

Pharmacy Quality Improvement Initiative

Practice Name: CNEMG Pawtucket

Lead Provider Name: Rabin Chandran/Katrina Roi

Lead Pharmacist Name: Ron Tutalo



PLAN

Aim Statement

1. Demonstrate improvement in maintenance inhaler adherence for patients with asthma and chronic obstructive pulmonary disease (COPD).
2. Expand pharmacy COPD service (previously demonstrated positive outcomes) to include referral for asthma, COPD, and smoking cessation, with focus on patient adherence.

Problem

1. Asthma and COPD are often undertreated in a primary care setting.
2. Many patients are not adherent to maintenance inhalers and do not properly use their inhalational device.

Goals

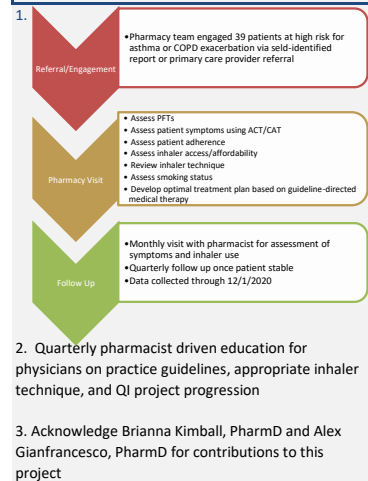
1. Maintain current maintenance adherence level and achieve 2% improvement. Baseline maintenance inhaler adherence rate is 54%.
2. Achieve clinically significant increase in average Asthma Control Test (ACT) and decrease in COPD Assessment Test (CAT) scores from initial visit to post pharmacy intervention
3. Decrease healthcare system utilization from year prior to post pharmacy intervention
4. Apply PDSA to optimize asthma/COPD pharmacy service

DO

Key Measures

1. Maintenance inhaler adherence (lag measure not determined during this PDSA project period)
2. Change in ACT/CAT symptom assessments (minimum clinically important difference defined as increase in ACT by ≥ 3 and decrease in CAT by ≥ 2 points)
3. # of exacerbations, hospitalizations, and emergency department visits
4. # of pharmacist interventions resulting in an inhaler change
5. # of patient and pharmacist encounters (in-person, virtual/telephonic)

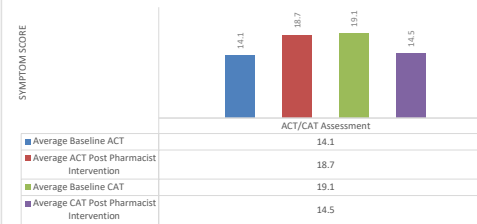
Methods



STUDY

Outcomes/Results

ACT/CAT ASSESSMENT RESULTS



- Hospitalizations year prior to pharmacy intervention: 2
 - Emergency Department visits year prior to pharmacy intervention: 11
 - Exacerbations year prior to pharmacy intervention: 26
 - Hospitalizations/Emergency Department post pharmacy intervention: 0*
 - Exacerbations post pharmacy intervention: 5**
 - 65 pharmacist facilitated inhaler changes
 - 116 pharmacist-patient encounters
- *Encompasses 130 total months for 39 patients
**4/5 exacerbations were triaged by pharmacy team leading to medication management

ACT

Sustainability & Next Steps

1. Continue to encourage referrals to pharmacy asthma/COPD/smoking cessation service
2. Pharmacist-led update on service as well as practice guideline review for asthma/COPD/smoking cessation provided to physicians at least biannually
3. Develop a structured referral process for asthma/COPD/smoking cessation management in EPIC by second quarter 2021
4. For patients not having had an exacerbation for 3 consecutive monthly visits, increase to quarterly visits
5. Incorporate In-Check Dial device to improve inhaler teaching according to COVID-19 policies
6. Incorporate after visit summary developed with patient input
7. Collaborative Practice Agreement for asthma/COPD at this practice site by end of 2021

Patient Engagement Strategies

What Matters Most to the Patient

1. Pharmacy team provided patient with education regarding asthma/COPD action plans. COPD/asthma action plans give patients the ability to advocate for their own health
2. Incorporated patient feedback to improve patient information on after visit summary
3. Used COPD Foundation inhaler administration videos to educate patients when performing virtual or telephonic visits

PATIENT AFTER VISIT TAKEAWAY

Name _____

Today we discussed: COPD / Asthma

BREATHING ASSESSMENT SCORE:

CAT/ACT Score (Initial) _____

CAT/ACT Score (Last Pharmacy Visit) _____

LIST OF YOUR INHALERS:

MAINTENANCE INHALERS: Use daily for maintenance of breathing symptoms.

