



New York City Emerging Healthcare Workforce: Health Homes Case Study Project

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Authors' Notes

The views and opinions expressed in the following report are those of the authors, Drs. Carrie Shockley, Shana Lassiter and William Ebenstein.

Please see Appendix A for a list of abbreviations used throughout the paper.

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Section One: Introduction

Project Overview

The **New York City Emerging Healthcare Workforce: Health Homes Case Study Project** was led by The City University of New York (CUNY) in collaboration with the Greater New York Hospital Association (GNYHA) and the 1199SEIU Training and Employment Funds (1199SEIU TEF). Funding was provided by the New York Alliance for Careers in Healthcare (NYACH) through the New York City Workforce Development Corporation. Additional funding was provided by Reaching Up, Inc., a non-profit founded by John F. Kennedy, Jr., as well as the 1199SEIU TEF. The project includes case studies of health care organizations in New York City that are implementing “innovative models of care” through their designation as provider-led Medicaid “Health Homes” (HHs) by the New York State Department of Health (DOH).

The study focuses on the experiences of Phase I designees, including all four organizations awarded HH status in the Bronx (which ranks last among New York’s 62 counties with respect to health outcomes and health factors)¹ and two of the organizations awarded HH status in Brooklyn. It covers the start-up period of these early adopters.

Participating organizations were contacted with the assistance of CUNY’s labor and industry partners. Both public and private non-profit entities were included. The participating organizations are:

- *New York City Health and Hospitals Corporation*, the largest municipal health care organization in the United States and safety net provider for New York City’s low-income, uninsured and underinsured populations.
- *Montefiore Medical Center*, one of the largest health care systems in the Bronx, providing care via a network of facilities throughout the borough.
- *Bronx-Lebanon Hospital Center*, the largest nonprofit health care system serving the southern and central portions of The Bronx.
- *Visiting Nurse Service of New York*, the largest provider of home health care services in New York, serving New York City and surrounding counties.
- *Maimonides Medical Center*, a long-standing provider in the borough of Brooklyn serving a culturally diverse community.

Representatives from CUNY, GNYHA and 1199SEIU TEF conducted the interviews on-site at the participating organizations. Interviewees were leaders from the participating organizations who were knowledgeable about their HH projects. Each interview was scheduled for 60-90 minutes and was recorded via audiotape and/or detailed notes. Interviews were conducted in a semi-structured fashion, following a protocol. (See Appendix B).

Following each interview, a summary was prepared by the interviewers using workforce related themes. The summary was then shared with the interviewees, who provided feedback. The final summaries are presented in Section Two of this report.

Care Coordination

Federal health care reform legislation, known as the *Affordable Care Act (ACA)*,^{2,3} was signed into law in March 2010. At its core, the ACA seeks to achieve three objectives that the nonprofit Institute for Healthcare Improvement (IHI) has called the Triple Aim:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.^{4,5}

Health care reform legislation provides guidance and support for innovative models of care aimed at bringing the nation closer to achieving the Triple Aim. Care coordination is a key element in most of these innovative models.⁶ There are numerous definitions for care coordination- some are general, while others are specialty-specific or disease-specific. No standard definition exists.^{6,7} One comprehensive definition, developed by the Agency for Healthcare Research and Quality (AHRQ), describes care coordination as:

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.^{7(p5)}

AHRQ further delineates two goals of care coordination, which are:

1. To *transfer information*, such as medical history, medication lists, test results, and patient preferences, appropriately from one participant in a patient's care to another. This includes transferring information to or from the patient.
2. To *establish accountability* by clarifying who is responsible for each aspect of a patient's overall care. This includes specifying who is primarily responsible for key care delivery activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants. The accountable entity (whether a health care professional, care team, or health care organization) accepts responsibility for failures in the aspect(s) of care for which it is accountable. The patient or family also at times may be the accountable entity.^{8(p2)}

Under the umbrella of these overarching goals, AHRQ outlines six key activities involved in care coordination:

1. Determine and update patient's care coordination needs;
2. Create and update a proactive plan of care;
3. Communicate (between provider and patient/patient's family, within health care teams and between health care teams/settings);
4. Facilitate transitions between two or more entities, including transitions between health care providers, between settings (e.g., inpatient to outpatient) and between care approaches (e.g., acute/episodic care to chronic disease management approach);
5. Connect with community resources; and
6. Align resources with population needs.^{8(p3-4)}

Care coordination is a complex process, requiring health care professionals and allied health personnel to collaborate across traditional disciplinary boundaries and organizational hierarchies, and involving patients and families as active players in the delivery of their own health care.

Innovative Care Models

Care coordination is a critical component of several innovative care models currently being implemented. Three such models are summarized below.

Patient-Centered Medical Home (PCMH): The concept of a medical home dates back to the 1960's, when the American Academy of Pediatrics issued standards calling for more coordinated care and enhanced communication between providers, to reduce duplication of services and to avoid gaps in service.⁹ The PCMH is a physician-led model of care intended to strengthen the relationships between primary care providers and their patients, improve care quality and enhance care coordination. PCMHs are designated by the National Committee for Quality Assurance (NCQA). In 2007, the NCQA partnered with prominent organizations representing primary care providers to develop the Joint Principles of the Patient-Centered Medical Home,⁹ which were revised in 2011. To achieve PCMH recognition, primary care practices must meet criteria across the following six categories¹⁰:

1. Enhance Access and Continuity;
2. Identify and Manage Patient Populations;
3. Plan and Manage Care;
4. Provide Self-Care Support and Community Resources;
5. Track and Coordinate Care; and
6. Measure and Improve Performance

Notably, these six categories overlap significantly with the six key care coordination activities outlined by AHRQ. As of September 2012 there were over 5,000 providers working in NCQA-recognized PCMHs in New York State.¹¹

Accountable Care Organization (ACO): An ACO is a team of physicians, hospitals and other health care providers and suppliers who voluntarily work together to provide high quality, coordinated care to Medicare enrollees, particularly those with chronic illnesses.^{12,13} When Medicare saves money on the health care costs for the ACO's patients, the ACO has the opportunity to receive funding that represents a portion of these savings. To receive their share of the Medicare savings, an ACO must meet federal standards in the following areas^{12,13}:

1. Patient/caregiver care experiences
2. Care coordination
3. Patient safety
4. Preventive health
5. At-risk population/frail elderly health

Montefiore/Bronx Accountable Healthcare Network (BAHN), an interviewee in this current study, was also selected as one of only 32 Medicare Pioneer ACOs nationwide, accountable for 22,000 Medicare beneficiaries.¹⁴

Health Home (HH): HHs provide coordinated, patient-centered care to Medicaid enrollees who are living with chronic illness or a serious and persistent mental illness (SPMI). As described by the Centers for Medicare and Medicaid Services (CMS), HHs expand the traditional medical home models to build linkages to other community and social supports, and to enhance the coordination of medical and behavioral health care.¹⁵

Section 2703 of the ACA (“State Option to Provide Health Homes for Enrollees with Chronic Conditions”) authorizes states to enroll Medicaid beneficiaries with complex health care needs in a HH model, where patients receive their care through a tightly coordinated web of service providers.^{15,16} Medicaid enrollees who are eligible for HH enrollment are among the most medically vulnerable patients, and would benefit greatly from intensive care coordination. These patients include those who are living with two or more chronic health conditions, those living with one chronic condition and at risk for at least one other chronic illness, and those living with SPMI. Enrolling these individuals in a program that integrates their acute care, chronic care, social and other health-related needs is expected to achieve the Triple Aim objectives of improving quality of care, improving patients’ health and reducing the costs that accrue due to fragmented care.

HH service providers are reimbursed for “outreach and engagement” activities, which involve locating and successfully encouraging patients to access care within the HH, and for “active care management,” which involves providing services in six core areas^{15,16}:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care;
4. Patient and family support;
5. Referral to community and social support services; and
6. Use of health information technology and link services.

Under the ACA, states have the latitude to create HH initiatives tailored to their needs and will receive a temporary enhanced 90% federal match rate to provide the HH services. New York is one of six states with at least one State Plan Amendment (SPA) currently approved by CMS. The other five states are Iowa, Missouri, North Carolina, Oregon and Rhode Island.¹⁷⁻¹⁹ At least an additional 14 states and the District of Columbia have been approved for federally-funded HH planning grants.¹⁸ Table 1 highlights key features of the first eight SPAs approved by CMS, across six states.

