CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome to Breakfast of Champions

Care Transformation Collaborative of R.I.

MARCH 13, 2021

Agenda

Topic *Presenter(s)*	Duration
Welcome & Introductions *Pano Yeracaris, MD MPH CTC-RI Chief Clinical Strategist*	5 minutes
Improving Population Health and Health Equity through Community Health Teams *Somava Saha, MD, MS, Executive Lead, Well-being and Equity (WE) in the World and Well-Being in the Nation (WIN) Network* *Craig Jones, MD, Partner, Capitol Health Associates; former Executive Director of the Vermont Blueprint for Health*	40 minutes
Highlights from a Pharmacy-Led Quality Improvement Initiative: Safe, Effective and Efficient Medication Use Among Older Adults *Stephen Kogut, Ph.D., MBA* *Kelley Doherty Sanzen, Pharm.D., PAHM, CDOE* *Ronald Tutalo, Pharm.D., BCACP, CDCES*	40 minutes
Wrap Up & Next Steps – Pharmacy Call for Applications and Breakfast of Champions Survey	5 minutes

CME Credits

- CTC-RI is in the process of applying for CME credits for this meeting.
- If interested in receiving CME credits in the event we are approved, please request them by completing the evaluation shared at the end of this session, also linked here for your reference:
  - www.surveymonkey.com/r/MarchBOC

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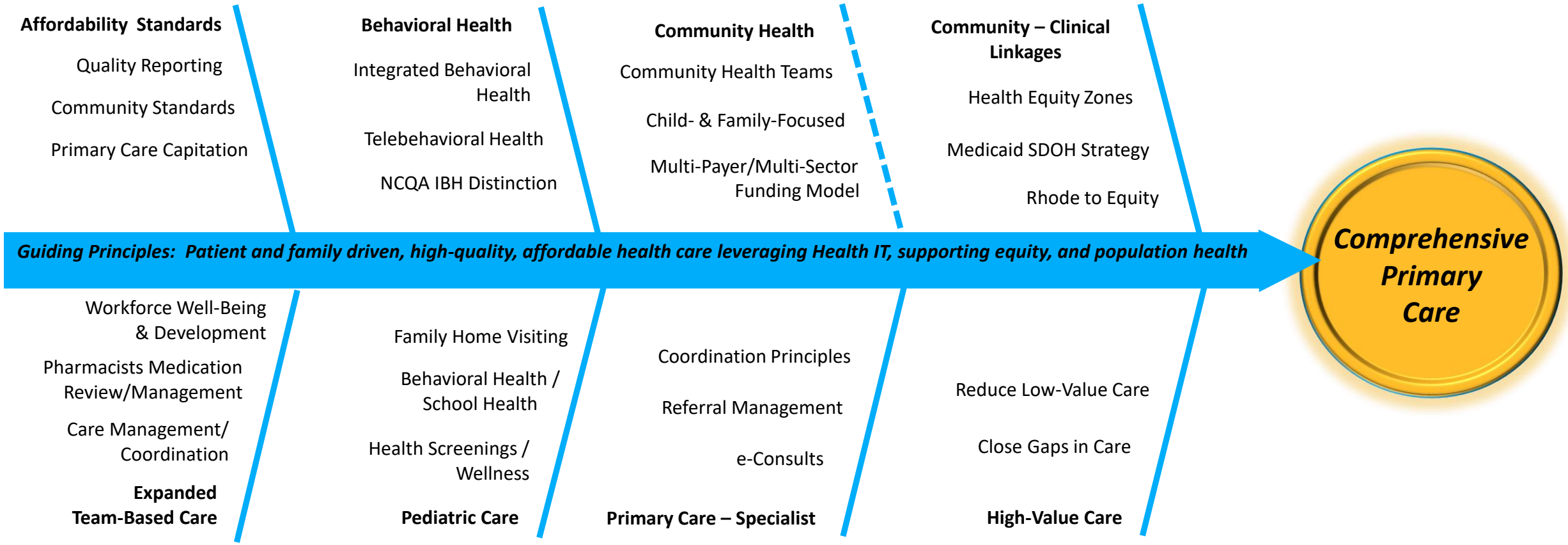
ADVANCING INTEGRATED HEALTHCARE

Today's Objectives

Objective #1 Have a deeper understanding of how community health teams can support practices to improve patient care.

Objective #2 Have a better understanding of the value pharmacists bring to the extended care team.

