Appendix A: PHARMACY QUALITY IMPROVEMENT MILESTONES SUMMARY DOCUMENT

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| Pharmacy Milestone Summary |
| Deliverable | **Timeframe Due Dates** | **Notes** |
| Identify members of the practice quality improvement (QI) team. The team should consist of 3 to 4 staff in different roles and include a pharmacy champion, practice clinical champion, an IT staff member, nurse care manager, practice manager | Identify as part of application  |   |
| Select ABPM or proCGM as topic of focus | Identify as part of application process |  |
| Practice QI team participation in monthly meetings with the practice QI facilitator and quarterly with project data facilitator | August 2022 - July 202424 months |  |
| Practice team participates in kick-off Learning Collaborative meeting (in person or virtual, TBD)* Content expert ABPM
* Content expert pro-CGM
 | August 23rd, 2022 |  |
| Project Planning and Preparation (Months 1-4): * Team reviews internal data and identifies population of focus.
* Evaluate equipment options including integration with EMR.
* Brainstorm workflow
 | September 2022 | IT/EMR representatives recommended to be present at practice facilitation meetings |
| Project Planning and Preparation: (Months 1-4):* Team discusses proposed workflow and refines, as needed.
* Evaluates and selects equipment including integration with EMR and places purchase order.
* Discuss Patient Engagement plan/strategy, including method of evaluation.
* Discuss Care Team Engagement plan/strategy, including method of evaluation
* Collaborate with IT/EMR team re: structured data vs. other source to track data.
 | October 2022 | PDSA to include rationale for selection.  |
| Project Planning and Preparation: (Months 1-4):Workflow outlined and submitted to CTC including the following: * Identification of patients (ie: provider referral, prospective chart review, retrospective chart review)
* Scheduling of patients
* Care team member responsible for scheduling, facilitating office visit, troubleshooting technology issues.

Communication and training plan developed and disseminated. | November 2022 | *PDSA to be submitted by 11/23/22. deliverables@ctc-ri.org* |
| Submit initial PDSA project plan | 2 weeks prior to learning collaborative |  |
| Quarterly learning collaborative: present QI work plan with content expert as applicable * Coding and Billing expert CGM
 |  December (Date: December 13, 2022) |  |
| Implementation (Months 5-23 ): * Meet monthly with practice facilitator
* Report metrics quarterly as specified on Data Tool and any additional metrics desired by team
* Assess patient engagement strategy/plan at Implementation Phase as specified in Milestone Document.
* Assess Care Team Engagement plan/strategy as specified in Milestone Document
* Evaluate patients at risk for complications. Determine follow up plan and stratify patients based on risk. (ie: Which care team member follows, interval for repeat ABPM, pro-CGM, when to discharge from pharmacist/care management services, etc.)
 | December 2022- July 2023 |   |
| Submit updated PDSA | 2 weeks prior to February learning collaborative | *PDSA to be submitted by 2/14/23. deliverables@ctc-ri.org* |
| Quarterly learning collaborative: present QI work plan with content expert as applicable * Coding and Billing expert ABPM
 | February 28,2023 |  |
| Obtain input from patients/care team for qualitative measures | March 2023 |  |
| Submit updated PDSA including patient engagement and care team engagement data, key findings and adjustments necessary to project plan | 2 weeks prior to May learning collaborative | *PDSA to be submitted by 5/9/23. deliverables@ctc-ri.org* |
| Quarterly learning collaborative: present QI work plan with content expert as applicable * *SDoH & Risk Stratification?*
 | May 23, 2023 |  |
| Submit updated PDSA  | 2 weeks prior to August learning collaborative | *PDSA to be submitted by 8/8/23. deliverables@ctc-ri.org* |
| Quarterly learning collaborative: present QI work plan with content expert as applicable  | August 22, 2023 |  |
| Obtain input from patients/care team for qualitative measures | September 2024 |  |
| Spread and sustainability (Months 13-14)* Identify plan to spread services to other providers/practices or offer to other populations of focus
* Determine who’s being missed by current workflow
 | September 2023-October 2023 |  |
| Submit PDSA with year 1 results and plan for spread and sustainability plan including risk stratification  | 2 weeks prior to Nov learning collaborative | *PDSA to be submitted by 11/14/23. deliverables@ctc-ri.org* |
| Quarterly learning collaborative: present QI work plan with content expert as applicable * Teams report out on Risk Stratification plan
 | November 28, 2023 |  |
| Spread and sustainability (Months 15-23) | November 2023 - July 2024 |  |
| Submit updated PDSA including patient engagement and care team engagement data, key findings and adjustments necessary to project plan | 2 weeks prior to Feb learning collaborative | *PDSA to be submitted by 2/13/24. deliverables@ctc-ri.org* |
| Quarterly learning: present QI work plan w/ content expert, as applicable | February 27, 2024 |  |
| Obtain input from patients/care team for qualitative measures | March 2024 |  |
| Submit updated PDSA  | 2 weeks prior to May learning collaborative | *PDSA to be submitted by 5/7/24. deliverables@ctc-ri.org* |
| Quarterly learning: present QI work plan w/ content expert, as applicable | May 21, 2024 |  |
| Obtain input from patients/care team for qualitative measures | June 2024 |  |
| Submit final Storyboard | 2 weeks prior to final learning collaborative | *PDSA to be submitted by 7/16/24. deliverables@ctc-ri.org* |
| Final learning collaborative  | July 30, 2024 |   |

