

Quality Care through a Quality Workforce

**A Toolkit for Advocates of Older Adults
Who are Dually Eligible for Medicare
and Medicaid**

ADVOCATING
TEAM CARE
FOR OLDER
ADULTS



**Eldercare
Workforce
Alliance**

Produced by



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The Eldercare Workforce Alliance is a group of [30 national organizations](#), joined together to address the immediate and future workforce crisis in caring for an aging America. The Institute of Medicine, in its critical report *Retooling for an Aging America: Building the Health Care Workforce*, called for immediate investments in preparing our health care system to care for older Americans and their families. In response, we formed the national Eldercare Workforce Alliance --representing consumers, family caregivers, the direct-care workforce, and healthcare professionals-- to propose practical solutions to strengthen our eldercare workforce and improve the quality of care.

Statements within this document reflect the consensus of the Eldercare Workforce Alliance and do not necessarily represent the position of individual Alliance member organizations. The resources included in this toolkit do not indicate endorsement by the Alliance or individual Alliance member organizations.

The Eldercare Workforce Alliance is a project of The Advocacy Fund and the Tides Center.

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Please send any questions, comments, or suggestions to: info@eldercareworkfoce.org.

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We are delighted to release the Eldercare Workforce Alliance (EWA) *Toolkit to Support Older Adults Who Are Dually Eligible for Medicare and Medicaid*. The Alliance, a coalition of [30 national organizations](#) joined together to address the immediate and future workforce crisis in caring for an aging America. EWA represents consumers, family caregivers and healthcare professionals—including direct care workers—to propose practical solutions to strengthen our eldercare workforce and improve the quality of care. EWA was formed in response to The Institute of Medicine's (IOM) critical report [Retooling for an Aging America: Building the Health Care Workforce](#), which called for immediate investments in preparing our health care system to care for older Americans and their families. Learn more about EWA [here](#).

We believe that a well-trained and supported workforce, and supported family caregivers are essential for dually eligible older adults to receive the quality care they deserve. We designed this toolkit to help advocates ensure that older adults are receiving coordinated, person and family-centered care, services and supports from health care professionals with geriatrics and gerontology. This toolkit includes:

- National and state-specific information on older adults who are dually eligible for both Medicare and Medicaid;
- Background on how a well-trained and supported eldercare workforce can impact the quality of care, services and supports being delivered; and
- Specific tools, checklists and resources for your advocacy efforts.

We thank you for your critical work, helping to ensure that every older adult receives the quality care, services and supports they deserve.

Sincerely,

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EWA Co-Convener

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Part I: The Issues

What's at stake?

Right now, people and organizations across the U.S. have the power to help ensure that millions of America's low-income seniors have access to the high quality health care and long-term care, services and supports (LTSS) they need and deserve.

Older adults make up the majority (58.8 percent) of the more than 10 million¹ people who, because of their age or disability status and income level, are enrolled in both [Medicare](#) and [Medicaid](#) for coverage of "critical medical and non-medical, supportive services."² Due to their eligibility for both of these programs, these consumers are often referred to as "individuals who are dually eligible," or some similar variation (additional examples are provided later in this toolkit). Many of the older adults who are dually eligible "are frail or have multiple chronic conditions,"³ and in trying to get their often complicated and unique care needs met, they and their family caregivers must navigate our nation's confusing health care and LTSS systems and the separate Medicare and Medicaid programs, and the coordination and quality of their care, services and supports may suffer.⁴

It doesn't have to be this way. *We can provide high quality, coordinated, person and family-centered health care and LTSS to older adults who are dually eligible for Medicare and Medicaid, while helping to control costs. We believe central to providing that quality care is a well-trained and supported workforce. But we can't accomplish this unless individuals and organizations across the country get involved and speak up.* This toolkit seeks to help with that advocacy.

The basics

About the toolkit

The goal of this toolkit is to promote high quality, coordinated, person and family-centered health care and LTSS for older adults who are dually eligible for Medicare and Medicaid, by helping to ensure the eldercare workforce is trained in gerontology and geriatrics, and is operating as part of a well-trained, coordinated and supported interdisciplinary care team to meet these older adults' and their family caregivers' unique needs.

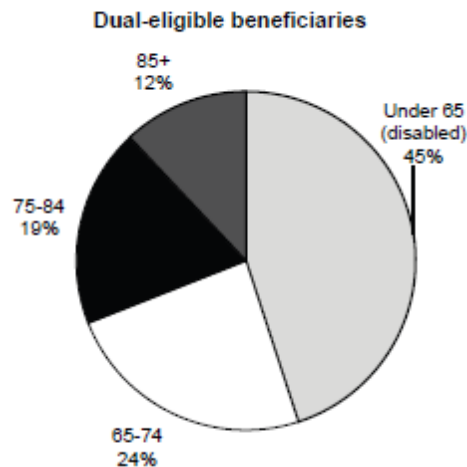
The toolkit is based on early thinking from EWA's diverse membership, and includes models and recommendations representative of this membership. As the state demonstrations focused on improving care and controlling costs (summarized later in the toolkit) progress, it will be important to learn from them and adapt advocacy approaches accordingly. Thus, the information and recommendations in this toolkit are subject to change as we get feedback over time.

Who are "dually eligible beneficiaries"?

Individuals who—because of their age or disability status and low-income—are enrolled in both Medicare and Medicaid to cover "medical and non-medical, supportive services"⁵ are the people often referred to as "individuals who are dually eligible," "dual eligible individuals," "duals," "dual eligibles," "dual beneficiaries" or some similar variation. It's a diverse population that "includes individuals with multiple chronic conditions, physical disabilities, cognitive impairments such as dementia, developmental disabilities, mental illness, and difficulties with activities of daily living," as well as some who are "relatively healthy."⁶ In total, the more than 10 million people enrolled in both Medicare and

Medicaid⁷ “are among the sickest and poorest individuals covered” under either program⁸—and the majority of the population of dually eligible individuals is age 65 and older.⁹

A lot of money is spent on the provision of care, services and supports to meet dually eligible beneficiaries’ often complex needs. In the Medicare program—which for dually eligible individuals primarily pays for their acute and hospital care, and prescription drugs—dually eligible individuals make up only 21 percent of enrollees but 36 percent of expenditures.¹⁰ And in Medicaid—which for dually eligible beneficiaries generally assists with Medicare premiums, cost sharing and long-term care, and other non-medical services—these individuals make up only 15 percent of enrollment but 39 percent of expenditures.¹¹



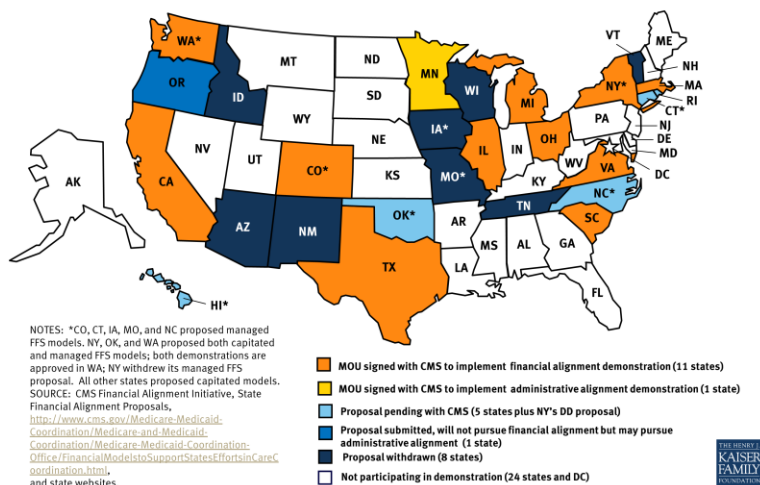
Source: [MedPAC Data Book, June 2014](#)

But significant spending doesn’t necessarily mean easy-to-navigate systems delivering high quality, coordinated care, services and supports that are centered on the consumer and their family caregivers. Dually eligible beneficiaries and their family caregivers have to navigate the complex and separate Medicare and Medicaid systems for their health care and LTSS needs; this can be confusing and many dually eligible individuals experience “poor care and unnecessary complications.”¹² Profiles of dual eligible beneficiaries—showing how their health care, finances and more are affected by their coverage under Medicare and Medicaid—are presented in [this report](#) and principles that have previously been created by the Leadership Council of Aging Organizations can be found [here](#).

The opportunity: state demonstration projects

This toolkit—in aiming to help ensure high quality, coordinated, person and family-centered care, services and supports for dually eligible older adults—focuses on the exciting and important opportunities presented by state demonstration projects launched by the [Centers for Medicare & Medicaid Services](#) (CMS), using [Affordable Care Act](#) (ACA) authority. The demonstrations “seek to improve care and control costs” for dually eligible individuals and “are introducing changes in the care delivery systems through which beneficiaries receive medical and long-term care services.”¹³

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, July 2014



“These demonstrations are changing not only the delivery of services for enrollees, but the financing arrangements among CMS, the states, and providers.”¹⁴ The two major types of demonstrations are capitated financial arrangement and managed fee-for-service. Under the capitated arrangement, Medicare and Medicaid payments will be made to a health plan and the enrollee will have one health plan that will coordinate all of their care and support needs, including long-term services and supports.

Source: [Kaiser Family Foundation, July](#)

Applying for these demonstrations was optional for states, and as of July 2014, CMS has signed Memorandums of Understanding (MOUs) with 12 states (for 13 demonstrations, with WA doing two types) where over 1.5 million beneficiaries will be eligible to enroll. State-specific information and technical assistance from CMS's Medicare-Medicaid Coordination Office is available [here](#).

The MOUs between CMS and participating states will test models to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long-term services and supports for enrollees. The MOU details the agreement between CMS and the state regarding the principles under which the initiative will be implemented and operated. It also outlines the activities which CMS and the state agreed to conduct in preparation for the implementation of the demonstration. Additional details about the managed care plans responsibilities are included in the three-way contract between CMS, a state and participating health plans.

Under a capitated model, a State, CMS, and a managed care plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. Under a managed fee-for-service model, a State and CMS enter into an agreement by which the state would be eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

An important way to help ensure person and family-centered care is to make sure the voices of dually eligible individuals are heard at the state policy level and the plan level. The latter was part of the application process for state demonstrations and continues as differently-named state stakeholder committees. Consumer Advisory Councils (CAC) are required for each managed care plan, under contract with the state. Additionally, CMS has provided federal funding and all states are required to have an ombudsman program. A chart on consumer engagement can be found [here](#). Up to date state-specific information can be found through [CMS](#), the [Kaiser Family Foundation](#), the [National Senior Citizens Law Center](#), and the [Integrated Care Resource Center](#). State-specific issue briefs addressing the population of dually eligible older adults and the eldercare workforce needs are available [here](#).