Roadmap to Comprehensive Primary Care



Health Information Technology: CurrentCare; Dashboards; Telehealth; Remote Monitoring

Best Practice Learning Collaborative

Pediatric Learning Community

Patient-Centered Medical Home

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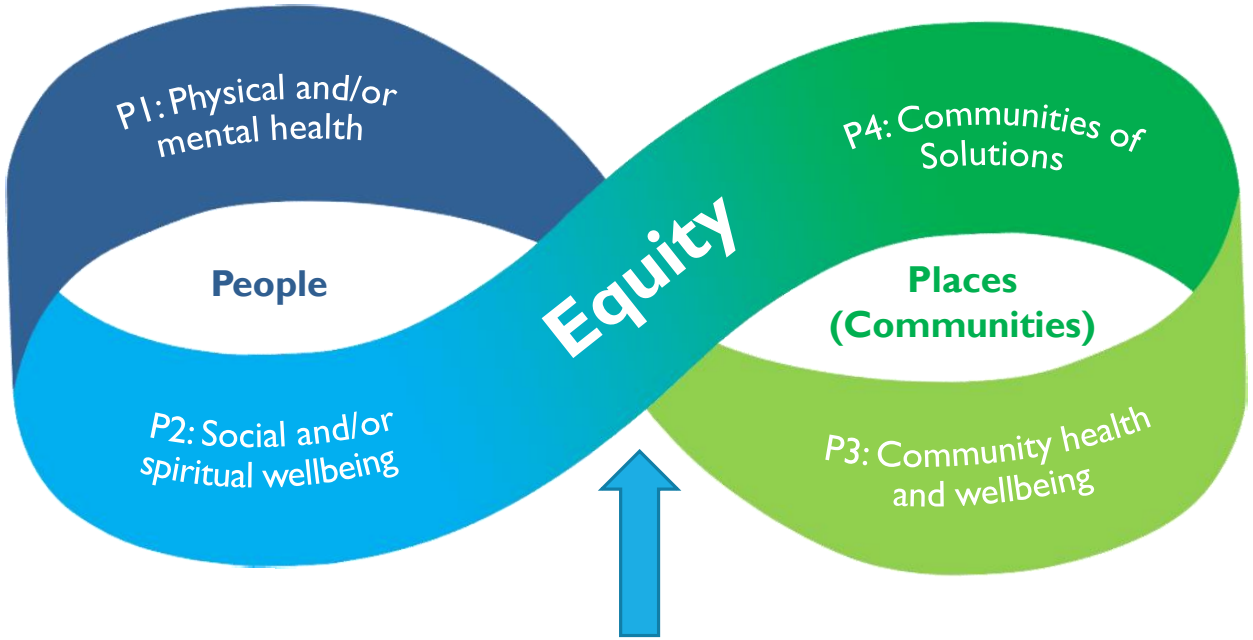
ADVANCING INTEGRATED HEALTHCARE

Improving Population Health and Health Equity through Community Health Teams

- Somava Saha, MD, MS, Executive Lead, Well-being and Equity (WE) in the World and Well-Being in the Nation (WIN) Network
- Craig Jones, MD, Partner, Capitol Health Associates; former Executive Director of the Vermont Blueprint for Health

Pathways to Population Health Equity

Clinical Care Teams - Improving the health and well-being of **people**



Health Equity Zones (e.g. public health, community-based organizations, community development)

Community Health Teams as a Bridge to Support Equity

Photo by Gift Habeshaw on Unsplash

Referred from: First Connections

Brief Client Description:

- Patient referred by FC nurse due to multiple concerns and risk factors
- Patient is a female in her late twenties with an infant son
- Patient lives with parents

Family Care Team Case study

Risk Drivers Identified:

- History of Substance Use Disorder, currently on methadone
- Uncontrolled chronic infectious disease
- Poor follow-through with primary care
- Lack of employment; Educational/Vocational needs
- No driver's license
- DCYF involvement
- Recently transitioned to home from residential placement
- Family conflict and poor natural supports

Interventions:

- Patient was referred to the CHT **Behavioral Health clinician** for counseling services and to the CHT Certified **Peer Recovery Specialist** (CPRS) who connected her to meetings (online/in-person)
- Assisted patient to **reinstate her license**; helped complete application and provided transportation to DMV.
- CCHW assisted patient in **completing resume and applying for jobs**
- CCHW assisted patient in **completing housing applications**

Family Goals:

- Finishing Medical Assistant schooling
- Secure employment
- Behavioral health counseling
- Peer Recovery services
- Family Therapy sessions
- License reinstatement for transportation

Care Team:

- Community Health Worker (CCHW)
- Behavioral Health Clinician (LMHC)
- Certified Peer Recovery Specialist (CPRS)

Other Partners/Services:

- Residential treatment center
- DCYF—Now closed
- Opioid Treatment Program—for medication assisted treatment and psychiatric care
- Early Intervention
- Healthy Families America
- Recovery Center

Outcomes:

- Actively attending online recovery meetings/ maintaining sobriety
- Baby is stable, attending all peds appointments, and mother is connected to recommended community providers
- Reporting a decrease in anxiety and improvement in sleep for parent
- Stable housing and relationship with family
- Chronic medical conditions are in control
- Patient has an active license, has been attending all appointments for child and herself
- Actively seeking employment
- DCYF has closed services
- Actively engages in an Early Intervention program.

DEBORAH IS A 52 YEARS OLD AND LIVES IN LOW-INCOME HOUSING WITH HER 15 Y.O. DAUGHTER AND 10 Y.O. ADOPTED GRANDDAUGHTER. PT WAS REFERRED TO CHT. PT WAS REFERRED BY SCH ON 11/11/2019, IS DISABLED, HAS POORLY MANAGED DIABETES AND CHF. SHE, HAS POOR ADLS AND POOR SUPPORTS. PT IS A FALL RISK AND STRUGGLES TO AMBULATE. PT HAS BEEN HOSPITALIZED RECENTLY FOR FALL RESULTING IN FRACTURED HIP AND SORE ON FOOT. PT CALLS THE AMBULANCE FOR SUPPORT IF SHE FALLS. PT DOES NOT HAVE TRANSPORTATION.

