GREATER NEW YORK HOSPITAL ASSOCIATION

GNYHA Care Coordination Training

CHCANYS Care Coordination Workshop
October 24, 2012

Hospital Initiatives

- Hospital-Medical Home Demonstration (H-MH)
  - Patient Centered Medical Homes
- Medicaid Health Homes
- Accountable Care Organizations
- Reducing Avoidable Hospitalizations and Readmissions

Principal Goals of H-MH Program

- Support efforts to transform ambulatory continuity sites to improve care for Medicaid beneficiaries and training experience for residents
  - Achieve Level 2 or 3 PCMH recognition under 2011 NCQA standards
  - “Extend or expand” continuity training experience for residents
- Focus on at least one of four care integration projects:
  - Care transitions/medication reconciliation
  - Integration of physical-behavioral health care
  - Improved access and coordination between primary and specialty care
  - Improved interpretation services and culturally competent care

Care Coordination Workforce Needs

- True understanding of the term “care coordination” and thinking of patient care in a pro-active way
- Understanding care coordination around the planned care cycle
  - Pre-visit → Visit → Post-visit
- Feeling of empowerment; knowing frontline staff *has* the ability and expertise for patient engagement
- How care coordination impacts outcomes, experience, and costs

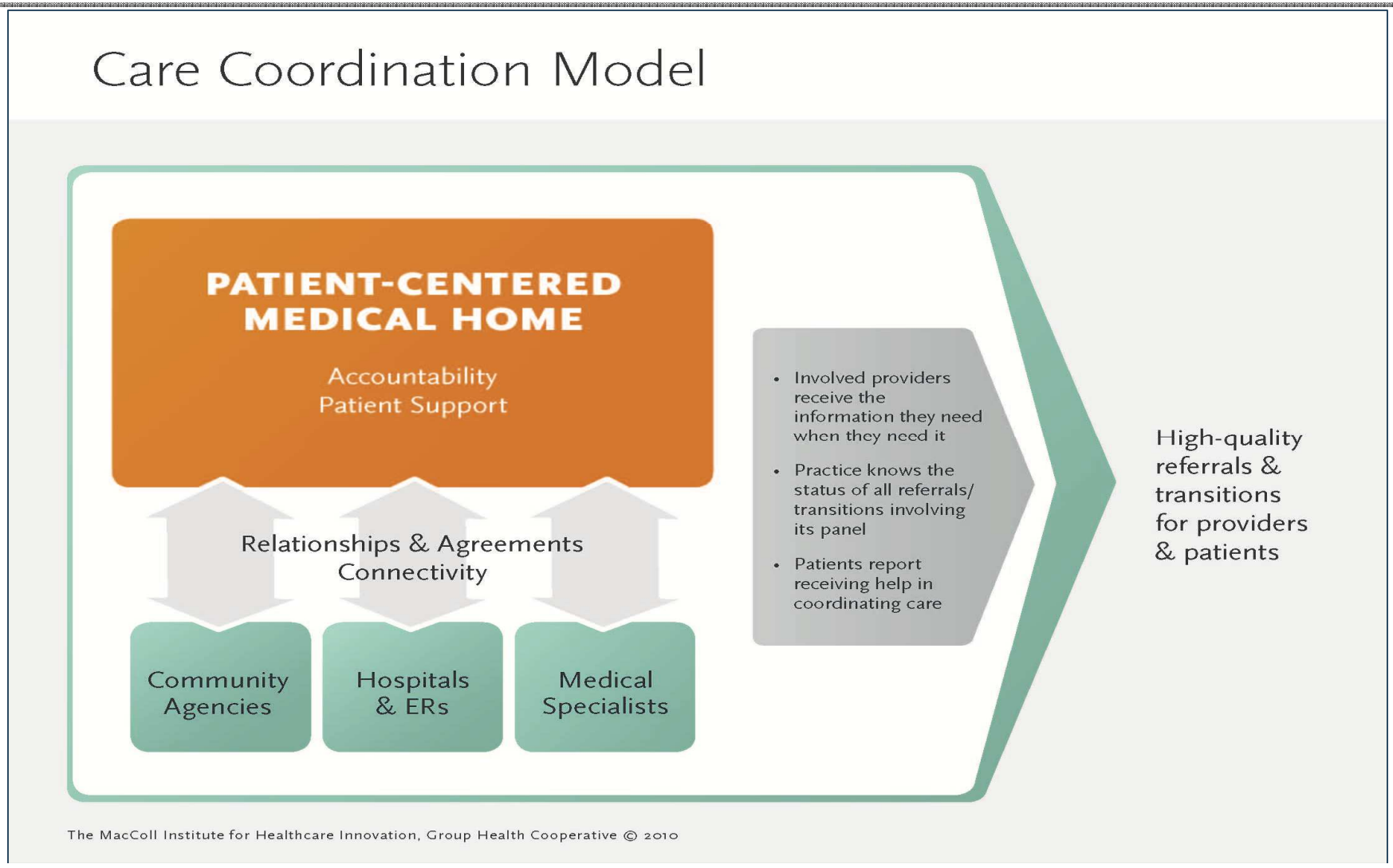
CC Training: Overview

- One-day, introductory education program
- Hospital ambulatory frontline staff:
  - RNs
  - LPNs
  - Patient Care Associates
  - Social Workers
  - Clerical Associates
  - Health Educators