Using this toolkit

With these state demonstrations underway—with ongoing oversight by public officials and state-level stakeholder committees—advocates have a critical role to help ensure that the managed care plans have a well-trained, coordinated and supported workforce to provide high quality, coordinated, person and family-centered care, services and supports for dually eligible older adults.

To this end, this toolkit provides a basic foundation of key background information, factsheets, checklists and additional resources to help advocates—including dually eligible older adults, the eldercare workforce and others—influence policy and practice at the state and/or plan level.

The toolkit should be used in whatever way is most helpful to advocates. For instance, those who need a basic primer can read through the key issues section in Part I; others who are more familiar with the arena might jump straight to the key workforce interventions section (advocacy topics and potential solutions) in Part II. Part III provides tools and a roadmap on how to organize advocacy efforts. Part IV contains the Appendices, with links to resources identified in the toolkit or related to this issue, as well as a glossary.

Key components

This section outlines several components that are central to high quality, coordinated, person and family-centered care. We believe that good care ensures there is geriatrics and gerontology competency; that care, services and supports are person and family-centered; and that data is collected to measure eldercare workforce readiness and care delivery.

Person and family-centered care

Person and family-centered care refers to care, services and supports that are planned, delivered and evaluated based on the needs and preferences of the consumer. When appropriate, the needs, preferences, and role of family caregivers should be incorporated.

The eldercare workforce

A wide and diverse array of health care and related providers—including direct care workers, nurses, physicians, psychologists, psychiatrists, pharmacists, physical therapists, social workers, dentists, family caregivers and more—help meet older adults' care, services and supports needs.

Family caregivers and direct care workers are two groups within the eldercare workforce that often work together and that warrant special attention; they are frequently overlooked in discussions and implementation of workforce investment and development, but they play a critical role in our nation's health and LTSS systems.

- Family caregivers—unpaid and paid—have a wide variety of roles and responsibilities related to their loved ones' care, services and supports, and “can face physical, emotional, mental, and financial challenges in their caregiving role.”¹⁵ In 2009, more than 42 million U.S. family caregivers “provided care to an adult with limitations in daily activities at any given point in time;”¹⁶ their unpaid contributions had an estimated economic value of approximately \$450 billion.¹⁷ It is also the case, particularly in states with consumer-directed models, that family caregivers are employed to provide personal care.
- Direct care workers—including certified nursing assistants, home health aides, home care workers, personal care aides and assistants and direct support professionals—provide approximately 70 to 80 percent of the paid hands-on personal assistance and long-term care to older adults or people with disabilities or other chronic conditions in the U.S. The direct care workforce is one of the largest and fastest-growing occupations in the nation;¹⁸ there are more than 4 million direct care workers in the U.S. today, and by 2020, that number “will likely exceed 5 million,”¹⁹ making the direct care workforce the largest occupational group in the country.²⁰ In particular, personal care aides and home health aides “top the list of the projected fastest-growing occupations” in the U.S. between 2010 and 2020.²¹

Overall, it is nearly impossible to overstate the impact that the eldercare workforce has on the quality of and access to coordinated, person and family-centered care, services and supports. National and state-specific information about the older adult population, the eldercare workforce, as well as the need for investments in eldercare workforce training and supports for family caregivers is available [here](#).

Care coordination & interdisciplinary care teams

Dually eligible older adults' care needs can be complex, and these individuals may need expertise, care and services from numerous different health care and related professionals. Having systems/processes in place to help ensure that pertinent professionals are connected and working together on a coordinated and thoughtful approach to meeting each dually eligible older adult's needs is important. This section of the toolkit focuses on the role of care coordination and interdisciplinary care teams (ICTs)

in high quality care, services and supports for dually eligible older adults. The makeup of the ICT is intended to address the range of medical, behavioral health, substance abuse, LTSS and social needs. Members of the care team can include: direct care workers, nurses, physicians, psychologists, psychiatrists, pharmacists, physical therapists, social workers, dentists, family caregivers and others.

For the purposes of this toolkit, we want to emphasize that within the current duals demonstrations, all projects are required to have an ICT at the managed care plan level to help create a care plan. Once enrolled in a health plan, an enrollee will be assigned a care manager and an interdisciplinary care team (ICT) who will help to create a care plan. Ideally, ICTs should also be at the provider level, delivering the care, however this is not necessarily a requirement of the demonstrations. In some cases, dually eligible older adults will receive care from many different people who are not necessarily part of a defined ICT. It is possible that emerging models, such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), can lead to better integrated systems within communities. EWA believes that well-trained and coordinated ICTs are essential to delivering care that meets the unique needs of older adults.

Each state has [different requirements for ICTs](#), including who they are comprised of and what role the ICTs play. Regardless of the requirements, it's critical that all ICT members at all levels of planning and care delivery have adequate training in geriatrics and gerontology to help ensure high quality care, services and supports.

“When healthcare providers work independently, care can be unduly fragmented and fail to address the older person’s overall needs. For example, an individual’s multiple health problems might be properly diagnosed, with appropriate treatments chosen, but the individual might also have cognitive and psychological problems that impede his or her understanding of those treatments, be unable to ambulate and perform activities of daily living, or lack the proper physical environment and adequate social support to live successfully at home. In an ICT, all of these needs can be addressed proactively and simultaneously, with providers working together to accomplish common goals and produce a well-conceived, comprehensive care plan.”^{1}*

Geriatric care “must be carefully coordinated” in order to be effective.²² Care coordination mainly seeks to meet individuals’ “needs and preferences in the delivery of high-quality, high-value health care. This means that the [person’s] needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate and effective care.”²³ It “unites a team of providers to meet individual needs, improves health care access and outcomes, and synchronizes the variety of long-term services and supports.”²⁴

The Partnership for Health in Aging Workgroup on Interdisciplinary Team Training in Geriatrics states that “the use of an interdisciplinary team [...] is an accepted and well-developed model of care coordination.”²⁵ ICTs convene the professionals whose expertise, care and/or services are needed to meet the older adult’s potentially wide array of health and support needs; they “can lead to better continuity and quality of care, better health outcomes, and lower costs. Other benefits of team care include enhanced communication among healthcare providers, greater patient safety, better care of common chronic illnesses, better medication adherence, fewer adverse drug reactions, preservation of function, and fewer hospital readmissions.”²⁶ The Alliance supports the integration into the team of consumers, direct care workers, family caregivers, and other allied health professionals.

In many care coordination models, a care coordinator “works closely with the individual, family caregivers, primary care provider, and other health care professionals to improve communication, resulting in improved individual well-being and outcomes.”²⁷ In the dual eligible demonstration projects, there is a care coordinator, most often called the care manager, so that’s the term we use throughout this toolkit. In the demonstrations, the care manager should play a critical role in ensuring that each dually eligible older adults’ needs are being met and preferences are being respected, and that their individualized care plan is properly implemented and updated as needed. The care manager can be the point of contact if the dually eligible older adult, family caregivers, or other ICT members have questions or concerns.

Findings from a recent [national poll](#) of older adults underscore the benefits of team care. “A large majority (83%) of those who say they already receive well-coordinated care from a team of providers say team care has improved their health. Even among older adults not currently receiving this type of care, 61 percent say they believe team care would improve their health, and 73 percent would want this type of care [...].”²⁸

A care plan—mentioned above—is important because it helps ensure high quality care, services and supports that meet the needs and preferences of dually eligible older adults—and their family caregivers. This [fact sheet](#) provides helpful information and tips related to care planning and plans in the nursing home setting, but the information and principles may be helpful for other settings as well.

More information about care coordination and older adults is available [here](#), and [this video](#) shares the story of a Massachusetts resident and highlights the role and benefits of coordination.

Training and education

It’s critical that the eldercare workforce is trained and educated to meet dually eligible older adults’ unique and often complex care needs across the physical, mental, cognitive and behavioral spectrum. To provide specialized, high quality care, services and supports for dually eligible older adults, health care and related professionals need education and training in gerontology—the study of the aging processes and individuals as they grow from middle age through later life, and geriatrics—the study of health and disease in later life, as well as the comprehensive health care of older persons and the well-being of their family caregivers.²⁹

Between 2010 and 2030, the U.S. population aged 65 and older is projected to increase by more than 77 percent, but our nation’s “supply of qualified health professionals with adequate training to serve the needs of aging adults is declining.”

To this end, many organizations and medical societies have created and promulgated geriatrics and gerontology competencies: the Partnership for Health in Aging, through the American Geriatrics Society, created [Multidisciplinary Competencies in the Care of Older Adults](#); the Hartford Institute for Geriatric Nursing created [Hospital Competencies](#); the Council of Professional Geropsychology Training Programs has developed the [Pikes Peak Geropsychology Knowledge and Skill Assessment Tool](#); the Council on Social Work Education’s (CSWE) Gero-Ed Center collaborated with the National Resource Center for Participant-Directed Services (NRCPDS) at Boston College Graduate School of Social Work to create [Person-Centered and Participant-Directed Social Work Competencies](#); and the

CSWE Gero-Ed Center and the Social Work Leadership Institute created the [Geriatric Social Work Competency Scale II With Life-Long Leadership Skills](#).

In addition to these important efforts, more must be done. Between 2010 and 2030, the U.S. population aged 65 and older is projected to increase by more than 77 percent (31,185,487 people).³⁰ But our nation's "supply of qualified health professionals [...] with adequate training to serve the needs of aging adults is declining."³¹ This decline reflects factors including: an anticipated gap between the number of people to fill the jobs and the expected demand; a shortfall of people who specialize in geriatrics and gerontology; and lack of geriatrics and gerontology competency of those who do fill/are employed in health professional and related positions. (More information about older adult and eldercare workforce trends is available in these [state](#) and [national](#) issue briefs and this education and training [chart](#)).

Regarding workforce preparedness relating to education and training, two recent Institute of Medicine (IOM) reports—[Retooling for an Aging America: Building the Health Care Workforce](#) and [The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands](#)—concluded that "the education and training of the entire health care workforce with respect to the range of needs of older adults remains woefully inadequate."³² This [issue brief](#) asserts that health care professionals' geriatrics and gerontology training and education "remains inadequate to prepare them for the health care needs of the future. [...] Despite some improvements, geriatric principles are still too often insufficiently represented in health care training curricula and clinical experiences focused on gerontology are not robust."³³ It is also worth noting that within the current requirements for the state duals demonstrations, there is limited mention/use of the term "geriatrics" or "gerontology."

The U.S. must recognize older adults' unique needs and the diverse array of skills necessary to address those needs, and put in place appropriately reflective eldercare workforce training requirements. Increased funding for/investment in training, education and support—including competence in geriatrics and gerontology principles and practices—is needed for the entire eldercare workforce.³⁴

We must recognize older adults' unique needs and the diverse array of skills necessary to address those needs.

