Growing Our Own:
Care Coordination Strategies in NY

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Impact of State-Level Reforms on NY Health

The Delivery System Reform Incentive Payment (DSRIP) Program, the State Health Improvement Plan (SHIP), and Population Health Improvement Plan (PHIP) are three state-level reform programs which strive to improve the quality of patient care and reduce cost.

The programs aim to:

1.) reduce number of inappropriate hospitalizations,
2.) transition care from inpatient to outpatient when appropriate, and
3.) improve integration of health services across a continuum of care.

Changing Landscape of NY Healthcare

- The redesign of the health care system impacts the healthcare workforce.

- Emerging models of care are:
  - Patient-centered,
  - Team-based,
  - Focused on care coordination, and
  - Developing new categories of healthcare workers.

The Changing Healthcare Workforce

- Many emerging titles are not included in health workforce data collection efforts.

- Different types of professionals are entering into these highly variable roles, so identifying the current workforce and assessing future needs is complex.

Emerging Questions

How do healthcare organizations build effective care coordination teams?

What strategies do healthcare organizations use to provide care coordination services?

Why FQHCs?

- Community health centers are uniquely positioned to provide integrated services to reduce health disparities for underserved populations.
- Care coordination is an important component of reducing disparities, improving outcomes and reducing costs associated with inappropriate hospitalizations.
- Federally Qualified Health Centers (FQHCs) participate in these patient centered care delivery models.
- Understanding care coordination strategies and issues may better support FQHCs in meeting the triple aim.

Methods

- This is a multi-year care coordination workforce project based on case studies of a small number of organizations located in New York City.
- The participating organizations represent different varieties of emerging care delivery models.
- Each year, participating organizations are interviewed to learn about changes in their approach to providing care coordination services.
- Open-ended interviews include questions on emerging workforce titles, required skills, and training needs to effect care coordination.

Methods (continued)

- In addition, CHWS helped administer and analyze two workforce surveys.
- Participants included both hospitals and health centers across New York State.
- Both surveys included questions about care coordination staffing strategies.

Theme 1

Health reform efforts such as DSRIP fuel increasing demand for care coordination services.

- Performing Provider Systems (PPSs) recognize the need for better, more comprehensive care coordination services.
- Strategies include efforts to reduce inappropriate emergency department visits and hospital admissions.
- Care coordination strategies include bridging health, and mental health services, and social services.

Theme 2

Health providers are concerned about unevenly distributed care coordination services among patients in need of these services.

- "Uncoordinated" care coordination services are provided to some patients by different organizations (e.g. insurers and providers).
- In contrast, other patients (e.g. patients with chronic diseases) are not currently eligible but would benefit from care coordination services.
- Duplication and lack of care coordination services means lack of effectiveness in serving patients and increased cost.

Theme 3

There is substantial variation in qualifications and, sometimes, functions associated with these positions.

- Some organizations reported requiring a bachelor's degree for specific positions (e.g. care manager, case manager, care coordinator, and health educator).

- These organizations reported that the requirements for a bachelor's degree ensured staff would have strong oral, written, and critical thinking skills for effective performance.

- Other organizations reported requiring a high school diploma and strong interpersonal skills for positions such as community health workers.

Theme 4

Participating organizations provide care coordination training to build effective teams.

- Organizations provide different levels of care coordination training based on team roles and occupation.

- Trainings may focus on communities' health needs, team-based work, health advocacy, and motivational interviewing.

Theme 5

Providers cited "promoting treatment adherence" and "improving patient engagement" as two of the most important functions of care coordination staff.

- Treatment adherence and improving patient engagement were universally identified as important aspects of patient self-management and education across all care coordination titles.

- Providers stressed the importance of care coordinators helping patients understand the health care delivery system and available resources and providing supportive counseling and coaching.

Theme 6

Technology is at the forefront of improving patient care.

- Organizations actively invest in information technology to create better access to clinical information and coordinate patient services across providers.

- IT strategies include use of electronic health records (EHR), patient portals, and universal IT platforms for care coordination team members.

Conclusions

- Engaging patients and coordinating with health and social welfare providers is important for better patient outcomes and cost effectiveness.
- Care coordination teams are uniquely structured around organizations' specific goals and patient's needs.
- Qualifications and education for emerging workforce positions vary based on unique needs of communities.

Conclusions

- Participating organizations each recognize the importance of investing in electronic health records and IT platform(s) to share clinical information and coordinate services.

- As organizations build networks of care, care coordination team members may work remotely in addition to on-site care.

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