Contract #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Budget: **Mass in Motion 2246175-531000 MOTIN**

**CITY OF NORTHAMPTON**

**MASSACHUSETTS**

**Contract for Consulting (exempt from 30B)**

THIS AGREEMENT, executed this seventh day of November, 2015 by and between **Hilltown Community Health Centers, Inc.,** Worthington Health Center, 58 Old North Rd., Worthington, MA 01098, hereinafter called "Vendor" or “HCHC” and the **City of Northampton**, a municipal corporation in the County of Hampshire, Commonwealth of Massachusetts, party of the second part hereinafter called "Owner" or “City.”

WITNESSETH, that for the consideration hereinafter mentioned, the Owner and the Vendor shall agree to the terms and conditions contained in this contract, enumerated as follows: This Owner-Vendor Agreement and the attached **Scope of Services.**

THE OWNER shall pay the Vendor for the performance of this contract in the sum of **Two Hundred Thirty-One Thousand and Ninety Five dollars ($231,095)** in accordance with the terms of this contract.

Of this:

**$ 63,822 shall be spent and invoiced between 11/1/2015 and 3/29/2016** (Year 1 HCHC FY16)

**$125,455 shall be spent and invoiced between 11/1/2015 and 6/30/2016** (Year 2 DPP & HCHC FY16)

**$ 41,818 shall be spent and invoiced between 7/1/2016 and 9/26/2016** (Year 2 DPP & HCHC FY17)

**$231,095 total**

**Any funds spent or any invoices received after these dates are not eligible for payment**

This contract shall not be altered in any particular without the consent of all parties to this contract. All alterations to this contract must be in writing and authorized as such by the Mayor and the agency signing this contract.

The Vendor shall not delegate, assign or transfer any of its duties delineated in the scope of services without prior written consent from the CITY.

In the event the Vendor is a corporation a certificate that the person executing this contract is duly authorized to sign, must accompany this contract.

Notwithstanding anything in the Contract documents to the contrary, any and all payments which the City is required to make under this Contract shall be subject to appropriation or other availability of funds as certified by the City Auditor. Obligations for payments beyond the current fiscal year are subject to appropriation and this Contract shall be canceled in the event of non-appropriation. Obligations for payments are subject to compliance with standards of the Massachusetts Dept. of Public Health.

Final payment on this contract shall release and discharge the Owner from any and all claims against the Owner on account of any work performed hereunder, or any alteration hereto.

The Vendor shall indemnify and hold harmless, the CITY and all of its officers, agents, and employees against all suits, claims or liabilities of every nature, arising out of, or in consequence of, the acts or omissions of the Vendor, its employees, agents, or sub-contractors in connection with their rendering of services or goods under this AGREEMENT and will, at the Vendor’s own cost and expense, defend any and all such suits and actions

By signing this contract the Vendor agrees to subject any dispute to mediation, at the option of the City, prior to filing suit in any forum.

This contract shall be deemed to be a Massachusetts contract and its interpretation and construction shall be governed by the laws of Massachusetts and the Charter and Ordinances of the Owner.

The provisions of this contract are severable. If any provision of this contract shall be held unconstitutional by any court of competent jurisdiction, the decision of such court shall not affect any other provisions of this contract.

The City of Northampton is not bound by this contract until approved by the Mayor of Northampton.

Pursuant to M.G.L. Chapter 62C, Section 49A, I certify under the penalties of perjury that I have, to my best knowledge and belief, complied with the law of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support. I further authorize the City of Northampton to deduct from the amounts due under this contract, any overdue taxes, real or personal, or any other fees due to the City of Northampton from the vendor which become due and payable by the vendor or its officers, directors or agents during the term of this contract or until the final amounts due under this contract are paid in full.

The vendor **does not** have a Northampton office.

**IN WITNESS WHEREOF the Owner caused these presents to be signed in quadruplicate and approved by David Narkewicz its Mayor and the said Vendor has caused these presents to be signed in quadruplicate and its official seal to be hereto affixed by its officer or agent thereunto duly authorized (by the attached corporate resolution). This instrument shall take effect as a sealed instrument.**

Vendor:

 Hilltown Community Health Centers, Inc (Vendor) Date

 it's Executive Director

 Eliza Lake (Authorized Signatory)

**Please attach one W-9 to this contract when you return it to the City.**

**Complete Certificate by Corporation OR attach a signed letter with the same information**

**Certificate by Corporation to Sign Contract**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secretary of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby certify that at a

 (Name) (Name of Corporation)

duly authorized meeting of the Board of Directors of the

 (Name of Corporation)

held on at which all the Directors were present or waived notice, it was

 (Date)

voted that, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be and he hereby is authorized to execute contracts

 (Name) (Title)

and bonds in the name and behalf of said corporation, and affix its Corporate Seal thereto, and such execution of any contract or obligation in this company's name on its behalf by such officer under seal of the company, shall be valid and binding upon this company,

 A TRUE COPY,

 ATTEST:

 (Secretary)

 Place of Business

 Date of this Contract

**CITY OF NORTHAMPTON:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_

Wayne Feiden, FAICP, Director of Planning and Development

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

 Joyce Karpinski, City Auditor, approved as to appropriation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_

Joe Cook, Chief Procurement Officer, approved as to form and c. 30B compliance

 Date

Mayor David Narkewicz

**Scope of Services**

**Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke grant (1422)**

The purpose of this contract is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke and reduce health disparities in these areas among adults. Hilltown Community Health Centers (HCHC) will support health system interventions and community-clinical linkages that focus on the general population and priority populations. Priority populations are those population subgroups with uncontrolled high blood pressure or at high risk for type 2 diabetes who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income.

All work shall to be done in accordance with Massachusetts Department of Public Health (MDPH) 1422 protocols and procedures. HCHC agrees that to follow such protocols and to work to ensure that MDPH standards and objectives are met to the extent feasible. Those elements of the 1422 Community Expectations Grid that relate to this project scope shall be followed by HCHC.

The line item budget, community expectations, work plan are part of this scope of services.

**Project Scope**

* To increase electronic health records (HER) adoption and the use of health information technology (HIT)
* To Increase the institutionalization and monitoring of aggregated/ standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities).
* Increase engagement of non-primary care provider team members (i.e., nurses, pharmacists, nutritionists, community health workers, patient navigators) in hypertension management
* Increase use of self-measured blood pressure monitoring tied with clinical support
* Implement systems to facilitate identification of patients with undiagnosed hypertension and people with pre- diabetes
* Provide a Diabetes Prevention Program for individual at risk of diabetes (NDPP or YDPP)

**Specific grant deliverables include:**

**Healthy systems/Quality Improvement**

* Identify a quality improvement (QI) team
* Team will attend QI training
* Participate in MDPH QI initiatives to improve identification and management of hypertension (HTN) and diabetes, along with all cardiovascular risk factors
* Implement QI strategies to address gaps
* Provide aggregate data for QI work and grant reporting purposes
* Assess gaps in clinical support and identify roles for non-physician team member
* Assess and identify community resources that will assist with population health management
* Implement bi-directional e-referral program with community-based NDPP or YDP program
* Assess role of community health worker for patient education and community linkages in practice
* Appropriate team members will attend/participate in a monthly meeting/call
* Appropriate team members will participate in learning sessions
* Team will identify hypertension and/or diabetes lead for grant
* Appropriate team members will participate in Hypertension continuing medical education (CME)

**Community Health Workers**

* Hire Community Health Workers (CHWs) to support identified at risk patients with HTN, who are at risk for diabetes and who have diabetes to improve and manage their health
* Engage CHWs to provide self-management support to patients with HTN
* Engage in appropriate training for CHWs and their supervisors
* Engage in quality improvement activities developed by clinical teams
* Promote the sustainability of CHWs

**Pharmacy**

* Develop and implement a pilot on community pharmacist intervention for HTN and diabetes that will likely include medication therapy management. Assist with coordination and communication between pharmacist and primary care or prescribing provider to meet pilot deliverables.

**Evaluation**

* Provide de-identified clinical data (EHR) to track QI outcomes/progress

**Implement Diabetes Prevention Program (DPP)**

* Participate in MDPH organized DPP training and conduct one DPP session per year.

**Line Item Budget:** The initial line item budget is as follows. Any changes to the overall project total requires an amendment to the overall contract. Items may be moved between budget line items in accordance with Massachusetts Department of Public Health requirements and only with the written authorization from the City of Northampton Director of Planning and sustainability.

