**CARE TRANSFORMATION COLLABORATIVE (CTC)**

**COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK**

**Consisting of 10 pages**

**Pharmacy Quality Improvement Initiative**

**Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Introduction/Purpose**

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 join a pharmacy quality improvement initiative. UnitedHealthcare and the Rhode Island Department of Health are providing financial support for this initiative.

Your practice is receiving funding to support your 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.

**Strategic Goals:**

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 Ambulatory Blood Pressure Monitoring (ABPM) or professional continuous glucose monitoring (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, ACO measures, and statewide efforts to improve quality and optimize care for populations at risk.

**Pharmacy Quality Improvement Initiative Objectives:**

1. 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;
2. 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;
3. Improve provider and practice team wellbeing through effective use of high function team based care;
4. Improve patient access to care and patient outcomes through pharmacy practice facilitation support, peer learning opportunities, and applied team-based performance;
5. 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;
6. Understand and incorporate “what matters most to the patient” as part of performance improvement plan;
7. 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;
8. Demonstrate the benefit of a pharmacy led quality improvement initiative;
9. Inform payers and policymakers regarding best practices for use of these modalities.

**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 $40,000, in three installments, that 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 University of Rhode Island, College of Pharmacy;
* 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.

Assumptions:

* Systems of care will provide practices with IT support needed to effectively participate in the Pharmacy Quality Improvement Initiative.

**Practice Responsibilities and Requirements:**

**24 Month Responsibilities**

Practice QI 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;
* Attends quarterly learning collaborative meetings;
* Collect and report qualitative and quantitative data as specified in the Appendix B: Measurement and Reporting.

**4 Month Preparation Period (August – November 2022): Identification and Planning for What Matters Most to the Practice/SOC and What Matters Most to the 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 by Nov 23, 2022;
* Presents performance improvement plan at quarterly meeting.

**QI Implementation and Evaluation Phase (Performance Period December 2022 to July 2023)**

Practice QI team:

* 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.);
* Submit updated PDSA by February 14, 2023;
* Attend quarterly learning collaborative and present QI work plan with content expert as applicable on February 28, 2023;
* Obtain input from patients/care team for qualitative measures by March 2023;
* Submit updated PDSA including patient engagement and care team engagement data, key findings and adjustments necessary to project plan by May 9, 2023;
* Attend quarterly learning collaborative learning collaborative and present QI work plan with content expert as applicable on May 23, 2023;
* Submit updated PDSA by August 8, 2023;
* Attend quarterly learning collaborative learning collaborative and present QI work plan with content expert as applicable on August 22, 2023;
* Identify plan to spread services to other providers/practices or offer to other populations of focus;
* Determine who’s being missed by current workflow;
* Obtain input from patients/care team for qualitative measures by September 2024.

**QI Spread and Sustainability Phase (September 2023-July 2024)**

Practice QI team:

* Develop plan for spread and sustainability based on risk stratification and gap analysis results;
* Submit PDSA with year 1 results and plan for spread and sustainability plan including risk stratification by November 14, 2023;
* Attend Quarterly learning collaborative: present QI work plan on November 28, 2023;
* Submit updated PDSA including patient engagement and care team engagement data, key findings and adjustments necessary to project plan by February 13, 2024;
* Attend Quarterly learning collaborative: present QI work plan on February 27, 2024;
* Obtain input from patients/care team for qualitative measures by March 2024;
* Submit updated PDSA by May 7, 2024;
* Attend Quarterly learning collaborative: present QI work plan on May 21, 2024;
* Obtain input from patients/care team for qualitative measures by June 2024;
* Submit final Storyboard by July 16, 2024;
* Attend Final Learning Collaborative on **July 30, 2024.**

*See Appendix A for Milestone Document of deliverables and due dates. CTC-RI reserves the right to change the above dates at their discretion.*

**Practice Compensation:**

Deliverable-dependent practice infrastructure payments of up to $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. The $40,000 of financial support will be paid out based on the following criteria being met:

* $15,000 with execution of the Participative Agreement and team participation in the kickoff meeting (August 2022);
* $20,000 at the end of year-one and all deliverables/outcomes have been achieved for the first year (August 2023);
* $5,000 at the end of the QI initiative and all deliverables/outcomes have been achieved for the program (August 2024).

Care Transformation Collaborative of RI Practice name:



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Signature: Debra Hurwitz, Signature of authorized staff:

Executive Director, CTC-RI Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Positon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix A: PHARMACY QUALITY IMPROVEMENT MILESTONES SUMMARY DOCUMENT

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

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

**Appendix B: Measurement and Reporting**

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

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

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

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

Open ended items:

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

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

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

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

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

|  |  |
| --- | --- |
| **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.