Health Homes in New York State

In January 2011, New York Governor Andrew Cuomo convened the Medicaid Redesign Team (MRT), a group of health care stakeholders who were charged with providing recommendations that would allow Medicaid to achieve the Triple Aim of enhanced quality of care, better health outcomes and reduced costs.²⁰ The HH model was a key component of the MRT’s plan for achieving a streamlined Medicaid program to better meet the needs of New Yorkers who require the most intensive care services and making progress toward the goal of “care management for all.”^{20,21}

The HH initiative incorporates best practices from other care coordination projects that have been implemented in the state, such as the Chronic Illness Demonstration Project (CIDP), the Office of Mental Health’s Targeted Case Management (TCM) Program, the HIV COBRA Program and the Managed Addiction Treatment Services (MATS) Program.¹⁶ New York’s version of the HH model, approved by CMS in February 2012, seeks to address the care needs of adults living with at least two chronic medical conditions, HIV/AIDS or SPMI.¹⁶⁻¹⁹ In New York, 975,000 individuals fall into one of these categories, representing nearly 20% of the more than 5 million New Yorkers enrolled in Medicaid.¹⁶ The DOH has already designated HHs in all 62 counties of New York.²²

Table 1: Comparative Summary of Early Implementation Health Homes

| State | Date SPA Approved | Target Patient Population | Providers | Payment Methodology |
|----------------|--------------------------|--|--|---|
| Iowa | 6/8/12 | Chronic Conditions | Primary Care Practices, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) | Per Member Per Month (PMPM); performance incentives begin in 2013 |
| Missouri | 10/20/11 | Mental Illness/ Behavioral Health | CMHCs | PMPM; also considering shared savings and performance incentive strategies |
| Missouri | 12/22/11 | Chronic Conditions | FQHCs, RHCs, hospital-operated primary care clinics | PMPM; also considering shared savings and performance incentive strategies |
| New York | 2/3/12 | Chronic Conditions & Mental Illness/ Behavioral Health | Partnerships between hospitals, clinics, primary care providers, medical homes, FQHCs, behavioral health providers and Community Based Organizations (CBOs) | PMPM, adjusted by region and case mix |
| North Carolina | 5/24/12 | Chronic Conditions | Medical Homes | PMPM, tiered by ABD (aged, blind, disabled) status; add-on payments for patients w/ special needs |
| Oregon | 3/13/12 | Chronic Conditions & Mental Illness/ Behavioral Health | Non-specialty physicians, clinics, group practices, FQHCs, RHCs, tribal clinics, CMHCs, community mental health programs, select drug/alcohol treatment programs | PMPM, tiered by Medical Home designation |
| Rhode Island | 11/23/11 | Children/Youth with Special Needs | CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-Evaluation) Family Centers | Alternate Fee for Service (rate based on level of effort and market hourly rate) |
| Rhode Island | 11/23/11 | Mental Illness/ Behavioral Health | Community Mental Health Organizations (CMHOs) | Statewide average case rate |

Sources: National Academy for State Health Policy,¹⁸ Integrated Care Resource Center,¹⁷ Kaiser Family Foundation¹⁹

Successful Medicaid reform, including effective implementation of the HH model, will require basic changes in the health care workforce. For example, care coordination, which is the foundation of many innovative care models, can be performed by individuals with a range of educational experiences and credentials, including community health workers (CHWs) and other assistive health personnel, and licensed and unlicensed professionals holding college or graduate degrees.^{23,24} To be effective and efficient, the health care system must make optimal use of the skills and capabilities of staff with different life experiences and levels of formal education.

Realizing the need to understand the health care workforce and maximize its flexibility, the NYS MRT included a Workforce Flexibility and Scope of Practice Work Group. The Work Group developed a series of proposals,²⁵ adopted by the MRT, aimed at:

- Removing statutory and regulatory barriers to implementing a full scope of practice for various occupations across the care continuum;
- Allowing assistive personnel with training and supervision to assume more responsibilities; and
- Supporting the development of career ladders.^{20(p81)}

Passage of the ACA accelerated ongoing changes in the healthcare delivery system, including trends toward community-based services, care coordination among multiple providers, a multi-disciplinary team approach, incorporation of new technologies such as electronic health records (EHRs), and accountability for the total care of the patient. The future healthcare system will also be more focused on primary and preventive care and will emphasize self-management of chronic diseases. Federally-funded reimbursement innovations are also accelerating reform efforts by aligning payments with services delivered across an episode of care rather than paying for services separately. Thus, new reimbursement methodologies are encouraging workforce flexibility, and creating financial incentives to develop new career ladders. In New York, funding for HHs will be on a per member per month (PMPM) basis. This capitated payment methodology will give providers the opportunity to employ a wide array of frontline workers to deliver required services.

The NYS MRT Waiver Amendment²⁰ describes the MRT's plan to develop a sufficiently sized and adequately trained workforce to meet the needs of a transformed healthcare delivery system. For its HHs, NYS requests funding to train incumbent and new workers "in emerging models of collaborative, interdisciplinary and team-based care."^{20(p82)} Funds could be used to train frontline workers as care managers, care coordinators, medical assistants, health coaches, patient navigators, etc. who are deployed on care teams. Waiver funds could also be used to train all personnel in the effective use of EHR and other health information systems technology.

The following case studies of early HH adopters can inform an inclusive planning process so that NYS can make the best use of these workforce resources, if and when the MRT Waiver Amendment is approved by CMS. Interviews were conducted between April and October 2012 and represent only a snapshot in time within the start-up period.

Section Two: Case Studies

Case 1: Bronx-Lebanon Hospital Center

Background

Bronx-Lebanon Hospital Center is a safety net hospital caring for low-income and uninsured residents of the South and Central Bronx. An estimated 70% of the Bronx-Lebanon patient population is covered by either Medicare or Medicaid. In operation for more than 100 years, Bronx-Lebanon has two hospital locations with 972 beds, medical practice sites, a psychiatric facility, and two long-term care facilities, among other community based services.²⁶

Bronx-Lebanon has been approved as a Phase I Medicaid HH provider and has participated in several projects that have prepared it for the implementation of this care model. By targeting patient subsets based on chronic disease or care need, Bronx-Lebanon has initiated care models for the following populations: patients with HIV/AIDS, diabetes, heart disease, or those needing prenatal care. In addition, Bronx-Lebanon piloted a project in palliative care and previously received recognition as a PCMH, a case management project focusing on whole-person care. Bronx-Lebanon has also achieved “meaningful use” of their data and managed financial risk through the administration of one capitated contract with HealthFirst. One specific initiative, tracking 50 of the highest hospital utilizers over 15 months who received care team support, demonstrated a decrease in hospitalizations among HealthFirst patients and Bronx-Lebanon achieved an impressive return on investment. These varied initiatives that target specific groups provided the foundation needed to implement an HH.

Implementation

Bronx-Lebanon views its HH as an enhancement to their PCMH model, expanded to include community based organization (CBO) partners. These partners offer social services (i.e. housing, shelter placement) while Bronx-Lebanon focuses on medical care. Both Bronx-Lebanon and partnering CBOs will share the patient panels. For Bronx-Lebanon, the HH model is an opportunity to develop stronger relationships with CBOs and thus far it has been a “positive learning” experience. Within the first three months of implementation, Bronx-Lebanon had 600 patients enrolled in the HH.

Bronx-Lebanon plans to build their HH on their care teams in the Department of Family Medicine, which have been in place for five years. These care teams are structured with the CHW at the center. The CHW provides services (i.e. health education, resource identification) to targeted populations, such as those with chronic illnesses, and is responsible for the care coordination services for HH patients who come through Bronx-Lebanon. In addition to CHWs who support outpatient and home activities, Bronx-Lebanon employs patient navigators who function similarly as CHWs on the inpatient hospital side.

Technology

For general patient record use, Bronx-Lebanon is using an electronic medical record product sold by Allscripts, a healthcare software provider. This system allows for quick identification of any HH patient entering the emergency department at Bronx-Lebanon. To manage patients through the PCMH and HH, Bronx-Lebanon plans to implement another Allscripts product called Care Management, a web-based clinical system. Allscripts describes Care Management as a “fully-integrated” system which “simplifies and consolidates utilization management, discharge planning, outpatient care management, documentation integrity, quality management and risk management.”²⁷ This management system along with the electronic medical record will support communication between members of the care team. Because Care Management is a web-based product, partnering CBOs will also be able to access and update patient records.

Staffing Plans

To care for the HH patients, Bronx-Lebanon plans to continue using a care team model that includes CHWs, case managers/social workers, nurse practitioners and a CHW administrator. It is also relying on the partner CBOs to manage and train the CBO staff to provide non-health care related services. Bronx-Lebanon will likely use fewer nurses as it has been increasingly difficult to find nurses with the needed experience in care management.

Currently Bronx-Lebanon has 18 CHWs on staff: 11 in family medicine and seven working in other disciplines. In addition to care coordination, the CHW is responsible for performing a non-clinical assessment as well as sending information to a clinician to develop the patient care plan. Although anticipated in the future as patient enrollment expands, there are no immediate plans to increase staff. With the implementation of the HH, there is likely an expanded role for CHWs in the ambulatory care setting, observation beds (24 hour care and evaluation beds) and inpatient care.

