

Medicaid Health Plan Community Partnership Series

HealthPartners: On-Site Community Care for the Most Vulnerable

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As state Medicaid programs are increasingly shifting beneficiaries into managed care organizations (MCOs), some MCOs are expanding their traditional role to better meet the needs of their vulnerable members and communities. This case study is one of a series that describes how select MCOs are addressing myriad barriers and changing the way care is delivered through community engagement and partnerships. The purpose was to identify examples of successful or promising approaches, internal and state policy drivers that motivated the MCOs, challenges they faced, and lessons learned. A Synthesis Report summarizing strategies, lessons for other MCOs serving vulnerable populations, key “ingredients” for successful MCO-community partnerships, and policy implications for state policymakers from the four case studies in this series will be available at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Apr/Forging-Community-Partnerships-to-Improve-Care.aspx?omnicid=20>.

Abstract

HealthPartners, a consumer-governed non-profit organization in Minnesota that is both a health system and an insurer, integrates clinical teams with services delivered in the community to better coordinate care and ensure that vulnerable seniors have access to needed services. They bring clinical teams to nursing facilities, an adult day care center, and a low-income housing complex to provide health assessments, clinical care, care coordination, and transition assistance to the most vulnerable Medicaid members.

Background and Drivers

HealthPartners is a consumer-governed non-profit organization in Minnesota, founded in 1957, that is both a health system and an insurer. Its medical group consists of 70 medical and dental clinics, 17 pharmacies, 780 physicians including 350 primary care physicians, and 60 dentists. The organization also operates four hospitals in Minnesota and Wisconsin. The HealthPartners health plan has 1.4 million members in total nationwide, with a network of 38,000 care providers in Minnesota, western Wisconsin, South Dakota, and North Dakota.

Minnesota’s Medicaid program has contracted with managed care organizations since the 1980s and with HealthPartners since the mid-1980s. HealthPartners currently covers about 84,000 Medicaid enrollees in the state, about 61,000 of whom are enrolled in traditional Medicaid, 18,000 in the state’s

MinnesotaCare program,¹ and the remaining 5,000 in the Minnesota Senior Health Options² (MSHO) program, which serves those dually eligible for Medicare and Medicaid.

HealthPartners emphasized that its community-based strategies are primarily internally driven, part of a longstanding population health-oriented approach that also includes health homes and other efforts to better coordinate and integrate care. HealthPartners' structure and history as an integrated system contributes to its ability and dedication to provide care in the most appropriate and patient-centered setting and to avoid unnecessary hospitalizations and readmissions. The plan is accustomed to having clinicians work outside clinics in untraditional community-based settings.

MCOs in Minnesota are required to be non-profit, which may help foster an emphasis on community engagement and accountability. Interviewees state that the HealthPartners does not expect a financial return from their community-based activities. However, they and community partners report their efforts are resulting in better coordination and more patient-centered care, better management of chronic illness, and increased likelihood that people receive care outside the hospital – which can reduce overall costs.

To a lesser degree, the external environment also appears to play some role in motivating the MCO's community engagement efforts. Both competition and collaboration with other plans, and flexibility from the state, have helped foster innovative approaches to integrating care. For example, the Minneapolis/Saint Paul metropolitan area is very competitive for managed care plans serving people enrolled in both Medicare and Medicaid, which pushes HealthPartners to be more innovative. It also makes the environment more complex, as any one MCO will not have exclusive relationships with its community partners. This may contribute to many collaborative relationships among the health plans and between the plans and major providers and community-based organizations in Minnesota.³

HealthPartners does not view state government as a key driver of its MCO-community partnerships but does consider the state a valued partner. The state establishes priorities but gives plans considerable flexibility to develop programs that align with them and convenes Medicaid MCOs to share best practices. Health plans are required to file "collaboration plans" that describe their activities to promote public health every four years (with updates every two years) and publicly report their community

¹ MinnesotaCare is a Medicaid waiver program that covers childless adults and people whose income exceeds the limits for traditional Medicaid eligibility (income eligibility varies for different population groups)
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006255

² See:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271

³ HealthPartners is invested in many collaborations now as it has been over its decades of operating in the state. For example, HealthPartners has an alliance with another large clinical system and key hospital through which they communicate about shared priorities, share data, and collaborate on care model best practices. They made a mutual promise not to engage in an "arms race" that could lead to excessive use of medical imaging or other technologies. Also, HealthPartners was closely involved in the development of Minnesota Community Measurement (MNCM) and Institute for Clinical Systems Improvement (ICSI) and in the development of the first National Quality Forum endorsed total cost of care measure.

