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

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

Delaware's goals by 2019

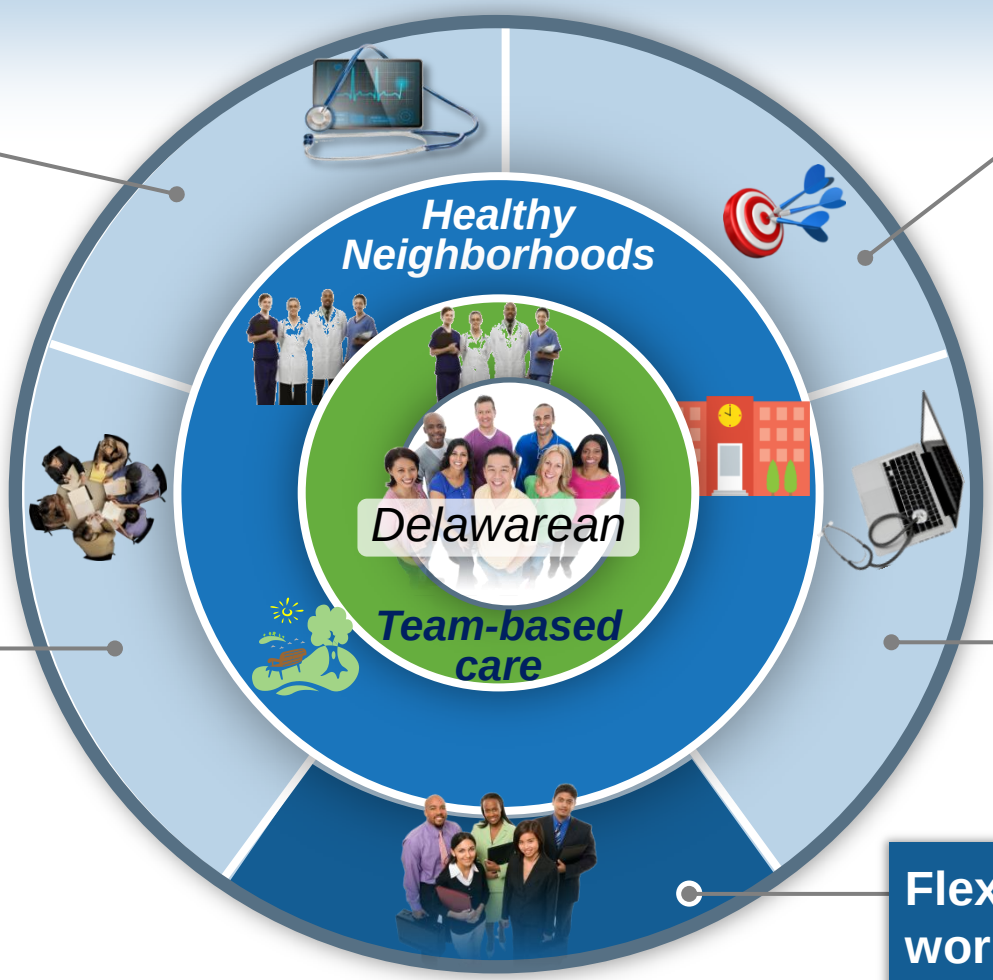
1 Delaware will be one of the five healthiest states in the nation

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)