SCH CHT Case Study 2020

Risk Drivers

Utilization: Pt has been hospitalized several times for fall and Diabetes and COPD related symptoms
Health Conditions/Literacy: Diabetes, CHF, broken shoulder, fractured hip, eye problems. Pt is poor historian and has little insight.
Care Coordination: none prior to CHT
Social/Emotional Support: Pt has sister and older daughter who live in the state; somewhat supportive.
Functional Limitations: Pt struggles with ambulating and is a fall risk. Struggles w/ judgement, following through on referrals, memory and organizational skills-forgets appts, etc..
Social/Familial/Environmental:
Family: Pt care for 2 children, her daughter, 15 and adopted granddaughter, 10.
Food Security: SNAP and utilizes food banks.
Housing: Lives in subsidized housing. Sleeps on couch. 2 br apt.
Transportation: Pt takes public transportation or relies on sister.
Insurance: NHP access/ Medicaid
Financial: SSDI $1500/ month.
Behavioral Health: Pt has depression, displays flat affect and apathetic demeanor.
RISK DRIVERS IDENTIFIED FOR OTHER FAMILY MEMBERS:
- Counseling advised for children.
- In home family therapy advised for parenting skills; lack encouragement.

Intervention

Utilization: Pt has in home supports through HH and CHT support. Pt has BH support with BHCM.
Health Conditions/Literacy: has VNA, OT and PT currently and CHT support.
Care Coordination: Coordinated HH diabetes coaching. Pt has 2/x week wound care and meets with OT & PT.
Social/Emotional Support: BHCM meets with pt for weekly support.
Functional Limitations: CHT suggested pt use calendar and phone for scheduling appointments.
Social/Familial/Environmental:
Family: Daughter registered with Big Sister for mentoring and will have intake.
Housing: Pt on waitlist for larger apt. Assisted living advised.
Transportation: no changes
Insurance: no changes
Financial: no changes
Behavioral Health: suggested in home counselor- pt struggles with follow through. Suggested inpatient at Butler to address Depression symptoms.
INTERVENTIONS BENEFITTING OTHER FAMILY MEMBERS
- A Big Sister referral for 10 y.o.
- B FCCP referral; kids did not qualify
- C Seeking in home family therapy

PEDRO IS ONE OF OVER 30,000 UNDOCUMENTED IMMIGRANST IN RHODE ISLAND. HE IS FROM GUATEMALA AND WORKS IN A FACTORY. A LOT OF PEOPLE HE KNOWS HAVE BEEN SICK WITH COVID. HE HAS HEARD ABOUT A VACCINE BUT IS AFRAID HE AND HIS DAUGHTER (WHO CAME WHEN SHE WAS 1) WILL BE DEPORTED OR REPORTED FOR PUBLIC CHARGE. HE USES THE EMERGENCY ROOM SEVERAL TIMES WHEN HE NEEDS TO.

Role of Community Health Teams

- As a primary engager (and caregiver) of people who are disconnected from and are at highest and medium/rising risk
- As an extender of, and complement to, primary care
- As a trusted intermediary between the health system and community
- As a resource for community multi-sector transformation

Community Health Teams - Strengthening Primary Care & Community Linkages

*2021 CPC+ Implementation Guide
Comprehensive Primary Care Functions

- **Practice/SOC Based Teams** – Enhance daily operations and capacity for advanced primary care, including proactive care management and more complete whole person needs
- **Community Based Teams** – Augment and support practice based teams with broader capabilities and services to **address rising risk and complex needs** (e.g. Developmental, BH, MH, SUD, Social, Economic, Safety)
- **Transitions** – Facilitate connections between practices and community based organizations, as well as transitions within and across health systems
- **Adaptable & Fluid** – Adjust to operate most effectively within communities and to meet regional priorities over time. Can supplement practice based operations (e.g. FQHCs, independent practices) as well as provide and connect with community based services (across all primary care settings)

Highlights from a Pharmacy-Led Quality Improvement Initiative: Safe, Effective and Efficient Medication Use Among Older Adults

- Stephen Kogut, Ph.D., MBA
- Kelley Doherty Sanzen, Pharm.D., PAHM, CDOE
- Ronald Tutalo, Pharm.D., BCACP, CDCES

Overview

Project Background

- Safe-Effective-Efficient Framework
- Using data to drive decisions

Practice Facilitation

- Overview of the projects
- Overall impact and lessons learned

Spotlight on COPD/Asthma

- What matters to patients
- Lessons learned and sustainability

Pharmacy QI Project Aims

1. Practice team/SOC to identify and implement a data-driven performance improvement action plan addressing a particular medication topic of concern among adults age 50+
   - Guided by S-E-E measure results for SoC
   - P-D-S-A

2. Improve **patient** medication management outcomes
   - Pharmacy practice facilitation support
   - Peer learning opportunities
   - Applied team-based performance improvement