RELIEF INHALERS: Use as needed for shortness of breath.

FOR MORE INFORMATION:

Please visit www.copdfoundation.org

Click on "Learn More" → "Educational Materials & Resources" → "Educational Video Series"

Pharmacy Quality Improvement Initiative

Practice Name: Brown Medicine

Lead Provider Name: Francis Basile, MD

Lead Pharmacist Name: Angel Pechie, PharmD



PLAN

Aim Statement

Provide our patients with cognitive, behavioral, physical, and environmental aspects to living well with chronic pain - with an ultimate goal of helping patient to de-escalate chronic, non-cancerous, opioid therapy. Cognitive behavioral therapy will be provided by embedded integrated health provider - Dr. Shauna Finley

Problem

The practice targeted has a disproportionate share of patients on chronic opioids for non-cancerous pain management. Providers have the desire to support patients in alternative methods of pain management but frequently do not have the experience or knowledge base to do so. The traditional approach - discussions about PT, referrals to psychotherapy, and unsupported de-escalation typically fail and poison the patient/provider relationship

Goals

1. Assess providers' level of comfort with cognitive behavioral therapy for pain management
2. Leverage the familiarity of the site's integrated behavioral health specialist
3. Provide a classroom style setting where patients can learn about their interpretation of pain and techniques to alter their perceptions
4. Encourage patients to share experiences to decrease self-pity and feelings of isolation
5. Empower patients with an understanding of pain physiology and cognitive skills ultimately enabling them to de-escalate opioid therapy by at least 50%

DO

Key Measures

Brief Pain Inventory - Short Form
Pain Catastrophizing Scale (PCS)
Chronic Pain Acceptance Questionnaire
Morphine Milligram Equivalents (MME)

Methods

1. Modified the current opioid report
2. Providers selected patients from the opioid report - likelihood of success, high risk meds
3. Providers initiated conversation with patient, followed by warm hand-off to Dr. Finley
4. Dr. Finley provided details of class to patient
5. Interested patients completed a 1:1 session
6. Dr. Finley determined likelihood of benefit from the class during 1:1 (? contemplative)
7. Patients likely to benefit were invited to enroll
8. A new billable "group visit" was created
9. RPH then contacted patient to provide class schedule and enrollment paperwork
10. Ten class sessions were led by Dr. Finley
11. Pappas Physical Therapy participated in one session
12. Follow up surveys were provided to patients at class completion
13. Survey responses to determine de-escalation strategy

STUDY

Outcomes/Results

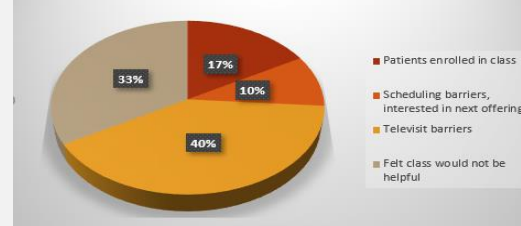
- Modification of the opioid report reduced patients listed by 45%
- Providers were given access and taught to use an embedded form of PDMP

ADD NEW RX

Type	Strength	Form	Dose	Route	Frequency	Duration
MedispanRx	5-325 MG	Tablet	1 tablet as need	Orally	every 6 hrs	
Oxycodone-Acetaminophan	2.5-325 MG	Tablet	1 tablet as need	Orally	every 6 hrs	
	7.5-325 MG	Tablet	1 tablet as need	Orally	every 6 hrs	
	10-325 MG	Tablet	1 tablet as need	Orally	every 6 hrs	

- A new billable visit type was created in our medical record for group therapy
- The providers introduced concept of the class to 42 patients (137 reviewed)

Distribution of 42 Patients



- 7 patients fully enrolled in the class, 5 completed, one pt de-escalated 25%
- Thus far: 36% decrease in pain severity, 44% decrease in pain interference

ACT

Sustainability & Next Steps

Brown will be expanding integrated BH in 2021!

What went well?

- Providers gained confidence in discussing CBT with patients knowing class option was available
- Organization of the class resulted in amazing collaboration of office RPH with integrated behavioral health specialist
- Creation of a new billing type for group sessions opens up reimbursement possibilities
- Zoom style teaching resulted in patients being more willing to share and somewhat eliminated scheduling barriers
- This was a unique success for this office which was especially impacted by the COVID epidemic
- Patients' response to class series was overwhelmingly positive

What needs to be improved?

