Call for Applications for a Pharmacy Quality Improvement Initiative:
Improving Population Health/Reducing Low Value Care in Primary Care through Ambulatory Blood Pressure Monitoring (ABPM) or Professional Use of Continuous Glucose Monitoring (proCGM)

The Care Transformation Collaborative of Rhode Island (CTC-RI) and Rhode Island Department of Health (RIDOH) in collaboration with the University of Rhode Island College of Pharmacy is pleased to offer primary care practices working within systems of care (SOC) the opportunity to apply for funding to join a pharmacy quality improvement initiative that has been funded by UnitedHealthcare and the Rhode Island Department of Health.

CTC-RI will provide funding to support health care practices, working within systems of care, in their efforts to participate in a data driven pharmacy quality improvement learning network initiative to improve the management of hypertension and diabetes through team-based care. The need for a pharmacy-specific learning network has grown out of the multi-payer, multi-stakeholder CTC-RI Clinical Strategy Committee and the RIDOH Pharmacy Workgroup, and is part of CTC-RI's overall effort to assist primary care practice teams and SOC with improving patient care. Up to six (6) primary care practices will be selected to participate in this initiative. **Applications are due on July 29th, 2022. Project activities will begin August 23rd, 2022 and will continue for 24 months.**

Benefits of Participation:

- Opportunity to develop, implement and/or enhance a sustainable team based structured approach to improve patient care;
- Opportunity to leverage pharmacists, technology, data and best practice sharing to better utilize resources and intervene in a timely manner for patients with hypertension and/or diabetes;
- Deliverable-dependent practice infrastructure payments of up to $20,000 each year for 2 years for a total of $40,000, which can be used to offset the costs associated with measuring, reporting and monitoring data needed for improving selected quality improvement metric(s). Funds may also be used for equipment, and to support staff time (pharmacist, provider champion, nurse care manager, practice manager, behavioral health clinician, as applicable) for conducting this project and participating in monthly and quarterly quality improvement activities;
- Monthly coaching from pharmacy practice facilitator and national content experts who can assist with selecting equipment and providing training on interpretation of ABPM/CGM data, billing and coding;
- Support for data collection, analysis and measure calculations from URI;
- Opportunity to learn from peers as part of the quarterly learning sessions;
- Opportunity to position practice/system of care for ongoing value-based care payments based on performance.

Prerequisites

- Outpatient primary care practice that works within a SOC and has a pharmacist embedded within the primary care team, or having other access to pharmacy expertise as described by the applicant;
- Uses an electronic medical record system;
- Submits a completed application and cover letter from practice team by 5pm on July 29th, 2022 indicating commitment and capacity for meeting the project expectations detailed below *(Please see Appendix B for template)*;
- Submits a letter of support from the system of care by July 29th, 2022 (*Please see Appendix C for template*);
- Agrees to principle of transparency for performance improvement information that will be shared with learning network members.

Pharmacy Quality Improvement Initiative Objectives

- Provide practices/SOC with an opportunity to select and implement a practice/SOC focus of ABPM or proCGM based on their own identified practice needs;
- Support primary care practice teams/SOC in the identification and implementation of data-driven performance improvement action plans to improve the management of hypertension or diabetes within primary care;
- Improve provider and practice team wellbeing through effective use of high function team based care;
- Improve patient access to care and patient outcomes through pharmacy practice facilitation support, peer learning opportunities, and applied team-based performance;
- Understand and address gaps in care and health disparities that are identified through risk stratification of patient population, performance improvement data, patient survey or other means;
- Understand and incorporate "what matters most to the patient" as part of performance improvement plan;
- Where/if appropriate, enhance pharmacy scope and standardization of practice though use of collaborative practice agreements, as applicable to the practice's selected area(s) of focus;
- Demonstrate the benefit of a pharmacy led quality improvement initiative;
- Inform policy and best practices for use of these modalities

Advancing the Use of ABPM and proCGM: Project Scope and Requirements of Participation

The goal of this pharmacy led team-based care initiative is to provide primary care practices with an interprofessional quality improvement learning opportunity with the aim of improving the management of hypertension and diabetes using ABPM and proCGM, respectively. Participating practices will work on one of these two areas over a two-year time period with the expectation of increased growth/utilization over time by the number of patients, providers, and sites (as applicable to practice site/system of care).

