could be reviewed to identify areas for improvement—especially where referral procedures and coverage of services is concerned.
- The state and plans could work together to inform MSHO members about what future options exist for them if the MSHO pilot project ends.

Based on these focus groups, it is clear that these seniors value aspects of care that other seniors seem to value as well, including:

- communication
- coordination of care
- personalized attention
- access to a wide range of home, community, long-term care and medical services
- a holistic approach to care and treatment
- better and more information about their condition, when requested and in the form needed
- a preventive focus
- a focus on continuity of care
- enhanced educational resources.

It is probable that these characteristics would be beneficial in any product offered to seniors.

Appendix A: Focus Group Letter



Minnesota Department of **Human Services**

August 19, 1998

Dear

In October, The Minnesota Department of Human Services is planning to conduct two focus groups for Minnesota Senior Health Options (MSHO) enrollees: one focus group of MSHO enrolled community members and one focus group of MSHO enrolled nursing home residents. The purpose of these focus groups is to measure the impact of combined financing, integrated care systems and care coordination on MSHO enrollees to help determine if the MSHO demonstration is meeting its goals. Although there are many ways to measure enrollees' experiences and reactions, these focus groups will provide a quick, relatively inexpensive method for getting feedback and evaluating the quality of services provided by MSHO.

To help facilitate the focus groups, the Department has contracted with the National Chronic Care Consortium (NCCC) to act as its technical and educational consultant on the project. NCCC will conduct the actual focus group sessions, and develop a report and a video tape based on these sessions. NCCC will allow the health plans and the State to preview the report and video tape before it is made available to the general public, to ensure that they do not contain any proprietary information.

Participants in the focus groups will be asked to sign a data practices release prior to participation. Further, participants will not be specifically identified in either the report or video tape produced by NCCC. Since NCCC will be acting under contract with the State, the State will require NCCC to abide by all state and federal laws related to the confidentiality of enrollee information. As such, health plans can also expect NCCC to abide by all applicable state and federal laws related to this type information.

Within the next few weeks you will be contacted by Sally Dunn from NCCC. Please feel free to discuss the proposed focus groups with her and to express any concerns you may have related to the project. If you have any additional questions or concerns, please feel free to contact Kimberly Halva, Project Coordinator for MSHO, at 612/296-1724.

Sincerely,

Maria Gomez
Assistant Commissioner
Minnesota Department of Human Services

Appendix B: Focus Group Letter



Minnesota Department of **Human Services** _____

September 15, 1998

Dear

In October, The Minnesota Department of Human Services is planning to conduct two focus groups for Minnesota Senior Health Options (MSHO) enrollees: one focus group for enrollees residing in the community and one for enrollees residing in nursing homes.

As an enrollee in an MSHO plan you may be contacted by our representative and invited to participate in a focus group. The purpose of these focus groups is to discuss MSHO enrollees' opinions and experiences with the MSHO program. If you agree to be a participant in a focus group you will be asked to respond to questions about the MSHO enrollment process, your interaction with you physician, how coordination of your care has worked and other experiences you may have had as a member of MSHO. This information from enrollees will help us learn about and improve the MSHO program.

Please note that participation in the focus groups will not affect the medical care you receive in any way.

The focus groups will be held on Friday, October 30, 1998. Enrollees living in the community will be invited to attend a session from 10:00 a.m. to 12:00 p.m. Nursing home residents will be invited to attend from 1:00 p.m. to 3:00 p.m. Transportation will be arranged, if needed.

The Department of Human Services has contracted with the National Chronic Care Consortium (NCCC) to assist on this project. Sally Dunn, from NCCC, may be contacting you within the next couple of weeks to tell you more about the focus groups and to determine if you would be willing and able to attend. It will be possible to bring a family member or close friend with you if you would like to do so. If you agree to participate, you will receive a \$50.00 gift certificate for attending. This certificate is available only to MSHO enrollees because we do not have a large enough budget to provide a certificate to a family member or friend who chooses to accompany you to the focus groups.

If you have any questions about the proposed focus groups, please feel free to contact Kimberly K. Halva at the Department of Human Services. We hope that you will be willing to participate and share your thoughts with us so that we may improve the MSHO program.

