Who's Going to Care?

Analysis and Recommendations for Building New York's Care Coordination and Care Management Workforce

By **Karla Silverman, MS, RN, CNM • Helen Schaub • Dan Lowenstein, MBA**

July 2015

Table of Contents

Acknowledgements

The authors wish to thank the 49 Health Home organizations that participated in the survey that was the basis for this publication; 1199SEIU Healthcare Workers East (1199SEIU) and the Primary Care Development Corporation (PCDC) leadership; Sandi Vito from the 1199SEIU Training and Upgrading Fund and Annabelle Heckler from 1199SEIU United Healthcare Workers East for key input; expert reviewers Jean Moore from the Center for Workforce Studies and Joslyn Levy from Joslyn Levy Associates; Therese Wetterman from PCDC, Robert Feferman from Housing Works and Elizabeth Lagone from NYC Health and Hospitals Corporation for their assistance with survey design and review; and Steven Hefter and Alex Wueger from PCDC for proofreading assistance.

About the Authors

Karla Silverman, MS, RN, CNM is PCDC's Director of Clinical and Training Initiatives. She directs healthcare workforce initiatives and leads programs that support the delivery of high quality care coordination and care management services.

Helen Schaub is Director of Policy and Legislation at 1199SEIU United Healthcare Workers East, where she oversees all New York State policy and legislative initiatives for the nation's largest local union.

Dan Lowenstein, MBA is PCDC's Senior Director of Public Affairs. He directs communications, public policy and advocacy initiatives to expand access to primary care in underserved communities.

1199SEIU Healthcare Workers East (1199SEIU)

1199SEIU United Healthcare Workers East is the largest union in New York and the largest healthcare union in the nation, representing over 300,000 members throughout New York State. The union's mission is to achieve quality care and good jobs for all.

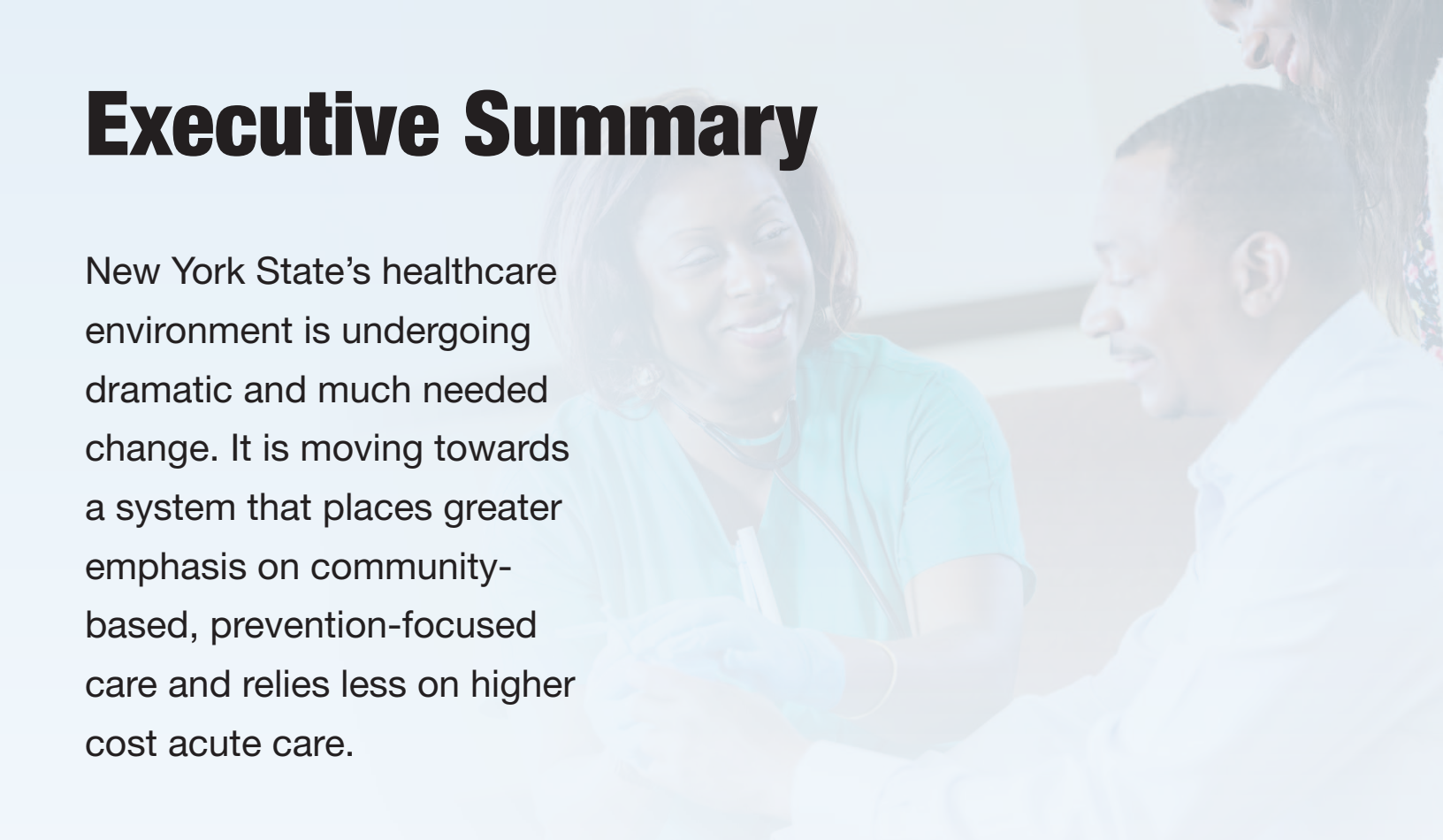
Primary Care Development Corporation (PCDC)

PCDC is a nationally recognized nonprofit whose mission is to expand access to primary care in underserved communities. PCDC achieves this mission by providing affordable capital financing to build and expand primary care infrastructure, expert technical assistance to help transform the primary care model and public advocacy to support policies that sustain and expand primary care.

July 2015

Cover photo by Jim Tynan • Designed by Bencom

Executive Summary



New York State's healthcare environment is undergoing dramatic and much needed change. It is moving towards a system that places greater emphasis on community-based, prevention-focused care and relies less on higher cost acute care.

A successful transition to this new system is highly dependent on a skilled workforce. New models of care require nonclinical and paraprofessional staff to assume greater levels of responsibility as they are called upon to work in multidisciplinary teams, conduct outreach to patients in the community and participate in the management of patient and population health.

Workforce development will be critical to healthcare transformation, yet today's workforce is largely unprepared for these changes. Indeed, New York's experiment in shifting care for elderly residents from nursing homes to a largely underpaid home care workforce offers painful and expensive lessons as the larger and more complex healthcare system embarks on a similar shift.

New York State's Health Home program can provide important insights on the steps needed to create and support a skilled care coordination and care management workforce for the healthcare system as a whole. Health Homes manage care of Medicaid enrollees with costly and complex chronic conditions that drive a high volume of inpatient episodes. The effectiveness of the Health Home workforce is thus a critical factor in the program's success or failure. The workforce lessons learned through Health Homes and other programs involving high levels of care management will be particularly relevant as New York State launches its five-year Delivery System Reform Incentive Payment Program (DSRIP), which has a goal of reducing avoidable hospitalizations by 25% in large part by building community-based healthcare capacity. Over $400 million will be available for workforce development under DSRIP.

To better understand provider challenges and expectations for the care coordination and care management workforce, 1199SEIU Healthcare Workers East (1199SEIU) and the Primary Care Development Corporation (PCDC) surveyed New York State Health Home providers about workforce roles and jobs, including education and skills requirements, salary range and training needs. Based on analysis of survey results and additional research in the field, 1199SEIU and PCDC developed recommendations for policymakers and healthcare organizations.

TURN THE PAGE FOR KEY SURVEY FINDINGS...

Key Survey Findings

1 A diverse and broad set of skills and competencies are needed by the care coordination and care management workforce.

Presented with 22 diverse skills and competencies, the vast majority of respondents were generally in agreement about what was needed to be effective in care coordination and care management roles. Basic knowledge of clinical conditions, advanced organizational and interpersonal skills and familiarity with many tasks that are typically in the nursing and social work domains are required in Health Home care coordination and care management roles.

---

2 Ongoing training and supervision are needed for staff who will provide care coordination and care management.

Despite the fact that skills such as patient-centered care and knowledge of chronic conditions were required of care managers by over 90% of the organizations surveyed, less than 60% provided training in these critical areas. In addition, fewer than half offered training in health coaching, working in a team, housing placement, stress management or running and reading reports – all skills that many organizations considered crucial to care coordination and care management roles.

---

3 Recruitment and retention challenges are prevalent, driven by insufficient salaries, high caseload and lack of appropriate skills and competencies.

A significant majority of organizations responding reported recruitment challenges (88%) and retention challenges (78%). More than half reported insufficient salary as a barrier to recruitment and retention, while large caseloads and insufficient skills and qualifications were also major factors. Half reported insufficient qualifications as a key recruitment challenge, and large caseloads and insufficient salary as key staff retention barriers. Salaries reported by organizations surveyed, the majority of which are community-based, are on average 27% - 50% lower than those for similar Health Home titles in the hospital workforce.

---

4 Job titles for those providing care coordination and care management are still evolving.

While 72% used the title "care manager" for the job of managing and coordinating patient care, there was no consensus about job titles for supervisory staff or those providing patient outreach and engagement. Without standard definitions, it may be difficult to bring needed training programs to scale or ramp up the care coordination and care management workforce.

SEE RECOMMENDATIONS ON NEXT PAGE...

Summary of Recommendations

1199SEIU and PCDC are proposing the following recommendations for policymakers and healthcare organizations seeking to build a strong and effective care coordination and care management workforce.

1 Collect data about the care coordination and care management workforce.

2 Require all payers to support care coordination and care management.

3 Ensure sufficient wages and benefits for care coordination and care management staff.

- Set a wage floor for care and care management workers;
- Ensure sufficient payment to meet compensation standards; and
- Ensure health plans are incentivized to invest in the community-based sector and community-based providers are incentivized to invest in their frontline staff.

4 Provide ongoing support for the development of the care coordination and care management workforce.

- Develop industry standards and certification programs;
- Fund education and training initiatives that leverage economies of scale;
- Establish care coordination and care management career ladders; and
- Provide clinical supervision and support for unlicensed care coordination and care management staff.

Conclusion

The success of New York State's healthcare transformation initiatives is heavily reliant on a workforce with the skills and competencies necessary to undertake the myriad complex tasks of coordinating patient care. There must be sufficient compensation, training and career ladders to build and sustain a skilled workforce for these positions of considerable responsibility. Failing to do so puts the entire healthcare transformation enterprise at risk.

Introduction

Driven largely by the unsustainability of healthcare costs and poor outcomes delivered for those expenditures, New York's healthcare system is undergoing a significant shift from one focused primarily on inpatient, acute care to one centered on preventive, community-based healthcare that incorporates mental health and social service provision.[1]

This change is causing a major shift in the workforce needs of healthcare organizations. Care coordination and care management jobs, in which staff working in communities help connect patients with services and coordinate their care, are growing in number. [2]

Through the Delivery System Reform Incentive Payment Program (DSRIP)[3] and healthcare delivery and payment transformation at the federal level and in the commercial sector, healthcare workforce changes in New York State are expected to accelerate over the next five years. However, the successful transition to a lower cost, higher quality community-based healthcare delivery system faces a number of major challenges. One of the most pressing challenges is the development of a sufficiently skilled care coordination and care management workforce.

The Need for a Skilled Care Coordination and Care Management Workforce[4]

In healthcare models such as the Patient-Centered Medical Home, New York State's Health Home program, Accountable Care Organizations (ACOs) and DSRIP, the correct medical diagnosis and a solid treatment plan are only part of the solution to improving patients' health.

---

[1] Joslyn Levy Associates. Care Management in New York State Health Homes. New York: NYS Health Foundation, 2014.

[2] College for America Workforce Strategy Report. Rise of the Medical Assistant and Five other Frontline and Nonclinical Healthcare Jobs that are Growing in Number, Complexity, and Importance. New Hampshire: Random, 2013.

[3] DSRIP is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP´s purpose is to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to $6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/.

[4] In the literature and in the field, the terms "care management" and "care coordination" are often used interchangeably. In this report we use the term "care management" to mean activities that are tailored to patients at highest risk for adverse, preventable outcomes and go beyond medical issues to address any psycho-social issues that may affect a patient's ability to engage in and access care. In contrast, "care coordination" is defined as ensuring that care is seamless across providers and transitions and care coordination activities are "systems-focused." Many experts believe that coordinating care is one of the key roles of staff who provide or support care management, but it is not the only service they must provide.

A team-based approach where care coordination is provided for all patients, and care management is provided for high-need, high-cost patients, is now being adopted as a way to lower costs and improve patient outcomes and engagement.[5]

These are new practice models for most healthcare organizations. In order to be successful, organizations have to shift their focus to meet the patient satisfaction and clinical outcome goals that will increasingly determine how much an organization gets paid, replacing traditional volume-based fee-for-service. They must examine their day-to-day operations and create new workflows. They must identify what new tasks need to be carried out, if their staff have the skills to perform these tasks and if there is an organizational understanding about how new roles fit together to provide coordinated, patient-centered care.

