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Dementia Care Coordination Workforce and Practices in Seven Dual Demonstration States

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I. Introduction/Background

As health systems continue to evolve toward more managed care models, care coordinators are playing an increasingly important role in ensuring that people with Alzheimer's disease or related dementias (ADRD) receive appropriate, well-coordinated, and cost-effective care. Research has shown that effective care coordination and referral to services and supports for patients with ADRD and their informal caregivers (family and/or friends who provide care) can decrease unnecessary medical services utilization, delay institutionalization, and improve the quality of life of both patients with ADRD and their caregivers. However, care coordinators are often unprepared to meet the needs of this challenging population. We systematically reviewed and analyzed care coordinator policies and practices within the health plans of 12 states participating in the US Centers for Medicare & Medicaid Services' (CMS) demonstration programs for dually-eligible Medicare and Medicaid beneficiaries (referred to as "duals").

II. Methods

Seven states were selected for this research based on 4 criteria, including: 1) a capitated financing alignment model; 2) enrollment begun on or before January, 2015; 3) demonstration programs that include older adults; and 4) demonstrations expected to continue beyond January, 2016. Three-way contracts between CMS, the states, and health plans or other contracted entities were reviewed from each of the 7 states. We also interviewed 24 key informants (KIs) selected for their national or state expertise in the care coordination workforce, dementia care coordination, or duals demonstration policy in the individual states or nationally.

III. Findings

The review of documents revealed that most state contracts had some language specifying care coordination workforce and practice requirements in duals demonstrations. The 3-way contracts generally defined the workforce conducting care coordination services as "care coordinators" or "care managers," and many states required a Bachelor's degree or education or certification in registered nursing or social work. Several KIs observed that there were insufficient numbers of qualified personnel to meet the needs of the duals demonstration members. For this and other reasons, states tended to opt for more flexibility rather then being too prescriptive in care coordination workforce requirements. Experience and training requirements for care coordinators were often broadly defined. While several state requirements mentioned experience in caring for the aged and persons with ADRD, there was little specificity about the training content or which competencies were required.

Conclusions and Policy Implications

1) Trained care coordinators can help to ensure that people with Alzheimer's disease or related dementias (ADRD) receive appropriate, well-coordinated, and cost-effective care. This research enhances our knowledge of the care coordination workforce and practice requirements in CMS's demonstration projects covering dually eligible Medicare and Medicaid beneficiaries. It highlights the need for a workforce of adequate numbers of dementia-capable care coordinators.

2) Although variability within the CMS duals demonstrations makes comparison across states difficult, all demonstrations will benefit from efforts to evaluate outcomes of policies impacting people with ADRD and their caregivers.

IV. Conclusion

The extent to which care coordinator requirements and practices were defined in duals demonstrations is related to several factors: 1) workforce availability and qualifications; 2) existing state policies concerning Medicaid waivers, Medicare Advantage Programs, and Managed Long-Term Services and Supports (MLTSS); and 3) the stakeholder process and strength of advocacy movements surrounding the creation of the duals demonstrations in the state. Several KIs noted an apprehension about making contracts too prescriptive, which would risk negative unintended consequences and prevent the innovation and flexibility necessary to achieve the overall goals of the demonstration.

V. Policy Implications

Promising practices for the utilization of existing workforce resources and dementia-capable training for care coordinators were identified. While the variability of the duals demonstrations makes it difficult to compare across states, all demonstrations will benefit from efforts to evaluate outcomes of policies impacting people with ADRD and their caregivers. The 3-way contracts are often the starting point of a process to more clearly define policies and practices in each state. As the dual demonstrations further develop the requirements related to the care coordination workforce and practice, it will be important to evaluate outcomes and share promising practices.

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