benefit activities in a standardized way. The collaboration plans describe how the MCOs will support high priority public health goals, measure and evaluate progress, and collaborate with local public health and other community organizations.^{4,5} To date, these collaboration plans are largely focused on the non-elderly population, so they were not a major driver of HealthPartners' specific efforts targeting vulnerable elderly described in this case study. However, the state is moving toward making innovative strategies to integrate care for dual Medicare and Medicaid enrollees a requirement for the plans that serve them.⁶ HealthPartners is in communication with the state as it develops these requirements through a public input process, and its strategies are examples of how more plans may proceed in the future.

This case study highlights three HealthPartners programs that integrate clinical care with services and settings in the community for individuals enrolled in the MSHO program. They bring clinical teams to nursing facilities, a day care center, and a low-income housing complex to provide health assessments, clinical care, care coordination, and transition assistance to the most vulnerable Medicaid members.

Bringing Care to Frail Seniors in Nursing Facilities

HealthPartners has had a long history, starting in 1973, of providing care to residents in nursing facilities and assisted living residences with onsite geriatric teams, a model of care that has been duplicated elsewhere in the country by care delivery organizations and health plans. Teams of nurse practitioners and geriatricians make regular and urgent visits and involve the patient and family in creating and implementing a personalized care plan.⁷

HealthPartners has prioritized a few facilities that are “hotspots”—facilities with a high concentration of patients with intense social challenges and medical complexity. The onsite teams work very closely with their hospitalist colleagues in partner hospitals. Together they developed a specific care process around transitions in and out of the hospital, with a high level of communication among hospitals, family members, and nursing facility teams, and increased attention to palliative and hospice care. There is a shared electronic health record with the partner hospitals, allowing all clinicians to share relevant information. This program appears to have caused readmission rates to decline from 17% in the initial

⁴ See *Community Benefit Provided by Nonprofit Health Plans*, Minnesota Department of Health, January 2009. <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/hlthplancommbenefit.pdf>

⁵ Minnesota legislation in 2011 started a process including creation of an advisory board to review and better define these requirements and to move toward more formal links between statewide health goals and the collaboration plans. The legislation rejected new reporting requirements for hospitals and plans, instead looking to streamline the requirements.

⁶ See the state of Minnesota description of its 2013 “Request for Public Input On The Identification of Best Practices for Development of Integrated Care System Partnerships (ICSPs) Between MCOs and Providers to Improve Care Delivery For People with Dual Eligibility for Medicare and Medicaid,” including new contract requirements for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) to propose and implement new models.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_141691

⁷ <http://www.healthpartners.com/public/care/providers/geriatricsfacilities/>

year to 12% two years later. HealthPartners has also developed contracts with a number of long term care facilities with incentives for quality outcomes. These contracts reward facilities if they meet agreed upon improvement targets or maintain improvements, e.g., preventing decubitus ulcers and prevention of falls with injury.

Integrating Clinical Care with Senior Day Care for People with Alzheimer's and Dementia

Through a partnership with the Amherst H. Wilder Foundation,⁸ which provides a range of health and human services to vulnerable populations, HealthPartners places a geriatrician, a geriatric nurse practitioner, and a case manager in an adult day health center to provide and help coordinate behavioral health and medical care for patients with Alzheimer's disease and dementia. This program is similar to the PACE model of care, emphasizing the day center as the most appropriate location to manage a frail population of elders. The HealthPartners onsite team provides care for approximately 28% of those attending the center, including both dual eligible individuals and patients who are only Medicare or Medicaid-eligible.

The program makes it unnecessary for vulnerable patients to travel to an outpatient clinic, and it means providers are available to reassess patients in a timely manner when day center staff are concerned about a change in condition. The HealthPartners providers hold monthly team-based interdisciplinary meetings with all relevant caregivers at the site to assess individuals' status. The Foundation has also supported the effort by allowing their center staff to take the additional time necessary to coordinate care with the geriatric onsite team. HealthPartners has worked with the organization to train staff to become more aware of changes in patients' health status.

