



Diabetes MESSAGES Study Request for Applications

Group visits, shared appointments in which patients receive education in a group setting and have a medical visit, have been shown to improve quality of care and clinical outcomes for patients with diabetes. The University of Chicago and the Midwest Clinicians' Network (MWCN) are looking for 20 health centers interested in receiving training and support for implementing a diabetes group visit program and a text messaging diabetes self-management intervention. Each health center will form a team of 3-4 providers and staff who will participate in training led by MWCN and the University of Chicago. Teams will gain the knowledge, skills, and motivation to implement a diabetes group visit and text messaging program.

In 2015, the University of Chicago and MWCN conducted a pilot study in which teams from 6 health centers in 5 states were trained to implement diabetes group visits at their health centers. After training, teams reported greater preparedness to implement group visits, and patients who enrolled in group visits at these health centers showed significant improvements in self-care and glycemic control (A1C). Recently, the University of Chicago received a grant from the Office of Minority Health's Partnerships to Achieve Health Equity program (CPIMP171145-01-00) to expand the study to 20 health centers across the Midwest. This larger study will also incorporate text messaging to reinforce self-care knowledge and goals between monthly group visits. Participating health centers will help the study team assess if diabetes group visits and text messaging improve outcomes for vulnerable populations, including low-income, racial/ethnic minority, migrant, and rural patients. At the end of the project, a toolkit with diabetes group visit program resources will be disseminated to health centers across the country.

The 18-month training program is designed to give health centers the opportunity to share and learn from other health centers' experiences. After an introductory welcome webinar, health center teams will attend a 2-day, in-person learning session in Chicago. This learning session will include expert presentations on best practices for implementing diabetes group visits, benefits of group visits, barriers and challenges to implementing group visits, strategies to overcome these barriers, and factors that facilitate the implementation of group visits and affect their sustainability. Teams will have time to work on individualized plans for implementation. After the learning session, teams will recruit patients and begin their group visit programs. Midway through the 6-month intervention, teams will attend a second learning session in Chicago during which they will present their program and discuss any challenges they have encountered. At this learning session, additional training will be provided on evaluation, sustainability, and other topics requested by the teams. Monthly webinars throughout the training period will provide opportunities for sharing, problem solving, peer support, and technical assistance. The final learning session will be a series of webinars with time for each team to give a formal presentation about their program.

Teams will recruit 15 adult patients with uncontrolled diabetes ($A1C \geq 8\%$) to participate in their programs. University of Chicago will provide a sample curriculum, but teams can tailor their program's structure and educational content to their patient population and available resources. The core components of the group visits are: medical visit, diabetes education, group social support, and goal setting. Patients will also participate in CareMessage's interactive diabetes education and self-management text messaging program. The text messaging program is available in English or Spanish and is designed for low literacy, racially and ethnically diverse, low-income patients. Patients will receive 3-5 text messages per week during the 6-month intervention period on topics like nutrition, exercise, stress management, and medication. CareMessage will provide training and technical assistance. After 6 months, teams will provide quarterly "booster" group visit sessions so that patients can sustain the changes they make during the intervention.

Health center teams will assist the University of Chicago and MWCN with evaluation of the training, group visit, and text messaging programs. Teams will complete periodic surveys and phone interviews to share their perceptions of the training, their confidence in being able to implement and sustain group visits, and their experiences conducting group visits. They will keep a record of patient recruitment efforts and attendance at each group visit session and access data on patients' engagement in the text messaging program through CareMessage. To measure the effects of group visits on patients' knowledge, attitudes, and skills for diabetes self-management, teams will administer patient surveys prior to the first group visit, immediately following the last group visit, and 6 months later. To measure changes in clinical outcomes, health care utilization, and processes of care, teams will collect data from patients' electronic health records (EHR) at specified time points. Teams will remove identifying patient information and send survey and EHR data to the University of Chicago team for analysis. The University of Chicago will provide instructions for secure, HIPAA-compliant means of transmitting data. Evaluation results will be shared with the health center teams.

The 20 health centers selected for this project will be randomly divided into 2 cohorts. Each cohort of 10 health center teams will complete the training together and implement group visits and text messaging at the same time. The first training cohort will begin the training in August 2018, attend learning sessions in Chicago in September 2018 and March 2019, conduct 6 monthly diabetes group visits between December 2018 and May 2019, and finish the training in December 2019. During the first cohort's training period, each health center in the second cohort will collect EHR data for 15 randomly selected patients with uncontrolled diabetes. These patients will serve as a control group for analyses. The second cohort will begin the training in February 2020, attend learning sessions in Chicago in March 2020 and September 2020, conduct 6 monthly diabetes group visits between June 2020 and November 2020, and complete the training in June 2021. During the second cohort's training period, health centers in the first cohort will collect follow-up survey and EHR data to assess longer term effects of the group visit intervention. The project ends for all health centers in December 2021.