**DPH 1422 Project: Heart Disease, Stroke, and Diabetes**

**HCHC Initial Budget for MiM/1422 Year 1 and Year 2: 11/07/2015 to 09/29/2016**

|  |  |  |  |
| --- | --- | --- | --- |
| **Personnel** | **FTEs** | **Salary** | **Justification** |
| QI Coordinator | 0.5 | $26,000 | QI Team, identify QI initiatives related to HTN and prediabetes |
| QI Coordinator | 0.5 | $26,000 | Implementation of QI strategies to address gaps, provide aggregate data for QI work and grant reporting, assess gaps in clinical supports and identify roles for non-physician team members |
| CHW | 0.5 | $16,994 | Conduct assessment regarding barriers, assist in development of plan to address barriers, home and agency visits, referrals to interventions |
| CHW | 0.5 | $16,994 | Train in Heart 360, review pts understanding of intervention, education, address ambivalence, help to set goals |
| CHW Managers | 0.5 | $18,000 | Supervises CHWs, assesses CHW roles, participates in meetings and calls, QI team members. Participates in PLC, learning sessions |
| Clinical Data Analyst/ EMR Spec | 0.4 | $20,369 | work w/ clinicians and QI team to develop, monitor and maintain data integration and warehousing |
| **Subtotal Personnel** |  | **$124,356** |  |
| Taxes and Fringe @16% |  | $19,838 |  |
| **Total Personnel** |  | **$144,194** |  |
|  |  |  |  |
| **Other Direct Costs** |  |  |  |
| DPP implementation |  | $6,000 |  |
| Pharmacy |  | $10,000 | Contracts with two local pharmacies |
| Travel |  | $880 | 1000 miles @.44/mile |
| VOIP upgrade to site |  | $8,040 | Tech, licensing fees for communications for grant activities |
| Rent  |  | $9,000 | 3 additional offices 9 Russell Rd site |
| Supplies |  | $2,300 | Food, meeting expenses, materials and supplies |
| Training |  | $3,600 | CHW Core Competency Trainings, other training expenses |
| E referral |  | $28,000 | Implement two-way E-referral program |
| **Total Direct Costs** |  | **$67,820** |  |
|  |  |  |  |
| **Project Subtotal** |  | **$212,014** |  |
| **Indirect Costs @9%** |  | $19,081 | Admin, monthly VOIP service |
|  |  |  |  |
| **Project Total** |  | **$231,095** |  |

(See breakdown on first page of contract for when funds need to be spent and billed. Any funds spent or billed after these dates are not eligible for payment under this grant.)

(Sources: 1422 Year 1= HCHC $63,822; 1422 Year 2= HCHC $160,700; 1422 Year 2= DPP $6,573)

**Community agrees to… …which includes: DPH will help by… Notes/Other**

|  |  |  |  |
| --- | --- | --- | --- |
| Offerat least oneDPP sessions per year in the community. | * Network with community partners to identify existing DPP within the community OR individuals willing to be trained to offer DPP.
* Provide aggregate, de-identified data to DPH on DPP participation and outcomes.
 | * Connecting communities to DPPs they may know of in the community.
* Coordinating and fund training for new coaches if necessary.
* Supporting coaches in connecting with each other and across the state to understand successes and barriers
 | * Lifestyle change program is defined as DPP.
* Communities cannot pay staff to run DPP but can (through October 2016) cover or subsidize participant cost.
* DPH will provide course materials as long as we are able (many in stock).
* Funds cannot be used to support salary for RD to provide nutrition counseling, nor is nutrition counseling considered “lifestyle change”.
 |
| Send a representative to DPH’s statewide network promoting insurance coverage of DPP. | * 4-6 meetings per year, strategic planning, and advocacy for coverage of DPP.
 | * Convening and facilitating network
 |  |
| Recruit worksites to participate in DPH’s “PWTF Worksite Wellness Program”. | * Help make the connection between the business and DPH so the PWTF WW program vendor can enroll the worksites.
* Goal is 20 worksites per community over the next 2 years.
 | * Enrolling businesses.
* Providing training and technical assistance to businesses on developing an infrastructure for wellness.
 |  |
| **NOTE:** All **GRAY** refers to community’s health systems* identify a quality improvement team
* Team will attend QI training
* Will identify QI initiatives to improve identification and management of hypertension and diabetes
* Implementation of QI strategies to address gaps
* Provide aggregate data for QI work and grant reporting purposes
* Assess gaps in clinical support and identify roles for non-physician team member
 | * Multi -disciplinary team
* 4-5 in-person regional QI training
* Data of Blood Pressure Control (Hypertension) NQF #18 and A1C Control (Diabetes) NQF#59
 | * Will work with sites to utilize EMR data for population health management
* Provide QI tools and on site coaching
* Will work with practices on creating, interpreting and utilizing feedback reports
 | * Webinar will be available on Population Health Management
* On-line QI sessions available
 |
| * Assess and identify community resources that will assist with population health management
* Assess role of community health worker for patient education and community linkages in practice
* Will initiate and implement a bi-directional e-referral systems to community resources
 | * Partners with and utilization of CHW, VNA, CBOs, Ys and others in the community
 | * Identifying resources, best practices and materials
* Provide community linkage training
 | * Webinars on community resources and partners will be available
 |
| * Team must attend/participate in a monthly meeting/call
* Team must participate in learning sessions
* Team will identify hypertension and/or diabetes lead for grant
* Team must participate in BP train the trainer
* Team must participate in Hypertension CME
 | * 10-12 meetings per year, assess the grant process and timeline
* 3-4 learning sessions a year including subject matter leads in hypertension and diabetes
* Heart 360 training will be provided
 | * Convening and facilitating process
* Convening learning sessions
 | * Subject matter webinars will be available
* Cannot pay for Blood pressure monitors
* Cannot pay for gym membership
* Refer patients to Weight Watchers and TOPS
 |
| Hire CHWs to support patients with HTN, who are at risk for Diabetes and who have Diabetes to improve and manage their health | * Enroll CHWs in appropriate CHW Core training and CHW supervision training in one of the CHW training centers
* Identify and manage patient’s barriers to care
* Assess systematic gaps in service provision between the clinical sites and the community and develop improvements to diminish those service gaps
* Develop formal relationships with culturally appropriate and accessible community-based organizations and resources and link patient successfully to these resources
* Make appropriate community and clinical linkages and referrals
* For people with HTN, CHWs educate on blood pressure self-monitoring activities
 | * Providing TA in the recruitment, hiring, training, and supervising CHWs
* Providing TA in the integration of CHWs into care teams
* Disseminating the CHW Program Toolbox and provide related TA on the programmatic areas of need
* Supporting CHWs and their supervisors in connecting with each other and across the state to understand successes and barriers
* Providing TA in developing and maintaining the e-Referral systems
* Providing training on self-monitoring of blood pressure
 | * CHW can be paid for linkages related efforts for both HTN, pre-diabetes and diabetes.
 |
| Engage CHWs to provide self-management support to patients with HTN | * Provide health education and support self-management
 | * Providing training resources to CHWs and supervisors
 | * Communities cannot pay for CHWs to do Diabetes or pre-Diabetes related self -management or health education related activities
 |
| Engage in appropriate training for CHWs and their supervisors | * Assess training needs of new and already hired CHWs
* Assess training needs of CHW supervisors
* Assess TA needs of care teams in the integration of CHWs
 | * Providing guidance around Core Competency trainings for CHWs and their supervisors
* Coordinating and funding motivational interviewing training of trainers and training to CHWs
* Coordinating and funding training for new CHWs if necessary
* Providing training or access to trainings for CHWs on HTN self-management
* Providing Heart 360 training
 |  |
| Engage in quality improvement activities developed by clinical teams | * Identify measures to improve
* Integrate QI activities and provide aggregate data
* Work with DPH to develop data measures for CHW activities including but not limited to: retention, engagement in health care services, referrals and patients reached
* Work with DPH in tracking health outcomes
 | * Providing TA on QI to all team members
* Providing support in identifying data measures to collect
 |  |
| Promote the sustainability of CHWs | * Encourage and assist CHWs in applying for certification
* Promote DPH’s White Paper that emphasizes the evidence and cost effectiveness of CHWs

  | * Working with clinical sites to identify major payers and collaborate on promoting coverage of CHWs to those payers
 |  |
| Conduct a pilot around community pharmacist intervention for HTN and diabetes. | * Coordination with DPH to identify community pharmacist to deliver the intervention.
* Assist with coordination and communication between pharmacist and primary care or prescribing provider to meet pilot deliverables.
 | * Assisting with identification of appropriate community pharmacists.
* Working with pharmacy stakeholders to develop the pilot, which will likely include medication therapy management.
* Providing TA to local community pharmacists who are delivering the intervention
* TA will include data collection and communications systems with primary care or prescribing providers, among other things.
* DPH will provide training in disease management as necessary.
 | * Communities cannot pay pharmacists to deliver the intervention.
* Community pharmacist is defined as one working in an independent or chain pharmacy. This does not include pharmacists working within a CHC, even if it is a retail 340b pharmacy within a CHC.
 |
| Dedicate about 10-12% of their budget for evaluation needs | * Dedicated evaluation staff/contractors
* Quarterly meetings/updates with MDPH evaluation personnel
 | * Working with the grantee’s evaluation staff to identify potential data sources and establish standardized data collection processes to track their progress
* Work with the grantee to set targets for each year
 |  |
| Provide de-identified clinical data (EHR) to track QI outcomes/progress | * Work with their clinical partners to provide de-identified clinical data from participating sites
 | * Providing a QI specialist to help with the data transfer
* Analyzing all the provided data to identify progress and areas for improvement
 |  |
| Work with clinical partner to establish an electronic system for physician referrals to lifestyle change programs in the community | * Work with MDPH and clinical and community-based partners to establish a system for physician referrals to lifestyle change programs in the community, to track referrals via electronic medical record or e-referral system and to build capacity within community-based organizations to track and report on referrals.
 | * MDPH will provide comprehensive technical assistance.
 |  |

**BLUE-DIABETES, WORKSITES; GRAY-HEALTH SYSTEMS, QUALITY IMPROVEMENT; YELLOW-COMMUNITY HEALTH WORKERS; ORANGE-PHARMACY; RED-EVALUATION**

**Work Plan for Health System and Quality Improvements for Year 1 and 2**

Strategy 2.1 Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance

Year 1

* Work with EMR consultants to map workflow processes and EMR usage to identify barriers and inefficiencies
* Identify multi-disciplinary QI team to address recommended workflow improvements related to EMR usage.

Year 2

* Identify and implement QI projects based on EMR consultants recommendations to increase use of EMR usage
* Spread and standardize successful changes in workflows and documentation
* Develop a registry for HTN (including undiagnosed) and Pre-diabetes pts
* Continually update and utilize registries on an to identify, monitor, manage HTN and prediabetes
* Participate in Learning Collaborative sessions to support population health management of HTN and pre-diabetes patients

Strategy 2.2 Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities)

Year 1

* Identify staff without QI methodology training and enroll QI online training offered by MDPH
* Provide data to MDPH for baseline and quarterly feedback reports on quality measures as well as analysis of health disparities.
* Meet with MDPH to review data for quarterly feedback reports

Year 2

* Identify staff without QI methodology training and enroll QI online training offered by MDPH
* QI teams will review clinic data (at least monthly, weekly…) to:
	+ Identify workflow and clinical interventions to improve HTN and pre-diabetes measures and outcomes
	+ Develop and implement PDSA cycles to test interventions.
	+ Evaluate PDSA results
* Develop and implement QI efforts to identify and manage clients with other cardio vascular risk factors and support interventions and workflow improvements to reduce risk of hypertension.

Strategy 2.3 Increase engagement of non-primary care provider team members (i.e. nurses, pharmacists, and nutritionists, physical therapists, and patient navigators/community health workers) in hypertension management in community health care systems

Year 1

* Enroll staff in Blood Pressure Measurement training sessions offered by DPH
* Attend educational offerings from DPH including webinars:
	+ Identification of Undiagnosed Hypertension Patients
	+ Improving Clinical Processes to Achieve Hypertension Control: The Million Hearts® Hypertension Control Change Package for Clinicians Utilizing your
	+ EMR and Patient Registry for continuous Quality Improvement

