Welcome
Goals for today

1. Kick-off a 1-2 year learning and development program for Delaware’s health care workforce
2. Learn from successful integrated care and care coordination programs
3. Identify the skills and capabilities required to integrate and coordinate care
## Agenda

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<tbody>
<tr>
<td><strong>1</strong> Welcome</td>
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<tr>
<td>▪ Overview of the day</td>
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<td><strong>5</strong> Overview of future delivery requirements in Delaware and core competencies</td>
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<td>▪ Healthcare Theatre simulation #2</td>
<td><strong>1:40 - 2:50</strong></td>
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<td>▪ Breakout discussions</td>
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<td><strong>3:50 - 4:00</strong></td>
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<tr>
<td>▪ Next steps and close</td>
<td><strong>4:00 - 4:30</strong></td>
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Delaware’s goals by 2019

1. Delaware will be one of the five healthiest states in the nation.

2. Delaware will be in the top ten percent in health care quality & patient experience.

3. Delaware will reduce health care costs by 6% (versus expected).
Delaware’s framework

- **Healthy Neighborhoods**
- **Delawarean**
- **Team-based care**
- **Payment linked to outcomes**
- **Shared resources and services to support providers**
- **Flexible workforce**
- **Multi-stakeholder governance**
- **Health information at point of care**
Aspiration: DE as a “learning state”

- Delaware has a strong workforce, including innovative learning programs!
- However, Delaware requires additional capacity and new skills/capabilities to support improved health care delivery
- Existing programs are working to address many of these (e.g., by extending work of GME consortium to all health professions)
Overall goals for Delaware’s workforce program

Build an infrastructure for the collection and analysis of professional health care workforce data

Support state-of-the-art health care workforce education and training programs

Ensure integrated and supportive practice environments for health care Professionals

Create and implement a comprehensive health care workforce recruitment and retention strategy
Healthcare Theatre introduction

What is Healthcare Theatre

- Interdisciplinary education program at University of Delaware
- Theatre students and actors portray patients and family members

Healthcare Theatre uses

- Health Sciences students practice technical and interpersonal skills
- Healthcare Theatre has visited hospitals to train current workforce
Healthcare Theatre scenarios

Scenarios for today

Now: “Before”
- How do patients and providers interact in an uncoordinated system?

After lunch: “After”
- What are the benefits of integrating and coordinating care?
## Agenda

1. **Welcome**
   - Overview of the day
   - Healthcare Theatre simulation #1

2. **How others have approached workforce transformation for coordinated care**
   - Speakers from innovative programs outside of Delaware
   - Panel discussion and Q&A with speakers

   **Break**

3. **Examples of ongoing innovation in Delaware**

4. **Overview of future delivery requirements in Delaware and core competencies**

   **Lunch**

5. **Building the learning and development journey for select roles**
   - Healthcare Theatre simulation #2
   - Breakout discussions
   - Plenary report back and discussion
   - Next steps and close

   **Reception**
Goals for this session

1. Learn about the setup of successful integrated care and care coordination programs

2. Identify lessons learned for Delaware
Examples of innovation in other locations

- Vermont
- Minnesota
- UK

Torbay and Southern Devon Health and Care
Craig Jones

» Director of the Vermont Blueprint for Health

» Institute of Medicine’s Consensus Committee on the Learning Healthcare System in America

» Roundtable on Value and Science Driven Healthcare
Patient Centered Medical Homes and Community Health Team Staffing in Vermont

1 Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.
# Leadership Network

<table>
<thead>
<tr>
<th>Program Leaders &amp; Extenders</th>
<th># People</th>
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<tbody>
<tr>
<td>Program Managers</td>
<td>14</td>
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<tr>
<td>Practice Facilitators</td>
<td>13</td>
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<tr>
<td>Community Health Team Leaders</td>
<td>14</td>
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<tr>
<td>Regional Housing Authority Leaders (SASH)</td>
<td>6</td>
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<tr>
<td>Self Management Regional Coordinators</td>
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## Learning Forum Network