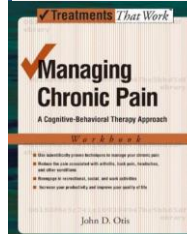
- Opportunity to evaluate internal process for grant funded projects
- The administrative demand of this class series did not require RPH expertise
- Co-teaching by RPH would have had more impact
- Process of patient enrollment and class facilitation needs to be more streamlined and timely
- Better mechanism for obtaining completed surveys (i.e. online mechanism if class is in zoom format)

Patient Engagement Strategies

What Matters Most to the Patient

- Having their voice heard
- Realizing they are not alone
- Being able to take time to share experiences
- Practical recommendations for cognitive-behavioral therapy pain management
- Patients asked Dr. Finley to delay de-escalation discussions with RPH until classes were completed

- ACCESSIBLE CONTACT PERSON
- AFFORDABLE ACCESS TO CLASSES



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Pharmacy Quality Improvement Initiative

Practice: Coastal Medical - East Providence Internal Medicine

Lead Provider: Matthew Propert, MD

Lead Pharmacist: Joseph Bizier, PharmD



PLAN

Aim Statement

Through the Coastal Medical benzodiazepine stewardship program, we will achieve a benzodiazepine prescribing rate below the state average based on prescription claims data. We will improve patient education and engagement as it relates to their benzodiazepine prescriptions as determined by patient engagement strategies.

Problem

- Benzodiazepines are high-risk medications associated with adverse effects, physical dependence, and addiction
- Coastal Medical has built programs to aide in judicious prescribing of other potentially overused medications
- There is no program reviewing benzodiazepine use
- Chronic prescribing of benzodiazepines at our practices is at or above the rate of other primary care practices in the state of Rhode Island

Goals

- Provide education to all patients who are taking a chronic benzodiazepine
- Offer medication adjustments to reduce benzodiazepine prescribing
- Develop a sustainable benzodiazepine stewardship program which can be replicated and expanded to all Coastal Medical practices
- Achieve a benzodiazepine prescribing rate below the Rhode Island state average based on pharmacy claims data.

DO

Key Measures

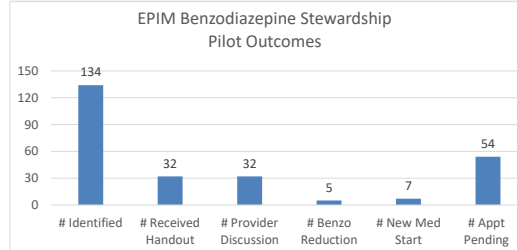
1. Number of patients identified for inclusion
2. Number of patients who received benzodiazepine education letters
3. Number of patients with documented conversation about their benzodiazepine
4. Number of patients with reduction in benzodiazepine dose
5. Number of patients who were started on alternative medications
6. Number of patients who's next appointment is pending from start of program

Methods

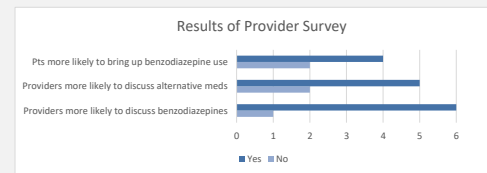
1. Reviewed patients identified by Coastal Medical data team for chronic benzodiazepine use
2. Changed patient identification strategy to triaging benzodiazepine refill requests. This ensures patients would be getting at least their second fill of the medication.
3. Identified patients who qualified based on taking chronic benzodiazepines either with or without other high-risk medications
4. Patients identified were tracked in an Excel file and mapped to their next appointment with their primary care provider
5. One to two weeks before their next appointment, patients were mailed the benzodiazepine educational letter and handout
6. Reviewed charts following appointment for the following:
 - a. Discussion of benzodiazepine use
 - b. Reduction in benzodiazepine dose
 - c. New medication starts

STUDY

Outcomes/Results



- Initial data was not successful in identifying pt's indicated for program
- Based on this, we began utilizing our pharmacy technician team as they field all benzodiazepine refill requests
- Refills for benzodiazepines were sent to the pharmacist for review
- This resulted in a more efficient means of finding patients taking chronic benzodiazepines



"My patients appreciated the information more than I expected"
- Response from provider survey

ACT

Next Steps & Sustainability

NEXT STEPS

1. Discuss project and results with Coastal Medical management team
2. Discuss the successes and failures, and how to role out program across the organization.



