

Connecting the Dots Along the Care Continuum

Introduction

This paper is designed to continue the conversation around the concepts discussed in AHA's "Hospitals and Care Systems of the Future", and the AHA Workforce Center's "Workforce Roles in a Redesigned Primary Care Model" and "Reconfiguring the Bedside Care Team of the Future" and explore them in greater depth. In doing so, we strive to build an even greater understanding of the best ways to transform care and educate the workforce so they can perform even more efficiently and effectively in the future.

In September 2011, the American Hospital Association's (AHA) Committee on Performance Improvement published a report outlining the changes hospitals are undergoing, from "first curve" volume-based care delivery to "second curve" value-based care. In this report, "Hospitals and Care Systems of the Future," four priority strategies were presented:

1. Aligning hospitals, physicians and other providers across the continuum of care to improve access to and quality of care.
2. Utilizing evidence-based practices to improve quality and patient safety.
3. Improving efficiency through productivity and financial management.
4. Developing integrated information systems in order to deliver care more efficiently and effectively.

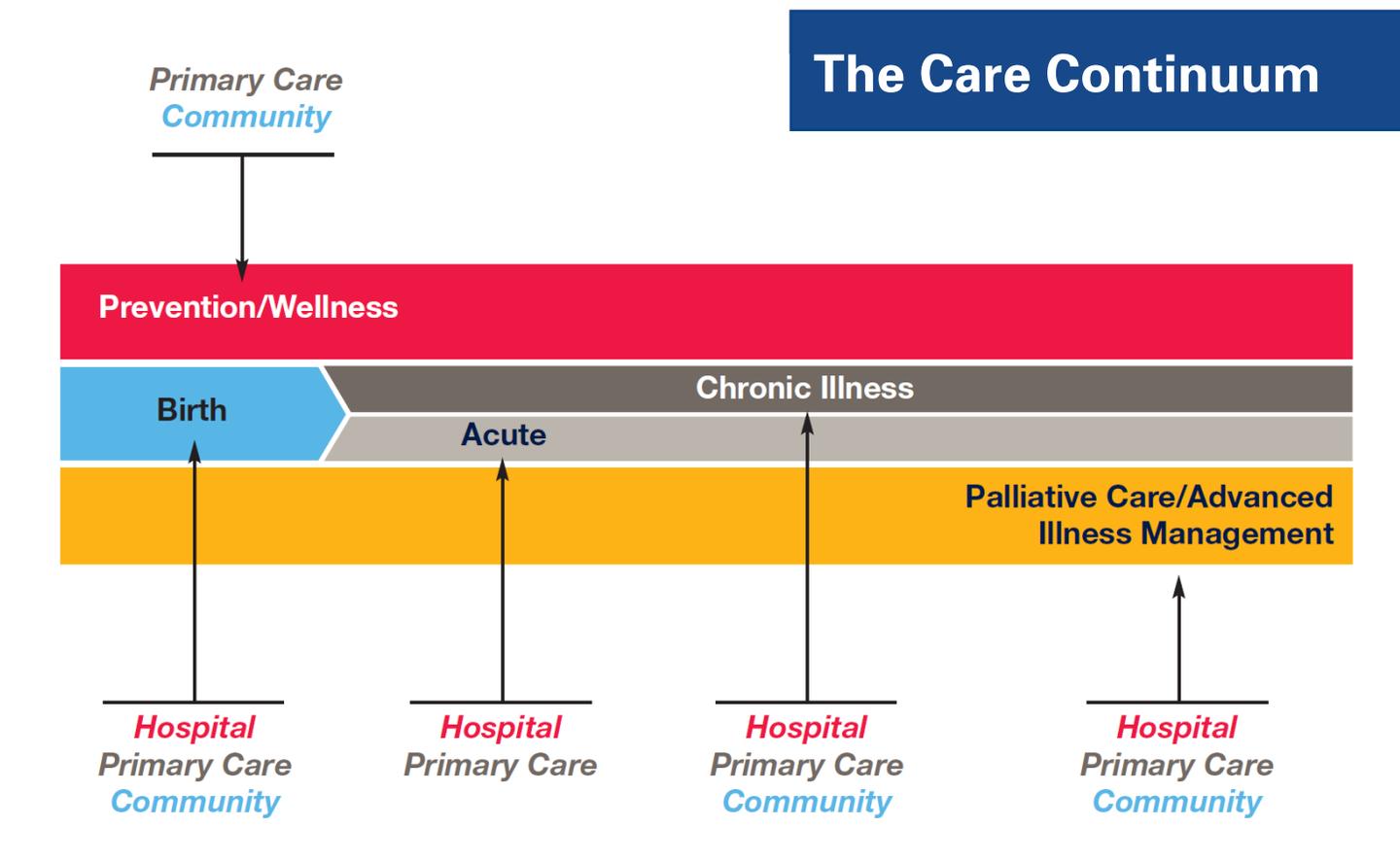
The report also covered core organizational competencies and included discussion questions that hospital and health system leaders can use to begin addressing strategies and methods of transformation.