> "There is a need for a very specific type of individual for this role (i.e. extremely organized, able to roll with change, comfortable in the field, able to manage large caseloads, professional, eager) and it's difficult to find individuals possessing these skills."
>
> COMMENT FROM RESPONDENT

Training a care coordination and care management workforce with the skills and competencies they need means teaching skills and creating roles that are quite different from what was expected previously. Among other tasks, those providing care coordination and care management need to be able to:

- **reach out to and engage patients;**
- **provide comprehensive assessments of patients' needs;**
- **link patients to resources;**
- **coordinate care;**
- **lead care planning;**
- **provide health coaching; and**
- **respond quickly and effectively to changes in patients' conditions to keep patients from using unnecessary services.**[6]

To be effective in their roles these frontline staff also have to be able to work well in multi-disciplinary teams and build trusting relationships with patients, their families, primary care providers and specialists.

Lastly, cultural competency is critical for patient engagement and a key skill for care coordination and care management staff. Care coordinators and care managers need to build trust and address the barriers their patients face in accessing and engaging in care in order to be successful. Ideally the care coordination and care management workforce of the future is drawn from the same communities in which patients live. Regardless of their backgrounds, all healthcare staff require training in how to provide culturally and linguistically appropriate services "that are respectful of and responsive to the health beliefs, practices and needs of diverse populations."[7] When frontline staff understand the needs of the communities in which they are working, they become a "bridge between patients and providers" and create stronger ties between patients and a healthcare system that can often seem intimidating and foreign.

---

[5] Hong, C.S., Siegel, A.L., & Ferris, T.G. "Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?" Commonwealth Fund. (2014): 2.

[6] Ibid.

[7] U.S. Department of Health and Human Services Office of Minority Health. Accessed June 9, 2015. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Care coordination and care management skills are sophisticated and not quickly learned. They result from a combination of didactic learning, shadowing and apprenticing, experience in the field and willingness to adapt and grow.[8] Being successful working in inter-disciplinary teams and building trusting relationships with patients also demands a level of self-awareness and a proficiency in communication that can be challenging for even the most experienced healthcare professional.

> "We have challenges in training new staff given the wide range of chronic illnesses across a caseload."
>
> COMMENT FROM RESPONDENT

Attention to workforce development is desperately needed. "While much attention and energy is focusing on practice redesign, relatively little has been devoted to ensuring that workers are trained to adapt to new systems and deliver patient care in a more coordinated, team-based fashion."[9] Healthcare education – especially for frontline and unlicensed workers – is woefully behind in meeting the needs of this rapidly shifting healthcare delivery system. Healthcare workers are limited by the predominant educational model that trains the different healthcare and social service professions in silos with a minimal focus on team-based care.[10] Sector-based training and education are essential to the success of the new care coordination and care management workforce.

If staff do not have the skills to perform well in these new care models, the models themselves are put at risk of failure. We may then conclude that the models were wrong or ineffective when in fact inadequate resources and attention were given to developing the workforce needed to implement them effectively.

---

[8] Ibid, 2.

[9] Ross, M. Svajlenka, N.P., Williams, J. Part of the Solution: Pre-Baccalaureate Healthcare Workers in a Time of Health System Change. Metropolitan Policy Program at Brookings. (2014),17.

[10] Ibid.

Home Health Aides: A Cautionary Tale

To carry out these enormous responsibilities, care coordination and care management staff need jobs with dignity, fair wages, training and educational opportunities and access to career ladders that fully recognize their importance to patients, healthcare organizations and those who pay for care.

With hospitals among the top ten largest private sector employers in every region of the State, it is important to ensure that wage, benefit and training standards are not undermined as some of these jobs are shifted to the ambulatory setting. But this goal cannot be met without a clearly thought out strategy driven by multiple stakeholders across a variety of fields including hospitals, primary care providers, community-based providers, government, labor unions, funders and educational and training entities.

New York's experience transitioning care for the elderly and people with disabilities from institutions to home care services should serve as a cautionary lesson as similar changes are sought in the broader healthcare system. The home care industry relied heavily on minimally skilled workers making minimum wage (or worse) and did not effectively integrate them into the overall care of patients. The result was predictable: burgeoning costs and hundreds of thousands of clients receiving lower-quality care than they should have because of a high-turnover, poorly-trained and poorly integrated workforce. Home health aides, from the very communities already struggling with poverty and other drivers of disparate healthcare outcomes, were unable to support their families.[11]

New York cannot afford to make the same mistakes as we build the new coordinated care sector. In particular, without effective policies in place, we cannot assume that upfront investments will be made to prepare frontline healthcare workers to participate fully in these new care models, nor that their value in improving health and reducing costs will be reflected in their compensation.

Through DSRIP over $400 million will be available for training and retraining the healthcare workforce. This presents a remarkable opportunity for New York State to minimize disruption for the existing healthcare workforce as it transitions to new settings and to provide meaningful careers for low wage, underemployed or unemployed individuals in low income communities, all while improving the quality of care for the highest need patients.

[11] "Paying the Price: How Poverty Wages Undermine Home Care in America". PHI (Paraprofessional Healthcare Institute). Accessed May 29, 2015. http://phinational.org/sites/phinational.org/files/research-report/paying-the-price.pdf.

Payment Reform: From Volume to Value

How healthcare organizations are paid for care coordination and care management services will directly impact their effectiveness. A national movement is underway to move healthcare financing from volume-based fee-for-service payment that defines much of healthcare today to models that value better health outcomes, patient satisfaction and cost savings.

Under DSRIP, 90% of all Medicaid payments are expected to be in Value-Based Payment (VBP) arrangements within five years.[12] The U.S. Department of Health and Human Services has likewise set a goal of tying 90% of Medicare payments to quality or value by 2018. The commercial market is also moving rapidly toward value-oriented payments.

Because care coordination and care management services can have a major impact on reducing the need for higher cost, higher intensity care, spending on these services should increase. Indeed, there has been a greater emphasis on paying for care coordination and care management. The New York State Health Home program pays a flat per member per month (PMPM) fee of $135 for outreach to patients and an additional acuity adjusted PMPM fee for coordination services.[13] Starting January 2015, the Center for Medicare and Medicaid Services (CMS) began paying physicians $42 PMPM to coordinate care for Medicare patients with two or more chronic conditions. CMS is also developing new ways for Medicaid to pay primary care providers that would include support for care coordination and care management. Likewise, private health insurance plans are beginning to support these services, though there is wide variation in both adoption and level of support.

---

[12] Accessed 6/11/15. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_vbp_webinar_slides.pdf.

[13] DOH Health Home Billing Practices, Effective July 1 2015. Accessed June 9, 2015.http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_billing_practices.htm. See also http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_hml.pdf, page 5.

Understanding the Care Coordination and Care Management Workforce:

Analysis and Recommendations from a Survey of Health Homes

Nowhere is the need for care management and care coordination more apparent than in Health Homes, which serve patients in New York State's Medicaid Program with the most complex chronic conditions that are often related to behavioral or social problems and drive a high volume of costly inpatient episodes.

The vision behind New York State's Health Home program is a healthcare delivery system that is integrated and coordinated across the disciplines of physical healthcare, mental health, chemical dependency treatment and social services provision. Though the level of service intensity will vary depending on patient acuity, the Health Home workforce model and its challenges are instructive to DSRIP as both rely on greater levels of care coordination and care management services to meet their cost and quality goals.

To better understand provider challenges and expectations for the care coordination workforce, 1199SEIU and PCDC conducted an anonymous survey of Health Home providers primarily from New York City and Downstate (NYC boroughs, Nassau, Suffolk, Westchester and Rockland counties). The survey was sent to 213 health homes (19 Health Home leads and 194 downstream providers) and received 49 valid responses (10 leads, 35 downstream and four that were both leads and downstream providers in another Health Home). The results are statistically significant at the 90% confidence interval with a margin of error of plus or minus 11%.

The survey asked questions related to workforce roles and job titles, education and skills requirements, salary range, training needs and caseload for staff that provide and supervise Health Home care coordination and care management services. Based on analysis of survey results and additional research in the field, 1199SEIU and PCDC developed recommendations for policymakers and healthcare organizations.

KEY SURVEY FINDINGS BEGIN ON NEXT PAGE...

The following terms for Health Home workers were defined in the survey:

Patient Outreach and Engagement
Responsible for outreach to patients, enrolling them into the program and re-engaging patients when they become lost to care. These staff may also assist care managers with coordinating care for patients, including conducting reminder calls about upcoming appointments and arranging transportation. Common job titles include outreach worker, patient navigator and care navigator.

Care Management
Lead care management activities for a panel of patients. These staff coordinate services for their patients and conduct activities such as coordinating with patients' providers, conducting needs assessments, developing patient focused care plans, providing health education and managing staff assigned to assist them with these tasks. Common job titles include care manager, case manager and care coordinator.

Supervisory
Responsible for the overall administration of care management teams at a particular site. These staff provide clinical supervision to care management staff, conduct staff training, monitor and report quality metrics to the organization, ensure that policies and procedures are being followed and may assist with the coordination of client services as needed. Common job titles include site director, site supervisor and care coordinator.

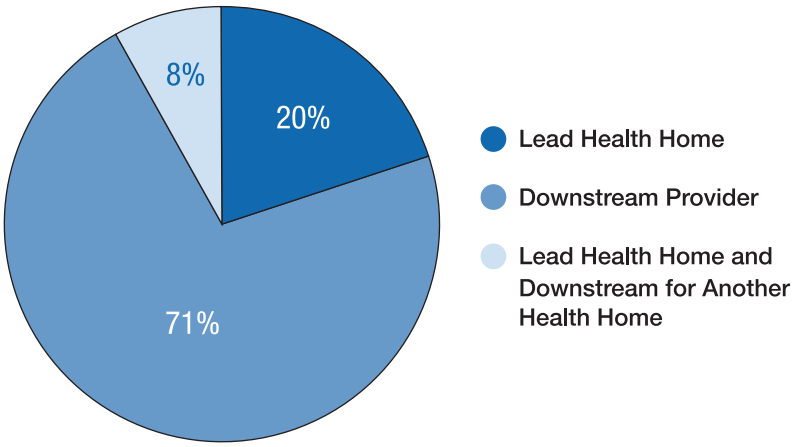
Key Survey Findings

Findings from the survey were generally in line with other research on the care coordination and care management workforce. For instance, recent analyses by the Center for Health Workforce Studies found similar challenges around recruitment and retention, defining roles and responsibilities for various job titles and skills and competency training.[14]
(All numbers rounded to nearest percent. See Appendix 2 for values.)

PROFILE OF RESPONDENTS

Health Home Status

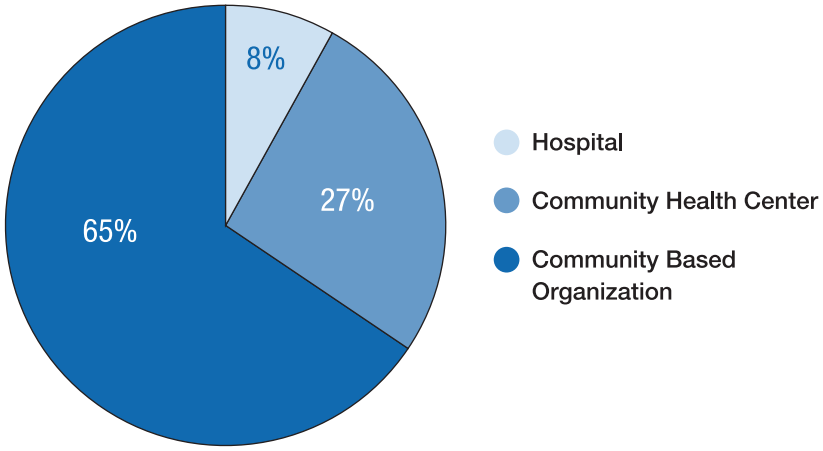
Of note, nearly 71% of survey respondents were from downstream provider organizations-meaning organizations that are contracted by lead Health Homes to provide care management services for patients.



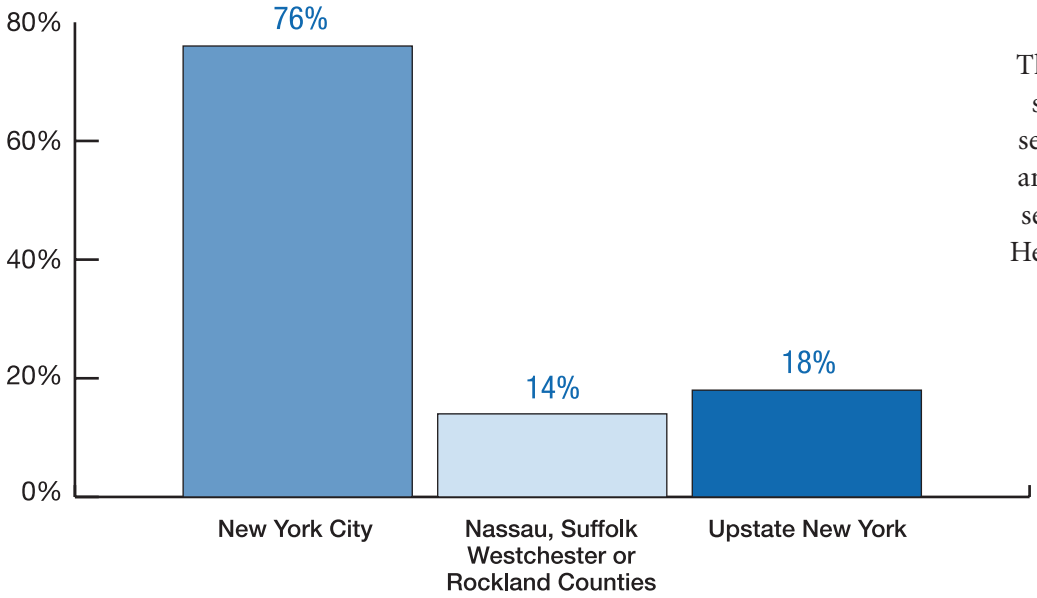
[14] "Care Coordination Case Study Preliminary Findings." Center for Health Workforce Studies. Accessed May 29, 2015. http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf. The "Health Care Workforce in New York: Trends in the Supply and Demand for Health Workers". Center for Health Workforce Studies. Accessed May 29, 2015. http://chws.albany.edu/archive/uploads/2014/08/nytracking2014.pdf.

Type of Organization

65% of respondents were from community-based organizations and 27% were from community health centers. Only 8% of respondents were from hospitals. This survey, unlike other recent examinations of the frontline care coordination workforce that focused on the changing hospital workforce,[15] primarily reflects the needs and activities of community-based Health Home providers including Federally Qualified Health Centers and community-based social service organizations.



Geographic Service Area

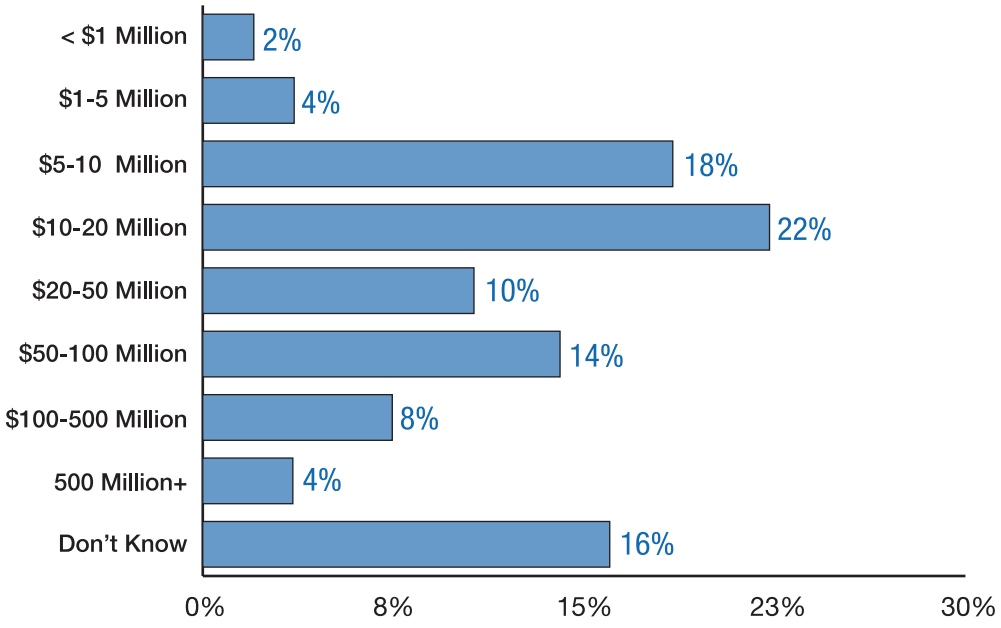


The majority (76%) of respondents served New York City, while 14% served Nassau, Suffolk, Westchester and/or Rockland counties and 18% served upstate communities. Some Health Homes served multiple areas.

[15] "Emerging Positions in Primary Care: Results from the 2014 Ambulatory Care Workforce Survey". Greater New York Hospital Association. Accessed April 19, 2015. http://www.gnyha.org/PressRoom/Publication/c5dbde90-559e-4ef8-adbd-4b9567143f24/.

Annual Organizational Budget

There was a diverse range of organization size as measured by annual budget with the plurality in the $10-$20 million range. Of note, 16% of respondents were not aware of their organization's budget, which may impact accuracy related to organization size.

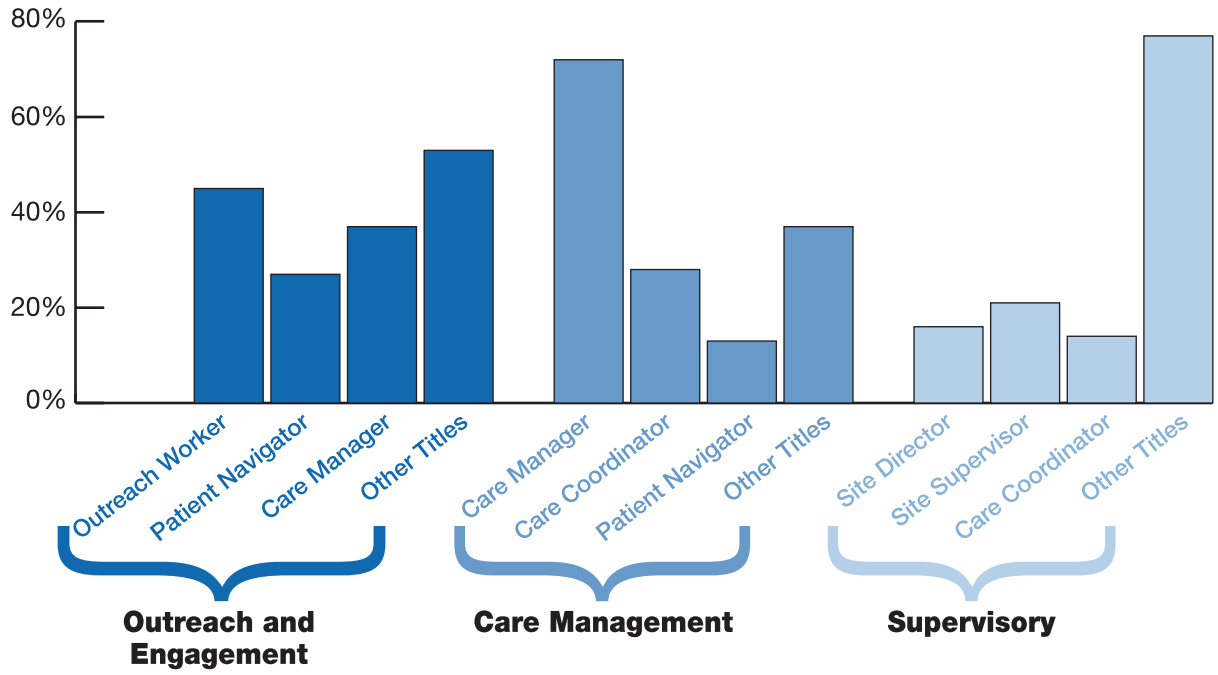


Job Titles

There was no clear consensus about job titles for **staff providing patient outreach and engagement** in New York Health Homes. The most common titles for those were **outreach worker** (45%), **care manager** (37%), and **patient navigator** (27%).

There was no clear consensus for the title most commonly used for **care management supervisory staff**. Titles such as **site director** (16%), **site supervisor** (21%) and **care coordinator** (14%) were listed most frequently for these positions. Other titles used include Director, Care Coordination Supervisor, Director of Care Management, Director of Care Coordination, and Client Services Manager. *(See next page.)*

There was more general agreement about the title for **staff providing care management**, with the majority of respondents indicating they used the term **care manager** (72%). Some organizations listed care coordinators and patient navigators as staff who also provide care management either instead of, or in addition to, care managers. Of note, care manager was not typically indicated as a "management" role as it is sometimes used in healthcare organizations. Instead, these workers manage the care of patients as indicated by the tasks reported.



Other Job Titles Used

Outreach and Engagement

Care Coordinator (5)
Care Navigator (5)
Care Technician
Case Manager
Certified Medical Assistant
Community Educator
Community Health Navigator
Community Health Worker
Community Searcher
Director of Community Outreach
Director of Registration Services
Director of Shelter Outreach
Health Navigator
Health Priorities Specialist
Intake Care Manager
Intake Case Manager
Intake Coordinator (2)
Marketing Rep
Mental Health Counselor
Housing Case Managers
Outreach and Engagement Specialist
Outreach and Recruitment Specialist
Outreach Coordinator
Outreach Specialist
Peer Health Coach
Peer Navigator
Program Manager
RN
Searchers
Senior Health Navigator
Senior Outreach and Engagement Specialist
Social Worker

Care Management

Care Coordinator
Care Management Team Leader
Care Navigator (4)
Case Manager (2)
Caseworker
Community Health Navigator
Disease Case Manager
Health Educator
Health Home Coordinator
Health Home Team Leader
Health Navigator
Intensive Case Manager
Peer Health Coach (Not staff)
Peer Navigator
Senior Care Coordinator
Senior Care Manager (2)
Senior Health Navigator
Wellness Counselor

Supervisory

Assistant Director
Care Coordination Supervisor
Care Management Coordinator
Care Management Team Leader
Care Manager (2)
Care Manager Supervisor, Clinical Supervisor
Chief Medical Officer
Client Services Manager
Clinical Director
Clinical Manager
Clinical Projects Manager
Clinical Supervisor
Director (5)
Director Care Coordination
Director of Care Coordination
Director of Care Management (2)
Director of Health Information Management and Quality Improvement
Director of Operations
Director of Support Services
Health Home Assistant Director
Health Home Care Management Supervisor
Health Home Director of Care Coordination
Health Home Program Manager
Manager
Program Coordinator
Program Manager (4)
Program Supervisor
QA Director
Regional Deputy Director
Senior Care Manager
Systems Manager
Team Lead
Team Leader
Unit Supervisor (2)
Working Supervisor

Minimum Educational Requirements

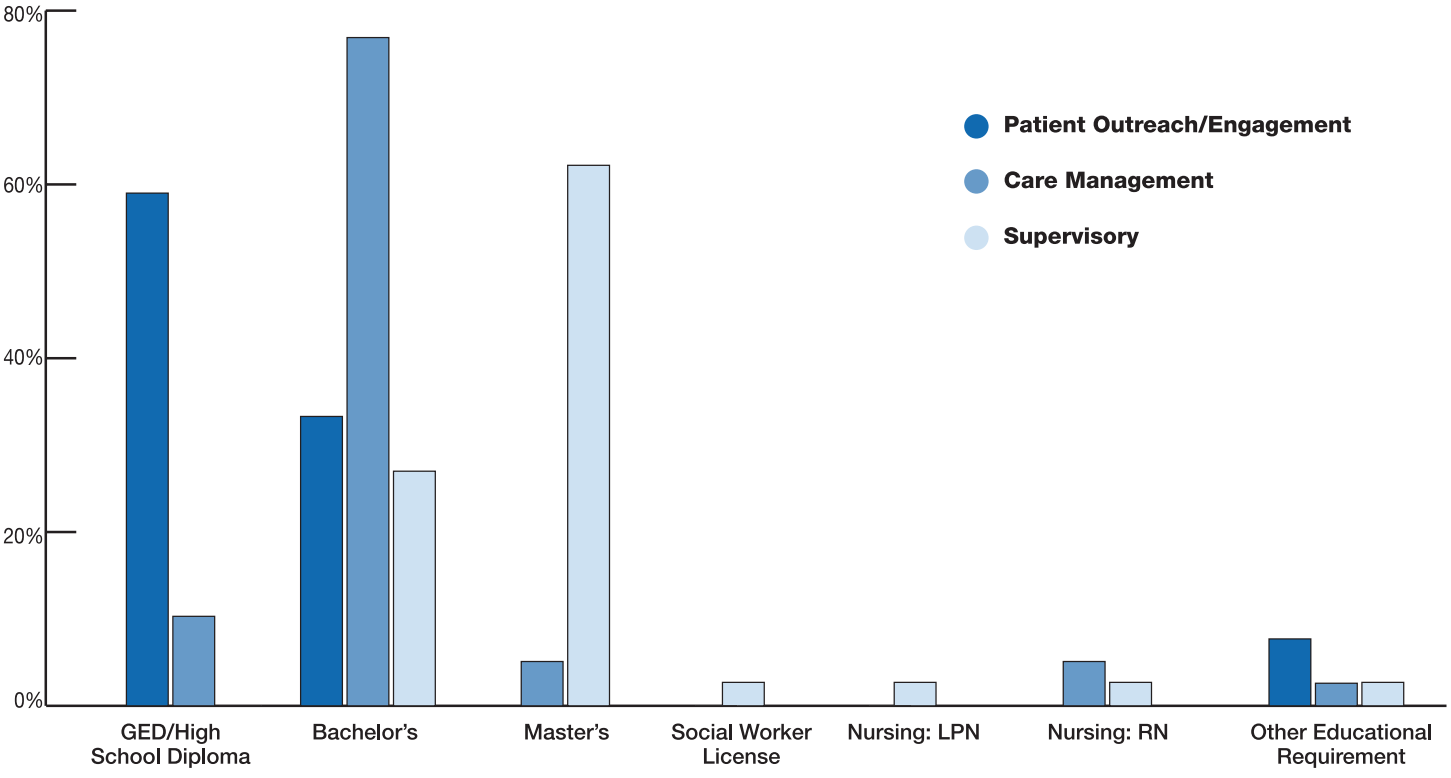
Most organizations required:

- High School diplomas or General Equivalency Diplomas (GED) for patient outreach and engagement staff, though one-third required a bachelor's degree.