Goals
- Patient-centered
- Improvement
- Collaboration
- Sustainability

Project Background

Baseline Measures

- Safe- Effective- Efficient framework
- APCD claims database

Project Planning

- Pharmacist- Provider leadership
- Enhanced integration in team
- Workflow development
- Patient engagement strategy

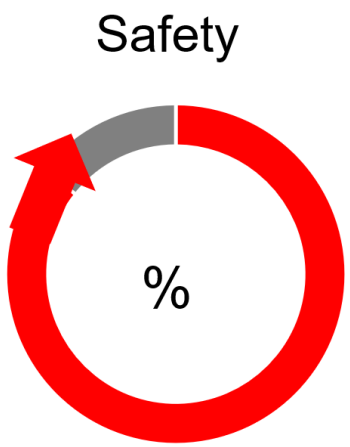
Implementation & Evaluation

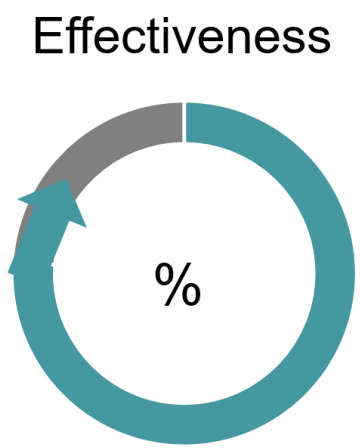
- Learning collaborative
- PDSA

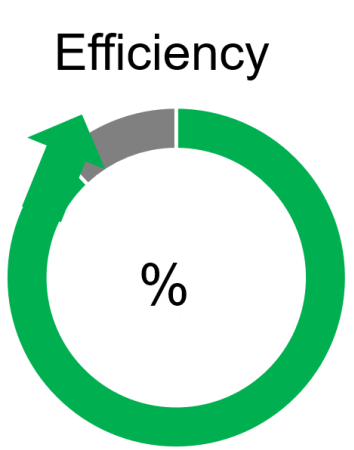
Safe, Effective and Efficient (S-E-E) Use of Medication in Older Adults (Age 50+)

Safe (S)	Effective (E)	Efficient (C)
Avoiding use of: 1. Opioids 2. Benzodiazepines 3. Other CNS depressants 4. NSAIDS, if using anticoagulants 5. Anticholinergics in dementia 6. Fluoroquinolones as initial therapy 7. Naloxone if opioid Rx 8. Higher-risk drugs (PIMs)	**Patient adherence to:** 1. Anticoagulants 2. Diabetes medications 3. Depression medications 4. Cholesterol medications 5. Respiratory inhalers **Evidence-based therapies:** 6. Statin use in diabetes 7. Prescribing controller inhalers if high use of albuterol	**Health system use:** 1. Limit number of prescribers 2. Avoid polypharmacy **Use of generics:** 3. Overall 4. Diabetes medications 5. Mental health medications **Other:** 6. Low Value Drugs 7. Erythropoietin

