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Integrated Care for Persons with Physical Disabilities

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Integrated Demonstration Programs

- ◆ Minnesota Senior Health Options (MSHO) – 1997
- ◆ Wisconsin Partnership Program (WPP) – 1999
- ◆ Minnesota Disability Health Options (MnDHO) – 2001
- ◆ Massachusetts Senior Care Organization (SCO) – 2004

Two Established Disability Programs

- ◆ MnDHO
 - AXIS Healthcare Program through UCare Minnesota serves disabled adults 18-64 years
- ◆ WPP
 - Community Health Partnership (CHP)
 - ◆ Rural program serving dual eligible seniors and disabled adults
 - Community Living Alliance (CLA)
 - ◆ Urban program serving disabled adults only

Integrated Disability Care Components

- ◆ A new vision of managed care
- ◆ Identify the problems with current system
- ◆ Important features of a disability care model
- ◆ Systems Coordination = Improved Outcomes
- ◆ Quality assurance
- ◆ Lessons from Minnesota and Wisconsin

New Vision

- ◆ Improve client outcomes and satisfaction
- ◆ Expanded consumer focus and choice
- ◆ Containing cost using integrated financing
- ◆ Coordinated strategy
- ◆ New efficiencies
- ◆ Elimination of cost shifting
- ◆ A better product!

Address Current System Problems

- ◆ Fee for Service – Medical Model
- ◆ Providers are islands in a larger system
- ◆ Assumes consumers can “build” service package
- ◆ Little response to consumer preference and interest
- ◆ No incentives for change

Features of Demonstration Models

- ◆ Accountability
- ◆ Fiscal management
- ◆ Financing that supports innovation and reinvestment
- ◆ Systems coordination and linkages in non-traditional medical areas – patient education and medical equipment
- ◆ Coordination to improve outcomes
- ◆ Improved client involvement

Improved Outcomes – Some Examples

- ◆ Improved transportation planning
- ◆ Managing complex medical conditions
- ◆ Effective service choices
- ◆ Better use of acute care system
- ◆ Better use of nursing resources
- ◆ Less bifurcation of duties = better care
- ◆ Transition back to work

Quality Assurance

- ◆ Required review and reporting
- ◆ Assure ISP quality for each individual
- ◆ Annual independent, personal interviews
- ◆ Need for more sensitive measurement of satisfaction and disability-specific quality measures
- ◆ CMS Performance Improvement Projects (PIP)

AXIS HealthCare – Care Management Model

Minnesota Health Care Programs

- ◆ MSHO and MnDHO integrated funding under CMS waiver
- ◆ Started with 3 health plans in metropolitan area
- ◆ 2006 – statewide – 9 plans with 12 programs
- ◆ Three county-based purchasing plans
- ◆ MnDHO is on hold until 2009 – still only serving metropolitan area

Minnesota Health Care Programs

- ◆ All plans became Dual Eligible SNPs on 1/1/06
- ◆ Minnesota integration waiver ends 1/1/08
- ◆ State is currently negotiating with CMS for continuation of waiver abilities – integrated appeals, integrated marketing
- ◆ Support from Center for Health Care Strategies (CMCS)

AXIS Healthcare

- ◆ Minnesota Disability Health Options Program (MnDHO) – provider-sponsored Care Management Organization (CMO)
- ◆ Operates as a subcontractor under Minnesota Senior Health Options (MSHO) health plan – UCare Minnesota
- ◆ Foundation for integrated SNP programs

AXIS Healthcare – Minnesota

- ◆ Joint venture founded in 1997 with Courage Center and Sister Kenny Rehabilitation Institute
- ◆ Avoid restraints of Fee for Service and traditional managed care models
- ◆ Focus on coordination of services across long-term care and acute care settings

AXIS Healthcare

- ◆ Currently serving over 900 individuals
 - Very slow growth
- ◆ Limited to metropolitan area of Minneapolis and St. Paul
- ◆ Serving adults aged 18-64 years with physical disabilities
 - Spinal Cord Injuries
 - Multiple Sclerosis
 - Cerebral Palsy

Care Coordination Model

- ◆ Core Team
 - Health Coordinator (RN)
 - Resource Coordinator (social services)
 - Member Services Coordinator (navigation)
 - Introducing Nurse Practitioner for high needs clients
- ◆ 70 clients to each team

AXIS' Role

1. Enrollment

- Outreach to prospective members
- Pre-assessment enrollment visit to explain program