Ambulatory Blood Pressure Monitoring (ABPM): The United States Preventive Services Task Force recommends that primary care clinicians use blood pressure measurements outside of the clinical setting for diagnostic confirmation of hypertension prior to initiating medications. ABPM is useful to evaluate for white coat effect, white coat hypertension, and masked hypertension, and allows for measurement while patients are awake and asleep which can be valuable for risk assessment. Moreover, obtaining a more complete understanding of ambulatory BP readings taken throughout the day can better guide drug therapy, and may preempt the need for emergency care. Involving the patient in the process may improve patient adherence to medication and management.

Professional Use of Continuous Glucose Monitoring (proCGM): The American Diabetes Association and the American Association of Clinical Endocrinologists support the use of continuous glucose monitoring in conjunction with insulin therapy to improve glycemic control, reduce hypoglycemia and lower diabetes costs. Measuring A1C has long been considered a gold standard for evaluating diabetes control, but time in range (TIR) and other CGM metrics have been gradually incorporated into the Standards of Care as complementary measures to A1C. The ADA 2022 standards of care recommend evaluating glucose management using a 14-day assessment from CGM because Time in Range, Time below Range, and Time above Range are additionally informative to medical decision-making. These metrics can also help patients with day-to-day diabetes management. Professional use of CGM, which means it is used intermittently under the direction of a health care professional, can be especially important for patients who cannot afford a personal device. Studies have shown that the additional data obtained can achieve reductions in A1C, lessen glycemic variability, decrease time in hypoglycemia, and improve diabetes-related quality of life and hypoglycemic confidence.

Pharmacist-driven implementation of ABPM and proCGM promotes pharmacists using their expertise to its fullest capacity, enhancing the ability to make targeted therapeutic recommendations and adjustments. Integration of these strategies in primary care settings can improve access to care and improve chronic disease management,

particularly in conditions where there are clear health disparities. Moreover, this effort aligns with Primary Care First measures, Medicare 5 Star Programs, HEDIS and ACO measures and state-wide efforts to improve quality and reduce low value care.

Requirements: Applying practices will chose either ABPM or proCGM as the project focus and define the population of interest. Applications should describe why the practice selected ABPM or proCGM, and explain how this modality is currently or will be utilized in their setting. Proposals should indicate the specific practice(s) and the number of and types of providers/care team members to be involved in the project. Proposals should also describe what the practice intends to learn from their implementation / expansion of ABPM / proCGM, using the model for improvement as a guide (see: http://www.ihi.org/resources/Pages/HowtoImprove). Salient facets will include how different team members will be involved in the project, workflows, clinician, staff and patient roles, data management and reporting, including selection of measures and how calculated. Practices should explain how medication management will be integrated (e.g. drug therapy changes in response to an out-of-range monitoring results). Proposals should clearly explain how patients will be engaged to participate, the target number of participants, and approaches to encourage patient retention and follow up. Populations of focus should be defined (e.g. new diagnoses, pregnancy). The potential impact of the program on vulnerable groups should be explained, in consideration of social determinants of health that may impact a patient's ability to participate and succeed in the program.

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)

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

2b. Clinical Measures Derived from the Device (reported quarterly, starting year 1, Q3)

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

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.

QI Initiative Activities: See Appendix A: Pharmacy Quality Improvement Milestones Summary Document that provides details on 24 months Performance Expectations

Practice QI team:

- Develops and implements action plans, staff training and workflows to support use of evidence based clinical strategies and project goals;
- Develops, tests and measures patient engagement strategy;
- Reviews and updates the Performance Improvement Plan based on patient engagement input;
- Submits updated P-D-S-A Nov 23, 2022
- Attends 3rd Learning Network meeting and reports out on progress/outcomes including results of patient engagement strategy (March 2023);
- Develops risk stratification strategy to identify and address gaps in care associated with factors such as insurance status, socioeconomic status, race, ethnicity, sex and/or other equity measure and updates P-D-S-A;
- Tests strategy to address gap in care, health disparities and measures impact;
- Submits final QI results using storyboard template, including a plan for sustainability and evidence of and projections for growth (July 2024)
- Attends final learning network meeting

QI Initiative Activities: 24 month responsibilities

- Team meets monthly with the clinical practice facilitator and quarterly with the project data facilitator with the frequency of ongoing meetings dependent on each practice's needs/performance results;
- Team attends quarterly learning collaborative meetings
- Team participates in team satisfaction survey (pre and post

Preparation Period (August –October 2022): Identification and Planning for What Matters Most to the Practice/SOC and What Matters Most to Patients

Practice QI team:

- Participates in kick off learning network meeting in August 23rd, 2022 at 7:30am – 9:00am
- Participates in monthly meetings with the practice QI facilitator;
- Participates in meeting with the project data facilitator
- Identifies and submits performance improvement plan (Plan-Do-Study-Act) including rationale, practice performance improvement measurement plan, target, clinical and patient engagement strategies; and completes the project's baseline needs assessment survey
- Presents performance improvement plan at quarterly meeting.

