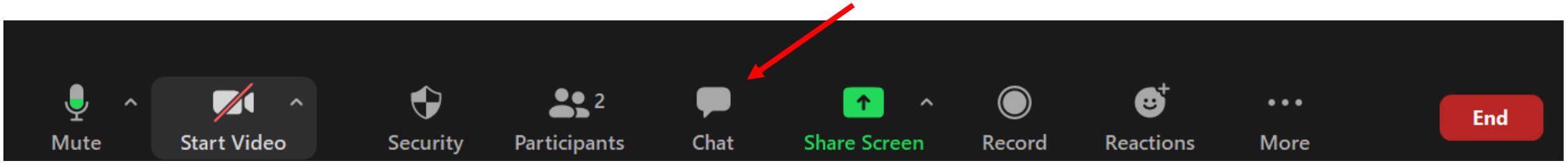
Pharmacy Quality Improvement Initiative Learning Network- June 25, 2020

CARE TRANSFORMATION COLLABORATIVE OF R.I.

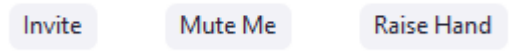
Zoom

Welcome! Please Chat in:

- Your Name and Organization



- ***Please mute yourself when not speaking***
- ***Please use the 'Raise Hand' feature***



Anchor Medical Associates

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: Deprescribing BZD

AIM: 1% decrease in the # of patients age 50+ prescribed a benzo in a quarter compared to same period of time last year.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Create a report in Athena / EMR that will identity patients prescribed a benzo medication	Kenny/Marna	Within 30 days	Create a report in Athena / EMR that will identity patients prescribed a benzo medication

Anchor Medical Associates

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

<u>Plan:</u> Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Create / adapt benzo risk/benefit education with provider input	Kenny	Within 60 days	
Review educational materials and patient feedback survey with Anchor PAFC members and gather input	Kenny	Within 60 days	
Work with IT to get educational materials and survey links uploaded to Anchor Website	Kenny/Marna	Within 90 days	
Use EMR/Athena's communicator tools to send targeted emails to patients on benzos in the last quarter	Kenny/Marna	Within 90 days	
Setup reason for visit type "benzo deprescribing" and start to use as patients engage / connect with pharm team for more info	Kenny/Marna	Within 90 days	

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1) Rerun Benzo prescribing rates quarterly and repeat automated patient outreach	

Brown Medicine

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: S1a – Avoid chronic use of opioids

AIM: Provide patients with sustainable alternative for pain management that allows for de-escalation of oral opioids.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
DURING COVID restrictions best step that can be achieved is identifying patients to target	Angel Prescribers	6/12	N/A

Brown Medicine

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Plan: Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Current report needs modification: update rxgroups and create unique report for Warwick office. -add in newer opioids -add in z drugs -modify report →column that notes if pt has benzo rx in current meds -note that tramadol patients are not being caught (to be addressed later)	Angel	6/12	N/A

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
These modifications will expand patient list to be considered for each provider.	Report will be run in both formats to ensure new report is more inclusive.

Care New England Medical Group Pawtucket

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: S1a – E5: Adherence w/ controller inhalers

AIM: To demonstrate improvement in maintenance inhaler adherence for patients with asthma and COPD. Internal reporting will be utilized to determine a baseline population and identify patients who have utilized emergency department or been hospitalized for asthma or COPD exacerbation from 4/1/2019 to 5/28/2020.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Education providers, NCM, and pharmacy team re: project plan Establish structured note for patient visits and follow ups and create excel spreadsheet to track interventions/metrics/etc.	Ron Tutalo	6/2020	

Care New England Medical Group Pawtucket

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Plan: Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Clinical Strategy: Identify patients seen in ED or hospital 4/1/2019 through 5/28/2020 to determine baseline population to outreach Create presentation to educate all providers and residents about project workflow as part of scheduled meeting 6/25 Send description of project and workflow to be included in email updates to staff (Donna Haddock), to residents (Dr. Roi and Dr. Donovan), and to physicians/residents (Dr. Wilkinson), Nurse Care Managers Develop excel spreadsheet to track interventions/metrics (symptom scales, exacerbations, pharmacist interventions, inhaler technique) Develop structured note for initial patient visits (telephonic, virtual, in person) and follow up visits	Ron Tutalo	By 6/25/2020	Family Care Center (or virtually)
Patient Engagement Strategy: Develop spreadsheet to track number of patient/pharmacist interactions (including encounters, visits, telephone calls etc) Implement workflow for review of COPD/Asthma action plans (in-person, telephonic/virtual) and organize area on spreadsheet to track patient experience with action plan and frequency of use during project.			

