**SYNC 2022 Tuition Assistance Project Focus Areas**

The Virginia Department of Health will cover the full SYNC Program tuition for teams that **select one of the following projects** as the focus of their Capstone Project and comply with the **2022 Terms of Agreement.**

Teams should select one project from the options below in the areas of Diabetes ◊ Hypertension|High Blood Cholesterol|Heart Disease|Stroke ◊ Alzheimer’s Disease/Related Dementia.

Projects and measures will be finalized in first 2 months of SYNC program. Measures will be reported to VDH in 6 – month intervals for a total of (4) measure points-- baseline (pre-capstone), 6 month, 12 month, 18 month

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|  | **Diabetes** *(Select one or more)* |
|[ ]  * **Capstone Project**: Improve access to and participation in ADA-recognized/ AADE-accredited DSMES programs in underserved areas (including optional strategy to support other DSME programs)

**Required Reportable Measures (Select)**: * + # of new ADA-recognized/AADE-accredited DSMES programs established (DSMES programs)
	+ # of people with diabetes with at least one encounter at an ADA-recognized/AADE-accredited DSMES program
	+ Proportion (numerator/denominator) of people with diabetes with an A1C > 9 (goal is to decrease)
 |
|[ ]  * **Capstone Project**: Implement systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention

**Required Reportable Measures (Select)**:* + # of patients served within a healthcare organization(s) with systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs, such as the National Diabetes Prevention Program (Total # of patients)
	+ # of patients with a prediabetes diagnosis identified
	+ # of patients with a prediabetes diagnosis referred to the National Diabetes Prevention Program
 |
|[ ]  * **Capstone Project**: Implement strategies to increase enrollment in CDC-recognized lifestyle change programs, such as the National Diabetes Prevention Program

**Required Reportable Measures (Select)**: * + # of participants enrolled in a National Diabetes Prevention Program(s)
	+ Achievement of a minimum average weight loss of 5% in participants in the National Diabetes Prevention Program(s)
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|  | **Hypertension, High Blood Cholesterol, Heart Disease and Stroke** *(Select one or more)* |
|[ ]  * **Capstone Project**: Facilitate use of self-measured blood pressure monitoring (SMBP) with clinical support among adults with hypertension

**Required Reportable Measure (Select)**: * + # and % of patients within a health care system(s)/clinic(s) that have policies or systems to encourage self-measured blood pressure monitoring (SMBP) with clinical support for patients with hypertension
	+ Proportion (numerator/denominator) of adults with known high blood pressure who have achieved blood pressure control
 |
|[ ]  * **Capstone Project**: Utilize remote patient monitoring and telehealth to monitor patients’ blood pressure to achieve blood pressure control

**Required Reportable Measure (Select)**: * + # and % of patients within a health care system(s)/clinic(s) that have policies or systems to encourage self-measured blood pressure monitoring (SMBP) with clinical support for patients with hypertension
	+ Proportion (numerator/denominator) of adults with known high blood pressure who have achieved blood pressure control
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|[ ]  * **Capstone Project**: Utilize electronic health records, health information technology, and dashboards to monitor health disparities among patients diagnosed with ischemic stroke, cardiovascular disease, hypertension, high blood cholesterol, or familial cholesterol. Screen patients for social determinants of health. Refer identified patients to lifestyle change programs, such as TOPS, Weight Watchers, Healthy Heart Ambassador Programs, virtual or text-based programs, etc.

**Required Reportable Measures (Select)**: * + # of patients diagnosed with ischemic stroke, cardiovascular disease, hypertension, high blood cholesterol, and/or familial cholesterol
	+ # of patients screened for social determinants of health and breakdown of aggregate results
	+ # of patients referred to a lifestyle change program, such as TOPS, Weight Watchers, Healthy Heart Ambassador Program, virtual or text-based programs, etc.
	+ Proportion of adults (numerator / denominator) with known high blood pressure who have achieved blood pressure control
	+ Proportion of patients (numerator / denominator) considered at high risk of cardiovascular events who have their cholesterol managed with statin therapy
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|  | Alzheimer’s Disease/Related Dementia *(Select one or both)* |
|[ ]  * **Capstone Project**: Increase the use of the EHR to identify and create a registry of patients with ADRD-related symptoms or positive assessments and refer (bi-directional preferred) to external supports and specialists.