Thinking about CC through the eyes of the patient…

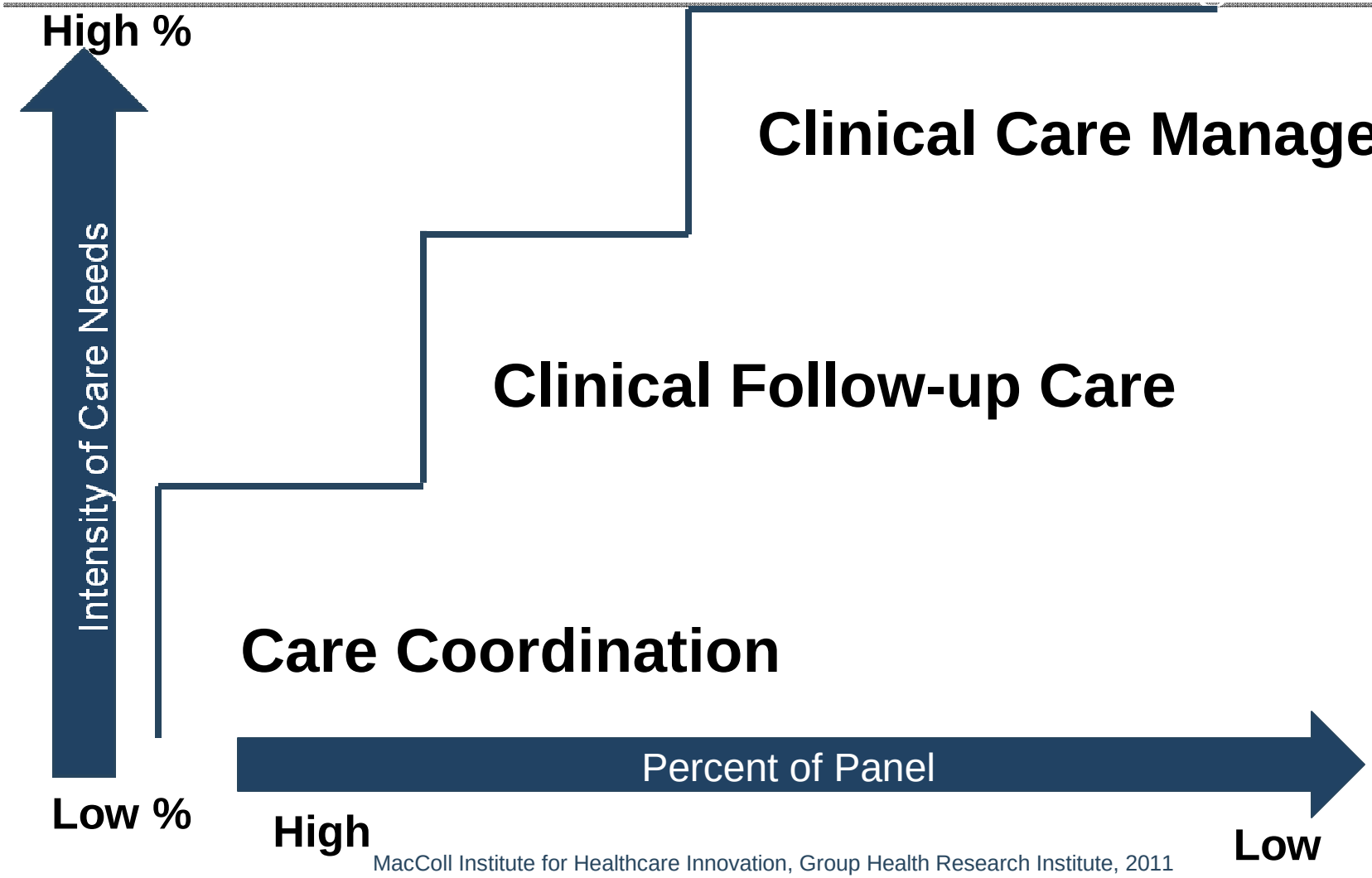
- Relating to personal examples as a patient or family member
- Developing a definition of "care coordination" *from a patient perspective*
- Thinking about ways in which the system is fragmented (by design) and how care coordination activities can alleviate it
  - …and why the government cares about this issue as well

Care Coordination Model



The Care Coordination Spectrum:

Care Coordination vs. Care Management



Case Studies: rewriting the scenario

- Anticipating the visit: care coordination activities prior to the visit for two different patients
- Identifying fragments in the system: what went wrong and what could have been done better

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Questions or Comments

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