Educational requirements have not been specified for the CHW role, with the current educational level ranging from high school/GED completion to master’s degrees. What is valued is a demonstrated commitment to the community and effective communication. When assessing skill requirements, previous experience in the field is preferred to a more formal educational background. For example, the CHW administrator is previously from the field having worked as a CHW. Firsthand experience is seen as beneficial for CHW responsibilities, such as patient advocacy, while the ability to perform other tasks like health education could be acquired while in the role.

Training Needs

Training in care coordination is being provided to CHWs, patient navigators, care managers, licensed practical nurses (LPNs) and patient care technicians through the 1199SEIU TEF. Additionally, CHWs are participating in both credit and non-credit training provided through CUNY’s Hostos Community College. There is interest in more general training for workers and

CBOs on the role of CHWs, and to enhance their general understanding of the PCMH and HH models. In the future, Bronx-Lebanon would like CHWs to receive external certification and sees a role for trade associations, labor unions and education partners such as CUNY to help with that process.

In addition, Bronx-Lebanon wants to see training and development in New York City in the field of Information Technology, across job categories and educational levels. While technical skills were perceived as important, there is particular interest in training for system security, systems interface, and workflow analysis and evaluation across workgroups and clinical functions. The ability to communicate with various levels of staff is also considered important.

Challenges

Bronx-Lebanon's key challenge is that growing community based services such as those provided through the PCMH and HH models may directly reduce the need for inpatient beds and services. Maintaining inpatient and outpatient workforce levels as care settings shift is a chief concern. New job descriptions, titles and compensation schedules are needed to adapt to new models of care and funding priorities. Close work with labor unions will be helpful in redefining roles and job titles as there is mutual interest in saving these jobs.

Case 2: New York City Health and Hospitals Corporation

Background

The New York City Health and Hospitals Corporation (HHC) is the largest municipal health organization in the United States. With a network of medical facilities that includes 11 acute care hospitals, four skilled nursing facilities, six diagnostic and treatment centers, more than 70 community based clinics and its own health plan, HHC serves more than 1.3 million New Yorkers each year.²⁸

Implementation

HHC's HH model was built on the foundation of its previously established PCMH and prior experiences with the CIDP, the HIV COBRA and TCM programs. Other case management initiatives that are borough and institution specific also provided a foundation and mindset for HHC's HH project. A few examples include care management for diabetes, depression, and heart failure, in addition to asthma management through the HHC health plan, MetroPlus.²⁹ Each of these projects was focused on intensive case management for chronic conditions and the use of data and technology to support care with specific target patient populations. Through these prior experiences, HHC learned how to operationalize care coordination and also provided staff with the experience needed for the HH.

HHC's HH and PCMH are seen as complementary, sharing common core concepts and principles rooted in care management and coordination. For successful implementation in the HH model, HHC leadership felt that the two models should be aligned despite the differences in coverage and the intensity of services needed by the targeted patient populations. Both models require a shift in current practice: to foster a proactive approach to care rather than one which is reactive, and a shift from an individual focus to one which is population focused. Both shifts will require staff to acquire new skills and to operate in a collaborative model which focuses on systems and processes. The PCMH and HH models are part of a longer term strategy of achieving designation as an ACO.³⁰

Whereas other provider-led HHs have CBOs as part of their network (included as part of their application and approved by DOH), HHC is currently in the process of formalizing its partnerships with CBOs. Therefore, to date, the role of CBOs has been limited in HHC's implementation of its HH. HHC is currently in the process of identifying partner CBOs and, in doing so, is looking at the quality of care provided at the organizations, including whether they are certified by the NCQA, if applicable, and have cultural competency training for their staff.

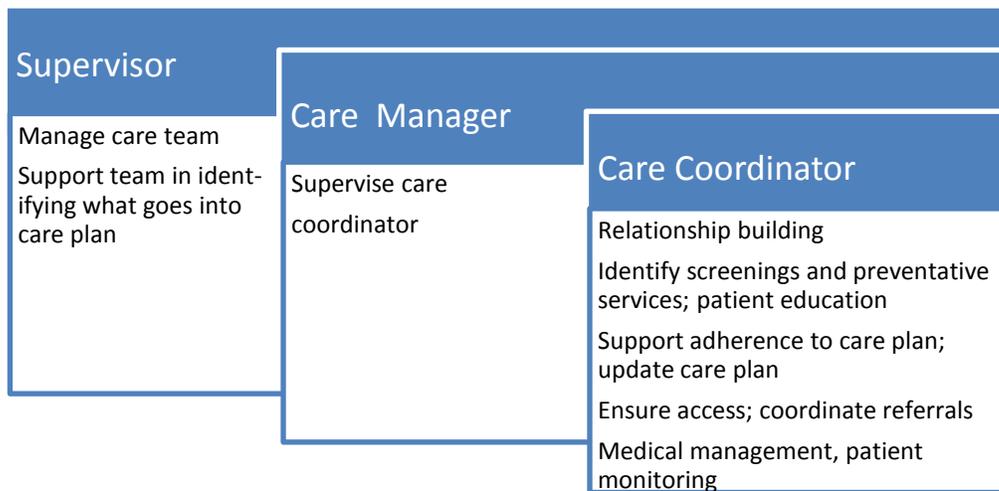
HHC's "soft launch" of their HH occurred in July, 2012 with three hospitals in the Bronx and Brooklyn focusing on approximately 200 patients. They are currently in the process of locating these patients and enrolling them into the HH.

General Workforce Approach – Collaborative Teams

In the short term, because of their extensive history in case management working on the CIDP, COBRA, and TCM initiatives, HHC plans to use incumbent staff to manage the initial patient panel of 200 individuals. The general workforce approach is to form care teams that will be a combination of care coordinators, care managers, and other care providers. Each member of the team will likely have different educational backgrounds, roles and caseloads.

Care coordinators, the linchpin of HHC’s model, are unlicensed individuals, trained to work with patients to ensure adherence to an individualized care plan and to ensure access to medical and behavioral services. Care coordinators must understand how to access services and need strong communication skills. They will be supervised by care managers, who are licensed individuals with either a medical background (i.e. registered nurse) or behavioral health background (i.e. social worker). Supervisors will be responsible for managing the care coordination team and helping team members determine what additional clinical or social support resources must be included or brought into the patient’s care plan. (See Figure 1.)

Figure 1: HHC Care Coordination Team



Both primary care providers and care coordination teams conduct an initial assessment of the patient and determine what kind of support would be needed in the medical, behavioral health, and social services realms. Based upon the identification of these needs, and discussions with the patient concerning their personal goals, a care plan is created. Care coordinators are then responsible for relationship building with the patient as well as all involved members of the patient’s team. They also support the patient to ensure that the care plan is followed and progress is being made towards achieving their goals. Each patient’s team will include a primary care physician and care coordinator, and may also include a medical assistant, registered nurse (RN), social worker, behavioral health provider, or other identified roles based on the patient’s needs. There are other frontline staff members (i.e. medical assistants, patient care associates, and

LPNs) who support the team by performing administrative duties, including scheduling and appointment reminders.

New Workforce

In addition to existing staff, HHC plans to hire new care coordinators for their HH once there are significantly more patients enrolled. HHC will most likely seek to hire care coordinators who are unlicensed, with a bachelor's degree, and ideally have a background in social work or social services. The number of staff hired will depend on the number of patients assigned and enrolled to HHC's HH. The ratio of care coordinators to patients is still being determined. HHC anticipates their care coordinator to patient ratio to be 1:35; however this ratio is still under discussion and will largely depend on the state's reimbursement rate for the program.

Care coordinators will have responsibility for managing a panel of patients and performing the following functions: developing care plans and assisting patients in following the care plan; updating the care plan as needed; identifying needed screenings and preventive services; coordinating referrals; providing medication management support; and sharing the care plan with providers. Care coordinators are also responsible for patient education (pertaining to care and services), patient engagement, and patient monitoring. To do so, the care coordinator must be able to effectively use information technology (IT) and interoperable systems, to extract meaningful data from the appropriate locations in a timely manner. The care coordinator also meets and reports to the other care team members through various mechanisms, including regularly held huddles.

In addition to care coordinators, HHC anticipates a need for mid-level providers, primarily supervisors (licensed RNs and social workers), housing coordinators, physician assistants (PAs), who could function as physician extenders, and nurse practitioners (NPs), who can manage their own patient panels. Both PAs and NPs would allow physicians to manage more complex clinical cases. However, given the early stages of the HH, it is difficult to predict precisely the level of staffing needed.

Training and Resources – Skill Development

The HH training model is based on prior initiatives and existing resources. Using the structure of the PCMH training and the curriculum from the CIDP project, staff across functions will receive general training and skills-based training specific to their position. This includes face-to-face training, webinars, and regular meetings.