Year 1 Implementation (Months 5-12) and Year 2 Implementation (Months 13-24) See Milestones Summary Document

Timeline for Selection Process

Step	Activity	Date
1	Call for Applications released	June 30th
2	Conference call with interested parties to answer any questions.	July 13th @ 8am July 19th @ 12pm
3.	Submit Letter of Intent (optional)	July 15th, 2022
3	Submit application electronically	July 29th, 2022
4	Notification will be sent to practices	August 10th, 2022
5	Orientation Kick Off meeting for newly selected practices	August 23rd, 7:30 am – 9:00am

Application Checklist

Item	Check if complete
1. **Letter of Intent:** Optional	
2. **Application form** filled out completely: https://www.surveymonkey.com/r/Pharm-APBM-CGM-App?name=[name_value] a. See questions before completing the application here	
3. **Practice cover letter** indicating the practice's commitment and acceptance of the conditions stated in the application, signed by all members of the quality improvement team and by a practice leadership representative. *(Please see Appendix B for template)* a. Please note, this will be uploaded as part of the application. You will not be able to submit your application via Survey Monkey without this document. b. If needed, you can close out of the application window and you will be able to return to the spot where your application left off. **You must complete the page and select next for it to bring you back to the same spot.** i. For example, if you want it to bring you back to page 2, you must complete all items on page 2 and select next to save your data. If you not able to fully complete a section, you will not be able to select next and it will not save the data from that page.	
4. **System of Care (i.e. accountable care organization or accountable entity) cover letter** indicating the level of support provided for the lead practice for participating in this initiative including information if SOC would like to include other practices. If yes, other information (practice(s) name and providers) needs to be included *(Please see Appendix C for template)* a. Please note, this will be uploaded as part of the application. You will not be able to submit your application via Survey Monkey without this document. b. If needed, you can close out of the application window and you will be able to return to the spot where your application left off. **You must complete the page and select next for it to bring you back to the same spot.** i. For example, if you want it to bring you back to page 2, you must complete all items on page 2 and select next to save your data. If you not able to fully complete a section, you will not be able to select next and it will not save the data from that page.	
5. **Response to questions**	

Completed application packages must be received by 5:00 PM on July 29th, 2022

For questions, contact: Carolyn Karner, ckarner@ctc-ri.org

CTC-RI Selection Committee Policy and Procedure

To ensure an objective, fair, and transparent process for reviewing applications, the following policy and procedures for application review is being shared with applicants:

Selection Committee Process for Review of Applications: The CTC-RI Selection team will convene in August 2022. All reviewers will read and score each application independently using the scoring criteria below. Questions: A total of 10 points is possible for each question. 2 points if question is answered; an additional 2-3 points if response demonstrated organizational interest/commitment and moderate degree of readiness; additional 4-5 points for above average response suggesting that the practice has high degree of readiness, has begun pharmacy transformation work and is making progress towards medication optimization. The CTC-RI team may request to interview applicants if further information is needed. The applications will be rank ordered by final scores. In the event of a tie, the following criteria will be used:

1. Completeness of application
2. Balance between the number of projects selecting ABPM and proCGM.
3. Priority will be given to practices/SOC that have an interest in practice standardization through collaborative practice agreement or other method of improving pharmacy impact
4. Priority will be given to opportunity to provide state-wide coverage across systems of care
5. Successful completion of a prior CTC-sponsored initiative.

Conflict of interest: Reviewers will disclose any potential conflict of interest related to a specific applicant, defined as a real or potential monetary benefit or having a work affiliation with the applicant. The Selection Committee will discuss the potential conflicts of interest and decide of whether a conflict of interest exists. If so, the reviewer must recuse themselves from the review of that application.

Proposal Rating

Identification of use of data to improve care	Max 3 Score	Identification of what matters most to the practice/SOC	Max 3 Score	Identification of what matters most to the patient	Max 2 Score
Practice is currently collecting data from ABPM/CGM devices	Add 1 point	Practice team is engaged in at least 1 pharmacy quality improvement initiative	Add 1 point	Practice team identifies patient engagement strategy to better understand what matters most to the patient	Add 1 point
Practice is currently utilizing data from ABPM/CGM devices to improve patient care	Add 1 point	Practice team is engaged in multiple pharmacy quality improvement initiatives and describes how it will align efforts	Add 1 point	Practice has described an approach for collecting and integrating feedback from patients	Add 1 point
Practice is currently utilizing data from ABPM/CGM devices to improve population health	Add 1 point	Practice has a disease management program addressing the focus area (i.e. APBM/ CGM)	Add 1 point		
Practice team readiness	**Max 4 Score**	**Practice sustainability**	**Max 3 Score**	**System of Care readiness**	**Max 3 Score**
Practice has pharmacist supporting practice with sufficient capacity to lead the project	Add 1 point	Practice team has articulated anticipated barriers and plan to address	Add 1 point	System of care has IT capacity and functionality to assist with this project	Add 1 point
Practice has provider leadership committed to the project	Add 1 point	Practice team is interested in standardizing care using collaborative practice agreements	Add 1 point	System of care is interested in 2-3 practices being involved in initiative	Add 1 point
Practice has identified other practice team members to support the project	Add 1 point	Practice has explained the sustainability plan for using / expanding ABPM/proCGM	Add 1 point	SOC is interested in more than 3 practices being involved in initiative	Add 1 point
Practice team has demonstrated ability to determine gaps in care based on race/ ethnicity/gender/ insurance status/ and /or other factors	Add 1 point				

Appendix A: Pharmacy Quality Improvement Milestones Summary Document

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 2024 24 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 to deliverables@ctc-ri.org*
Submit initial PDSA project plan	November 23, 2022	*PDSA to be submitted to deliverables@ctc-ri.org*
Quarterly learning collaborative: present QI work plan with content expert as applicable - **Coding and Billing expert CGM**	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	February 14, 2023	*PDSA to be submitted to 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	May 09, 2023	*PDSA to be submitted to 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	August 08, 2023	*PDSA to be submitted to 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	November 14, 2023	*PDSA to be submitted to 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	Feb 13, 2024	*PDSA to be submitted to 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	May 07, 2024	*PDSA to be submitted to 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	July 16, 2024	*PDSA to be submitted to deliverables@ctc-ri.org*
Final learning collaborative	July 30, 2024	

Appendix B: Lead Practice Support Cover Letter Template

To: CTC-RI Pharmacy quality improvement Selection Committee
From: Practice Leadership Representative
RE: CTC-RI Quality Improvement Initiative
Date:

On behalf of (practice name_____), please accept the following practice support cover letter for the Pharmacy Quality Improvement Initiative. As an organizational leader representative, I can attest the following staff members accept the conditions stated in the application and if awarded, are committed to achieving the objectives of this initiative.

Practice Name/Address: _____
_____
_____

Phone: _____

Quality improvement team, including providers, and potentially a nurse care manager, behavioral health clinician, practice manager, social worker, medical assistant, IT support staff member, as applicable to the practice with the understanding that members of the team will be invited to participated in monthly practice facilitation meetings based on planned agenda :

Position	Name	Email
Key contact person responsible for project implementation		
Provider champion		
Pharmacy champion		
Nurse Care Manager		
Practice manager		
IT support staff member		
Other		

Phone number of provider champion: _____
Phone number of key contact person: _____

Letter signed by practice leadership representative and all members of the quality improvement team:

_____ _____ _____ _____
Practice Leadership Representative Date Quality Improvement Team Member Date

_____ _____ _____ _____
Quality Improvement Team Member Date Quality Improvement Team Member Date

_____ _____ _____ _____
Quality Improvement Team Member Date Quality Improvement Team Member Date

_____ _____ _____ _____
Quality Improvement Team Member Date Quality Improvement Team Member Date

_____ _____ _____ _____

Quality Improvement Team Member Date Quality Improvement Team Member Date

Appendix C: System of Care Letter of Support Template

To: CTC-RI Selection Committee
From: System of Care Representative
RE: Pharmacy Quality Improvement Initiative
Date:

[Practice name and site] is a member of our System of Care. The practice is interested in participating in the Pharmacy Quality Improvement Initiative. We believe that this practice would benefit from participation and as a system of care, we are willing to provide the management support to assist the practice with making this transformation.

As a system of care, we will provide the practice with (check all that apply):

☐ Practice reporting Pharmacy Performance

☐ IT assistance for practice team templates within the practice electronic health record as needed to capture performance

☐ A System of Care representative that will meet with the pharmacy practice facilitator during the startup phase and thereafter as needed

☐ Commitment to collaborate and communicate with the pharmacy practice facilitator and URI to ensure that initiative requirements are met within designated timeframes;

☐ Commitment to crosswalk the pharmacy initiative with other related quality improvement projects and support and align efforts;

☐ Other: (please describe below)

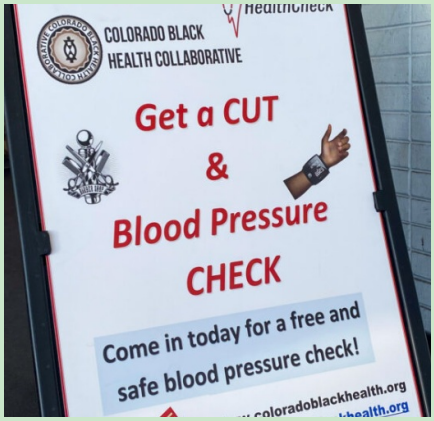
_____	_____	_____	_____
Signature of System of Care	Date	Signature of Practice team	Date
_____		_____	
Position		Position	
_____		_____	
Email		Email	
_____		_____	
Phone		Phone	

Care+Community+Equity Program Reminders & Updates

Next CCE Best Practices Sharing meeting is September *28, 2022 8:00 – 9:30am*

This is a virtual meeting and will be conducted via **Zoom**. Updated calendar invites and zoom information have been sent out and are provided in the outlook calendar invitation. Please contact ***Der Kue*** with questions.

- Practices will meet with Practice Facilitators in July and August to help plan PDSAs and incentive work for year 4
- Topics for Quality Improvement deliverables are due by our next best practices sharing meeting, September 28,2022



Read All About It

Meeting people where they are: How free health screenings at barbershops and salons are aiming to improve health

Colorado Black Health Collaborative hosts the barbershop and salon screenings every week

What's Happening Week of August 8, 2022

National Health Center Week, observed August 7-13, is a celebration of the work done by health center programs. Health centers provide millions of patients with low-cost primary and preventive care services every year. They are also important in addressing disparities in healthcare access and affordability for members of racial and ethnic minority communities

Each day of National Health Center Week will**focus on a particular topic**:

- August 7: Public Health in Housing
- August 8: Healthcare for the Homeless
- August 9: Agricultural Worker Health
- August 10: Patient Appreciation
- August 11: Stakeholder Appreciation
- August 12: Health Center Staff Appreciation

- August 13: Children's Health

The **HRSA Health Center Program** began in 1965 and provides federal funding to public or nonprofit organizations that provide comprehensive primary health care to underserved populations as Federally Qualified Health Centers.

Health Centers Hit Historic Milestone of Patients Served

Join HRSA next week to celebrate National Health Center Week (August 7-13).

The 2021 Uniform Data System (UDS) data is expected to be published Monday, August 8. It will appear in HRSA's Data Warehouse on the ***Health Center Program Data and Reporting webpages***.

Join a webinar to learn about trends in the 2021 data on health center patient demographics, staffing, and clinical quality measures. You'll gain insights on health centers' growth, recovery, and performance.

Tuesday, August 9
1:00-2:00 p.m. ET

Register Here

Patient-Centered Medical Home 2023 Standards Update

Hosted by the National Committee for Quality Assurance

Wednesday, August 10
2:30-3:30 p.m. ET

Register Here

Integration of Diabetes and Oral Health

This Breakthrough Series Learning Collaborative works with health centers to implement the **NNOHA User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies**. Participants will learn how they can improve outcomes for people with diabetes by increasing the number of dual users of medical and dental services.

Apply by 2:59 a.m. ET on Saturday, August 20. Presented by The National Network for Oral Health Access.

Other News & Resources

Community Health Network

Thank You for your support. Please continue making CHN referrals.

Help broaden communication efforts of the CHN by adding contacts and point persons from your organization to the CHN email distribution list. Access the link below to add and/or provide updates to the list:

Add/Update to CHN List

Check out CHN Classes

Join Know Diabetes by Heart for an expert panel discussion on new science released at the 82nd American Diabetes Association's Scientific Sessions.

Panelists discuss clinical highlights from the 2022 Scientific Sessions related to cardiovascular disease and renal risk management and how to apply these relevant highlights to improve patient outcomes.

Watch Now

Quick Start Guide to Act Rapidly

This resource will help you act rapidly in managing your patient's elevated blood pressure by explaining what tools are available to you.

CME Course: Acting Rapidly with Pharmacotherapy – Step 2 in Hypertension Control

At the completion of this course, the learner will be able to:

Home Blood Pressure Monitoring with Clinical Support

Home blood pressure monitoring is informative but inaccessible for some outside of strengthened clinical support. Learn how you can utilize shared decision-making to better engage patients in their health care and support improved health equity. Subscribe to the Unmet Needs in Hypertension Treatment Options podcast series in **Apple Podcasts** or **Listen Here**.

Help Them Make the Heart-Healthy Choice

How can you help your patients make better choices at the grocery store? Tell them to look for the Heart-Check mark. This symbol means that a product has met stringent nutritional guidelines set by the American Heart Association. Visit **Heartcheck.org** for more information.

New Check. Change. Control. Cholesterol™ Audiocast Series

This three-part podcast series guides all members of the care team to properly manage and support their ASCVD patients – from all socio-economic backgrounds. Dr. Howard Haft discusses topics covering equity

- Define therapeutic inertia, list contributing factors, and impact on BP control.
- Describe the importance of treatment intensification in improving blood pressure control.
- Review strategies to address therapeutic inertia and increase treatment intensification.

gaps in lipid management, medication adherence, and the transition of care. **Listen Now**.

Watch Here

On Demand:
Join the **Ask the Experts** event, Type 2 Diabetes and Cardiovascular Disease Risk held on July 12 to learn about the connection between diabetes and the risk of cardiovascular disease.

Learn how to reduce your risk of developing heart complications and what treatments are available.

Care+Community+Equity Program Reminders & Updates

Next CCE Best Practices Sharing meeting is September *28, 2022 8:00 – 9:30am*

This is a virtual meeting and will be conducted via **Zoom**. Updated calendar invites and zoom information have been sent out and are provided in the outlook calendar invitation. Please contact ***Der Kue*** with questions.

- Practices will meet with Practice Facilitators in July and August to help plan PDSAs and incentive work for year 4
- Topics for Quality Improvement deliverables are due by our next best practices sharing meeting, September 28,2022

Million Hearts Tobacco Cessation Change Package

Download Here

Watch the Tobacco Cessation Change Package Tutorial Video

What's Happening Week of August 15, 2022

Integration of Diabetes and Oral Health

This Breakthrough Series Learning Collaborative works with health centers to implement the **NNOHA User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies**. Participants will learn how they can improve outcomes for people with diabetes by increasing the number of dual users of medical and dental services.

Apply by 2:59 a.m. ET on Saturday, August 20. Presented by The National Network for Oral Health Access.

Other News & Resources

Community Health Network

Thank You for your support. Please continue making CHN referrals.

Help broaden communication efforts of the CHN by adding contacts and point persons from your organization to the CHN email distribution list. Access the link below to add and/or provide updates to the list:

Check out CHN Classes

Add/Update to CHN List

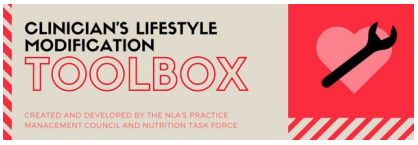
Peripheral Artery Disease (PAD) for Professionals

Despite the significant health burden of PAD, under diagnosis and undertreatment can lead to major adverse cardiovascular and limb events. This series aims to address this along with highlighting key points from the 2016 guidelines for the management of PAD and identifying significant disparities which increase PAD risk and the need for appropriate community-based intervention.

Watch PAD Webinars

In case you missed it, check out these tools and resources:

- National Hypertension Control Initiative Health Center Hub | 2022 Core Curriculum Calendar of Events
- HRSA: Addressing Challenges and Barriers to Self-Measured Blood Pressure Monitoring (SMBP) Implementation
- CME COURSE: Partnering with Patients Using Lifestyle Modification and Motivational Interviewing – Step 3b In Hypertension Control
- AMA Improving health outcomes: Hypertension publications



The Clinician's Lifestyle Modification Toolbox (CLMT) is a project created and developed by the NLA Nutrition Task Force in conjunction with the NLA Practice Management Council. The CLMT includes patient education material that is based on the NLA Recommendations for Patient-Centered Management of Dyslipidemia—Part 2. The CLMT resources are designed to assist clinicians and healthcare professionals in beginning a conversation with their patients about achieving successful lifestyle changes that promote their lipid health. The NLA recommends patient referral to a registered dietitian nutritionist for personalized medical nutrition therapy to enhance and support sustained healthy lifestyle changes.

