

Overview:

The **Population Health Care Coordinator Certificate Program** (NCCP) is designed to prepare care coordinators and care coordination teams to lead and collaborate with other health care professionals, patients and their families to deliver quality safe care in the least expensive environment. The focus is on achieving desired outcomes in the implementation of the Patient Centered Medical Home (PCMH) model of care. This program will prepare participants to be leaders, excellent communicators and team members as they implement care management within physician practices and acute care organizations.



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

- Population Health Overview and Business Essentials
- Quality and Safety in Care Coordination
- Risk Stratification and Use of Data
- 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 care to direct care and assist patients to take an active part in management of their own behaviors
- Understand the use of information technology to proactively manage a population for individuals who are at risk, track them to ensure they receive all evidence based care and facilitate provider efforts to coordinate care and help them self-manage their condition
- Build overall leadership capabilities of healthcare team

In-depth Program Descriptions:

- **Health Care Trends**

This seminar will describe how the current state of healthcare came about. Explore how the following factors significantly influenced 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.

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.

- **Population Health Overview**

The Population Health movement that has been gaining momentum over the past decade has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group". It is an approach to health that aims to improve the health of an entire human population.ⁱ Population Health seeks to reveal patterns and connections within and among multiple systems to develop approaches that respond to the needs of the population. In this session, explore the role Population Health plays in health management strategies and the role of care coordination as a means to addressing community needs and affecting change.ⁱⁱ

- **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.

- ***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 forefront and back office processes, providing teaming consistent with care management and coordination, measuring the percent

- ***Data Drivers for Population Health & Care Coordination Outcomes***

Focus on population health as a proactive approach to healthcare that is heavily dependent on IT to surveil a population for individuals who are at risk, track them to ensure they receive all evidence base care, and facilitate provider efforts to coordinate care and help them self-manage their conditions. This workshop will explore the use of data to understand measures and outcomes, drive your strategies and decision making, and affect your populations' health.

- ***Population Based Behavioral Health***

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.

- ***Patient Focused Behavior Change***

In this seminar the participant will learn how to utilize a stepped-care approach to effective assessment and intervention. Learn to utilize broad screening methods as first line approaches to behavioral health intervention. Integrate new ways of employing stepped care approaches to behavioral health. Tailor behavioral health screening methods to meet the needs of patient centered care. Participants will have the opportunity to practice stepped care strategies through caseexamples.

- ***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.

- ***Building Your 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.

- ***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.

- ***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.

- ***Bringing it all together: speaker & Panel Q&A***

TBD

ⁱ www.healthcareitnews.com,

ⁱⁱ Population Health Creating a Culture of Wellness, Nash, Fabius, Skoufalous, Clarke, Horowitz