Shaping the Rhode Island Duals Demonstration: The Power of Partnerships between Advocates and Geriatrics Experts

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ABSTRACT

This paper describes a unique collaboration between consumer health care advocates, experts in geriatrics, a state, and a health plan to improve care for adults with both Medicare and Medicaid. Ineffective care coordination between the Medicare and Medicaid programs has led to poor care and high costs. As part of the Affordable Care Act (ACA), CMS initiated state demonstrations to align financing and care delivery. In 2016, Rhode Island launched an integrated care model. Geriatrics experts teamed up with an aging services advocate to work on the Rhode Island project. The team's objective was to bring a geriatrics lens to policy development and clinical care. The team made critical recommendations to the state and CMS during the planning stage, and geriatrics experts presented trainings to health plan care providers. The project demonstrated the potential for geriatrics experts partnering with consumer advocates to influence policy development and implementation.

KEYWORDS: dually eligible, advocacy, policy, care integration, geriatrics care

BACKGROUND

Persons eligible for both Medicare and Medicaid are referred to as dual-eligible enrollees. In 2016, there were 11.7 million dual-eligible enrollees. They comprised 20% of Medicare beneficiaries, accounting for one-third of all Medicare spending and one-third of Medicaid spending (total $306 billion in 2012).[1,2] Although diverse in need and diagnoses, they share many important characteristics. Two-thirds have three or more chronic conditions, 41% have a mental illness, about half use long-term supports and services, and nearly 20% report poor health (compared to 6% among non-dually eligible Medicare beneficiaries).[3] A way to think about these vulnerable citizens is as two distinct populations: one is older (age 65 and over) and sicker than traditional Medicare beneficiaries; the other is younger with severe disabilities (physical, behavioral, or intellectual/developmental).

Financial Alignment Initiative Demonstrations

Differences between Medicare and Medicaid benefits and payment policies present an ongoing barrier to coordinating care for dual-eligible persons. These beneficiaries desperately need care integration and coordination. To overcome this, in 2012 the Centers for Medicare and Medicaid Services (CMS), under new provisions in the ACA, began approving State Financial Alignment Initiative (FAI) demonstrations to better align the financing and integration of service delivery of the two programs. At the end of 2016, there were demonstrations in thirteen states. Eleven were testing capitated models serving approximately 380,000 beneficiaries as of May 2018.[4]

The Rhode Island FAI, called the *Integrated Care Initiative* (ICI), was developed in two phases. In Phase 1, dually eligible beneficiaries could enroll in the Neighborhood Health Plan of Rhode Island (NHP-RI, also "the Plan") *UNITY* product to manage their Medicaid long-term care services and receive some care coordination. In April 2016, a three-way contract with CMS, the State, and NHP-RI (the only health plan that applied to participate in the program) was signed.[5] With the signing of the 3-way contract, voluntary enrollment in Phase 2, the fully integrated Medicare and Medicaid managed care program, began. This program is called *INTEGRITY* (See **Table 1** for enrollment numbers).

Since many elderly dually-eligible beneficiaries have multiple chronic conditions, the principles of geriatrics medicine are an essential foundation for their care. These include the knowledge and skills of an interdisciplinary care team to conduct comprehensive geriatrics assessment of the major domains of function – physical, cognitive, emotional and social; and to construct a care plan based on findings. In Rhode Island, the introduction of the FAI provided an opportunity for a unique partnership between advocacy organizations and geriatrics experts to shape the state's demonstration so that it better serves older adults. This partnership, accomplished through the Voices for Better Health (VBH) program, represents a promising approach to improving care for older adults that could serve as a national model.

METHODS

Voices for Better Health

With funding from the Atlantic Philanthropies, Community Catalyst, a national non-profit advocacy organization working to build the consumer and community leadership required to transform the American health system, started

Table 1. Enrollment in UNITY and INTEGRITY as of June 2018

Enrollee Status	PROGRAM				Total Eligible
	Neighborhood UNITY (Medicaid only managed by Plan)	Neighborhood INTEGRITY (Medicaid and Medicare managed by Plan	PACE	Fee-for-Service Duals not in ICI	
In Nursing Home	2,422	429	261	1,599	4,450
In Community with Long-Term Services & Supports	1,093	1,298		1,255	3,646
Intellectual & Developmental Disabilities	887	1,218		474	2,579
Severe and Persistent Mental Illness	540	1,347		481	2,368
In Community without Long-Term Services & Supports	7,497	9,131		4,197	20,825
Medicaid Only	710	-	24	317	1,051
Total	**13,149**	**13,423**	**285**	**8,323**	**35,180**

Reference: Long Term Care Coordinated Council: Minutes of the meeting held Wednesday, June 13, 2018. https://opengov.sos.ri.gov/Common/DownloadMeetingFiles?FilePath=/minutes/223/2018/67529.pdf

the Voices for Better Health (VBH) program in 2013. Its goal was to promote person-centered, integrated care for older adults eligible for both Medicare and Medicaid in the FAI demonstrations. It would accomplish this by strengthening the voices of consumers, caregivers, and provider groups in program design and implementation.[6] Organizations from five states participating in the demonstration (Michigan, New York, Rhode Island, Washington, and Ohio) were funded to participate in VBH.

