**What is this Opportunity?**

The Kentucky Diabetes Prevention and Control Program (KDPCP) within the Department for Public Health (DPH), working under a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC), is implementing a Prediabetes Learning Collaborative (PLC) to improve clinical practice and patient outcomes around prediabetes. The PLC is a partnership between primary care practices and National Diabetes Prevention Program\* (NDPP) providers, with technical assistance and support provided by the Kentucky Regional Extension Center (KY REC), the Kentucky Health Information Exchange (KHIE), and the KDPCP.

Diabetes prevention is critical since an estimated 96 million adults aged 18 years or older had prediabetes in 2019. Among US adults aged 18 years or older, crude estimates for 2017–2020 were 38.0% of all US adults had prediabetes, based on their fasting glucose or A1C level. 19.0% of adults with prediabetes reported being told by a health professional that they had this condition Completing the NDPP lifestyle change program reduced program participants’ chances of developing type 2 diabetes by 58% compared to placebo (71% for individuals aged 60 and older), nearly twice as much as the reduction among the group taking metformin (31%).

The Prediabetes Learning Collaborative 1 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 to make “breakthrough” increases in the adoption and use of clinical systems and care practices to improve health outcomes in people with prediabetes. Targeted clinical system changes will include: identifying patients with prediabetes, utilizing appropriate screening methods, targeting outreach, increasing the number of electronic referrals sent for providing NDPP, and increasing attendance in NDPP. Education will be provided by CBO collaborative partners, through the National Diabetes Prevention Program (NDPP), a CDC-recognized lifestyle change program. Bi-directional referral and communication processes will be established and maintained throughout the length of the collaborative.

The structure for this collaborative learning will be based on the Institute for Healthcare Improvement (IHI) Breakthrough Series. 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.

Participants will participate in conference calls, technical assistance calls, and webinars with experts and other organizations in the collaborative. The support and opportunities for this PLC1 will be provided without charge to selected participating organizations. Dates subject to change.

**Timeline**

September 9 2022  **Applications due**

September 12, 2022 Decisions Announcement

September 29 2022 12 p.m.- 1 p.m. EST Preparation Call

**January 25, 2023 Learning Session 1 Virtual**

**Monthly Webinars-1 hour, 12-1 p.m. EST**

Feb 2023

March 2023

April 2023

**May 9, 2023 Learning Session 2 Virtual**

**Monthly Webinars-1 hour, 12-1 p.m. EST**

June 2023

July 2023

August 2023

**September 12, 2023 Learning Session 3 Virtual**

**Monthly Webinars-1 hour, 12-1 p.m. EST**

October 2022

November 2022

**December 12, 2023 Learning Congress**

**Why Participate in this Opportunity?**

***Involvement in the PLC can…***

* **Help improve clinical outcomes for your patients and practice.**
* **Contribute to and augment your other quality improvement programs and initiatives to improve healthcare outcomes.**
* **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 prediabetes prevention and self-management behavior.**
* **Provide technical assistance from a team of diabetes and health system experts led by KDPH and the KY REC.**
* **Improve efforts in other preventative health areas through spreading successful quality improvement (QI) mechanisms and processes.**
* **Improve staff satisfaction as they take ownership of their QI efforts.**

**What to Expect?**

1. Participate in the following:
	1. Preparation Call (1 hour)
	2. Attend 3 Learning Sessions (1 day virtual)
	3. Attend 1 Learning Congress (3-4 hours virtual)
	4. Monthly facilitation meetings (1 hour)
	5. Attend and participate in monthly educational webinars
2. Report progress monthly by 10th of each month. Track improvement work monthly.
3. Limited financial assistance is available for each participant accepted into the collaborative based on CDC grant funds availability.

**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 Cara Castleberry cara.castleberry@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 National DPP providers and clinical partners, as needed, 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

Reference:

\*[https://www.cdc.gov/diabetes/prevention/index.html](https://www.cdc.gov/diabetes/prevention/index.html%20)