Care New England Medical Group Pawtucket

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Plan: Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
- Predict sufficient baseline population from ED/Hospitalization report (population of at least 75 patients) - Presentation and emails to staff will be positively received and result in increased referrals (ie encouraging pharm referrals for COPD/asthma patients with adherence concerns/overly symptomatic/frequent health system utilizers) - Spreadsheet for tracking patient measures, pharmacist interventions, actions plans etc.	- Number of patients identified on initial ED/hospitalization report - Increase referrals to pharmacy team will increase from baseline by at least 2 per week - Utilize structured note and engage at least 5 patients per week to start - Utilize spreadsheet and track data for at least 5 patients per week to start

Coastal Medical EPIM

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: Benzodiazepine stewardship.

AIM: 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 a patient survey.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
We will develop a patient handout which describes benzodiazepines risks and benefits. This handout will be mailed or sent via electronic means to patients 1-2 weeks before their next appointment with their primary care provider. We will track the outcomes of these appointments. This will include discussions documented regarding benzodiazepine use, changes or reductions in benzodiazepine prescription, and deprescribing of the benzodiazepine.			

Coastal Medical EPIM

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

<u>Plan:</u> Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Work with provider champion and other members of Coastal' s CTC team in determining criteria for patients to be identified			
2. Ask Coastal' s CTC team to run data based on these criteria			
3. Review this list to ensure accuracy and narrow down to appropriate patients, focusing on highest risk patients o ≥ 65 years of age o Patients taking multiple CNS depressants o Patients taking opioids as well as benzodiazepines o Patients not taking chronic anxiety medication (SSRI, SNRI, bupropion, mood stabilizers)			
4. Develop handout with guidance of provider champion			
5. Coordinate with Coastal's marketing team to ensure appropriateness of handout and to help in making it patient-friendly			
6. Discuss handout with providers of the EPIM practice to ensure agreement on having this mailed to patients before appointments			
7. Identify patients who have multiple benzodiazepine			
8. Coordinate with available resources who are physically in Coastal offices for printing/mailing of the handout			
9. Review appointment notes of patients who received handout to determine outcomes			
10. Ask Coastal's data team to run list based on these criteria			

Medical Associates of RI

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: Anti-hypertensive adherence/ BP Control

AIM: Improved adherence/ BP Control in targeted patients

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Initial trial of home BP monitoring Initiative	Pharmacists & NCMs	June/ July	

Medical Associates of RI

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

<u>Plan:</u> Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Purchase and prepare supplies	Pharm D/ NCMs	ASAP	
2. Identify and schedule patients	Pharm D/ NCMs	JUNE	
3. Collect baseline data	Pharm D/ NCMs	JUNE	
4. Complete initial appointments	Pharm D/ NCMs	JUNE/JULY	

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1) Rerun Benzo prescribing rates quarterly and repeat automated patient outreach	

Providence Community Health Center

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: Medication adherence rate of antidepressants measure in patients ≥ 50 years of age

AIM: 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.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
To determine how many patients not contacted by the clinical pharmacist completed their first refill in April 2020.	Lillian	May 2020	PCHC-Central remotely

