CARE COORDINATION

DESCRIPTION

Care Coordinators, while not new to the health care delivery system, are becoming increasingly important as healthcare transitions to accountable care organizations (ACO), patient centered medical homes, or other new models of delivery.

The Agency for Health Research and Quality developed the following working definition of care coordination based on a systematic review of the many definitions of care coordination that exist:

“Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”

Care coordination is a patient- and family-centered, team-based activity designed to bridge the gaps that can occur in care transitions either between care settings or care givers by addressing potential gaps in meeting patients’ interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes.

Care coordination is further described in the report Interprofessional Care Coordination: Looking to the Future (New York Academy of Medicine with support from the Josiah Macy Jr. Foundation):

Care coordination teams and team leadership will vary depending on patient and family needs. The team may include physicians, physician extenders, nurses, social workers, pharmacists, nutritionists, physical and occupational therapists, dentists, community health workers, and patient navigators. Community health workers and peer/patient navigators can play a special role as trusted community members who can serve as a bridge between the patient and the health care system and help the team address cultural competency and literacy issues. Reimbursement policies for care coordination need to be aligned to promote interprofessional care coordination. This may involve clarifying and/or removing regulatory impediments around scope of practice, professional reimbursement, and/or revenue sharing from savings as envisioned in health homes and ACOs.

OVERVIEW OF WORKFORCE NEEDS

Care coordination is designed around teams, but most of health professions education occurs in the silos of individual professional education. One of the biggest challenges in creating opportunities for interdisciplinary and interprofessional education. This is particularly challenging in a state where many health professions programs are hundreds of miles from programs in other disciplines. A second area of development is the role of the care coordinator – a role that plays a central patient centered role in managing the care received by a patient in the team environment. A patient care coordinator is frequently a registered nurse (RN) but this is not a requirement at all facilities. Some clinics are utilizing medical assistants in the care coordinator role. A patient care coordinator may work in hospitals, physician’s offices, dental offices, clinics, specialty care centers, and nursing care facilities. Duties can vary widely but typically include:

• Developing and coordinating patient care programs
• Managing and preparing public relations information
• Managing human resources
• Handling patient case management
• Managing patient care
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The Montana Medical Association has initiated a project to develop and promote a new function/profession called health behavior coach. Health behavior coaches would guide patients to more optimal health behaviors and choices. They would work as a member of the healthcare team, likely in a clinic setting, and would empower, educate, motivate and guide patients with healthcare needs. While not quite the same as a care coordinator, many of the same skills would apply. It was proposed that the coaches would need an AA or BA to function effectively in this position. Additional educational considerations may be a BS in Community Health, or the ACE Certified Health Coach designation.

A third area of development in Montana is the role of Community Health Worker (CHW). CHWs are a newly evolving role in Montana. A separate section on the strategies for developing a CHW role, curriculum and training system is included in this plan.

WORKFORCE DATA

Little data exists for the Care Coordinator workforce other than the anecdotal evidence gathered in the initial employer assessment conducted by the HealthCARE Montana Workforce Coordinators, in which responding employers identified care coordination as a high priority staffing need in the future. Because care coordination team members are identified by their profession (nurse, social worker, pharmacist, physician, etc.) there is no secondary data source on the care coordination workforce.

EDUCATION AND TRAINING

Education requirements for Care Coordinators are quite variable across employment settings. LPNs and RNs have been quite successful in this role. The Chronic Care Professional certification has also prepared staff (both clinical and non-clinical) to function well in specific work settings. The CCP certification is a 40 hour, online course which runs about $1500 to $1800. Employers may prefer a patient care coordinator to have at least two years of experience in healthcare and previous experience in a supervisory position. Some employers prefer candidates to have specific experience in managing patient care.

Montana State University College of Nursing offers a Clinical Nurse Leader masters degree which prepares grads for a wide range of leadership skills in the healthcare delivery system, including: client advocacy, team manager, information manager, outcomes manager, systems analyst/risk anticipator, and educator.
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CARE COORDINATION STRATEGIES

Through the regional AHEC workforce coordinators (funded through the HealthCARE Montana grant), gather more precise information about workforce needs related to care coordination, Patient Centered Medical Homes, Accountable Care Organizations, Comprehensive Primary Care Plus (CPC+) and other care coordination efforts.

- Identify and find methods to share specific education and training programs available in Montana that support the care coordination workforce development.

Consider the recommendations related to interdisciplinary care coordination included in the Macy Report:

- Refine core competencies for interprofessional care coordination and incorporate into general professional education, credentialing, and continuing professional education opportunities of all professional groups central to patient-centered care coordination.

- Develop pre-clinical experiences to prepare students from multiple disciplines for more effective interprofessional clinical training.

- Establish roles for community health workers who are being increasingly identified as important contributors to community-based care coordination.