**What is this Opportunity?**

The Kentucky Diabetes Prevention and Control Program (KDPCP) at the Kentucky Department for Public Health (KDPH) 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 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. A Learning Model makes participating practices part of a network of experts and fellow-learners. The expanded 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 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 meaningful use, participate in Quality Payment Programs and achieve Patient Centered Medical Home recognition.

**Timeline**

* June 2022 through Sept 2022 – Planning and recruitment
* February 2023 through January 2024 – Learning Collaborative

**Why Participate in this Opportunity?**

*Health Care Systems/Clinical Practices*

* **Can help improve clinical outcomes for your patients and practice.**
* **Can contribute to and augment your other quality improvement programs and initiatives to improve healthcare, reduce cost, and move to value based care.** Some of these programs include: EHR Incentive Program, Meaningful Use, Promoting Interoperability, Patient Center Medical Home (PCMH) recognition, and preparing for the Medicare Access and CHIP Reauthorization Act (MACRA).
* **Can help enhance population health efforts and expand the continuum of care.**
* **Improve care coordination through bi-directional referrals to improve communication between the organization and CBO.**
* **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 areas.**
* **Improve staff satisfaction as they take ownership of their QI efforts.**

**What to Expect?**

1. Participate in data validation meetings virtually or in person at beginning of the Collaborative.
2. Participate in 3 learning Collaborative meetings (Meetings are generally held in-person, but may be held virtually as needed due to COVID. Each Collaborative meeting will be 1 day in-person or virtually) over the course of 12 months:
	1. Pre-work: Participants will have reading material, take survey and will be asked to develop a storyboard to share their current efforts around quality improvement. Baseline data will be requested and data validation meeting will occur.
	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.
3. Report progress monthly by **10th** of each month. Track improvement work monthly.
4. Attend and participate on monthly webinars.
5. Limited financial assistance is available for each participant accepted into the collaborative (based on CDC grant funding availability)
6. Participate in a monthly call w/REC advisor for technical support and update current status.

**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) Theresa Renn at Theresa.Renn@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 Meaningful Use and MACRA 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. For more information on KHIE CareAlign <https://khie.ky.gov/Services/Pages/default.aspx>