- Bachelor's degrees for care management staff, although 10% of respondents said that staff that fill their care manager roles only need a GED or High School diploma. This was in contrast to results from a recent survey of the hospital-based care coordination workforce, which found most care manager roles are filled by RNs or social workers.[16]

- Master's degrees for supervisory staff (62%), although 27% of the organizations surveyed reported only requiring a bachelor's degree for these roles.

While not indicated in the survey results, follow up interviews confirmed that for organizations requiring site supervisors to have a master's degree, the most common type was a master's degree in social work. Other educational credentials that Health Homes reported as being acceptable were master's degrees in human services, for example counseling, mental health counseling, public health and public administration.

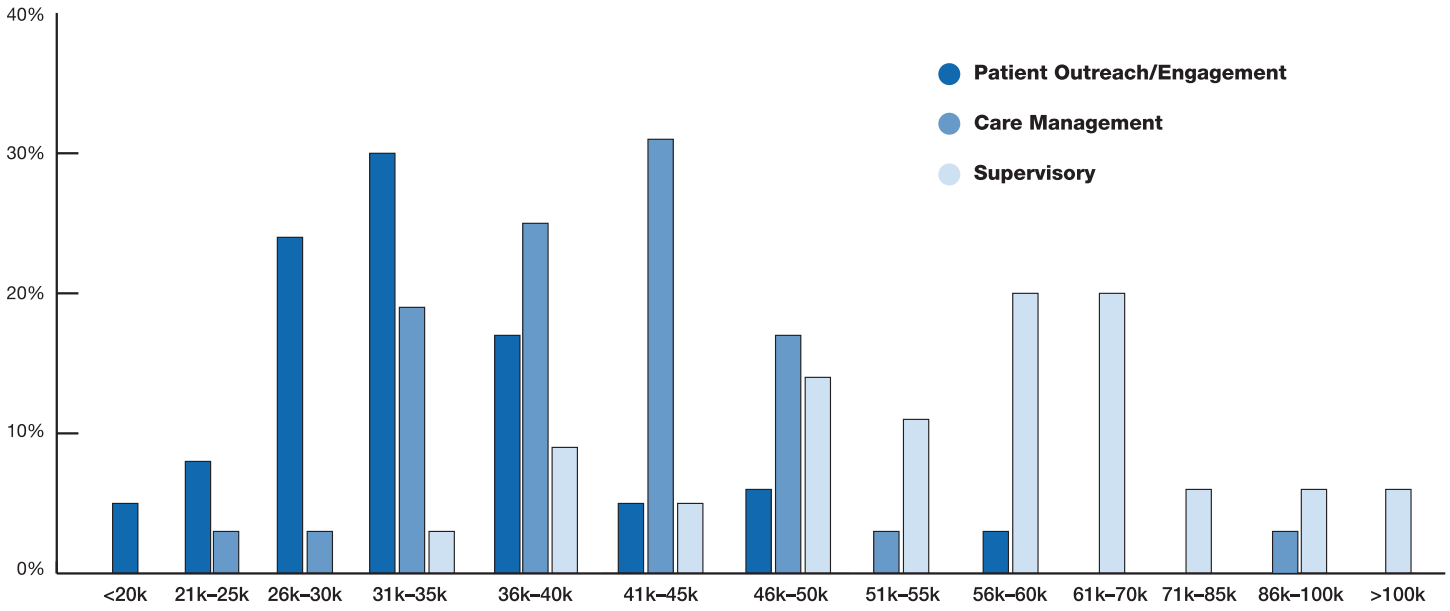


[16] "Emerging Positions in Primary Care: Results from the 2014 Ambulatory Care Workforce Survey." Greater New York Hospital Association. 2015. 9.

Annual Average Salary for Care Coordination Staff

While there was a broad salary range for each of the job categories, the majority of organizations responding reported that:

- **Patient Outreach and Engagement staff** earn between $26,000 and $40,000 annually, with the $31,000 – $35,000 range the most frequently reported. For comparison, health home employees with patient outreach and engagement titles represented by 1199SEIU, many of whom are based in hospitals, have a range of $33,000 – $53,000 per year, with an average of $42,000.[17]
- **Care Management staff** earn between $31,000 and $50,000, with the $41,000-$45,000 range the most frequently reported. In comparison, health home Care Managers represented by 1199SEIU earn between $41,000 and $83,000, with an average of $65,000,[18] which is consistent with other findings.[19]
- **Supervisory staff** earn between $46,000 and $70,000, with the $56,000-$70,000 range the most frequently reported.



Employment Status

- 95% of staff reported by respondents were employed full time with benefits
- 87% of respondents employed 95%-100% of Patient Engagement/Outreach Workers full time with benefits
- 8% employed between 40%-80% of Patient Engagement/Outreach workers full time with benefits and also employed workers part time or hourly (with and without benefits)
- 6% only employed Patient Engagement/Outreach Workers part time or hourly (with and without benefits)

---

[17] Employer Data Reported to League of Voluntary Hospitals and 1199SEIU.

[18] Ibid.

[19] Ebenstein, W. Ph. D. and Dale, T. M.S. "Emerging Career Pathways in the New York City Healthcare Workforce: Changes in the Nursing Career Ladder." The City University of New York. (June 2013):9 Accessed June 9, 2015.http://nyachnyc.org/wp-content/uploads/2014/10/Emerging-Career-Pathways-Nursing-Career-Ladder-June-2013.pdf.

Required Job Tasks and Roles

Outreach and Engagement staff

In addition to outreach to patients, 84% of responding organizations require these staff to *enroll patients in the Health Home*, 66% said they *conduct reminder phone calls*, and more than 40% said they *follow up with patients and arrange transportation for patients.*

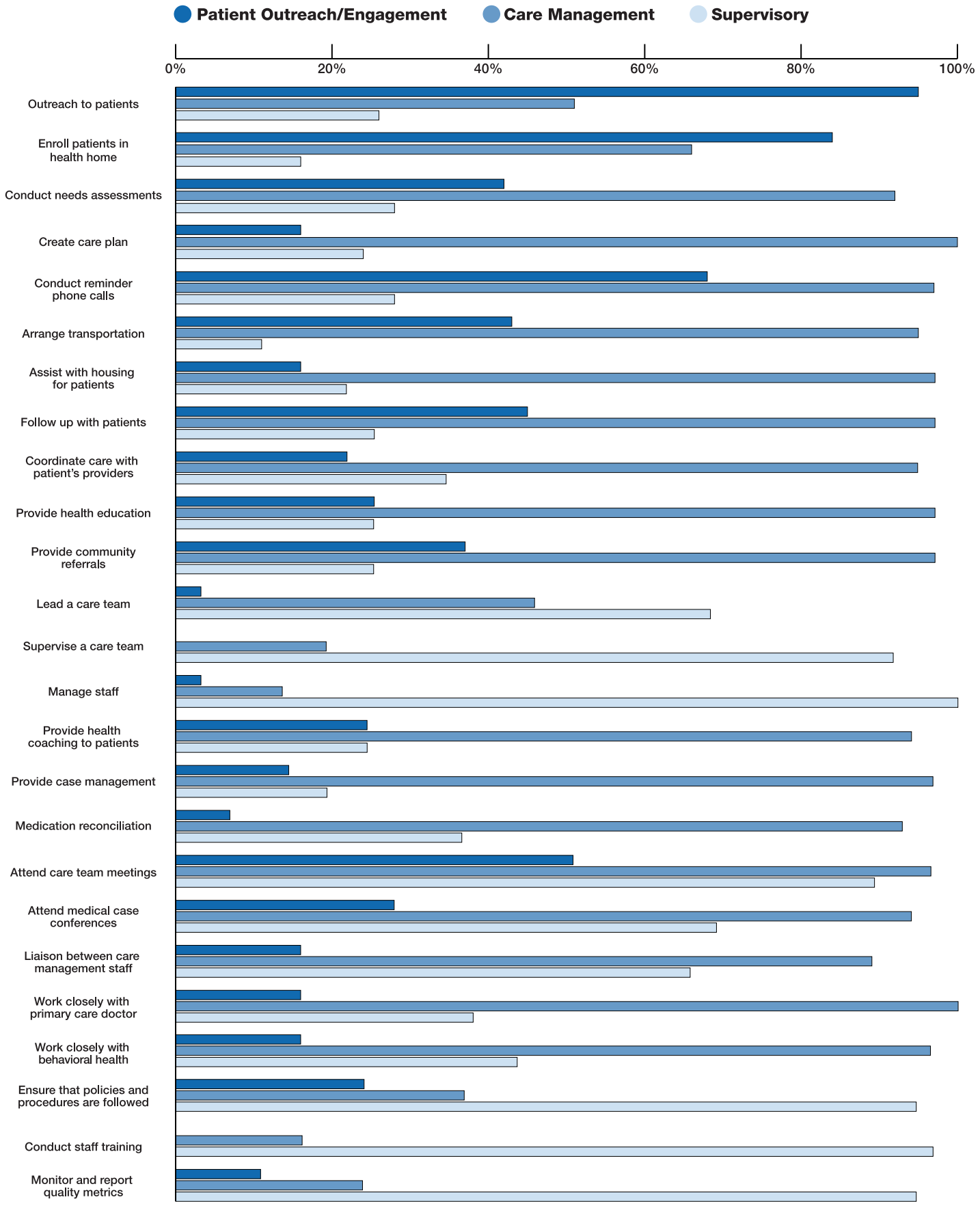
Care Management staff

All of the organizations that responded said care management staff *create care plans* and *work closely with primary care doctors.* Over 90% of the organizations said that care management staff *assist with housing for patients, provide case management, follow up with patients, provide community referrals, attend care team meetings, work closely with behavioral health providers, arrange transportation, coordinate with the patient's providers, attend medical case conferences* and *provide health coaching and medication reconciliation.* 89% said that care management staff must *serve as a liaison between patients and clinicians,* including physicians. It is worth noting that many of these tasks require familiarity with clinical processes even though these are generally unlicensed positions. At a minimum staff require training to be able to provide health coaching, medication reconciliation and other health-related tasks effectively and safely.

Supervisory staff

In addition to managing staff, over 90% of organizations responded that supervisors are also responsible for *conducting staff trainings, monitoring and reporting quality metrics* and e*nsuring that policies and procedures are followed.*

Required Job Tasks and Roles



Required Job Skills and Competencies

Outreach and Engagement staff

Oral communication was the primary skill needed by outreach and engagement staff for over 90% of survey respondents. Over 80% require outreach and engagement staff to have *written communication skills, good judgment, fluency in a language other than English, the ability to provide culturally competent care, computer skills, field safety skills* and *attention to detail.*