Providence Community Health Center

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Plan: Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Population health department provided pharmacy department with an outgoing prescription report of PCHC patients in the past 3 months.	Dan	Once	PCHC
2. Clinical Pharmacist sorted report to show Central Health Center providers and filtered outbound prescriptions by drug class (SSRI and SNRI) written in April 2020.	Lillian	Once	PCHC
3. Clinical Pharmacist utilized PBRx retrospective data from the EHR for each patient to determine patient inclusion criteria. If the patient filled a SSRI or a SNRI prescription in the past 180 days the patient was excluded from the pharmacy test.	Lillian	Once	PCHC
4. Clinical Pharmacist used PBRX history to determine if patient filled original prescription and if it was subsequently refilled at month 1.	Lillian	Once	PCHC
5. Pharmacist summarized findings to determine adherence rates for patients prescribed an antidepressant in the SSRI and SNRI family of drugs for the month of April of 2020 at the Central Health Center.	Lillian	Once	PCHC

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
The prediction is that only 50% of the patients refilled their prescription at month 1	Prescription report from providers and EHR PBRx history

University Internal Medicine

Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

Selected Metric: ***Improve patient safety by decreasing the use of high risk meds in patients 50 and older by 3%***

AIM: ***Decrease the percentage of high risk medications prescribed by our practitioners for patients 50 and older***

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Give providers a list of their patients on high-risk meds. We will develop a high-risk med protocol to be shared with the providers.	The team	June 2019	Weekly provider meeting

University Internal Medicine

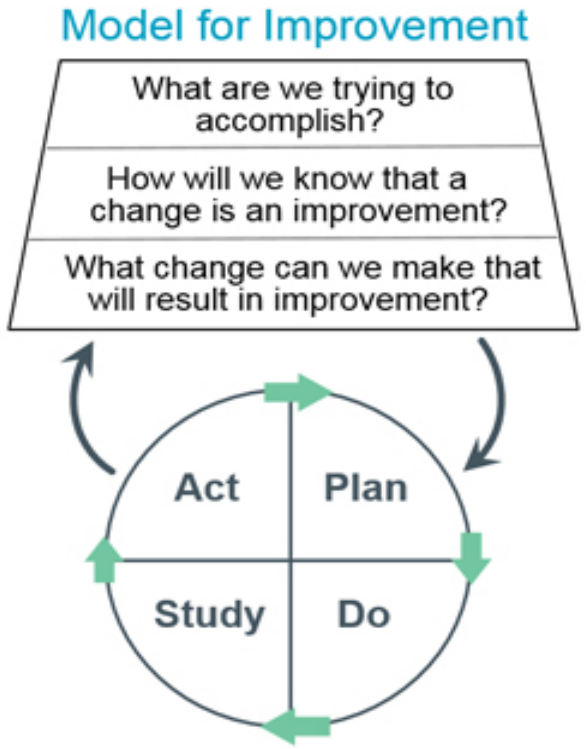
Safe-Effectiveness-Efficiency (S-E-E) and Plan for Patient Engagement

<u>Plan:</u> Identify both the clinical strategy (i.e. example: de-prescribing tool) AND patient engagement strategy

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Providers will review the current meds: (consider safer alternatives with the patient, discontinue unnecessary meds, consider non-pharmacological alternative)	Providers and the team	June 2019	Face-to-Face or telephonically
2. 1 on 1 counseling with the pharmacist			
3. Educate the staff on the project and the goals at June Staff Meeting			
4. We will discuss this project and our goals at the next PFAC and ask for suggestions from our patient counsel on how to improve this metric			
5. Provide patients with education tools to support patients with alternatives			
6. Our practice will also work on developing a brief patient behavioral change survey to identify their knowledge, attitude, beliefs and motivation regarding their high-risk medications.			

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
De-prescribing of hi-risk meds will be reduced by 3%	- reports - monitoring of ER and IP Utilization

Science of Improvement: Linking Tests of Change



A team learns from the test — What worked and what didn't work? What should be kept, changed, or abandoned? — and uses the new knowledge to plan the next test. The team continues linking tests in this way, refining the change until it is ready for broader implementation.

Tips for Successful Linked Tests of Change

- Plan multiple cycles for a test of a change.
- Think a couple of cycles ahead.
- Scale down the size of the test (the number of patients or location).
- Test with volunteers.
- Do not try to get consensus when testing as this may delay your efforts and learning. (Consensus and "buy-in" are necessary for implementation, but not when testing.)
- Be innovative to make the test feasible.
- Collect useful data during each test.
- Test over a wide range of conditions. Try a test quickly; ask, "What change can we test by next Tuesday?"