Here—as in the previous section—family caregivers and direct care workers warrant special attention; their contributions as members of the eldercare workforce are critical, and significant changes and investments must be made in their education, training and support.

- The majority of family caregivers "feel they need more help or information related to caregiving."³⁵ We must provide family caregivers with training opportunities, access to supportive services and funding to ensure adequate community-based training opportunities.³⁶
- Direct care workers' "preparation and training is underfunded and inconsistent,"³⁷ and current training requirements are outdated and insufficient.³⁸ "Training requirements vary from state to state and often fail to give direct-care workers the skills and knowledge they need to care for the complex needs of today's older and frailer consumers."³⁹ The minimum federal requirement for nurse aide and home health aide training is a mere 75 hours⁴⁰ and there are no federal training requirements for personal care aides.⁴¹ We must invest in direct care worker training standards, curricula and infrastructure,⁴² and ensure updated and sufficient training requirements. Specifically regarding nurse aide training, the IOM recommended "that minimum federal requirements be increased to at least 120 hours."⁴³ Investments in specialized training linked to certification and higher wages—for a profession whose "workers are among the most poorly compensated of all U.S. workers"⁴⁴—can help increase "opportunities for direct care

workers to advance without leaving the profession.”⁴⁵ Learn more about training [here](#) and [here](#). Additionally, EWA released a paper on an [Advanced Direct Care Workers](#) position – an opportunity to potentially improve care, while creating a career ladder.

The need and urgency to focus on training, education and support for the entire eldercare workforce—so that it is prepared and able to meet dually eligible older adults’ needs—is clear.

Improving quality, reducing costs

In addition to the importance of a well-trained and supported eldercare workforce—working as part of an ICT to deliver coordinated care—for high quality care, services and supports for dually eligible older adults, there are cost-savings implications as well.

There are numerous elements of care coordination models—related to person and family-centered care, team-based care and evidence base—found to reduce system cost or remain cost-neutral.⁴⁶ “There is a strong argument that geriatric team care can lead to a cost savings due to a reduction in such issues as re-hospitalization, polypharmacy, falls and other geriatric syndromes. [...] At the very least, studies have shown that geriatric team-care can result in higher quality that is ‘cost neutral from the healthcare delivery system perspective.’”⁴⁷ Regarding ICTs in particular, use of an ICT in older adults’ care can lead to lower costs.⁴⁸

Investing in and improving training and support for direct care workers is another area for potential cost savings, given the connection to factors—like few opportunities for advancement, low pay and poor working conditions—that contribute to direct care workers’ typically high levels of job dissatisfaction and turnover.⁴⁹ While estimates of turnover rates vary, “the rates are dangerously high. Studies have shown rates of aide turnover ranging between 44 and 65 percent.”⁵⁰ In addition to contributing to poor care, high turnover “costs consumers, families and providers time and money, because they have to hire and train new direct care workers.”⁵¹

There is a strong argument that geriatric team care can lead to a cost savings due to a reduction in such issues as re-hospitalization, polypharmacy, falls and other geriatric syndromes.

Part II: Key Workforce Interventions

This section of the toolkit contains three key workforce interventions/advocacy topics to help advocates focus their efforts:

1. Ensure competency by providing geriatrics, gerontology, and team-based training opportunities and requirements for all health care and related professionals.
2. Deliver high quality person and family-centered coordinated care, services and supports.
3. Collect data to measure eldercare workforce readiness and care delivery.

Topic 1

Ensure competency by providing geriatrics, gerontology, and team-based training opportunities and requirements for all health care and related professionals.

The Institute of Medicine [2008 report](#) brought increased attention to the need for all health care professionals, regardless of their setting or discipline, to have basic knowledge and skills in the unique aspects of geriatrics and gerontology care. Currently, many health care providers have no specialized training in the care of older adults, yet many will be caring for frail elders and elders with multiple chronic health conditions, particularly likely among those dually eligible for Medicare and Medicaid. The appropriate geriatrics and gerontology training of the workforce can lead to higher quality care for older adults.

Suggested Workforce Interventions

- States, in their contracts with the managed care plans:
 - Require managed care plans to have a certain percentage of their network providers trained in geriatrics or gerontology —and make that percentage requirement increase annually. Have someone with geriatrics expertise oversee the program.
 - Encourage managed care plans to provide a bonus to providers certified in geriatrics or gerontology.
 - Require a certain percentage of continuing education credits be in geriatrics or gerontology (as is the case with [California state law](#)).
 - Require care managers receive training in both geriatrics or gerontology and [team-based care](#).
 - Require the ICT members be competent to care for older adults (as measured by the [Partnership for Health in Aging's Multidisciplinary Competencies for Caring for Older Adults](#)) and work as part of a team.
- States mandate managed care plans or managed care plans mandate providers to have training that is aligned with the [Partnership for Health in Aging's Multidisciplinary Competencies for Caring for Older Adults](#) and/or addresses specific geriatric conditions such as: [dementia care](#), multiple chronic conditions, substance use, and mental and behavioral health care.
- Managed care plans require each care team member (ICT or provider teams) to select geriatrics or gerontology specific topics to present on a regular basis, such as: a resource

from ConsultGerRN.org, [Primary Care for Older Adults](#), NASW [Standards for Social Work Practice with Family Caregivers of Older Adults](#).

- States or managed care plans explore creating a role for an [Advanced Direct Care Worker](#), specifically trained to care for older adults, through a demonstration or test project.
- Managed care plans require that participating providers dedicate a percentage of continuing education credits in geriatrics or gerontology (as is the case with [California state law](#)).
- States mandate managed care plans or managed care plans self-impose a requirement to allocate a percentage of plan premium dollars for geriatrics/ gerontology and team-based training.
- States mandate that managed care plans or managed care plans mandate that providers demonstrate competency (i.e. around geriatrics, gerontology, or specific conditions such as dementia) with a holdback of money if they do not.
- States mandate managed care plans or managed care plans mandate providers to develop and implement best practices related to training in geriatrics and gerontology based on Geriatric Education Centers (GECs) creation of best practices such as those in [South Carolina](#), [Central Plains GEC](#), and [Iowa GEC's Oral Health Training](#), to name just a few.
- States mandate managed care plans and managed care plans mandate providers to require geriatrics and gerontology culturally-competent training that promotes a workforce able to serve all older adults in a way that is respectful of, and responsive to, people's diverse needs, regardless of their languages, ethnicities, cultures, and health beliefs, race, sexual orientation, gender identity, disability status, socio-economic, and geographical location.
 - Possible resources include: [Doorway Thoughts](#), [Stanford Geriatric Education Center's Ethnogeriatric Resources](#), Arizona Geriatric Education Center's [LGBT Older Adults in Long-Term Care Facilities](#) resource, NASW's [standards](#) and [indicators](#) for cultural competence, and ConsultGerRN.org.

Topic 2

Deliver high quality person and family-centered coordinated care, services and supports.

Care, services, and support programs should be person and family-centered and provided through a team based approach, where each team member plays a valuable role in providing quality coordinated care, services and supports. Ideally, care will be delivered by a workforce that reflects the diversity of the dually eligible older adult population. Providers and the interdisciplinary care teams (ICTs) should be trained to meet the whole-person needs of the dually eligible older adult, including their medical, behavioral, social, and LTSS needs.

Suggested Workforce Interventions

- Encourage managed care plans to promote interdisciplinary care team at the provider level so that health care professionals delivering care are working as part of a coordinated team that includes the dually eligible older adult and their family caregiver.
- Require standard policies for consumer and family caregiver orientations:

- Ensure dually eligible older adults, family caregivers and all members of the ICT and providers have clear roles and are identified. Materials should explicitly identify the appropriate person to contact with questions or for help.
- Inform the dually eligible older adult and family caregiver about the tenets of person and family-centered care, including their role pertaining to the care plan.
- Include ombudsman contact information in all welcome packets for dually eligible older adults as well as information about other opportunities to provide feedback or address concerns.
- Require that the care manager's contact information is provided to all providers and the dually eligible older adult and family caregiver—and that the care manager can be quickly reached via this contact information.
- Providing dually eligible older adults and their family caregivers opportunities for feedback, with processes in place to minimize/avoid retaliation fears/incidents:
 - The required consumer satisfaction surveys should include questions on ICT(s) and providers in order to assess team care and support, as well as on process.
 - Upon any complaint, managed care plans are required to remind dually eligible older adults and family caregivers of their right to contact the ombudsman and Consumer Advisory Committee, and provide the contact information.
- Require managed care plans to evaluate the needs of dually eligible older adults:
 - Require that, when appropriate, the [Vulnerable Elders Survey](#) (VES-13) be administered and included in the care plans for older adults over 65.
 - Require that, when appropriate, the [Get Up and Go](#) screening or [INTERACT II](#) tool be administered and included in the care plans for older adults.
 - Prior to nursing home placement, perform [Preadmission Screening and Resident Review](#) (PASRR), a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care.
 - When beneficiary resides in assisted living settings, managed care plans are required to administer the [Toolkit for Person-Centeredness in Assisted Living](#), which includes questionnaires to be completed by assisted living residents and staff.
 - By offering to consumers the CMS Annual Wellness Visit (AWV), conducted by, or with oversight from, a geriatrician or geriatric specialist.
- Require managed care plans to evaluate the needs of family caregivers, when appropriate:
 - Perform a caregiver assessments using uniform assessment tools from [specific states](#), the [VA Caregiver Self-Assessment Worksheet](#), or to evaluate [caregiver stress and mental health](#). Additional helpful resources are the NASW [Standards for Social Work Practice with Family Caregivers of Older Adults](#), [Family Caregiver Briefcase](#) and [Family Caregiving: Nursing Standard of Practice Protocol](#).
- Managed care plans must provide to all dually eligible older adults and family caregivers resources, supports, and training opportunities that consider their physical and mental health and well-being:
 - Resources include local [Area Agencies on Aging](#), the [Eldercare Locator](#) (also available at 1.800.677.1116), [Resource Locators](#), [ConsultGerRN.org](#), [Pioneer Network](#), and the [VA Caregiver Toolkit](#).
- Encourage managed care plans to adopt models of care that support the needs of older adults and promote person and family-centered care from an interdisciplinary team

- Adopt proven care coordination models, such as those highlighted in the EWA and N3C [issue brief](#).
- Ensure ICT provisions in the state’s MOU or three-way contract are being put into practice.

Topic 3

Collect data to measure eldercare workforce readiness and care delivery.