In response, the AHA Workforce Center then released two white papers, "Workforce Roles in a Redesigned Primary Care Model" in 2012 and "Reconfiguring the Bedside Care Team of the Future" in 2013. Both papers addressed workforce-specific changes that hospitals and health systems need to examine as they move from the "first curve" to the "second curve."

The AHA Workforce Center recognized the immense challenges hospitals and health systems were facing. Delivering safe patient care is challenging in an industry dealing with considerable financial pressure, regulatory requirements and rapid, major changes, such as transitioning from a paper-based environment to an electronic health record (EHR), to name a few. These two white papers offered new ways of defining one aspect of this ever-changing field, by addressing the roles, teams and expectations of the current and future workforce.

Understanding the Guiding Principles

The **Guiding Principles** outlined in each of the white papers describe the need to examine workforce roles in a care continuum. The graph shown here illustrates how hospitals, primary care, and the community all have distinct but inter-connected roles along the continuum and, in turn, so does the workforce.



Source: "Workforce Roles in a Redesigned Primary Care Model," AHA, 2012.

Key Takeaway

This care continuum is the focus of many AHA Workforce Center efforts because, in order to achieve health care's Triple Aim—improving the patient experience of care (both quality and safety), improving the health of populations and reducing the per capita cost of health care—stakeholders must begin to discuss not only what the workforce must do, but *who* should be providing care.

This section takes these Guiding Principles and "connects the dots" among a variety of resources the AHA has developed that help to link the work of the bedside care team to primary care on the care continuum. It also provides an overview of what other professional associations and groups are doing as they transition into "second curve" value-based care.

Both previously published white papers included their own Guiding Principles:

Guiding Principles Set Forth in “Workforce Roles in a Redesigned Primary Care Model”

1. In partnership with the patient, the primary health care team is guided by what is best, needed and helpful to the patient and family.
2. The workforce must change how it functions on multiple levels. Care must be provided by inter-professional teams where work is role-based, not task-based, and the team must be empowered to create effective approaches for delivering care.
3. Hospitals can serve as conveners and enablers in primary care delivery. Primary care should be integrated into current and future care systems, and hospitals should form effective partnerships with the community and patients in a way that provides the infrastructure primary care teams need to deliver quality care.

Guiding Principles Set Forth in “Reconfiguring the Bedside Care Team of the Future”

1. The patient and family are essential members of the core care team.
2. Bedside care team members are fully engaged at the broadest scope of their practice.
3. The bedside care team is focused, highly effective and autonomous, coordinating communication with the patient/family.
4. Evidence-based guidelines that improve care are developed and consistently followed by every bedside care team member.
5. Technology replaces some clinical tasks, augmenting decision-making and complementing the clinical judgment of the care team.
6. Patients needing acute care move safely through the health care system no matter where they are in the care cycle – whether at the onset of disease, in the middle of community-based care or at the end of life.

All these Guiding Principles fall within four broad categories:

- Patient and Family Engagement;
- Team-based Care;
- New/Emerging Health Care Models; and
- Care Coordination and Transition Management.

Patient and Family Engagement

Guiding Principle: “In partnership with the patient, the primary care team is guided by what is best, needed and helpful to the patient and family.”

Engaging patients and their families is critical to achieving the Triple Aim and ensuring that key strategies and practices are implemented reliably and monitored for improvement. This is an important step toward effective patient and family engagement.¹

Patient Activation Measure: The Patient Activation Measure is the metric most often used to quantify a patient’s engagement, activation or self-management capabilities. Designed to assess a person’s knowledge, skill and confidence related to managing his or her health and health care, the measure is a 13-item scale that has demonstrated strong psychometric properties.

There is a growing body of literature indicating that patients who are more activated, as assessed by this metric, make more effective use of health care resources and engage in more positive health behaviors compared to other patients. For example, patients with results that indicate higher activation are more likely to have a regular source of care, more likely to obtain preventive care, and less likely to delay getting care, compared to less activated patients. This is true after differences in sociodemographic factors and insurance status are considered.²

The Institute for Patient- and Family-Centered Care (IPFCC): By promoting collaborative, empowering relationships among patients, families and health care professionals, the IPFCC facilitates change and improvement in all health care settings where individuals and families receive care and support. IPFCC **resources** include guidance publications, videos/DVDs and self-assessment tools.

The Nursing Alliance for Quality Care (NAQC): The NAQC further illustrates the importance of patient and family engagement in its white paper, *Fostering Successful Patient and Family Engagement: Nursing’s Critical Role*. It explains how patients and families can contribute to improving quality and reducing medical errors and harm to patients. It also discusses how nurses, no matter what their background, must play a central role in fostering successful engagement.

The paper also discusses guiding principles for patient engagement, models for enhancing the nursing role’s contributions to successful engagement, and a roadmap for building a strategic plan to maximize nursing’s contribution to patient engagement.

¹ Health Research & Educational Trust. “Patient and family engagement and patient satisfaction: Results of a national survey.” April 2015. (Accessed on September 25, 2015: at www.hpoe.org)

² Greene, J.; Hibbard, J.H.; Sacks, R.; Overton, V. and Parrotta, C.D. “When Patient Activation Levels Change, Health Outcomes And Costs Change, Too.” *Health Affairs* 34.3: 431-37. March 2015. (Accessed September 25, 2015: <http://content.healthaffairs.org/content/34/3/431>)

Guiding Principle: “The patient and family are essential members of the core care team.”