2. Member Services

- First point of contact for members
- Communications and arrangements with providers

3. Provider Relations

- Identification and engagement of needed providers
- Referral management
- Fee negotiation for services outside fee schedule

AXIS' Role (continued)

4. Utilization Management

- Ensure timely, coordinated services covering full continuum of care
- Urgent assessment and intervention by RN 24/7
- Authorization authority covering all services

AXIS' Role (continued)

- ◆ Health Coordination
 - Partner with member and primary care physician to ensure effective and coordinated care
 - Coordinate entire spectrum of health care from acute care to mental health and community-based services
 - 24/7 availability for emergent concerns
 - Refer for appropriate services and care from experienced providers

AXIS' Role (continued)

- Utilize prevention and risk management strategies
- Involve consumers to facilitate self-responsibility for health status
- Coordinate related services; including vocational, educational, housing, social services, recreational

What AXIS Does: A Member Perspective

- ◆ Previous Experience of Medicaid System
 - Could never get the answers I needed
 - Referred from one place to the next, many of which were fruitless
 - Competency varied greatly among providers
 - Help was available, but on their timeline
 - Things happened to me, instead of me being able to make things happen

Why this Model Works

- ◆ Consumers: Tangible results
 - Hospitalization have been more than halved, to 100 hospitalizations/1,000 members
 - Hospital length of stay has been reduced by more than 60%
 - 40+ people have been transitioned out of nursing homes
 - 90% of members report satisfaction with their health care services, as compared with 10% satisfaction prior to enrollment
 - 85% of members reported receiving help managing their health care services, as compared with 5% receiving help prior to enrollment

Why this Model Works

- ◆ Single point of entry
- ◆ A place where everyone knows your name
- ◆ Comprehensive medical record and information system
- ◆ Specialized clinical protocols and expertise from team enhances primary care
 - UTI
 - Wound Care

What's not working so well...

- ◆ Fundamentally a medical model with better service arrangement – still not community and social service supports
- ◆ Improved coordination is happening in medical domain - still not certain what value add is in community integration
- ◆ Team approach at care management level still not well integrated with rest of care team
 - Introduction of NP collaborative practice

Challenges from Provider Perspective

- ◆ Lack of partnership and understanding of traditional health and human services systems
- ◆ Lack of skills in fostering meaningful business relationships
 - Nurse does not like something and relationship falls apart
- ◆ Financing model may or may not fit with what regulators want
- ◆ Community licensing and community program rules are confusing and teams don't have background
 - Housing – Department of Health – Fire Marshal

What's Next?

- ◆ Policy implications:
 - Can AXIS model expand to other places and populations?
 - ◆ Current Fee for Service expenditures and demographics indicate continued cost growth
 - ◆ Individuals with mental illness and developmental disabilities experience similar challenges with health care and community living
 - ◆ Growing number of seniors with developmental disabilities

What's Next? (continued)

- ◆ What can AXIS offer the private insurance market?
 - Trend of consumer-driven health care is increasing
 - Traditional disease management programs don't address needs of people with disabilities
 - Commercial market potential
 - Employer-based purchasing to better manage medically complex individuals

Future Trends

- ◆ State just issued contracts to 7 health plans for Medicaid disability program – acute care only
- ◆ Special Needs Basic Care (SNBC)
- ◆ State will monitor success of health plans in delivering SNBC
- ◆ Disability stakeholder group will monitor and drive decision making

Wisconsin Partnership Program

Wisconsin Model

- ◆ Wisconsin Partnership Program
- ◆ Community Health Partnership (CHP)
 - Rural program serving elderly and adult disabled
- ◆ Community Living Alliance (CLA)
 - Urban program serving disabled adults ages 18-64 only

WPP Care Coordination

- ◆ Integrated team approach
- ◆ PACE-like model without requirements of day care center or PACE physicians
- ◆ Each team typically manages 50 -75 clients
- ◆ Centralized staffing approach
- ◆ Broad primary care network
- ◆ Less shared knowledge of program and model

Challenges and Limitations for Disability Care Integration

- ◆ Development and operations are complex
- ◆ Financing and regulations
- ◆ Only two states have actually implemented integrated programs for disabled population
- ◆ No comprehensive evaluation of value add
- ◆ Managed Care programs are not attractive to the disability community
- ◆ No clear guideline for Care Management Organization
 - Should we have a qualified CMO?

Questions - Discussion