Data collection is an important part of measuring and otherwise assessing the workforce ability to care for dually eligible older adults. Reports should also reveal the degree to which care is person and family-centered and coordinated.

Suggested Workforce Interventions

- States, in their contracts with the managed care plans:
 - Require managed care plans to provide an annual report that describes how they will develop an adequate qualified workforce for covered long-term care services (as was the case with the [Tennessee contract](#)).
 - Require annual reporting on: geriatrics, gerontology, and team-based competence and training for ICT; training of providers in geriatrics, gerontology, and team-based care; recruitment and retention practices; training expenditures; practices employed to assess the needs of dually eligible older adults and family caregivers; orientation practices; training and delivery of culturally competent care; and effective models of care.
 - Require managed care plans to provide an annual summary of the consumer satisfaction survey.
 - Require the Ombudsman to provide an annual report of complaints and other feedback, as well as resolution data, with processes in place to protect privacy.
 - Require that all data be shared publicly and a summary of the data be shared with all managed care plan participants.
- CMS, in their contracts with states:
 - Require states to have a workforce advisory committee, that includes representatives from the entire care team (i.e., dually eligible older adults, family caregivers, physicians, nurses, direct care workers, mental health providers, care managers, etc.), to advise state officials on workforce standards, demonstration status, field updates. Representatives are trained to participate and processes are in place to minimize/avoid retaliation fears/incidents.
 - Require that Consumer Advisory Committees ensure representation/participation by (more than one each) dually eligible older adults and family caregivers, and that they take into consideration workforce issues. Representatives are trained to participate and processes are in place to minimize/avoid retaliation fears/incidents.
- Federal program evaluators:
 - Be directed to include metrics on workforce, training and support.

Part III: Strategizing & Tools

Roadmap

Designed to provide step-by-step guidance for advocates on how to best utilize this toolkit, here are eight steps.

8 Steps for Advocates

1. Understanding the dually eligible population and eldercare workforce in your state
 - a. Read through the EWA Toolkit to Support Older Adults Who are Dually Eligible for Medicare and Medicaid.
 - b. Review the EWA Dually Eligible Older Adults [Issue Brief](#) for your state.
2. Understanding your state's demonstration
 - a. Review state-specific charts provided in the toolkit.
 - b. Review online resources with updated state-specific information.
3. Connecting with other advocates from your state
 - a. Review [Community Catalyst's Partners](#) in your state.
 - b. Reach out to other potential advocates in your state.
4. Selecting recommended workforce interventions
 - a. Review the potential solutions listed within the toolkit and on the checklist.
 - b. Complete tasks and timelines planning worksheet.
5. Requesting meetings
 - a. Identify contacts, using the contact worksheet.
 - b. Reach out to representatives at the state, managed care plan, and partner level.
6. Preparing for your meeting
 - a. Review and identify questions you would like to ask.
 - b. Create meeting talking points.
 - c. Print out materials for the meeting.
7. Meeting follow-up
 - a. Send a follow up email, using the template provided if helpful.
 - b. Provide feedback to Eldercare Workforce Alliance.
8. Congratulations on your work!

Step 1

Understanding the dually eligible population and eldercare workforce in your state

Read through the EWA Toolkit to Support Older Adults Who Are Dually Eligible for Medicare and Medicaid:

[Part I](#) describes dually eligible older adults, the demonstration projects, how to use this toolkit, and key components of quality care.

[Part II](#) suggests workforce interventions that can ensure a competent workforce, promote person and family-centered care delivery, and help to measure eldercare workforce readiness.

[Part III](#) provides a roadmap of how to advocate for these interventions.

[Part IV](#) contains additional resources and a glossary of terms.

Review eldercare workforce state-specific information by visiting:

EWA's **Dually Eligible Older Adults** [state issue briefs](#)

Step 2

Understanding your state's demonstration

Review the Community Catalyst state-specific charts on:

[Interdisciplinary Care Teams \(ICTs\) Requirements](#)

[Care Manager/Care Coordinator Requirements](#)

[Consumer Engagement Requirements](#)

Review online resources with updated state-specific information:

[Medicare-Medicaid Coordination](#) website

[Integrated Care Resource Center](#) website

Kaiser Family Foundation [Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared](#) website

[National Senior Citizens Law Center](#) website

[Community Catalyst](#) website

Comparison of Interdisciplinary Care Team (ICT) ¹ Provisions*

State	Memorandum of Understanding (MOU)	Three-Way Contract
<i>States linked to MOUs and Contracts</i>	<i>A MOU is a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and individual states</i>	<i>The Three-Way Contract operationalizes the MOU and is an agreement between the federal and state governments and contracted managed care plan</i>
California	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • ICT for each enrollee, as necessary, to be person-ctrd & integrate medical, behavioral hth & LTSS (pgs. 69 and 73) • Coord betw managed care plans and counties to facilitate IHSS participation on ICT, as needed. (p. 77) • ICT is one of 11 elements of the MOC.² (p. 97) 	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • ICT for each enrollee, as necessary, to be person-ctrd & integrate medical, behavioral hth & LTSS care (p. 32) • Contractor to support multiple levels of interdisc communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. (p. 34) • Enrollees guaranteed the right to request reassessment by ICT. (p.189) • Enrollees receive complete and accurate info on his or her health and Functional Status from ICT. (p.190)
Colorado	No references found	Not applicable – state using managed fee-for-service model
Illinois	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • Medical homes to provide evidence-based primary, acute, behavioral hth care (where appropriate), chronic hth condition mgt, referrals for specialty care and for LTSS to be part of the ICT (p. 60) • Enrollees have input and access to develop person-ctrd ICT led by a Care Coord. (p. 62) 	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • Care Coord. and ICT assigned to each enrollee (p. 42) • Provider network to incl focus on FQHCs, CMHCs and multi-specialty PCP-ctrd medical groups and private practice PCP offices. (p. 76) • Use of ICT to analyze and address delivery systems issues as part of the analysis of clinical care and related services, including behavioral hth, LTC and HCBS Waiver services. (p. 129)

¹ Some states use the term multi or trans disciplinary

² CMS requires each Model of Care to have eleven clinical and non-clinical elements, which will be scored

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		<ul style="list-style-type: none"> • Enrollees guaranteed right to request reassessment by ICT and complete and accurate info. on their health and functional status from ICT. (p. 241)
Massachusetts	<p>ICT language throughout document:</p> <ul style="list-style-type: none"> • ICOs shall: <ul style="list-style-type: none"> ○ Offer care coordination services to all Enrollees through an IL-LTSS Coord, contracted from a community-based organization, for LTSS. IL-LTSS Coord to be full member of the ICT. (p. 58) ○ Support ICT for each member; primary care provider and ICT will be person-ctrd. (p. 58) • Requires ICT participate in approved training on person-ctrd planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the Commonwealth (p. 59) 	<p>ICT language throughout document:</p> <ul style="list-style-type: none"> • ICT for each enrollee consisting of: PCP, Behavioral Hth clinician, Care Coord or Clinical Care Mgr., and IL-LTSS Coord, if indicated. And, as appropriate, the ICT may also include: registered nurse, specialist clinician, social workers, community hth workers, qualified peers, family members, other informal caregivers, advocates, and state agency or other case managers. (p. 28) • Completion of comprehensive assessments for each new enrollee and an interdisc review or revision of the ICP. (p. 46) • During evaluation process, Contractor must address ICT performance, including resolution of service plan disagreements (p. 64) • Provider/Pharmacy Network directory to include description of ICT role and process for enrollees to select and change PCPs. (p. 137) • Enrollees guaranteed the right to request reassessment by ICT. (p. 234)
Michigan	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • Right for enrollees to determine involvement of other members of ICT in accordance with applicable privacy standards (p. 63) • Enrollee be offered ICT and decide their own level of involvement (p. 67) • ICT to work collaboratively with Enrollee to ensure the IISCP is fulfilled according to the person-ctrd planning process and the enrollee’s stated goals (pgs. 67 and 72-73) 	Not yet available

	<ul style="list-style-type: none"> • ICO Care Coord to lead the ICT – must be a MI licensed RN, NP, PA, or Bachelor’s or Master’s prepared social worker (p. 68) • ICO must initiate an ICBR for Enrollee and grant access to ICT (p. 76) • ICT is one of 11 elements of the MOC (p. 85) 	
Minnesota	No references found	N/A (Minnesota’s demonstration will test the integration of administrative functions without financial alignment)
New York	<p>ICT (referred to as IDT in the actual document) language throughout document requires:</p> <ul style="list-style-type: none"> • Cost of services the IDT determines necessary not included in Medicaid baseline (p. 44) • Care mgt services are available to all enrollees and monitored by IDT (pgs. 60 and 62) • Comprehensive reassessment if requested by IDT (p.61) • If nursing home level services needed, care mgr. or IDT must inform enrollee of feasible alternatives and choices (p. 61) • IDT for each enrollee, as necessary, person-ctrd that integrates medical, behavioral hth, and LTSS (pgs. 62-63) • IDTs provide any prior authorizations to ensure that delays don’t adversely affect discharge plng when enrollee in hospital waiting discharge (p. 64) • Managed care plans have discretion to offer addtl non-covered services determined necessary by IDT (p. 70) • Plan IDT responsible for coordinating, arranging, & ensuring receipt of certain services by the enrollee from the Medicare and Medicaid FFS programs when called for in a Person-Ctrd Service Plan (p. 71) • FIDA plans encouraged to use an electronic hth record system that allows enrollee’s info to be accessible to the IDT (p. 88) 	Not yet available

