Transforming the Workforce for a New Delivery System

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Emerging Models of Care

- New York State Health Home
- Accountable Care Organizations
- Delivery System Reform Incentive Payment (DSRIP) Program
- Level 3 Patient Centered Medical Home
- Managed Long Term Care
A “virtual network” of agencies providing coordinated care to individuals with complex needs.
Key themes for care givers?

- Shift in focus to primary and preventive care
- Effective management of chronic diseases
- Emphasis on care coordination and care transitions
- Team based care
- Payment reform, e.g., incentives for keeping people healthy and penalties for inappropriate hospital readmissions
• **Core Competencies Categories:**
  - Communication and Team Skills
  - Knowledge of Chronic Diseases
  - Patient Care Access
  - Electronic Medical Records and Computer Skills
  - Patient Care Follow-Up
  - Resource Support
  - Ethics and Confidentiality
  - Home Visits (if applicable)
Core Competencies Training

- **Chronic Disease Management - Wellness**
  - Understand the basics of common diseases, including common diagnostic tests and treatments
  - Self-care measures patients can use
  - Characteristics of common mental illness
  - Characteristics of substance abuse
  - Wellness as it relates to chronic disease; nutrition, obesity, smoking, exercise
Sample Key Care Team Roles

The Care Manager has overall day-to-day responsibility for:

- Coordinating the activities of the Care Team
- Facilitates access to medical and social services
- Coordinates/writes with input Care Plan
- Identifies and removes barriers to care
- Utilizing resources efficiently and effectively to enable patients to access needed services and avoid unnecessary use of inpatient and ER services

The Care Navigator ensures successful implementation of the care coordination activities through:

- Communication and collaboration with the Care Manager
- Utilization of health IT tools to monitor and track patient health information to accomplish care coordination
- Monitoring alerts regarding patient hospitalizations to ensure timely communication to select clinical staff and appropriate follow-up
- Monitoring and sharing information with other care team members throughout care transitions
- Monitoring that patients have follow-up appointments after a medical or psychiatric discharge as needed
Findings – Coordination Roles
Survey of Health Centers

73% of practices reported staffing at least one dedicated coordination role

- Care Coordinator
- Care Manager
- Case Manager
- Community Health Worker
- Patient Navigator

Positions have overlapping responsibilities, including:

- Pre-visit planning and participation in team meetings and huddles
- Self-management and patient education activities
- Conducting population health management activities and coordinating care transitions

Source: Emerging Positions in Primary Care: Survey Results, Greater New York Hospital Association
Survey Findings – Hiring Requirements for Coordination Positions

Source: Emerging Positions in Primary Care: Survey Results, Greater New York Hospital Association
EMERGING JOBS

- RN Care Manager
- Care Manager
- Peer Navigator
- Certified Chronic Disease Educator
- Advanced Home Health Aide
- Peer Support Worker
- Community Health Worker
- Behavioral Health Specialist
Common Skills & Competencies

- Advance Home Health Aide
- Patient/Care Navigator
- Community Health Worker
- Peer Provider

Skills/Competencies
RECRUITMENT CHALLENGES AND TRAINING NEEDS

Source: *Emerging Positions in Primary Care: Survey Results*, Greater New York Hospital Association

**Recruitment Challenges:**
- Relevant work experience
- Related job skills
- Bilingual candidates

**Training Needs:**
- Team-based care
- Care coordination
- Patient communication
Training and Education

- New skills for existing workers
- Redeployment/mobility/career pathways
- New Workers & New Jobs
Training Capacity

Evaluate Coordinate

Abundant Training Exists
- Community Health Workers
- Communication, Active Listening
- Care Coordination
- Medical Assistant

Build

Capacity Needed – Curricula Exists
- Nurse Practitioner
- Certified Asthma and Diabetes Educators
- Behavioral Health
- Advanced Home Health
- Community-based Care Management

Create

New Curricula Needed?
- Not Yet Clear
QUESTIONS

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Appendix

Additional:

Core Competencies ➔ Training
Available at:
Communication

- Principles of care coordination
- Effective verbal and non verbal skills
- Elements of effective patient relationship
- Motivational interviewing
- Potential roadblocks to communication
- Characteristics of effective communication with collaborators and other professionals
- What it means to be part of a health team
- How personal bias and culture can impact the way people interpret illness; including identifying your own bias
- Effective interviewing skills to better understand patient's behavior and belief system
- Culturally competent questions to understand beliefs
Core Competencies Training

- **Patient Care Access**
  - Strategies for scheduling timely appointments
  - How different centers schedule patients
  - Barriers patients face when accessing care
  - Differences between patient services in hospitals, outpatient and other settings
  - Barriers that patients face transitioning between a hospital setting and outpatient, clinic or community setting
  - Ways to help patients transition between settings
  - Transition to Care: Steps involved when a patient is referred to a specialty provider
  - Basics of Medicaid, Medicare, insurance systems
  - Obtaining authorization for service
• **Resource Support**
  
  - Effective skills/strategies for working with community agencies, team, etc.
  - Ways to find appropriate resources and match them to patient needs
  - Identify characteristics of credible and non-credible sources of information
  - Access resources for uninsured
  - Social support and the form it might take, including housing
  - Ways to help enhance patient's support network
  - Assess a patient's support system and identify/review areas where support is needed