**What Is It?**

The Kentucky Diabetes Prevention and Control Program (KDPCP) at the Kentucky Department for Public Health (KDPH) recently received a multi-year grant from the Centers for Disease Control and Prevention (CDC) to improve diabetes clinical outcomes. Kentucky is choosing to focus on the implementation of a robust Diabetes Clinical Quality Improvement Learning Collaborative (DLC).

This Collaborative will be a 12 month process by which health care organizations come together to learn from one another and from experts in the field, and then undertake small tests of change to reach self-identified objectives within their own organizations. The focus for the collaborative will be to assist health care organizations make “breakthrough” increases in the adoption and use of clinical systems and care practices to improve health outcomes in people with diabetes. Targeted clinical system changes will include clinical decision support within the EHR for DSMES referral, establishment of bi-directional referral processes with DSMES providers, and other evidence-based care practices. Clinical participants will track referrals for DSMES, A1C and blood pressure values, and other clinical measures.

The structure for this collaborative learning will be based on the Institute for Healthcare Improvement (IHI) Breakthrough Series. At the heart of this approach are three models:

* **Learning Model** - participating practices are part of a network of experts and fellow-learners
* **Chronic Care Model (CCM)** (developed by Ed Wagner MD, MPH, and Director of the MacColl Institute for Healthcare Innovation), outlines all the elements of good chronic care
* **Improvement Model** enables teams to rapidly test and implement changes to improve care

Content for the learning sessions and recruitment will incorporate and align with current practice efforts to achieve Medicaid Promoting Interoperability (formerly Meaningful Use), participate in Quality Payment Programs and achieve Patient Centered Medical Home recognition.

**Timeline**

* October 2018 through Sept 2019 – Planning and recruitment
* October 2019 through Sept 2020 – Learning Collaborative

**Why Participate?**

*Health Care Systems/Clinical Practices*

* **improve clinical outcomes for your patients and practice**
* **contribute to and augment your other quality improvement programs and initiatives to improve healthcare, reduce cost, and succeed in value-based care.** Some of these programs include: EHR Incentive Program, Promoting Interoperability (formerly Meaningful Use), Patient Center Medical Home (PCMH) recognition, and the Quality Payment Program (QPP).
* **Help enhance population health efforts and expand the continuum of care**
* **Provide your patients an opportunity for more in-depth education and support to improve diabetes prevention and self-management behavior**
* **Provides technical assistance** from a team of diabetes and health system experts led by KDPH and the KY REC
* **Lessons learned from improving outcomes can be directly translated to improvement in other preventive health care areas**
* **Improve staff satisfaction as they take ownership of their QI efforts**

**What to Expect?**

1. Participate in 3 learning collaborative meetings (1 days each) over the course of 12 months:
	1. Pre-work: Participants will have reading material, take a survey, and will be asked to develop a storyboard to share their current efforts around quality improvement
	2. Meeting One: Overview of the model for Improvement, PDSA cycle and use of the model for improvement to accelerate the rate of improvement for your projects. Share Storyboards. Review Chronic Care Change Package, charter and measurement strategy. Review AIM Statement. Preparing for Action Period 1.
	3. Meeting Two: Hearing from teams in action, making meaning of the data, learning from each other, self-assessment, accelerating improvement, engaging peers, preparing for action period 2.
	4. Meeting Three: Share progress, perspectives from the road ahead, vision commitment, achieving and sustaining gains, using data to guide action, self-assessment, ready to spread, team recognition and leaving in action.
2. Report progress monthly by 10th of each month
3. Limited financial assistance is available for each participant accepted into the collaborative.

**How can I participate?**

1. This Learning Collaborative is only taking a limited number of eager participants.
2. Participants must complete an application.
3. Participants must commit to one year effort.
4. If selected, participants will be notified within 30 days of the application deadline.

**SUPPORT PARTNER ROLES**

**The Kentucky Department for Public Health (KDPH)** serves as the lead agency for facilitation of the CDC grant, develops the grant work plan in collaboration with partners and provides all reports to CDC. KDPH will provide limited financial support for pilot participants as well as training, curricula and educational materials as appropriate. Contact (Diabetes) Reita Jones at Reita.Jones@ky.gov

**The KY Regional Extension Center (KY REC)** serves as the lead agency for the pilot and will facilitate meetings and serve as expert consultant in electronic health record workflow. For the practices, KY REC will assure alignment with Promoting Interoperability (formerly Meaningful Use) and the Quality Payment Program (QPP) as well support Plan, Do, Study, Act cycles on workflow changes. KY REC will coordinate meetings, collect monthly data and provide technical assistance. Contact Mary LuvisiMLU242@uky.edu or Michelle Hibbard Michelle.Hibbard@uky.edu.

**The Kentucky Health Information Exchange (KHIE)** serves as an important partner to set up LHDs and YMCA with CareAlign DSM accounts/mailboxes to support bi-directional exchange of secure patient health information with select practices. They will vet the Direct Trusted Agent(s) for each organization and provide training regarding utilization of the CareAlign mailboxes. Contact Brandi.Genoe@ky.gov