<p>Ohio</p>	<p>Trans-disciplinary Care Team language throughout document requires:</p> <ul style="list-style-type: none"> • Each ICP to support a person-ctrd Trans-disciplinary Care Mgt Team to ensure integration of enrollee’s medical, behavioral hth, substance use, LTSS and social needs (p. 54) • ICT as one of the 11 elements of the MOC (p. 65) 	<p>Trans-disciplinary Care Team language throughout document requires:</p> <ul style="list-style-type: none"> • Covered Services managed and coordinated by the Integrated Care Delivery System (ICDS) Plan through the TDCT (p. 29) • ICDS Plan communicate the assignment of or change to risk level to the enrollee’s TDCT (p. 33) • TDCT members will be one source used to formulate Comprehensive Assessment (p. 34) • Process to develop, update, and review the ICP with the enrollee, family/caregivers, the PCP, specialists and members of the TDCT as appropriate. (p. 36) • Care Manager assigned to lead the TDCT. (p. 38) • ICDS Plan formulate a TDCT in cooperation with the enrollee (p. 38) • In-person visits may be conducted by any member of the TDCT (p. 41) • Current centralized enrollee record accessible 24/7 to members of the TDCT (pp. 41, 42) • ICDS Plan perform duties to support waiver service plan develop, implementation, and monitoring conducted by the Waiver Service Coord. in collaboration with the TDCT (p. 48) • Care Mgr. or TDCT to report outcomes of service delivery or unmet needs (p. 49) • Managed care plan to conduct annual professional training sessions for Care Mgrs & staff on the TDCT on the following topics: person-ctrd care planning processes, cultural and disability competence, communication, accessibility and accommodations, independent living and recovery, and wellness principles, ADA/Olmstead requirements, and other topics as specified by the state. (p. 52) • Managed care plan to develop and keep updated a community resource guide made available to the TDCT. (p. 54)
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		<ul style="list-style-type: none"> • Managed care plan maintain a provider/pharmacy network directory which includes description of the PCP & TDCT and Care Mgt (p. 108) • Enrollees or their designated rep have right to request reassessment by the TDCT & be fully involved in any reassessment (p. 181) • Provide complete and accurate info. to enrollee on their health and functional status by the TDCT (p. 181)
South Carolina	<p>Multidisciplinary Team (MT) language throughout document requires:</p> <ul style="list-style-type: none"> • Coordinated and Integrated Care Organizations (CICO) have full accountability for managing the capitated payment to best meet the needs of enrollees according to person-ctrd ICPs developed by enrollees, their caregivers, and MTs. (p. 4) • Medical homes be supported by health IT & be part of the MT to assist in coordinating care across full spectrum of available services, incl behavioral hth care and managing care transitions. (p. 66) • Access to a Care Coord. and MT for enrollees based on their needs and preferences encouragement to participate in decision making with respect to their care (p. 73) • MT may request a comprehensive reassessment of enrollee after observing a change that requires further investigation. (p. 75) • MT ensure the integration of enrollee’s medical, behavioral hth, psychosocial, nursing facility, and HCBS (p. 76) • MT be person-ctrd (training provided), built on the enrollee’s specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. (p. 76) 	<p>Not yet available</p>

	<ul style="list-style-type: none"> • Care Coord as MT lead (p. 76) • In Phase I, waiver case managers will be fully integrated through their participation in MT (pgs. 80 and 83) • Integration of HCBS into MT by Oct 2014. (p. 84) • Enrollees eligible to receive a Palliative Care benefit based on the recommendation of a physician or MT (p. 93) • Lists Care Team as one of the 13 elements of the MOC. (p. 97) 	
Texas	<p>Service Coordination Team (SCT) language throughout the document requires:</p> <ul style="list-style-type: none"> • STAR+PLUS MMPs have full accountability for managing the capitated payment to best meet the needs of enrollees according to their person-ctrd Plans of Care developed by enrollees, their caregivers, and SCT. (p. 3) • Person-ctrd SCT to ensure integration of the enrollee’s medical, behavioral hth, substance use, LTSS, and social needs. (pgs. 58-60) • SCT may request a comprehensive reassessment of enrollee after observing a change that requires further investigation. (p. 58) • SCT participate in approved training on person-ctrd planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. (p. 60) 	Not yet available
Virginia	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • Person-ctrd ICT for each enrollee to integrate member’s medical, behavioral hth, and LTSS care. (p. 65) • Targeted case manager to be part of ICT for enrollees receiving Medicaid State Plan Targeted Case Mgt services. (p. 65) 	<p>ICT language throughout document requires:</p> <ul style="list-style-type: none"> • ICT manages covered services and coordinates with PCP (p. 33, 35) • ICT for each enrollee, as necessary, to be person-ctrd and integrate the member’s medical, behavioral hth, and LTSS care. (p. 35)

	<ul style="list-style-type: none"> • ICT involvement in some situations with enrollees affected by DOJ <i>Olmstead</i> Agreement. (p. 67) 	<ul style="list-style-type: none"> • ICT consist of at least: PCP, behavioral hth clinician (if indicated), care mgr, LTSS provider (if indicated), targeted case manager (if applicable), pharmacist (if indicated) and enrollee has option of adding additional members. (p. 35) • Documented training by contractor of ICT members. (p. 37) • Contractor ensure ICT is accessible to enrollee. (p. 37) • ICT develop a Plan of Care (POC) with enrollee and communicate internally regarding medical, functional and psychosocial condition of enrollee. (p. 37) • ICT role to ensure that relevant aspects of the enrollee’s care be addressed in a fully integrated manner on an ongoing basis. (p. 45) • Notification and participation of the enrollee’s ICT in discharge planning, coordination, and re-assessment as needed. (p. 53) • Written protocols for ICT continuing ed programs. (p. 59) • Contractor address ICT performance including resolution of service plan disagreements. (p. 59) • Contractor maintain a provider manual that includes provider responsibilities as part of the ICT. (pgs. 67, 68 and 140) • Contractor has process to notify the PCP or ICT of an Emergency Medical Condition or Urgent Care within one business day and record info. within 18 hours after notification. (pgs. 93 and 94) • Enrollees or their designated rep have the right to request a reassessment by the ICT and be fully involved in any such reassessment. (p. 224) • Enrollees receive complete and accurate info on their health and Functional Status by the ICT. (p. 224)
Washington	<p>Managed FFS: Enrollees assigned Health Home Care Coordinator and specialty care managers if needed; no mention of ICT</p> <p>Capitated: ICT language throughout document requires:</p>	<p>Not yet available</p>

	<ul style="list-style-type: none"> • ICT help develop enrollee’s ICP to achieve team-defined health goals based upon individual needs and preferences. (p. 73) • Access to an ICT and based upon need, include primary care, mental hth, chemical dependency treatment providers, direct care workers, nutritionists/dieticians, social workers, pharmacists, peer specialists, family members or housing representative. (p. 77) • ICP within 90 days created and managed by the Enrollee, his or her selected support system, his or her Medicare-Medicaid Integration Plans (MMIP) care mgt team, and his or her ICT. (p. 80) • Enrollee and ICT be involved in process to update HCBS plan. (p. 82) • All enrollees are assigned Care Manager or Intensive Care Coord. and have access to an ICT to ensure the integration of medical, mental hth, chemical dependency use, LTSS, and social needs. (pgs. 83 and 85) • Each ICT be composite of knowledgeable key competencies including, but not limited to: person-ctrd planning, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles. (p. 85) • Lists seven requirements of ICT. ³ (pgs. 85-86) • Lists ICT as one of the 11 elements of the MOC. (p. 98) 	
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³ The seven requirements are: 1. Assure appropriate and efficient care transitions, including discharge planning; 2. Assess the physical, cognitive, social, behavioral, and LTSS risks and needs of each Enrollee; 3. Provide Enrollee health education on complex clinical conditions and wellness programs; 4. Assure integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate; 5. Maintain frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the Enrollee’s needs and tier level; 6. Assist in the development of an ICP within 90 days after enrollment; and 7. Assist in the implementation and monitoring of the ICP.

Glossary of Acronyms:

ADA - American's with Disabilities Act

CDPA - Consumer Directed Personal Assistance Services

CICO - Coordinated and Integrated Care Organizations

CMHC - Community Mental Health Centers

FFS - Fee for Service

FIDA - Fully Integrated Duals Advantage

FQHC - Federally-Qualified Health Center

HCBS - Home and Community-Based Services

ICBR - Integrated Care Bridge Record

ICDS - Integrated Care Delivery System

ICO - Integrated Care Organization

ICP - Individualized Care Plan

ICT – Interdisciplinary Care Team

IDT - Interdisciplinary Team

IHSS - In Home Supportive Service

IICSP - Individual Integrated Care and Supports Plan

IL-LTSS - Independent Living Long Term Services and Support

LTSS - Long-Term Services and Support

MMIP - Medicare-Medicaid Integration Plan

MOC - Model of Care

MOU - Memorandum of Understanding

MT - Multidisciplinary Team

PCP - Primary Care Provider

POC - Plan of Care

STAR+PLUS MMPs - State of Texas Access Reform Plus Medicare-Medicaid Plans

Care Manager Requirements by State

State	Care Manager/Care Coordinator Requirements
<i>States linked to CMS documents</i>	<i>Every managed care plan must assign a care manager or care coordinator to work with a beneficiary. Within the Memorandum of Understanding (MOU), requirements of the care manager or care coordinator are defined as such:</i>
<u>California</u>	Care manager is licensed RN or other individual licensed to provide clinical care management
<u>Colorado</u>	State testing managed fee-for-service model using its existing Accountable Care Collaborative program for Medicaid beneficiaries, a hybrid of a primary care medical home and an ACO. Pilot is statewide.
<u>Illinois</u>	Care Coordinator could be RN, LCSW, Rehabilitation Specialist or other with relevant clinical background
<u>Massachusetts</u>	Clinical Care Manager – licensed RN or other individual licensed to provide clinical care management
<u>Michigan</u>	ICO Care Coordinator: RN, Nurse Practitioner, Physician Assistant or Bachelor or Masters prepared SW
<u>Minnesota</u>	N/A (Minnesota’s demonstration will test the integration of administrative functions without financial alignment)
<u>New York</u>	An appropriately qualified professional
<u>Ohio</u>	Care Manager must be an appropriately qualified manager
<u>South Carolina</u>	Clinical Care Manager must be licensed RN or other individual employed by Primary Care Providers or CCIO and licensed to provide clinical care management
<u>Texas</u>	No language
<u>Virginia</u>	No language
<u>Washington - Capitated</u>	Washington will utilize both a managed fee-for-service demonstration and a capitated model. Its managed fee-for-service relies on a Health Home Lead Entity (HHLE) who subcontract with a Health Home Coordinated Care Organization (HCCO) to coordinate the health home services.

	<p>The capitated demonstration, will take place in two counties (King and Snohomish) and has the following care manager provisions: Intensive Care Coordinator: RN, Masters in behavioral health sciences and one year paid on-the-job social services experience; bachelors in behaviors or health sciences and two years of paid on-the-job social services experience; or bachelors and four years paid on-the-job experience.</p>
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*as of August 2014

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State Dual Demonstration Consumer Engagement Provisions*

State	State Level Committees	Managed Care Plan Level Committees	Ombudsman
<i>States linked to CMS documents</i>		<i>Language from each Memorandum of Understanding (MOU)</i>	<i>Award/Date for Ombudsman program</i>
California	None	Requires beneficiary and community input through a range of approaches (may include participation on plan's governing boards and quality review bodies); each plan must establish at least one Consumer Advisory Committee reflecting the diversity of the enrollee population, meet monthly and have a process for providing that input to the governing board.	CMS funded \$1,854,183 (Yr. 1 = \$708,366; Yr. 2 = \$1,145,817) as of October, 2014.
Colorado	State will provide opportunities for beneficiaries to provide input and participate in the CO Medicare/Medicaid Enrollees Advisory Subcommittee, the ACC Program Improvement Advisory Committee, the Community Living Advisory Group, and the Nursing Facility Culture Change Accountability Board.	Vague; requires mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements.	CMS funded \$210,760 as of October, 2014.
Illinois	None	Requires meaningful beneficiary input on issues of Demonstration management and Enrollee care; each plan must establish a beneficiary advisory committee (reflecting the diversity of the demo population including Enrollees, caregivers, and local representation from key community stakeholders such as faith-based organizations, advocacy groups, and other community-based organizations; meet quarterly.	CMS funded \$267,556 as of December, 2013.