<table>
<thead>
<tr>
<th>Program Activities</th>
<th>Frequency</th>
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<tr>
<td>Program Managers Meetings</td>
<td>Every 6 weeks</td>
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<tr>
<td>Practice Facilitators Meetings</td>
<td>Twice monthly</td>
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<td>Community Health Team Leader Meetings</td>
<td>Monthly</td>
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<td>Self Management Regional Coordinator Meetings</td>
<td>Quarterly</td>
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<tr>
<td>Tobacco Treatment Specialists Meetings</td>
<td>Quarterly</td>
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<tr>
<td>Hub Care Coordinator Learning Community</td>
<td>Monthly</td>
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<tr>
<td>SASH DRHO Executive Directors</td>
<td>Weekly</td>
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<tr>
<td>SASH Regional Team Meetings (3 regions)</td>
<td>3 Times per Year</td>
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<td>SASH Local Meetings</td>
<td>Quarterly</td>
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<td>Blueprint Conferences</td>
<td>Twice a year</td>
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<td>Office Based Opioid Therapy Collaborative (9 months)</td>
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<td>Asthma Collaborative (6 months)</td>
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# Self Management Network

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<tr>
<th>Health Service Area</th>
<th>HLW General</th>
<th>HLW Diabetes</th>
<th>HLW Chronic Pain</th>
<th>Tobacco Cessation</th>
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Department of Vermont Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.
# Health Services Network

<table>
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<tr>
<th>Key Components</th>
<th>December 2013</th>
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<tbody>
<tr>
<td>PCMHs (scored by UVM)</td>
<td>121</td>
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<tr>
<td>PCPs (unique providers)</td>
<td>629</td>
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<td>Patients (per PCMHs)</td>
<td>514,385</td>
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<td>CHT FTEs (core staff)</td>
<td>120</td>
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<tr>
<td>SASH provider FTEs (extenders)</td>
<td>46.5</td>
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<tr>
<td>Spoke Staff FTEs (extenders)</td>
<td>30.45</td>
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Summary – Results to Date

- Improved healthcare patterns
- Reduced medical expenditures per capita
- Linking Medicaid population to non-medical support services
- Similar or higher rates of recommended assessments
Mandy Seymour

» Chief Executive Officer of Torbay and Southern Devon Health and Care NHS Trust

» Piloted an integrated health and social care model across the Torbay region in England
Setting the stage

- Population: 140,000
- 26% of the population is aged over 65
- Popular retirement destination and therefore little local family support for the elderly
- 92 GPs working in 22 practices
- Almost all specialist care commissioned from Torbay Hospital
- Decision was made to combine the PCT and adult social services to form a Care Trust in 2005 (budget of £225 million)
What does our model look like?

- Locality Teams defined by GP patient population
- Single managers with a pooled health and social care budget
- Co-located multi-disciplinary teams
- Single community H&SC record
- General management/Professional Leadership
- Strong focus on performance
In Torbay, providers work together to coordinate care in a region

If a patient presents to A&E and does not require admission, HSCC reaches out to various agencies to ensure the patient can go home or receive temporary placement.

Patients and providers have one number to call

All calls come into Health and Social care coordinators who then direct calls as needed e.g. check patient’s history and situation, etc.

Some GPs come to the zone in the morning to do their triage calls from there and directly reach out to the most appropriate team to discuss the best path for patient.

Note: DN – District Nurse; SW – Social Worker; CCW – Community C.Worker; HSCC – Health and Social Care Co-ordinator; RCO – Referral Co-ordinators; IC – Intermediate Care Team

SOURCE: Torquay North Health and Social care team
A story about “Mrs Smith” was created to convey a clear message across the system to rally providers around the need for change.

“Right care, right time, right place”

SOURCE: Integrating health and social care in Torbay, King’s Fund, Peter Thistlethwaite, March 2011
## A pivotal role: Health and Social Care Coordinators

Health and Social Care Coordinators (created in 2004) bring together teams and provide consistency for patients by:

- Acting as the single point of contact to streamline and control the referral process
- Liaising with team members to decide who should handle referrals and how
- Working closely with Intermediate Care teams to prevent admission or facilitate discharge
- Coordinating the “virtual ward” (proactive and reactive)
- Gathering information and coordinating optimal care response
- Administering and coordinating the daily IC MDT meetings
Health and Social Care Coordinators work closely with multi-disciplinary staff, augmenting the effectiveness of their work

- One telephone number for patients and GPs to call for any type of community care or in case of crisis
- Linked to a specific number of GP practices to foster collaboration and relationships
- Staff available in a zone
  - District Nursing
  - Social care
  - Occupational therapists
  - Intermediate care
  - Health and Social care coordinators
- Staff seated in open plan space

“You develop really strong relationships and get to know who people are. If my client needs long-term care, I know who to hand it over to”
– Health and social care coordinator
What did we set out to achieve?