for a *healthier* community

Delaware's framework



Health information at point of care

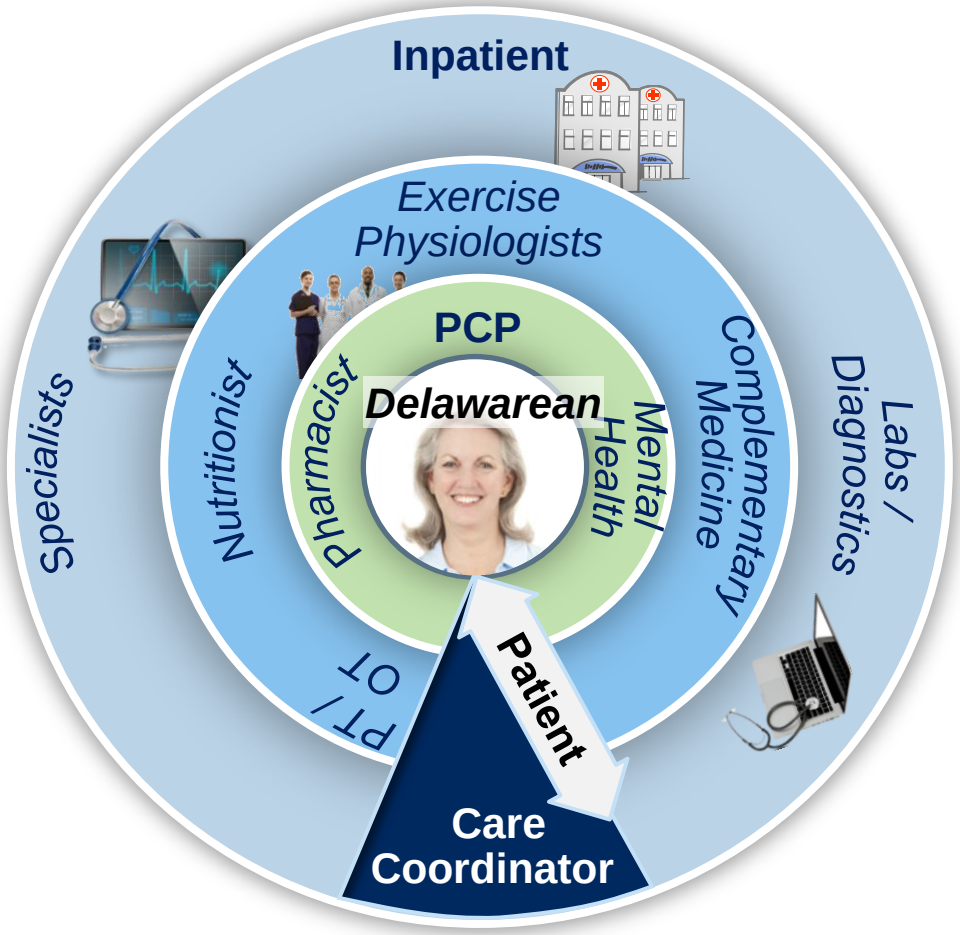
Payment linked to outcomes

Multi-stakeholder governance

Shared resources and services to support providers

Flexible workforce

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

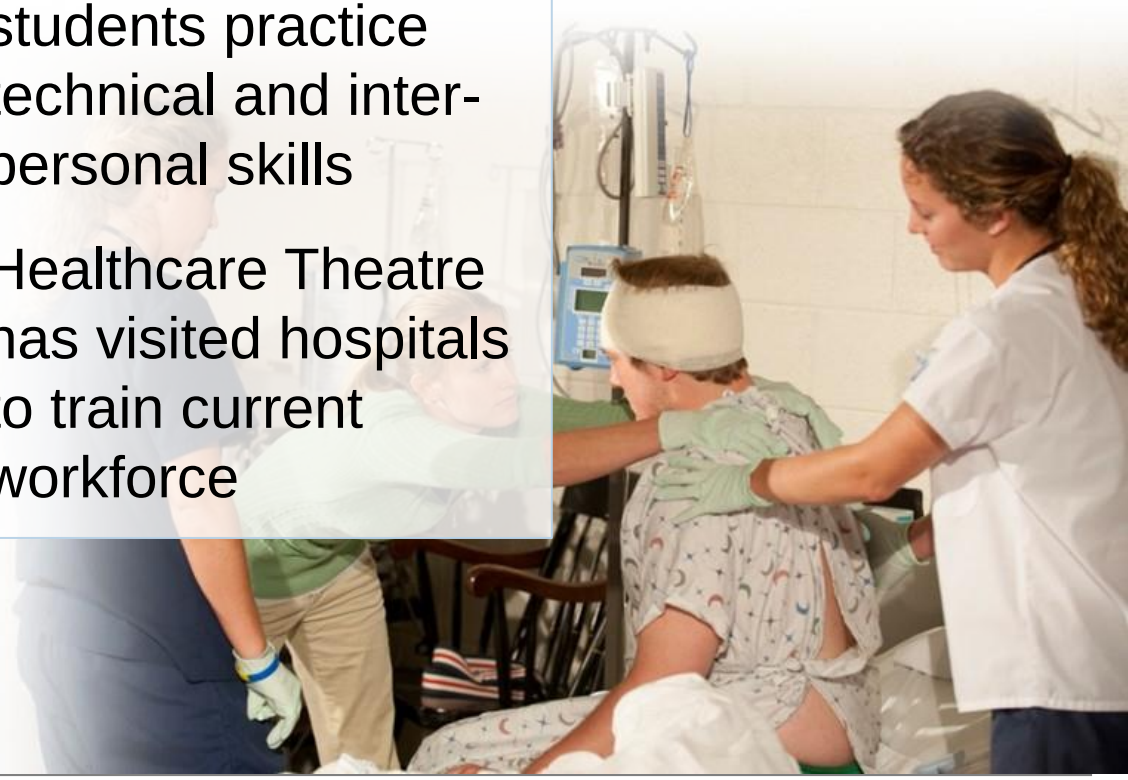
Healthcare Theatre introduction

What is Healthcare Theatre

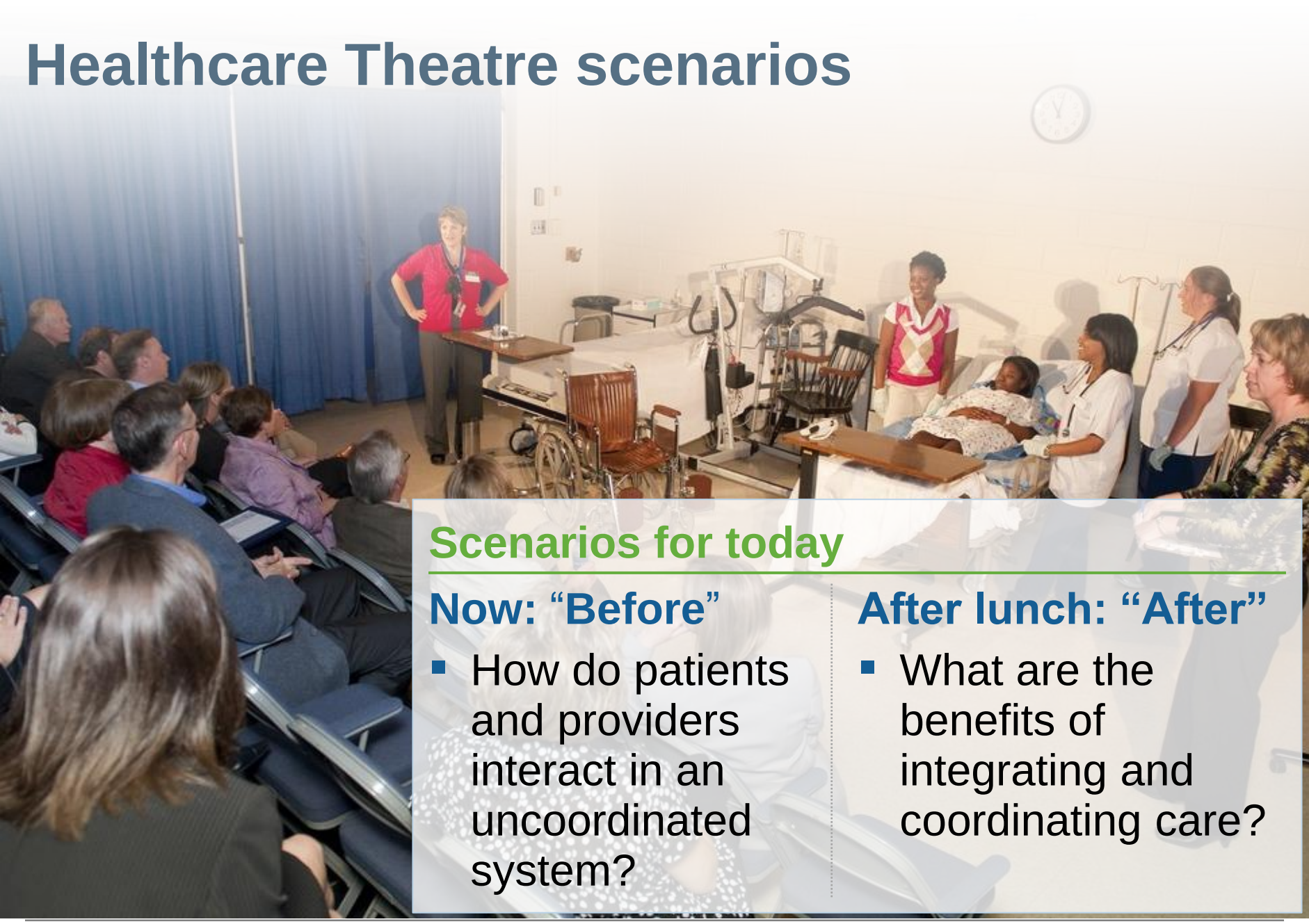
- Interdisciplinary education program at University of Delaware
- Theatre students and actors portray patients and family members

Healthcare Theatre uses

- Health Sciences students practice technical and inter-personal 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?