In summary, health centers will be required to complete the following activities as part of the study:

- Designate 3-4 providers and staff who will participate in the training
- Obtain the support of health center leadership
- Attend 2 mandatory 2-day learning sessions in Chicago
- Participate in a mandatory third learning session conducted through a series of webinars
- Participate in monthly webinars during the training period
- Participate in a webinar and check-in phone calls with CareMessage
- Complete surveys before training, after each learning session, and at follow-up
- Participate in up to 2 phone interviews during and after group visit implementation
- Complete a training in the protection of human subjects in research
- Identify all eligible patients and recruit 15 patients for the program
- Implement a 6-month diabetes group visit intervention and enroll patients in text messaging program
- Keep records of recruitment process and attendance at group visits
- Conduct quarterly booster group visit sessions after the 6-month intervention
- Administer patient surveys before the first group visit, after the sixth group visit, and 6 month follow-up

- Collect EHR data after the first group visit, sixth group visit, 6 month follow-up, and 1 year follow-up
- Collect EHR data at 2 year follow-up (Cohort 1)
- Collect EHR data for selected control group patients (Cohort 2)
- Remove patient identifiers and send data to the University of Chicago
- Present group visit and text messaging program to peers during learning sessions
- Present group visit and text messaging program to local stakeholders, state primary care organizations, or other professional groups

University of Chicago will provide funding to support health centers' participation in this project. Health centers will receive \$2000 after the first and second learning sessions (\$4000 total) to cover team members' costs of traveling to Chicago. Health centers will receive \$750 at the beginning of the 6-month group visit program to use for program supplies (e.g., food, educational materials, patient giveaways). Health centers will receive \$500 after the third learning session to support presenting their program locally, regionally, or nationally (e.g., travel to a state primary care association meeting, abstract submission fee for a conference). Health centers will receive \$3750 for their data collection time and effort, paid in graduated installments: \$250 at enrollment, \$500 in December 2018, \$750 in December 2019, \$1000 in December 2020, and \$1250 in December 2021. Thus, health centers that complete the project will receive a total of \$9000 over the course of their participation.

To be eligible for participation, health centers are expected to:

- Be affiliated with MWCN, or be willing to become affiliated with MWCN if selected for the study; health centers can become MWCN members by submitting a membership application to MWCN along with the \$400 membership fee (<https://www.midwestclinicians.org/membership>)
- Have at least 3 providers and staff members available to participate in all training activities; at least 1 team member must be a clinician (physician, physician assistant, or nurse practitioner)
- Contact the University of Chicago team to be screened for eligibility before completing the application
- Complete the attached application and submit it by the deadline along with letters of support from health center leadership (executive director/CEO and medical director) stating their endorsement and support for provider and staff members' participation in the project

Health centers with and without prior experience implementing group visits may apply; however, health centers that participated in the pilot study with the University of Chicago are not eligible. The MWCN Research Committee will review all applications and select 20 health centers that represent different regions of the Midwest, offer a diverse set of patient populations, and demonstrate the greatest interest and ability to attend the learning sessions, implement the diabetes group visit and text messaging programs, and collaborate in evaluating the training and group visit intervention. If selected to participate, the health center's executive director/CEO and medical director will be asked to sign an agreement acknowledging the requirements of the study and stating they will support the team in completing the study requirements.

If you are interested in applying or have any questions, please contact Erin Staab, Project Manager, at estaab@medicine.bsd.uchicago.edu or 773-702-3962 in order to be screened for eligibility. The completed application is due May 1, 2018.



Diabetes MESSAGES Study
Health Center Application: Please type or print.

1. Name of Organization:

2. Check all funding sources that apply:

- Community Health Center
- FQHC
- FQHC Look-alike
- Healthcare for the Homeless
- Public Housing
- Integrated Service Delivery Network
- Dental On-site
- Black Lung Program
- NHSC Free-Standing Site
- Rural
- Migrant: Is migrant program FT PT Year-Round Seasonal Voucher
- Other / Explanation:

3. Is your center: Urban Suburban Rural Frontier

4. Health Center Address:

5. Phone: _____ Fax: _____

6. Email: _____

7. Center Facts:

- ❖ Number of annual total patients seen: _____
- ❖ Number of annual total patient visits: _____
- ❖ Number of patients with type 2 diabetes: _____
- ❖ Are you accredited? _____ By whom? _____ Date: _____

8. Center Leadership:

❖ Name of ED/CEO:

○ Phone: _____ Fax: _____

○ Email: _____

❖ Name of Medical Director:

○ Phone: _____ Fax: _____

○ Email: _____

○ Role in Project: _____

Please attach a letter of support from your executive director and medical director (can be one letter signed by both individuals or two separate letters).

9. Key Contact: The key contact will be contacted to arrange training logistics and will be the main point of contact for our research team. The key contact should be one of the team members who will participate in the training. If your health center is invited to participate in the study, we will also ask for the contact information for the rest of the team members who will be participating in the training.

❖ Name of Key Contact:

○ Phone: _____ Fax: _____

○ Email: _____

10. Data Collection Information:

❖ Will at least one team member be designated as responsible for collecting the required patient data for this study? Yes No

❖ Would your health center be willing to sign a data use agreement in order to send us limited data sets of patient health information abstracted from the EHR/patient charts? Yes No

Note: The types of data that will be abstracted are described in question 16.

Please answer questions 11-16 in a separate Word document.

11. Briefly describe your health center and your patient population with diabetes. Please include the following in your response:
 - a. The geographic area in which your center is located
 - b. Key services offered to patients at your center
 - c. The number of full-time and part-time providers at your center
 - d. A description of the population of patients with diabetes that your center serves (% of total patient population with diabetes, racial/ethnic breakdown of patients with diabetes, % of patient with diabetes with an A1C greater than 8.0%, etc.)
 - e. Any other information that you believe is important for the MWCN Research Committee to know about your health center and/or how it is unique.

12. Please describe why your health center is interested in participating in this study. Briefly describe any experience your health center has with diabetes group visits and/or text messaging. If your health center had diabetes group visits and/or text messaging in the past but not currently, why did the program(s) stop? Has your health center participated in research studies, evaluation projects, or learning collaboratives with other organizations previously?

13. Which personnel and what resources do you currently have that could allow you to successfully implement a group visit program in your health center?
 - a. List the names and titles of potential team members who will attend the learning sessions and implement the group visit program at your center. Briefly describe their potential roles on the team. Include a brief description of each individual's past experience with group visits and the strengths they would bring to the team.
 - b. Describe the resources your center could provide for the implementation of the group visit program. Consider resources such as space, equipment, technology, patient incentives, and/or educational materials. If your health center has multiple sites, please also describe the site at which you would like to implement the group visit program.

14. Please describe why you think patients at your health center would be interested in participating in the group visit and text messaging program. Do you anticipate any challenges recruiting 15 patients who meet these eligibility criteria?
 - a. Adult with type 2 diabetes
 - b. English or Spanish speaking
 - c. At least 2 visits at the health center in the past year, at least 1 in the past 6 months
 - d. Most recent A1C \geq 8%, tested within past 6 months
 - e. Owns a cell phone with text messaging capabilities, able to read and send text messages
 - f. Does not have dementia, cognitive impairment, uncontrolled psychiatric problem, or hearing difficulties; not currently pregnant, homebound, or planning to relocate in next year
 - g. Assent of patient's primary care provider to patient's participation in program

15. If the opportunity were available, would your health center be interested and able to conduct two group visit sessions concurrently (i.e., two groups of 15 patients who meet at different times)? If so, would the groups be held at the same site or different sites? Would they be implemented and conducted by the same team of providers and staff or different teams?

16. Please briefly describe your center's EHR capabilities and the types of patient data that your center collects and evaluates on a regular basis. Please also describe your center's ability to collect patient data as outlined in the request for applications (EHR/chart abstraction, survey administration). Please address whether your center has the ability to fairly easily collect the following patient measures via EHR/chart abstraction:

- a. Clinical measures: A1C, blood pressure, cholesterol, height, weight, albumin/creatinine ratio, GFR, diabetes complications, family history of diabetes, medications
- b. Process of care measures: Dates of A1C tests, BP measurements, cholesterol tests, flu and pneumonia vaccination, dilated eye exams, foot exams, dental exams, depression screening
- c. Health care measures: Referrals, dates of primary care appointments, specialist appointments, ER/ED visits and hospitalizations
- d. Patient characteristics: age, gender, race/ethnicity, insurance, language, mental health history, smoking status