**Required Reportable Measures:** Both measures are needed* Proportion (numerator/denominator) of people with ADRD identified through EHR in comparison to the total patient population
* Proportion (numerator/denominator) of people with ADRD referred to support services and specialists
 |
|[ ]  * **Capstone Project**: Integrate [Clinical Provider Practice Tool](https://www.actonalz.org/sites/default/files/documents/ACTNAT-Provider-ClinicalPracticeTool.pdf) to streamline protocol for managing cognitive impairment and guiding decisions for screening, diagnosis, and disease management.

**Required Reportable Measures:*** Documented integration process including types of assessments used: If the team elects this capstone and they can only commit to the QI process to integrate, then this measure suffices
* Proportion (numerator/denominator) of people screened through annual exams and tools in comparison to the total patient population: the protocol implementation requires practices to use a decision tree to determine the next steps for diagnostic workup and internal referral
* # of people receiving a total workup
* # of people referred to champion in your practice
* # referred by resource type
 |

***SYNC:*** *Transforming Healthcare Leadership***| VDH Terms of Agreement 2022**

**Virginia Department of Health Chronic Disease**

**Expectations** of each team include*:*

* ***If any of the requirements of this agreement are not met, or the capstone project falls outside of the VDH Terms of Agreement, the registered team is responsible for full tuition costs.***
* ***Team***: Each interprofessional team should include a clinician.
* ***Attendance***: The expectation is the same team members participate in each virtual session, unless further discussed with the SYNC staff.
* ***Learning Leader***: Each team must designate (1) Learning Leader as the point of contact for technical assistance by SYNC and VDH staff. Learning Leaders are also responsible for the coordination of team members for in-person and online sessions, as well as internal meetings and progress on projects between sessions.
* ***Capstone Project Selection***: Teams must select a project that will result in improved VDH-recommended Chronic Disease health outcomes as identified by VDH. Project selections will be subject to a set of required data reporting (*See Reporting*). Projects will be reviewed by VDH staff to determine scholarship eligibility. Teams must confirm the selected project focus area to VDH by **December 15, 2022** for full tuition costs to be covered. *See Tuition Assistance Project Focus Areas for eligible projects.*
* ***Documentation***: Each team member must complete necessary evaluation and survey forms throughout the program.
* ***Reporting***: Teams must submit data associated with the selected VDH Chronic Disease focus area. Baseline (January 15, 2023), 6-month (June 30 2023), 12-month (Jan 15, 2024), 18-mo (June 30, 2024). Teams will be prompted with due dates. Post project data will be collected to demonstrate outcomes of the capstone project. Aggregate measures will be shared with VDH for tracking, trending and analysis purposes. Failure to report will result in program tuition to be rescinded.
* ***Online Learning Portal***: Each team member must activate their account in the SYNC online learning portal.
* ***Teach-back Session***: Each team must present their Capstone Project at the final SYNC Teach-back Session (PowerPoint template will be provided).

**VDH Responsibilities:**

* ***Tuition Costs****:* VDH, in partnership with MSVF, will cover full program tuition for each team and eligible travel expenses (if applicable). Small budgets may be available to teams to purchase equipment to benefit capstone project outcomes.
* ***Project Selection****:* VDH will review proposed Capstone Projects for scholarship eligibility and review all requirements via phone consultation prior to start of program. Teams will be contacted if there are further questions before eligibility is determined.
* ***Technical Assistance****:* In addition to the SYNC staff, VDH staff will provide technical assistance regarding the Capstone Project and any associated data reporting. VDH staff is also available to discuss how to support project outcomes and team learning.
* ***Reporting****:* VDH staff will work with approved SYNC teams on identifying data and outcome measures related to the selected chronic disease project and suggest a data reporting template.

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**Submit this form signed and scanned to** **aswierczewski@msv.org** **or Fax (804) 377-1056**