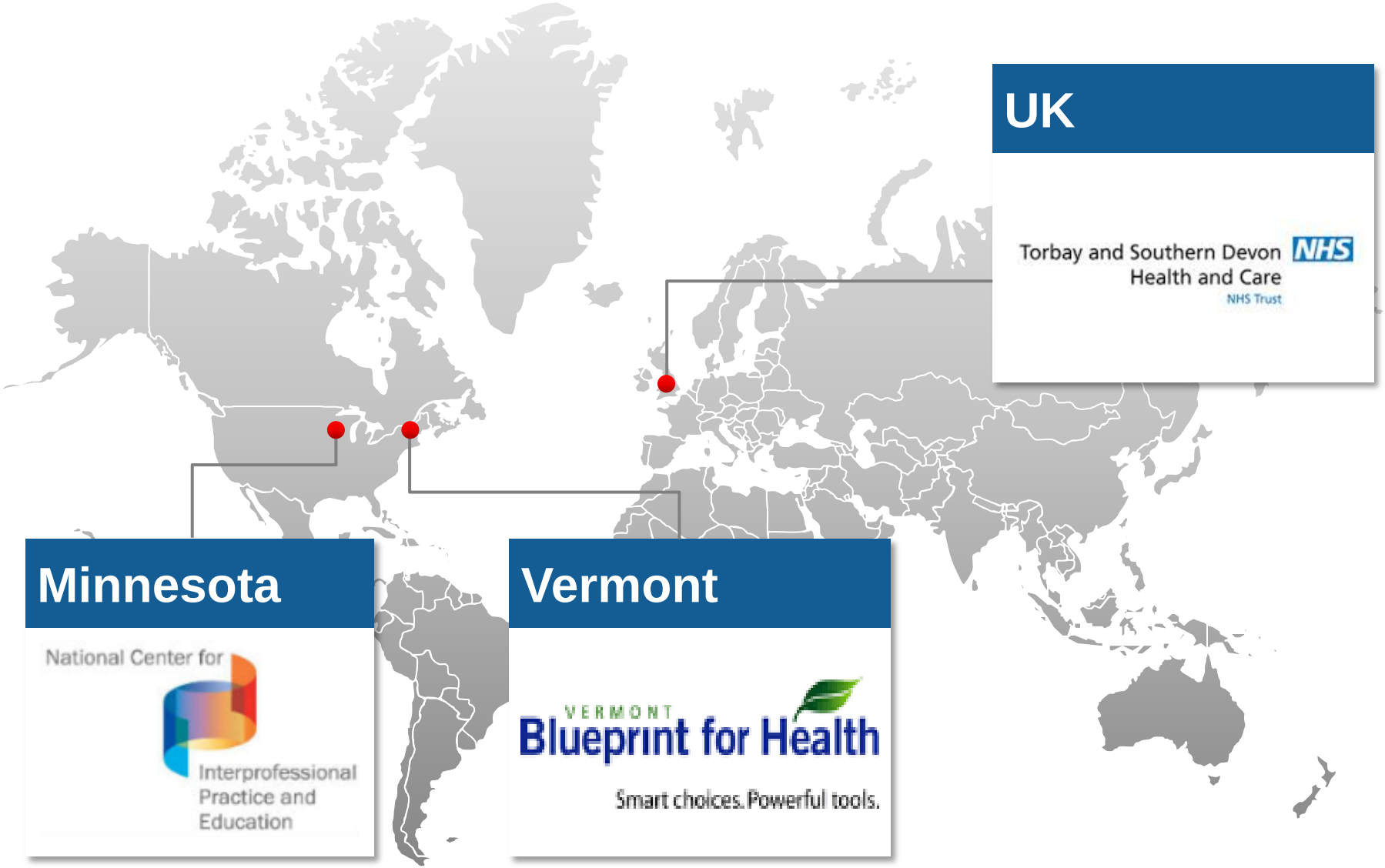
Agenda

1 Welcome	
▪ Overview of the day	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

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

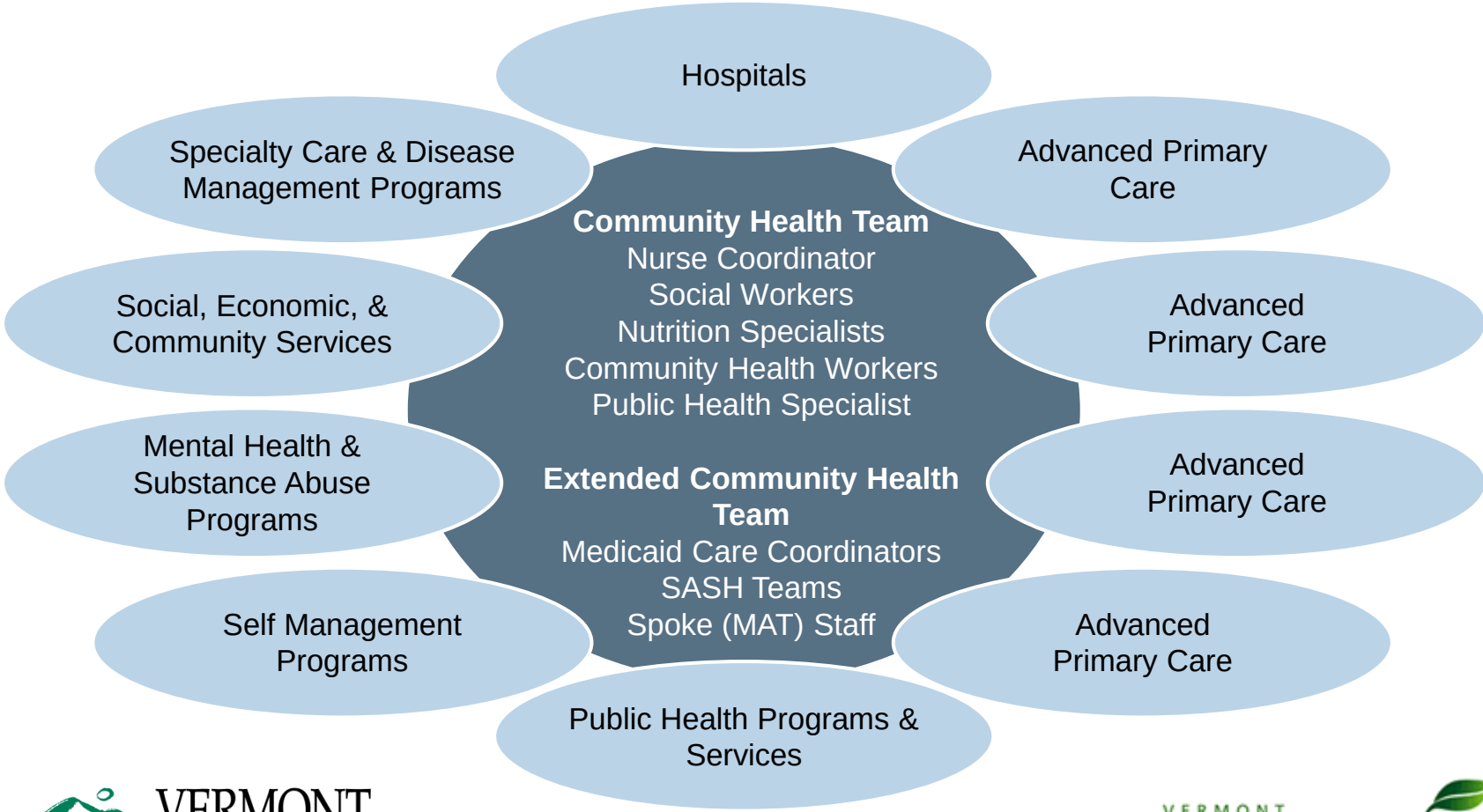


Craig Jones

- 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

VERMONT Blueprint for Health

Smart choices. Powerful tools.

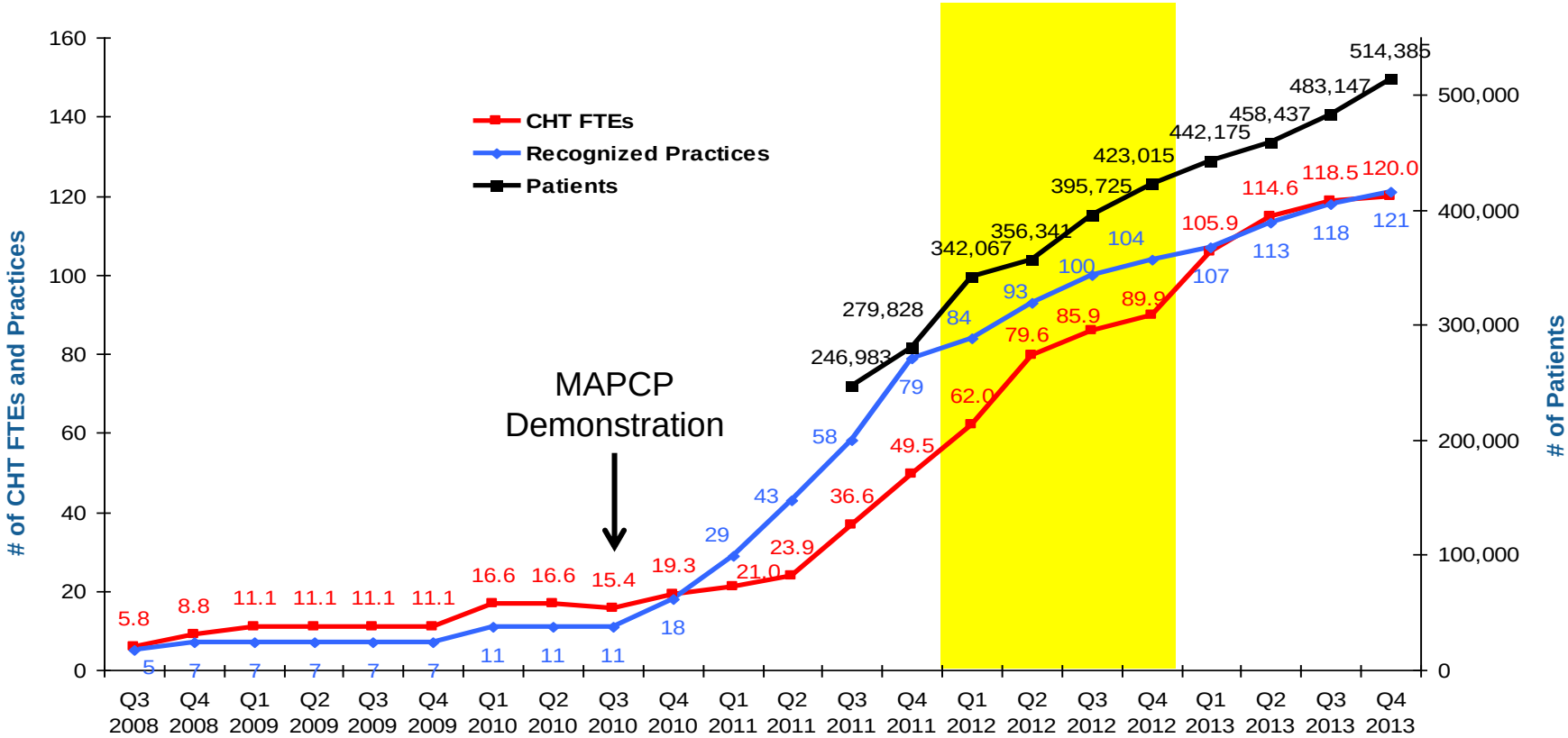


VERMONT
Department of Vermont Health Access

Health IT Framework
Evaluation Framework
Multi-Insurer Payment Reform Framework

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Patient Centered Medical Homes and Community Health Team Staffing in Vermont



VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

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

Program Leaders & Extenders	# People
Program Managers	14
Practice Facilitators	13
Community Health Team Leaders	14
Regional Housing Authority Leaders (SASH)	6
Self Management Regional Coordinators	14

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Learning Forum Network

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

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Self Management Network

Health Service Area	HLW General	HLW Diabetes	HLW Chronic Pain	Tobacco Cessation	WRAP	DPP
Bennington	Offered			Offered	Planned	Planned
Brattleboro	Offered		Offered	Offered	Offered	Offered
Barre	Offered	Offered	Offered	Offered	Offered	Offered
Burlington	Offered	Offered	Offered	Offered	Offered	Offered
Middlebury	Offered			Offered	Offered	Planned
Morrisville	Offered	Offered	Offered	Offered	Planned	Offered
Newport	Offered	Offered		Offered		
Randolph	Offered	Planned	Offered	Offered		Offered
Rutland	Offered	Offered	Offered	Offered	Offered	Offered
St. Albans	Offered	Offered	Offered	Offered	Offered	Offered
St. Johnsbury	Offered			Offered		Planned
Springfield	Offered	Offered		Offered	Offered	Offered
Upper Valley	Offered		Planned	Offered	Planned	Planned
Windsor	Offered		Offered	Offered	Offered	

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Health Services Network

Key Components	December 2013
PCMHs (scored by UVM)	121
PCPs (unique providers)	629
Patients (per PCMHs)	514,385
CHT FTEs (core staff)	120
SASH provider FTEs (extenders)	46.5
Spoke Staff FTEs (extenders)	30.45

Barre HSA
Full Network
Node color indicates sub-network membership
Node size indicates Betweenness Centrality

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

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

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

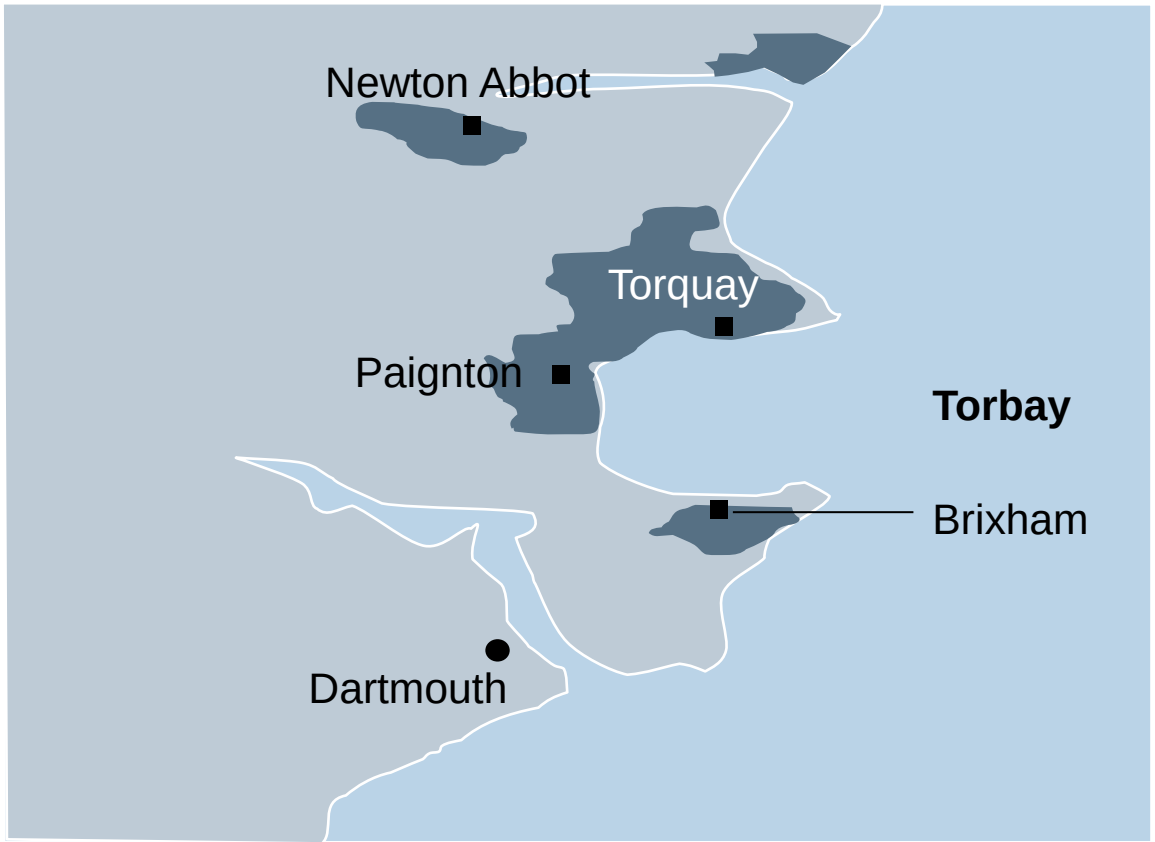
Mandy Seymour

- 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

Torbay and Southern Devon Health and Care NHS Trust

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

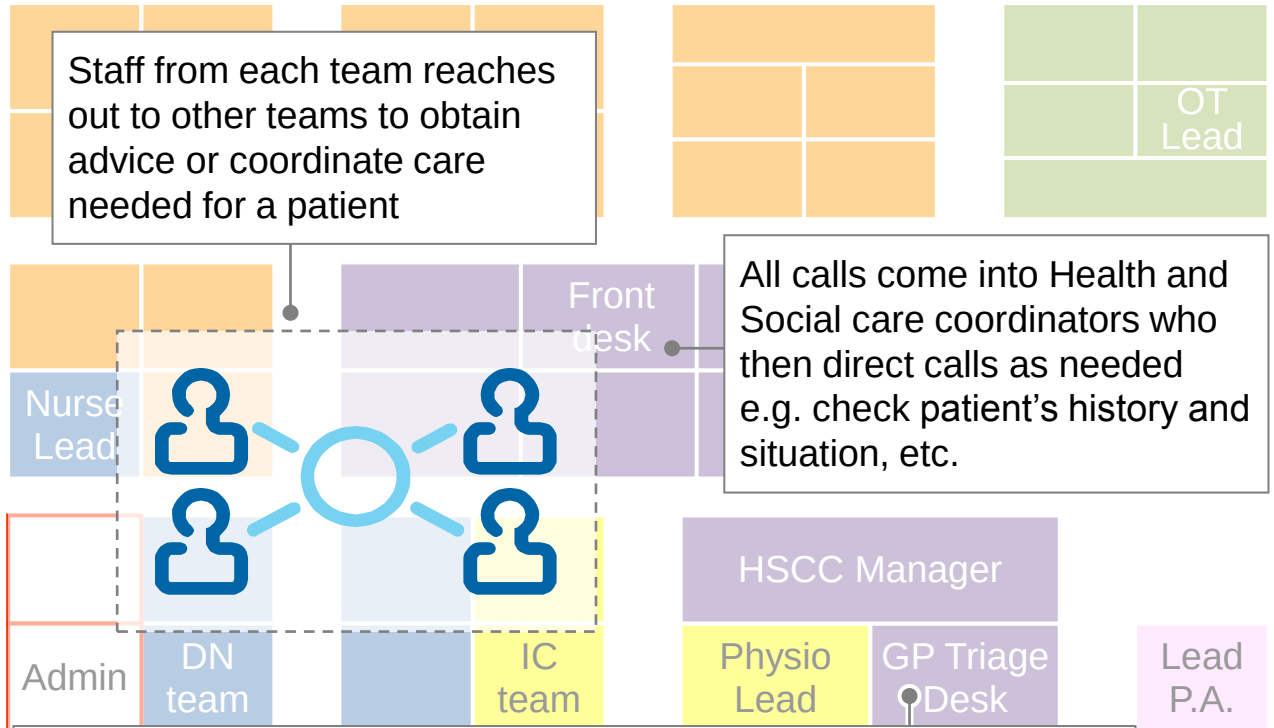
In Torbay, providers work together to coordinate care in a region

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

Staff from each team reaches out to other teams to obtain advice or coordinate care needed for a patient

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



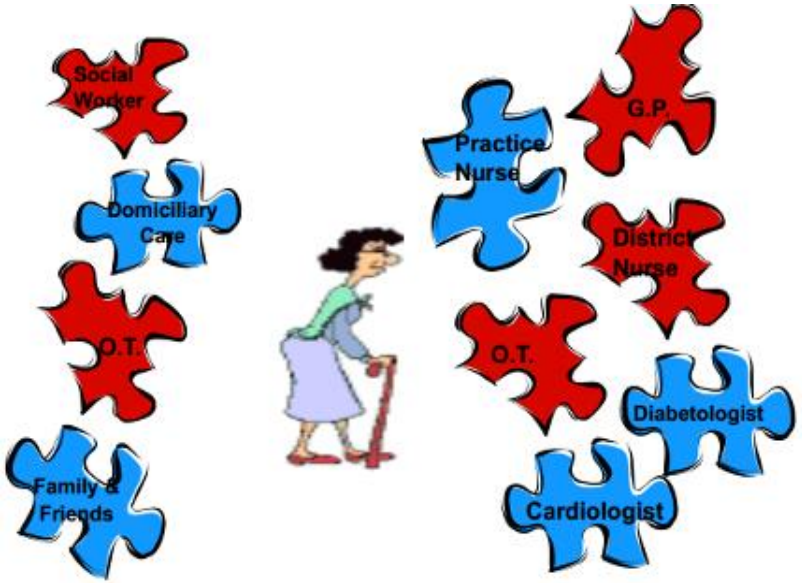
Some GPs come to the zone in the morning to do their triage calls from there and directly reach out to the most appropriate team to discuss the best path for patient

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

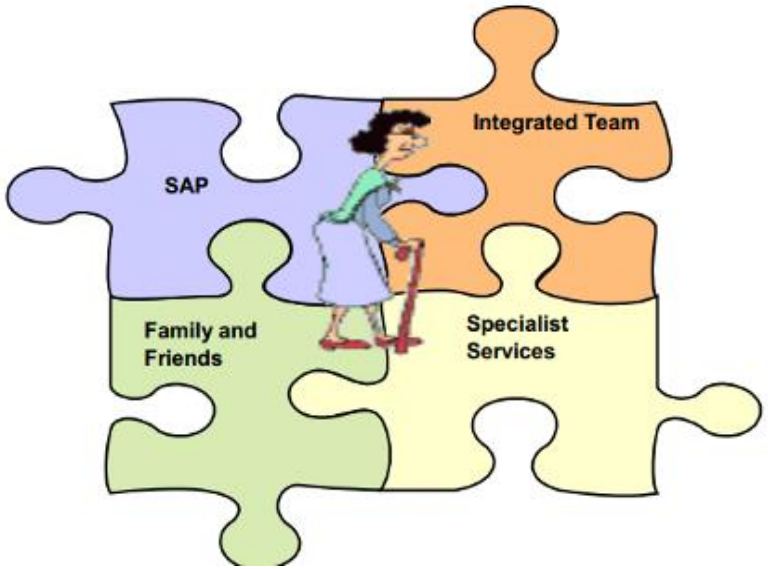
SOURCE: Torquay North Health and Social care team

A story about "Mrs Smith" was created to convey a clear message across the system to rally providers around the need for change

From …



… to



"Right care, right time, right place"

SOURCE: Integrating health and social care in Torbay, King's Fund, Peter Thistlethwaite, March 2011

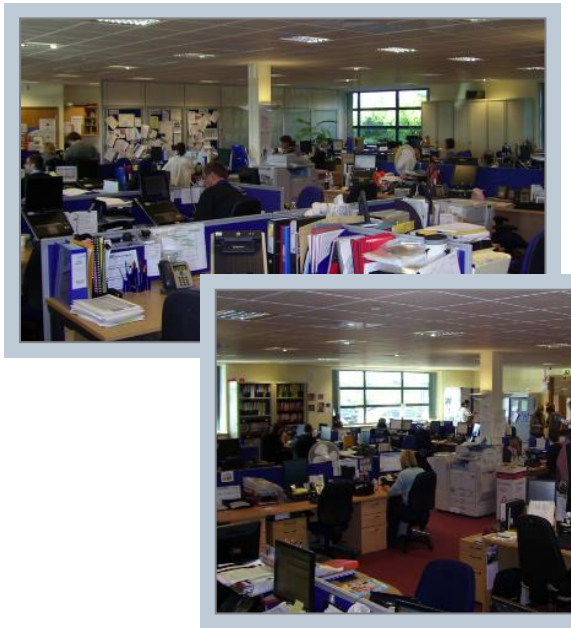
A pivotal role: Health and Social Care Coordinators

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!

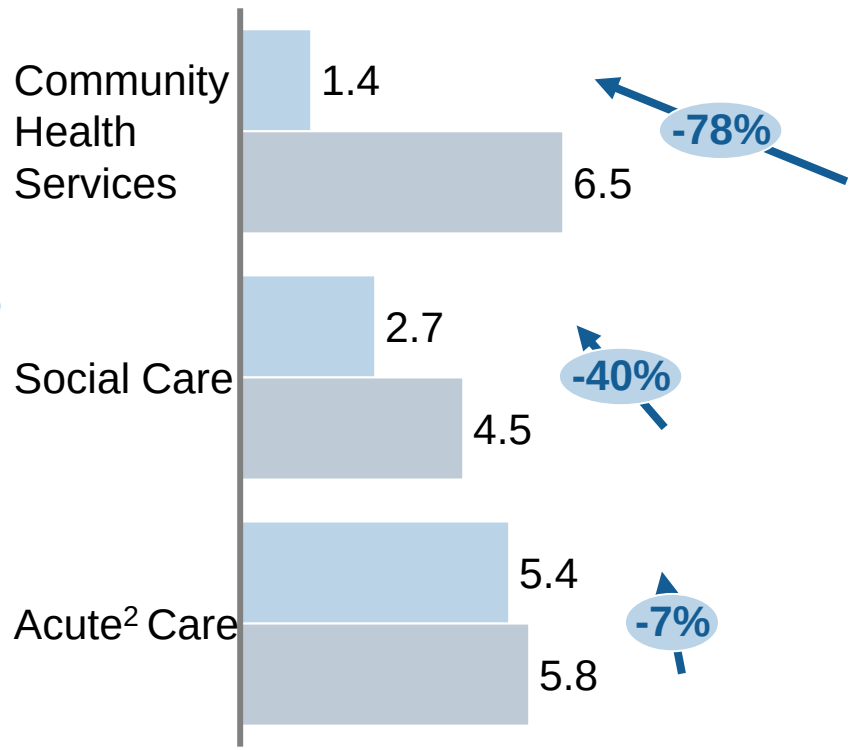
The difference care coordination makes

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

07/08 - 10/11 CAGR, in %



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 Inter-professional Practice and Education

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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

Current interest in interprofessional practice and education

- Institute for Healthcare Improvement "Triple Aim"
  - Improving the patient experience of care;
  - Improving the health of populations; and
  - 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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

It’s about practice and health outcomes.

