# 2023 Kentucky Prediabetes Learning Collaborative 1

## Learning Collaborative Pilot Participant Application

### EXECUTIVE SUMMARY

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 PLC1 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 (KyREC), 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 26, 2022  **Applications due**

September 27, 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**

### EXPECTATIONS OF LEARNING COLLABORATIVE MEMBERS

Learning collaborative members must agree to participate in the following learning activities over the period of 9/2022 through 12/2023.

* Attend and participate in monthly webinars;
* Attend 3 Virtual Learning Sessions (1 full day)
* Attend 1 Learning Congress (3-4 hours Virtual)
* Communicate with other teams and the Learning Collaborative facilitators;
* Participate in a monthly technical support call with your KY REC advisor;
* Participate in small tests of change (PDSA)
* Use data collected for progress reports to measure progress; and
* Share results on a regular basis with the Collaborative;
* Identify patients with prediabetes to improve screening, diagnosis, and prevention process;
* For interested patients, refer patients to National Diabetes Prevention Program (NDPP);
* Participate in bi-directional referral and communication processes

Each learning collaborative member agrees to establish a team consisting of approximately three members, depending on the size of the organization. 2 staff minimum for Learning Sessions. Larger organizations may have other team members. Team members should include:

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

### 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 at risk for type 2 diabetes (with A1C between 5.7% and 6.4% or other qualifying lab values) or no current A1C result;
* You must have time and capacity to participate in this project

### SELECTION PROCESS

Approximately three to five organizations will be selected to participate in this collaborative. The Kentucky Prediabetes 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 prediabetes. In addition, priority may be given to practices with a high prevalence of people with, or at risk for, prediabetes.

SUBMITTING THE APPLICATION

**Applications must be received electronically by KY REC by noon ET on September 26, 2022.** Applications submitted after the deadline will be considered only if space is available. Applicants will be notified via email of decisions by September 27, 2022. Please submit 2021 Year End report for NQF 59 with your application. **Submit applications and send report to:** [**mlu242@uky.edu**](mailto:mlu242@uky.edu)

If you have any questions, contact Mary Luvisi by email at [mlu242@uky.edu](mailto:mlu242@uky.edu) or Michelle Hibbard by email at michelle.hibbard@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**:

1. Describe what your organization hopes to gain from the Learning Collaborative?.
2. Describe what your organization will bring to the Learning Collaborative that will benefit the collaborative and your community.
3. Describe how you will spread what you learn within your organization.
4. 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.

1. Can you identify your adult patient population with prediabetes?

* Yes
* No
* Not yet, but we are in the process of developing the capacity
* How many adult patients with prediabetes do you have? \_\_\_\_\_\_\_

1. Do you have any vendor or Electronic Health Record (EHR) issues pulling NQF 59 data? (check one)

\*Please let us know if you plan to change your EHR vendor anytime in 2022.

* Yes
* No
* Describe issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* List current EHR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Assistance**.** Overview of current financial assistance.

1. Does your organization receive financial assistance from any federal, state or local agencies to assist patients with diabetes or prediabetes? \_\_\_\_\_\_\_\_

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.

1. 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 prediabetes related measures:

1. Do we agree to provide this information monthly by 10th 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.

1. Team Leader Contact Name:
2. Team Leader Title:
3. Team Leader Phone Number:
4. Team Leader E-Mail Address:
5. 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 Prediabetes 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