CCC Program Staffing Models

This tool is designed to assist community and health care leadership determine the type and level of staffing required for care coordination functions to be performed within a community-based care coordination (CCC) program.

Time needed: 2 hours

Suggested other tools: Population Risk Stratification and Patient Cohort Identification; Resource Checklist for CCC; Matrix of Care Coordination Related Activities and Staff Roles

Table of Contents

How to Use

1. **Understand** that there is currently not a significant amount of experience with CCC staffing models.

2. **Review** the staffing models in this tool to determine the type of model to implement that is most likely to be effective for the CCC program being established.

3. **Consider** a flexible approach to initial staffing for the program. Monitor the selected model as patients are brought into the program and experience is gained in what works best for the number of patients and types of services provided. Modify the staffing model as needed.

Background on Community-Based Care Coordination Staffing

Community-Based care coordination (CCC) – in which patients are engaged after a hospitalization for ongoing medication management, symptom recognition and management, and self-care for chronic conditions – is a relatively new function within the health care system. Where it does exist, the function is implemented in various forms and settings, and a variety of types of services are being provided over different durations of time. Therefore, different types of staffing models support different types of programs.

Initially, care coordination was considered the responsibility of primary care physicians, who would follow their patients intensively post-discharge. In providing reimbursement for such care coordination, Medicare recognizes physicians or qualified practitioners performing transitional care management (TCM) per specified CPT codes. As a result, many programs considered it important to use only physicians or other qualified clinicians, such as advanced practice nurses or physician assistants, to provide care coordination services.

As the accountable care organization (ACO) model of value-based purchasing emerged, however, the proportion of "care coordination" as compared to "direct care" and the duration of such services moving from within 30 days post-discharge to a potential ongoing relationship with patients quickly led some care coordination programs to consider the need for other types of clinical professionals, including registered nurses and medical social workers, to provide the care coordination services, or to supplement qualified practitioners with other staff who can provide more of the administrative coordination needs.

The following table serves to differentiate between various functions that involve care coordination:

Type of Care	Provider-based Enhanced Discharge Planning	Provider-based Care Transitions Management (TCM)	Case Management / Care Management / Disease Management	Community-Based Care Coordination (CCC)
Goal	Hospital works to reduce preventable re-hospitalizations and ED visits	Hospitals and primary care providers work to improve quality and contain costs	Health plans work to ensure care needs are met to reduce overall cost of care	Team of coordinated resources improve the quality of life and satisfaction, and reduce hospital readmissions and costs for patients
General Process	Telephone-delivered follow-up with patient to promote patient safety (including medication taking and follow-up physician visits) and patient satisfaction	Complex assessment of patient needs in hospital followed up by telephone and in-person visit(s) with PCP	Telephone delivered follow-up with patient to encourage medication taking and follow-up visits with PCP to reduce overall cost of care	Complex pre-discharge assessment of patient needs to develop ongoing plan of care and patient action plan; follow up by telephone and in-person visit(s); ongoing advocacy, education, and communication to ensure fulfillment of plan of care

Types of Patients	All patients discharged from hospital	Patients with complex conditions	Patients with targeted conditions at high risk for costly care services	Patients with complex and/or chronic conditions (often in a value-based purchasing initiative)
Typical Duration	2 to 14 days post-discharge	Hospitalization to 30 days post-discharge	Quarterly to annual for duration of condition	Pre-discharge and ongoing
General Tasks	• Patient tracking • Telephoning on medications, provider follow-up and red flags • Referrals to TCM or CCC	• Clinical needs assessment through chart review, telephone- and in-person visits • Communication with providers to ensure plan of care is in place	• Patient tracking • Telephoning on medications and provider follow-up	• Clinical and social needs assessment through chart review, telephone- and in-person visits • Managing logistics to meet clinical and social needs • Coordination among providers and community resources
Staff Qualifications	• Registered nurse *or* • Social worker *or* • Allied health professional	• Registered nurse *or* • Medical social worker	• Registered nurse *or* • Social worker	• Physician or other qualified practitioner (as defined by Medicare for purposes of reimbursement) *and* • Registered nurse, social worker, and/or allied health professional *and/or* • Administrative assistant

Note: Table was compiled from multiple sources

Primary Factors Influencing Patient Load for Care Coordinators in a CCC Program

The patient population to be served heavily influences the patient load for care coordinators in a CCC program. The patient cohort(s) to be included in the CCC program needs to be defined early in the program planning phase, and may be determined to be:

❑ All patients in a given health care catchment area

❑ All Medicare patients

❑ All Medicare, Medicaid, and other safety net patients

❑ Portion of patients in a given health care catchment area based on risk stratification