SUSTAINABILITY

1. Utilize pharmacy technicians for initial review of refills
2. Patients identified input to a central spreadsheet for final review by a pharmacist
3. Pharmacy technicians will state patients' last appointment date when sending refills to providers
4. Change outreach strategy from a mailed handout to a link to an online PDF, sent to patients either through the patient portal or text message
5. Include a benzodiazepine handout with every initial prescription
6. The letter and handout could be sent to patients annually, such as before their annual appointment
7. Patients interested in further discussing options for altering their medication regimens could be referred to their Coastal pharmacist

Patient Engagement Strategies

What Matters Most to the Patient

- When project was initiated, our goal was to facilitate providers in having meaningful interactions with their patients about benzodiazepine use
- Letters and handouts were sent in advance of appointments to avoid surprising patients
- This strategy allowed for patients to be prepared for a conversation about their benzodiazepine use
- Our letter to patients included concerns we have heard from pt's in the past which could be related to benzodiazepine use
 - Mental acuity
 - Not being physically dependent on a medication
 - Potential for falling and losing independence
- By listening to our patients and communicating with them in a way that worked best for them, we were able to have more meaningful discussions with them

**Pharmacy Quality Improvement Initiative:
Self-Monitored Blood Pressure (SMBP)**

Practice: Medical Associates of RI

Lead Provider: Leslie Mohlman, MD

Lead Pharmacist: Alexander Pease, PharmD



PLAN

Aim Statement

By January 2021, MARI will have established a data-driven, pharmacist-directed SMBP program to support practice-wide quality performance. Fifty (50) patients will have been identified and engaged by end-of-year (EOY) 2020.

Problem

Per S-E-E data, adherence to antihypertensives at MARI is lower than that to other targeted classes. Pharmacist resources at MARI have historically been underutilized in hypertension. SMBP may offer a way to utilize the pharmacist to improve quality data and enhance patient engagement.

Goals

- 1) Educate providers on the requirements for using SMBP readings to support quality metrics
- 2) Create an efficient workflow to identify and engage patients in need of SMBP intervention
- 3) Assess patient preferences regarding SMBP intervention, especially re: remote monitoring
- 4) Assess the potential impact of SMBP intervention on practice-wide CBP performance

DO

Key Measures

Clinical Measures

- CBP gap closures
- Engagement to EOY 2020
- Enrolled vs pending/declined patients
- Blood pressure reduction
- Most current chart value
- Medication adjustments

Patient Engagement Measures

- Proportion of engaged patients enrolling in SMBP program
- Proportion of enrolled patients adherent to SMBP recommendations (i.e. recording 2 readings twice daily for at least 3 days)
- Proportion patients opting for telehealth or remote monitoring visits

Methods

Phase 1 (Apr-Jun 2020)

Review initiative with primary care providers, and conduct pilot program with referred patients

- Assess patient/provider engagement and identify potential barriers

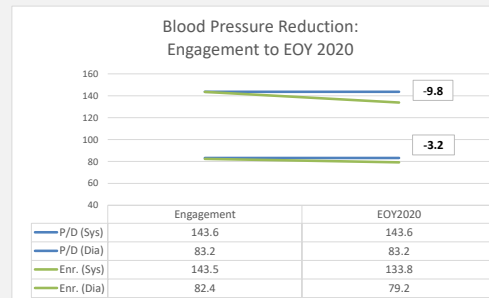
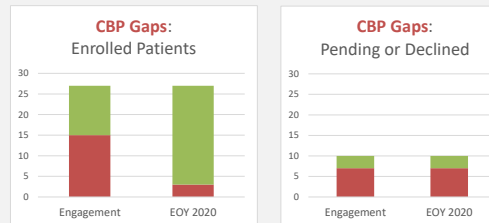
Phase 2 (Jul-Dec 2020)

Expand program to include patients identified by quality data

- Establish optimal data source and parameters for patient identification
- Optimize workflow for engaging patients identified by quality data

STUDY

Outcomes/Results



ACT

Sustainability & Next Steps

Successes

- 80% (12/15) of CBP gaps among enrolled patients closed by EOY 2020
- 55% (12/22) among all engaged patients
- 48% (13/27) of enrolled patients did not require a medication change
- Diagnosis of white coat hypertension or correction of SMBP technique

Failures

- 74% (37/50) of engagement goal achieved
- 10 chart reviews to identify 1 intervention

Program Expansion

Phase 3 (Jan 2021 -)

Engage all patients ≥65 years (n=229) who failed the CBP metric in the previous year

- Contact two weeks before upcoming appt
- Assess SMBP status and request readings
- Follow-up at appointment and as indicated