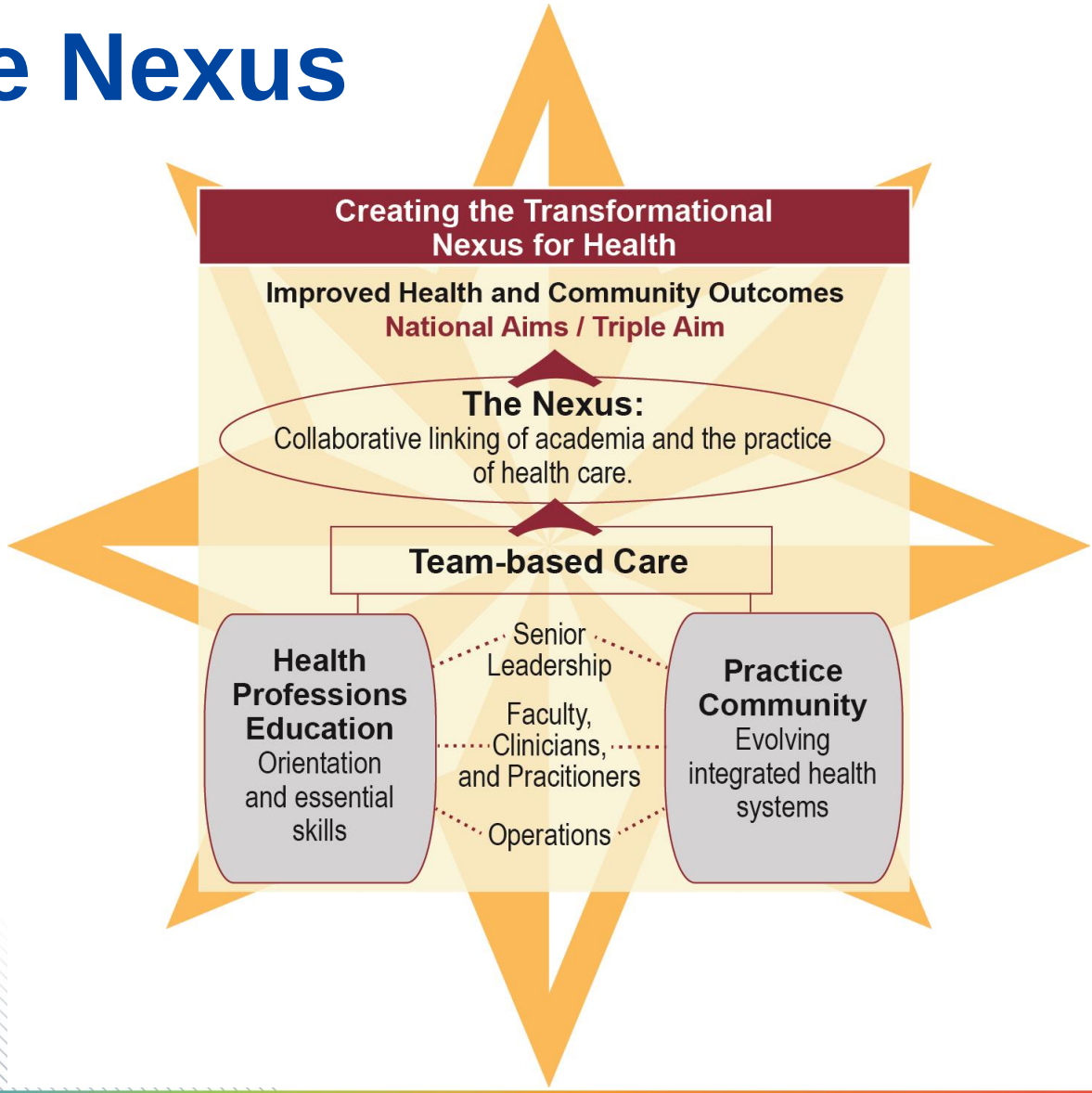
Interprofessional education +

Interprofessional, collaborative practice =

The new IPE: Interprofessional practice and education

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

The Nexus



The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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:

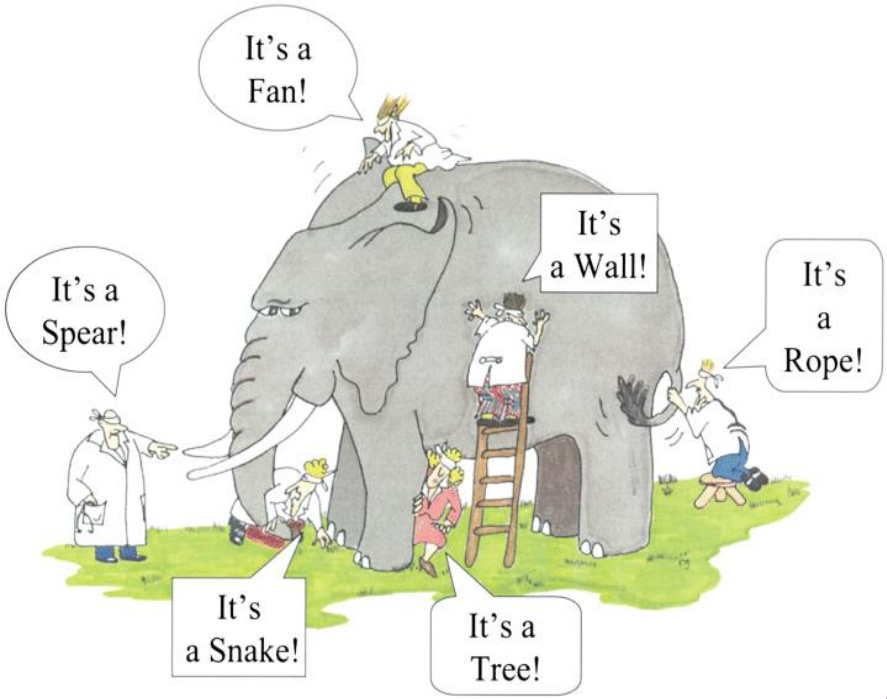
- When to start?
- What dose?

Few templates to guide curriculum design

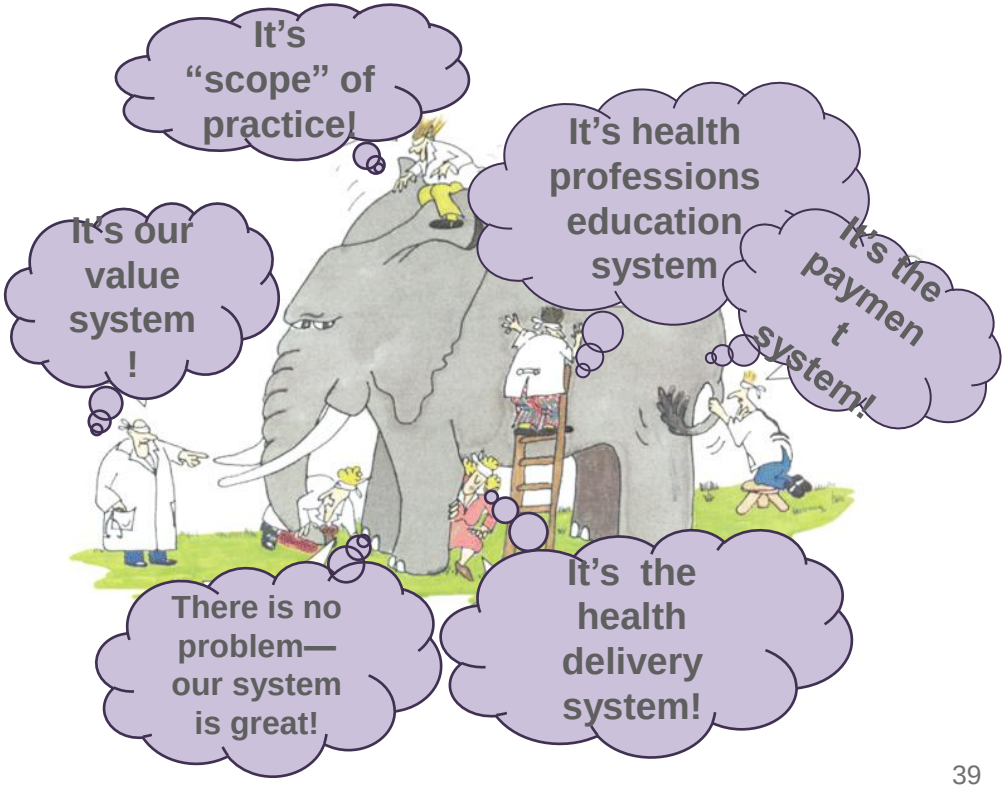
Lack of metrics and standardization in the field

Early adopter need evidence of ROI now

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.