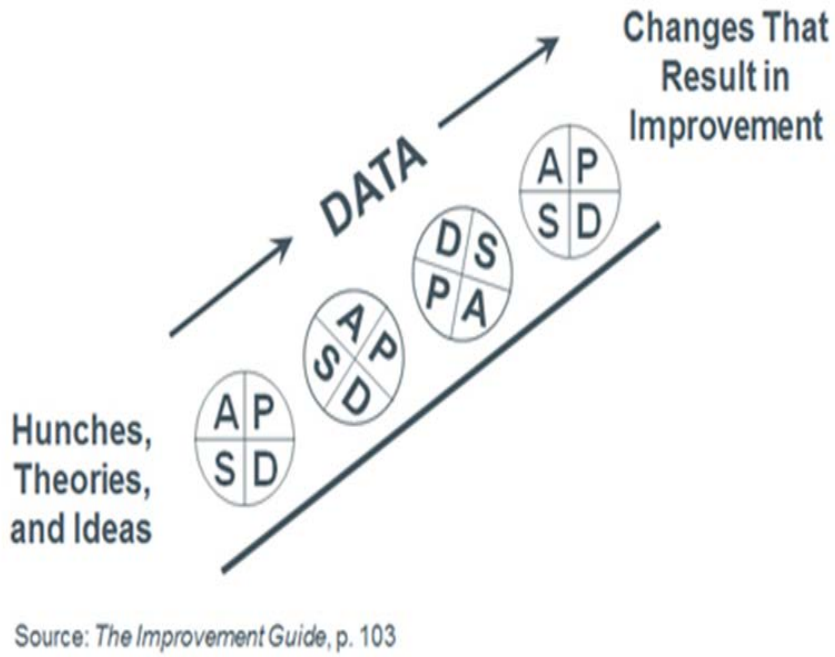
Examples of Linked Tests of Change

Example 1: Improve management of the diabetic population blood sugar levels.

- Cycle 1: Develop a system to track hemoglobin A1c levels for the diabetic population.
- Cycle 2: Establish a protocol for hemoglobin A1c routine measurements.
- Cycle 3: Undertake collaborative planning for control levels.
- Cycle 4: Set targets for hemoglobin A1c levels.
- Cycle 5: Implement the protocol with all staff.

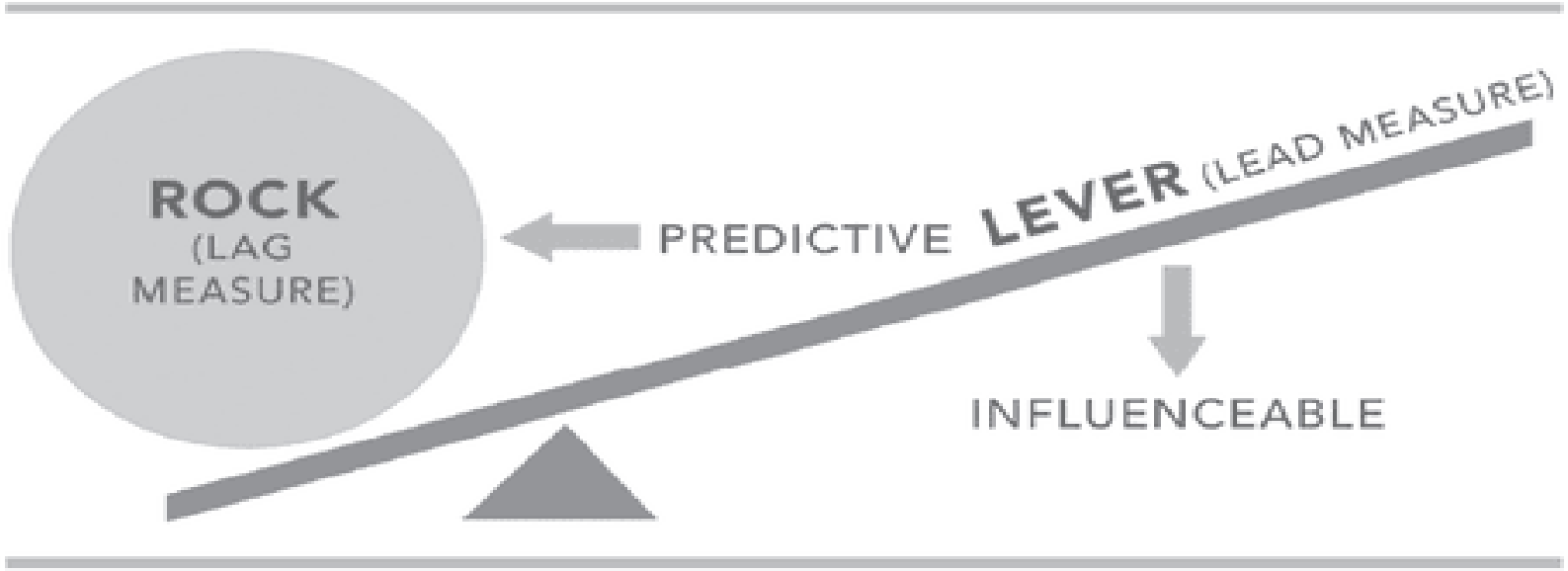
Example 2: Decrease length of stay (LOS) for Emergency Department (ED) patients with x-rays.