Massachusetts	Duals Demonstration Implementation Council has 21 members and includes representation of comm-based organizations and home care union; Council will play a key role in monitoring access to health care and compliance with the ADA, tracking quality of services, providing support and input to EOHHS, and promoting accountability and transparency.	Requires plans to obtain consumer & community input on issues of program mgt and Enrollee care through a range of approaches, which may include beneficiary participation on plan governing boards and quality review bodies; requires ICO to establish at least one consumer advisory committee and a process for that committee to provide input to governing board; requires ICO to demonstrate participation of consumers with disabilities, including Enrollees, within the governance structure of the ICO.	CMS funded \$159,084 (May, 2014)
Michigan	Michigan Dept. of Community Health will establish a MI Health Link Advisory Committee for its dual demonstration; it will be chaired by a consumer (as of May 2014).	Requires ICOs to obtain meaningful enrollee and community input on issues related to Demonstration mgt, quality, and enrollee services and supports; each ICO must establish at least one advisory board reflecting diversity of the demo; advisory boards must have a process to provide input to the governing board and include a mix of enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, & other community-based organizations; one third composed of enrollees; must have written policies and procedures for elections; meet at least quarterly; provide a permanent record of proceedings to MDCH; ICOs must accommodate and support the advisory board members by arranging transportation, communications, and other measures to ensure and encourage their full participation on the advisory board; member of the HMO's governing board must participate on the advisory board and serve as the advisory board's direct liaison to the HMO governing body.	
Minnesota		N/A (Minnesota's demonstration will test the integration of administrative functions without financial alignment)	

New York	<p>The Medicaid Managed Care Advisory Review Panel is the consumer input mechanism for all Medicaid managed care programs in New York State, including the duals demonstration; there will be one member of the consumer advocates' duals coalition on the panel.</p>	<p>Requires plans to obtain participant & community input on issues of program mgt and participant care through a range of approaches; each plan must establish one Participant Advisory Committee (PAC) that meets quarterly and is open to all participants (reflects diversity of the enrollee population); participation of individuals with disabilities, including participants, within governance structure of the plan; have process for the PAC to provide input to the Plan; PAC members and the Participant Ombudsman will be invited to participate in the State's ongoing stakeholder process; plans will also be encouraged to include Participant representation on their boards of directors.</p>	<p>New York State Department of Health has dedicated \$23,750,000 for 2014 – 2019.</p>
Ohio	<p>MyCare Ohio Implementation Team authorized by the Ohio Dept. of Medicaid to provide input and advice on the implementation of the dual eligible demonstration project beginning August 2014 to meet every other month. Schedule to be re-evaluated in January 2015.</p>	<p>Requires plans to obtain beneficiary and community input on issues of program mgt and Enrollee care through a range of approaches; plan must establish at least one beneficiary advisory committee and a process for that committee to provide input to the governing board; plan must also demonstrate that the advisory committee composition reflects the diversity of the enrollee population & participation of individuals with disabilities, including Enrollees, within the governance structure of plan.</p>	<p>CMS funded \$272,354 as of March, 2014.</p>
Rhode Island	<p>The Executive Office of Health and Human Services established the Integrated Care Initiative Consumer Advisory Council under its Long Term Care Coordinating Council to provide input on the dual demonstration. (MOU pending – Link to state's proposal to CMS.)</p>		

South Carolina	None	Requires plans to obtain meaningful beneficiary input on issues of Demonstration mgt & Enrollee care; each plan must establish an independent Demonstration Enrollee advisory committee, reflecting diversity of the enrollee population, and meet regularly; have a process for that committee to provide input to the governing board; committee members and Ombudsman will be invited to participate in State's ongoing stakeholder process; in addition to the advisory committees, plans must include participation of Enrollees, including individuals with disabilities within the governance structure of plan.	
Texas	No specific dual demonstration Advisory Committee; state will utilize existing avenues for stakeholder and enrollee participation via the Promoting Independence Advisory Comm., the Quality Improvement Advisory Comm., the STAR+PLUS stakeholder meeting, STAR+PLUS Quality Council, Managed Care Advisory Committee and other various advisory and stakeholder meetings devoted to services for Medicare/ Medicaid enrollees.		
Virginia	Vague; the state will maintain additional processes for ongoing stakeholder participation and public comment.	Requires plans to obtain meaningful beneficiary input on issues of Demonstration mgt & enrollee care through a range of approaches; plans must establish an independent demonstration beneficiary advisory committee, reflecting the diversity of the demo population; have a process for that committee to provide input to the governing board; plans must include participation of individuals with disabilities, including Enrollees, within the governance structure of the plan.	CMS funded \$245,079 as of November, 2013.
Washington - Capitated	The HealthPath Washington Advisory Team (HAT) was organized to inform the Department of Social & Health Services (DSHS) & the Health Care Authority	Capitated: Requires MMIPs to obtain Enrollee and community input on issues of program mgt & enrollee care through a range of approaches; each MMIP will	CMS funded \$203,468 as of May, 2014.

	<p>(HCA) as the two agencies work to integrate the delivery, financing, technology and human touches experienced by beneficiaries in Washington State who are eligible for both Medicare and Medicaid; There are consumer advocates on the Health Path Advisory team.</p>	<p>establish an independent MMIP Enrollee advisory committee, reflecting the diversity of the Demonstration population including Enrollees, caregivers, and local representation from key community stakeholders such as faith-based orgs, advocacy groups & other community-based organizations; meet no less than quarterly with the Enrollee advisory committee.</p> <p>FFS: Requires Health Home Networks to establish mechanisms to ensure meaningful beneficiary input processes & involvement of beneficiaries in planning and process improvements; this will be addressed in State's qualification process for Health Home Networks.</p>	
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*as of October 2014

Prepared by [Community Catalyst](#) for the *Eldercare Workforce Alliance*

Sources: CMS Medicare Medicaid Coordination Office <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html> and Kaiser Family Foundation Issue Brief July 24, 2014 <http://kaiserfamilyfoundation.files.wordpress.com/2014/07/8426-06-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared.pdf>

Step 3

Connecting with other advocates in your state

Review partners in your state:

Visit [Community Catalyst Voices for Better Health](#) web page and click on “Partners”

Think about and reach out to other potential advocates.

Step 4

Selecting recommended workforce interventions

Review the suggested workforce interventions listed in:

[Part II](#) of the toolkit

Select workforce interventions that will be recommended in your meeting, using the:

[Potential managed care plan workforce interventions](#) checklist

[Potential state workforce interventions](#) checklist

If working with other advocates, determine roles and deadlines by completing the:

[Timeline and tasks planning](#) worksheet.

Checklist of Recommended Workforce Interventions for Managed Care Plans & States

Ensure competency by providing geriatrics, gerontology, and team-based training opportunities and requirements for all health care and related professionals:

- Require that all participating practitioners have a percentage of their mandatory continuing medical education (CME) or continuing education (CE) in the field of geriatrics or gerontology.
 - TALKING POINTS:
 - No additional cost to the managed care plans or providers, benefit of content knowledge increase.
 - This suggestion is based on an existing California law, which requires that all participating general internists and family physicians, if more than 25 percent of patients are over 65, complete at least 20 percent of their mandatory continuing medical education (CME) in the field of geriatric medicine.
 - MATERIALS:
 - Print out of [California law](#)

- Require each care team member (ICT or provider teams) to select geriatrics or gerontology specific topics to present on a regular basis.
 - TALKING POINTS:
 - Continuing education based on feedback from team.
 - Encourages team based training.
 - MATERIALS:
 - A resource from [ConsultGeriRN.org](#), [Primary Care for Older Adults](#), NASW [Standards for Social Work Practice with Family Caregivers of Older Adults](#).

- Explore creating a role for an Advanced Direct Care Worker who is specifically trained to care for older adults.
 - TALKING POINTS:
 - Can be specially trained in the needs of the consumers and family caregivers.
 - Potential to fill gaps in care.
 - MATERIALS:
 - EWA brief on the [Advanced Direct Care Worker](#)

- Require that providers confirm competency of each new hire or existing providers, using the Partnership for Health in Aging's Multidisciplinary Competencies for Caring for Older Adults.
 - TALKING POINTS:
 - These intentionally broad competencies can be adjusted for the discipline and role.
 - They can help to gauge where additional training may be utilized.
 - MATERIALS:
 - Print out [Partnership for Health in Aging's Multidisciplinary Competencies for Caring for Older Adults](#)

- Require that all members of the team receive training on how to provide culturally-competent care that addresses the variety of languages, ethnicities, cultures, and health beliefs of older adults.

- TALKING POINTS:
 - Meeting needs of older adults requires providing quality care regardless of their race, sexual orientation, gender identity, disability status, and geographical location
 - The examples here offer online training that can happen at the provider's convenience.
- MATERIALS:
 - Print out of [Stanford Geriatric Education Center's Ethnogeriatric Resources](#) and Arizona GEC's [LGBT Older Adults in Long-Term Care Facilities](#), American Geriatrics Society's [Doorway Thoughts](#), [Stanford Geriatric Education Center's Ethnogeriatric Resources](#), Arizona Geriatric Education Center's [LGBT Older Adults in Long-Term Care Facilities](#) resource, NASW's [standards](#) and [indicators](#) for cultural competence, and [ConsultGerIRN.org](#).
- Mandate providers develop and implement best practices related to training in geriatrics and gerontology and adopt models of care that support the needs of older adults and promote person and family-centered care.
 - TALKING POINTS:
 - Can do so based on Geriatric Education Centers (GECs) creation of best practices
 - Existing models have proven effective, such as those in the EWA and N3C issue brief.
 - MATERIALS:
 - Print out of examples such as those in [South Carolina](#), [Central Plains GEC](#), and [Iowa GEC's Oral Health Training](#), to name just a few.
 - Print out [Care Coordination & Older Adults Issue Brief](#) by Eldercare Workforce Alliance (EWA) & National Coalition on Care Coordination (N3C)
- Require that all members of the team receive monthly training around the assessment tools appropriate for caring for older adults.
 - TALKING POINTS:
 - The goal of the *Try This: Best Practices in Nursing Care to Older Adults* series of assessment tools is to provide knowledge of best practices in the care of older adults.
 - Each *Try This* issue is a 2-page document with a description of why the topic is important when caring for older patients on the first page, and an assessment tool that can be administered in 20 minutes or less on the second page.
 - MATERIALS:
 - Print out sample *Try This* issues such as [fall risk assessment](#), [predicting pressure ulcer risk](#), and the [hospital admission risk profile](#).
 - For more information and to view all Try This Assessment Tools, visit the [ConsultGerIRN.org](#) website.