**Ethos of the role**

- Responsive 7 days per week 8 a.m. to 10.30 p.m.
- Close working with Intermediate Care Teams to prevent admission or facilitate discharge
- Supporting members of the multi-disciplinary team
- Co-located in the locality team
- Holistic assessment – history/medication/carers info
- Access to clinical information across Community, Primary Care and Acute Trust
- Understanding the ‘System’ and community resources
- Builds relationships and trust
- To make the right thing to do the easiest thing to do

**Desired goals**

- Maximise people’s independence
- Provide rapid MDT assessment
- Provide suitable alternatives to admission
- Switch on services immediately
- Manage risk and maintain peoples’ safety
- Provide confidence to primary care
- Make things happen!
The difference care coordination makes

**Approach**

- Integrated delivery of Health and Social care
- Four zones of citizens with total population of 40-50k each
- Care coordinators sit in four hubs
- Care coordinators for discharge are based in hospitals
- Change in decision making process reduces 7 steps to 2, and the time from 6 weeks to 2 hours

**Impact**

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<thead>
<tr>
<th></th>
<th>Torbay</th>
<th>Peer group</th>
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<tbody>
<tr>
<td>Community Health Services</td>
<td>1.4</td>
<td>6.5</td>
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<tr>
<td>Social Care</td>
<td>2.7</td>
<td>4.5</td>
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<tr>
<td>Acute² Care</td>
<td>5.4</td>
<td>5.8</td>
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Long Term Residential Placements have reduced from **1298** in 2008 to **676** as of today
Frank Cerra

Senior Advisor and Interim Deputy Director, National Center for Interprofessional Practice and Education
Transitions in Healthcare Creating Need for Redesign of Education and Clinical Practice

- non-integrated to integrated care delivery systems
- independent to employed providers;
- fee-for-service to new financial models and payment systems, or “volume to value” in care delivery;
- uninsured to insured; increasing demand and access;
- an emphasis on disease and acute care to greater focus on health, wellness and prevention;
- autonomous providers to interprofessional teams, necessitating new models of education and training
Current interest in interprofessional practice and education

• Institute for Healthcare Improvement “Triple Aim”
  o Improving the patient experience of care;
  o Improving the health of populations; and
  o Reducing the per capita cost of health care.

• Collaborative practice and care coordination

• Quality, patient safety and systems improvement

• Patient Protection & Affordable Care Act

• New payment and care delivery models

• New defined interprofessional competencies

• ACGME, LCME and other accreditation expectations

• Patients, families and communities engagement/activation
Six Key Current Trends Driving IPECP

The state of readiness of the health care system for redesign and transformative change, driven by cost, quality, and policy, linked to the Triple Aim

Renewed movement toward using interprofessional teams and new workforce development models that incorporate patients, families and communities

The resurgence of interest in interprofessional education to potentially have a positive impact on learning and professional development (i.e., knowledge, attitudes and skills), and ultimately health outcomes
Six Key Current Trends Driving IPECP

The recognized need to reconnect education and practice on multiple levels (i.e., micro, meso, macro levels)

A lack of published evidence connecting interprofessional education to collaborative practice and the Triple Aim outcomes

The role of informatics and big data in health systems to create learning organizations with potential to extend to education
It’s about practice and health outcomes.

Interprofessional education +
Interprofessional, collaborative practice =

The new IPE: Interprofessional practice and education
The Nexus

Creating the Transformational Nexus for Health

Improved Health and Community Outcomes
National Aims / Triple Aim

The Nexus:
Collaborative linking of academia and the practice of health care.

Team-based Care

Health Professions Education
Orientation and essential skills

Senior Leadership

Faculty, Clinicians, and Practitioners
Operations

Practice Community
Evolving integrated health systems

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067. © 2013 Regents of the University of Minnesota, All Rights Reserved.
The current state of IPE

A great deal of enthusiasm and experimentation
National momentum driving local work
New offices to manage IPE with investments
Little evidence for program development:
  When to start?
  What dose?
Few templates to guide curriculum design
Lack of metrics and standardization in the field
Early adopter need evidence of ROI now
It’s a Fan!
It’s a Wall!
It’s a Rope!
It’s a Snake!
It’s a Tree!