Year 2

* Enroll staff in Blood Pressure Management training sessions offered by DPH
* Enroll staff (CHW and other clinical staff) in Heart 360 training.
* Engage with pharmacies, local boards of health, and other community partners to promote blood pressure screenings and referrals to clinicians for follow up on potential hypertension
* Assess gaps in clinical support and identify roles for non-primary care providers as care team members
* Attend educational offerings from DPH including webinars addressing other cardio vascular risk factors

Strategy 2.4 Increase use of self-measured blood pressure monitoring tied with clinical support

Year 1

* Assess and identify community resources that will assist in population health management
* Create and implement a reporting system for bi-directional e-referral between clinical and community settings.
* Conduct inventory of pre-existing policies to support BP self-monitoring in selected clinical settings

Year 2

* Ongoing engagement of community health worker in patient education and community linkages
* Enroll providers and staff in Heart360 Training
* CHW utilizes Heart 360 tool to support HTN patient health documentation of self-monitored BP
* Incorporate Heart 360 patient data in communication with provider

Strategy 2.5 Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes

Year 1

* Identify hypertension and/or prediabetes lead for grant
* Design an intervention and workflow which includes outreach to patients on who are identified on the undiagnosed hypertension and prediabetes registries.

Year 2

* Implement an intervention and workflow which includes outreach to patients on who are identified on the undiagnosed hypertension and prediabetes registries.
* Provide encounter level, de-identified data to MDPH on a quarterly basis using CHIA DRVS (a web-based system that downloads EHR data into portal for DPH to analyze) or embedded EMR systems.
* Use Feedback Reports to monitor progress towards identifying and addressing undiagnosed HTN and prediabetes
* Improvement team regularly (eg. monthly/weekly) review QI data to evaluate PDSA cycles of improvement

**Work Plan for Community Health Workers for Year 1**

**Milestone #1: Hire CHWs to support patients with HTN, who are at risk for Diabetes and who have Diabetes to improve and manage their health**

**Activities:**

1. Hire CHWs
2. Hire/Identify a CHW supervisor
3. Identify training and TA needs for both the CHWs and Supervisor
4. Communicate these training and TA needs with the MDPH Program Staff coordinating CHW initiatives

**Milestone #2: Engage in appropriate training for CHWs and their supervisors**

**Activities:**

1. All hired CHWs complete the CHW Core Competency trainings in one of the CHW Training Centers
2. CHW supervisor completes the supervision training in one of the CHW training centers
3. Assess and identify additional training needs for CHWs
4. Assess and identify additional training needs for CHWs
5. Assess TA needs for integration of CHW services into the Primary care team and communicate them in a timely manner to your MDPH Program staff
6. Work with MDPH Program staff to plan and implement integration related trainings
7. Enroll the CHWs and their supervisors/trainers and related team in the MDPH Linkages Motivational interviewing training

**Milestone #3: Engage CHWs to provide self-management support to patients**

**Activities:**

1. CHWs identify and manage patient’s barriers to care. Self-management activities can be paid for with 1422 funds if they are focused on hypertension. 1422 will not fund self-management activities related to prediabetes (see time-limited exception below). CHW led self-management activities should be billed to component 2, heart disease and stroke.
	1. Conduct assessment regarding the barriers by asking about past patterns of care, missed appts., medication adherence, beliefs about illness, relationships with providers, ER use and in patient hospitalizations, etc.
	2. Begin to work on a plan to address these common barriers by asking the patient what they want to work on and what goals they have
	3. Home visits, agency visits
	4. May also include making referrals to related social services/resources/interventions
2. Develop formal relationships with culturally appropriate and accessible community-based organizations and resources and link patient successfully to these resources. Linkages activities are allowable for both hypertension and prediabetes. They should be billed to component 2, heart disease and stroke, if focused on hypertension. If focused on prediabetes, they should be billed to component 2, diabetes.
3. Make and document appropriate community and clinical linkages and referrals. (Same guidance as #2.)
4. Making referrals to related social services/resources/interventions
5. May include accompaniment to these resources to ensure successful referral
6. Assess systematic gaps in service provision between the clinical sites and the community and develop improvements to diminish those service gaps. System assessments and improvements are allowable for both hypertension and prediabetes. They should be billed to component 2, heart disease and stroke, if focused on hypertension. If focused on prediabetes, they should be billed to component 2, diabetes.
7. For people with HTN, educate on blood pressure self-monitoring activities. This is focused on hypertension and should be billed to component 2, heart disease and stroke.
8. Be trained in the Heart 360 curriculum and then review the patient’s understanding on the intervention, help them learn their part and support their progress
9. Follow up in assessing the patient’s motivation to adhere to the provider’s treatment recommendations
10. Address ambivalence, education, and help them set their own goals to improve their health
11. Provide health education and support self-management