***16 patients engaged in the first 2 weeks**

***Projected 3.5% improvement in CBP metric**

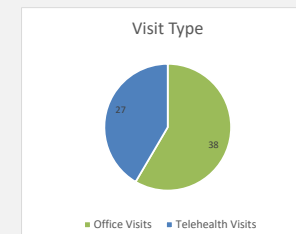
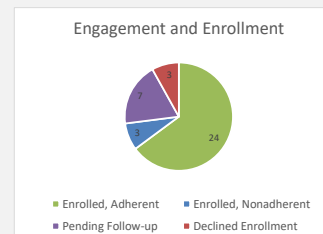
Patient Engagement Strategies

What Matters Most to the Patient

-92% (34/37) of engaged patients enrolled in/pending intervention

-89% (24/27) of enrolled patients were adherent to SMBP protocol

-59% (16/27) of enrolled patients opted for at least one telehealth/remote monitoring visit



Pharmacy Quality Improvement Initiative

Practice Name: University Internal Medicine, Inc.

Lead Provider Name: Derrick Robinson PA-C

Lead Pharmacist Name: Cristina Santos Pharm D, CDOE



PLAN

Aim Statement

To improve care for older adults (50+) by optimizing prescription medication use according to the domains of safety, effectiveness, and/or efficiency.

Adopting the 2019 updated American Geriatrics Society (AGS) Beers Criteria for Potentially Inappropriate Medication (PIM) Use in Older Adults, with the goal to improve the care of patients 50 or older, by reducing their exposure to PIMs that have an unfavorable balance of benefits and harms compared to alternative treatment options.

Problem

Older adults are at greatest risk for adverse drug events. Polypharmacy and prescribing high-risk meds can result in confusion, falls, and physical dependence which can lead to increased healthcare cost and utilization. In reviewing RI APCD data, the team noted an opportunity to focus on high risk medications as the statewide average for avoidance was 91% vs. UIM at 88%.

Goals

1. Decrease the percentage of high-risk medications prescribed by our practitioners for patients 50 or older by 3%.
2. Provide patients with education tools to support them with alternative options.
3. Develop a brief patient behavioral change survey to identify their knowledge, attitude, beliefs and motivation regarding their high-risk medications.
4. Administer survey to the providers at the conclusion of the project to assess if their knowledge and confidence has resulted in safer and effective prescribing patterns.

DO

Key Measures

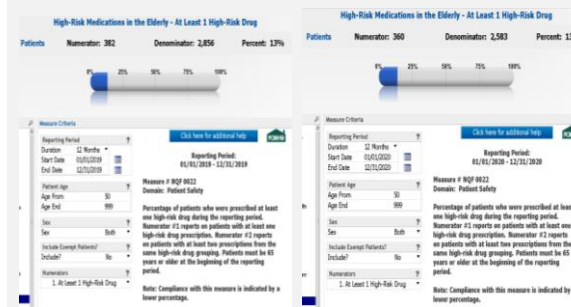
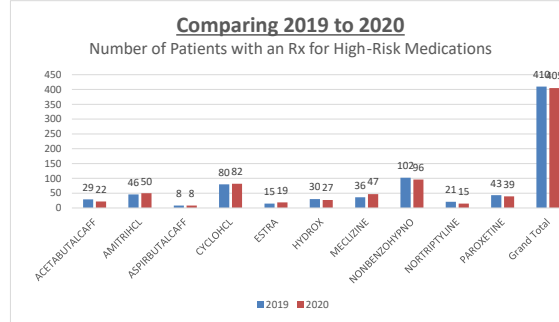
1. Number of individual patients with high risk medication scripts from 2019 CQM-156 High Risk Medications in the Elderly, at least 1 High Risk Drug in targeted class compared to number of patients in 2020.
2. Patient satisfaction survey.
3. Provider survey developed to assess for barriers to project implementation and sustainability.

Methods

1. Ran Practice Analytics dashboard report 2019 CQM-156 High Risk Medications in the Elderly, at least 1 High Risk Drug to obtain baseline data.
2. Identified top 10 medications of focus based on utilization data.
3. Educated the UIM Health Care Team on the QI project and the goals at the June Staff Meeting.
4. Developed library of decision-making tools, education materials and alternative options such as cognitive behavioral therapy.
5. Patients targeted for optimizing prescription safety were flagged in Care Program section in EHR as: PharmQI.
6. Gave providers a list of their patients on high-risk meds to review.
7. Providers utilized the Beers list for risk rationale and recommended alternatives.
8. Provider consulted with Pharmacist to discuss alternatives and options.
9. Providers reviewed the current meds:
 - a. Considered safer alternatives w/ the patient.
 - b. Discontinued unnecessary meds.
 - c. Considered non-pharmacological alternatives.
10. Providers whose patients are resistant to alternatives were referred to Pharmacist for 1 on 1 counseling.