HHC has begun general training for all staff, which includes an overview of the HH concept, the context for it, and the necessary skills for collaborative care management. Care coordinators will learn how to develop patient care plans, utilizing assessment tools and transitioning care to other members of the team.

Following general training, HHC will move to skills-based training. A primary focus of the skills-based training will be on broadening the staff's knowledge around chronic disease and behavioral health. For example, if a staff member has experience in care coordination under the TCM program, they will have experience with behavioral health issues but not as much with chronic disease. HHC will focus on expanding the care coordination team's knowledge so that they have a comprehensive understanding of both chronic disease and behavioral health issues. Other focus areas of the skills-based training will include motivational interviewing, health coaching, and communication skills.

As the trainings progress, HHC will use simulation to support team-based learning. The goal is to have care teams (of 3-4 people) train together alongside one another. Through simulation, they will be able to replicate the ambulatory care environment and may include actual patients so that they are part of the process. These sessions will include a didactic component, three cases, and a debriefing session.

Challenges

A challenge that will need to be addressed is the idea of proactive patient care instead of reactive patient care. The concept of the HH relies on care management of chronic diseases, and physicians and other care team members must learn how to implement this population health management model and not just conceptualize it. Another challenge will be retraining staff to fit the new model of care. One example of this is training the care coordinator to communicate with the clinical care team at a level that will be respected, listened to, and acted upon by all levels of staff.

Case 3: Maimonides Medical Center

Background

Maimonides Medical Center, founded in 1911,³¹ is a 711-bed teaching institution located in Brooklyn.³² In an effort to better meet the needs of patients with serious and persistent mental illness (SPMI) and chronic medical conditions, it applied for and received designation from DOH to implement a Medicaid HH, called the Southwest Brooklyn Health Home (SWBHH). This systems-based approach to managing patients with chronic conditions or persistent mental health problems will be coordinated through the use of interactive electronic patient care plans. Care plans will be developed based on the specific patient data that is shared across the HH network to allow for a coordinated, patient-centered approach to preventing and treating chronic conditions.

Implementation

The SWBHH is built upon the success of a pilot jointly developed by South Beach Psychiatric Center and Maimonides. This co-located model showed an improvement in communication and coordinated care by bringing together mental health and primary care providers in a central location along with structured, weekly case conferences for patients. Additionally, Maimonides received grant funding from the NYS Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) program that was used to leverage health information technology tools and to create the Southwest Brooklyn Patient-Centered Medical and Mental Health Home. The model was developed to coordinate medical and behavioral services for patients with SPMI with the goal of driving measurable improvements in patient outcomes, including reduced inpatient admissions and readmissions and improved overall health and satisfaction.

Building on this experience, Maimonides Medical Center was designated as a Phase I provider-led HH in Brooklyn to provide coordinated behavioral and medical services to high-need, low income Medicaid patients. Over fifty organizations, including mental health and social service providers, have created a consortium to provide coordinated services to patients within the HH, as shown in Table 2.

Table 2: SWBHH Care Management and Network Providers

| Care Management Providers | Network Providers |
|--|---|
| Maimonides Medical Center Lutheran Medical Center Visiting Nurse Service of New York CAMBA iHealth: - AIDS Service Center NYC - HELP/PSI Services Corp - Gay Men’s Health Crisis, Inc. - Harlem United - Bailey House - Richmond Home Need Services Inc. - APICHA - Housing Works - VillageCare - Diaspora Community Services - Argus Community, Inc. Health Care Choices FEGS Health and Human Services System Promoting Specialized Care and Health The Jewish Board of Family and Children's Services Ohel Children’s Home and Family Services Brooklyn Community Services (BCS) Catholic Charities Neighborhood Services NADAP Services for the Underserved (SUS) The Puerto Rican Family Institute, Inc. Interborough Developmental and Consultation Services Family Services Network of New York, Inc. Heartshare Human Services of NY Salvation Army South Beach Psychiatric Center | Center for Urban Community Services First to Care Home Care Institute for Community Living Brooklyn Plaza Medical Center Phoenix House National Alliance on Mental Illness (NAMI) Liberty Behavioral Management The Brooklyn Hospital Center St. John’s Riverside Hospital Medisys Health Network Providers Brookdale Hospital Beth Israel Medical Center SUNY Downstate Medical Center Brooklyn AIDS Task Force Realization Center Bridge Back to Life Kingsboro Psychiatric Center Seafield Center White Glove Community Care, Inc. Public Health Solutions (PHS) Baltic Street AEH |

Maimonides has established a limited liability corporation (LLC) to govern the HH and join key activities of the participating organizations, including expanding the IT systems and monitoring the implementation of common clinical standards. Further, the LLC has formed a joint venture with Coordinated Behavioral Care, an external behavioral health consortium, to more efficiently deliver a 24-hour call center, collaborate on analytics, and negotiate with managed care plans.

The backbone of the SWBHH is the care plan housed on GSI Health’s Health Information Exchange platform, which will be integrated with the Brooklyn Health Information Exchange (BHIX), formed through previous HEAL grants. This robust IT infrastructure allows for collaboration between providers within the SWBHH, and allows for shared data which can be

accessed by providers through GSI’s web-based platform. As of August 2012, there were almost 200 patients enrolled in the SWBHH.

The lessons learned from the development of the Medical and Mental Health Home model prepared Maimonides for the implementation of the HH. The IT system is seen as the crux for successful implementation, as it will enable providers to access secure patient data at any given location within the HH and monitor patient activities through an electronic alert system. Care teams will have access to the electronic data which will allow them to create customized care plans based on their patients’ specific medical and behavioral health needs.

In addition to a solid IT infrastructure, Maimonides has prior experience with projects that centered on their work with CBOs, such as the CIDP. This initiative provided valuable lessons learned in care management, which will inform the implementation of the HH.

Workforce Approach

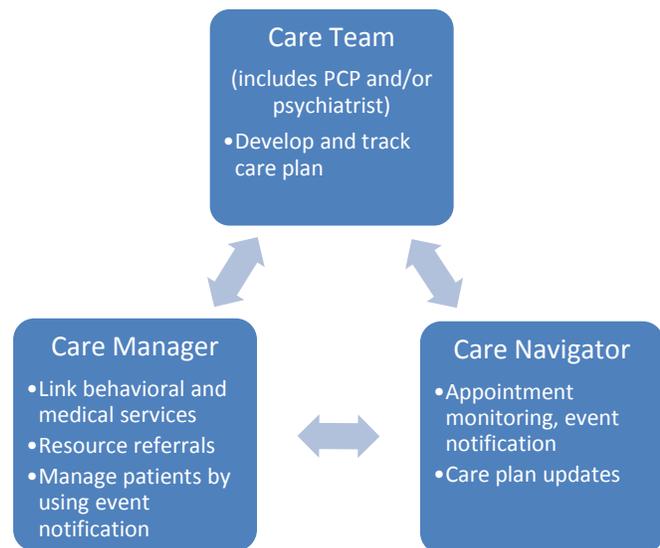
Collaborative Teams

SWBHH will be structured around a care team that will include a primary care provider, care manager, and care navigator, as well as a psychiatrist and therapist for patients with SPMI. (See Figure 2.) Care manager and care navigator caseloads will be variable based on illness acuity and/or diagnosis. Ratios will be determined by the SWBHH’s Clinical Committee, but there is an understanding within the HH that there is a need for a model that is both dynamic and coordinated.

New Workforce and Recruitment

Two new roles will be created to support the implementation of the HH: the care navigator and the care manager. The exact number of new positions created will be determined once the number of patients in each patient panel and the total number of patients enrolled in the HH is determined. The new navigator job title and job description was created with union concurrence and serves as a model for labor-management cooperation.

Figure 2: Maimonides Care Team



Care managers and care navigators will be expected to function at the top of their licenses and qualifications. This change in practice will allow primary care physicians more time to focus on clinical challenges of patients and to spend less time on data entry associated with care coordination and patient tracking. Maimonides has expressed the fundamental need to develop career ladders for upward mobility for these care workers.

Care Navigator - The newly implemented care navigator role will be primarily responsible for addressing non-clinical patient needs (i.e. appointment monitoring, event notification), providing care plan updates to the care manager prior to a patient encounter, and conducting telephonic outreach to patients in between visits. The role of the care navigator will likely evolve as IT systems and processes are refined. Maimonides is working towards achieving a fully functioning IT system in which IT staff would be able to run automated patient reports for the care managers on a weekly basis. Patient reports will identify patients with the highest need for services, enabling the care managers to follow up directly with those patients.

The ideal candidate for the care navigator position is someone who is community-oriented and is a high school graduate. The care navigator is based at the various community based agencies that are part of the HH.