**Milestone #4: Engage in quality improvement activities developed by clinical teams**

**Activities:**

1. Identify measures to improve
2. Integrate QI activities and provide aggregate data
3. Work with DPH to develop data measures for CHW activities including but not limited to: retention, engagement in health care services, referrals and patients reached
4. Work with DPH in tracking health outcomes

**Milestone #5: Promote the sustainability of CHW**

**Activities:**

1. Encourage and assist CHWs in applying for certification
2. Promote DPH’s White Paper that emphasizes the evidence and cost effectiveness of CHWs

**Work Plan for Community Health Workers for Year 2**

**Milestone #1: Hire and train CHWs and Supervisors**

**Activities:**

1. Newly hired CHWs complete the CHW Core Competency trainings in one of the CHW Training Centers
2. Assess and identify additional and new training needs for CHWs and supervisor
3. Communicate new training and TA needs with the MDPH Program Staff coordinating CHW initiatives

**Milestone #2: Engage CHWs to provide self-management support to patients**

**Activities:**

1. CHWs identify and manage new patient’s barriers to care (see details under year 1)
2. Systematize health education and self-management activities of CHWs into the ongoing activities of the care team
3. Develop improved systems between the clinical sites and the community based services and share these best practices with DPH program staff

**Milestone #4: Engage in quality improvement activities developed by clinical teams**

**Activities:**

1. Develop new measures to improve that directly relate to the CHW activities

**Milestone #5: Promote the sustainability of CHW**

**Activities:**

1. Identify which CHWs have applied for CHW certification
2. Identify barriers to application for CHW certification
3. Identify any CHWs who have successfully become certified
4. Encourage any new CHWs to apply for certification

Note: CHW’s can be paid for Year 1 and 2 only to be trained as a Lifestyle Coach and deliver new CDC-recognized NDPP or YDPP classes. After Year 2, any CHWs delivering NDPP or YDPP classes must be paid from another funding source.

**Work Plan for Pharmacy for Year 1 and Year 2**

YEAR ONE

**Milestone #1: Collaborate with DPH to assess chronic disease activities conducted by community pharmacists in the catchment area.**

**Activities:**

1. Work with DPH evaluation vendor (as necessary) to help make connections between vendor and local pharmacies

YEAR TWO

**Milestone #1: Increase engagement of community pharmacists in the provision of medication-/self-management of adults with high blood pressure.**

**Activities:**

1. Identify community pharmacist to partner in pilot and establish necessary agreements.
2. Work with DPH, Pharmacy TA provider, clinical partner(s), and community pharmacist to develop details and logistics of community pharmacy pilot. This will include identification of patients appropriate for referral, establishing effective communications system between referring provider and community pharmacist (and back to referring provider), and identification of appropriate quantitative and qualitative data elements to track.

**Milestone #2: Launch pilot (not expected until Q4 of Year 2)**

**Activities:**

1. Implement pilot developed in Milestone #1
2. Implement communications system to refer patients and deliver feedback to referring provider.
3. Participate in regular meetings with clinical partner, community pharmacist, and Pharmacy TA provider to assess progress on the pilot and identify barriers and facilitators to successful outcomes.

**Work Plan for DPP for Year 1**

**Milestone #1: Promote awareness of prediabetes and DPP among both consumer and priority populations**

**Activities:**

1. Work with DPH to develop strategic marketing and communications materials (i.e. posters, pamphlets, advertisements).
2. Tailor materials for priority populations of focus within community.
3. Conduct marketing research if needed (i.e focus groups, key informant interviews, surveys).

**Milestone #2: Increase provider awareness of prediabetes and DPP, and implement systems to identify people with prediabetes**

**Activities:**

1. Work with clinical partner to develop screening and identification systems for people with prediabetes (i.e. CDC risk test, AMA prediabetes algorithm).
2. Use CDC/AMA Prevent Diabetes STAT toolkit with providers in clinical partner sites to screen, test, and refer people with prediabetes to DPP classes.