While the Foundation provides space for these meetings and for exams, the providers are also able to circulate in the facility to make assessments and provide care wherever patients are. Family members are included in the assessment process, which the teams have found leads to better communication about patients' progress on their plans of care. HealthPartners is also working to provide more robust advance directive counseling to patients. As a result of interest from the Foundation, HealthPartners is facilitating training for Foundation staff on the Respecting Choices Model of Advance Care Planning, a formal advance care planning process intended to ensure that patient choices are honored and communication is strengthened.⁹

To date, HealthPartners does not have data to show improvements in health outcomes, though it plans to shift its focus to outcomes-based measures. However, Wilder Foundation interviewees support the program strongly and cite the monthly team-based meetings as valuable to improving care, and the on-site nurse practitioner as being effective in identifying problems early, preventing hospital visits, and easing the burden on family caregivers.

⁸ See <http://www.wilder.org/Pages/default.aspx>

⁹ See <http://respectingchoices.org/>

Providing Onsite Care in Low-Income Housing

In a partnership with Presbyterian Homes and Services, which offers an array of housing options for seniors in Minnesota and the Midwest, HealthPartners provides on-site care, including post-hospital transition care, to people living in low-income housing who are enrolled in both Medicare and Medicaid.¹⁰

For example, in a low income high-rise in downtown Saint Paul, common home-based services were already available, but there was an unmet need for support to manage medical conditions, and a high rate of co-morbid mental illness. A team including a HealthPartners physician, nurse practitioner and case manager, and home care staff from Presbyterian Homes is providing care for 42 residents of the 110 in the building. HealthPartners also provides financial support for home care services for these individuals through their dual eligible benefit. Care can be provided in residents' apartments or in an exam room in the residential building. The care team holds regular meetings to solve problems collaboratively, and the nurse practitioner has the flexibility to reassess patients' status as appropriate, making assessments more timely and therefore more valuable in planning care. Over several years of the program's operation, the clinicians who work in the building have come to be seen as accessible and trusted. When patients miss appointments, staff can easily reach out to them or visit them at their apartments. Over last three years, the hospital readmission rate for those served by this program has decreased from 24% initially to 12% in 2012.

HealthPartners has an incentive contract with Presbyterian homes that rewards attention to advanced directives and coordination of care around hospitalization. The incentive includes a per member per month payment that is tied to the number of patients served and increases incrementally as the number of participants grows, with an additional incentive payment if specific quality metrics are achieved.

Challenges and Lessons

Although partnerships between health plans and local organizations are common in Minnesota, interviewees stressed that more engagement by MCOs with community partners is needed. HealthPartners' experience suggests that developing meaningful partnerships with community organizations requires a major ongoing commitment of time and resources. Lessons include the following:

- It takes time to develop and maintain partnerships and implement initiatives; six to nine months from first approaching an organization to deploying providers on-site has been typical.
- Partnerships must involve staff from the top leadership on down, at both the plan and the community organization. Appreciating and respecting community partners is critical.
- MCOs need to recognize that community partners may have staffing challenges and are often concerned about their own financial sustainability over the long term. Financial incentives from

¹⁰ See <http://www.preshomes.org/>

the MCO, though not sufficient to ensure CBO viability, are helpful for supporting community organizations and incentivizing participation and improved care and outcomes.

- There must be a balance between finding economies of scale in the programs and containing their growth enough to ensure that they are sustainable and feasible.

HealthPartners' structure and history as an integrated, not-for-profit system contribute to its commitment to improve population health and its ability to place providers in untraditional, community-based settings. HealthPartners' experience suggests that a collaborative approach, even in a competitive environment, can benefit all participants and the health of the people being served.

The state Medicaid program can be a partner and help drive these efforts by setting care integration and community engagement as priorities, establishing community benefit guidelines, giving plans flexibility to be innovative, and convening plans to share best practices.

Acknowledgments

We would like to thank Thomas VonSternberg, MD, Associate Medical Director for Care and Disease Management and Government Programs; Donna Zimmerman, Senior Vice President, Government and Community Relations; and Jennifer Clelland, Senior Director of Government Programs—all of HealthPartners—and Jocelyn Schowalter, Director of Aging Services, Community Services for Aging; and Amy Ward, Manager of Healthcare Initiatives—both of the Amherst H. Wilder Foundation.

This work was supported by a grant from The Commonwealth Fund. The authors gratefully acknowledge the guidance of Dr. Pamela Riley, Program Officer, Vulnerable Populations, The Commonwealth Fund.

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