Geriatrics Provider Advocates

Recognizing the importance of the FAI in caring for older adults, The John A. Hartford Foundation of New York City provided additional support to the VBH program to ensure the demonstrations made use of geriatrics expertise and best practices to improve care and quality of life for older adults enrolled in the demonstrations. Geriatrics experts in the five VBH states were recruited from medicine, nursing, social work, and other professions. Referred to as Geriatrics Provider Advocates (GPAs), two GPAs were selected for each state. Their role was to collaborate with the consumer advocates in that state to recommend policy and practice changes in support of a high quality "best practice" delivery system to serve dual-eligible older adults.

Rhode Island Voices for Better Health Program

The Rhode Island VBH program is a partnership between the Senior Agenda Coalition of Rhode Island (an advocacy organization working to promote aging in the community), the Rhode Island Organizing Project, and the Economic Progress Institute of Rhode Island. Rhode Island has a critical need for education in geriatrics best practices. The state has the highest percentage of persons age 85 and over in the country.[7] People age 65 and older are projected to make up 23% of the state population by 2030.[8]

Two geriatrics clinical experts were recruited in 2014: a geriatrician (RB) and an advanced practice geriatrics clinical nurse specialist (MW); along with an experienced health and aging policy advocate (MM) to promote geriatrics-competent care in its FAI demonstration.

As NHP-RI had previously focused much of its effort on providing quality care for children and families, the Rhode Island GPAs wanted to ensure the Plan's workforce was trained to meet the needs of dually eligible older adults. They also wanted to make sure that program design considered the special needs of this population.

Intervention

Initially, the GPAs worked to raise awareness about the need for the ICI and to support its potential to provide better coordination and integration of care for these older adults. They wrote guest editorials published in state newspapers[9,10] and reached out to the medical community through insertions in physician and nurse newsletters published by the Rhode Island Department of Health.

The GPAs' objective was to bring a geriatrics lens to policy development and clinical care as the state developed its contract with the federal government and the Plan. Using "*Quality Care through a Quality Workforce: A Toolkit for Advocates of Older Adults Who are Dually Eligible for Medicare and Medicaid*"[11] as a framework, the GPAs developed a set of recommendations (see **Table 2**) for the ICI development and promoted their recommendations with state, federal and NHP-RI management.

The partnership provided input on editing the content of ICI enrollment letters and outreach materials to ensure the language was "consumer friendly" and helped develop the governance structure for the state's consumer-led ICI Implementation Council.

The geriatrics clinical nurse specialist played a key role in

promoting quality clinical care in the context of the ICI. She designed and provided a six-session geriatrics-focused curriculum for the nurse case managers and other clinical staff working in the ICI. Topics, based on a staff survey done to identify interest and educational needs, included: Pain Management in Elders; Delirium, Depression, and Dementia; Communication; Falls; Frailty; and Care Transitions.

Table 2. GPA Recommendations for ICI Development

Recommendations Related To Workforce
20% of Plan's primary care provider network trained in geriatrics or gerontology in year one. Increase annually by 10%.
Require plan medical providers obtain 50% of state-required CME credits in geriatrics or gerontology-related topics.
Plan case managers receive training in both geriatrics or gerontology and team-based care.
Plan offers training for providers and internal clinical staff aligned with the *Partnership for Health in Aging's Multidisciplinary Competencies for Caring for Older Adults* and/or address geriatric conditions, such as: dementia care, multiple chronic conditions, and mental and behavioral health issues including substance abuse.
Allocate a percentage of plan premium dollars for training for geriatrics/gerontology and team-based training to include cultural competency.
Plan to report annually on training of providers in geriatrics, gerontology, and team-based care.
Recommendations Related To Care Delivery
Provide ICI enrollees and family caregivers (when appropriate) with materials that describe the role of team members and identify appropriate persons to contact for help; Provide contact information for care mangers to client, family caregiver (as appropriate) and providers of record.
Require consumer surveys include additional questions on consumer satisfaction to address matters relating to team care and support, and process of care; require results of survey be made public.
Require that, when appropriate, the Vulnerable Elders Survey (VES-13) be included in care planning for older adults and falls screening.
Require primary care providers offer Medicare's Annual Wellness Visit.
Require, when appropriate, plans evaluate family caregivers' needs using a uniform assessment.
Require plan provide the dually eligible older adult and family caregiver, when appropriate, information about community resources, supports and training opportunities.
Include ICI ombudsman contact information in enrollee welcome packets and information on other opportunities to provide feedback or address concerns; require ICI ombudsman to provide annual report.
Require plan to employ specially trained dementia care managers.
Require plan to provide primary care home visits for the elder chronically ill and homebound.
Encourage plan to make use of telehealth and remote technologies as appropriate.