**Milestone #3: Increase referrals to and use of DPP**

**Activities:**

1. Work with clinical and community partners to recruit and enroll priority populations in DPP classes.
2. Work with CHWs on developing engagement strategies to recruit and enroll priority populations in DPP classes.
3. Develop paper/physical referral system to DPP in lieu of bidirectional eReferral
4. Track number of referrals to DPP and report to DPH on a quarterly basis.

**Milestone #4: Train lifestyle coaches in DPP**

**Activities:**

1. Ensure at least 2 lifestyle coaches are trained in year 1.
2. Ensure lifestyle coaches complete all prerequisite and requisite DPP trainings such as motivational interviewing, facilitating change in small groups, HIPAA.
3. Encourage CHWs to be trained as lifestyle coaches to deliver DPP.

**Milestone #5: Deliver DPP in the community**

**Activities:**

1. Identify new/existing organizations to deliver DPP in the community. At least 1 organization must be identified for year 1.
2. Negotiate contract with DPP provider(s) to agree upon funding method.
3. Fund local organization(s) to deliver DPP for up to two years.
4. Ensure DPP participant enrollment and outcomes data is being tracked for aggregate submission to CDC per Diabetes Prevention and Recognition Program standards.

**Milestone #6: Participation in statewide networks**

**Activities:**

1. Send at least 1 representative to participate in diabetes prevention network meetings.
2. Encourage CHWs to participate in diabetes prevention network meetings.
3. Encourage DPP lifestyle coaches in community to participate in state lifestyle coach network.

**Work Plan for DPP for Year 2**

**Milestone #1: Promote awareness of prediabetes and DPP among both consumer and priority populations**

**Activities:**

1. Potentially revise and disseminate strategic marketing and communications materials throughout the community. May incorporate elements of CDC consumer awareness toolkit (anticipated release Q1 2016).

**Milestone #2: Increase provider awareness of prediabetes and DPP, and implement systems to identify people with prediabetes**

**Activities:**

1. Work with clinical partner to implement screening and identification systems for people with prediabetes.
2. Utilize eReferral in clinical settings to help providers identify people with prediabetes in the EHR.
3. Ensure adoption of some elements of CDC/AMA Prevent Diabetes STAT toolkit with providers in clinical partner site(s) to screen, test, and refer people with prediabetes to DPP.

**Milestone #3: Increase referrals to and use of DPP**

**Activities:**

1. Work with clinical and community partners to continue to recruit and enroll priority populations in DPP classes. Aim for at least 80 referrals in year 2.
2. Work with CHWs to implement engagement strategies to recruit and enroll priority populations in DPP.
3. Utilize bidirectional eReferral system and enhanced work flow with clinical partner(s) and DPP provider(s) to increase referrals to DPP classes.
4. Disseminate physical/paper referral system to DPPs if necessary.
5. Continue to track number of referrals to DPP and report to DPH on a quarterly basis.

**Milestone #4: Train lifestyle coaches in DPP**

**Activities:**

1. Ensure at least 2 more lifestyle coaches are trained in year 2.
2. Ensure lifestyle coaches complete all prerequisite and requisite DPP trainings such as motivational interviewing, facilitating change in small groups, HIPAA.
3. Continue to encourage CHWs to be trained as lifestyle coaches to deliver DPP.

**Milestone #5: Deliver DPP in the community**

**Activities:**

1. Identify 1 more organization or location to deliver DPP in the community in year 2.
2. Negotiate/modify contracts with new or existing DPP providers to agree upon funding method.
3. Continue to fund local organizations to deliver DPP for up to two years.
4. Ensure a minimum of 2 DPP classes are launched by October 1st 2016.
5. Work with DPP providers on developing a sustainability plan.
6. Continue to ensure DPP participant enrollment and outcomes data is being tracked for aggregate submission to CDC per DPRP standards.

**Milestone #6: Participation in statewide networks**

**Activities:**

1. Continue sending at least 1 representative to participate in diabetes prevention network meetings.
2. Continue to encourage CHWs to participate in diabetes prevention network meetings.
3. Continue to encourage DPP lifestyle coaches in community to participate in state lifestyle coach network.