Sincerely,

Maria Gomez
Assistant Commissioner, Aging Division
Minnesota Department of Human Services

Appendix C: Script

MEMBER NAME: _____ SS#: _____
ADDRESS: _____
PHONE: _____
HEALTH PLAN: _____ CARE SYSTEM: _____

SCRIPT OR CHECKLIST FOR MEMBER CALLS

1. Explain purpose of focus group: To determine MSHO enrollees experiences and reactions to MSHO
2. Describe what to expect at Focus Groups: Arrival time, meal first, number of participants, videotaping
3. Explain that participants will receive \$50 at the end of the focus group session
4. Ask member if he/she will agree to participate
 - If no, ask if they would want a family member to participate in their place?
 - if need more time to think about it, set a date/time for return call: _____
 - If yes, continue with checklist
 - If no to themselves, but yes for family member, make arrangements to call family member: _____
5. Explain that they will need to sign a consent to participate and to be videotaped. This will be mailed prior to the session with a return envelope.
6. A map and directions will be mailed: NOTE HERE DATE MAILED _____
7. Determine if transportation will be needed. If yes, ask how they are usually transported and note here: _____
8. Tell the person that they may bring a family member along if they will need help to get to the bathroom or need other personal assistance.
9. For nursing home residents only: explain that I will call the charge nurse to be sure that the nursing staff record that the resident will need to be ready to attend and to arrange transportation as needed. A letter also will then be sent to the Director of Nursing and/or administrator to make sure s/he knows about and supports this.

Appendix D: Videotape Release Form

VIDEOTAPE RELEASE FORM

Minnesota Department of Human Services: Minnesota Senior Health Options Project

The Minnesota Department of Human Services is sponsoring focus groups for enrollees of the Minnesota Senior Health Options project, as well as for care givers of people enrolled in the project. To assist the Minnesota Department of Human Services, I understand that I may allow the Minnesota Department of Human Services to videotape my participation in these focus groups. I also understand that during these focus groups I may be asked questions about my past or present medical condition(s), and about medical care or medical treatment(s) I may have received; and that my response to these types of questions will be videotaped. Further, I understand that my decision whether to participate in the focus groups will not affect my medical care or medical treatment in any way.

By signing this release, I give the Department of Human Services any and all interest(s) I may have in the finished videotape and/or copies of the original videotape. I also give the Department of Human Services the right to give, transfer, distribute and/or exhibit the original videotape or copies of the videotape. Further, I understand that I will be paid only fifty dollars (\$50.00) for my participation in the focus groups, and that I will receive no additional payment(s) for the use, distribution or publication of the videotape.

Having read the information above, I hereby grant the Department of Human Services permission to videotape my participation in the Minnesota Senior Health Options' enrollee focus groups. In addition, I hereby release the Minnesota Department of Human Services from any and all claims that may grow out of signing this release.

This release is valid for an indefinite period of time. I understand that I may revoke my consent to be videotaped at any time prior to the videotaping.

Name

Date

Appendix E: Survey

MINNESOTA SENIOR HEALTH OPTIONS
FOCUS GROUP PARTICIPANTS
BACKGROUND INFORMATION
(14 of 16 returned)

1. Living situation:
 - 3 live alone
 - 5 live with spouse
 - 1 lives with other family
 - 3 live in a nursing home or board and care residence
 - 2 live with non-family companion
 2. In the previous 12 months, have you stayed overnight as a patient in a hospital?
 - 6 responded Yes
 - 8 responded No
 3. In the previous 12 months, have you used an emergency room?
 - 4 responded Yes
 - 10 responded No
 4. In the previous 12 months, how often have you seen a physician or nurse practitioner?
 - 1 responded 1-2 times
 - 7 responded 3-4 times
 - 6 responded 5 times or more
 5. In the previous 12 months, have you been a resident in a nursing home for more than two weeks?
 - 5 responded Yes
 - 9 responded No
-

Appendix F: Evaluation

MINNESOTA SENIOR HEALTH OPTIONS
FOCUS GROUP
OCTOBER 30, 1998
EVALUATION SUMMARY
(15 of 17 evaluations returned)

1. Please rate the moderator on the following items. 1=low; 5=high

- | | |
|---|-----|
| a. Made me feel comfortable about talking | 4.8 |
| b. Kept discussion moving along | 5.0 |
| c. Encouraged everyone to speak | 5.0 |

2. Please rate the facility. 1=low; 5=high

- | | |
|-----------------------|-----|
| a. Room | 4.6 |
| b. Food | 4.7 |
| c. Location | 4.6 |
| d. General atmosphere | 4.8 |

3. Were you able to express your opinions or concerns related to the issues discussed?

Yes	14
No	0
No answer	1
Comments:	see attached

4. Please give your overall rating for this focus group: 1=low; 5=high
4.8

5. Do you have other comments? Room Warm

6. Are you interested in becoming a member of an advisory committee for Minnesota Senior Health Options?

Yes	8
No	5
No answer	2

Comments:

- It was about people who live in their own homes and not about anyone in a nursing home so I couldn't quite understand all of it.
- Would like to see more representatives from nursing homes.
- Each participant spoke openly about his or her concerns. Interesting meeting.
- My wife and I were very satisfied to participate in such an important meeting.
- I had a really nice time. Thank you for your caring.
- So glad I was invited to be part of this focus group. I felt I was a person and not a number. The group contributed things that I can use. Thank you.
- I enjoyed the whole experience - especially hearing how the MSHO affects a variety of people.

*The two couples each completed one evaluation for both of the couple.

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