Best Practices for Adapting to the Remote and Hybrid Workforce in Team-Based Care

Telehealth and remote work are going

STAR²CENTER
SOLUTIONS TRAINING AND ASSISTANCE FOR RECRUITMENT & RETENTION

Access Resources

to continue to be a “way of life” even after the pandemic is over. This newly released publication [lnks.gd] provides health center leadership with ideas and best practices on how to adapt policies and procedures for a remote and hybrid workforce. The Association of Clinicians for the Underserved’s (ACU) STAR2 Center and the Health Information Technology, Evaluation, and Quality (HITEQ) Center (both HRSA-funded NTTAPs) collaborated on this publication.

NTTAP
National Health Center Training & Technical Assistance Partners
A PROJECT OF Community Health Center, Inc. and the weitzman institute

Quality Improvement Strategies in a Team-Based Care Environment

March 24, 20022

Watch Webinar

Quality Improvement Strategies in a Team-Based Care Environment

Overview: This webinar addresses building a quality improvement infrastructure within team-based care as it is an organizational strategy that will establish a culture of continuous improvement across departments and improve quality in all domains of performance.

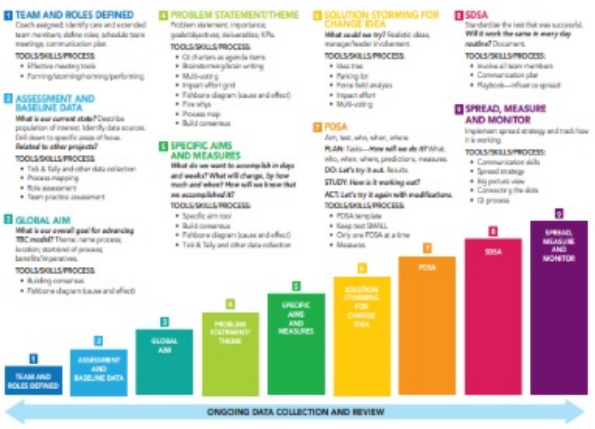
View webinar at: https://bit.ly/2022-NTTAP-QI

Takeaways:

- QI is not a department
- Data-driven care is a building block of primary care and team-based care
- Builds on unique context of individual staff in specific clinical units in a larger organization
- Elevates skill level of staff, ownership of improvement and practice, team-ness
- Uses trained coaches to guide staff

Notable Participant Live Feedback:

- *“Focusing on the team-based approach, and not relating QI to a department.”*
- *“I liked the examples and breakdowns of the different strategies on the models for improvement.”*



Rhode Island Health Center Association | 235 Promenade Street, Suite 455, Providence, RI 02908

Care+Community+Equity Program Reminders & Updates

Program Reminder for September 2022:

1. Practices will meet with Practice Facilitators in July and August to help plan PDSAs and incentive work for year 4 Topics for Quality Improvement deliverables are due by our next best practices sharing meeting, September 28,2022
2. Attend CCE Best Practices Sharing meeting will be held virtually on **September 28, 2022 8:00 – 9:30am** via ***Zoom***; updated Outlook invitations have been sent with zoom access embedded. Please contact ***Der Kue*** with questions.

What's Happening Week of August 29, 2022

"Whole Person" approach to care means treating a person inclusive of their individual mental health, behavioral and lifestyle factors, and their social and economic environment.

Register to participate in a discussion of: the evidence behind integrated care that includes **drug-less approaches, lifestyle and self-care, and community services**; how these interdisciplinary approaches can be successfully carried out in a range of care settings; and what a greater focus on whole-person health looks like for patients. Panelists will explore how advanced primary care can reorient away from treating sickness in a fragmented system and towards fostering greater wellbeing and health equity for all communities.

Register Today!

Tobacco Cessation for Persons of Reproductive Age, Including Pregnant Persons

Wednesday, August 31
1:00-2:00 p.m. ET

Register

Fixed-Dosed Combination Antihypertensive Medications Coverage: A Review of Resources for Health Centers

Thursday, September 1
3:00-4:00 p.m. ET

Register

Prepare by reviewing the ***FDC antihypertensive medication Medicaid coverage guide***

Other News & Resources

Community Health Network

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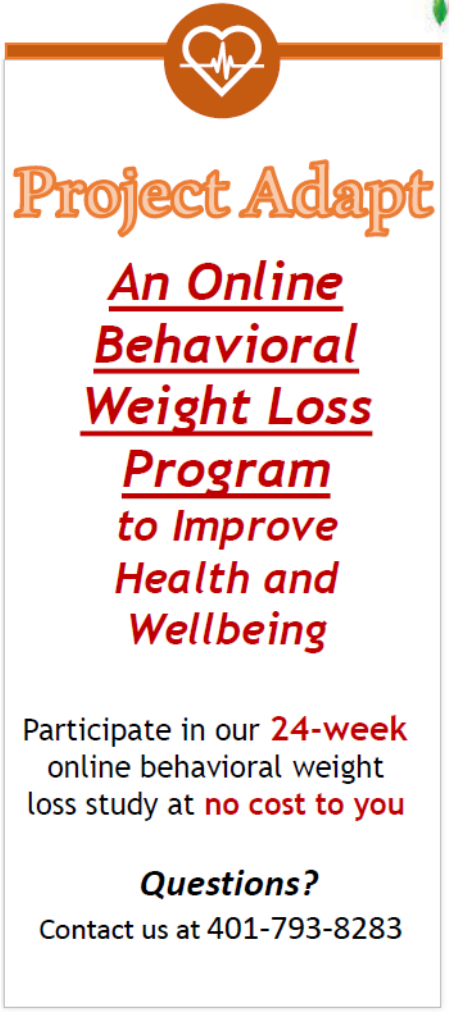
Add/Update to CHN List

The research study, called **Project Adapt**, is a 6-month lifestyle modification program in which patients are provided with gold-standard, empirically-supported weight loss treatment **at no cost**.

Participants will be encouraged to use an online program and new smartphone app to make gradual changes to eating and exercise habits. As a result, most patients lose 5-7% of



their starting body weight if that is their goal. There are no meal replacements or medications involved.

All patients must have one of the following cardiovascular disease risk factors to participate: high blood pressure, high cholesterol, prediabetes or Type 2 diabetes.

Download Program Brochure

Download Program Flyer

NTTAP
National Health Center Training & Technical Assistance Partners
A PROJECT OF
Community Health Center, Inc. and the weitzman institute

Submit applications by Friday September 30th, 2022

Apply Here

Is your health center looking to start or refresh its high-performance, team-based comprehensive primary care model?

Apply today for the Comprehensive and Team-Based Care Learning Collaborative!

This free eight-month participatory experience is designed to equip health centers and look-alikes with the knowledge, tools, and coaching support they need to develop highly trained clinical primary care teams that will enhance their model of high-performing team-based care.

The Team-Based Care Collaborative will engage teams in work focused on implementing and measuring outcomes for a model of team-based care best suited to their organization by:

- Assessing their current team-based care model to identify areas for process improvement and role optimization
- Developing a problem statement based on data
- Using quality improvement concepts and skills with coaching support

to systematically achieve one or more specific aims.
- Developing a specific aim, global aim statement, and process map based on the problem statement
- Developing a Team-Based Care playbook in your organization

NCQA
Measuring quality. Improving health care.

WHAT IS DIABETES RECOGNITION?

The Diabetes Recognition Program recognizes clinicians who use evidence-based measures to provide quality care to their patients with diabetes. Recognition makes you part of an elite group that is publicly recognized for providing the highest level of diabetes care.

Diabetes Recognition Program

WHAT IS HEART/STROKE RECOGNITION?

This program recognizes clinicians who use evidence-based measures to provide quality care to their CVD and stroke patients. Recognition makes you part of an elite group that is publicly recognized for providing the highest level of care.

Heart/Stroke Recognition Program

AHA CPR & First Aid

Find a Class Near You!

AHA's network of authorized Training Centers and Instructors offer in-person classroom training and skills sessions. Schedule training, find contact information, or see course options for your local Training Center with their online tools.

The Affordable Connectivity Program was created by the FCC to help households struggling to pay for internet service. As part of that effort, the FCC is mobilizing people and organizations to help raise awareness about the ACP. The materials below are available for public use, and you can download and

customize them to meet your needs. Eligible households can enroll in the ACP through an approved provider or by visiting ***AffordableConnectivity.gov.***

ACP Consumer Outreach Toolkit

S2E6: Women's Cardiovascular Health

Lipid Insights 30 minute pod cast

Listen to Podcast