Overview:

The Nurse Care Coordinator Program (NCCP) is designed to prepare care coordinators to lead and collaborate with other health care professionals to deliver quality safe care in the least expensive environment, while achieving desired outcomes in the implementation of the Patient Centered Medical Home (PCMH) model of care. This program will prepare the care coordinators to be excellent communicators and team members as they implement care management within physician practices and care coordinators across the community.

The Nurse Care Coordinator Program (NCCP) is comprised of fourteen modules encompassing 50 class hours organized into four main topics:

- Health Care Business Essentials
- Case Management
- Analytics
- Building Leadership Capabilities

Takeaways:

After completing this program participants will be able to:

- Promote quality and safe health care delivery through effective inter-professional collaboration with other members of the healthcare team
- Identify and understand quality improvement, risk stratification methodology, planned care for high risk patients and tasks to support care transitions
- Utilize Patient Centered Medical Homes to direct care and assist patients to take an active part in management of their own behaviors
- Understand use of Electronic Medical Records for their organization of data and planning of care priorities, reporting of trends and outcomes
- Build overall leadership capabilities of healthcare team
In-depth Program Descriptions:

Module 1: Health Care

This seminar will explore many of the following significant factors influencing care coordination in the new environment of health care delivery as a response to the implementation of the Affordable Care Act:

Health Care Reform: The net effect of the health care act passed in 2010 has led to dramatic changes in health care delivery and a focus on Patient Centered Medical Homes. Changes required of insurance firms, physicians and other care providers, along with burdens placed on state budgets (for increased Medicaid coverage), pharmaceutical companies and many types of providers of goods and services will be discussed along with Ohio’s HB 198 and dash board of services provided.

The Aging of America: The U.S. population is aging rapidly. At the same time, the life expectancy of seniors is extending. Senior citizens will place a significant strain on the health care system in coming years. America’s 76 million surviving Baby Boomers begin turning 65 in 2011. The future obligations of Medicare and Medicaid are enough to cause vast problems for the federal budget for decades to come. The number of seniors covered by Medicare will continue to grow at an exceedingly high rate, from 45.5 million people in 2009 to 78.0 million in 2030.

Unhealthy America: Few Americans focus on leading healthy lifestyles that would prevent disease and cut both the amount and the cost of medical care. Obesity-related illnesses along with Diabetes are adding an immense amount to the nation’s health care costs. The three biggest issues in Ohio are smoking, alcohol abuse and mental health. While only a relatively modest amount of money is spent on preventive medicine and health education, about 70% of health care funds are spent on chronic disease.

Module 2: Form and Organize Project Teams

This seminar will introduce teaming and leadership skills as part of interprofessional collaboration competencies associated with TeamSTEPPS™. TeamSTEPPS™ is an evidence-based set of teamwork tools developed by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ) which focused on enhancing patient outcomes by improving communication, leadership and teamwork skills among health care professionals. Health care professionals are expected to establish interprofessional communication and teamwork skills. This rapidly emerging change in practice challenges health care professionals and educators in all settings to integration of these new behaviors into practice.
Modules 3-4: Case Management

Module 3: Behavioral Management and Motivational Interviewing

This seminar will introduce ways in which patient centered approaches can effectively incorporate the use of brief targeted goal-oriented Action Plans and Intervention for patients presenting with myriad co-morbid and/or chronic illnesses and symptoms. The overarching goal of this seminar will be to increase health provider knowledge, skill and confidence in fostering enhanced patient outcome, collaboration and function. Participants will be able to utilize techniques of rapid assessment, motivational enhancement and patient centered-collaborative goal setting. Participants will also be able to practice use of these strategies in overcoming barriers to success in complex patient presentations. Participants will also understand how to develop effective action plans for a variety of presenting behaviorally linked chronic illnesses and conditions.

Module 4: Risk Stratification

This seminar will address risk stratification for the identification of High Risk patients to support improved health outcomes, lower total cost of care, and improved patient experience. Included in the discussion will be scoring sheets, risk prediction models for hospital readmission, predicting financial risks of seriously ill patients, use of health-related, quality-of-life metrics to predict mortality and hospitalization in community-dwelling seniors. Included is a discussion of risk assignment methodology and resource management for primary, secondary and tertiary prevention strategies in the care coordination of patients enrolled in the physician practice settings. Participants will have practice with a risk stratified care management-work plan for front and back office processes, providing teaming consistent with care management and coordination, measuring the percentage of patients in each risk category and preparing for transition between levels.

Modules 5 - 11: Leading Yourself and Teams

Module 5: Mental Health Assessments and Interventions

Effective assessment of mental health symptomatology in primary care medical settings is often the cornerstone of maximizing patient outcomes for a variety of presenting problems. In this seminar the participant will learn how to utilize a stepped-care approach to effective assessment and intervention. There are three specific learning goals for this seminar: 1) Utilize broad screening methods as first line approaches to behavioral health intervention; 2) Integrate new ways of employing stepped care approaches to behavioral health; 3) Tailor behavioral health screening methods to meet the needs of [your] own patient centered medical home practices. Participants will have the opportunity to practice stepped care strategies through case examples.
Module 6: Care Management within a Physician Practice Setting

This seminar will explore the differences between Care Management and Care Coordination. The focus on Care Management will include strategies for engaging patients and their families in the development of patient-centered health goals. Innovative models of care delivery such as group care, shared visits, and self-monitoring programs will be introduced. Research supports the effectiveness of such models in improving health outcomes for individuals particularly those at greatest risk for poor outcomes. Participants will have the opportunity to apply content by identifying a patient population within their practice that may benefit from an alternative model of care and designing a basic plan for implementation.

Module 7: Care Coordination and Interprofessional Resource Management

Interprofessional (IP) collaboration is the cornerstone of delivering high quality, patient-focused, safe, and cost-effective care. Delivery of high quality, patient-focused health care is increasingly being done at the community level. Effective care coordination is critical to establishing patient/family-focused health outcomes in an environment that is often fragmented and difficult to navigate. Families often find themselves experiencing multiple transitions of care. This seminar will provide participants an opportunity to engage in simulated experiences that require application of care coordination skills to develop, implement and evaluate patient-centered plans of care. Identification and reflection on professional roles and communication among care coordination team members will be incorporated into the seminar.

Modules 8-10: Analytics

Module 8: Quality and Safety in Health Care

Patient harm at the hands of practitioners in our healthcare systems has reached epidemic proportions. The latest report in the Journal of Patient Safety indicates that there are between 200,000-400,000 patient deaths per year from preventable adverse errors in our nation’s healthcare system. Moreover, millions of patients experience serious harm from preventable adverse errors. This seminar will explore the myriad causes of these errors using a systems approach. We will also explore the quality and safety initiatives healthcare systems have employed as a response to these errors. Topics of discussion will include engaging patients and families as advocates for their care, encouraging accountability for harm through transparent reporting, analyzing root causes to determine system failures, and collaborating with team members for improved communication.
Module 9: Using EMR for Managing Data Documenting, and Reporting

Mining and Reporting Data for Organizational Decision Making:

This session will analyze best practices in the secure use of the EMR. Learners will also explore strategies to effectively manage and mine data and manage complex projects using tools that support continuity of care and improved organizational decision making.

Topics include: Data Mining, Different types of reporting, Planning for reporting, Report audits, Tools for reporting—Examples, Resources, Organizational decision making, Project management Waterfall Model; Gantt Chart; Work Breakdown Structure; Risk Breakdown Structure; Executive summaries; Security - HIPPA & computerized documentation, Authentication of users, Security threats, Goal of nursing informatics & how to utilize EMR, Case study Palliative Care; Diabetes Management; Acute Care of the Elderly; Smoking Cessation; Patient Experience; Medication Reconciliation; Joint Commission requirements; Electronic Continuity of Care; Discharge instructions software Patient education and avatars

Module 10: Process and Quality Improvement

EMR workflow, standardized terminologies, predictive modeling, HITECH Act, core measures and health information exchange.

This session will demonstrate how to design improved care coordination workflows using Lean, Six Sigma, and IHI methodologies. Learners will describe data capture and management techniques using standardized terminologies that support core measures and continuous quality improvement. Risk stratification, predictive modeling and the future of the human-technology interface will also be explored.
Modules 11-14: Leadership

Module 11: Influencing Without Authority

Leadership is not about having the power to exercise your authority. Leadership is about behaving in ways that influence the feelings, thoughts and actions of others.

“The key to successful leadership today is influence, not authority.” ~ Ken Blanchard

In a world of multi-functional teams, globalization and flatter organizational structure, what it means to be a leader is shifting. You simply can’t rely on a position of power to make demands; rather you need the ability to influence others to help you achieve your goals. Influencing Without Authority will teach you how to engage others, manage interactions and best of all, shape outcomes enabling you to become a more effective manager and leader.

Module 12: Leading Innovation and Change

Leading in a changing world requires that we must constantly encourage innovation and change within our organizations. We will look at what innovation is, and explore some simple tools for facilitating it within our work teams. We will consider the role that company culture plays in both accelerating change, as well as retarding it.

This program also examines innovation as a process and you will learn how to encourage creative thinking and ideas from everyone. Finally, this session will suggest behaviors that we as leaders can adopt that help condition our organizations to act, moving them from one where people are dragged down by the pressures of daily work tasks to one where people are engaged in co-creating the kind of future organization at which they would like to work.

Most teams cannot be driven to change (at least not in a sustainable way). They must be led with a sense that they are doing so at their own choosing. A change process that engages as many people as possible may seem slower at first, but generally produces quicker overall results. Sometimes slow IS fast.
**Module 13: Critical Conversations**

In this workshop participants will learn the tools they will need to effectively handle important and difficult conversations in the work place. Concepts and strategies include bringing up difficult topics in a way that the listener does not become defensive, remaining calm, respectful, and rational during heated discussions, developing effective solutions, and creating and maintaining good working relationships.

**Module 14: Application of Care Coordination Scenarios**

This application session will provide students with the opportunity to apply skills and knowledge in holistic care coordination. Content from other course sessions will be applied in real life situations that are commonly experienced in care coordination of complex and chronic care patient populations. The experience will include role playing, use of communication, leadership, shared decision making, interprofessional collaboration, and TeamSTEPPS concepts with identification and application of informatics and quality management tools and reports.