**SCOPE OF WORK**

Care + Community + Equity

**Diabetes Control and Prevention (Prediabetes)**

June 30th, 2022 – September 29th, 2023

This scope of work is aligned with HRSA’s Diabetes Quality Improvement Initiative.

**Aims**

Through Care + Community + Equity (CCE), the Diabetes, Heart Disease and Stroke Program (DHDS) at the Rhode Island Department of Health (RIDOH) seeks to improve population health outcomes and the quality of care for people with diabetes and prediabetes.

DHDS envisions a health care system where providers are connected to the communities in which they serve, and communities are connected to the providers within their neighborhood.

Within this scope of work, DHDS aims to:

1. Identify patients with prediabetes, improve care, and refer them to evidence-based lifestyle programs as appropriate
2. Improve diabetes control in patients with diabetes and refer them to evidence-based lifestyle programs and other treatment supports as appropriate

**Scope of Work**

To effectively participate in this work, each practice must have the ability to:

* Generate reports from their electronic health records (EHRs) of all patients with documented HgbA1c in poor control (CMS 122v10)
* Identify all patients who meet the clinical criteria for prediabetes and diabetes (see measure definition below)
* Develop and implement workflows that support prediabetes screening efforts and referrals to evidence-based lifestyle change programs (i.e., the Diabetes Prevention Program)
* Implement the use of a multi-disciplinary, team-based approach for the care of patients with diabetes and prediabetes

The following deliverables outline in greater detail the responsibility of the practices.

Year 4 of CCE is designed to demonstrate improvements in diabetes control and prevention (prediabetes). Deliverables listed below are categorized as “core” deliverables or “incentive.” Core deliverables comprise up to 80% of the funding available to a practice or agency.

*Core Deliverables for Year 4 of Care+Community+Equity*

* Meet with your CTC-RI practice facilitator quarterly or more, based on meeting performance and scope of work requirements to review progress, address barriers, and obtain support for diabetes control and prevention (prediabetes) activities.
* Identify members of the CCE project team. Include clinical staff and, if applicable, a CHW, who will be involved in the QI project/PDSA and can participate in these meetings.

1. Submit the following data quarterly by the 15th of October, January, April, and July to the CCE Portal (link and measure specifications to be provided). The final data submission will be due September 29, 2023 (data through September 15, 2023).

**Adult Patient Panel:** Number of adult patients who are active (seen by a primary care provider for at least one medical visit) in the practice in the last 12 months

**Diabetes in Poor Control (CMS 122v10):** Percent of patients with diabetes whose HgbA1c is >9% or missing

**Prediabetes:** Practice can choose to define this measure in one of four ways. The measure will be reported quarterly to your practice facilitator as part of your PDSA.

Option 1:

Numerator: Number of patients who have been ordered a screening laboratory test for prediabetes

Denominator: Number of patients who are at risk for diabetes

*and/or*

Option 2

Numerator: Number of patients who meet the clinical criteria for prediabetes:

* A1c 5.7 to 6.4%
* Fasting Plasma Glucose (FPG) 100 to 125 mg/dL
* or Oral Glucose Tolerance Test (OGTT) 140 to 199 mg/DL

Denominator: Number of patients screened (with lab tests) for prediabetes

*And/or*

Option 3

Numerator = Number of patients with a diagnosis code of prediabetes in the EMR (i.e., R73.03 or R73.09)

Denominator = Number of patients who meet the clinical criteria for prediabetes

*And/or*

Option 4: Other definition that best meets practice needs. Definition must include a numerator and denominator.

1. Attend and participate at quarterly CCE best practice sharing meetings (dates TBD in September 2022, December 2022, March 2023, June 2023, and September 2023)

Please come prepared to discuss best practices and progress on your PDSA. This discussion will be incorporated into each meeting. Invite members of the care teams to participate in these meetings.

1. Meet with your CTC practice facilitator to draft and finalize your Year 4 QI projects/PDSA and aim statements. Your PDSA and aim statements must address improving outcomes for those at risk of diabetes *and* those with uncontrolled diabetes. We strongly suggest using the PDSA template that will be provided by your practice facilitator.

While the completed QI project/PDSA will be submitted in June 2023, reporting on its components will take place throughout the year.

* During July and August, develop a timeline and due dates for each component of the QI project/PDSA
* Submit the Plan section of the PDSA and the aim statement(s) to RIDOH in September. Plans will be shared during the September best practice sharing meeting
* Summarize and present your test of change during the December and March best practice sharing meetings
* Present a final report during the June best practice sharing meeting

1. Complete a final evaluation survey, due September 29, 2023.

If deliverables cannot be completed by the due dates in the CCE Year 4 Project Plan, practices must notify RIDOH’s quality improvement consultant (Jayne Daylor) via email, preferably in advance. A plan of corrective action may need to be submitted.

