

2021 Kentucky Diabetes Learning Collaborative

Learning Collaborative Participant Application

EXECUTIVE SUMMARY

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. One of the strategies in this grant opportunity Kentucky has chosen focuses on the implementation of a robust clinical quality improvement Diabetes Learning Collaborative (DLC).

This Collaborative will be a 14-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 DCL will be to assist health care organizations to make “breakthrough” increases in the adoption and use of clinical systems and care practices to improve health outcomes in adult people with diabetes. Targeted clinical outcomes will include improvement in glycemic and blood pressure control. Targeted clinical system changes will include clinical decision support within the EHR for Diabetes Self-management Education and Support (DSMES) referral, the 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 selected by participating practices.

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. A Learning Model makes participating practices part of a network of experts and fellow-learners. The Chronic Care Model (CCM), developed by Ed Wagner MD, MPH, and former Director of the MacColl Institute for Healthcare Innovation, outlines all the elements of good chronic care and the Model for Improvement 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 meaningful use, participate in Quality Payment Programs and achieve Patient Centered Medical Home recognition.

Participants will join in conference calls, in-person meetings, peer site visits, hands-on technical assistance, and webinars with experts and other organizations in the Collaborative. The support and opportunities for this DLC will be provided without charge to selected participating organizations. Learning sessions are held in person, but may be moved to virtual as needed due to COVID. Dates subject to change.

TIMELINE

Feb 24, 2021 (Noon-1 p.m.)	Conference call regarding questions on application
March 3, 2021 (Repeat Noon-1 p.m.)	Conference call regarding questions on application
March 30, 2021	Applications due
April 2, 2021	Decisions Announcement
May 5, 2021	Kickoff Call. Pre-work sent to participants
April/May 2021	Data Validation Meetings with each practice
June 15-17, 2021	Learning Session 1 -half days virtually 1 p.m.-5 p.m.

Action Period 1: Monthly Webinars (4 rd Wednesday of each month (1:00 p.m. - 2 p.m. EST)	
July 28, 2021	Monthly Call on Project
August 25, 2021	Monthly Call on Project
September 22, 2021	Monthly Call on Project
October 19-20, 2021	Learning Session 2 (1.5 Days or 3 half days virtually Oct 19-21)
Action Period 2:	
November 24, 2021	Monthly Call on Project
December 15, 2021	Monthly Call on Project
January 26, 2022	Monthly Call on Project
Feb 23-24, 2022	Learning Session 3 (1.5 Days or 3 half days virtually Feb 22-24)
Action Period 3:	
March 23, 2022	Monthly Call on Project
April 27, 2022	Monthly Call on Project
May 25, 2022	Monthly Call on Project
June 15, 2022	Learning Congress (3 hours)

EXPECTATIONS OF LEARNING COLLABORATIVE MEMBERS

Learning collaborative members must agree to participate in the following learning activities over the period of 4/7/2021 to 6/30/2022.

Learning Activity
Pre-work: <ul style="list-style-type: none"> • Establish teams • Prepare baseline data • Review orientation materials
Learning Session 1: One and a half-day in-person meeting or 3 half day virtual sessions <ul style="list-style-type: none"> • System of care for diabetes: overview of Chronic Care Model • Overview of the gap of the science and practice of diabetes • Overview of the Model for Improvement • Understanding the 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
<ul style="list-style-type: none"> • Complete data validation • Implement action plans • Start PDSAs • Conduct peer site or virtual visits • Continue monthly conference calls
Learning Session 2: One and a half-day in-person meeting or 3 half day virtual sessions <ul style="list-style-type: none"> • Hearing from teams in action

<ul style="list-style-type: none"> • Making meaning of the data • Learning from each other • Self-assessment • Accelerating improvement • Engaging peers • Preparing for action period 2
<ul style="list-style-type: none"> • Implementation of action plans • Continue PDSAs • Conduct peer site or virtual visits • Continue monthly conference calls
<p>Learning Session 3: One and a half-day in-person meeting or 3 half day virtual sessions</p> <ul style="list-style-type: none"> • Share progress • Perspectives from the road ahead • Vision commitment • Achieving and sustaining gains • Using data to guide action • Self-assessment • Readiness to spread • Team recognition and • Leaving in action
<p>Learning Congress: 3-hour meeting virtual or in person</p> <ul style="list-style-type: none"> • Share progress • Plans for sustainability and spread

Each learning collaborative member agrees to establish a team consisting of approximately three members, depending on the size of the organization. Larger organizations may have other team members. Team members should include:

- An executive director;
- A program director; and
- A frontline staff member.

Each learning collaborative member is expected to actively participate in learning collaborative meetings, site visits, and monthly phone conferences.

TEAM MEMBER COMMITMENTS

- Attend all sessions;
- Complete pre-work and prepare clear goals before Learning Collaborative Session 1;
- Meet between two and four times a month with your team to share successes, identify challenges, and discuss next steps for practice and system improvements;
- Communicate with other teams and the Learning Collaborative facilitators;
- Participate in conference calls once per month with the group;
- Participate in a monthly technical support call with your KY REC advisor;
- Participate in a small test of change (PDSA)
- Use data collected for progress reports to measure progress; and

- Share results on a regular basis with the Collaborative.