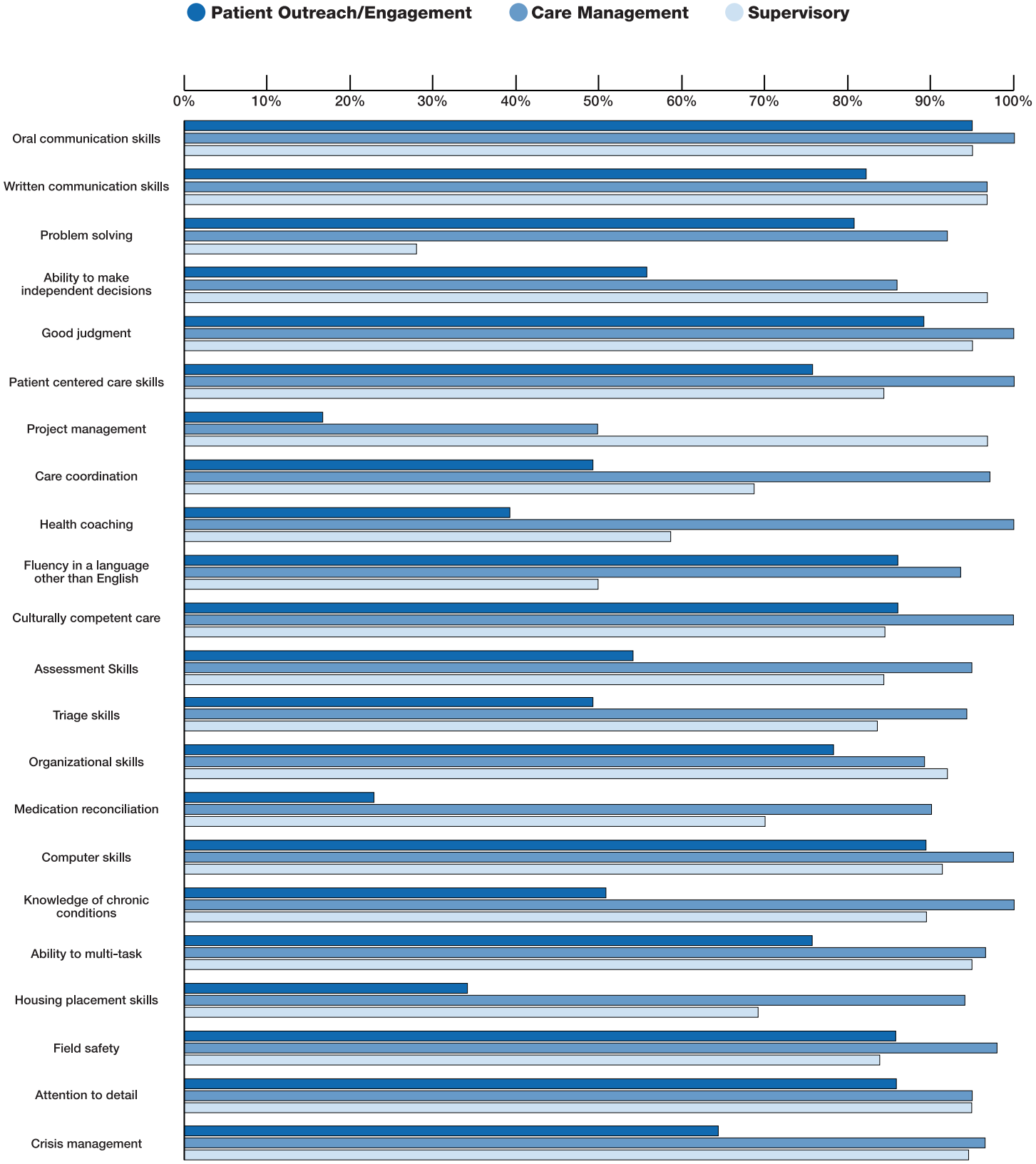
Care Management staff

There was universal agreement among survey respondents that all care managers need *oral and written communication skills, good judgment, patient-centered care skills, health coaching skills, ability to provide culturally competent care, computer skills* and *knowledge of chronic conditions.* Over 90% also cited *problem solving, care coordination, fluency in a language other than English, assessment and triage skills, the ability to multitask, housing placement skills, field safety knowledge, attention to detail* and *crisis management skills.* It is worth noting that the sheer range and diversity of competencies that these positions require draw on experience with clinical conditions, nursing, social work and sophisticated organizational and interpersonal skills.

Supervisory staff

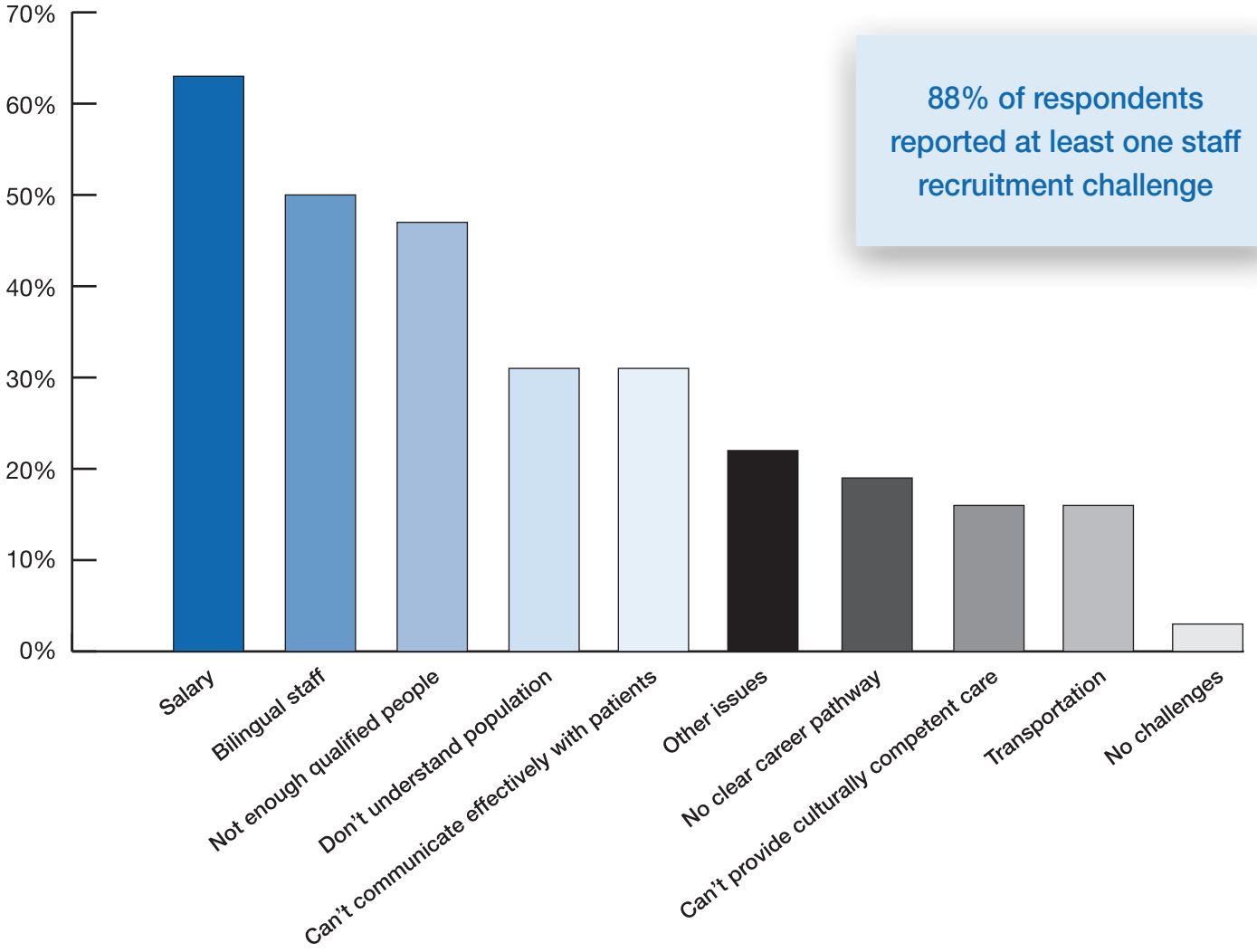
Over 90% of the organizations listed *oral and written communication skills, problem solving skills, the ability to make independent decisions, project management and organizational skills, computer skills, ability to multitask, attention to detail* and *crisis management* as the primary required competencies for supervisory staff.

Required Skills and Competencies



Staff Recruitment Challenges

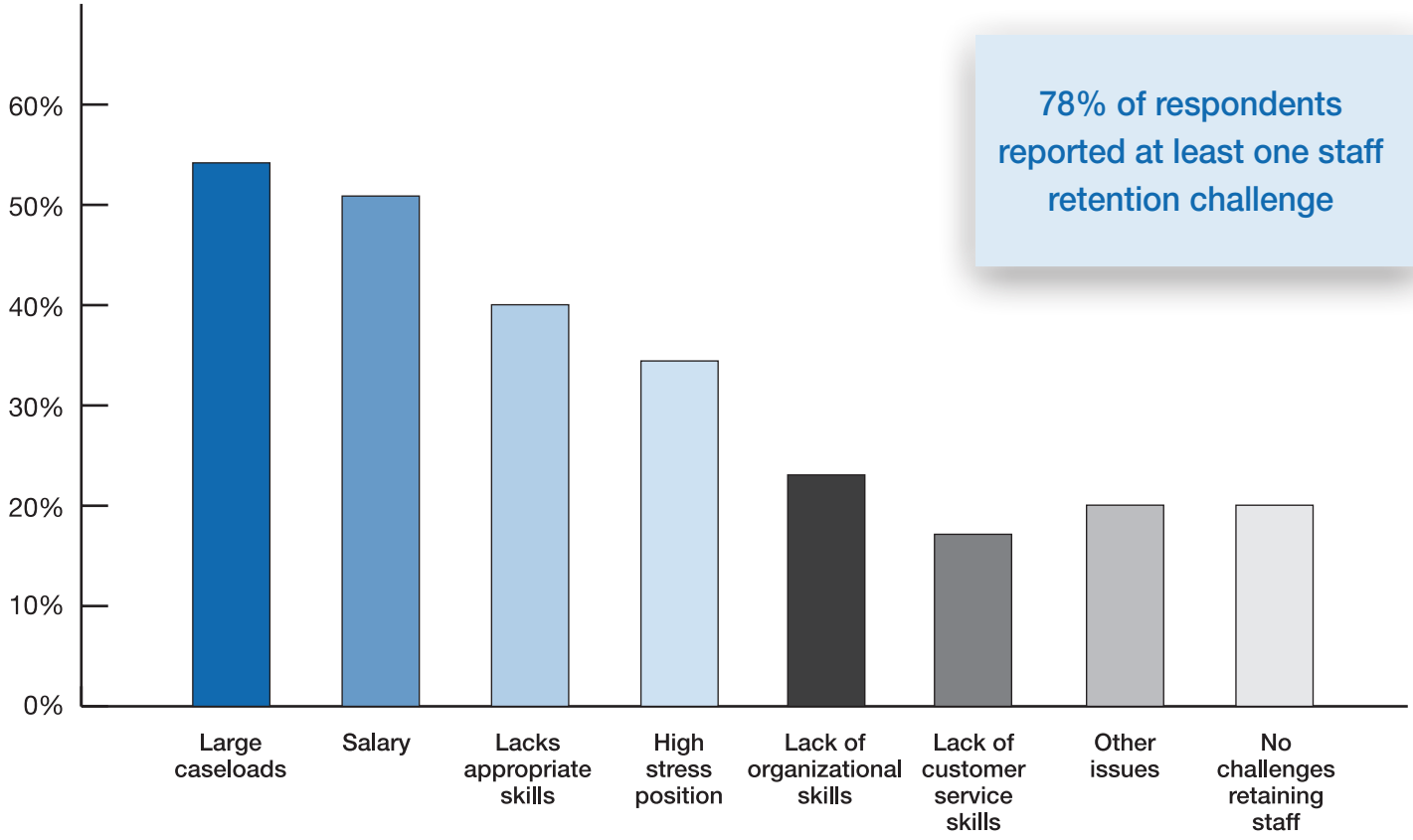
Fully 88% of respondents reported at least one challenge to staff recruitment. More than 60% reported inadequate salaries as a reason. Insufficient qualifications and the inability to speak a second language were also significant factors.



88% of respondents reported at least one staff recruitment challenge

Staff Retention Challenges

Fully 78% of respondents reported at least one challenge to staff retention. More than half reported that large caseloads and insufficient salaries were barriers to retaining staff and 40% reported that lack of appropriate skills impacted retention.



78% of respondents reported at least one staff retention challenge

"We have been able to retain our current staff, but they do not hold a master's or bachelor's degree in social work and thus require a lot of training."

COMMENT FROM RESPONDENT

Key Comments:

There is a need for a very specific type of individual for this role (i.e. extremely organized, able to roll with change, comfortable in the field, able to manage large caseloads, professional, eager) and it's difficult to find individuals possessing these skills. Also, the ability to provide supervision for licensed individuals has been an issue.

These are difficult, high stress jobs.

We have trouble finding staff who are able to handle the caseload sizes.

The work requires a lot of travel within the five boroughs. This makes the position strenuous.

Training Challenges

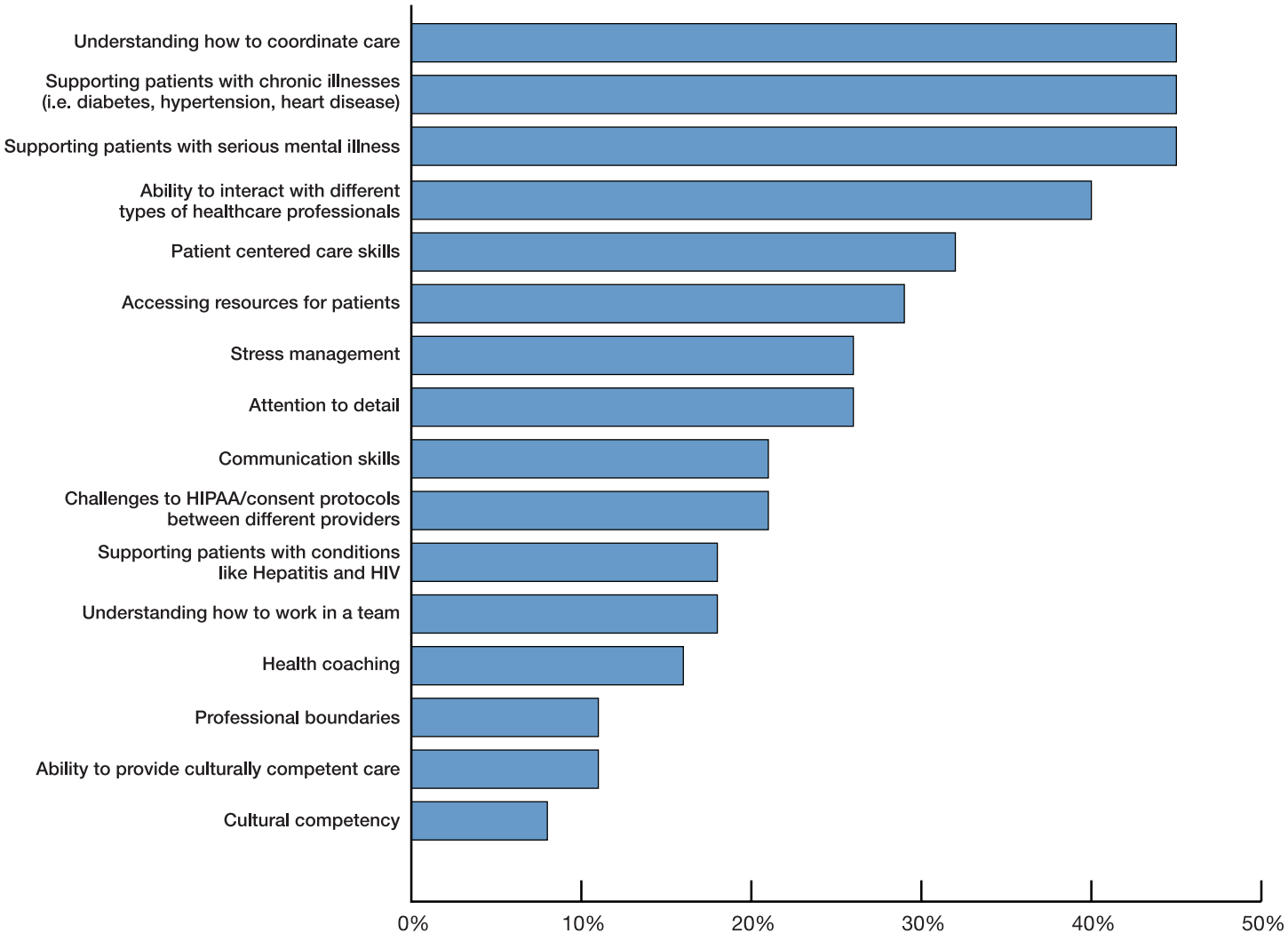
45% of respondents reported that the most significant training needs were in *understanding how to coordinate care* and *supporting patients who have chronic illnesses and/or serious mental illness* while about 40% reported that interacting with various healthcare providers was a key training challenge.