*Incentive Options for Year 4 of Care+Community+Equity*

Incentive payments will be distributed annually if *three* of the following deliverables are met (up to 20% of funds allocated within each CCE scope of work). Incentive payments will be prorated if fewer than three deliverables are achieved and dispersed as a lump sum at the end of the contract year.

By the end of the Year 4 contract:

1. Complete a practice-designed incentive

With members of your care team, craft an incentive with target(s) consistent with the goals of this scope of work. Establish benchmarks to demonstrate achievement of the targets by June 29th, 2023. Review and discuss with your practice facilitator and RIDOH for approval by September 15th, 2022.

Options:

1. Craft a target that aligns with your PDSA; Establish and monitor progress so that achievement of the agreed-upon target could be demonstrated by June 2023.
2. Participate in the Rhode to Equity (July 1, 2022 to June 30, 2023) for diabetes and/or prediabetes.
3. Participate in CTC’s Pharmacy Quality Improvement Initiative for continuous glucose monitoring, which is scheduled to begin in June 2022 or September 2022.
4. Demonstrate that the percentage of patients with HgbA1c in Poor Control (HgbA1c is >9% or missing) is at or below the goal of 30%. This target must be met and sustained each quarter.
5. Stratify or review the stratification of your Year 3 data for CMS 122v9. Propose and implement ways to address disparities, either independently or as part of your Year 4 CCE QI project/PDSA.

Example – Uncontrolled diabetes is higher in Hispanic females across our practices, compared to other demographic groups. To address this disparity, we will redesign our workflows to ensure Hispanic females with uncontrolled diabetes are identified and referred to DSMES through the CHN. We will stratify diabetes in poor control by race and ethnicity again in Year 4 (December 2022 and March 2023) to evaluate changes in diabetes control rates from the baseline seen in Year 3.

1. Identify members of your care team who refer patients to evidence-based programs within the CHN and meet with the CHN Manager in July, August, or September to develop or adapt existing workflows that support CHN referrals. Submit the finalized workflow to your practice facilitator in October or November. Strategies to support workflows for CHN referrals may include the following:
2. Identify and group patients based on defined criteria (i.e., clinical criteria for prediabetes) and submit a bulk referral to the CHN
3. Create an "always" event, standing order, or an EHR flag to support automatic referrals to the CHN
4. Implement the use of a fillable PDF CHN referral form that may be embedded into the EHR, mimicking referrals made to specialists or outside services
5. Implement the RIghtMoves Provider Toolkit for physical activity counseling and utilize its resources to generate CHN referrals
6. Incorporate CHN referrals into existing PDSA(s) or create and test a tailored 6-month PDSA for CHN referrals.
7. Refer patients to DPP or DSMES through the contract year. Practices can refer to DPP and DSMES through the CHN. Practices will receive the incentive if all three steps are achieved:

Step 1: Refer at least 25 patients by October 15th, 2022, with at least 15 referrals to DSMES or DPP

Step 2: Refer an additional 25 patients by February 15th, 2023, with at least 15 referrals to DSMES or DPP

Step 3: Refer an additional 25 patients by June 29th, 2023 with at least 15 referrals to DSMES or DPP

Note: If practices have the capacity to offer DPP or DSMES on site, this may satisfy the intent of this incentive. Please discuss with your practice facilitator and the CHN Manager.

1. At a CCE Best Practice Sharing meeting scheduled for September, December, March, or June, a clinical care team member presents a practice or patient story that demonstrates successes and/or challenges in addressing diabetes/prediabetes.

The following deliverables outline in greater detail the responsibility of RIDHDS.

RIDHDS will:

* Provide practice facilitation and EHR technical assistance through existing contracts with CTC-RI and AHP
* In collaboration with the Rhode Island Health Center Association, provide training and technical assistance opportunities to FQHCs and free clinics serving vulnerable populations
* Provide technical assistance on RIDOH’s Community Health Network (CHN)
* Assist with evaluation of process measures and other analytical/data support (i.e., analyzing de-identified data, pre-post evaluations, etc.)
* Report quarterly on the number of CHN referrals made by each site
* Facilitate and strengthen connections between each health center and RIDOH programs (i.e., HEZs, CHN, DPP, WISEWOMAN)
* Distribute funds
* Alert practice to new resources and continuing education opportunities through regular programmatic updates