**Appendix B: Measurement and Reporting**

1. *Qualitative assessment* of the use of ABPM / proCGM per experiences of patients and care team members. Patient survey will include the items below, which may be administered by paper or computer/app.

***Patient survey questions*** to be obtained after device use:

Scale items: Strongly disagree | disagree | unsure or neutral | agree | strongly agree

* My care provider clearly explained the benefit of using this device
* My questions about the device were sufficiently addressed
* Wearing the monitor was comfortable
* The information obtained from the device was useful to my medical care
* I was satisfied with my experience using the device

Open ended items:

* Please tell us what you liked about using this device
* Please tell us what you disliked about using this device
* Please share any other information that you think would be useful for us to know

***Care team questions*** to be reported at project midpoint and conclusion:

* In the pharmacist’s/clinician’s/practice manager’s view, what were the top barriers to using the modality effectively? How were these barriers overcome (if so)?
* What patient and practice-related factors were associated with the successful use of the device?
* Has this initiative impacted team satisfaction? Explain.
* What benefits of using the device were identified, particularly those that may not be captured by clinical quality measures?

*2. Quantitative assessment* will be guided by the project data facilitator (S. Kogut, URI), who will provide a tool for participants to track key variables associated with items 2 and 3 below.

2a. Project Evaluation Measures (reported quarterly, starting year 1, Q3)

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| --- | --- |
| **APBM**  | **Pro-CGM**  |
| * # patients (referred/offered, declined, enrolled)
* # providers ordering the service
* # practice sites using the service, if applicable
* Demographics of patients utilizing the device: age; sex; primary diagnosis; Payer type, product (e.g. HMO, PPO) and insurer name (e.g. UHC))
* Pharmacist interventions (e.g. # and type of regimen modification, diet)
* Results of device use: #/% of patients diagnosed / w classification
* Follow-up BPs after ABPM use (3, 6 mo.)
* Therapeutic goal achieved? yes/no; comment
 | * # patients (referred/offered, declined, enrolled)
* # providers ordering the service
* # practice sites using the service, if applicable
* Demographics of patients utilizing the device: age; sex; primary diagnosis; Payer type, product (e.g. HMO, PPO) and insurer name (e.g. UHC))
* Pharmacist interventions (e.g. # and type of regimen modification, diet)
* Results of device use: #/% of patients diagnosed / w classification
* Follow up glucose / A1c readings (3, 6 mo.)
* Therapeutic goal achieved: yes/no; comment
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2b. Clinical Measures Derived from the Device (reported quarterly, starting year 1, Q3)

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| --- | --- |
| **APBM**  | **Pro-CGM**  |
| * Duration of device use
* Total # of valid measurements
* Tracking of systolic/diastolic/pulse/pulse pressure; overall, awake and asleep
* Relationship between ABPM, office BP, home BP readings
 | * Duration of device use
* Total # of valid measurements
* % time devices were active (average)
* Tracking of readings: average glucose, % of results within, above, and below range; Time in Range (TIR)
* Glucose Management Indicator (%)
* Glucose Variability/Coefficient of Variation (%)
* Relationship between proCGM and A1C
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Practices are not expected to be able to calculate all of these metrics at the start of the project. By participating in this initiative, the practice will develop methods for collecting the required data and incorporating these measures into their care processes. The most successful practices will be able to aggregate standardized patient-level data and report these measures for their populations (e.g. percentage of participants who achieved glycemic variability of ≤36%). Please note that practices will be asked to provide results specific to UnitedHealthcare patients (in aggregate) by the end of the project.