STUDY

Outcomes/Results



Patient Engagement Strategies

What Matters Most to the Patient

- Patient/provider engaged in conversations regarding high-risk meds and safe alternatives.
- Barriers: transitioned to new patient portal and PFAC delayed due to COVID.

Promoting Patient Medication Safety Survey	Strongly Disagree	Disagree	Agree	Strongly Agree
I understand my health problems (n=7)	0%	0%	43%	57%
I am confident in my ability to manage my health problems (n=7)	0%	0%	43%	57%
I know what each of my prescribed medications do (n=7)	0%	14%	29%	57%
I know the risk and side effects I should watch for with my medications (n=7)	0%	29%	43%	29%
I am able to afford my medications	0%	0%	43%	57%
Sometimes I worry about becoming dependent on my medicines (n=7)	29%	43%	29%	0%
I feel the medication change has been beneficial my health (n=6)	0%	0%	50%	50%

ACT

Sustainability & Next Steps

Promoting Medication Safety Physician Survey	Strongly Disagree	Disagree	Agree	Strongly Agree
Did this project hinder productivity or add longer hours to your day? (n=7)	14%	86%	0%	0%
Did you find the patient self-engagement material (Choosing Wisely) valuable? (n=7)	0%	0%	100%	0%
Do you find the American Geriatric Society Beers Criteria for Potentially Inappropriate Medications Use in Older Adults criteria clinically appropriate for improving medication selection and reducing adverse drug events? (n=7)	0%	0%	86%	14%
Do you feel this project has helped improve safety and quality of care? (n=7)	0%	0%	86%	14%
Did you feel you had appropriate team support on this project? (n=7)	0%	0%	43%	57%
Do you feel there could be additional tools/resources to help reduce high risk meds in elderly? (n=6)	0%	50%	33%	17%
Do you feel this project has changed the way you may choose medications for a patient in the future? (n=7)	14%	0%	43%	43%
Do you feel patients were receptive to engaging in discussion of medication safety? (n=7)	14%	29%	43%	14%

1. In 2021 utilize PFAC group to discuss this project and get feedback from members on how to improve this metric.
2. Build on provider confidence and skills in implementing evidence-based patient engagement and tools for optimizing medication use.

Pharmacy Quality Improvement Initiative

Practice Name: Anchor Medical Associates

Lead Provider Name: Diane Siedlecki, MD

Lead Pharmacist Name: Kenny Correia, PharmD



PLAN

Aim Statement

1% decrease in the # of patients age 50+ prescribed a benzodiazepine in a quarter compared to same period last year

Problem

Long-term use of benzodiazepine receptor agonists (BZRAs) is common in adult patients 50+. The use of these types of medications has been associated with acute and long-term adverse effects. These include drowsiness, increased reaction time, ataxia, motor incoordination, anterograde amnesia, cognitive impairment. There can also be an increased risk for motor vehicle accidents, hip fractures and increased risk of overdose when combined with an opioid medication.

Goals

Our goal is to show improvement in prescriber familiarity and comfort level with benzodiazepine deprescribing and hopefully a decrease in the number of patients on long-term benzodiazepines, especially at high doses. Our goal is to decrease the number of patients on long term benzodiazepines, especially at high doses.

DO

Key Measures

- 1) # of Providers trained on age-related risks of long-term benzodiazepines. We plan to provide methods to decrease risk thru deprescribing
- 2) Decreased # of Patients identified as "at risk" based on longterm use of benzodiazepines and/or coprescribing with other high risk medications like opioids
- 3) # of patients contacted for patient education
- 4) Assess patient engagement / feedback about this targeted educational program thru a survey

Methods

- 1) Conducted pharmacist led training on the deprescribing guidelines for clinical team.
- 2) Identified population using EMR prescribing and active medication list data.
-> Population: At risk adults 50+ on BZD.
- 3) Developed "What you should know about benzodiazepines" letter and educational information. Posted to our patient portal that discusses the risk/benefits of these types of medications.
- 4) Provided list of patients to each prescriber to exclude patients who aren't candidates for deprescribing.
- 5) Disseminated text messaging to final population.
- 6) Developed workflow for patients to engage with pharmacist in further risk/benefit discussions.
- 7) Evaluated patient feedback.

