Health Workforce Policy Brief

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The Care Coordination Workforce: Case Studies of Four Health Care Systems

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I. Introduction/Background

The lack of coordination in patient care is frequently cited as a major contributor to healthcare overutilization, high cost, and poor health outcomes.[1] Emerging payment models, such as accountable care organizations (ACOs) and bundled payments that hold providers accountable for the total cost of patient care are changing how care is organized and delivered. Healthcare providers are increasingly adopting care coordination systems into their practices,[2] devoting more attention and resources to ensuring that patients receive timely, appropriate levels of care. Included in these systems are efforts to address social determinants of health that may have been given little attention in the past.[3] According to AHRQ[4], care coordination involves deliberately organizing patient care activities and sharing information among professionals concerned with a patient's care to achieve safer and more effective care. It is generally viewed as a key to success for systems seeking to adapt to a range of risk-based payment policies. Job functions and the professional base of care coordinators varies across health systems. This study explores the history and configurations of the care workforce in four health systems. Understanding the care coordination role and requirements will assist workforce planning for this growing role.

II. Methods

Researchers at the University of California, San Francisco and George Washington University conducted 46 semi-structured, telephonic interviews with executives, care coordination program directors, social work, nursing, medical, and unlicensed staff engaged in care coordination at four diverse health systems: Bellin Health (urban Wisconsin), the Health Plan of San Mateo (suburban Northern California), Montefiore Health System (urban New York City), and Rush University Medical Center (urban Chicago). Questions centered on how the workforce was organized and staffed in each system, specific roles, functions and training of the workers, key challenges and successes of the efforts, and the financial support for these functions. We sought to identify patterns in the evolution of their approaches.

III. Findings

Interviews at the four sites revealed wide variation in the approaches to care coordination. Some systems adopted an approach that was embedded in the

Conclusions and Policy Implications

1) To adopt care coordination approaches, healthcare systems have independently developed roles and job titles specific to each system's care delivery and payment model.

2) Care management organizational structures often have a professional lens corresponding to the organizational history of who performed those functions in the past.

3) The Institute of Medicine has identified care coordination as a key strategy to realize improvements in the effectiveness and efficiency of the healthcare system, yet insurance reimbursement structures rarely incentivize these efforts. Efforts to further develop this important role must consider workforce rules and payment structures.

healthcare delivery setting. One system incorporated the care management function within a subsidiary care management organization. Three of the four sites primarily utilized telephonic engagement with patients, while one opted primarily for in-person and home visits. All sites had some degree of risk assessment to identify patients most in need of care coordination.

The health systems often had a particular professional lens corresponding to the organization's historical preference for the type of provider who had performed those functions in the past and/or related to whether the primary functions were nursing or social services. The process of adopting care coordination approaches involved developing positions and establishing job titles specific to each system. Job titles reflected a wide array of naming conventions, such as care coordinator, care manager, and case manager, without consistency across sites in role definitions. In all four sites, care coordination roles for the highest risk patients were typically filled by registered nurses or social workers. The use of unlicensed personnel to carry out some of the more routine care coordination tasks appeared to be a trend. Formal training programs for care coordination personnel were primarily on the job; certification as a care coordinator was generally not a requirement in any of the case study systems. Care coordination was viewed as having a positive impact in achieving outcomes such as reduction in unneeded emergency room and hospital visits, improved access to primary and specialty care, and addressing issues related to social determinants of health. In some cases, care coordination was financially supported by capitated payments from payers; in fee-for-service systems the programs were supported by the overall budget of the health system. Some systems also participated in alternative payment models, such as ACOs, where the prospect of shared savings incentives helped spur investment in care coordination activities. Two systems emphasized the challenge of allowing specific contracts with insurers to determine differences in program offerings, reporting that their goal is to attain a financing base across payers that will allow them to avoid segmentation by payer.

IV. Conclusion

The care coordination workforce is growing despite a lack of consensus on role definitions, professional base, job titles, competencies, and training. Roles are often filled by nurses and social workers who had traditionally filled these functions. Care coordination approaches encompass various staffing and operational structures, and their effectiveness may lie in tailoring interventions to meet the needs of a defined and risk-assessed target patient population. Individual organizations set up care coordination activities depending on patient need and payment systems.

V. Policy Implications

The Institute of Medicine identifies care coordination as a key strategy to potentially achieve a more effective and efficient healthcare system[1], yet health insurance reimbursement structures rarely incentivize care coordination efforts. As care coordination develops, policy makers must address issues of workforce rules and payment structures. Development and analysis of this role will benefit the workforce development policy community as well as the patients who receive more coordinated care.

[1] McDonald K, Sundaram V, Bravata D, et al. AHRQ Technical Reviews Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US). 2007
[2] Berenson R, Burton R, McGrath M. Do accountable care organizations (ACOs) help or hinder primary care physicians' ability to deliver high-quality care? *Healthcare*. 2016; 4(3)155-159. http://dx.doi.org/10.1016/j.hjdsi.2016.02.011
[3] Blue Cross Blue Shield of Massachusetts Foundation. Leveraging the Social Determinants of Health: What works? 2015. Available at: http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf. Access date: September 2016.
[4] Agency for Healthcare Research and Quality. Care Coordination. 2016. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Access date: September 2016

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