Delivering high quality person and family-centered coordinated care, services and supports:

- Require standard policies for consumer and family caregiver orientations, including identification of team roles, rights, and contact information.
 - TALKING POINTS:
 - Ensure all consumers and family caregivers have accessible materials that explicitly identified the appropriate person to contact with questions, complaints, or for help.

- All welcome packets should include consumer rights, including contact information of Ombudsman, and information on consumer satisfaction surveys, and notification of the CMS Annual Wellness Visit.
 - MATERIALS:
 - Print out “[My Care Team](#)” worksheet.
 - Require that, when appropriate, screenings such as the Vulnerable Elders Survey (VES-13) and “Get Up and Go” test, be administered.
 - TALKING POINTS:
 - The average time to complete the screening is five minutes and the VES-13 and “Get Up and Go” test can be used and scored by both clinicians and non-clinicians.
 - The VES can be used without charge by researchers, health care professionals, and provider organizations, with proper citation.
 - MATERIALS:
 - Print out: [VES-13](#) and “[Get Up and Go](#)” initial screening tools
 - For more information, visit the [Rand Corporation website](#)
 - Require that the Preadmission Screening and Resident Review (PASRR) is administered to all older adults prior to consideration of nursing home placement.
 - TALKING POINTS:
 - Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.
 - PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.
 - MATERIALS:
 - For more information, visit the [Medicaid.gov](#) website and [PTAC](#), the PASRR Technical Assistance Center.
 - When beneficiary resides in assisted living settings, managed care plans are required to administer the [Toolkit for Person-Centeredness in Assisted Living](#), which includes questionnaires to be completed by assisted living residents and staff.
 - Require providers to offer to perform a family caregiver assessment, as well as provide family caregiver resources.
 - TALKING POINTS:
 - Family caregivers fill gaps in health and long-term care; are often the key to effective care planning and outcomes; and can themselves be vulnerable and have health and well-being needs. When appropriate, they should be acknowledged, valued, and seen as integral members of the team.
 - Family caregivers should be offered resources to support them in their caregiving role.
 - MATERIALS:
 - Print out assessment tools such as: [state-specific assessment tools](#), [VA assessment tool](#), [caregiver stress tool](#) and [mental health tool](#).

- Print out of family caregiver resources such as: [Eldercare Locator](#), local [Area Agencies on Aging](#), NASW [Standards for Social Work Practice with Family Caregivers of Older Adults](#), [Pioneer Network](#) information, and [EWA Resource](#) webpage.
 - For more information, view the [Listening to Family Caregivers](#) brief or the [Caregivers Count Too](#) toolkit or the [Family Caregiver Briefcase](#) and [Family Caregiving: Nursing Standard of Practice Protocol](#).

- Require that all consumers, their family caregivers, and all team members receive a list of all care team members and their specific roles. Share consumer resources such as the Speak Up™ program materials.
 - TALKING POINTS:
 - The Joint Commission’s Speak Up™ program urges patients to take an active role in preventing health care errors by becoming involved and informed participants on their health care team. The Speak Up program features brochures, posters, animated videos and now infographics, which can be downloaded for free.
 - MATERIALS: Print out [sample team worksheet](#) and [Speak Up](#) materials.

- Require for the case manager/care coordinator’s contact information (as well as a back-up contact) be given to each team member, be in all medical records, and be on the consumer’s insurance card as well as on a magnet on the consumer’s fridge. Require state ombudsman contact information be provided to the consumer.
 - TALKING POINTS:
 - Easy solution that can help to improve care coordination and quality of care.

- Require that all consumers be offered organizational and planning tools such as a *Pill Card*, powers of attorney for financial decision making or for health care, or Physician Orders for Life Sustaining Treatment (POLST).
 - TALKING POINTS:
 - Can help consumers use organizational and planning tools.
 - MATERIALS:
 - Print out example [Pill Card state-specific POLST details](#), [Durable Power of Attorney information](#), or [State advance directive](#) forms.
 - For more information, visit the above websites.

- Require that all consumers be offered an Annual Wellness Visit (AWV), conducted by, or with oversight from, a geriatrician or geriatric specialist.
 - TALKING POINTS:
 - Paid for by Medicare and serves as a preventative tool.
 - MATERIALS:
 - Print out Medicare Learning Network’s [“The ABCs of Providing the Annual Wellness Visit”](#) and American College of Physicians [Consumer Letter and Checklist](#).
 - For more information on coding, coverage, and payment visit this [CMS Quick Reference Guide](#).

Data collection to measure eldercare workforce readiness and care delivery:

- Require provider groups to provide annual data on geriatrics training and demographics of older adult consumers
 - TALKING POINTS:
 - Can be used to compare effectiveness of training and consumer needs

- Require that all managed care plans provide state boards with an annual report on the status of its qualified workforce development strategies.
 - TALKING POINTS:
 - As was included in the original TENNCARE requirements, contractors were responsible for developing an adequate qualified workforce for covered long-term care services. The contractor was charged with developing and implementing strategies to increase the pool of available qualified direct care staff, and to report annually.
 - MATERIALS:
 - Sections 2.11.6.7 and 2.30.8.7 of the [Contractor Risk Agreement](#) created by TENNCARE

- Require that annual reports on workforce, training, and care delivery
 - TALKING POINTS:
 - Require annual reporting on: geriatrics, gerontology, and team-based competence and training for ICT; training of providers in geriatrics, gerontology, and team-based care; recruitment and retention practices; training expenditures; practices employed to assess the needs of dually eligible older adults and family caregivers; orientation practices; training and delivery of culturally competent care; and effective models of care.
 - Require managed care plans to provide an annual summary of the consumer satisfaction survey.
 - Require the Ombudsman to provide an annual report of complaints and other feedback, as well as resolution data, with processes in place to protect privacy.
 - Require that all data be shared publicly and a summary of the data be shared with all managed care plan participants.

Additional Suggestions:

- _____
 - TALKING POINTS:
 - _____
 - Examples: _____
 - MATERIALS:
 - Print out of _____

Timeline and tasks planning worksheet

Task	Deadline	Point Person	Notes
Review materials on your state's population of dually eligible older adults and the eldercare workforce			
Review materials to better understand your state's demonstration project			
Connect with other advocates, partners, and reach out to potential advocates in your state			
Select your recommended workforce interventions			
Reach out to identified stakeholders and request meetings			
Schedule planning calls with other advocates			
Review and identify questions to ask			
Create talking points			
Identify meeting roles			
Prepare and print materials			
Send follow up email			
Provide feedback to EWA			
Debrief with group			

Step 5

Requesting a meeting

Identify the appropriate contacts for your state:

Visit the state website for the correct contact person at the state level and for a list of participating managed care plans

If helpful, use the [Meeting contact](#) worksheet

Reach out to state-based partner organization, your state office, or representatives of participating managed care plans or providers.

Meeting contact worksheet

State Medicaid/demonstration offices:

_____	_____	_____
<i>Contact Listed on website</i>	<i>Phone</i>	<i>Email</i>
_____	_____	_____
<i>Contact Listed on website</i>	<i>Phone</i>	<i>Email</i>

Managed care plans:

_____	_____	_____
<i>Contact Listed on website</i>	<i>Phone</i>	<i>Email</i>
_____	_____	_____
<i>Contact Listed on website</i>	<i>Phone</i>	<i>Email</i>

Partner organizations/individual health care providers:

_____	_____	_____
<i>Contact</i>	<i>Phone</i>	<i>Email</i>
_____	_____	_____
<i>Contact</i>	<i>Phone</i>	<i>Email</i>

NOTES:

Step 6

Preparing for your meeting

Review and identify questions you would like to ask during your meeting:

Questions on [topic 1](#): **ensuring competency by providing geriatrics, gerontology, and team-based training opportunities and requirements for all health care and related professionals.**

Questions on [topic 2](#): **delivering high quality person and family-centered coordinated care, services and supports.**

Questions on [topic 3](#): **data collection to measure eldercare workforce readiness and care delivery.**

Create meeting talking points:

Talking points [template](#) and [sample](#) worksheets

Print out materials (identified as “MATERIALS” on the checklists) that support recommended workforce interventions.

Ensure competency by providing geriatrics, gerontology, and team-based training opportunities and requirements for all health care and related professionals.

Questions for advocates to ask for additional information

1. Describe the ICT at the managed care plan and/or provider level.
2. What kind of certification or training in geriatric care is required for members of the managed care plans' ICT?
3. Is any incentive provided or requirements by the managed care plan for providers in their network to receive training in geriatric competent care?
4. Will the managed care plans' care managers/care coordinators be certified or otherwise trained in geriatric assessment and care? How are they trained in team care?
5. Describe the training provided to ICT members to help them function and coordinate as a team.
6. Describe the frequency of these trainings?
7. What should a dually eligible older adult, family caregiver, or other team member do if they feel a provider needs additional training or education?
8. Is a consumer-directed model of care available and training provided?
9. What are the turnover and vacancy rates among direct care workers?

Delivering high quality person and family-centered coordinated care, services and supports

Questions for advocates to ask for additional information

1. What is your orientation and person and family caregiver assessment process?
2. Describe how the care, services and supports are person and family-centered.
3. What is your process in creating an individualized care plan and how is it implemented? How often is the care plan updated, what is the process and who is involved?
4. Are there ICTs at both the managed care plan and provider levels?
5. Describe the ICT(s) in detail, including the role of each member, and how you are ensuring consumer and family caregiver participation.
6. Describe how the care will be coordinated.
7. Are supports and resources made available throughout all settings and models of care, including during care transitions? Including consumer-directed models?

Data collection to measure eldercare workforce readiness and care delivery

Questions for advocates to ask for additional information

1. What data do you collect and how do you use it to measure and assess the quality of the care, services and supports and the extent to which it is person and family-centered?
2. In regards to readiness, how will you measure the adequacy of the workforce to meet the needs of the older population?
3. How often do you collect the data?
4. How are the advisory committees involved?
5. When collecting and analyzing data, what are the roles of dually eligible older adults, family caregivers, and providers?
6. In what ways are the ombudsman programs involved in this process?
7. What happens with the results of the data collection, measurement and assessment? Is it publicly available (including to dually eligible older adults, family caregivers and the workforce)?