STUDY

Outcomes/Results

- 1) A total of 37 providers (20 MD/DO; 6 PAs; 7 NPs, 4 NCMs) received information/training based on the Deprescribing Guidelines in the Elderly project. As part of this project, a deprescribing algorithm for benzodiazepine receptor agonists and education video series was shared to help educate providers, nurse care managers. they learned the risks of benzodiazepines and safe ways to deprescribe these medications.
- 2) Patients > age 65 (N=573), while only making up about 33% of the total patients prescribed benzodiazepines in our practice (N= 1605) the group makes up more than 50% of the total # of units of benzodiazepines (56%). Specifically the group in the age 65-75 (N=359) represented about 30% of our prescribing. We decided to target this subgroup for the 1st rounds of this pilot program.
- 3) We were able to run a test on 35 patients in this subgroup and sent a targeted email/text message asking them to read info posted on our website:
Example:
<http://www.anchormedical.org/patient-resources/what-you-need-to-know-about-benzodiazepine-medication-use>
- 4) 18 patients of first 35 test push answered the patient engagement/ feedback survey. 12 marking Agree or strongly agree to "found helpful" 6 were routed to pharmacy team to review. 4 patients wanted to work on tapering off meds. 1 ask for clarification about which of his meds was a benzodiazepine and 1 was a pt (who is also an MD) with a general comment. 2 patients subsequently were successful in being tapered off the benzo and 1 was able to cut daily intake by >50%.

ACT

Sustainability & Next Steps

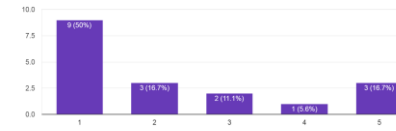
Unfortunately the unexpected emergence of the COVID-19 worldwide pandemic resulted in a significant impact which required a major shift in priorities for the practice. Most of the provider and information technology staff resources that would have been used for this project had to be reallocated to a total redesign of how we provide care to our patients. The implementation of COVID-19 related health delivery was also challenges due to staff sickness, isolations and quarantine which further limited our ability to expand this pilot as originally planned.

Fortunately, this pilot was able to support our providers with timely education and training. During this time many of our patients were experiencing acute increases in anxiety from the pandemic itself and other stressors. examples of these would be job loss, illness and at times loss of family member, financial concerns etc. . This training allowed our providers to work with patients to address their needs without the use of benzodiazepines. Providers were also able to share or direct patients to the benzo related educational information that was created as part of this program. Our providers have shared feedback that this training delayed/prevented the initiation of benzos in many of their patients. This also led to early involvement / referral to the pharmacist for non-benzo related mental health medication consults before benzos would be prescribed. As this was an unexpected positive effect of this program, unfortunately we did not have a way to formally measure this effect, but believe this is a great example of the sustainability we are seeing from the training and support from this program. We hope to restart the targeting of at risk patients with educational messages soon.

Patient Engagement Strategies

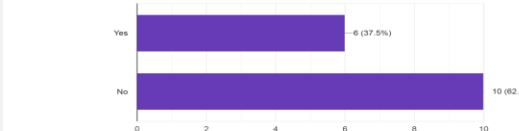
What Matters Most to the Patient

I read the article "What you need to know about Benzodiazepine Medication Use on the Anchor Medical Website, and I found the information helpful.
18 responses



1 Strongly agree to 5 disagree.

Do you have any questions about Benzodiazepine medication use that was not covered in the article?
16 responses



Pharmacy Quality Improvement Initiative

Practice Name: Providence Community Health Centers

Dr. Nadine Hewamudalige

Lead Pharmacist Name: Lillian Nieves



PLAN

Aim Statement

Our goal is to achieve a 10% increase in the percent of members who remain on the effective continuation phase treatment of antidepressant medication therapy for a total of 180 days from treatment initiation.

Problem

The 2018 All Payers Claims Database (APCD) demonstrated low antidepressant adherence rates for Central and Prairie Health Centers, -8.5 and 12.2% respectively. PCHC currently lacks a standardized process to assess the efficacy and safety of antidepressant therapy initiation in its patient population.