❑ All high-risk patients with a certain chronic condition or multiple conditions

❑ Other (define your population):_____

Other Factors Influencing Patient Load

Once the *population* of patients to be served, the *nature of the CCC tasks* and *duration of service* provision, and *qualifications* of available staff (from the table above) are determined, there are some additional factors to be considered that may influence how many patients a care coordinator in a CCC program can manage and what, if any, additional resources are needed. Some of these factors include:

❑ **Distances to be traveled**
For example, if there are many high-risk patients in a geographically large, rural community – travel time becomes an important factor. Strategies can be developed to reduce such travel time, such as having the care coordinator see patients before or after a planned provider office visit or by using other means of staying in touch with the patient, such as through home monitoring or telehealth.

❑ **Risk level of patients served**
Risk stratification should consider not only the nature of the clinical condition of the patients but social needs as well. For example, patients with special language, literacy, financial, and other social challenges will need more time and coordination than patients without such challenges but with the same level of clinical risk.

❑ **Available technology resources**
If a community has sophisticated registry functionality that enables easy patient, provider, and community resource referrals and tracking, a care coordinator may not need as much administrative support.

❑ **Maturity of the CCC program**
A CCC program just starting out requires development of provider and community resource relationships. Similarly, patient trust needs cultivating. New workflows and processes will need to be developed and refined over time. A care coordinator in a new CCC program will very likely be involved in all of these aspects, even when there are additional staffing

resources to recruit providers, community resources and patients, and to do the non-patient-facing administrative tasks such as making appointments and tracking test results.

Staffing Level Examples

The following examples of care coordination staffing requirements are taken from a presentation delivered at Aging In America (2011) by Schraeder, Volland, and Golden, entitled "Promising Models of Care Coordination for Beneficiaries with Chronic Illnesses."

- 1 registered nurse per 50-60 patients based in a primary care practice working with 3-5 physicians

- 1 advanced practice nurse and 1 social worker per 100-125 patients in collaboration with a primary care provider and a geriatric interdisciplinary team led by a geriatrician

- 1 registered nurse care coordinator per 350-500 patients in a large primary care clinic with multiple care coordinators

A review of contemporary health care literature on care coordination, combined with collective experience in current CCC programs, suggests the following recommendation for consideration:

In general, **1.0 FTE care coordinator** in a community-based care coordination program should be able to conduct 1200 in-office patient visits per year (five patient visits per workday). The average patient may have between three and six interactions per year with the care coordinator, with some patients declining such services and others, depending on their self-management interests and/or current health risk status, requiring considerably more interactions. Therefore, one care coordinator should plan to work with a population of approximately 300-400 chronically ill or high-risk patients. (See *Resource Checklist for CCC*.)

Additional Resources

Although some of the following references are focused more on care management or case management than community-based care coordination, each provides greater specificity in task delineation, percent of time spent on various tasks, availability of certification programs, and evaluation tools.

- Anderson, St. Hilaire, and Flinter (May 31, 2012). "Primary Care Nursing Role and Care Coordination: An Observational Study of Nursing Work in a Community Health Center" *The Online Journal of Issues in Nursing* Vol. 17, No 2, Manuscript 3. Available at: http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-17-2012/No2-May-2012/Primary-Care-Nursing-Role-and-Care-Coordination.html

- Case Management Caseload Concept Paper: Proceedings of the Caseload Work Group, Case Management Society of America National Association of Social Workers, October 30, 2008. Available at: https://www.socialworkers.org/practice/aging/Caseload%20Concept%20Paper%20final.pdf

- Policy Brief: Implementing Care Coordination in the Patient Protection and Affordable Care Act, Prepared by the National Coalition on Care Coordination (N3C). Available at: http://www.nyam.org/social-work-leadership-institute/docs/publications/N3C-Implementing-Care-Coordination.pdf

- American Nurses Association. The Value of Nursing Care Coordination, A White Paper of the American Nurses Association, June 2012. Available at: http://www.nursingworld.org/carecoordinationwhitepaper

- Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination (2010). A Consensus Report, National Quality Forum. Available at: http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

- Social Work Leadership Institute of The New York Academy of Medicine, Who is Qualified to Coordinate Care? Social Work Leadership Institute. Available at: http://www.nyam.org/social-work-leadership-institute/docs/publications/Recommendations-on-the-Qualified-Care-Coordinator-FINAL-9-10-09.pdf

- National Association of Professional Geriatric Care Managers, Certification. Available at: http://www.caremanager.org/join-us/certification/