These responses likely reflect the reality that community-based providers typically have less wide-ranging clinical experience and less experience interacting and coordinating care between a diverse array of medical providers as is required in the Health Home model.

For example, a community-based organization may have many years of experience providing case management and coordinating care for HIV-positive patients but have care managers who have considerably less experience working with patients with conditions like diabetes and heart disease. They also may have much less experience interacting with the doctors that provide the clinical care to those patients.

Conversely, there may be care managers who come from a medical case management background who are now being asked to address social determinants of health for their patients but have little experience and need training to carry out these tasks. For example, medical case managers may not have previously been tasked with finding housing for their patients or with coordinating with substance abuse providers but are now being asked to do so as Health Home care managers.

Training Challenges



Key Comments:

Caseloads are large and clients are very needy.

Information technology as it applies to the care managers and supervisors in their day to day work and reporting requirements is an important need.

We have challenges in training new staff given the wide range of chronic illnesses across a caseload. We would like [training] resources available on a regular basis to send new hires.

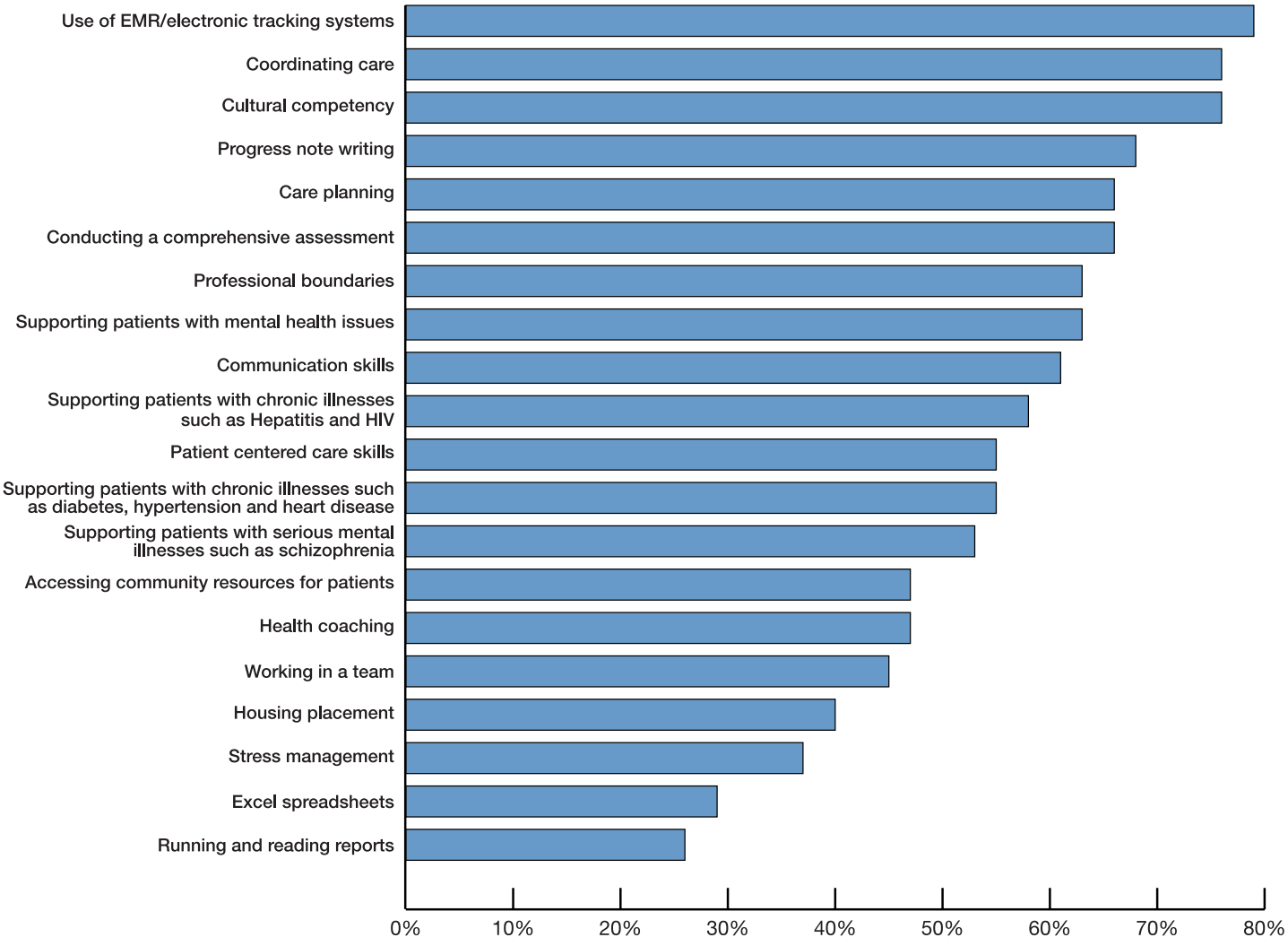
Managing all the paperwork needed for such large caseloads is difficult.

Understanding behavioral health needs of clients is a challenge.

Training Provided By Organizations

The most common trainings offered by between 70-80% of respondents were in *electronic health records/electronic tracking systems, coordinating care* and *cultural competency.*

Despite the fact that skills such as patient-centered care and knowledge of chronic conditions were required of care managers by over 90% of the organizations surveyed, less than 60% provided training in these critical areas. In addition, fewer than half offered training in *health coaching, working in a team, housing placement, stress management* or *running and reading reports* – all skills that many organizations considered crucial to all three roles (outreach, care manager and supervisor) and that the majority of respondents considered critical skills needed for the care manager role.



Key Comments:

There is very little funding to provide ongoing training.

We offer training in the use of our care management system and policies and procedures.

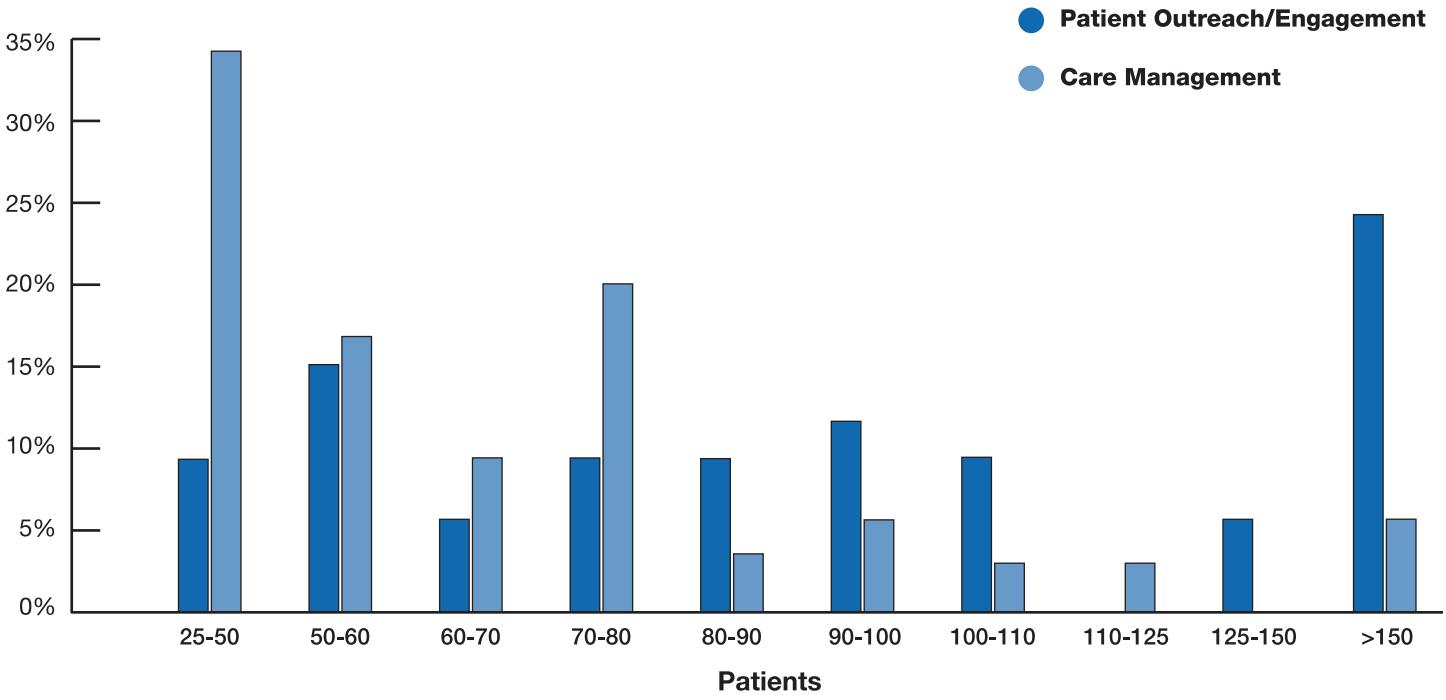
Suicide prevention training (SAFE Talk, ASSIST), Safety Training (office and home visits) and software training are provided. Trainings are provided through certified medical assistants.

Training is individualized per the need of the coordinator and addressed in supervision.

Mock interviewing, behavioral activation are offered.

Maximum Patient Caseload

There was wide variance reported in the maximum patient caseload for patient outreach and care management staff. This may be explained by variation in case severity, but also suggests a lack of consistency in caseload for these job titles. The higher caseloads could also be driving staff recruitment and retention challenges.



Recommendations

Based on analysis of the survey results and additional data, as well as extensive experience in the field, 1199SEIU and PCDC propose the following recommendations for policymakers and healthcare organizations seeking to build a strong and effective care management and care coordination workforce.

1. Collect Data About the Care Coordination and Care Management Workforce

Given the importance of the care coordination workforce, New York State needs to understand how the sector is developing. The state should collect data about the care coordination workforce. Drawing on this data and consultations with industry and educational leaders, the State can propose occupational definitions and standards. Categories of measurement should include:

- Number of positions
- Types of positions and naming conventions for the positions
- Caseloads
- Required educational levels for various positions
- Required skills, competencies and responsibilities for each position
- Wages and benefits
- Geographic distribution of staff (where they live vs. where they work)
- Race, ethnicity and languages spoken
- Training provided
- Vacancies and turnover

The workforce plans that Performing Provider Systems are developing under DSRIP are one source of this information. Data on the current state of the workforce, including on wages and benefits, should be collected using a common template. The Center for Health Workforce Studies at SUNY Albany can assist in creating a common template for collection. In addition, this data should be submitted to the State rather than retained at the PPS level and be resubmitted periodically during the DSRIP period.

2. Require All Payers to Support Care Coordination and Care Management

Following policies underway and being established in Medicare and Medicaid, all payers should be required to pay adequately for care coordination and care management services at the provider level. Not only will this support be vital for care coordination and care management capacity in healthcare organizations, it will also help eliminate the "free rider" problem in which payers (and their enrollees) who do not pay for care coordination and care management services benefit from those services funded by other payers. Payment can take the form of a specific care coordination and care management fee or be funded as an element of a bundle or other value-based arrangement.

3. Ensure Sufficient Wages and Benefits for Care Coordination and Care Management Staff

More than half of respondents indicated that lack of a sufficient salary was a major barrier to recruiting and retaining staff. In addition, care coordination salaries of the respondents to the survey, many of whom are community-based organizations, were up to 50% lower than typical salaries for the similar work at hospitals.