Goals

* To improve antidepressant adherence rate by 10% at Central and Prairie Health Centers of patients

DO

Key Measures

- To determine how many patients not contacted by the clinical pharmacist completed their first refill in April 2020.
- To determine how many patients refilled their first prescription after the clinical pharmacist phone contact 3 weeks after the original prescription was written.
- To determine how many patients refilled their first prescription after pharmacy technician's contact 3 weeks after the original prescription was written.
- To determine how many patients followed up with a primary care provider (PCP) within 6 week of therapy initiation.
- To determine how many patients followed up with an Integrated Behavioral Health (IBH) provider after antidepressant therapy initiation.

Methods

- Obtained weekly outgoing SSRI and SNRI prescription report.
- CPhTech used PBRx data to determine patient inclusion criteria.
- CPhTech used PBRx to determine if original prescription was filled and subsequently refilled.
- CPhTech called patient 3 weeks after the original prescription was filled. Pharmacy team contacted patient if the original prescription was NOT filled 7-10 days from prescription issue date.
- CPhTech outreached patients via telephone and connected them to PCP and IBH teams.
- Pharmacist warm hands off occurred if patients were experiencing side effects and completed phone consult.
- CPhTech auto-populated Care Message with a welcome message for patients and set up subsequent dates to serve as refill reminders a week prior prescriptions were due to fill.
- Educational handouts were attached to texts in SPA and ENG.
- Patients were sent a survey via text to determine their level of satisfaction of the services provided. If there was no response via text, a telephone call was placed.

STUDY

Outcomes/Results

- A total of 483 patients were screened and only 8% met the inclusion criteria. The cohort comprised of a total of 40 patients ≥50 y/o diagnosed with a new onset episode of mild to moderate depression and had no SSRI or SNRI prescribed in the preceeding 180 days.
- Pharmacist early intervention to prevent primary medication non-adherence proved effective as only 7.5% (3/40) of patients never filled their initial prescription compared to the national average of 33%.
- Approximately 52.5% of patients filled their first refill prescription (21/40) and 30% completed the acute phase (12/40) of treatment. However, only a small percentage 17.5% (7/40) moved onto the continuation phase.
- Most patients received IBH services prior to medication therapy initiation (77.5%) and surprisingly, the percentage remained unchanged after therapy initiation even though there were no follow up appointments booked in advanced.
- Results demonstrated that prescriber 4 to 6 weeks follow up from therapy initiation was also high at 80% - and most appointments were not booked in advanced. It can be concluded that both, IBH and PCP high follow ups rates can be greatly attributed to pharmacy telephonic interventions. Medication check ins proved to be effective to assess for possible side effects and served to connect patients to timely IBH and PCP follow up services.
- There were only 5 patients who reached the continuation phase and only 27.5% (11/40) were on track to continue beyond not accounting for early refills.
- Of the 21 patients who were on track to complete the acute phase only 57.1% (12/21) were successful. However, only a total of 43.2% of patients did not proceed to complete the acute phase after the second refill.
- During chart reviews it was noted that dose optimization and patient frequent follow up did not occur as often compared in these patients compared to those who successfully transitioned to the continuation phase. The most dramatic medication adherence decline was observed 4-6 weeks after therapy initiation where only 4 patients completed refill 2 and 3 refill, respectively.
- In conclusion, to improve medication rates in the acute phase and subsequently, the continuation phase of treatment it is advisable for clinical teams to perform monthly patient medication check ins and include dose optimization beyond the recommended 4 to 6 weeks of therapy initiation.

ACT

Sustainability & Next Steps

- Provider should make an effort to introduce IBH services to patients prior to initiating therapy.
- Provider team should make an effort to complete a warm hands off to the IBH team when antidepressant therapy is initially prescribed.
- Clinical team provides patient an educational handout with a treatment progress scale and an IBH direct contact if unable to be initially introduced.
- Pharmacy will continue current workflow including telephonic outreach to patients.
- Text messages will be sent monthly to patients or designee to serve as provider appointment reminders and STOP text feature will be activated.
- Text refill reminder messages will be sent to patients or designee and attachments to educational handouts will be sent via text links.
- Clinical operation teams will be informed of PDSA findings and encouraged to share best practices.
- A needs assessment survey will be sent to providers and analysis will also guide workflow improvements with the goal of improving antidepressant rates in the acute and continuation phases of treatment.
- Consider inviting a guest psychiatrist to present at medical staff meeting to share treatment algorithms and best clinical practices. Record meeting and make it available for those not in attendance.

Patient Engagement Strategies

What Matters Most to the Patient

- Appointment reminders
- Telephonic outreach for medication check in
- Prompt follow up with provider for a medication assessment
- Patients who opened text link with educational materials found them useful
- All the patients liked receiving text messages some requested to add their care takers