Care Manager - The care manager is an information-focused, knowledge-based position and is seen as the link between behavioral and medical services. The care manager will provide necessary resource referrals and will manage the patient through event notifications, which are electronic alerts generated from the IT system that will alert the care manager of patient activities (i.e. missed appointments, hospital admissions). Care managers will work collaboratively with the interdisciplinary care team to develop care plans, organize and participate in case conferences, and link patients to needed social services and community supports.

Training and Skills Development

SWBHH has established a training program that provides an overview of the HH network as well as specific activities needed in the scope of work. Training topics include: a program overview and an introduction to the BHIX, motivational interviewing, diabetes education, and SPMI education. More general training needs include: patient communication, coordination of services, and management of chronic conditions. Because care managers will have responsibility for supporting both medical and behavioral needs, those coming from one or the other discipline need cross training. Proper IT training is essential; GSI Health will conduct training on the IT system in small groups organized by role, as each member of the care team may utilize the functionality differently.

Challenges

A challenge for Maimonides as they implement their HH has been not yet having the patient volume to support many of their implementation activities. HH network partners are reluctant to

hire new/additional staff because they do not yet have the patients and associated reimbursement. Maimonides is also challenged by the need to uniformly prepare its care coordination workforce despite educational and discipline differences. With federal funding from The Center for Medicare & Medicaid Innovation, Maimonides is collaborating with the 1199SEIU TEF on a universal curriculum for all care team members. This training will start with incumbent workers and then expand to those who are newly hired. Training will also be offered to network partners. Lastly, a challenge has been the adoption of health information technology and creating one integrated care plan that all clinicians and staff will adopt.

Case 4: Montefiore Medical Center - Care Management Organization

Background

Montefiore Medical Center is a 1,491 bed academic medical center and integrated delivery system located in Bronx, New York. Serving over 500,000 Bronx and Westchester county residents each year, Montefiore is a comprehensive system which includes four hospitals, twenty-one primary care outpatient clinics, a comprehensive array of specialty services, and a home care agency.^{33,34}

During the 1990's, New York City saw several changes to the healthcare landscape which included several hospital mergers, closures, and reorganizations. Montefiore Medical Center formed an Independent Practice Association (IPA), representing both the institution and its employed and community-based physician community. At the same time, Montefiore established the Care Management Organization (CMO) as a wholly-owned subsidiary to provide care management, claims processing, customer support, and provider relations services necessary for Montefiore IPA to enter into risk arrangements with health plans. The CMO is currently responsible for care coordination for more than 225,000 individuals, through a combination of capitation and shared savings arrangements.

Over the last 16 years, the CMO has expanded its care management infrastructure, enhancing its care management information, developing its telemonitoring capabilities, and developing specific chronic care management initiatives. Montefiore's primary care centers have been recognized by the NCQA as PCMHs. Also, CMO and hospital staff members have collaborated on the implementation of various care transition programs that can prevent unnecessary hospital readmissions. Montefiore was selected as one of only 32 Medicare Pioneer ACOs nationwide, accountable for 22,000 beneficiaries. It is building strong partnerships within the practice community to support coordinated care for patients across health plans and settings, and has been a leader in the shift toward team-based "touches," which focuses on patient education, improved medication adherence, prevention and early treatment of identified health problems.

Implementation

Montefiore Medical Center was designated as a lead agency for the Bronx Accountable Healthcare Network (BAHN) in Phase I of the New York State HH program in November 2011. Conceptually, the HH is seen as a "virtual integrated care coordination delivery system" and along with Montefiore, the BAHN includes Acacia Network, Albert Einstein College of Medicine, Morris Heights Health Center, St. Barnabas Hospital, and Union Community Health Center. These partners are collaborating to manage the chronically ill Medicaid population in the Bronx.

The BAHN leadership, through shared governance, plans to maximize its resources through shared technology, quality standards, and best practices. During implementation, it became

evident that the BAHN partners, and the CBOs that assist in care coordination, differed significantly in the level of available resources and past experience in care management. The BAHN assumed the initial costs of setting up the IT infrastructure for the HH initiative. This is particularly important given that there was no external start-up IT or administrative funding provided by New York State. Montefiore's IT group (Emerging Health Information Technology) and CMO staff developed an information portal at startup to share critical elements for HH care coordination. The portal allows its partners to share assessments, plans of care, and consents. The portal also allows the BAHN to track work effort, which has been instrumental to its successful startup. In addition, the BAHN is working closely with the Bronx Regional Health Information Organization (Bronx RHIO) to allow for secure, interoperable health information exchange between BAHN partners and the other approved HHs in the Bronx. This will allow BAHN health care professionals to access inpatient and outpatient health information that all BAHN partners are sharing with the RHIO for patients who have signed a data-sharing consent, as well as with most of the Bronx hospitals and other delivery systems.

Workforce Approach

Staffing Plans

Montefiore and the BAHN have identified a range of skills and knowledge essential for HH team members, including communication skills (for both patient and provider interactions), understanding of community resources, ability to assist patients navigating care across many medical and behavioral care providers, developing and implementing care plans, patient education, understanding the impact of psychosocial and economic barriers to accessing care and adhering to care plans, and technological skills.

Montefiore CMO is planning to hire 40-50 new staff at all levels to support the HH program for its assigned patients. This hiring includes:

- provider liaison workers, who will inform community providers about the HH;
- patient educators to provide community and patient education;
- social workers to work with the care management team;
- LPNs to conduct initial assessments;
- RNs to review and implement care plans and supervise LPNs; and
- certified diabetes educators (RNs)

The other BAHN partners will initially hire on a smaller scale.

New roles for workers at different educational levels have been identified, all primarily focused around the ability to provide care coordination. Qualifications include the ability to be comfortable with field-based and telephone-based patient navigation, an understanding of socioeconomic factors which may create barriers to health, and an in-depth knowledge of

technology. For care workers who are unlicensed, a high school diploma would be required; however, a bachelor's degree may be required in the near future. Care workers, who could be medical assistants, LPNs, COBRA case managers, or mental health counselors, are the first point of contact with the patient, completing the initial assessment and developing a draft care plan for a licensed clinical or behavioral specialist to review and approve. The care worker is also responsible for introducing the HH concept to the patient.

In addition to care workers who provide initial services, licensed clinical specialists will review the baseline assessment and approve, or modify as necessary, the care plan. Typically, these positions are called accountable care managers. Behavioral health accountable care managers must have a master's in social work, whereas clinical accountable care managers must be a RN, PA, or NP. In the early phase of implementation, flexibility in these roles is necessary while HHs evolve to improve quality outcomes while accounting for the cost-effectiveness of services.

Case managers create a standardized comprehensive care plan based on a detailed patient assessment (which will be approved or modified by an Accountable Care Manager), reach out to patients twice a month, schedule follow-up appointments, maintain contact with patients, and update care plans regularly.

Training

Montefiore CMO has been providing training to the BAHN partners and its own HH staff. The first phase is primarily informative and focuses on the requirements of the HH program. Information sessions provide a general overview, which includes a briefing on New York State policy, care coordination concepts, and specifically, the structure of the HH. Also covered are the respective roles and responsibilities of the CMO and its BAHN partners. BAHN leaders participate in quarterly conference calls to discuss progress to date, policy concerns, and capacity building. Care workers and behavioral/clinical specialists, who develop and use the care plans, receive practical training on the use and importance of assessment and care plan forms, use of the web-based portal, and an orientation to the Bronx RHIO.

The second phase of training is for CMO employees who are part of the HH, and a train-the-trainer program for BAHN partners. CMO employees receive a customized training that covers care management and other information systems available for Montefiore patients, the elements of effective care coordination, physical assessment, legal elements of behavioral health, accessing the Bronx RHIO, and external reporting to NYS through the Health Information Exchange Survey. This standardized format is delivered by CMO and all partners receive the same materials, including care plans, RHIO consent forms, and assessment forms. While each BAHN partner delivers training to their own staff, BAHN leadership supports the partners with site visits and technical assistance. Current employees are being retrained to work at the highest skill level associated with their degrees and credentials.

In addition to these initiatives, there are other areas that need to be covered in a HH training program such as: the importance of technology in the HH, how to integrate clinical and behavioral care, and training on care coordination for chronic conditions (i.e., diabetes). Curriculum should include case studies to simulate real-life scenarios, which has been proven to be an effective and practical approach to training staff.

The interviewees stressed the importance of dismantling the “silos” of teaching and focusing on cross-disciplinary education and training programs that mirror professional health care settings. There is also an anticipated demand for bachelor’s prepared employees who are equipped to handle higher levels of responsibility. Career ladders need to be established for those workers who have not yet earned a bachelor’s degree. Montefiore’s affiliated academic institution, The Albert Einstein College of Medicine, Department of Substance Abuse, has successfully implemented a career ladder for those who have completed the Credentialed Alcoholism and Substance Abuse Counselor (CASAC) certification.

