Maine Quality Counts
Diabetes & Hypertension Learning Collaborative Pilot
Memorandum of Agreement for Participation

**Introduction:** Maine Quality Counts (QC), under a contract with the Maine Center for Disease Control and Prevention (Maine CDC), is conducting a pilot to provide quality improvement support for primary care practices in Maine to improve population health outcomes for patients with hypertension (HTN) and diabetes (DM). QC will work with primary care practices, provider groups, and health systems to improve care through the implementation of quality improvement (QI) processes and the use of Electronic Health Records and Health Information Technology at the provider and system level to ensure reliable systems of care. The pilot is planned as a 3-year effort, beginning in 2014. The Memorandum of Agreement serves to outline the anticipated benefits and expectations for primary care practice sites participating in the Pilot.

**Mission:** The Diabetes & Hypertension Learning Collaborative will provide practice level coaching that will support primary care practices in implementing best practices in chronic disease care and will result in improvements in hypertension and diabetes outcomes among their patients.

**Vision:** The Diabetes & Hypertension Learning Collaborative will result in better health outcomes of Maine residents with chronic disease.

**Benefits of Participation**
The Diabetes & Hypertension Learning Collaborative Pilot offers an opportunity for primary care practices to make significant improvements in their systems of care for all patients in their practice relative to hypertension and diabetes. Participants in the Pilot receive the following benefits:
- Coaching on clinical best practices, practice transformation to support improvements and data collection,
- Access to clinical specialists and case-conferencing for improving dx and management of Diabetes and Hypertension
- Maintenance of Certification credits or Category I CME credits for attendance at Collaborative Learning Sessions
- Patient and provider tools to improve care
- Access to online educational modules at no cost
- Assistance with PQRS reporting (QIO partnership)

**Expectations of Participating Practices** – Primary care practice sites selected for participation in the Maine Primary Care Quality Improvement Initiative Pilot are asked to commit to the following:

2. Participate in the full duration of the anticipated 9-month Pilot. Participation of Pilot practice sites means active participation of all healthcare professionals and staff in the practice site.
3. Track and report the Pilot clinical measures hypertension control (NQF 0018); and diabetes A1C control (NQF 0059), using the practice’s electronic medical record or registry, and report clinical outcomes to Pilot staff and evaluation team monthly or every other month (frequency
dependent upon Maintenance of Certification participation). Definitions are included in Table 1.

4. Reporting of four additional performance measures at beginning and end of pilot. Reporting is expected to be streamlined Y/N; and will also include support from the evaluation team for collection. Details to be provided in orientation.

5. Participate in a baseline assessment at the beginning of the Pilot.

6. Identify a “Leadership Team” within the practice to serve as champions for QI improvement efforts and to attend Learning Collaborative Learning Sessions. The Leadership Team at your practice must include (at a minimum) a lead primary care provider, practice administrator, and a clinical support staff.

7. Participate in the Learning Collaborative, including consistent attendance by all members of the practice Leadership Team for the duration of the Pilot, in:
   a. Two (optional up to three) 1-day Learning Sessions,
   b. On-site Practice Support,
   c. Bi-monthly Case Conferencing Calls,
   d. Optional Virtual (online) Learning Opportunities,
   e. Optional Virtual (online) Team Sharing & Collaborative Learning.

8. Continually assess and improve care processes and structures within the practice, working in partnership with Pilot staff.

9. Participate actively in collaborative learning with other Pilot practices through sharing learning with other teams over the duration of the pilot.

10. Participate in Pilot evaluation activities, including surveys and interviews with evaluation team, to be completed within three months of completion of the Pilot.

By signing below, I acknowledge my understanding of the goals and expectations of the Diabetes & Hypertension Learning Collaborative Pilot, and commit to full participation in the Pilot as defined by agreement to fulfill the expectations noted above:

Practice name: __________________________________________________________

Practice Address (site): __________________________________________________

Provider Leader:
Signed: ______________________________ Date: __________

(Name): ______________________________

Practice Manager or lead Administrator:
Signed: ______________________________ Date: __________

(Name): ______________________________

Please return to Lise Tancrede, ltancrede@mainequalitycounts.org, 16 Association Drive, Manchester, ME 04351, or FAX 622.332
<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Source</th>
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<tbody>
<tr>
<td>NQF 0018 Hypertension Control</td>
<td>Percentage of patients 18 to 85 years of age with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year reliance.</td>
<td>Patients from the denominator with last blood pressure measurement with systolic blood pressure less than 140 mm Hg and the diastolic blood pressure less than 90 mm Hg</td>
<td>All patients 18 to 85 years of age with a diagnosis of hypertension (HTN) during the measurement year reliance.</td>
<td>NQF</td>
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<tr>
<td>NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&gt;9.0%)</td>
<td>The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is &gt;9.0% or was missing a result during the measurement year.</td>
<td>Patients from the denominator with a most recent HbA1c test greater than 9%.</td>
<td>All patients 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2)</td>
<td>NQF</td>
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