- Cycle 1a: Pilot quick-look for extremity x-rays on one shift. Monitor LOS for patients with x-rays and error rate. Review results with Radiology.
- Cycle 1b: Revise documentation process and try quick-look for two days.
- Cycle 1c: Redesign viewing area and continue quick-look for two weeks.
- Cycle 1d: Make quick-look standard practice and monitor.



Source: *The Improvement Guide*, p. 103

Lead and Lag Measures



Lag:

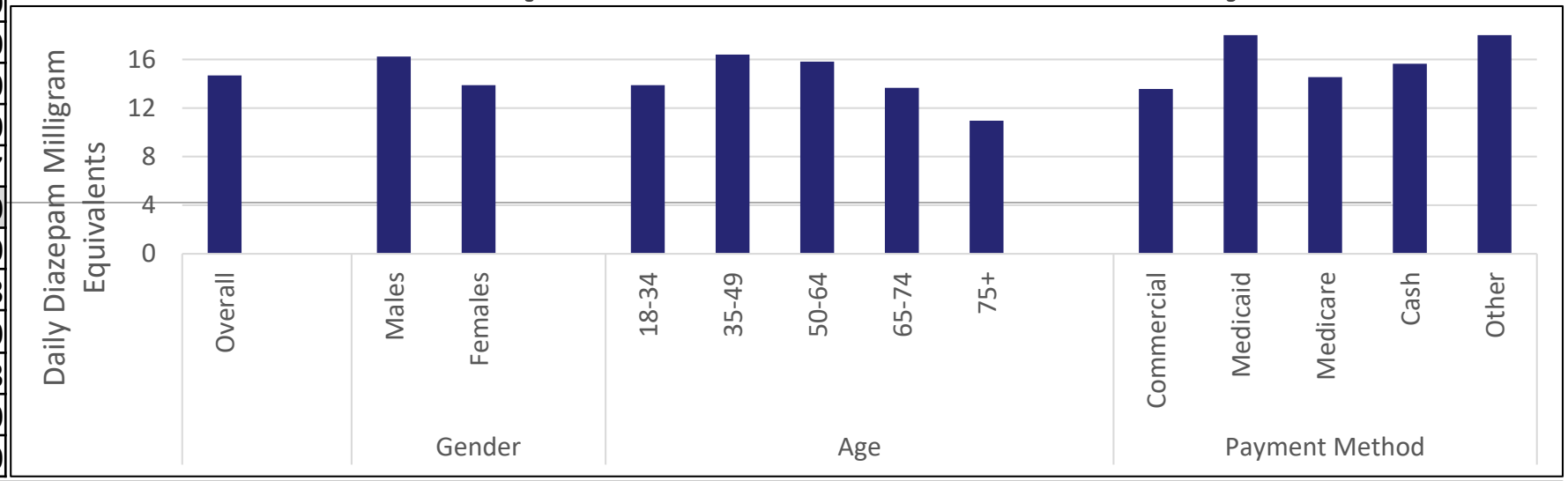
- Easy to get
- When known, it is too late