100% is optimal for all measures







		POPULATION: AGE 50+ EXCLUDING PTS W ONCO RXS				*The column "vs APCD" is point difference from RI APCD*										
		100% is optimal for all measures (higher is better)	**2018 RI APCD**			**SoC 1**				**SoC 2**				**SoC 3**		
		DESCRIPTION	%	n		%	vs APCD	n		%	vs APCD	n		%	vs APCD	n
	S1a	Avoid chronic use of: opioids	93.2	232,894	S1a	95.2	2.0	2,932	S1a	94.3	1.0	6,338	S1a	95.1	-1.0	8,433
S	S1b	Avoid chronic use of: benzodiazepines	89.5	232,894	S1b	87.2	-2.3	2,932	S1b	90.7	1.2	6,338	S1b	94.4	4.9	8,433
A	S1c	Avoid chronic use of: skeletal muscle relaxants	97.0	232,894	S1c	97.8	0.8	2,932	S1c	97.3	0.3	6,338	S1c	94.1	-2.9	8,433
F	S1d	Avoid chronic use of: "Z" drugs	97.3	232,894	S1d	96.3	-1.0	2,932	S1d	98.0	0.7	6,338	S1d	96.6	-0.7	8,433
E	S1e	Avoid chronic use of: barbiturate	99.7	232,894	S1e	99.6	0.0	2,932	S1e	99.7	0.1	6,338	S1e	99.9	0.3	8,433
T	S1f	Avoid chronic use of: any of above	81.3	232,894	S1f	80.2	-1.1	2,932	S1f	83.6	2.3	6,338	S1f	84.5	3.2	8,433
Y	S2a	Avoid combined use of any CNS drugs above	97.1	196,364	S2a	97.5	0.4	2,636	S2a	97.9	0.9	5,704	S2a	97.2	0.1	7,361
	S2b	Avoid combined use of opioids and benzodiazepines	98.7	196,364	S2b	99.1	0.4	2,636	S2b	99.0	0.3	5,704	S2b	99.4	0.8	7,361
	S3	Avoid NSAIDS if using anticoagulant	93.9	6,359	S3	95.3	*	*	S3	96.7	*	*	S3	88.5	-5.4	148
	S4	Avoid anticholinergics if dementia	85.0	1,885	S4	83.3	*	*	S4	87.0	*	*	S4	72	-13.3	*
	S5	Avoid fluoroquinolones as initial antibiotic in elderly	85.3	21,826	S5	89.3	4.0	355	S5	86.8	1.5	667	S5	81.7	-3.7	453
	S6	Rx for naloxone if chronic Rx opioid use	14.0	15,747	S6	16.4	*	140	S6	19.2	*	364	S6	18.3	4.3	415
	S7	Avoid high risk drugs in the elderly	91.0	101,978	S7	91.4	0.4	1,554	S7	92.1	1.1	3,044	S7	87.5	-3.5	2,789
	S8a	If Rx for buprenorphine for OUD, avoid other Rx opioids	93.6	1,645	S8a	100	*	*	S8a	>98	*	*	S8a	96	*	*
	S8b	If Rx for buprenorphine for OUD, avoid benzodiazepines	77.0	1,645	S8b	100	*	*	S8b	>98	*	*	S8b	86	*	*
E	E1	Adherence with anticoagulants	73.7	9,596	E1	69.6	*	158	E1	73.6	*	288	E1	75.6	1.9	205
F	E2	Adherence with metformin	69.9	8,863	E2	64.2	-5.7	109	E2	71.1	1.2	277	E2	62.1	-7.8	441
F	E3	Adherence with antidepressants	81.4	40,760	E3	82.2	0.8	590	E3	82.9	1.5	1,252	E3	69.5	-11.9	1,247
E	E4	Adherence with cholesterol medication	82.3	33,752	E4	85.6	3.3	452	E4	84.9	2.6	976	E4	70.0	-12.3	1,509
C	E5	Adherence with controller inhalers	49.8	9,509	E5	51.6	1.8	157	E5	50.8	1.0	335	E5	45.8	-4.0	432
T	E6	Adherence with antihypertensives	84.2	68,180	E6	86.0	1.8	1,006	E6	85.4	1.3	2,031	E6	77.9	-6.3	3,016
I	E7	Adherence with buprenorphine/nlx for OUD	86.0	1,328	E7	100.0	*	*	E7	88.0	*	*	E7	92	6.2	77
V	E8	Statin use in diabetes	80.1	24,495	E8	84.5	4.4	277	E8	84.3	4.2	745	E8	81.7	1.6	1555
E	E9	Use of long acting inh if multiple rx for inh albuterol	56.8	3,716	E10	64	7.2	50	E10	66	9.5	89	E10	58.9	2.0	231
E	C1	Care coordination: patients with 5 or less total prescribers	75.3	232,894	C1	65.6	-9.7	2,932	C1	70.7	-4.6	6,338	C1	67.5	-7.8	8,433
F	C2	Polypharmacy: patients with less than 10 unique rxs	93.2	182,307	C2	91.9	-1.3	2,535	C2	93.7	0.5	5,413	C2	87.3	-5.9	7,029
F	C3	Overall generic utilization rate	89.7	12,986,067	C3	86.9	-2.8	181,745	C3	88.9	-0.8	339,433	C3	91.6	1.9	549,046
I	C4	Use of generics: oral antidiabetic medication	81.1	245,199	C4	65.6	-15.5	2,538	C4	82.7	1.7	6,492	C4	84.6	3.5	16,169
C	C5a	Use of generics: mental health - antidepressants	98.9	784,068	C5a	96.2	-2.7	10,611	C5a	99.2	0.3	23,410	C5a	99.9	1.0	32,253
I	C5b	Use of generics: mental health - antipsychotics	97.4	167,284	C5b	98.5	1.1	789	C5b	98.3	0.9	3,600	C5b	97.0	-0.3	9,120
E	C6	Avoiding low value drugs: rate per 10,000 rxs	95.6	12,986,067	C6	94.4	-1.2	181,745	C6	92.9	-2.7	339,433	C6	92.5	-3.1	549,046
N	C7	Avoiding Use of erythropoietin: rate per 100,000 rxs	95.7	12,986,067	C7	90.0	-5.7	181,745	C7	90.9	-4.7	339,433	C7	96.7	1.0	549,046
T																

Project Timeline

Oct 2019

- **Funding Received**
- **Call for applications**
- **APCD Data Acquisition**
- **Data Analysis**

Feb 2020

- **Kickoff mtg**
- **S-E-E data provided**
- **Provider self-efficacy**
- **Practice Facilitation**
- **Patient Advocate Incorporated**

May 2020

Learning Collaborative

Initial PDSA/Project Plan

Aug2020

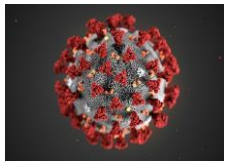
Learning Collaborative

Barriers Encountered

Nov 2020

Learning Collaborative

Patient engagement



**Covid-19 resulted in 1 month pause April*

February 2021 Learning Collaborative

- Storyboard Results sharing
- Sustainability and spread
- Provider self-efficacy