In addition to the educational sessions for NHP-RI staff, the GPA team reached out to the RI Care Transformation Collaborative (CTC),[12] the state's robust Patient-Centered Medical Home program, to offer trainings for their nurse case managers working in primary and specialty practices. This resulted in several educational sessions conducted for 44 CTC nurse case managers and staff. A session was added that focused on the social determinants of health, and included a panel providing information on community-based resources available to meet social needs. Participant evaluations of the trainings showed agreement that the trainings were relevant and would be helpful to their work.

In outreach to the state's Community Health Centers, the project's geriatrician identified falls and fall-risk assessment as an area of interest for clinical staff and developed a web-based presentation shared with clinicians working in the Centers. The geriatrician is also disseminating a co-management program for older hospitalized patients combining geriatrics expertise with multiple specialties.

RESULTS

The Rhode Island GPA team achieved some successes in bringing a geriatrics lens to the state's ICI three-way contract.[13] The qualifications for lead case managers now include having a clinical background in and knowledge of aging and loss and other geriatrics-related issues. NHP-RI also must establish policies for appropriate training of care coordinators. The three-way contract also requires lead case managers to receive training on interdisciplinary care coordination and for the Plan to offer training programs in a number of areas. These include the special needs of enrollees that may affect access to and delivery of services; identification and coordination of long-term supports and services and behavioral health services for primary care providers; and cultural competency.[14] In addition, the Plan must train its providers on disability literacy, including various types of chronic conditions prevalent within the target population, use of evidence-based practices, and specific requirements for dementia care training as recommended by the GPAs. To meet this latter requirement, the Plan employs a certified dementia trainer and collaborated with the University of Rhode Island Geriatrics Education Program to offer a mandatory three-session dementia-training curriculum for all its care managers.

The GPAs recommended the Plan provide enrollees and family caregivers with information about community resources, supports and training opportunities. For family caregivers, with the enrollee's consent, the Plan must share a copy of the Individual Care Plan with the family caregiver and offer information about supports and resources. The Plan has also provided a small grant to a non-profit entity to bring the evidence-based *Powerful Tools for Caregivers* program to the community.[15]

In addition to work within the state, the GPAs shared their experiences through participation in several nationally available webinars and conference presentations, including those sponsored by Community Catalyst, The Hartford Foundation, the American Geriatrics Society, and the Gerontological Society of America. Additionally, special sessions for GPAs from all the participating states were offered at Community Catalyst's annual VBH convening. These sessions resulted in robust exchanges amongst the GPAs about what was working in their states and sharing of the geriatrics training presentations developed by the geriatrics clinical nurse specialist with GPAs in several other states.

DISCUSSION

Partnering geriatrics experts with advocates for improving healthcare for older adults in the ICI achieved some success in incorporating geriatrics principles of care into the demonstration's policy framework and three-way contract provisions. The policy advocate had worked for many years with advocacy groups and aging service and long-term care providers. Her standing and reputation helped facilitate discussions with key state officials about the need to promote geriatrics-competent care in the project. Likewise, the high regard held for the geriatrician lent enormous credibility to the GPA work, as did having one of the state's few geriatrics clinical nurse specialists on the GPA team.

The vast majority of the state's seniors are on Medicare, but not Medicaid; with most receiving care from primary care practices that do not necessarily have geriatrics training beyond what may have been offered in medical school or residency programs. Many of these practices are engaged in the state's robust Patient-Centered Medical Home (PCMH) initiative. Nurse care managers are a critical component of PCMH practices – monitoring care outcomes, helping with care transitions, providing detailed patient assessments of social needs, making referrals to needed services, and supporting family caregivers. Offering geriatrics-focused trainings to these nurse care managers was an excellent way to expand the work of the GPAs and was positively received.

The Rhode Island VBH program demonstrated the effectiveness of geriatrics providers and state consumer advocacy groups partnering to bring policy and practice closer together. Consumer advocates know the policy and political realm well and offered GPAs an opportunity to become involved in a project they may not have otherwise engaged in, given their busy practices. Additionally, GPAs brought care expertise and credibility in care of older adults that consumer advocates do not usually have. The GPA partners elevated the voices of the consumer advocates in promoting key policy developments. As front-line staff are crucial in getting persons to the right care at the right time, the geriatrics clinical nurse specialist trainings were important for a health insurer with little prior experience in caring for elders. Replicating partnerships between consumer advocates and providers, as done in the GPA project, could be of enormous benefit as we work to engage consumer voices in shaping reform efforts and to create more age-friendly health systems for our older population.

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