A Professional Care Coordinator’s Guide to Partnering with Family Caregivers:

From the beginning of any patient encounter, the family caregiver should be closely involved in care coordination and planning. This role can be confusing and stressful for the caretaker as they navigate the health care system, help manage patient medications and more. Family caregivers

can benefit from a professional care coordinator’s knowledge and insights, and the guide, [A Professional Care Coordinator’s Guide to Partnering with Family Caregivers](#), by Next Step in Care can help. It details how professional care coordinators can build partnerships with family caregivers and prepare them for taking on additional coordination responsibilities when their professional care services end.

Guiding Principle: “The bedside care team is focused, highly effective and autonomous, coordinating communication with the patient/family.”

Structured Interdisciplinary Bedside Rounds (SIBR):

Emory Healthcare (EHC) implemented SIBR to help remedy fragmented hospital care. Fragmented hospital care has been associated with higher hospital mortality and length of stay, and failures of communication and teamwork are the most commonly identified sources of “sentinel events” in hospitals – unexpected occurrences that result in death or the risk of death, or physical or psychological injuries.³

During these SIBRs, all unit-based team members who are responsible for a patient visit him or her together each day. The team includes the attending physician, primary nurse and other health professionals, such as those working within pharmacy, social services or palliative care. The team cross-check perspectives and complete a quality-safety checklist with the patient, family and each other, then develop a shared care plan for the day and create a specific discharge plan.

Vision, leadership and daily commitment from the top down is required to make this model work. The satisfaction of working in high functioning teams resonated strongly with staff, according to the *Harvard Business Review* [article](#) that reported on the SIBR model at EHC.

Health Research & Educational Trust (HRET) Survey:

HRET, funded by The Gordon and Betty Moore Foundation, surveyed U.S. hospitals about patient and family engagement strategies in order to learn more. Patient and family engagement practices at the bedside were addressed in the study. Survey respondents were asked questions including:

- Are patients and families encouraged to participate in nurse change-of-shift reports?
- Are multidisciplinary rounds conducted with patients and family members?
- Is teach-back used with patients?
- Are white boards used for patients’ daily care?

The HRET survey findings show that there are a number of patient/family engagement practices at the organizational and bedside levels that have positive association with patient experience. These practices are contributing to the achievement of the Triple Aim because they improve the patient experience of care.

Detailed survey findings and additional resources are available on the *Hospitals in Pursuit of Excellence* (HPOE) [website](#).

³. Stein, J.; Murphy, D.J.; Payne, C.; Clark, D.; Bornstein, W.A.; Tong, D.; Castle, B.; Shapiro, S. “A Remedy for Fragmented Hospital Care.” *Harvard Business Review*. November 2013. (Accessed August 10, 2015: <https://hbr.org/2013/11/a-remedy-for-fragmented-hospital-care>)

The Lucian Leape Institute: The Lucian Leape Institute’s mission is to provide a strategic vision for improving patient safety. The Institute has focused on identifying and framing vital transforming concepts that require system-level attention and action such as:

- Medical education reform;
- Transparency as a practiced value in all aspects of care; and
- Integration of care within and across health care delivery systems.

The Institute’s paper, **Transforming Healthcare: A Safety Imperative**, details transforming concepts for a health care vision in which the culture is open, transparent, supportive and committed to learning; where doctors, nurses and all health workers treat each other and their patients competently and

with respect; where the patient’s interest is always paramount; and where patients and families are fully engaged in their care.

Connecting the Dots: Patient and Family Engagement Workforce Implications

- Providers should receive training and guidance focused on ways to inspire and engage patients.
- Providers should actively include others in their conversations and decision-making about a patient’s care, including other providers, the patient and family caregivers.
- Health care professionals should take a leadership role in transforming their relationship with patients and family caregivers. This means they should take specific actions to demonstrate that they are collaborative team members in the patient’s care.

Team-based Care

Guiding Principle: *“Care must be provided by interprofessional teams where work is role-based, not task-based, and the team must be empowered to create effective approaches for delivering care.”*

Agency for Healthcare Research and Quality (AHRQ) Study:

In order to transform care, the focus needs to shift from students in the pipeline to educating the existing workforce. It is the 18 million workers already in the system who have the power to begin the transformation today, not just the new graduates or students in the pipeline.⁴ Supporting innovative, “model” interprofessional practice sites in community-based settings will drive current and future workforce role transformations and the delivery of care toward achieving the Triple Aim.

In a 2005 study conducted by AHRQ, evidence linked team training to improved patient safety and reduced medical errors. AHA’s Physician Leadership Forum (PLF) recognized that better collaboration with physicians and strong physician leadership are essential to manifest effective team-based care.

Team-Based Health Care Delivery: Lessons from the Field: This guide is based on discussions that took place during a session at the Health Forum/ AHA Leadership Summit in 2012. It outlines current team-based care models, as well as in-depth reviews of examples from AtlantiCare Health System, Brigham and Women’s Hospital and Marquette General Health System.