Participating Practices: Medication Safety/Deprescribing

Practice Site	Pharmacist Lead	Provider Champion(s)	Project Focus
Anchor Medical	Kenny Correia	Diane Siedlecki	Benzodiazepines
Brown Medicine	Angel Pechie	Francis Basile	Opioids
Coastal Medical	Joseph Bizier	Matthew Propert	Benzodiazepines
University Internal Medicine	Cristina Santos	Derrick Robinson	High Risk Medications in patients > 65 years old

Participating Practices: Chronic Condition/Med Adherence

Practice Site	Pharmacist Lead	Provider Champion(s)	Project Focus
CNEMG- Pawtucket (Integra)	Ronald Tutalo	Rabin Chandran Katrina Roy	COPD/Asthma
Medical Associates of Rhode Island	Alex Pease	Leslie Mohlman	Hypertension
Providence Community Health Center	Lillian Nieves	Nadine Hewamudalige	Depression

Lessons Learned:
Using Data to Drive Decisions

1. Pharmacists help update and enhance existing practice reports
2. Data helps with project selection but didn't always target the correct population
   - Time spent chart reviewing for inclusion was often excessive
   - Provider referrals or alternate workflows (eg: refill requests) yielded a more appropriate population

Lessons Learned: Patient Engagement

1. Education pieces about medication safety needed to focus on patient impact and quality of life
   - Benzos: Impact to personal life if a fall/accident
   - Opioids: Lack of confidence in managing pain w/o meds. Coping and mindfulness skills were needed.
2. Patient barriers need to be considered
   - Access to medications is an issue
   - Perceptions about disease state exist and can result in non-adherence
3. Age was broadened to 55+ in order to initiate high risk med conversations earlier

Lessons Learned: Sustainability and Spread

1. Regular provider-pharmacist communication helped
   - Participation in provider meetings
   - Leading educational/didactic sessions
2. Relationships with other healthcare team members were enhanced (eg: NCM, BH, etc)
3. Capacity issues exist for pharmacists
   - Leveraging other practice resources is important for non-clinical work (eg: scheduling appointments, administrative functions, etc).

PROVIDER HIGHLIGHTS: What have you learned from the Pharmacy QI Initiative?

"Medication management is way harder than I had originally thought."

"Many medications that patients have been on for years can be harmful as they age (more aware of this than previously)."

"The value of collaborative care with our pharmacists."

"Prescribing without a behavioral health referral is unlikely to lead to adherence early on. There should be a better way of deciding with patients if they are really ready to try medication..."

"It has helped because I am not alone in explaining things to patients."

PROVIDER HIGHLIGHTS: What have you learned from the Pharmacy QI Initiative?

“Think before you prescribe.”

“I've learned how difficult it can be to overcome health care system barriers- for clinical teams to opt to NOT change even if the current practices do not show good or optimal results.”

“Patients who have in trust their provider are more likely to agree and implement deprescribing.“

“It certainly has helped improve a team approach to work.

“It was my first attempt on working in a quality initiative. I learned a lot! Especially, to create and recreate workflows along the way to streamline processes and optimize time with patients.”

“Closer teamwork with pharmacists and behavioral health continues to take stress and frustration out of my day.“

PROVIDER HIGHLIGHTS: How has this project impacted the patient?

“It has improved compliance and education.”

”Positively for sure. I don't think every patient was going to be adherent, but I'm sure this helped some patients get benefits from the medication.”

“It has helped patients have a better understanding of their medications and has helped some patients stop or avoid starting on higher-risk medications.”

“Patients are happy with the project which makes me feel satisfied.”

“Patient satisfaction is really high! The patients always had time to do a quick medication check and were really happy to reconnect with IBH and PCP teams for timely follow-ups. The patients always expressed their appreciation for our genuine interest on their health and well-being.”

What does “good” look like?

Projects selected by practices are medication focused

- Selected based on data, practice needs, and opportunities

Improve patient medication management

- Understand **voice of the patient** prior to and during intervention
- Align with **safe, effective, efficient** medication management

Enhance the role of the pharmacist in teams

- Leverage members of the practice to assist in the project (NCM, IBH, MA)
- Develop pharmacist-prescriber Collaborative Practice Agreements, if appropriate

Measure results and project impact

Share barriers encountered and lessons learned

Kudos to the sponsors and all the pharmacist leaders involved!

Kenny Correia
Anchor Medical

Angel Pechie
Brown Medicine

Joseph Bizier
Coastal Medical

Ron Tutalo
CNEMG/Integra

Alex Pease
MARI

Lillian Nieves
PCHC

Cristina Santos
UIM

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

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)

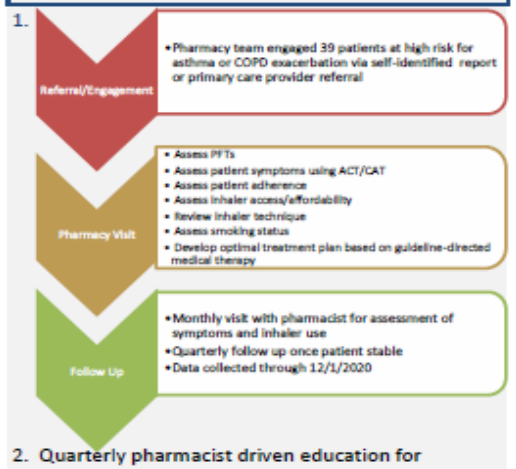
3. # of exacerbations, hospitalizations, and emergency department visits

4. # of pharmacist interventions resulting in an inhaler change

5. # of patient and pharmacist encounters (in-person, virtual/telephonic)

Methods

1.

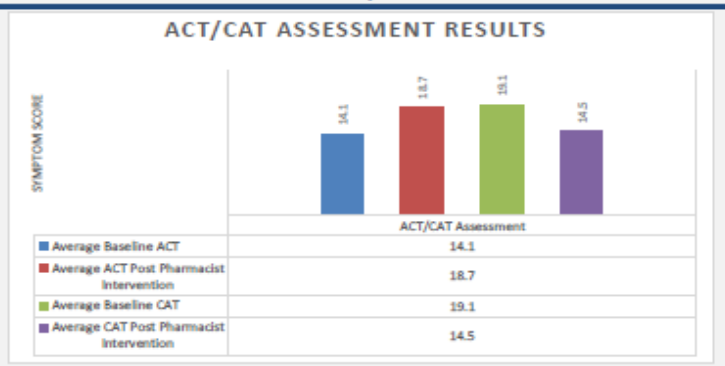


2. Quarterly pharmacist driven education for physicians on practice guidelines, appropriate inhaler technique, and QI project progression

3. Acknowledge Brianna Kimball, PharmD and Alex Gianfrancesco, PharmD for contributions to this project

STUDY

Outcomes/Results



Average Baseline ACT	14.1
Average ACT Post Pharmacist Intervention	18.7
Average Baseline CAT	19.1
Average CAT Post Pharmacist Intervention	14.5

- Hospitalizations year prior to pharmacy intervention: 2
- Emergency Department visits year prior to pharmay 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 (Today): _____

CAT/ACT Score (Last Pharmacy Visit _____): _____

LIST OF YOUR INHALERS:

MAINTENANCE INHALERS:
Use daily for maintenance of breathing symptoms

RESCUE INHALERS:
Use as needed for shortness of breath

FOR MORE INFORMATION:

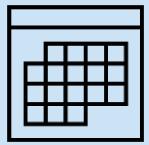
Please visit www.copdfoundation.org

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

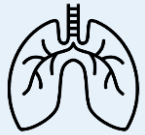
RESULTS

39
Patients

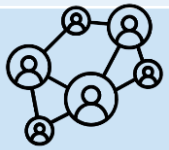
130
total months

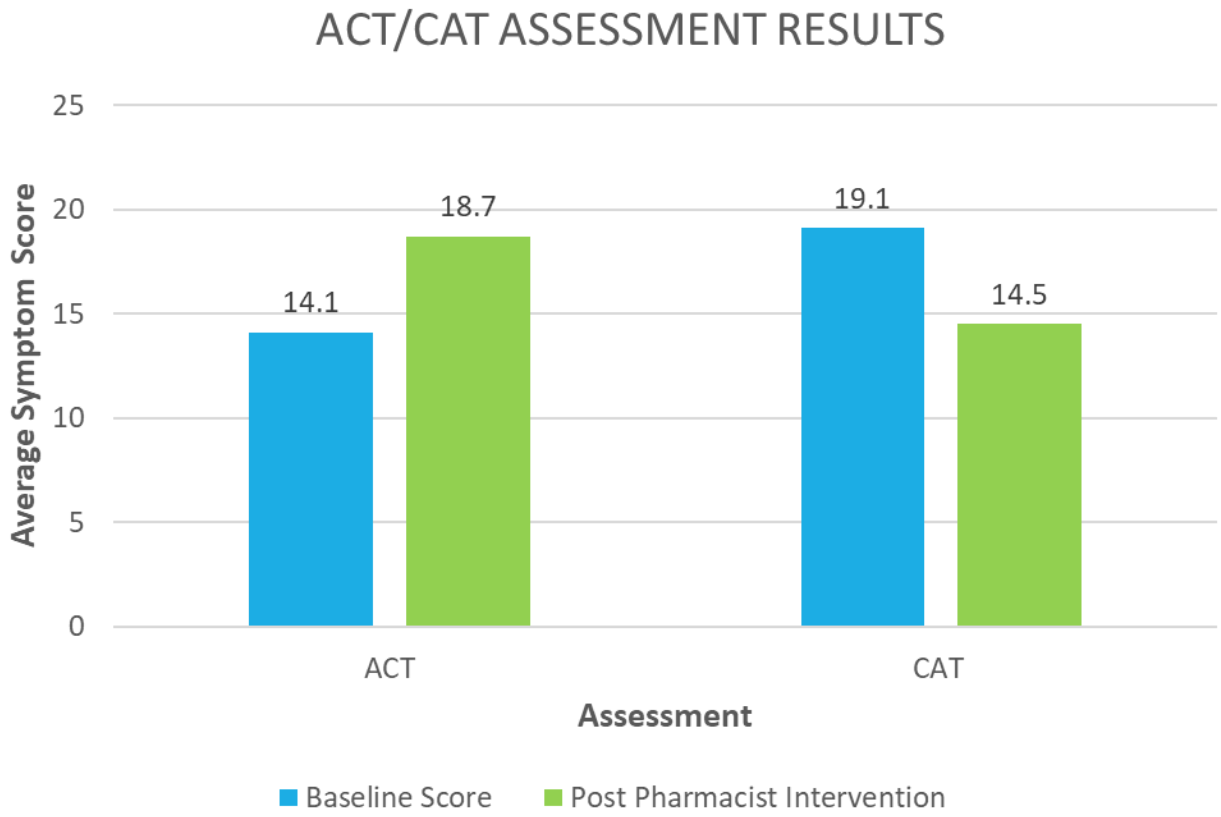


65
Pharmacist-facilitated inhaler changes



116
Pharmacist-patient encounters





Utilization	Prior	Post
Hospitalizations	2	0
ED visits	11	0
Exacerbations	26	5

Lessons Learned from Patients

- Inhaler access is a real problem
- Inhaler technique has room for improvement
- Appropriate inhaler selection contributes to positive outcomes
  - Medication class
  - Device/delivery system

Sustainability

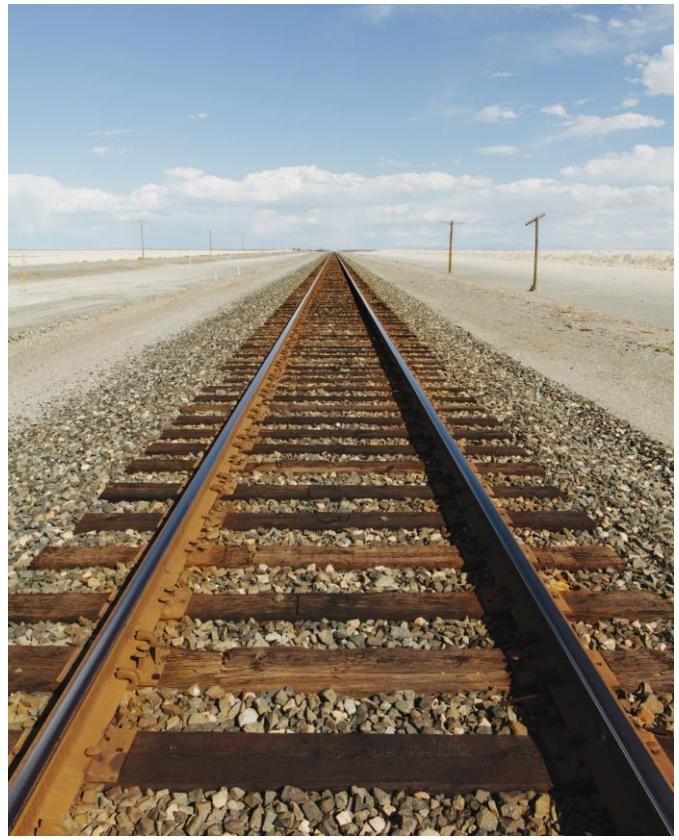
- Implementation of a regular cadence of provider communication enhanced pharmacist collaboration
- Workflows are being refined to:
  - Use practice resources for scheduling appointments
  - Formalize follow up structure and plan to enhance pharmacist capacity
- Collaborative practice agreement is in development

What's on the Horizon?

Pharmacy QI Learning Collaborative

Focus: Reducing ED/Hospitalizations

- Hypertension
- Diabetes
  - Short-term complications
  - Long-term complications
- COPD/Asthma
- Heart Failure
- Community Acquired Pneumonia
- Urinary Tract Infections



Call for applications due April 16, 2021!

Questions & Discussion

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

Call for Applications: Pharmacy Quality Improvement Initiative Reducing Preventable Hospitalizations and Emergency Department Usage through Team-Based Care

Step	Activity	Date
1	Call for Applications released : Click here	Friday, March 12th
2	Conference call with interested parties to answer any questions. Join Zoom Meeting https://ctc-ri.zoom.us/j/4665707463?pwd=V2huN0VDSmtrTUY4TTNQZi9iRHZ2dz09 Meeting ID: 466 570 7463 Passcode: 646876	April 1, 2021 12-1pm April 7, 2021 8-9 am
3	Submit Letter of Intent (optional) to: deliverables@ctc-ri.org	Friday, April 2nd
4	Submit application electronically to: deliverables@ctc-ri.org	Friday, April 16th
5	Notification will be sent to practices	Friday, April 30th
6	Teams submit W9 and Participatory Agreements	Monday, May 10th
7	Orientation Kick Off meeting for newly selected practices	Thursday, May 20th (7:30-9:00am)

Upcoming meetings:

- **CTC-RI Clinical Strategy Committee Meeting:**
  March 19, 7:30-9:00 am
- **CTC-RI Community Health Team Oversight Committee Meeting:**
  March 26, 9:00-10:00 am
- **Pediatric Alternative Payment Model Learning Session:**
  March 31, 6:00-7:30pm
- **Breakfast of Champions:**

  June 11, 7:30-9:00am

Evaluation and CME Credits

CTC-RI may be able to offer CME credit for this meeting. If you are interested in CME credits, **complete the evaluation and request credits in the last question.** Thank you!

www.surveymonkey.com/r/MarchBOC

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE