Center of Excellence in Care Coordination

A program of
Southwestern Colorado AHEC
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Progress Report
January 2015

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Since March 2014, the Center of Excellence in Care Coordination (CoECC) has made progress towards the deliverables of the planning grant in the following areas:

I. Define care coordination for the region
II. Share data and learning
III. Functionally integrate care coordination across communities
IV. Support efforts to achieve the triple aim for populations with complex care needs
V. Inform policy

The CoECC team consists of a stakeholder liaison, a program coordinator, a team leader/supervisor, a project director, as well as a web master and a communications coordinator. The CoECC team has been working together since March 2014 and engaged in the following activities to advance care coordination in an eight county rural area in Southwest Colorado. In March 2014, the team conducted internal workshops to develop draft VISION/MISSION/VALUES statements, which were subsequently presented and endorsed by the advisory board at the April advisory board meeting. In May 2014, the CoECC held its first care coordinator training in response to community demand for evidence-based education. In June 2014, the CoECC officially kicked off with a well-attended event to engage the greater care coordination community. The event spawned many ideas and refined the strategic goals of the CoECC. The CoECC was able to source its regional definition of care coordination through follow-up phone-calls and ongoing conversation with the community after the event. The regional definition of care coordination, as it currently stands, understands *care coordination as deliberately collective action on community wide shared goals to provide high-quality, cost-effective health and social services for better population health outcomes through appropriate, culturally-acceptable, and cost-effective chronic disease management of high-needs and high-cost clients.*

In July 2014, the CoECC was represented as partner of the Colorado Health Foundation at the Colorado Health Symposium in Keystone, CO. The event provided opportunity to connect with state-level stakeholders and exchange about a shared vision for statewide population health through local level care coordination. In August 2014, the CoECC invited Dr. Thompson, Dean of the University of Colorado's College of Nursing, for an introduction to the CoECC as education and community-participatory research lab around rural care coordination. The conversation further revolved around the role of nurses within Southwest Colorado communities and the education needs of nurses to take on advanced roles in preparation for effective population health management. The month of August also provided opportunity to take the CoECC on the road to see our community partners in Pagosa Springs. The visit incited many ideas about furthering care coordination in the Eastern part of the region. Many phone calls and in-person meetings followed about a joint resource directory, common outcome measures, and feasible payment options for care coordinators.

Around mid-August, the CoECC had to reluctantly say good-buy to AHEC's intern Sarah Stammard, who contributed with her keen insight into messaging strategy for the CoECC. That month, the CoECC began work on its website, which is designed as open access and serves as the knowledge management platform for shared regional learning, a repository for research-based evidence, success stories and challenges, as well as a virtual hub for resources and networking. By the end of August, the CoECC obtained approval through the greater leadership community to lead in dissolving the Community Care Team Oversight Committee and instead build three task-oriented work groups that would convene around actionable agendas to advance delivery system integration. Several stakeholder meetings were staged with individual partner organizations to gain buy-in for the initiative and insight into the best processes to achieve the best results during the meetings.

The CoECC now convenes three distinct groups of direct-care providers, community leaders, and hosts a biannual summit for networking and knowledge exchange, known as the "CoECC Biannual Dialogue Event". In September 2014, the CoECC presented its first findings from its experience with community engagement at the "Engaging Communities in Education and Research" in Vail, CO during the poster session. The poster attracted the interest of a variety of researchers and led to a conversation around a prospective collaboration between the CoECC, the CU College of Nursing, and the CU School of Medicine (Family Medicine) around interdisciplinary care teams. In October, the CoECC regretfully accepted the resignation of Jamie Robb to further his academic education. The CoECC was fortunate to win Mary Dengler-Frey onto the team. Mary came to the CoECC with experience in education, administration, and group management, and now serves as the new client liaison. She picked up where Jamie left off in building a comprehensive web-based resource directory for our partners.

Later in October, the CoECC convened a consortium of Durango based care coordinators, social workers, promotoras, primary care providers, and community health workers to an inter-organizational case conferencing pilot. This project is a response to the request by the larger care coordination community for real-time case conferencing across institutional boundaries to provide wrap-around services for community members who have come to the attention of the system as above average utilizers of health care resources without the benefit of better health or satisfaction outcomes. These meetings are conceptualized to facilitate real-time inter-agency exchange across systems that do not support clinical data sharing yet. The meetings are designed to create momentum towards the ultimate goal of client self-management by allowing the client to occupy the center of exchange. One month later saw the first HIPAA compliant case conference. Representatives from large and small health care organizations came together in a meeting for clients and their support network. The Regional Care Collaborative Organization (RCCO 1) sponsored the HIPAA compliant cloud-computing platform for ongoing virtual collaboration, record storage, and evaluation.

De-identified data and collective learning from the case management group are then synthesized and presented to inform the decisions of the leadership group. This group is charged with setting community-spanning strategy, making plans for the targeted investment of resources, and evaluation of community-wide outcomes.

In November 2014, the CoECC team went on the road to meet with organizational partners in Montezuma, Dolores, and San Miguel counties. The exchanges were insightful and strengthened the partnership for future collaboration across geographic distances. Also in November, the CoECC provided input to the State of Colorado's Accountable Care Collaborative. The CoECC understands its role as advocate for local control over rural care delivery systems. The CoECC supports statutory and regulatory policy aligning payment incentives that reward performance outcomes within the accountable care model.

The remainder of the fall 2014 was used to 1. collect baseline survey data on community wide readiness for evidence-based chronic disease management, to 2. complete the website, and to 3. assist its partners overcome barriers to care coordination. The CoECC worked with individual partner organizations to identify actionable outcomes metrics to quantify care coordination and its success through patient-level outcomes. The CoECC acted as mediator between Cortez and Durango providers to streamline pre-surgical protocols to enhance the client experience, save system costs, and achieve standardization across providers.

In order to provide partners with tools for patient self-management support, the CoECC is now providing synthesized and open-access research evidence as decision-aids 24/7 on its website. The CoECC has

connected care coordinators across the region with each other and with state level organizations, such as the Regional Care Collaborative Organization. It further enabled more education opportunities through the University of Colorado and is actively researching suitable community health worker training programs. The CoECC now regularly convenes three community meetings to drive the ongoing community wide dialogue around care coordination. Meeting times are scheduled one year out and web-conferencing and call-in options are always available for remote attendance.

In sum, the CoECC serves as the backbone organization (Kania & Kramer, 2011) for the collective impact collaborative of all its partner organizations, thus having an extended reach to a population of 30,000-40,000 rural residents. The success of the CoECC in its role has been made evident by

- Stakeholder engagement to arrive at a common definition of care coordination across Southwest Colorado

- The provision of an infrastructure for virtual and in-person collaboration among greater than 30 health and social services providers across 7 counties

- Knowledge capture and management of shared learning derived from meetings, summits, web sourcing, and surveys

- Spanning of institutional boundaries to facilitate wrap-around medical, social, dental, and behavioral-mental health services to meet the needs of complex care coordination clients

Please visit carecoordination.swcahec.org for more information.

WHAT WE DO

- We connect professionals with each other
- We further evidence-based practice in care coordination
- We enable shared learning
- We offer education and networking events
- We link care coordinators, providers, and decision-makers
- We develop efficiency systems to fill gaps & avoid duplication
- We maintain a central resource directory for patient navigation
- We take action to overcome barriers to coordinated care

VISION

To foster a functionally integrated care delivery system that meets the health needs of communities

MISSION

Care coordination for all individuals in Southwest Colorado enabling access to patient-centered, high-quality, and cost-effective health care and social support.

VALUES

The Center of Excellence in Care Coordination (CoECC) strives for functional system integration to promote health, health equity, and value in health care through its support of care coordination. We value diversity of opinion, culture, age, gender, profession and practice as engines of creativity, resourcefulness, and resilience within communities. The CoECC is guided by the framework of the Collective Impact Model to facilitate nimble adaptation and sustained change.