⁴Fraher, E; Machta, R.; Morrison, M. “How can we transform the workforce to meet the needs of a transformed health system?” The Cecil G. Sheps Center for Health Services Research, UNC Chapel Hill. April 2014. (Accessed September 25, 2015: http://www.healthworkforceta.org/wp-content/uploads/2014/11/HWTAC_Webinar_How_Transform_WF_to_Meet_Needs_of_Transformed_Health_System.pdf)

Team Strategies and Tools to Enhance Performance and Patient Safety

(TeamSTEPPS): TeamSTEPPS is aimed at improving teamwork in health care settings and teaches caregivers to understand one another's roles and responsibilities and ways to collaborate to improve quality and patient safety. The training program focuses on four competencies—leadership, situation monitoring, mutual support and communications—but goes beyond general health care team needs to include a set of tools for customizing the team performance based on the needs of the team.⁵

A 2008 study published in *The Joint Commission Journal on Quality and Patient Safety* showed significant increases in the quantity and quality of pre-surgical briefings and the use of quality teamwork behaviors during cases as well as increases in patient perceptions of a culture of safety and teamwork as a result of TeamSTEPPS training.

Multiple Chronic Conditions: A Framework for Education and Training: The U.S. Department of Health and Human Services' (HHS) Multiple Chronic Conditions Education and Training Repository is a searchable database of education and training resources that specifically address the care of persons living with multiple chronic conditions (PLWMCC). Included is **Multiple Chronic Conditions: A Framework for Education and Training**, which outlines the core domains and competencies essential to caring for PLWMCC. *The Education and Training Curriculum on MCC* are web-based modules for educators to equip health care professionals and paraprofessionals with useful tools and knowledge on caring for PLWMCC. The curriculum can be integrated into existing education and training programs or individual modules may be used selectively.

⁵ "Team-Based Health Care Delivery: Lessons from the Field," American Hospital Association. 2012. p. 8.

The proper education initiatives must be developed through academic/practice partnerships in order to prepare the workforce to deliver the transformed care that improves health outcomes and patient experiences, as well as reduces health care spending.

Interprofessional Education Collaborative

(IPEC): Interprofessional learning helps prepare students for enhanced team-based care and can improve population health outcomes. Once students learn how to work interprofessionally and as members of a collaborative practice team, health systems will begin to more rapidly move toward a position of strength and value-based care. Developed by organizations that represent higher education across multiple health professions, IPEC provides **resources** that outline core competencies for interprofessional collaborative practice to guide curricula development at health professions schools.

New Jersey Nursing Initiative (NJNI):

NJNI is a multi-year, multi-million-dollar project of the Robert Wood Johnson Foundation and the New Jersey Chamber of Commerce Foundation. In addition to addressing the issue of the nurse faculty shortages throughout the state, NJNI has begun focusing on reshaping curricula and clinical experience to better prepare RNs to provide community-based and population-based health care. Through academic and clinical partnerships, creative practices in health care education, and support of new and sustainable innovations in nursing curricula, NJNI hopes to dramatically change the way nursing students are prepared.

It is paramount to develop and maintain academic-practice partnerships in a variety of community settings, such as ambulatory care centers, senior centers, long-term facilities, and other community organizations, all of which provide rich opportunities for practice and research.⁶

⁶ Fortier, M.; Fountain, D. M.; Vargas, M.; Heelan-Fancher, L.; Perron, T.; Hinic, K.; Swan, B. A. "Health Care in the Community: Developing Academic/Practice Partnerships for Care Coordination and Managing Transitions." School of Nursing Faculty Papers & Presentations. Paper 70. May 2015. (Accessed on September 25, 2015: <http://jdc.jefferson.edu/nursfp/70/>)

Academic Progression in Nursing (APIN)

APIN is a grant initiative of the Robert Wood Johnson Foundation with a goal of seamless academic progression and increasing the number of nurses with a baccalaureate degree to 80 percent by 2020. APIN is working with community colleges, universities and practice partners to help ensure that the nursing workforce is prepared to deliver high-quality patient care across all practice settings.

In partnership with the Tri-Council for Nursing and administered by the American Organization of Nurse Executives (AONE), APIN collaborates with state action coalitions and their partners to accelerate implementation of promising practices related to strengthening the nursing workforce, including the critical role of nurses on interprofessional teams and across the care continuum.

Connecting the Dots: Team-based Care Workforce Implications

- Health professionals work best in teams to coordinate care across the continuum.
- Future and current health professionals will have to collaborate and work on interprofessional teams much more than in the past. This will require training, but also flexibility and respect on the part of all team members.
- Focusing more strongly on the current workforce and educating them about team-based care will drive the transformation from “first curve” volume-based to “second curve” value-based care.
- Health professionals should develop a good understanding of and appreciation for their colleagues’ skillsets and competencies in order to provide quality integrated, coordinated care.