Challenges

The overlapping implementation of the Medicaid HH and the PCMH results in competition for staff time and attention. For a successful implementation to occur there must be buy-in from all levels of the organization including frontline staff and senior management. All staff must recognize that the movement towards coordinated care is not just another clinical documentation improvement project; rather, it must be recognized as the future of healthcare. Montefiore is focused on balancing and aligning goals and resources. The planned approach is to standardize components of each initiative across the system.

Another anticipated challenge is the redefining of roles. New staff will be hired, but existing staff will be asked to change their current practices to focus more on continuity of care, care transitions, and coordination of medical and behavioral care services. The staff perception of an increased workload must also be managed. In addition, there is a need to redesign existing jobs and create new job descriptions, including defining competencies, roles and compensation. With the change in work and union requirements, there is recognition that staff may need re-training to approach work differently and to successfully serve in these new capacities. Newly implemented concepts such as work reorganization, development of a “shared integrated medical and behavioral model,” mentoring, leadership development, and continuous reinforcement will encourage alignment across the HH.

Case 5: The Visiting Nurse Service of New York

Background

The Visiting Nurse Service of New York (VNSNY), founded more than 100 years ago, provides nearly 2.5 million home visits per year. Services include home care, rehabilitation, long term care and mental health services, among others.^{35,36} Their community based experiences in clinical and behavioral services, along with the experiences of their partnering agencies, will provide the network upon which their HH model will be built. The structure of the NYS Medicaid HH, which focuses on care delivery, partnerships, and collaboration, is aligned with the vision of the new VNSNY leadership.

VNSNY has several existing initiatives which demonstrate their experience and readiness for the HH initiative. These include the VNSNY Centers of Excellence programs, which provide services across the continuum of care for individuals with chronic illnesses (including diabetes and heart disease) and for those who need support with wound, ostomy, or continence care.³⁵ Since 1989, VNSNY has had one of the largest case management programs for seriously mentally ill populations, making them a leader in the field of case management for this population. VNSNY also has two large New York City Human Resources Administration (HRA) funded substance abuse contracts and provides a range of services for the chronically mentally ill. Both of these client bases have a wide range of other chronic diseases such as diabetes or metabolic syndrome that require management. VNSNY Choice Health Plans provides coverage as well as coordinated care for those who are Medicaid and/or Medicare eligible or need long term care. VNSNY is also able to connect patients to supports outside of their scope of services through programs such as MATS.

Implementation

For the HH implementation, VNSNY has established a network which extends their community-based services and is built on several existing care initiatives and relationships. They have partnered with seven other health providers including: Mount Sinai Medical Center, HIV and COBRA providers, and several Federally Qualified Health Centers (FQHCs). VNSNY and its seven partners plan to form an LLC as the corporate structure of the HH. Currently in the early stages of implementation, VNSNY plans to: establish the corporate structure; build its technological infrastructure; and prepare VNSNY staff and staff at partnering agencies for delivering coordinated care.

Role of Information Technology (IT)

The use of IT will be an integral part of the HH care management model, and includes the following functions: developing patient rosters; generating referrals internally and between partners; and locating patients. External databases (i.e. HRA, NYC Way, Homeless Services) will support locating patients in the community. Presently, the HH partners are exploring care management IT products that will enable easier communication with partners and support

linkages between Regional Health Information Organizations (RHIOs). Resolving this issue will be important for a citywide provider like VNSNY. Needed resources are anticipated by June 2013 to support IT development as well as solidification of the governance structure.

Workforce Approach – Staffing Plan

VNSNY is planning for a team-based approach to care delivered by these four roles: care manager, outreach worker, care navigator and supervisor. Described below are the conceptual roles and educational requirements. While some of the positions do not require post-secondary degrees, advanced education is preferred.

Care Managers are bachelor's prepared "health partners", often bilingual, who have the most responsibility on the care team and most direct patient contact. Care managers will help enrollees connect to services and will escort patients to and from appointments. Their role will change from their present focus on mental illness issues to one that includes substance abuse, HIV/AIDS and other chronic illnesses. The position will play an important advocacy role for patients. Additionally, the care manager will likely see an increase in the number of patients assigned to them.

Outreach Workers are field-based workers who have a high school diploma (or equivalent) or higher education. They are computer literate and possess technical skills as well as engagement skills that allow for communicating in a way that makes the patient feel comfortable. They also need skills for finding enrollees out in the community.

Care Navigators have a high school diploma (or equivalent) or higher education. This new position is the least defined at this time and will likely continue to evolve. However this individual is perceived as an "air traffic controller" who is "savvy" and has access to the full range of IT data. The care navigator will likely monitor patient activities, provide reminders and follow up, and alert care managers when needed (i.e. missed appointments).

Supervisors are master's prepared and will oversee the care teams.

Although some new job openings are anticipated, hiring has not yet occurred. The primary reason cited is the HH reimbursement model based on a "legacy rate" which provides a higher PMPM for existing patients (\$600 per month compared to \$140 per month for new patients). This encourages enrollment of existing patients prior to new enrollees, and therefore would not necessitate an increase in staffing in the short-term. In addition, only small numbers of referrals have materialized thus far, and have been managed by dividing the lists of potential enrollees among the myriad of partners, further reducing the need for new staff.

Training

VNSNY had an existing training program for care management which, after being enhanced to include behavioral health, is being offered to the employees of partnering agencies. This one day training for all HH employees covers behavioral health, as well as chronic diseases, clinical paths, adherence, indicators, and decision making support for these indicators. There are plans to convert the training materials to an electronic format that is portable and can support workers in the field.

Educational Needs

There was a perceived need for external training support for workers entering the care coordination field, with an emphasis on soft skills. The themes included: engagement, professionalism, communication and writing skills. This skill set would support better communication with colleagues as well as professional requirements such as writing progress notes. There was also a recommendation for related certificate education as a portable credential that frontline workers can build on and is also practical.

Challenges

The dual roles for VNSNY as one of the lead entities in the HH as well as participating as a partnering agency in other New York City based HHs has presented a challenge for this model. For a successful implementation to occur, their various networks must address sharing patient data across several IT systems across the City. Anticipated funding will help address this in spring 2013.

Section Three: Analysis of Case Studies

The current study highlights the early experiences of Phase I designees, including all four of the organizations awarded HH status in the Bronx (Montefiore Medical Center, New York City Health and Hospitals Corporation, Visiting Nurse Service of New York and Bronx-Lebanon Hospital Center) and two organizations awarded HH status in Brooklyn (Maimonides Medical Center and New York City Health and Hospitals Corporation). The information provided in these case studies encompasses the startup period of these early adopters, from April – October 2012. During this time period patient panels numbered between 11 – 600 patients.

Organizational Issues

Perhaps the most general statement that can be made about HHs is that: Once you have seen *one* HH, you have seen *one* HH. On the other hand, although each HH is quite unique and rooted in the particular history and mission of the lead organization, there are some common themes and challenges. For example, all the organizations in this case study project seek to align HH activities with their existing programs. They are building upon and creating synergies with other innovative care coordination projects that have already been incorporated into their respective organizations such as the PCMH, ACO, CIPD, TCM, HIV COBRA and MATS programs. In addition, all the organizations have significant experience implementing other case management programs and pilots for persons with chronic illnesses such as diabetes, asthma and mental illness. These administrative experiences may include managing capitation payments and thus assuming financial risk.

Each of the medical center-led HHs is expanding its partnerships with local CBOs. This requirement is part of their ongoing movement beyond inpatient acute care to involvement in a wider array of community-based services. The starting point of VNSNY's HH is fundamentally different than the medical center-led HHs because of VNSNY's 100 year-long mission of working directly with individuals in their own homes and with their families. Bronx-Lebanon is building its HH around the care teams in its Department of Family Medicine which is already staffed with CHWs. Although HHs are evolving in the context of existing organizational structures, two of the participants in these case studies -Maimonides and VNSNY- have formed or plan to form LLCs to provide a new corporate governance entity for their HHs. Montefiore's HH is being integrated into its existing CMO, a wholly-owned subsidiary that already provides a care management infrastructure for more than 225,000 individuals. Thus, the design of HHs is part of a dynamic continuum that is creating new types of health care organizations to facilitate and administer health care reforms.

Priority of Incumbent Workers and the Need for Labor-Management Cooperation

Incorporating the HHs into evolving organizations also requires the integration of incumbent staff into new delivery systems. Thus far there have been relatively few new job hires. At the time of these case studies there was an expectation that current staffing would be adequate to absorb the small number of patients currently enrolled in the HHs. Also, in the early stage of the development of the HHs there is a financial advantage to enrolling patients who are already receiving services. Thus the training and redeployment of incumbent workers is a clear priority.

Most of the organizations are providing in-house training to incumbent workers that builds upon their previous experiences in providing case management services to targeted at-risk populations. Some workers are already receiving staff training in care coordination and community health through various programs currently underway, including through the 1199/SEIU TEF, the GNYHA and CUNY. Additional initiatives and collaborations involving labor unions, trade associations and institutions of higher education are needed to retrain all staff to work differently within an evolving service delivery system.

From a hospital perspective it is possible that expanding community-based services and decreasing readmissions will also reduce the need for inpatient beds. Many existing hospital-based jobs will be re-defined, while expanding patient panels are also likely to result in new jobs with CBOs. The HH model will require cultural as well as procedural changes in how care is delivered and by whom. Labor-management cooperation will be needed to maintain adequate workforce levels and to save jobs by redefining staff roles and responsibilities.

The Care Team Model

For the participating organizations, the “Care Team Model” is the basic workforce unit of their HHs. The care team has a collective identity and shared responsibility for a patient or group of patients. It usually consists of a primary care provider (often an NP), a care team supervisor or care manager (usually an RN or social worker), and some combination of care coordinators/care navigators/CHWs (unlicensed positions with educational requirements ranging from high school/GED to bachelor’s level with an ability for community outreach). One exception is Bronx-Lebanon Hospital, where the “care team supervisor” is an experienced CHW. Other assistive health personnel such as medical assistants and LPNs may be included on the team either as care coordinators or in their more traditional roles. While the particular team membership may vary depending on the organization and the particulars of the patient, the linchpin of the Care Team Model is the cadre of unlicensed assistive health personnel.

Assistive Health Personnel

Assistive health personnel are known by many job titles such as CHWs, medical assistants, patient navigators, peer counselors, assistant health educators, outreach workers, social work assistants, mental health aides, health advocates, etc. They are employed in hospitals, community

health centers, mental health agencies, clinics, and neighborhood health and social services agencies. Ongoing healthcare reform will require a more sophisticated frontline worker with a broader scope of responsibility and practice. HHs are required to provide “health promotion,” “patient and family support” and “referral to community and social support services” and assistive health personnel can play a prominent role in all these areas. There is growing evidence that with appropriate training and supervision unlicensed staff can contribute to improving quality outcomes by helping underserved populations access and navigate a fragmented healthcare delivery system. Their first-hand knowledge of the community and their cultural and linguistic diversity make them valuable assets to care teams. For example, a report published by the Center for Health Care Strategies on *Lessons for Health Homes Identified through the Chronic Illness Demonstration Project Learning Collaborative*³⁷ identified successful staffing patterns that included peer counselors and health navigators. Another recent report, *Making the Connection: The Role of Community Health Workers in Health Homes*,³⁸ published by the New York State Health Foundation, highlighted roles that CHWs can play within the HH model.

VNSNY and other organizations implementing HHs are just beginning to partner with FQHCs. According to a 2011 report by the NYS Center for Health Workforce Studies on *The Community Health Center Workforce in New York*,³⁹ while medical assistants are employed in great numbers by community health centers, they are also among the most difficult personnel to retain. A lack of career ladder opportunities contributes to their high turnover. Indeed, medical assistants are employed across all ambulatory care settings. Although they are not licensed in any states, their role continues to evolve as health reform provides incentives to use allied health personnel on multi-disciplinary teams to deliver culturally competent primary and preventive care. Several emergent care models use bilingual/bicultural medical assistants as health coaches to support patients in self-care management.^{40 (p5-11)} This model has led to positive outcomes including decreases in wait times, no-show rates, rehospitalizations and staff turnover. It is likely that medical assistants will play a more prominent role on care teams as the relationships between HHs and FQHCs continue to develop.

Higher Education and Career Ladders

The ability of all personnel to work to the full extent of their training is essential for transforming the healthcare delivery system. The care team provides a multi-disciplinary context in which care coordinators and other frontline staff can assume greater responsibility in the delivery of services. It has a less hierarchical structure that should improve communication and increase the likelihood that the contributions of each team member will be respected. Through a broader scope of services including the delegation of tasks performed under the supervision of licensed clinicians such as RNs, there will be opportunities to create career ladders for assistive health personnel.

Detailed job descriptions for care managers and care coordinators are offered in several of the case studies. Their scope of responsibilities is comprehensive. Several of the organizations

expressed a preference for bachelor-level personnel for these positions and/or emphasized the importance of community liaison. Higher education is not inconsistent with the capacity to perform community outreach. Indeed, there is a need to provide access to higher education and career ladder opportunities for all personnel, but especially for those individuals who have the skills and experience to reach out and communicate with patients in the community. As indicated in the Montefiore case study:

For care workers who are unlicensed, a high school diploma would be required, however, a bachelor's degree may be required in the near future.... There is also an anticipated demand for bachelor's prepared employees who are equipped to handle higher levels of responsibility. Career ladders need to be established for those workers who have not yet earned a bachelor's degree.

In addition to access to college-level courses to earn undergraduate and graduate degrees, other organizations suggested that CUNY provide a "certification" program or "portable credential" for assistive health personnel, including those employed by affiliated CBOs. CUNY has developed credited college-level certificates, in health coaching and care coordination for example, that articulate to degrees in areas such as community health, health education and social work.

Staff Training at CBOs

In general, at this early stage, there appears to be only a tentative connection between the lead organizations and their partner CBOs on the training of frontline workers. This issue will become more important as patient panels grow, there are more new hires, and there is an increase in services provided through affiliated agencies. The Maimonides-led HH has made the most progress insofar as their new care navigator positions will be based at their various partner CBOs. The "co-location" of key staff across partnering agencies may be advisable in some situations. Moving forward there are likely to be challenges associated with the interface of CBOs with the lead organizations, especially in the areas of training and the sharing of data through EHRs. The HH model tries to mitigate the deleterious effects of a fragmented health and social services delivery system, especially for at-risk patients. At the same time it seeks to capitalize on the wide range of existing community-based services to address the needs of the whole person. Thus, it will be important to implement a comprehensive workforce strategy that encompasses the training of personnel across all service settings within and among the HH partnering organizations.

Assistive Health Personnel and the Patient's Experience of Care

Assistive Health Personnel will also have a responsibility to advocate on behalf of patients and families, including educating them on client rights and referring them to peer supports. This is a critical role and an enhanced status for those staff who have direct communication with patients. Staffing will be needed to evaluate the success of the HH model in terms of the patient's

experience of care. Frontline workers could be especially instrumental in soliciting feedback from beneficiaries on consumer assessment surveys that can determine whether the care that is provided is experienced as satisfactory on a variety of measures, including culturally competent care and quality-of-life measures. They can provide leadership on the care team by engaging patients, families and communities in their own healthcare.

Caseloads for Care Managers

Several of the interviewees indicated that at this early stage they were not sure of the appropriate caseload for the case managers. According to a 2011 United Hospital Fund report, *Measuring Quality for Complex Medicaid Beneficiaries in New York*,⁴¹ some states set maximum caseloads per case manager serving the highest risk patients. Setting HH caseloads for the most vulnerable beneficiaries will be one of the most important factors in determining the quality and cost of care as well as appropriate staffing levels. Funding for the HH model is on a PMPM basis. This capitated payment methodology will give providers the flexibility to create career ladders for care team members who deliver measurable quality care outcomes. However, some organizations in the case study expressed concern about the adequacy of the reimbursement rates, especially for new enrollees.

Information Technology (IT) Infrastructure

Several organizations expressed concern about the start-up costs required to implement an IT system that can be accessed by a range of personnel across all the partnering organizations. Also, each HH reported a different stage of readiness in this area. Montefiore assumed the initial cost of setting up its own IT infrastructure. Over the last several years, using HEAL funding, Maimonides developed a sophisticated IT infrastructure that is the centerpiece of its HH model. Some lead organizations were preparing to expand their existing EHR so that partners would have access. Others discussed the need to purchase or develop a new product. VNSNY is exploring case management IT products that have the capacity to share patient data across several IT systems, including the HRA database. VNSNY anticipates receiving additional funding to address this challenge. The success of an HH is highly dependent on the quality of its IT infrastructure. All the organizations emphasized the need to train all personnel in the effective use of EHR and other health information systems. Moreover, job responsibilities of at least some staff will likely be designed around the specific capabilities of the IT systems.

Cross Training and Interprofessional Education

Cross training and interprofessional education are considered best practices in supporting team-based care. Montefiore interviewees in particular stressed the importance of dismantling the “silos” of teaching and focusing on cross-disciplinary education and training programs that mirror professional health care settings. Even as universities begin to expand opportunities in interprofessional educational for students enrolled in their health professions programs, organizations that are already implementing innovative models such as PCMHs, ACOs and HHs must develop strategies to grow their own “collaborative practice” workforce. Cross-training in

both chronic illness and behavioral health was cited by most interviewees. The need to integrate medical and mental health training is inherent in the targeted high-risk population associated with Phase I HHs. Thus, interprofessional training involving RNs, PAs, social workers and assistive health personnel is a priority.