RESOURCES AND SUPPORT PROVIDED BY LEARNING COLLABORATIVE EXPERTS

Kentucky Department for Public Health (DPH), Kentucky Regional Extension Center (KY REC) and the Diabetes Steering Committee is the resource for organizations participating in the Diabetes Learning Collaborative. These organizations will provide materials, expertise, small financial incentives and forums for organizations to accomplish the goals they set out for themselves as a part of the Learning Collaborative. However, organizations must be prepared to provide their staff with the time, flexibility, support, and resources to accomplish these goals. More specifically, these organizations will:

- Organize, plan, and implement learning collaborative meetings, conference calls, and online forum;
- Provide expertise in diabetes management as well as organizational expertise related to shifting to a quality improvement model; and
- Gather data on Collaborative Progress and report to the Center for Disease Control and Prevention (CDC)

WHO CAN JOIN A LEARNING COLLABORATIVE?

- Your practice must be based in Kentucky
- Must have been in operation for longer than one year
- Must have at least two full-time staff members
- Must serve 100 or more adult patients who currently have type 2 diabetes
- You must have time and capacity to participate in this project

SELECTION PROCESS

Approximately ten to twenty organizations will be selected to participate in this Collaborative. The Kentucky Diabetes Learning Collaborative seeks to be inclusive of all eligible organizations interested in participating. However, selection will be based, in part, on the capacity and ability of the organization to rapidly address quality improvement around diabetes. In addition, priority may be given to practices whose service region and patient population incorporate Appalachia where diabetes prevalence is significantly higher.

SUBMITTING THE APPLICATION

Applications must be received electronically by KY REC by noon ET on March 30, 2021. Applications submitted after the deadline will be considered only if space is available. Applicants will be notified via email of decisions by April 2, 2021. Please submit 2020 Year End report for NQF 59 and NQF 18 with your application. **Submit applications and send report to: mlu242@uky.edu**

If you have any questions, contact Mary Luvisi by email at mlu242@uky.edu

Learning Collaborative Application Questions

ORGANIZATION BACKGROUND

1. Program/Agency Name:
2. Program/Agency Address:
3. Primary Staff Contact Name:

4. Primary Staff Contact Title:
5. Primary Staff Contact Phone Number:
6. Primary Staff Contact E-Mail Address:
7. Number of providers in the practice:
8. Number of practice locations/where:
9. What is your current numerator, denominator and performance rate for NQF 59 or MIPS 1 (hemoglobin A1C poor control > 9%)
10. What is your total patient population?

NARRATIVE RESPONSE

Please answer the questions below in **three to five sentences**:

11. Describe what your organization hopes to gain from the Learning Collaborative.
12. Describe what your organization will bring to the Learning Collaborative that will benefit the collaborative and your community.
13. Describe how you will spread what you learn within your organization.
14. Describe your organization experience with clinical quality improvement efforts.

ORGANIZATION CAPACITY

Assessment of Barriers. Please describe any barriers your organization might face during this year-long project.

15. Can you identify your patient population with diabetes?
 - Yes
 - No
 - Not yet, but we are in the process of developing the capacity
 - How many patients with diabetes do you have? _____
16. Do you have any vendor or EHR issues pulling NQF 59 data? (check one)
 - *Please let us know if you plan to change your EHR vendor anytime in 2021 or 2022.
 - Yes

- No
 - Describe issues
-
-

Financial Assistance. Overview of current financial assistance.

17. Does your organization receive financial assistance from any federal, state or local agencies to assist patients with diabetes? _____

Community Health Worker/Patient Navigator. Community health workers or patient navigators link program participants with services in the community, such as child care, employment, education, and other services to address barriers.

18. Does your organization currently provide care management or navigation? (check one)
- Yes
 - No

Outcomes and Data Collection. We plan to collect monthly data on PDSA work and diabetes related measures:

19. Do we agree to provide this information monthly by 15th of each month (check one)
- Yes
 - No

ORGANIZATION COMMITMENT

Identify the staff member who will serve as the Team Leader for your organization's team.

20. Team Leader Contact Name:

21. Team Leader Title:

22. Team Leader Phone Number:

23. Team Leader E-Mail Address:

24. Please have your Team Leader and the Executive Director verify the statements below. (Note: this may be the same person, depending on your organization's size and structure):

As the Team Leader, I commit to:

- Lead my organization's team in ensuring that the team conversation is genuine and that all voices, including those of consumers, are heard;
- Lead the team in making improvements;
- Serve as the primary team liaison

- Coordinate data collection as needed;
- Submit monthly progress reports in a timely manner;
- Ensure that monthly progress reports and lessons learned are shared with team members and organization staff;
- Have influence and authority to make systemic changes and spread these throughout the organization;
- Provide the team with the resources, including time, materials and equipment, access to local experts, and support necessary to implement the selected changes;
- Participate in conference calls on a regular (monthly) basis;
- Connect the Learning Collaborative goals to strategic initiatives of the organization;
- Hold team members accountable for initiating, maintaining, and evaluating the goals and tasks set out for themselves as a part of the collaborative;
- Facilitate the implementation of successful changes throughout the organization; and
- Provide continuing opportunities to disseminate what has been learned and to continue change processes within the organization.

I agree (check here)

Name of Team Leader

- As the Executive Director, I unequivocally support and endorse the efforts of my staff in this Diabetes Learning Collaborative and will provide them with the time (including time needed to attend both mandatory sessions), flexibility, support, and resources to accomplish these goals.

I agree (check here)

Name of Executive Director

Date