Set a wage floor for care and care management workers

A minimum compensation standard in Medicaid-funded home care downstate has finally begun to stabilize a workforce notorious for its high turnover. A similar policy can be instituted for the new care coordination and care management workforce. This will not only ensure that care management staff are assured a living wage, it also can increase retention and thus help ensure continuity of care for patients. Different wage floors should be established based on educational attainment and job category using a methodology similar to "prevailing wage" statutes common in other industries.

Ensure sufficient payment to meet compensation standards

New York State Medicaid enrollees represent the largest and most intensive use of care coordination services. Medicaid and Medicaid managed care organizations must pay providers enough to meet compensation standards for the care coordination workforce and allow for investment in training.

Ensure health plans are incentivized to invest in the community-based sector and community-based providers are incentivized to invest in their frontline staff

Under value-based payment, quality metrics for providers should include direct measures of investment in employees such as compensation, turnover, caseload, satisfaction and access to career ladders as well as key measures of access and coordination.

4. Provide Ongoing Training for the Care Coordination and Care Management Workforce

Fully 45% of respondents indicated that their care coordination and care management workforce required training in core areas. Given the enormous demand to fill these positions and the insufficient supply of skilled individuals who can fill them, there is clear need for workforce initiatives that can rapidly and continuously train a large number of workers. While DSRIP is providing a $400 million investment in training and workforce development, it will be important to ensure that these dollars are used effectively and that resources are available once the DSRIP period is over. This will require industry-wide collaboration, both regionally and statewide. Otherwise, significant resources could be wasted in duplication.

Develop industry standards and certification programs

Given the evolving nature of these job categories, we do not recommend state level licensure at this time. There should however be a State-sanctioned certification process and a standard definition for each of the job titles in the care coordination and care management category, drawn from the research and industry consultation discussed above.

Certification could be based on skills and competencies for each of the job titles (i.e. care coordination, communication, culturally competent care, health coaching, assessment and care planning). These must be carefully constructed to avoid artificial barriers to entry for community members, who may be the most suited to provide peer support and culturally and linguistically competent services. Programs should allow for students to build on previous certifications and earn college credit to allow for the development of career ladders.

Fund education and training initiatives that leverage economies of scale

The overwhelming need for qualified care coordination staff demands standardized curricula and training methods that can be easily replicated (and modified as appropriate) across numerous healthcare settings throughout New York State. Significant investment has already been made in curricula development in New York State and across the country. A clearinghouse for best practices in training should be created. Existing curricula should be identified, evaluated and built upon to provide access to high quality training programs, while avoiding duplication and waste.[20] Just as important, colleges should be encouraged to incorporate and build upon existing training in order to provide more career pathway options.

Bonds and collaboration must be strengthened between healthcare practice organizations and healthcare training and educational institutions to better match training of workers to current healthcare practice needs. As a recent Brookings report stated, "In order to meet the triple aim of better care, better health, and lower costs, the worlds of healthcare practice and healthcare education (at all levels of credentials) need to exponentially strengthen their bonds and interactions so that education and training for both incumbent and future workers is more connected to the actual delivery of care."[21] This collaboration should be regional and industry-wide where possible to avoid duplication of effort.

---

[20] 1199SEIU Training and Employment Fund and PCDC developed the Care Coordination Fundamentals training curriculum specifically for nonclinical healthcare workers. Accessed June 8, 2015. http://www.pcdc.org/resources/quality-improvement/resources/care-coordination.html

[21] Ross M., Svajlenka N. P., Williams J. "Part of the Solution: Pre-Baccalaureate Healthcare Workers in a Time of Health System Change" Metropolitan Policy Program at Brookings. July 2014. 17. Accessed June 9, 2015 http://www.brookings.edu/~/media/research/files/reports/2014/07/healthworkforce/healthcare-workers-report.pdf

Establish care coordination and care management career ladders

Healthcare organizations should create programs to enable successful unlicensed staff to continue their training and go on to obtain allied health degrees in emerging and growing occupations. Career ladders for frontline staff should be considered a measure of the organizations' quality. These types of programs are particularly important to ensure that the professional workforce is fully culturally competent and reflective of the community it serves. Crucial job benefits should include tuition assistance for those wishing to further their education and move up in the area of care coordination and care management or move into nursing or social work. Healthcare organizations could work with labor unions or other workforce partners to create apprenticeship programs for care coordinators and care managers that would provide on-the-job training for new graduates and a career ladder for seasoned care coordinators and care managers, who could serve as mentors.

Successful career ladder programs such as the 1199SEIU Training and Upgrading Fund (TUF) have developed comprehensive support systems for working adults as they return to school. By proactively addressing challenges faced by many worker-students through programs including child care, peer cohorts, academic support and early intervention for struggling participants, TUF has achieved high completion rates.

Provide clinical supervision and support for unlicensed care coordination and care management staff

While most Health Home organizations surveyed reported requiring RN or MSW degrees for care management or supervisory roles, not all required them. Clinical supervision by registered nurses and licensed social workers should be the standard of care both to ensure high quality care for patients and to prevent burnout for care management staff who are supporting patients with complex medical, behavioral health and social service needs. To build a robust frontline healthcare workforce, clinical support and supervision will be needed in each and every institution.

Appendix 1: Survey Methodology and Questions

Methodology

An online survey tool was developed and implemented through a survey collection website. Email requests were sent to Health Home Leads and Downstream providers in the New York City and Downstate regions (Nassau, Suffolk, Westchester and Rockland Counties) on March 17 and March 26, 2015, with a March 30, 2015 completion deadline. The survey was sent to 213 health homes (19 Health Home leads and 194 downstream providers), primarily in the New York City/Downstate area. Some Upstate health homes also responded and their responses were included in the results. The survey generated 49 valid responses (10 leads, 35 downstream and four that were both leads and downstream providers in another Health Home). The results are statistically significant at the 90% confidence interval with a margin of error of plus or minus 11%.

TURN THE PAGE FOR QUESTIONNAIRE...

Health Home workforce survey

Thank you for taking the time to complete this survey. Primary Care Development Corporation (PCDC) and 1199SEIU United Healthcare Workers East are interested in learning more about the developing workforce roles and jobs related to new care management healthcare delivery models such as Health Homes. This survey asks questions related to your Health Home care management staff positions including education and skills requirements at your organization, salary range and benefits, and caseload and training needs. This survey is anonymous. Results will be used to help providers and policymakers better understand the evolving community based healthcare workforce to ensure effective reimbursement policies and training resources.

If you are a lead Health Home we would appreciate if you can both complete this survey (only one per organization please) and forward it to one contact at each of your downstream provider organizations so that they may fill it out as well.

Please complete this anonymous survey by Monday, March 30th, 2015. Organizations that participate will receive the complete aggregated anonymous data set if they would like it (please email ksilverman@pcdc.org indicating that you have completed the survey and would like to receive the anonymous data set)

If you have any questions please contact Karla Silverman, Director, Clinical and Training Initiatives, Primary Care Development Corporation at 212-437-3912 or ksilverman@pcdc.org

Definition of Terms used in this survey:

Definition: Patient Outreach/Engagement:
Responsible for outreaching to patients, enrolling them into the program, and re-engaging patients when they become lost to care. These staff may also assist care managers or care management teams with coordinating care for patients, including conducting reminder calls about upcoming appointments and arranging transportation. Common job titles include: Outreach workers, patient navigators, and care navigators.

Defintion: Care management:
Lead care management activities for a panel of patients. They are responsible for the coordination of services for their patients and conduct activities such as coordinating with patients' providers; conducting needs assessments; develop patient focused care plans; providing health education; and managing staff assigned to assist them with these tasks. Common job title is care manager, case manager or care coordinator.

Definition: Supervisory:
Responsible for the overall administration of care management teams a particular site. These staff provide clinical supervision to care management staff; conduct staff training; monitor and report quality metrics to organization; ensure that policies and procedures are being followed; and may assist with the coordination of client services as needed. Common job titles include: site directors, site supervisors, care coordinators.

1. Please indicate if you are a:

- ◯ Lead Health Home provider organization
- ◯ Downstream/contracted care management provider for a Health Home
- ◯ Both a lead Health Home and a contracted care management provider in another Health Home

Other (please specify)

1

Health Home workforce survey

2. Please indicate if you are a:

- ◯ Hospital
- ◯ Community health center
- ◯ Community based organization

Other (please specify)

3. Please indicate what area of New York your organization is located in. Please check all that apply.

- ☐ New York City area
- ☐ Nassau, Suffolk, Westchester or Rockland Counties
- ☐ Upstate New York

4. Please indicate the annual budget range of your overall organization (not just Health Home program)

- ◯ < $1 million
- ◯ $1-5 million
- ◯ $5-10 million
- ◯ $10-20 million
- ◯ $20-50 million
- ◯ $50-100 million
- ◯ $100-500 million
- ◯ $500 million +
- ◯ don't know

Health Home workforce survey

Patient Outreach / Engagement

Patient Outreach/Engagement:
Responsible for outreaching to patients, enrolling them into the program, and re-engaging patients when they become lost to care. These staff may also assist care managers or care management teams with coordinating care for patients, including conducting reminder calls about upcoming appointments and arranging transportation. Common job titles include: Outreach workers, patient navigators, and care navigators.

5. Please indicate the job title(s) for staff at your organization that provides Patient Outreach/Engagement in the Health Home program (Check as many as apply)

- ☐ Outreach Worker
- ☐ Patient Navigator
- ☐ Care Manager
- ☐ Other titles (please specify)

6. What is the approximate number of staff members across all Health Home sites at your organization with the Patient Outreach/Engagement job title indicated above?

7. Please indicate the percentage of outreach/engagement staff that are...

Full-time with benefits:	
Part-time with benefits:	
Hourly with benefits:	
Full-time/no benefits:	
Part-time/no benefits:	
Hourly/no benefits:	

3

Health Home workforce survey

Care Management

Care management:
Lead care management activities for a panel of patients. They are responsible for the coordination of services for their patients and conduct activities such as coordinating with patients' providers; conducting needs assessments; developing patient focused care plans; providing health education; and managing staff assigned to assist them with these tasks. Common job title is care manager, case manager or care coordinator.

8. Please indicate the job title for staff at your organization that provides Care Management for your Health Home patients: (Check as many as apply)

- ☐ Care Manager
- ☐ Care Coordinator
- ☐ Patient Navigator
- ☐ Other titles (please specify)

9. What is the approximate number of staff members across all Health Home sites at your organization with the care manager job title role indicated above?

10. Please indicate the percentage of care management staff that are...

Full-time with benefits:	
Part-time with benefits:	
Hourly with benefits:	
Full-time/no benefits:	
Part-time/no benefits:	
Hourly/no benefits:	

Health Home workforce survey

Care Management Supervisor

Supervisory:
Responsible for the overall administration of care management teams for a particular site. These staff provide clinical supervision to care management staff; conduct staff training; monitor and report quality metrics to organization; ensure that policies and procedures are being followed; and may assist with the coordination of client services as needed. Common job titles include: site directors, site supervisors, care coordinators.

11. Please indicate the job title for staff at your organization that acts as Care Management Supervisor in your Health Home program (Check as many as apply):

- ☐ Site Director
- ☐ Site Supervisor
- ☐ Care Coordinator
- ☐ Other titles (please specify)

12. What is the approximate number of staff members across all Health Home sites at your organization with the Care Management Supervisor job title indicated above?

13. Please indicate the percentage of supervisory staff that are...

Full-time with benefits:	
Part-time with benefits:	
Hourly with benefits:	
Full-time/no benefits:	
Part-time/no benefits:	
Hourly/no benefits:	

5

Health Home workforce survey

Requirements, Salary Information, and Competencies

14. Please indicate the minimal educational requirement and average salary for each full-time Health Home staff role at your organization:

	Minimal Educational Requirement	Average Annual Salary
Patient Outreach/Engagement		
Care Management		
Supervisory		

Additional Comments

15. What is the average minimum and maximum patient case load per each full time Health Home staff role at your organization?

	minimum case load	maximum case load
patient outreach and engagement		
care management		
care supervisory		

If case loads are assigned to a team please indicate how many staff would manage how many patients:

Health Home workforce survey

16. Please indicate the corresponding tasks that are required of each types of Health Home staff at your organization (check all that apply)

	Patient Outreach/Engagement Staff	Care Management Staff	Supervisory Staff
Outreach to patients	☐	☐	☐
Enroll patients in health home	☐	☐	☐
Conduct needs assessments	☐	☐	☐
Create care plan	☐	☐	☐
Conduct reminder phone calls	☐	☐	☐
Arrange transportation	☐	☐	☐
Assist with housing for patients	☐	☐	☐
Follow up with patients	☐	☐	☐
Coordinate care with patient's providers	☐	☐	☐
Provide health education	☐	☐	☐
Provide community referrals	☐	☐	☐
Lead a care team	☐	☐	☐
Supervise a care team	☐	☐	☐
Manage staff	☐	☐	☐
Provide health coaching to patients	☐	☐	☐
Provide case management	☐	☐	☐
Medication reconciliation	☐	☐	☐
Attend care team meetings	☐	☐	☐
Attend medical case conferences	☐	☐	☐
Liaison between care management staff and clinicians/doctors	☐	☐	☐
Work closely with primary care doctor	☐	☐	☐
Work closely with behavioral health provider	☐	☐	☐
Ensure that policies and procedures are followed	☐	☐	☐
Conduct staff training	☐	☐	☐
Monitor and report quality metrics	☐	☐	☐

Please provide any additional comments or tasks that are not listed above.

7

Health Home workforce survey

17. Please indicate core competencies or skills that your organization requires for the following staff roles in your Health Home program (check all that apply)

	Patient Outreach/Engagement Staff	Care Management Staff	Supervisory Staff
Oral communication skills	☐	☐	☐
Written communication skills	☐	☐	☐
Problem solving	☐	☐	☐
Ability to make independent decisions	☐	☐	☐
Good judgement	☐	☐	☐
Patient centered care skills	☐	☐	☐
Project management	☐	☐	☐
Care coordination	☐	☐	☐
Health coaching	☐	☐	☐
Fluency in a language other than English	☐	☐	☐
Culturally competent care	☐	☐	☐
Assessment skills	☐	☐	☐
Triage skills	☐	☐	☐
Organizational skills	☐	☐	☐
Medication reconciliation	☐	☐	☐
Computer skills	☐	☐	☐
Knowledge of chronic conditions such as diabetes and hypertension	☐	☐	☐
Ability to multi-task	☐	☐	☐
Housing placement skills	☐	☐	☐
Field safety	☐	☐	☐
Attention to detail	☐	☐	☐
Crisis management	☐	☐	☐

Please provide any additional comments or competencies that are not listed above.

8

Health Home workforce survey

Training and Retention

18. What are your biggest challenges in retaining staff? (check all that apply)

- [ ] Staff do not have appropriate skills for the position
- [ ] Lack of customer service skills
- [ ] Lack of organizational skills
- [ ] High stress position
- [ ] Large caseloads
- [ ] Salary
- [ ] No challenges retaining staff

Other issues, please explain

19. What are your most significant challenges in recruiting care management/care coordination staff? (check all that apply)

- [ ] Not enough qualified people
- [ ] Salary
- [ ] No clear career pathway
- [ ] No challenges recruiting care management/care coordination staff
- [ ] Bi-lingual staff
- [ ] Not enough qualified people who understand needs of patient population
- [ ] Not enough qualified people who are able to provide culturally competent care
- [ ] Not enough qualified people who can communicate effectively with patient population
- [ ] Need to have a car or supply their own transportation

Other issues, please explain

9

Health Home workforce survey

20. What are your biggest training challenges? (check all that apply)

- [ ] Communication skills
- [ ] Patient centered care skills
- [ ] Understanding how to coordinate care
- [ ] Attention to detail
- [ ] Cultural competency
- [ ] Professional boundaries
- [ ] Stress management
- [ ] Health coaching
- [ ] Accessing resources for patients
- [ ] Supporting patients with chronic illnesses such as diabetes, hypertension and heart disease
- [ ] Supporting patients with chronic illnesses such as Hepatitis and HIV
- [ ] Supporting patients with mental health issues such as depression and anxiety
- [ ] Supporting patients with serious mental illness such as schizophrenia
- [ ] Understanding how to work in a team
- [ ] Ability to interact with different types of healthcare professionals
- [ ] Ability to provide culturally competent care
- [ ] Lack of consistency in HIPAA/consent protocols between different providers

Other (please specify)

10

Health Home workforce survey

21. In which of these areas does your organization provide training for care management/care coordination staff? (check all that apply)

- [ ] Communication skills
- [ ] Patient centered care skills
- [ ] Coordinating Care
- [ ] Cultural competency
- [ ] Professional boundaries
- [ ] Stress Management
- [ ] Health coaching
- [ ] Accessing community resources for patients
- [ ] Supporting patients with chronic illnesses such as diabetes, hypertension and heart disease
- [ ] Supporting patients with chronic illnesses such as Hepatitis and HIV
- [ ] Supporting patients with mental health issues such as depression and anxiety
- [ ] Supporting patients with serious mental illness such as schizophrenia
- [ ] Understanding how to work in a team
- [ ] Use of EMR/electronic tracking systems
- [ ] Excel spreadsheets
- [ ] Running and reading reports
- [ ] Care planning
- [ ] Progress note writing
- [ ] How to do a comprehensive assessment
- [ ] Housing placement

Other training you provide, please list:

If you would be willing to speak with someone about this survey, please send an email to ksilverman@pcdc.org. Thank you for taking the time to complete this survey.

11

Appendix 2: Values

Health Home Status	
Lead Health Home	20%
Downstream Provider	71%
Lead Health Home and Downstream for Another Health Home	8%

Type of Organization	
Hospital	8%
Community Health Center	27%
Community Based Organization	65%

Geographic Service Area	
New York City	76%
Nassau, Suffolk, Westchester or Rockland	14%
Upstate New York	18%

Annual Organizational Budget	
< $1 million	2%
$1-5 million	4%
$5-10 million	18%
$10-20 million	22%
$20-50 million	10%
$50-100 million	14%
$100-500 million	8%
$500 million +	4%
Don't Know	16%

Job Titles	
Outreach Worker – *Outreach and Engagement*	45%
Patient Navigator – *Outreach and Engagement*	27%
Care Manager – *Outreach and Engagement*	37%
Other Titles – *Outreach and Engagement*	53%
Care Manager – *Care Management*	72%
Care Coordinator – *Care Management*	28%
Patient Navigator – *Care Management*	13%
Other Titles – *Care Management*	37%
Site Director – *Supervisory*	16%
Site Supervisor – *Supervisory*	21%
Care Coordinator – *Supervisory*	14%
Other Titles – *Supervisory*	77%

Minimum Educational Requirements	GED/High School Diploma	Bachelor's	Master's	Social Worker License	Nursing: LPN	Nursing: RN	Other Educational Requirement
Patient Outreach/Engagement	59%	33%	0%	0%	0%	0%	8%
Care Management	10%	77%	5%	0%	0%	5%	3%
Supervisory	0%	27%	62%	3%	3%	3%	3%

Annual Average Salary	>20K	21K-25K	26K-30K	31K-35K	36K-40K	41K-45K	46K-50K	51K-55K	56K-60K	61K-70K	71K-85K	86K-100K	>100K
Patient Outreach/Engagement	5%	8%	24%	30%	19%	5%	5%	0%	3%	0%	0%	0%	0%
Care Management	0%	3%	3%	17%	25%	31%	17%	3%	0%	0%	0%	3%	0%
Supervisory	0%	0%	0%	3%	9%	6%	14%	11%	20%	20%	6%	6%	6%

Required Job Tasks and Roles	Patient Outreach/ Engagement Staff	Care Management Staff	Supervisory Staff
Outreach to patients	95%	54%	26%
Enroll patients in health home	84%	68%	19%
Conduct needs assessments	46%	92%	26%
Create care plan	14%	100%	24%
Conduct reminder phone calls	66%	95%	26%
Arrange transportation	42%	95%	11%
Assist with housing for patients	16%	97%	22%
Follow up with patients	45%	97%	26%
Coordinate care with patient's providers	22%	95%	35%
Provide health education	26%	97%	26%
Provide community referrals	37%	97%	26%
Lead a care team	3%	46%	68%
Supervise a care team	0%	19%	92%
Manage staff	3%	13%	100%
Provide health coaching to patients	25%	94%	25%
Provide case management	14%	97%	19%
Medication reconciliation	7%	93%	37%
Attend care team meetings	51%	97%	89%
Attend medical case conferences	28%	94%	69%
Liaison between care management staff and clinicians/doctors	16%	89%	66%
Work closely with primary care doctor	16%	100%	38%
Work closely with behavioral health provider	16%	97%	43%
Ensure that policies and procedures are followed	24%	37%	95%
Conduct staff training	0%	16%	97%
Monitor and report quality metrics	11%	24%	97%

Required Job Skills and Competencies	Patient Outreach/ Engagement Staff	Care Management Staff	Supervisory Staff
Oral communication skills	95%	100%	95%
Written communication skills	82%	100%	95%
Problem solving	81%	97%	97%
Ability to make independent decisions	56%	86%	97%
Good judgement	89%	100%	95%
Patient-centered care skills	76%	100%	84%
Project management	17%	50%	97%
Care coordination	49%	97%	68%
Health coaching	39%	100%	58%
Fluency in a language other than English	86%	93%	50%
Culturally competent care	86%	100%	84%
Assessment skills	54%	95%	84%
Triage skills	49%	94%	83%
Organizational skills	78%	89%	92%
Medication reconciliation	23%	90%	70%
Computer skills	89%	100%	92%
Knowledge of chronic conditions	51%	100%	89%
Ability to multitask	76%	97%	95%
Housing placement skills	34%	94%	69%
Field safety	86%	97%	83%
Attention to detail	86%	95%	95%
Crisis management	64%	97%	94%

Staff Recruitment Challenges	
At least one recruitment challenge	88%
Salary	63%
Bilingual staff	50%
Not enough qualified people	47%
Don’t understand population needs	31%
Can’t communicate effectively with patients	31%
Other issues	22%
No clear career pathway	19%
Can’t provide culturally competent care	16%
Transportation	16%
No challenges	3%

Staff Retention Challenges	
At least one retention challenge	78%
Large caseloads	54%
Salary	51%
Lacks appropriate skills	40%
High stress position	34%
Lack of organizational skills	23%
Lack of customer service skills	17%
Other issues	20%
No challenges retaining staff	20%

Training Challenges	
Understanding how to coordinate care	45%
Supporting patients with chronic illnesses (i.e. diabetes, hypertension, heart disease)	45%
Supporting patients with serious mental illness	45%
Ability to interact with different types of healthcare professionals	40%
Patient-centered care skills	32%
Accessing resources for patients	29%
Stress management	26%
Attention to detail	26%
Communication skills	21%
Challenges with HIPAA/consent protocols between different providers	21%
Supporting patients with conditions like Hepatitis and HIV	18%
Understanding how to work in a team	18%
Health coaching	16%
Professional boundaries	11%
Ability to provide culturally competent care	11%
Cultural competency	8%

Training Provided by Organization	
Use of EMR/electronic tracking systems	79%
Coordinating Care	76%
Cultural competency	76%
Progress note writing	68%
Care planning	66%
Conducting a comprehensive assessment	66%
Professional boundaries	63%
Supporting patients with mental health issues	63%
Communication skills	61%
Supporting patients with chronic illnesses such as Hepatitis and HIV	58%
Patient-centered care skills	55%
Supporting patients with chronic illnesses such as diabetes, hypertension and heart disease	55%
Supporting patients with serious mental illness such as schizophrenia	53%
Accessing community resources for patients	47%
Health coaching	47%
Working in a team	45%
Housing placement	40%
Stress Management	37%
Excel spreadsheets	29%
Running and reading reports	26%

Maximum Patient Caseload	25 - 50	50 - 60	60 - 70	70 - 80	80 - 90	90 - 100	100 - 110	110 - 125	125 - 150	>150
Patient Outreach and Engagement	9%	15%	6%	9%	9%	12%	9%	0%	6%	24%
Care Management	34%	17%	9%	20%	3%	6%	3%	3%	0%	6%

Appendix 3: Additional Resources

There is a growing base of literature about care coordination and care management. Below are useful information sources that can help guide policymakers, provider organizations and educators and other stakeholders as we seek to build a well-trained care coordination and care management workforce.

Care Management in New York State Health Homes.
New York State Health Foundation. Prepared by Joslyn Levy & Associates. August 2014. Accessed April 19, 2015.
http://nyshealthfoundation.org/uploads/resources/care-management-new-york-state-health-homes-aug-2014.pdf

Care Coordination Case Study Preliminary Findings. Center for Health Workforce Studies.
April 2014. Accessed May 29, 2015.
http://chws.albany.edu/archive/uploads/2014/04/carecoordinationprelim2014.pdf.

The Health Care Workforce in New York: Trends in the Supply and Demand for Health Workers.
Center for Health Workforce Studies. June 2014. Accessed May 29, 2015.
http://chws.albany.edu/archive/uploads/2014/08/nytracking2014.pdf

The Paraprofessional Healthcare Institute.
Researches and advocates for home health aides and other paraprofessional healthcare workers.
Accessed April 19, 2015. http://phinational.org

Emerging Positions in Primary Care: Results from the 2014 Ambulatory Care Workforce Survey.
Greater New York Hospital Association. March 2015. Accessed April 19, 2015.
http://www.gnyha.org/PressRoom/Publication/c5dbde90-559e-4ef8-adbd-4b9567143f24/

Who is Qualified to Coordinate Care?
Recommendations presented to the New York State Department of Health and the New York State Office for the Aging by the Social Work Leadership Institute of The New York Academy of Medicine, 2011. Accessed April 19, 2015.
http://www.nyam.org/social-work-leadership-institute/docs/care-coordination/N3C-Recommendations-on-the-Qualified-Care-Coordinator.pdf

Part of the Solution: Pre-Baccalaureate Healthcare Workers in a Time of Health System Change.
By Martha Ross, Nicole Prchal Svajlenka, and Jane Williams. Metropolitan Policy Program, Brookings, July 2014.
Accessed June 9, 2015.
http://www.brookings.edu/~/media/research/files/reports/2014/07/healthworkforce/healthcare-workers-report.pdf


healthcare
workforce
partnership
skills
complexity
training
patients
advancement
community
opportunity
prevention
outcomes
treatment

July 2015