Lead:

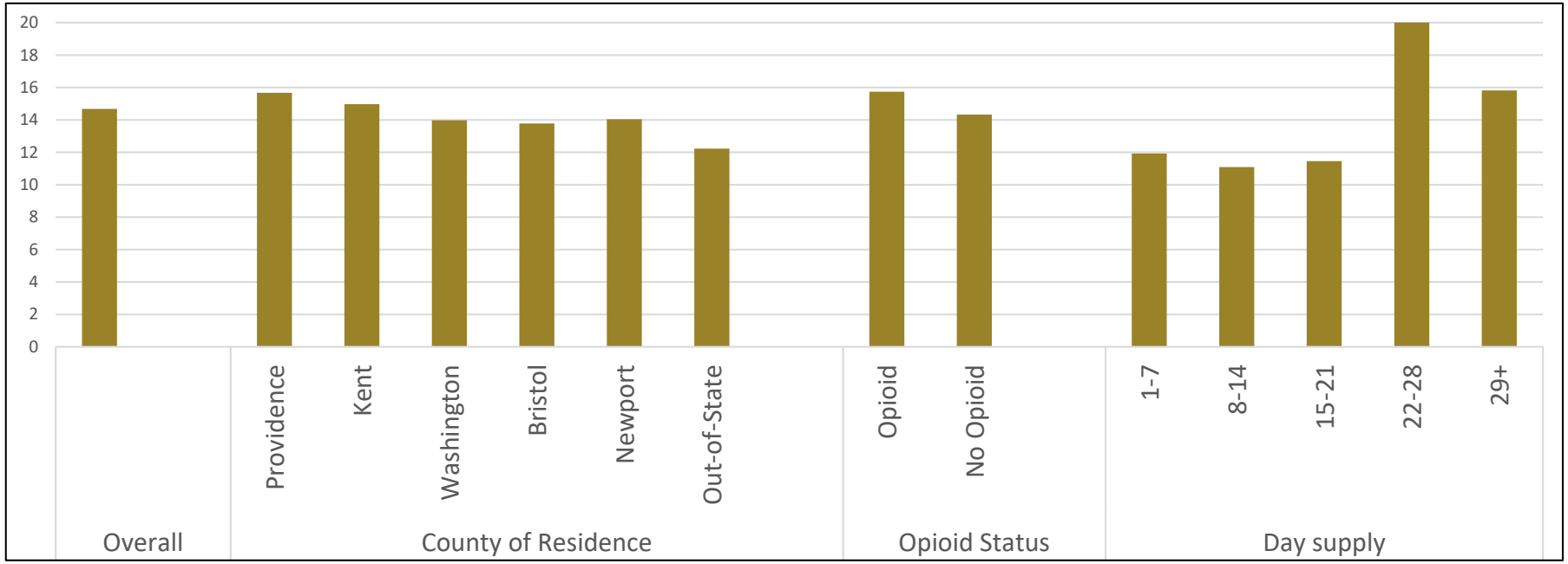
- Hard to get
- Everyday effort
- Actionable

Benzodiazepine Dose Intensity

Medication	Equivalence	Conversion Factor
Alprazolam	0.50mg	10.00
Chlordiazepoxide	12.50mg	0.40
Clobazam	10.00mg	0.50
Clonazepam	0.25mg	20.00
Clorazepate	7.50mg	0.67
Diazepam	5.00mg	1.00
Estazolam	0.67mg	7.50
Flurazepam	15.00mg	0.33
Lorazepam	1.00mg	5.00
Oxazepam	15.00mg	0.33
Temazepam	10.00mg	0.50
Triazolam	0.25mg	20.00



Medication	Number of Rx (%) 2018 PDMP
Clonazepam	175,224 (31.4)
Alprazolam	157,053 (28.2)
Lorazepam	146,892 (26.4)
Diazepam	51,607 (9.3)
Temazepam	18,111 (3.2)
Triazolam	3,010 (0.5)
Other	~ 10%



Resources for Older Adults

Basic Needs

Health Insurance

Call Point: 462-4444

http://www.oha.ri.gov/ship

RHODE ISLAND OFFICE OF HealthyAging

RI SHIP - 1-800-884-8721
POINT - (401) 462-4444

Access Point

Are you age 55 or older, an adult living with a disability, or a caregiver? Do you have a question about opportunities available to you? Call or visit the Point to talk with a specialist today and get connected to resources in your area – for free. Explore options for healthcare, employment, and more; get help with applying to public and private programs.

RHODE ISLAND ship state health insurance assistance programs
NATIONAL NETWORK
RI SHIP Line: 1-888-884-8721

R.I. Regional SHIP Offices:

Providence: dial 2-1-1 or 462-4444 (POINT)
Northern RI: (401) 349-5760 x2635
West Bay: (401) 921-5118
South County: (401) 789-3016 x2379
East Bay: (401) 435-7876
Newport County: (401) 848-4185

The R.I. Office of Healthy Aging is the RI grantee for the National Network of SHIPs

Dealing with Social Isolation & Anxiety

RHODE ISLAND OFFICE OF HealthyAging

Project HELLO

"Connecting older adults you with a Friendly Caller"

Enroll at: 462-4444

digi AGE – Tech Access

BH LINK

FOR CONFIDENTIAL SUPPORT AND TO GET CONNECTED TO CARE 24/7: CALL 401-414-LINK (5465)

Age-Friendly RHODE ISLAND
An initiative of Rhode Island College

Welcome to Rhode Island's Virtual Community Center!

Keeping our bodies healthy, minds sharp and spirits high.

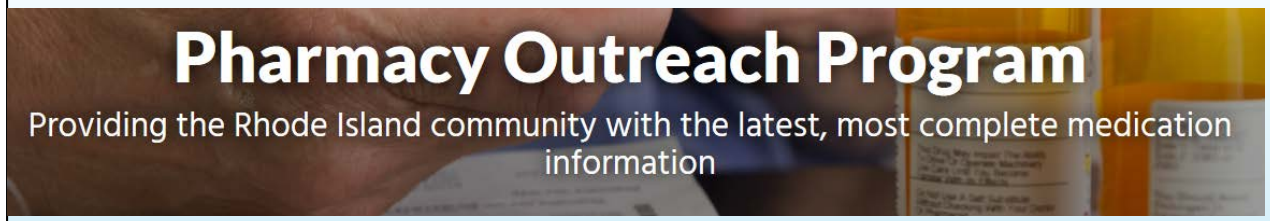
The Age-Friendly RI Virtual Community Center is the place to go to connect, learn, and play online when in-person community experiences are not possible.

Visit us at **https://agefriendlyri.org** to find a full schedule of free, engaging activities every day. Click and enjoy!

SNAPSHOT OF ACTIVITIES!

Laughter Yoga with Larry O'Brien	Daily Fitness classes with BCBSRI	Dance for All People with Rachel Balaban	Mindfulness with Robyn Earley	Aging Strong: Fitness with ShipShapeRI	Tech Time with Libby & URI Cyber Seniors
Tuesdays @ 11am	Daily @ 10am	Wednesdays @ 1:30pm	Fridays @ 2:30pm	Weekends @ 10am	Tues & Fri at 9:30am

Consumer Engagement Tools



Providing the Rhode Island community with the latest, most complete medication information

Services

Medication Cost Resources

Medication Information Hotline

call 1.800.215.9001 or email reachrx@etal.uri.edu.

Prepared by: Maureen Maigret
maureenmaigret@gmail.com

https://www.patientsafetyinstitute.ca/en/Pages/default.aspx

Updates:

- United Healthcare Update
- Updated PDSA- July 31
- Next Pharmacy QI Initiative: August 20th