We have our own Sufi Tale!



The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

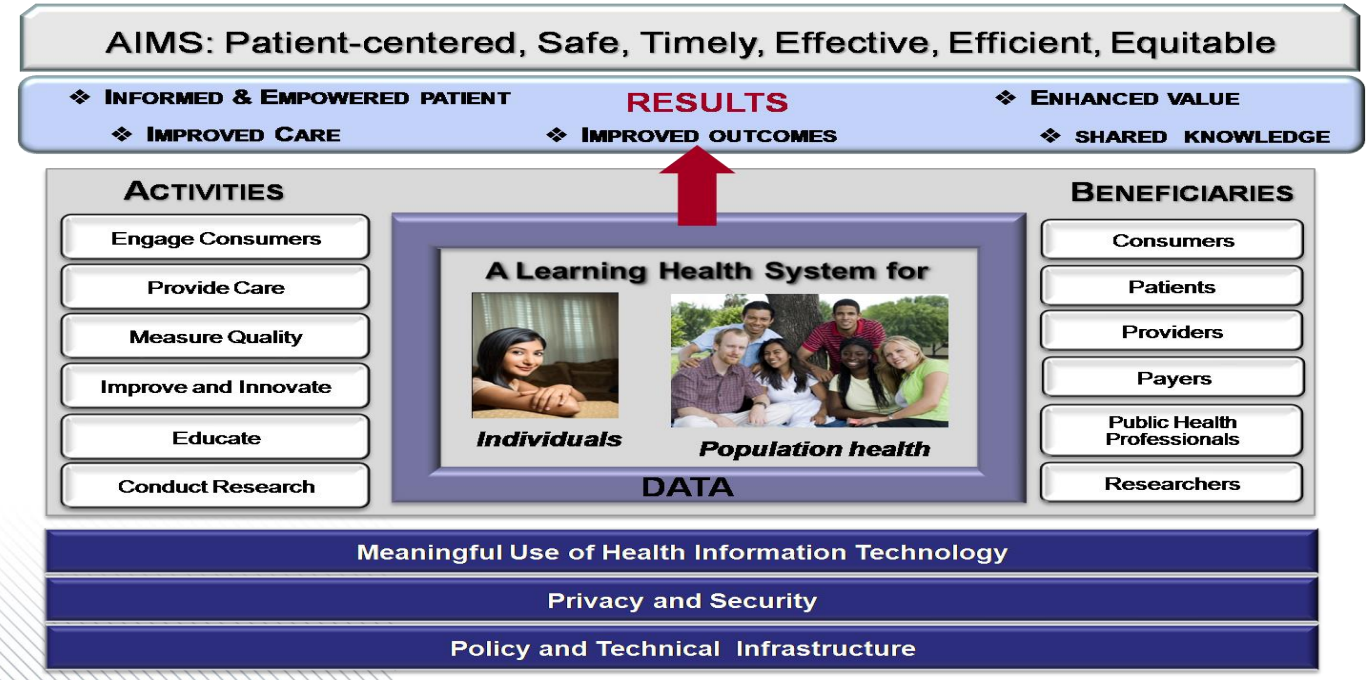
Working collaboratively to achieve the Triple Aim in both health care *and* higher education: cost, quality and the user experience

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

Vision - Learning Health System

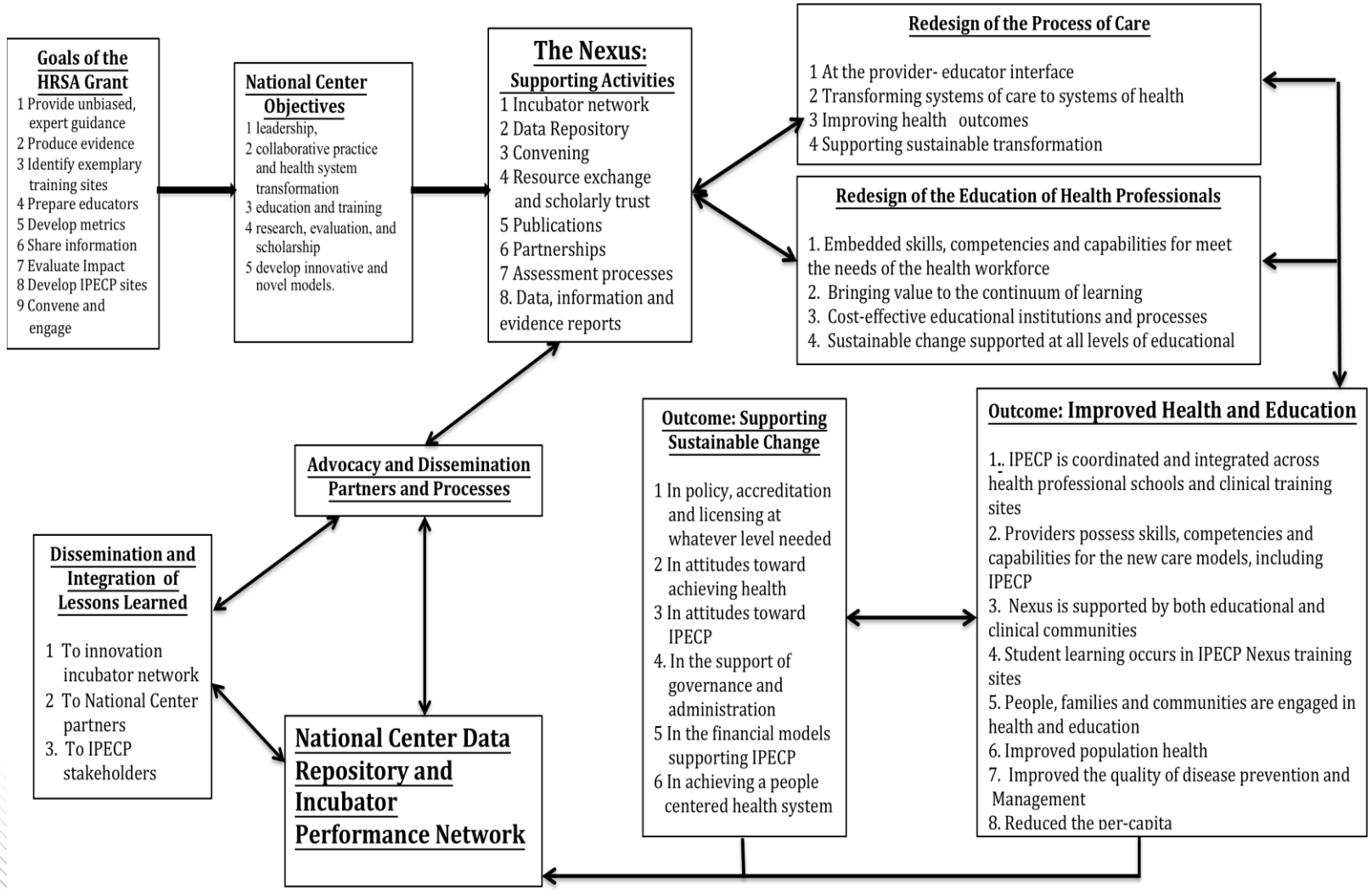
A system that is designed to generate and apply the best evidence for the collaborative health care choices of each patient and provider; to drive the process of new discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care. (Charter of the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

Health Information Technology Strategic Framework For A Learning Health System



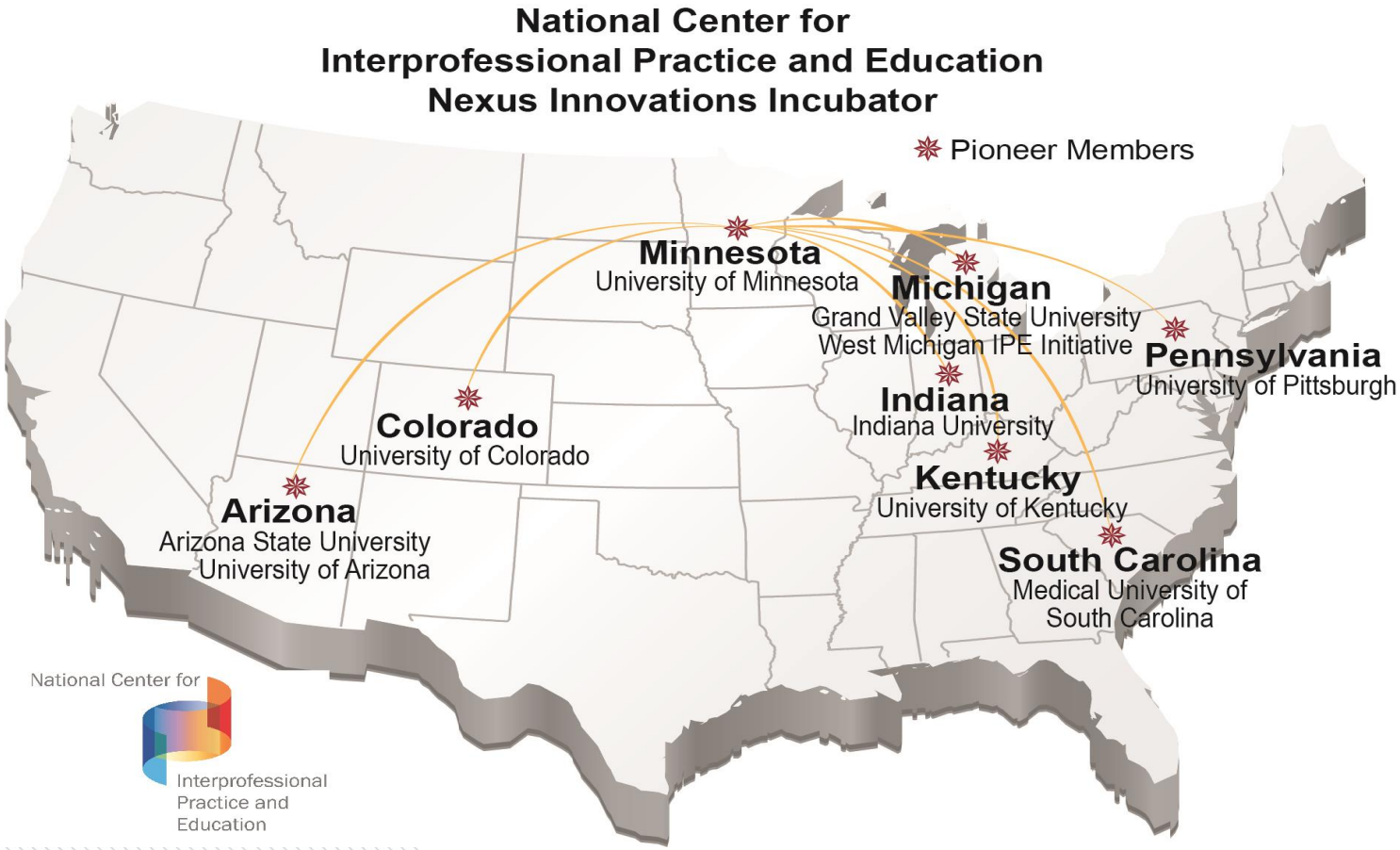
The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

National Center Nexus Logic Model for Improving Health and Education Outcomes



The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

Strategic Priority 3: Nexus Innovations Incubator



The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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?

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067.

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

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

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

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

NOT EXHAUSTIVE

Delaware Academy of Medicine

Delaware Health Care Commission

Delaware Health and Social Services

University of Delaware

Bayhealth
Kent General · Milford Memorial

Delaware Tech

Nanticoke Health Services
Always Caring. Always Here.

Nemours

Beebe Medical Center

St. Francis Hospital

Jefferson
Thomas Jefferson University

Division of Public Health

Christiana Care Health System

MSD
Medical Society of Delaware

Delaware Health Sciences Alliance
HEALTHCARE EDUCATION, RESEARCH & SERVICES

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

Beebe Cares

- 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
- **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**

Nanticoke PCMH

- PCMH that emphasizes coordination of care and action based on patient analytics (i.e., management of hypertension)
- **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**

Christiana Medical Home Without Walls

- Interdisciplinary care team (physician, nurse, social worker) who connects "super users" to a medical home, coordinates clinical care and addresses psychological and social needs
- **Strategies include visiting patients in shelters, taking them to medical appointments and addressing factors impacting health such as hunger, addiction and domestic violence**

Delaware Cancer Consortium

- Free cancer screening and treatment for those ineligible for insurance
- **Care coordinators guide patient through testing and treatment, and offer advice, emotional support and practical help**

Common themes

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

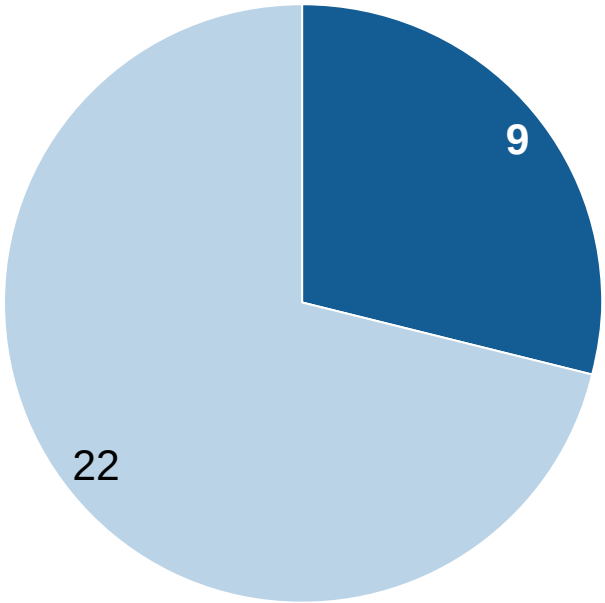
- What do we mean when we say integrated care?
- What are the different roles involved in integrated care?
- What are the competencies required for the individuals delivering it?

Survey results: formal care coordination programs

Have a formal CC program | Do not have a formal CC program

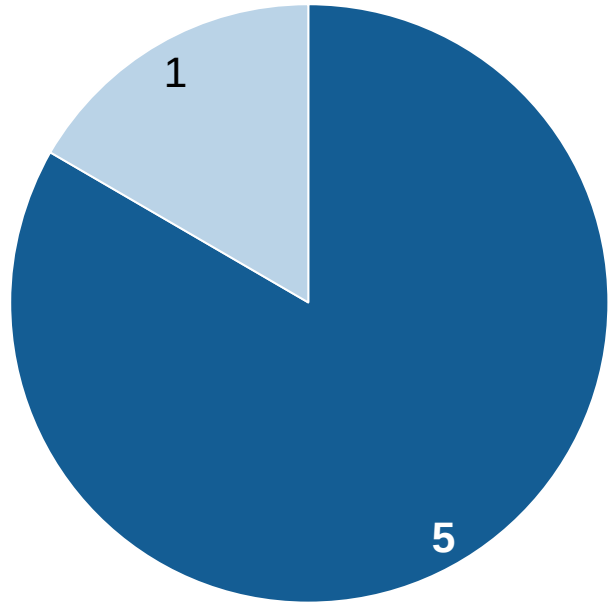
Clinics/outpatient practices

Number of unique respondents



Hospitals/health systems

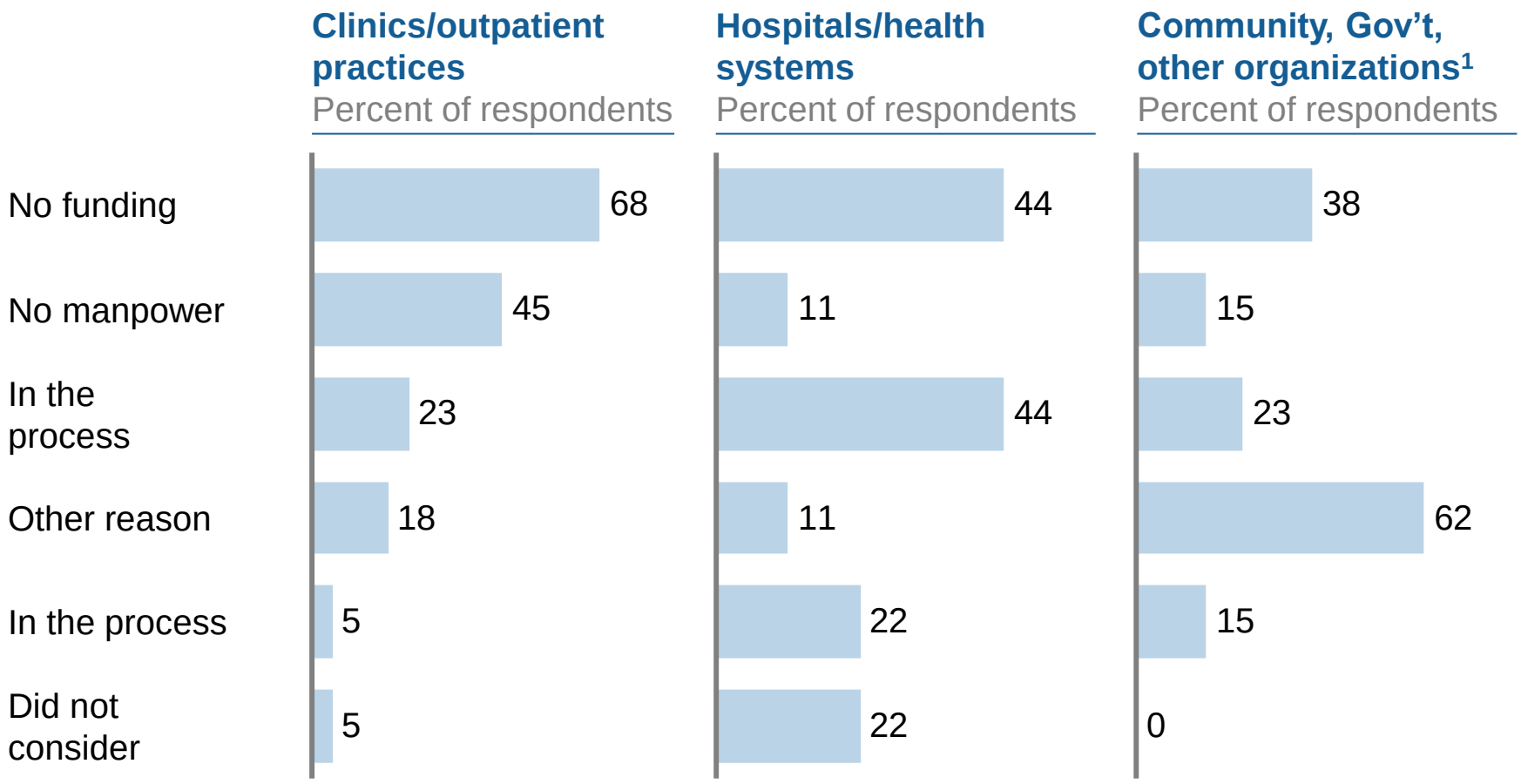
Number of unique respondents



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



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

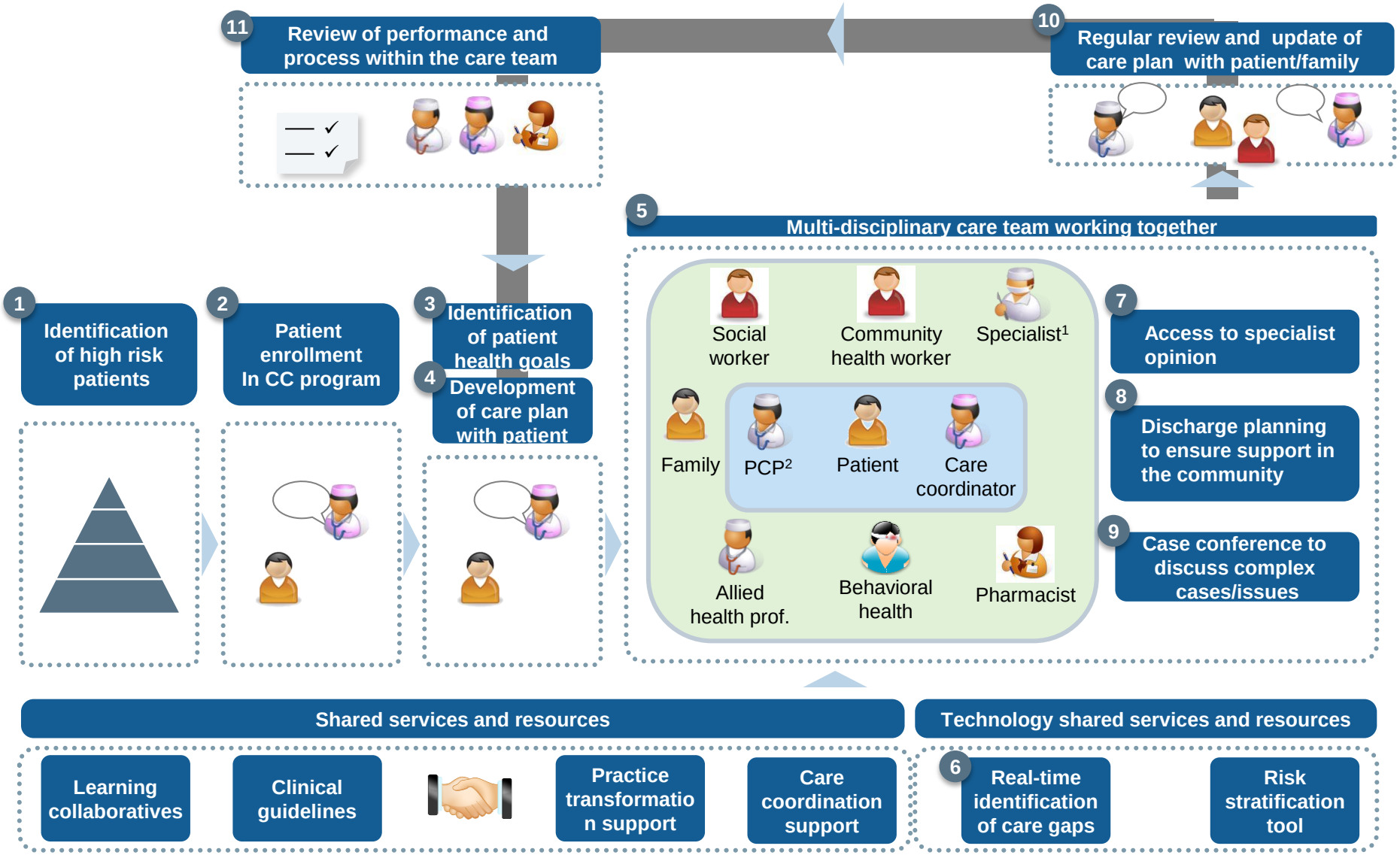
Agenda

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 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants

Potential members of care teams

- Home health aides
- Personal care aides
- Nursing assistants
- Medical assistants

1

- Dentist
- Orthodontist
- Oral surgeon

- Surgeon
- Medical specialist

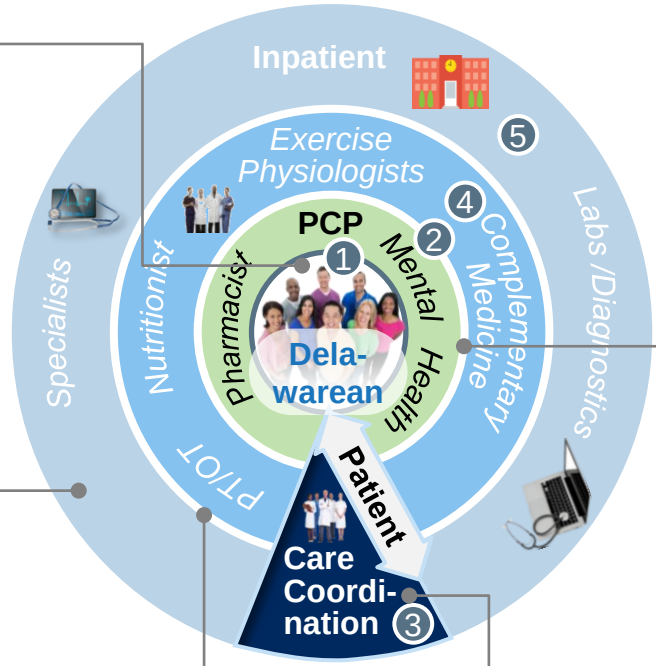
5

4

- Dietician
- Nutritionist

- Occupational health worker

- Physical therapist



- Care coordinator
- Case manager
- Patient navigator
- Wellness coach

- Community health worker
- Health ambassador
- Health coach

3

2

- 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

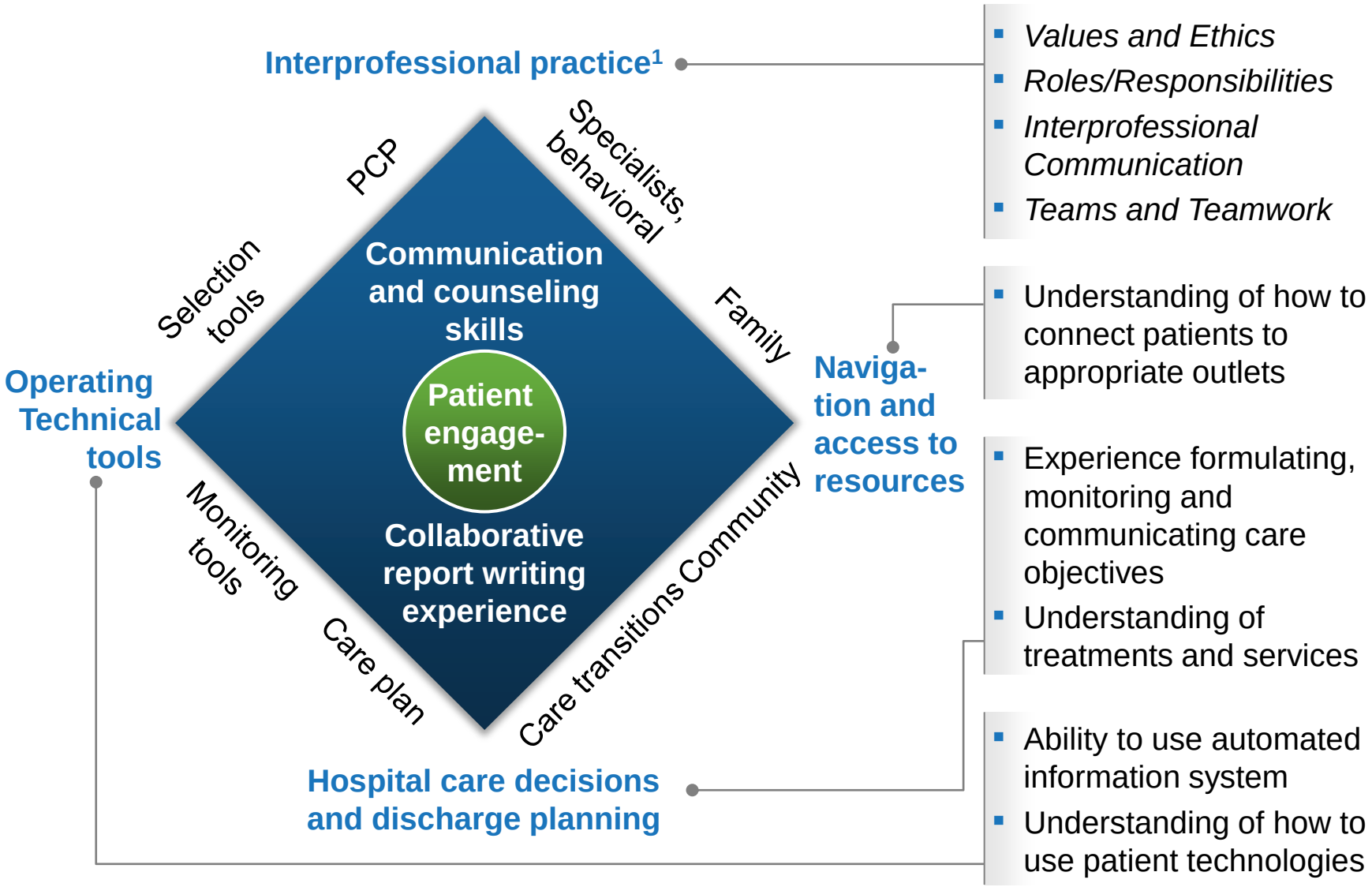
care co·or·di·nat·or
(kār kō-ōr'di-nā-tŏr)
Deliberately organizes patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services[1]

health coach (helth ˈkōch)
An individual who helps patients achieve their health goals and self-managed chronic conditions through behavioral change strategies and techniques.[2]

com·mu·ni·ty health work·er
(kə-ˈmyü-nə-tēˈ helth ˈwər-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.[2]

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"

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

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

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

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

2014

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!