Designing training programs that cut across disciplines and also span all educational levels is a challenge. Nevertheless, team-based trainings that bring together assistive health personnel with a high school diploma or some college, licensed and unlicensed staff with bachelor's degrees, and health professionals and primary care providers with graduate degrees, is an important goal. Despite the educational and discipline differences, several of the organizations that were interviewed are already designing "universal" or "standardized" curricula for a range of care team members. Several interviewees also proposed using simulations and/or realistic scenarios as a pedagogical approach that has been effective in other types of team-based trainings.

Section Four: Next Steps and Recommendations

The **New York City Emerging Healthcare Workforce: Health Homes Case Study Project** is the second of three documents commissioned by the New York Alliance for Careers in Healthcare (NYACH) in its contract with the Office of the University Dean for Health and Human Services of the City University of New York. The first report, *New York State's Community Health Center Workforce: A Mixed-Methods Analysis*, is posted on the CUNY website at <http://www.cuny.edu/about/administration/offices/hhs/CHC.Report.Final.pdf>. As part of the Health Homes Case Study Project, the NYACH contract calls for recommendations for follow-up workforce research and other related workforce development activities:

Additional Case Studies of HHs

Plans to scale up HHs as a major vehicle to transform the healthcare delivery system in NYS are ongoing. Therefore, we recommend that:

NYACH fund a follow-up study of Phase I early adopters who participated in this case study project beyond their start-up period. A second round of interviews should be conducted from April – October 2013.

NYACH fund a similar study that focuses on organizations that are implementing HHs that target patients in long-term care and people with developmental disabilities.

In general NYACH should build on this first study to track workforce issues associated with the development of what is arguably the most innovative model of care in NYS and nationally.

The Need for Labor-Management Cooperation

Workforce issues cannot be separated from broader organizational changes that are taking place as part of the gradual transformation of the service delivery system, especially the impact of those changes on existing positions that are staffed by unionized employees. Therefore NYACH should facilitate efforts by organized labor including 1199 SEIU, and DC37 to negotiate with healthcare organizations including the League of Voluntary Hospitals and the HHC to reach a consensus on new job descriptions and job titles, the core competencies needed for these new jobs, the credit and non-credit training and education programs needed to support the new positions, and a salary structure that links the new positions to career ladders. A long history of successful labor-management cooperation in the healthcare sector in NYC provides a strong foundation for this new challenge. For example, in the Maimonides-led HH, the new care navigator job title and job description was created with union concurrence and serves as a model for further labor-management conversations. Maximum caseloads for case managers and staffing ratios for other care team members serving high risk populations that require labor intensive services should also be included in these discussions.

Access to Higher Education and Career Ladders for Unlicensed Assistive Health Personnel

Since most of the organizations anticipate a growing need for assistive health personnel with bachelor's degrees for leadership positions within the care team it is important to enhance access to higher education and career advancement opportunities for all staff but especially for those individuals who have the skills and life experiences to communicate with and outreach to patients from culturally diverse communities. Motivated staff including unlicensed personnel deployed on care teams should be able to enroll in customized college-level certificates in areas such as health coaching, care coordination and patient advocacy that articulate to undergraduate degrees in community health, health education, social work and other health related disciplines. For workers who need additional preparation in reading, writing, and critical thinking skills, non-credit, bridge-to-college classes, such as those developed by 1199 SEIU TEF and CUNY should be available. Completion of these college level certificates should also be linked to promotions, salary increments and increased job responsibilities. Therefore, NYACH should resource efforts by CUNY, organized labor and healthcare providers to expand these types of educational options and to integrate them into a new incentivized system of career ladders.

NYC Center for Cross Training and Interprofessional Education

Since HHs and other innovative models facilitated through the ACA are founded on interdisciplinary care teams, NYACH should consider supporting a city-wide educational entity that is aligned with the new federally-funded national Coordinating Center for Interprofessional Education and Collaborative Practice. Through such a training center the core competencies for “interprofessional collaborative practice” that were recently identified by a consortium of professional associations could be modeled, learned and disseminated. The proposed center could also prepare academic and practice faculty to teach interprofessional competence. It could provide technical support to providers that are implementing cross trainings to care teams, including the development of simulations and case scenarios. Finally, it could provide technical assistance to CUNY schools on ways to enhance interprofessional education for students studying to become RNs, NPs, PAs, and social workers, by increasing their opportunities to learn and practice together to improve their team-based competencies.

These preliminary recommendations will inform a third document that is part of the CUNY-NYACH contract - a Career Mapping and Workforce Planning Document - that will use information from the Community Health Centers and Health Homes reports to develop a more detailed strategy to strengthen the workforce associated with these innovative models of care delivery.

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Appendix A: Abbreviations

1199SEIU TEF: 1199SEIU Training and Employment Funds
ACA: Affordable Care Act
ACO: Accountable Care Organization
AHRQ: Agency for Healthcare Research and Quality
BAHN: Bronx Accountable Healthcare Network
BHIX: Brooklyn Health Information Exchange
CBO: Community Based Organization
CHW: Community Health Worker
CIDP: Chronic Illness Demonstration Project
CMHC: Community Mental Health Center
CMMI: Center for Medicare and Medicaid Innovation
CMO: Care Management Organization
CMS: Centers for Medicare and Medicaid Services
CUNY: City University of New York
DOH: New York State Department of Health
EHR: Electronic Health Record
FQHC: Federally Qualified Health Center
GNYHA: Greater New York Hospital Association
HEAL NY: Health Care Efficiency and Affordability Law for New Yorkers
HH: Health Home
HHC: New York City Health and Hospitals Corporation
HRA: New York City Human Resources Administration
IHI: Institute for Healthcare Improvement
IPA: Independent Practice Association
IT: Information Technology
LLC: Limited Liability Corporation
LPN: Licensed Practical Nurse
MATS: Managed Addiction Treatment Services program
MRT: Medicaid Redesign Team
NCQA: National Committee for Quality Assurance
NP: Nurse Practitioner
NYACH: New York Alliance for Careers in Healthcare
NYS: New York State
PA: Physician Assistant
PCMH: Patient-Centered Medical Home
PMPM: Per Member Per Month
RHC: Rural Health Center
RHIO: Regional Health Information Organization

RN: Registered Nurse

SPA: State Plan Amendment

SPMI: Serious and Persistent Mental Illness

SWBHH: Southwest Brooklyn Health Home

TCM: Targeted Case Management program

VNSNY: Visiting Nurse Service of New York

Appendix B: Interview Protocol

Case Study on Workforce Strategies for Implementing Medicaid Health Home Initiative

Health Home Approach

- Please describe your organization's general programmatic approach to the Medicaid Health Home initiative (e.g., how does it build on existing initiatives that you are implementing, how does the initiative fit into the organization's overall vision)?
- How does your designation as a health home relate to your development of patient-centered medical homes and participation in other initiatives that seek to promote care management?

Workforce Approach in the Health Home Application

- Please identify the proposed health care professionals and other members of the interdisciplinary provider team that will provide care management and coordination of integrated services?
- Please provide the description of the care manager positions, including professional discipline (if applicable), and relevant education, training, and experience?
- How has the general workforce approach changed since you received designation from DOH and have started to implement the program?

New Positions Being Recruited

- How many additional FTE staff in total do you anticipate hiring during Year 1 of the program as a result of participating in the health home initiative?
- Approximately how many people and FTE staff do you anticipate hiring for each of the new job titles?
 - Is your organization creating any new job titles in order to implement the health home initiative? If so, what are the job responsibilities and requirements associated with these new titles?
 - What are the minimum training, education, and experience requirements for an applicant?
- Has your organization developed an additional in-house training program that new hires will go through before working on the health home program? If so, please describe.

- From where are you recruiting for these new positions (internal, the community)? Have you had difficulty recruiting for particular positions?

Incumbent Staff Undergoing Training

- Is your organization planning to provide training to incumbent staff on the health home initiative? Please describe. Will all the incumbent staff receiving training be directly providing health home services? Will preliminary training be offered to incumbent staff who are not yet directly involved in the initiative?
- How is your training programs linked to job promotion, change in responsibilities or change of role? (e.g., RN to chronic care manager) If so, how have staff perceived this opportunity?
- If you are planning or currently providing training, what organization is developing the curriculum and who delivers the training? What is the training design? What is the expected outcome of the training?
 - (Looking for specific topic areas and how the training is tailored to specific professions.)
- In your view, what are scope of practice or scope of responsibility limitations that hinder effective deployment of the workforce in implementing the health home initiative?

Resources Needed

- What workforce resources would be helpful to you as you develop the health home program at your organization?
- How could our institutions (GNYHA or 1199 or CUNY) support various health home participants in addressing workforce needs?
- How can higher education organizations support the health home initiative, health home concepts, or your organization's workforce needs? For example, how might colleges enhance their current curricula to support the health home concept or partner with your organization to develop new training/education programs?