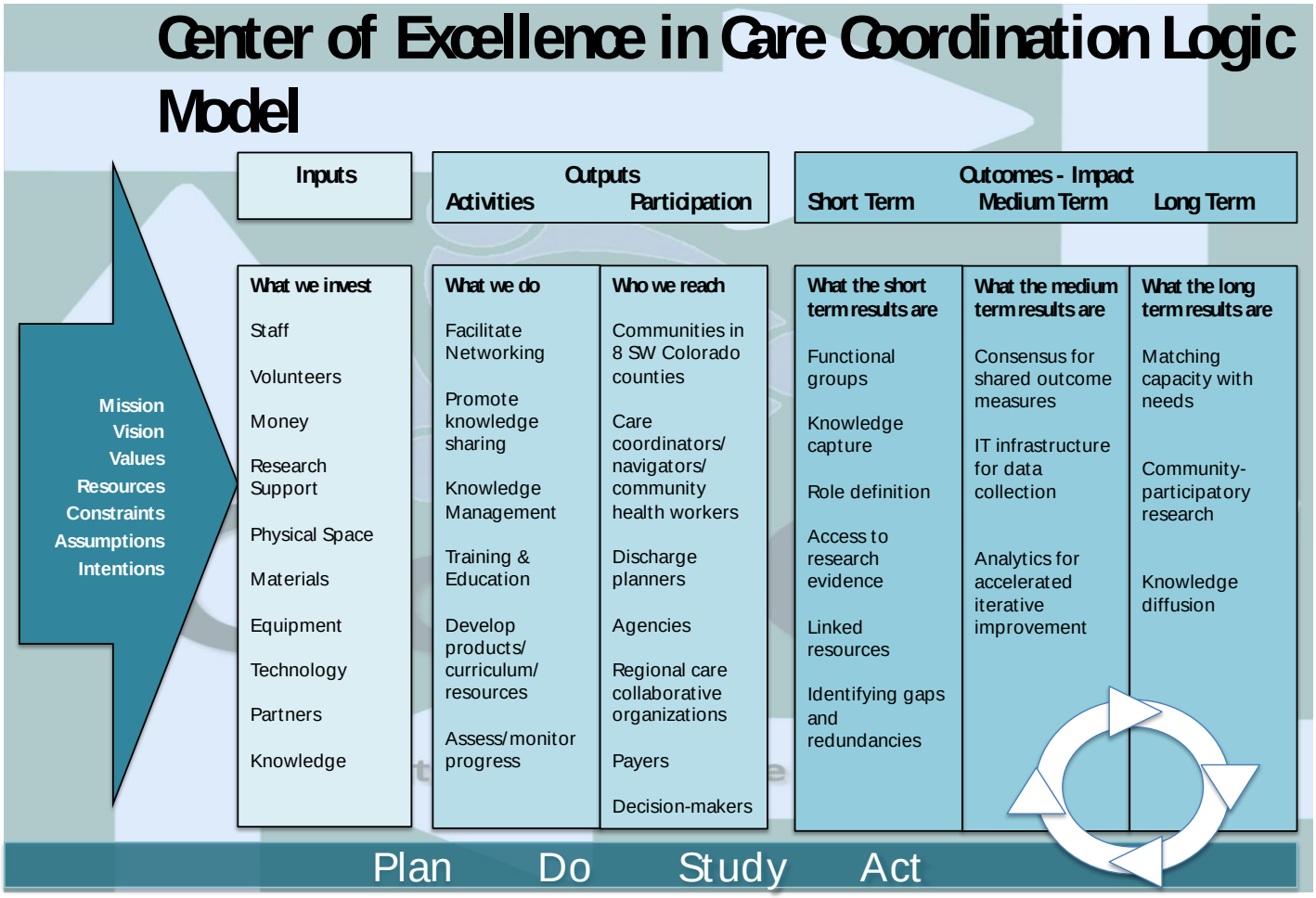
STRATEGIC GOALS

1. All care coordinators within Archuleta, Dolores, Hinsdale, La Plata, Montezuma, Ouray, San Juan, and San Miguel have access to a functional network of health and social services providers by 2014.

2. Southwest Colorado communities have opportunities to advance care coordination by merging community capital, knowledge, innovation, and evaluation of outcomes by 2015.

3. Communities have access to information captured through shared learning and evidence-based practices through knowledge management technology by 2015.

3. Communities receive responses to actual workforce needs through education and training in emerging roles related to care coordination by 2016.



Short Term Goals:

☑ By October 2014 the CoECC has established three functional groups; the action-focused groups convene direct-care providers, leaders and stakeholders, and allied community organizations serving as resources to achieve a functionally integrated delivery system.

☑ By November 2014 the CoECC makes available a resource directory for each county, the region, and for Colorado as a whole. The directory is cloud-based with 24/7 access.

☑ By December 2014 the CoECC website serves as an open access repository for terms and definitions around care coordination, as well as for evidence-based practice and practice-based evidence for chronic disease management, patient self-management support, and care coordination.

☑ By December 2014 the CoECC develops a document to provide understanding and guidance among the multiple, interdisciplinary roles involved in care coordination. The document is accessible through the website.

☑ By January 2015 the CoECC obtains results from its baseline community survey to identify strengths and weaknesses within the system so that it can facilitate improvement of chronic care without gaps or duplication across the region.

Medium Term Goals:

☑ By December 2014 the CoECC establishes Box©and Treo Solutions' State Analytics Data Contractor (SDAC) for Medicaid as workable IT infrastructure until the Colorado wide network developed by Colorado Regional Health Information Company (CORHIO) becomes available.

☐ By February 2015 the CoECC aligns all operation according to a formal data-driven, iterative evaluation plan.

☐ By October 2015 the CoECC notes consensus for shared outcomes measures across all eight Southwest counties.

Long Term Goals:

☐ By December 2015 the CoECC has collected baseline data measuring the collective impact of community-level care coordination based on shared outcome measures (see medium term goal).

☐ By December 2016 the CoECC is graduating the first cohort of community health workers after developing a community health worker curriculum and coordinating training logistics.

☐ By January 2016 the CoECC submits a manuscript portraying the collected impact of a local community-based care coordination initiative to achieve functional delivery system integration across organizations.