It’s “scope” of practice!
It’s health professions education system
It’s the payment system!
There is no problem—our system is great!
It’s the health delivery system!

It's our value system!

We have our own Sufi Tale!
IPEC Competencies

- Values & ethics for interprofessional practice
- Roles & responsibilities
- Interprofessional communication
- Teams and teamwork

Other Needed Competencies

- Population health, including social determinants
- Patient-center decision-making
- Evidence-based decision-making
- Cost-effective practices
- Quality improvement and safe practice
- Stewardship
- Systems thinking
- Informatics
Our vision for a transformed health system
New Nexus

Working together to transform education to keep pace with the rapidly transforming processes of care

Creating a closed loop model for continuous improvement of the delivery of health care

Working collaboratively to achieve the Triple Aim in both health care and higher education: cost, quality and the user experience
Vision - Learning Health System

A system that is designed to generate and apply the best evidence for the collaborative health care choices of each patient and provider; to drive the process of new discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care. (Charter of the Institute of Medicine Roundtable on Value & Science-Driven Health Care)

Health Information Technology Strategic Framework
For A Learning Health System

AIMS: Patient-centered, Safe, Timely, Effective, Efficient, Equitable

- Informed & Empowered Patient
- Improved Care
- Improved Outcomes
- Enhanced Value
- Shared Knowledge

ACTIVITIES
- Engage Consumers
- Provide Care
- Measure Quality
- Improve and Innovate
- Educate
- Conduct Research

BENEFICIARIES
- Consumers
- Patients
- Providers
- Payers
- Public Health Professionals
- Researchers

Data

Meaningful Use of Health Information Technology
- Privacy and Security
- Policy and Technical Infrastructure
Critical Queries of the Database

Does interprofessional education and collaborative practice…

• improve the Triple Aim outcomes on an individual and population level
• result in improvement in educational outcomes?
• identify environmental factors essential for achieving Triple Aim outcomes?
• identify factors essential for sustainability of the transformation of the process of care?
• identify changes needed in policy, accreditation, credentialing and licensing?
Research and Evaluation

1. Searchable data base on the National Center’s website with information of the 500 articles that present and analyze empirical data, to be updated regularly

2. Descriptive review of the current literature that highlights key findings for further research and program development

3. Framing paper that outlines a research agenda in interprofessional practice and education mapped to the outcomes of the Triple Aim

4. Collection of validated instruments for measuring various aspects of interprofessional practice and education

5. Paper describing approach to selecting measurement instruments for IPECP

6. Interprofessional criteria for clinical and teaching sites
Panel discussion

How did you prioritize among potential options for developing a workforce for coordinated care?

What local features of our workforce should we pay close attention to as we develop our program?

Questions from audience regarding Delaware’s workforce
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Overview of where we are in Delaware

- There is a lot of ongoing innovation within the state
- Care coordination and integrated care are spreading but not fully covering the state
- There are a number of reasons which have been identified for the slow spread of integrated care
Many institutions and programs in DE are working to address needs.

Delaware Health Care Commission

Delaware Health and Social Services

Delaware Health Sciences Alliance

Medical Society of Delaware

Delaware Health Care Commission

Not Exhaustive
Some example programs

### Project ECHO
- Weekly telemedicine/telehealth conference to improve management of patients with complex conditions
- Multi-disciplinary teams of specialists teach PCPs about complex conditions via telemedicine conference

### Delaware Patient Centered Medical Home Initiative
- Pilot with 20 practices statewide and an additional 60 practices by May
- Practice transformation coaching for 30 practices between the two cohorts with focus on change management, process and culture change to support the PCMH model

### Nurse Managed Health Center (NMHC)
- Provides holistic primary care to patients via a multi-disciplinary model of care delivery
- Working together nurse practitioners, physicians, physical therapists, exercise physiologists serve as role models for interdisciplinary care delivery while mentoring graduate students in the health sciences

### NMHC Satellite Office at Horizon House
- Co-located NMHC office within the outpatient office of a mental healthcare provider
- Provides onsite access to primary care services for individuals with chronic mental health problems. NMHC team works collaboratively with Horizon House to coordinate patient care
Some example programs continued

<table>
<thead>
<tr>
<th>Beebe Cares</th>
<th>Nanticoke PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ 90-day post-discharge care coordination program for highest-risk patients assisting patients with transitioning back into the home setting and learning how to manage their health conditions</td>
<td>▪ PCMH that emphasizes coordination of care and action based on patient analytics (i.e., management of hypertension)</td>
</tr>
<tr>
<td>▪ Multidisciplinary nurse practitioner, registered nurse, and social worker team (MDT) co-creates short-term care plans with patients, coordinates care provided by PCP and other resources (e.g., home health), and empowers patients to self-manage their chronic illnesses</td>
<td>▪ Care coordinators provide organization and management of care, and educate patients, families, and caregivers regarding the patient’s care plan and self-care management responsibilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Christiana Medical Home Without Walls</th>
<th>Delaware Cancer Consortium</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Interdisciplinary care team (physician, nurse, social worker) who connects “super users” to a medical home, coordinates clinical care and addresses psychological and social needs</td>
<td>▪ Free cancer screening and treatment for those ineligible for insurance</td>
</tr>
<tr>
<td>▪ Strategies include visiting patients in shelters, taking them to medical appointments and addressing factors impacting health such as hunger, addiction and domestic violence</td>
<td>▪ Care coordinators guide patient through testing and treatment, and offer advice, emotional support and practical help</td>
</tr>
</tbody>
</table>
Common themes

- A lot of different pathways for integrating care
- Differences in focus of program, but similarities in their vision for care
- Variation among members of care teams, but similarity in communication between roles

Implications

- What do we mean when we say integrated care?
- What are the different roles involved in integrated care?
- What are the competencies required for the individuals delivering it?
Survey results: formal care coordination programs

Clinics/outpatient practices

- Number of unique respondents:
  - Have a formal CC program: 9
  - Do not have a formal CC program: 22

Hospitals/health systems

- Number of unique respondents:
  - Have a formal CC program: 5
  - Do not have a formal CC program: 1

SOURCE: Care Coordination survey, launched February 17, 88 individual responses across 63 unique organizations (counting each anonymous response as unique)
Survey results: Why has your organization not created care coordination?

For respondents saying “no” to having a formal program

<table>
<thead>
<tr>
<th></th>
<th>Clinics/outpatient practices</th>
<th>Hospitals/health systems</th>
<th>Community, Gov’t, other organizations¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>No funding</td>
<td>68</td>
<td>44</td>
<td>38</td>
</tr>
<tr>
<td>No manpower</td>
<td>45</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>In the process</td>
<td>23</td>
<td>44</td>
<td>23</td>
</tr>
<tr>
<td>Other reason</td>
<td>18</td>
<td>11</td>
<td>62</td>
</tr>
<tr>
<td>In the process</td>
<td>5</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Did not consider</td>
<td>5</td>
<td>22</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ Includes community organizations, gov. organizations, payers, vendors, anyone who responded with 'other organization'

SOURCE: Care Coordination survey released on 2/17/14, 88 responses
# Agenda

1. **Welcome**
   - Overview of the day: 9:00-9:10
   - Healthcare Theatre simulation #1: 9:10-9:40

2. **How others have approached workforce transformation for coordinated care**
   - Speakers from innovative programs outside of Delaware: 9:40-10:30
   - Panel discussion and Q&A with speakers: 10:30-11:20

   **Break**
   - 11:20-11:35

3. **Examples of ongoing innovation in Delaware**
   - 11:35-12:05

4. **Overview of future delivery requirements in Delaware and core competencies**
   - 12:05-12:25

   **Lunch**
   - 12:25-12:55

5. **Building the learning and development journey for select roles**
   - Healthcare Theatre simulation #2: 12:55-1:40
   - Breakout discussions: 1:40-2:50
   - Plenary report back and discussion: 2:50-3:50
   - Next steps and close: 3:50-4:00

   **Reception**
   - 4:00-4:30
We just heard about innovative programs, now we’re going to...

1. Align on a common definition of what integrated and coordinated care looks like

2. Discuss the implications for the skills required to deliver that model of care
Approach to integrated, coordinated care

1. Identification of high risk patients
2. Patient enrollment in CC program
3. Identification of patient health goals
4. Development of care plan with patient
5. Multi-disciplinary care team working together
6. Real-time identification of care gaps
7. Access to specialist opinion
8. Discharge planning to ensure support in the community
9. Case conference to discuss complex cases/issues
10. Regular review and update of care plan with patient/family
11. Review of performance and process within the care team