New/Emerging Health Care Models

Guiding Principle: *“Primary care should be integrated into current and future care systems and hospitals should form effective partnerships with the community and patients in a way that provides the infrastructure primary care teams need to deliver quality care.”*

Forward-thinking health systems are already integrating primary care more broadly across their communities. These systems are using technology to broaden access to health information and care outside traditional office hours; reorganizing teams to deliver care inside and outside traditional settings; and reconsidering what belongs under the umbrella of primary care.⁷

New models of care promote potentially more efficient approaches to care delivery while also shifting goals toward patient-centered primary care. Examples include:

- The Patient-Centered Medical Home (PCMH) initiative of the National Council for Quality Assurance (NCQA);
- Accountable Care Organization (ACO) demonstrations supported by the Centers for Medicare & Medicaid Services (CMS); and
- The Health Home (HH) initiative funded by CMS and the New York State Medicaid program.⁸

⁷ Sarasohn-Kahn, J. “Primary Care, Everywhere: Connecting the Dots Across the Emerging Health Landscape.” California Healthcare Foundation, pp. 6-8. November 2011. (Accessed September 25, 2015: <http://www.chcf.org/publications/2011/11/primary-care-everywhere>)

⁸ The Center for Health Workforce Studies. “Care Coordination Case Study Preliminary Findings.” April 2014. (Accessed on September 25, 2015: <http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf>)

The increased focus on caring for patients in the community must involve the expanded presence and roles of social workers, patient navigators, community health workers, home health workers, dietitians and other community-based workers.

Health Care Home (HCH): Minnesota health care reform legislation launched the HCH program, a PCMH model designed to improve health outcomes and patient and family experiences, while also lowering costs by encouraging providers and patients and their families to work together. A detailed [study](#) looks at how the Minnesota HCH program utilizes nurse planners to coach and certify primary care clinics as HCHs. The study also shows how policy decisions that created this initiative influence the role of the nurse planner.

Guiding Principle: *“Bedside care team members are fully engaged at the broadest scope of their practice.”*

The rapid and ongoing health system change will require a workforce with “career flexibility.”¹⁰ No longer can health professionals remain in silos or rely on narrow clinical skills to achieve desired health outcomes.

Those who will help drive health system transformation for communities will need knowledge and skills in preventive medicine, care coordination, care process re-engineering, dissemination of best practices, team-based care, continuous quality improvement and the use of data.

¹⁰ Fraher, E. “How can we transform the workforce to meet the needs of a transformed health system?” The Cecil G. Sheps Center for Health Services Research, UNC Chapel Hill. 2014. (Accessed September 25, 2015: https://www.shepscenter.unc.edu/workforce_product/webinar-meeting-needs-transformed-health-system-4-09-14/)

Wisconsin Hospital Association’s 2014

Workforce Report: This report emphasizes the importance of team-based care to provide the right care, at the right time, in the right place. The Wisconsin Department of Workforce Development has seen the number of hospital employees compared to workers in ambulatory care settings reversed in just three years (2011-2014), with larger numbers reported working in ambulatory care. The report warns that the move to educate health care workers in outpatient, ambulatory and home environments may not be keeping pace with future needs and urges hospitals, policy makers and academia to work together to create an educational and regulatory structure that will support tomorrow’s needed workforce.⁹

For example, there are very strong opinions expressed regarding scope-of-practice rules, with advanced practice nurses making strong claims on primary care and nurse anesthetists being questioned about their contributions by anesthesiologists.¹¹

Some health care professionals are concerned about lower-cost professionals acting as substitutes for higher-cost professionals, for instance a nurse practitioner substituting for a physician. However, if physicians could view nurse practitioners as clinicians who are contributing to their success, as well as to lowered health care costs, they might be more supportive of this practice.

⁹ Grasmick, M.K. “Team-Based Health Care Scores Big with Patients.” Wisconsin Hospital Association. 2014. (Accessed on September 25, 2015: <http://www.wha.org/pubarchive/reports/2014WorkforceReport.pdf>)

¹¹ Ricketts T.C.; Fraher E.P. “Reconfiguring Health Workforce Policy So That Education, Training, And Actual Delivery of Care are Closely Connected.” *Health Aff (Millwood)*. 32(11):1874-80. 2013. (Accessed September 25, 2015: <http://www.ncbi.nlm.nih.gov/pubmed/24191074>)

Guiding Principle: “Evidence-based guidelines that improve care are developed and consistently followed by every bedside care team member.”

Developing new coordinated, comprehensive systems for specific care, such as the care of patients with strokes, is being established by multiple states, enabling patient access and improving care.

“When Stroke Care is a Statewide Effort”:

Hospitals & Health Network’s article, “**When Stroke Care is a Statewide Effort,**” highlights the creation of evidence-based guidelines that enhance collaboration among hospitals and others to effectively treat stroke victims. The Centers for Disease Control and Prevention (CDC) provides funding to get stroke systems off the ground through its Paul Coverdell National AcuteStroke Program. Measurable health outcome improvements are being seen among stroke victims due to new care models. A 2014 Georgia Department of Public Health data summary showed the percentage of acute stroke patients who received correct and timely care protocols jumped from 50 percent in 2009 to 76.3 percent in 2013.

Designing new health care models focused on disease area as well as constructing “idealized patient journeys” in mental health, aged care, primary care, maternity services, rehabilitation services, eye health and musculoskeletal health are suggestions by Erin Fraher, PhD, MPP, assistant professor of Departments of Family Medicine and Surgery, University of North Carolina-Chapel Hill.

PMH Community Paramedics: PMH Medical Center, in Prosser, Wash., developed a Community Paramedic Program, an excellent example of a creative, team-based community health initiative reaching across the continuum. The program utilizes paramedics who are already in the field to work with the community, and operate as a safety net for the medically vulnerable. Because the medical center serves a rural population, it also makes the program all the more important, since it bridges gaps in primary and preventive care.

The program began its funding with a three-year grant from the Center for Medicare & Medicaid Innovation (CMMI), which enabled the hospital-owned ambulance and paramedic team to help promote better health and lower costs. Visits from the Community Paramedic are mainly referral-based from a physician upon when a patient is discharged. The paramedics assist patients with chronic conditions by offering monitoring, education and recovery services in their home.

The program resulted in a savings of \$1.3 million in three years, with an average savings of \$670 per patient. More information is available on the PMH Medical Center [website](#).

Mission Health System’s “Good to Go”:

Using video and audio discharge instructions for high-risk patients is an approach being used by Mission Health System of Asheville, N.C. This practice is reducing unnecessary readmissions and improving care. A recent *Modern Healthcare News* article highlighted this initiative.¹²

Efforts to effectively manage patients after they’ve been discharged is a key feature distinguishing high-performing health systems from their peers, according to Truven Health Analytics. Therefore, new models that take discharged patients into consideration will help shift delivery of care toward a patient-centered, health management approach that spans the continuum to achieve the Triple Aim.

¹²Rice, S. “Top-performing health systems focus on improving across care continuum.” *Modern Healthcare*, April 2015. (Accessed September 25, 2015: <http://www.modernhealthcare.com/article/20150418/MAGAZINE/304189979>)

Connecting the Dots: New/Emerging Health Care Models Workforce Implications

- The opportunity for new and expanding health care roles will continue to grow as new care models expand to address population health.
- Continuing, interprofessional education will become increasingly necessary as health care professionals will need to work within new health

care models with more flexible roles, and with team members who have varying skills and competencies.

- New health care models include delivering care in multiple settings, so health care professionals will need to be knowledgeable and comfortable working in a variety of community settings.

Care Coordination and Transition Management

Guiding Principle: *“Patients needing acute care move safely through the health care system no matter where they are in the care cycle – whether at the onset of disease, in the middle of community-based care, or at the end of life.”*

Effective care coordination and transition management are essential to delivering patient-centered, quality care. Those who provide these services must be trained and qualified to meet patients’ social service and medical needs. Health insurance plans with robust care manager training often are more successful in building strong, trusting relationships with their members, which in turn enables health plans to learn more about members’ needs and, ultimately, better address them.¹³

Furthermore, teams must consider the needs and skills of everyone working with the patient, whether that person is a highly trained physician or an unlicensed employee such as a medical assistant or community health worker.¹⁴

CHWS Care Coordination Case Study: This study identified a core set of activities that occurred in the majority of care coordination efforts:

- Communication among and between patients and these providers and workers: care coordinators and members of the care team, including primary care and specialty clinicians; mental health service providers; pharmacists; nurses; social service professionals and program personnel; therapists; nutritionists; health educators; community health workers; hospital staff; home health and long-term care providers; administrative and information technology workers; and others. They participate in:
 - » Effective information exchange;
 - » Team-based decision making;
 - » Medical and social services tailored to individual patient needs;
 - » Empowering patients to better manage their own health care and health behaviors; and
 - » Monitoring patients’ health status over time.¹⁵

¹³ Ensslin, B.; Barth, S. “Strategies for Hiring and Training Care Managers in Integrated Programs Serving Medicare-Medicaid Beneficiaries.” February 2015. (Accessed September 25, 2015: <http://www.chcs.org/resource/strategies-hiring-training-care-managers-integrated-programs-serving-medicare-medicoid-beneficiaries/>)

¹⁴ Ricketts T.C.; Fraher E.P. “Reconfiguring Health Workforce Policy So That Education, Training, And Actual Delivery of Care are Closely Connected.” *Health Aff (Millwood)*. 32(11):1874-80. 2013. (Accessed September 25, 2015: <http://www.ncbi.nlm.nih.gov/pubmed/24191074>)

¹⁵ The Center for Health Workforce Studies. “Care Coordination Case Study Preliminary Findings.” April 2014. (Accessed on September 25, 2015: <http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf>)

Care coordination varies from health program to facility and even from patient to patient. Whether care coordination is episodic versus longitudinal, in the community versus in a hospital setting, a function of the entire clinical team versus a specific role for a care coordination professional, the broad array of relationships and interactions are focused on patient health and appropriate care coordination and delivery.

Center for Health Care Strategies (CHCS):

With support from the California Healthcare Foundation (CHCF) and the SCAN Foundation, CHCS interviewed five health plans with integrated care models about their strategies for hiring and training care coordinators and case managers. A resulting brief, “Beneficiaries,” shares ideal qualifications, curriculum development, and training strategies to support staff in these roles. Although the focus of the brief is for integrated care programs for Medicare-Medicaid beneficiaries, the broad strategies identified are transferable to other health plans and states.

Several titles have been associated with care coordination in addition to variation in functions across organizations. Commonly used titles are patient navigator (also called care navigator, community health worker, or patient service representative) and care coordinator (also called case manager or care manager). Despite the variation in titles and hiring requirements, there are notable overlaps in the tasks and activities performed with each of these roles. A breakdown of the varying responsibilities and qualifications can be found in [The Center for Health Workforce Studies’ Care Coordination Case Study](#) and Greater New York Hospital Association’s Primary Care Workforce Report, [“Emerging Positions in Primary Care: Results from the 2014 Ambulatory Care Workforce Survey.”](#)

AONE/AAACN Joint Statement: A new joint [statement](#) from AONE and the American Academy of Ambulatory Care Nursing (AAACN) released in September 2015 examines the role of the nurse in care coordination and transition management. The statement includes six principles for hospitals and health systems to better equip clinical leaders in both inpatient and outpatient settings to coordinate care transitions to enhance safety and minimize confusion to the patient.

The principles address the need for engaging patients, families and all staff in care coordination, and to optimize technology that enables efficient and seamless care coordination and transition planning. Furthermore, AAACN has developed a [Care Coordination and Transition Management Core Curriculum](#) to teach clinicians about managing care transitions across the continuum. Another aspect of care coordination is the use of technology to help improve links between patients and providers.

Connecting the Dots: Care Coordination and Transition Management Workforce Implications

- Training all team members about the value of care coordination is essential, especially so they understand how it contributes to the Triple Aim.
- Building strong, trusting relationships with patients and families is key to addressing their needs; care can be better coordinated when they are active participants.
- Providers must begin to shift their mindset from one of delivering episodic care to practicing a long-term, whole-person approach.
- By standardizing the titles used for care coordinators as well as their competencies, patients and families will better understand who to contact when they need help.
- Strong executive leadership is needed to advocate for the value of each care provider in effective care coordination and transition management.

Technology Will Support the Transition

Technology has—and will continue to have—a huge impact on the transition of care delivery and the associated workforce roles and responsibilities. Technology is the common fiber that supports patient and family engagement; team-based care; new/emerging health care models; and care coordination and transition management as the field transforms from volume-based care to value-based care.

Hospitals and health systems are making tremendous efforts to implement and optimize health IT to support clinical care and patient engagement, and to gather and use information to support new care models. According to an April 2013 AHA comment letter to the Office of the National Coordinator for Health Information Technology, a complete picture of how federal investments and activities plan to advance interoperability and the electronic exchange of health information on the national level, without undue burden, is necessary. This information will help move hospitals and health systems forward on improved clinical care, better coordination of care, fully informed and engaged patients, and improved public health.

HITECH and HEAL-NY: The promise of technology as the way to improve the quality of care, drive efficiencies and lower costs, especially via the EHR, has been promoted widely.

Interoperable health information systems are key to configuring service delivery in new and emerging care coordination models. The EHR is an important tool to advance the quality of communication and information exchange across provider systems and to improve health outcomes. Financial incentive programs, including the federal Health Information Technology for Economic and Clinical Health (HITECH) Act and the New York State Health Care Efficiency and Affordability Law (HEAL-NY) encourage adoption and meaningful use of EHRs. Although EHRs are not yet interoperable, interoperability was the goal of Stage 2 meaningful use. These programs are supporting the development of the health information infrastructure necessary to improve health care service delivery systems.¹⁶

EHRs must demonstrate the consistent use of standards, implementation requirements and the results of product testing. Once accomplished, hospitals can identify and prioritize the areas where improved interoperability is most needed and can review and modify the workflow of the care team. To be optimally effective, EHRs require broad adoption, practitioners must pay constant attention to data entry to minimize errors and care coordination patterns have to be reengineered to accommodate EHR usage.¹⁷

¹⁶ The Center for Health Workforce Studies. "Care Coordination Case Study Preliminary Findings." April 2014. (Accessed on September 25, 2015: <http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf>)

¹⁷ Ricketts T.C.; Fraher E.P. "Reconfiguring Health Workforce Policy So That Education, Training, And Actual Delivery of Care are Closely Connected." *Health Aff (Millwood)*. 32(11):1874-80. 2013. (Accessed September 25, 2015: <http://www.ncbi.nlm.nih.gov/pubmed/24191074>)

Huron Consulting Group: Andy Ziskind, M.D. managing director of Huron Healthcare Practice at Huron Consulting Group Inc., believes that technology can be particularly effective when used for analytics and patient engagement. Despite the huge investment being made by health care organizations across the U.S. in EHRs and other technology, the true value of the information has yet to be realized. By applying analytics, providers can start to predict which patient will need certain resources and when they will need them. Much like how a big box store can determine exactly how to position products so they will generate the most sales, health care is now beginning to use the same kind of analytics to most effectively distribute care management resources to the patients who need them most. ¹⁸

AHA Trendwatch on Telehealth: Telehealth connects patients and families to providers remotely, such as via phone or Skype and is one of the fastest growing areas of health care. A two-part series ([January](#) and [May 2015](#)) report focused on the myriad issues surrounding telehealth and its impact on providers and patients including: coverage and payment issues; health professional licensure; credentialing and privileging; medical malpractice and liability insurance; online prescribing; and privacy and security considerations. This is a topic that the AHA will continue following closely. The report recognizes that federal and state governments, as well as the private sector, are trying to find ways to reduce barriers to care in order to implement innovative health policy reforms that give better access for patients and improve health outcomes, and telehealth could be a viable solution.

¹⁸ Galoozis, C. "Care Implications Under the ACO Model." Modern Healthcare Custom Media. (Accessed September 25, 2015: <http://www.modernhealthcare.com/article/20140503/SPONSORED/140509995>)

Payer Funding Impacts Care Coordination

Some serious drawbacks to providing program-specific care coordination stem from challenges in funding to support these services. For example, one patient with diabetes might be eligible to receive formal care coordination services through their health insurance, while another patient with diabetes but with different insurance coverage might not.

Therefore, a key reason why care coordination staffing varies is funding. Patient-Centered Medical Homes (PCMHs) are most likely to report that the clinical care team is responsible for providing care coordination services, while ACOs and Health Homes (HHs) are more likely to report using specific care coordination staff.

While care coordination is minimally funded by only a few payers in PCMHs, there is a clearly defined role for a care coordinator with dedicated funding available for these services in HHs. In programs such as ACOs where risk is shared, however, there is no funding for care coordination. The financial incentive for providing care coordination in ACOs is the savings realized from providing more efficient health services, intervening early when acute problems arise, and improving health outcomes over the long term. ¹⁹

¹⁹ The Center for Health Workforce Studies. "Care Coordination Case Study Preliminary Findings." April 2014. (Accessed on September 25, 2015: <http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf>)

We must ensure that changes in the delivery system drive payment reforms that will benefit both patients and providers, which will require three steps:

1. Educate payers so they clearly understand how care coordination can contribute to lower costs.
2. Present quantifiable data and compelling evidence that demonstrates how care coordination contributes to better outcomes and lower costs.
3. Set appropriate payment levels by taking into consideration the varying socioeconomic determinants of health in each community.

The Time to Act is Now

Hospitals planning or already embarking on this journey to better collaboration and value-based care have a window of opportunity now to put a solid foundation in place—systems, workforce teams, new practices and models, education and more, all of which are important to answering the question of not only *how* will we deliver care differently, but *who* will be the workforce along the care continuum. By taking action today, we will be better positioned to handle the many challenges that will continue to face healthcare—whether they be provider shortages, a rapidly aging population, new diseases that arise, or another challenge that is yet unknown.

Imagine how a value-based model could look five years from now:

- Workforce planning and development strategies are aligned with hospital and health system strategic plans and operations. Hospitals have strategic plans that include workforce planning and development for current needs and three-five years into the future. These plans include education and training for redeploying the current workforce, as well as integrating emerging and new roles. In essence, hospitals are able to describe in detail how they are transforming their workforce to achieve the Triple Aim.
- Hospitals and health systems have multiple partnerships in place that enable students to experience a variety of learning modules, including community-based clinical placements, to enable them to expand their training across the continuum in the variety of locations where they may practice.
- Hospitals and health systems are able to respond to patient needs with teams of providers who leverage technology and their combined skill sets to provide a seamless patient experience across the care continuum.

Now, imagine what might happen in five years if this value-based model is not in place:

- Shortages due to an aging workforce and specialty and geographic maldistribution of providers will increase, making it harder for patients to access care when they need it.
- There will be an increase in dissatisfaction with care due to inability to access providers, which could lead to a sicker population.
- The aging population and those with chronic diseases, who will need more care coordination and support, will be unable to access care when they need it, thereby putting an even greater financial burden on the health care system and, in turn, hospitals and health care systems.

Where to Begin

Step 1: Assess your current workforce and patient population to establish what kind of care you should be delivering. Use tools such as the AHA/ASHHRA/AONE Developing an *Effective Workforce Planning Model* assessment found here: www.aha.org/workforce and Association for Community Health Improvement Community Health Assessment found here: <http://www.assesstoolkit.org/>.

Step 2: Ensure your workforce is knowledgeable about the challenges facing your community in order to effectively engage patients and their families. Building a workforce around the population being served will improve patient and family engagement, as well as the quality of care and outcomes. Additionally, this type of care motivates patients to actively participate in their health and well-being, such as adopting healthy habits and behaviors.

Step 3: Require interprofessional education and team-based care for your current and future workforce. Whether through programs such as TeamSTEPPS or academic/practice partnerships, the skills and competencies gained have been linked to improved patient safety and reduced medical errors.

Step 4: Begin engaging with higher education programs to establish partnerships in a variety of health care settings and within the community so students can learn in an environment where care coordination is practiced.

Step 5: Meet with leaders from health and business IT to discuss ways to analyze and leverage data collected by the EHR to not only learn more about each patient, but about a population. Using data analytics can transform the delivery of care.

Step 6: Educate clinicians on all aspects of managing care transitions across the continuum. Care coordination needs to be consistent and valued by all team members in order to enhance safety and decrease patient risk.

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