Meeting with _____ <i>State, Managed Care Plan, Provider</i>		State _____
Topics	Talking Points	Speaker
Thank you	We appreciate the opportunity to meet with you to discuss how we can provide high-quality care, services and supports for dually eligible older adults in _____ (<i>state</i>).	
Introductions/ Overview	<i>(How are you connected to dually eligible older adults? Ex: I'm a geriatrician. I provide care to dually eligible older adults.)</i>	
State of Dually Eligible Older Adults in _____ <i>State</i>	<p>We want to help you understand the unique needs of dually eligible older adults in _____ (<i>state</i>):</p> <ul style="list-style-type: none"> ▪ _____ (<i>state's</i>) population of older adults is set to increase _____% by 2030. ▪ _____% of current Medicare-Medicaid enrollees in _____ (<i>state</i>) are age 65 and older. ▪ Dually eligible beneficiaries have a variety of health care needs, 11% of dually eligible beneficiaries have five or more chronic conditions, while 38% have one or none. ▪ 24% of dually eligible beneficiaries need assistance in daily activities of living, like bathing and dressing. 	
Opportunity for Questions	Can you tell us how you are working to address the needs of this population? <i>(Refer to the list of questions for managed care plans in appendix A to help guide the conversation.)</i>	
General Workforce Overview	To meet the needs of dually eligible older adults, we believe the care should be person and family centered, delivered by a well-trained workforce.	
Asks	We have three solutions that you can implement to help address the needs of this population.	
Thank you	<ul style="list-style-type: none"> ▪ Recap any next steps ▪ Thank you again for your time 	

Meeting with Managed Care Plan		SAMPLE: New York
Topics	Talking Points	Speaker
Thank you	We appreciate the opportunity to meet with you to discuss how we can provide high-quality care, services and supports for dually eligible older adults in New York.	Advocate A
Introductions/ Overview	<i>(How are you connected to dually eligible older adults? Ex: I'm a geriatrician. I provide care to dually eligible older adults.)</i>	All
State of Dually Eligible New Yorkers	<p>We want to help you understand the unique needs of dually eligible older adults in New York:</p> <ul style="list-style-type: none"> ▪ New York's population of older adults is set to increase 50% by 2030. ▪ 68% of current Medicare-Medicaid enrollees in New York are age 65 and older. ▪ Dually eligible beneficiaries have a variety of health care needs, 11% of dually eligible individuals have five or more chronic conditions, while 38% have one or none. ▪ 24% of dually eligible beneficiaries need assistance in daily activities of living, like bathing and dressing. 	Advocate B
Opportunity for Questions	Can you tell us how you are working to address the needs of this population? <i>(Refer to the list of questions for plans in appendix A to help guide the conversation.)</i>	Advocate C
General Workforce Overview	To meet the needs of dually eligible older adults, we believe the care should be person and family centered, delivered by a well-trained workforce.	Advocate A
Asks	We have three solutions that can be implemented on the managed care plan level to help address the needs of this population.	Advocate B
Thank you	<ul style="list-style-type: none"> ▪ Recap any next steps ▪ Thank you again for your time 	Advocate C

Step 7

Meeting follow up

If helpful, use the prepared follow-up templates:

[Meeting follow-up](#) email template

[Feedback](#) report to the Eldercare Workforce Alliance

[Reflection](#): what worked well, what would you do differently next time?

Email template following meeting

Please feel free to send your own message, but if helpful, here is a template.

Dear _____,

Thank you for taking the time to meet with us today. We believe that a well-trained and supported workforce, and supported family caregivers are essential for dually eligible older adults to receive the quality care, services and supports they need and deserve.

We appreciate your willingness to incorporate strategies that can help ensure dually eligible older adults receive care from a competent workforce. Attached you will find electronic versions of the materials we shared with you:

- Attachment 1
- Attachment 2
- Attachment 3

Additionally, an electronic version of the Eldercare Workforce Alliance toolkit can be found [here](#).

We will follow up with you in the next couple of weeks with information about:

1. Next Step 1
2. Next Step 2
3. Next Step 3

If you have any questions, please feel free to contact us at:

- Name, email, phone
- Name, email, phone

Sincerely,

Sample report-back to the Eldercare Workforce Alliance

Please feel free to let us know about your meeting and how we can support your efforts.

Email: info@eldercareworkforce.org

Subject: Dually eligible older adults meeting follow-up from [STATE]

Today we met with: Name, position, email, phone, state.

During the meeting we suggested the following interventions be adopted:

1. Workforce intervention 1
2. Workforce intervention 2
3. Workforce intervention 3

During the meeting we identified the following next steps:

1. Next Step 1
2. Next Step 2
3. Next Step 3

It would be helpful if we had the following resources/information/assistance:

We found the following parts of the toolkit very helpful:

We think you can improve upon the following parts of the toolkit:

If you have any questions, please feel free to contact us at:

- Name, email, phone
- Name, email, phone

Reflection

For your own use, if you'd find it helpful.

What three things worked best about this meeting:

1. Success
2. Success
3. Success

What three things would I do differently next time:

1. Change
2. Change
3. Change

Step 8

Congratulations on your work!

Change takes time and your work is critical to improving the workforce and quality of care for older adults who are dually eligible for Medicare and Medicaid.

Part IV

Appendix 1: Toolkit resources

- Aging Network Workforce Competencies Project
- America’s Direct Care Workforce factsheet
- Caring for Dually-Eligible Older Adults state-specific issue briefs
- [CMS Demonstrations](#)
- Dual Eligible Demonstration Projects: Top Ten Priorities for Consumer Advocates
- EWA member organization [expert contacts](#)
- EWA’s Principles in Designing Models of Care
- Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage
- Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS
- Funding to Support Ombudsman Programs information
- Integrated Care Resource Center
- Joint Commission [Speak Up](#) program
- Leadership Council of Aging Organizations [Dual Eligible Principles](#)
- National Association of Social Workers (NASW) [Standards for Social Work Practice with Family Caregivers of Older Adults](#) and Cultural Competence [standards](#) and [indicators](#).
- National Senior Citizen’s Law Center – [State Profiles](#)
- Overview of the Education and Training of Professionals in Geriatrics factsheet
- Person-Centered and Participant-Directed Social Work Competencies
- Position Statement on Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Health Care for Older Adults
- Public Poll: “On Your Team: What Older Adults Think About Team Care and Medical Home Services”
- Retooling for an Aging America: Building the Health Care Workforce Institute of Medicine report
- The Financial Realities for Direct Care Workers factsheet
- The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands Institute of Medicine report
- Training and Certification for Direct Care Workers factsheet

Appendix 2: Issue-related resources

- About Direct Care Workers [factsheet](#)
- Aging and Disability Resource Center (ADRC) [contact information by state](#)
- [Aging Network Workforce Competencies Project](#)
- [AGS Fact Sheet: Training Requirements for Multiple Disciplines](#)
- Alzheimer’s Association [Dementia Care Practice Recommendations](#)
- Community Catalyst [Voices for Better Health website](#)
- [ConsultGeriRN.org](#) for information about nursing care of older adults.
- [Dementia Care: Social Work Practice Interventions](#)
- [Home Alone: Family Caregivers Providing Complex Chronic Care](#)
- [Key Attributes](#) of High-Performing Integrated Health Plans for Medicare-Medicaid Enrollees
- LCAO principles: [Long-Term Services and Supports](#) and [Advanced Care, Hospice, and End of Life](#)

- National Association of Social Workers (NASW) [Standards for Social Work Case Management](#)
- National Health Law Program [website](#)
- National Quality Forum (NQF) [Dual Eligible Beneficiaries Workgroup](#)
- National Senior Citizens Law Center (NSCLC) [Dual Eligibles website](#)
- [Partnerships for Person-Centered and Participant-Directed LTSS Project](#) Family care and paid care: Separate worlds or common ground? [issue brief](#)
- Rhode Island RHO PDF
- State and/or Area Agency on Aging (AAA) [contact information by state](#)
- State Health Insurance Assistance Program (SHIP) [contact information by state](#)
- The Henry J. Kaiser Family Foundation [Dual Eligible website](#)

Glossary

Glossary terms, wherever possible, are linked to their online source.

- [Care coordination](#) - Care coordination is a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services that are tailored to individuals' needs and goals. Services are managed and monitored by a trained care coordinator or interdisciplinary team according to established standards of care.
- [Care manager/care coordinator](#) - A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a consumer or group of consumers. Often the care manager/care coordinator is the point of contact for the consumer and their family caregivers.
- [Care plan](#) - A written plan for care. It tells what services will be provided to reach consumer-identified goals and keep the best physical, mental, and social well-being possible.
- Consumer – within this toolkit, refers to the older adult who is receiving care, services and supports. Often used instead of the term “patient.”
- [Cultural Competency](#) - Cultural competency involves a number of things, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services.
- [Culture change](#) - the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living.
- [Direct care worker](#) - Direct-care workers provide an estimated 70 to 80 percent of the paid hands-on services and supports received by persons with disabilities or chronic care needs. These workers help consumers bathe, dress, and eat, among other daily tasks.
- [Dually eligible individual](#) - A Medicare beneficiary who also receives either a full range of Medicaid benefits offered in his or her state, or help with Medicare out-of-pocket expenses, usually through Medicaid.
- [Eldercare](#) - Public, private, formal, and informal programs and support systems, that aim to meet the needs of the older adults.

- [Family caregiver](#) - Relatives and friends who help with personal care, medication management and a range of household, medical and health, social, and financial matters. Sometimes referred to as caregiver.
- [Geriatrics](#) – the study of health and disease in later life, as well as the comprehensive health care of older persons and the well-being of their family caregivers.
- [Gerontology](#) – the study of the aging processes and individuals as they grow from middle age through later life, including: the study of physical, mental, and social changes in older people and changes in society.
- Interdisciplinary care team – as defined within this document, the interdisciplinary care team or ICT is the plan-level team of health care professionals, and ideally including consumers and their family caregivers, who devise a care plan.
- [Long-term care \(LTC\)/long-term services and supports \(LTSS\)](#) - Ongoing health and social services provided for individuals who need continuing assistance with activities of daily living and/or instrumental activities of daily living. Services can be provided across all settings.
- [Managed Care](#) - A health care delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided.
- Managed Care Plan – also referred to as Managed Care Organization, health plan, or plan.
- Person and family-centered care - Person and family-centered care refers to care, services and supports that are planned, delivered and evaluated based on the needs and preferences of the consumer. When appropriate, the needs, preferences, and role of family caregivers should be incorporated.
- Provider – as defined within this document, providers are the health care professionals delivering care.

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