Specialists in both inpatient or outpatient settings
Includes primary care physicians, advanced practice nurses, physicians assistants

Shared services and resources

- Learning collaboratives
- Clinical guidelines
- Practice transformation support
- Care coordination support

Technology shared services and resources

- Risk stratification tool
- Real-time identification of care gaps

Family
PCP
Patient
Care coordinator
Allied health prof.
Behavioral health
Pharmacist
Social worker
Community health worker
Specialist

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Potential members of care teams

- Home health aides
- Personal care aides
- Nursing assistants
- Medical assistants
- Dentist
- Orthodontist
- Oral surgeon
- Surgeon
- Medical specialist
- Dietician
- Nutritionist
- Occupational health worker
- Physical therapist
- Care coordinator
- Case manager
- Patient navigator
- Wellness coach
- Community health worker
- Health ambassador
- Health coach
- Nurse Practitioner
- Physician Assistant
- Family medicine
- Internal medicine
- Pediatrician
- Geriatric physician
- Psychologist
- Psychiatrist
- Registered nurses
- LP/VN
- Pharmacist
More clarity is needed for some roles, particularly for care coordination roles.

1. Roles are not exhaustive - many other versions also to be considered, e.g., healthcare ambassador, nurse navigator, etc.

2. Currently includes: Care manager; Care coordinator; Case manager; Health educator; Health manager; Health coach.

SOURCE: 40 job descriptions from program websites from Montefiore, Intermountain, Kaiser Permanente, Mayo Clinic, Cleveland Clinic, St. John’s Health System, Geisinger Health System, Inova Health System.
Aligning on common definitions for today

care co·or·di·nat·or
(kār kō-ör'di-nā-tŏr)
Deliberately organizes 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.

health coach (helth ’kōch)
An individual who helps patients achieve their health goals and self-managed chronic conditions through behavioral change strategies and techniques.

community health worker
(kə-’myū-nə-tē helth ’wər-kər)
An individual indigenous to a given community that serves as a health advocate, reaching out to their community through various outreach and interactive actions to promote the health of individuals within that community.

SOURCE: 1 AHRQ, Dr. Michael Peterson, Director Graduate Certificate Program in Health Coaching at the University of Delaware
2 Dr. Michael Peterson, Director Graduate Certificate Program in Health Coaching at the University of Delaware
Competencies for care coordinators

1 American Association of Colleges of Nursing, "Core Competencies for Interprofessional Collaborative Practice"
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   **1:40-2:50**
   **2:50-3:50**
   **3:50-4:00**

   **Reception**

   **4:00-4:30**
Lunch

- Please grab your lunch from the table
- After picking up lunch, proceed to your assigned breakout room (assignments are on handout)
  - Group 1: Room 110
  - Group 2: Room 111
  - Group 3: Room 111
  - Group 4: Atrium (rear)
  - Group 5: Atrium (front)
  - Group 6: Room 113
  - Group 7: Room 113
  - Group 8: Mezzanine (up the stairs)
- Introduce yourself to your breakout group
- Reconvene in atrium by 12:55 PM
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   - 4:00-4:30
Breakout discussions

Instructions

Breakout Discussion (1 hour 10 min):

- Please go to your assigned room
- Discuss these three topics:
  - What are the 5 most important skills for care coordination and integrated care which we should prioritize?
  - Which of these skills have the biggest gap today?
  - What is the best way to learn these skills? (e.g., workshop, experiential learning)
- Prepare several takeaways to share with the larger group

Report back and reflect (1 hour)
Reflections from your breakout discussion

- What were your specific answers for each question?

- What are the challenges and opportunities before us as we go toward the one year journey for the skills we just heard about?

- What other reflections and questions do you have from the breakout and from the day?
How this could work going forward

**Learning Forums**

- **Illustrating skills for care coordination**
  What competencies are needed for working on an integrated care team

- **Teaching self-management and prevention**
  What are the tools and skills needed for self-care

- **Using technology and analysis**
  What are the tools for selecting and monitoring patients

**Learning sessions**

- **Practicing developing a coordinated care plan**
  What are the steps and considerations for making a care plan

- **Connecting patients to community and social resources**
  What resources are available and how to utilize them
Wrap up and next steps

- Share a summary of today’s learnings and agree on the calendar for the rest of 2014
- Begin long-term development program

Thank you!