Care Coordination for Elders with Diabetes and other Chronic Conditions

Health Center Information and Questionnaire

Section I. ECE Learning Collaborative Overview

Project Summary

In an effort to accelerate learning and collaboration within HRSA Health Center grantees across the U.S. that aim to improve the health outcomes for the ever growing older adult population in their communities, the National Center of Equitable Care for Elders (ECE) is launching a national learning collaborative.

The National Center ECE is funded by the Health Resources and Services Administration (HRSA) through a National Training and Technical Assistance Cooperative Agreement (NCA) that provides training and technical assistance (TA) to Community Health Centers, Federally Qualified Health Centers (FQHC) and look-alikes committed to improve health care delivery to the older adult population. The Learning Collaborative will take place from April to June 2018. The overall goal of the ECE Learning Collaborative is to provide health centers' workers with the tools they need to improve health equity among their older adult population by increasing access to care, improving health outcomes and serve as a resource or guide to social services to improve services for the elderly. This learning collaborative will achieve all of this by promoting care coordination models that emphasize care coordination across disciplines and settings of care, including long-term care and other non-medical settings for elderly patients with diabetes and other co-morbid conditions.

Minimum Eligibility Criteria

ECE seeks responses from HRSA health center grantees.

Learning Collaborative Structure

● Identify a minimum of two individuals to serve as team members for the ECE Learning Collaborative (ie. medical champion, social worker or geriatric health champion), and a project lead, which can be one of the ECE Learning Collaborative team members.

● Between April and July 2018, participate in four (4), 1 hour, learning collaborative **video-conferencing calls** with ECE and the other participating health centers, to review and share strategies for comprehensive care coordination for elderly patients with diabetes and other co-morbidities.

Evaluation Strategy

● Evaluations will be sent out at the end of each session to assess participants' knowledge, impact and satisfaction. Evaluation may also include interviews and additional data collection. ECE staff will document promising practices that participating health centers develop to address barriers in implementing care coordination models and that incentivize providers to engage in ECE projects, in order to develop resources to share these practices with other health centers nationwide.

Benefits of Participation

The ECE Learning Collaborative is an excellent opportunity for eligible health centers to:

● Improve ability to provide high-quality care for elderly diabetic patients

● Gain knowledge on care coordination programs with positive, rigorously evaluated and broadly replicable results

● Build relations with other organizations that will facilitate peer leaning experiences, both during this activity and beyond.

● Develop, test and refine strategies that other health centers can learn from and model in the future.

Section II. Questionnaire Form

Please complete the ONLINE APPLICATION by 5:00 PM EST on March 30, 2018

Applications can be sent through the online form or via email (ece@hsdm.harvard.edu)

1. Contact Person	
a. Name, credentials	
b. Title	
c. Email address	
d. Phone Number	

2. Health Center Information	
a. Organization Name	
b. Number of medical clinic sites	

3. Health services provided (Please list all)

4. Health Information Technology Information	Yes/ No
a. Does every provider have access to EHR patient information?	

Section III. Questionnaire Form

A. Level of Care Coordination and Practice Readiness for Implementation

1. Coordination of referrals and specialists for diabetic patients…
   - ☐ does not exist
   - ☐ is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team
   - ☐ occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care
   - ☐ is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement
2. Data systems/patient records …
   - ☐ are based on paper records only; separate records used by each provider
   - ☐ are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps
   - ☐ use a data system (paper or EHR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals
   - ☐ has a full EHR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process
3. Physician, team and staff education and training for diabetic care and other co-morbidities …
   - ☐ does not occur
   - ☐ occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic
   - ☐ is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes care coordination methods such as modeling and practice for role changes; training monitored for staff participation
   - ☐ is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care coordination
4. Organizational leadership for coordinated care …
   - ☐ does not exist or shows little interest
   - ☐ is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care

- ☐ is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)
- ☐ strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models

5. Patient care team for implementing coordinated care …
   - ☐ does not exist
   - ☐ exists but has little cohesiveness among team members; not central to care delivery
   - ☐ is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills
   - ☐ is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled