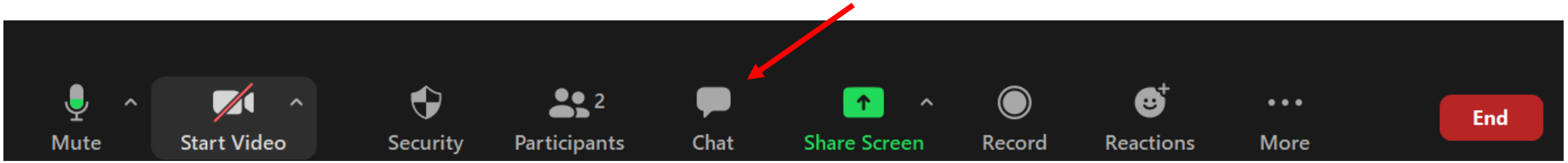
Pharmacy Quality Improvement Initiative Learning Collaborative -August 19, 2021

CARE TRANSFORMATION COLLABORATIVE OF R.I.

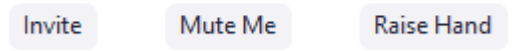
Zoom

Welcome! Please Chat in:

- Your Name and Organization



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



Agenda:

- Welcome & Introductions
- Review of PDSAs
  - What challenges did you face?
  - What changes are you making to overcome them?
- Preliminary Well-Being Survey Results
- Next Steps

Coastal Medical

Improving the Quality of Care and Reducing the Cost of Care for Patients with Heart Failure through Pharmacist Intervention

AIM

- Goal is to reduce emergency department and inpatient hospital utilization for our patients with heart failure to a level below the average of the Rhode Island systems of care. Specifically, we will aim to reduce inpatient utilization by 10% for patients enrolled and followed on remote patient monitoring for CHF. Through reduced utilization we aim to achieve direct and indirect cost avoidance of $2.2 million in this population.

Baseline DATA

- 2019 data for Coastal Medical's heart failure population:
- 17.9% emergency department utilization
- 14.9% inpatient hospitalizations
- 2019 average data for Rhode Island systems of care:
- 17.5% emergency department utilization
- 14.2% inpatient hospitalizations.
- Patients enrolled in RPM for CHF 226 (as of April 30, 2021)

Patient Engagement Strategy

- To reduce unnecessary utilization in our CHF population, we aim to increase patient engagement with the heart failure care team through enrollment in a remote patient monitoring program.
- Patients will obtain or be provided with equipment such as scales and blood pressure cuffs.
- Patients will be surveyed to understand their experience with remote monitoring programs.

Coastal Medical Lifespan

WHAT CHALLENGES ARE YOU FACING?

- Technology issues
  - Patients unable to use the portal
  - Patients without smart phone or computer
- Patient engagement
  - Enrolling patients into program
- Coordination with outside cardiology

WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?

- Technology
  - Coordinating with family members and caregivers
  - Patients can call in home measurements to designated phone line
- Engagement
  - Framing of program and applet as a way to directly reach care team members
  - Added “nudging” into workflow for those enrolled, but not fully engaged in program
- Coordination
  - Leverage new relationship with Lifespan
  - Target practices with clinical pharmacists in place

RIPCPC

Care Team Management of Patients with Diabetes to Reduce Preventable Ed/Inpatient Hospital Utilization

AIM

- To evaluate and implement a standardized workflow addressing patients with emergency department visits and/or hospitalizations related to diabetes short and long term complications with a goal of reducing preventable visits

Baseline DATA

37 patients for a total of 39 visits evaluated (60 days prior)

Type	Inpatient	ED
Hyper	7	19
Hypo	6	7
Total	13	26

Patient Engagement Strategy

- Care team members are contacting patients telephonically to assess reasons for ED/IP utilization. Education regarding appropriate ED/IP utilization is being conducted and the care team is intervening where appropriate. Qualitative patient case studies will be used to inform the project. Quantitative patient experience surveys will be used to evaluate the success of interventions.

RIPCPC

WHAT CHALLENGES ARE YOU FACING?

- Inability to have a designated point person in ED at Kent
- Lack of consistent messaging
- Correlation of blood glucose goals to A1c (age dependent)

WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?

- Manual review of Kent patient tracking (time consuming but providing data)
- Established team (nurse, pharmacist and social worker representatives) to review all patient education materials and standardize
- Approval of standardized blood glucose goals by Dr. Chen and pharmacy committee

Women Medicine Collaborative

Reducing hypertension ED visits by optimizing blood pressure control among women in a primary care practice

AIM

- We hope to achieve our goal of 82% clinic-wide hypertension control by creating a pharmacist and nurse-care manager driven home blood pressure monitoring program. We aim to do this by enrolling 50 patients into our home blood pressure monitoring initiative over the next 12 months.

Baseline DATA

- As of 7/1/21, 61% of our patients with hypertension have achieved blood pressure control (918 out of 1514). The remaining 596 patients either have a most recent blood pressure reading that is not at goal of <140/90, or do not have a recorded blood pressure measurement in 2021.

Patient Engagement Strategy

- 1) Identify appropriate candidates for intervention (identified by providers during monthly high-risk quality huddles as well as with office manager who has been working with hypertension quality).
- 2) Pts identified as candidates for home blood pressure monitoring are referred to RN/RPh for education and set up with BP monitoring program
- 3) Based on insurance benefits, pt either to obtain home BP cuff (if covered as benefit) or will receive loaner cuff
- 4) Follow up established (either phone or portal) 2 weeks following education visit
- 5) Continued follow up q2-4 weeks until average BP <140/90 achieved (maximum follow up: 12 weeks)

WMC: Project Challenges

WHAT CHALLENGES ARE YOU FACING?	WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?
Low inventory of BP cuffs currently	Utilize anticipated funding towards additional BP cuffs Maximize use of insurance benefits
Maintaining inventory and ensuring prompt return of cuffs	Secure storage of BP cuffs Establish patient-signed contract Consider implementing penalties for nonreturned cuffs Create tracking sheet with due dates
Calling patients for home BP readings is time consuming	Optimizing use of technology patient outreach strategy Enlist help of other staff members
Maintaining organization of data/file sharing among individuals involved	Use of live, secure shared documents (e.g. Microsoft Sharepoint)

Thundermist Health Center

Decreasing ED visits and hospitalizations associated with short-term and long-term diabetes complications through the use of team-based care.

AIM

- Primary Aim: Decrease ED and hospitalizations due to short-term and long-term diabetes complications by 25% by 4/2022 using team-based care.
- Secondary Aim: Achieve A1c <9% for 73% of patients using team-based care by 7/2022

Baseline DATA

- The following fields will exist on this report with a lookback period of >= 3/1/2019:
  - Date and reason for IP/ED/Urgent Care visits
  - Date of referral to endocrinology
  - Date of most recent assessment for hypoglycemia and/or hyperglycemia

Patient Engagement Strategy

- NCMs will generate an automatic referral to clinical pharmacy for new ED visits and hospitalizations related to short-term or long-term DM complications. Referral will be sent to clinical pharmacist (via Telephone Encounter in eCW) regarding referral and clinical pharmacist will outreach patient to schedule visit.

Thundermist- Challenges

WHAT CHALLENGES ARE YOU FACING?

- Patient engagement (loss to follow up, not patient's top priority, complex care needs) and barriers (financial, housing)
- Low healthy literacy - lifestyle, condition, ED utilization
- Insufficient data collection due to coding issues – first report did not accurately pull ED/hospitalizations that relate to short-term/long-term diabetes complications

WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?

- Identify the "why" and expand resources to social services, community health team, behavioral health, visiting nurse practitioner, etc. Telemedicine has helped.
- Re-educating in a manner that matches the patient's health literacy and that meets patient's interests (time, gratification)
- Running a new report with different fields to capture the intended target population

Medical Associates of RI

Pharmacist-directed 24-hour ambulatory blood pressure monitoring in a high-risk population

AIM

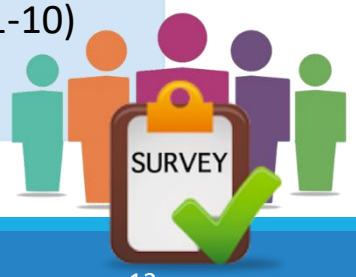
- Complete initial ABPM study for 50 patients in the target population by end of December 2021. Achieve individualized blood-pressure goal in 75% of targeted patients by end of March 2022.

Baseline DATA

- Practice-wide admissions for HTN and related conditions (last 12 months); admissions history for identified patients (last 24 months); initial BP for identified patients

Patient Engagement Strategy

- **<u>Three-question exit survey:</u>**
- 1) ABPM helped my provider better manage my blood pressure (1-10)
- 2) I am confident that my blood pressure is well-controlled (1-10)
- 3) I am confident in my ability to be an active part of my blood pressure management (1-10)



24-hour ABPM in high-risk patients

WHAT CHALLENGES ARE YOU FACING?

- Establishing inclusion criteria
  - What defines “high-risk” as it relates to blood pressure management?
- Identifying data sources
  - Utilization reports
  - Payor and/or practice identification
- Evaluating patient identification workflows
  - Provider referrals
  - Document handling (TOCs, etc.)
  - Data mining

WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?

- Maximize current systems
  - Utilize existing high-risk coding system
  - Leverage established workflows
    - 5+ referrals per week since program inception (Feb 2021)
    - NCMs also touch all TOC documents
- Minimize redundant work
  - Avoid report-based identification and enrollment
    - Reconsider if workflow does not yield appropriate patients

Providence Community Health Center

Decrease ER/IP Pediatric Asthma related admissions from patients at Capitol Hill

AIM

- Goal is for pharmacy interventions at the Capitol Hill PCHC clinic high-risk pediatric asthma population to yield a reduction in ED utilization. The pharmacist will meet with the identified pediatric population who had an emergency room or inpatient admission as identified in RIQI dashboard for intervention opportunities.

Baseline DATA

- RIQI Asthma and airway reactive disease retrospective report of patients who has an emergency room and inpatient admission in the past 6 months n=61

Patient Engagement Strategy

- Parent/guardian and patient outreach, education, pharmacy consults that include motivational interviewing to identify barriers and unmet needs. Shared decision making will be employed to increase patient and family engagement.

PCHC- Challenges

WHAT CHALLENGES ARE YOU FACING?

- Administered survey to 10 patients as a test run
- Some parents/guardians unaware of child diagnosis
- Asthma control test administered at the beginning, middle or end of survey
- Asthma control test is difficult to administer telephonically
- Time survey took to complete (18-20 minutes)

WHAT CHANGES ARE YOU MAKING TO OVERCOME THEM?

- Retired pediatrician performing chart reviews for diagnosis accuracy
- Asthma control test worked best administered at the end of survey but still difficult.
- Removed asthma control test from survey
- Decreased survey administration time by 50%.
- Survey take 8 - 10 minutes to complete now

Anchor Medical Associates

Pharmacist Managed Remote Patient Monitoring for high risk Heart Failure patients

AIM

- Goal is to enroll at least 20% of our patients with an active diagnosis of heart failure that are engaged with our nurse care management program in a remote patient monitoring program (RPM) that were not already engaged with palliative/hospice care by the end of 2021.

Baseline DATA

- Total of 293 high risk patients as a possible diagnosis of heart failure from our high-risk panel.
- Total of 298 ER visits and admissions in this 293-patient cohort.
- After completing chart reviews and discussions with patient primary care providers, 215 of the 293 were found to have an active dx of heart failure.
- Excluded patients that were active under palliative care and/or hospice care. This left 209 patients that we would outreach to offer the RPM tool.
- These 209 patients represented 196 of the prior years ER visits and admissions.

Patient Engagement Strategy

- During the month of July, we focused on outreach to patients to offer the RPM tool. Patients were contacted either by phone, mail and/or electronic portal messages. During the month of July, we were able to outreach to 90 patients. The importance of daily weight monitoring and the role of symptom monitoring for heart failure was reviewed with 88 of the 90 patients.

Well-Being Survey

Preliminary Well-Being Survey Results

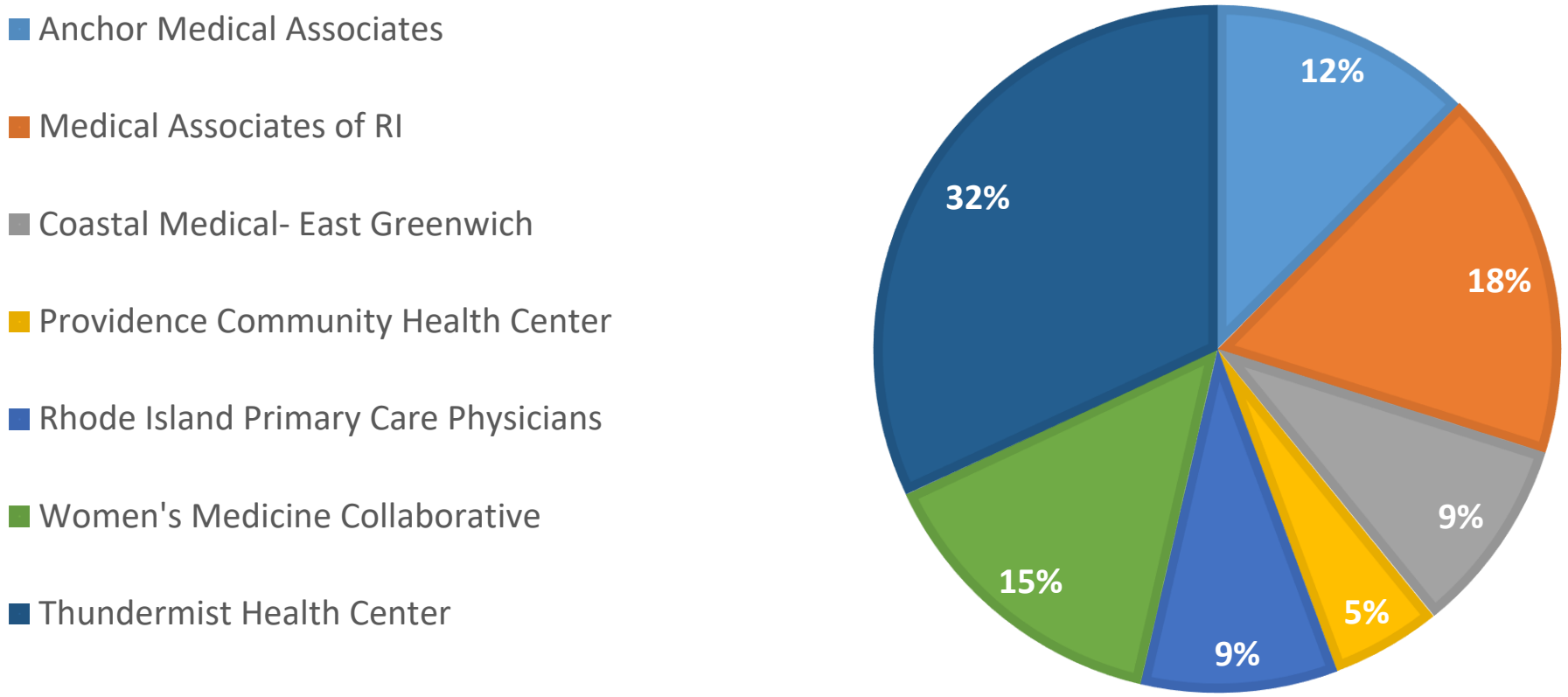
Years of Experience
- 0-5 years | 19%
- 6-10 years | 21%
- 10-15 years | 27%
- 15+ years | 33%

Total Survey Respondents

Provider Role
- Medical Assistant|5%
- Nurse Care Manager| 8%
- Nurse Practitioner| 7%
- Pharmacist| 19%
- Physicians | 28%
- Physician Assistant| 3%
- Practice Manager| 3%
- Other | 27%

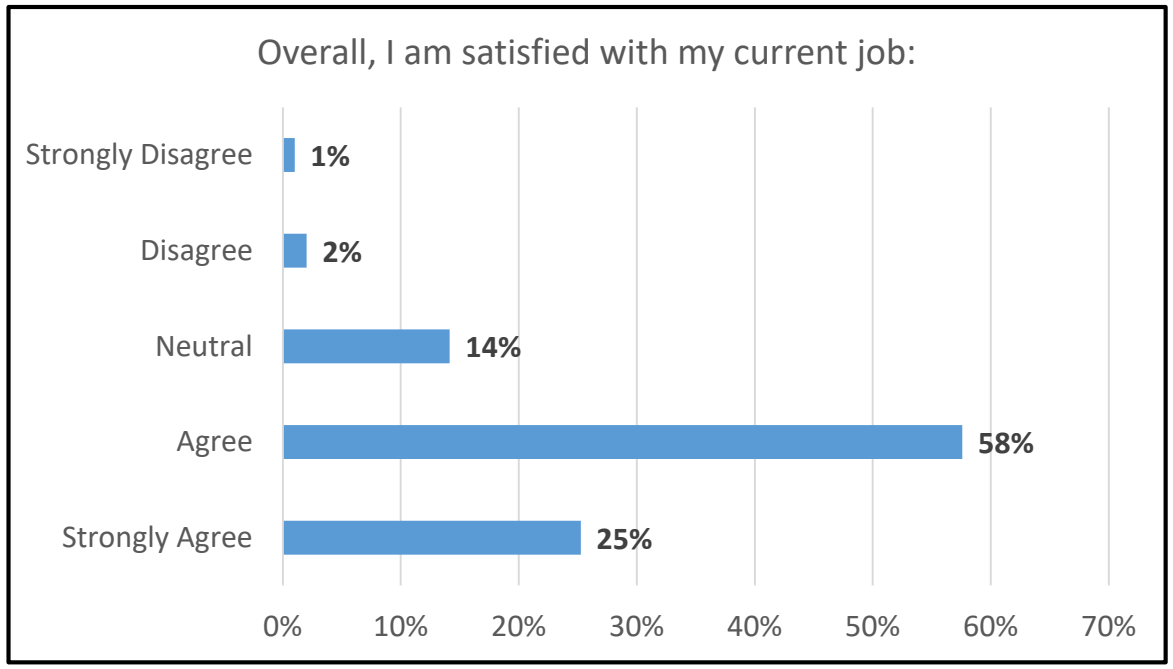
Gender
- Woman| 80%
- Man| 19%
- Prefer not to say| 1%

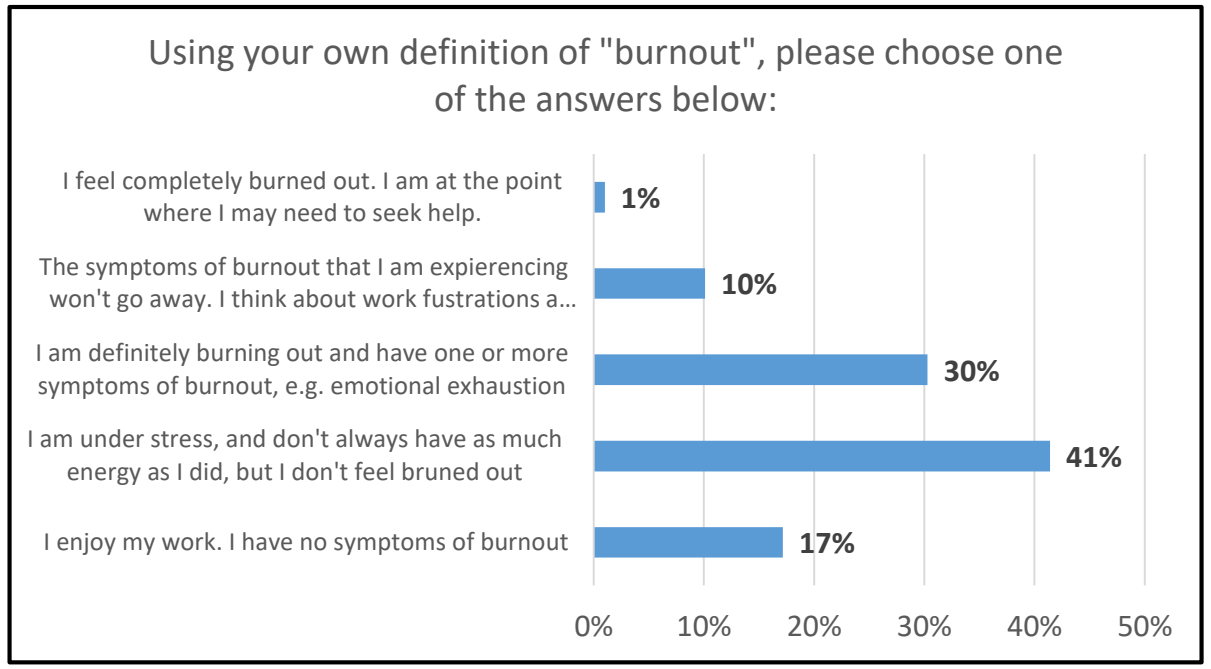
Respondents by Practice

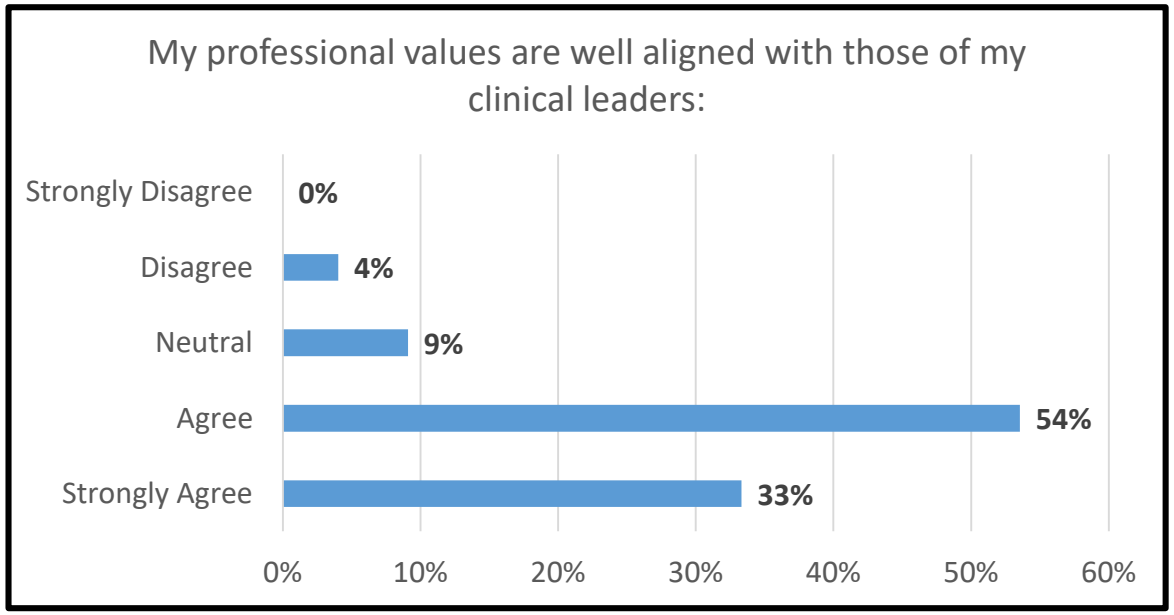


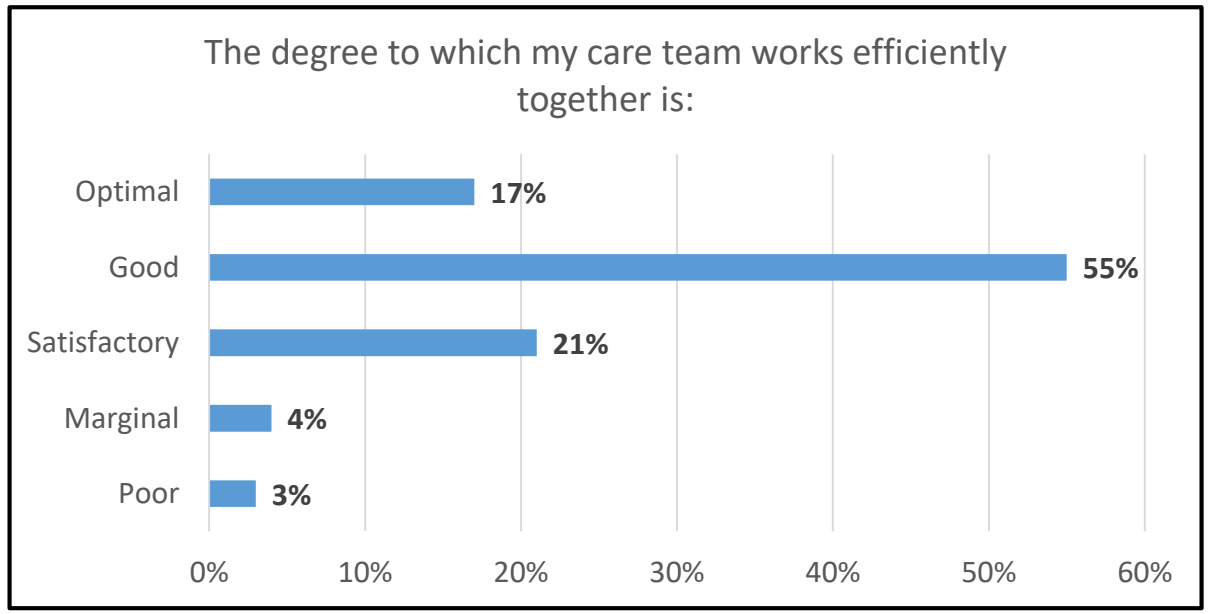
Well-Being Survey Highlights

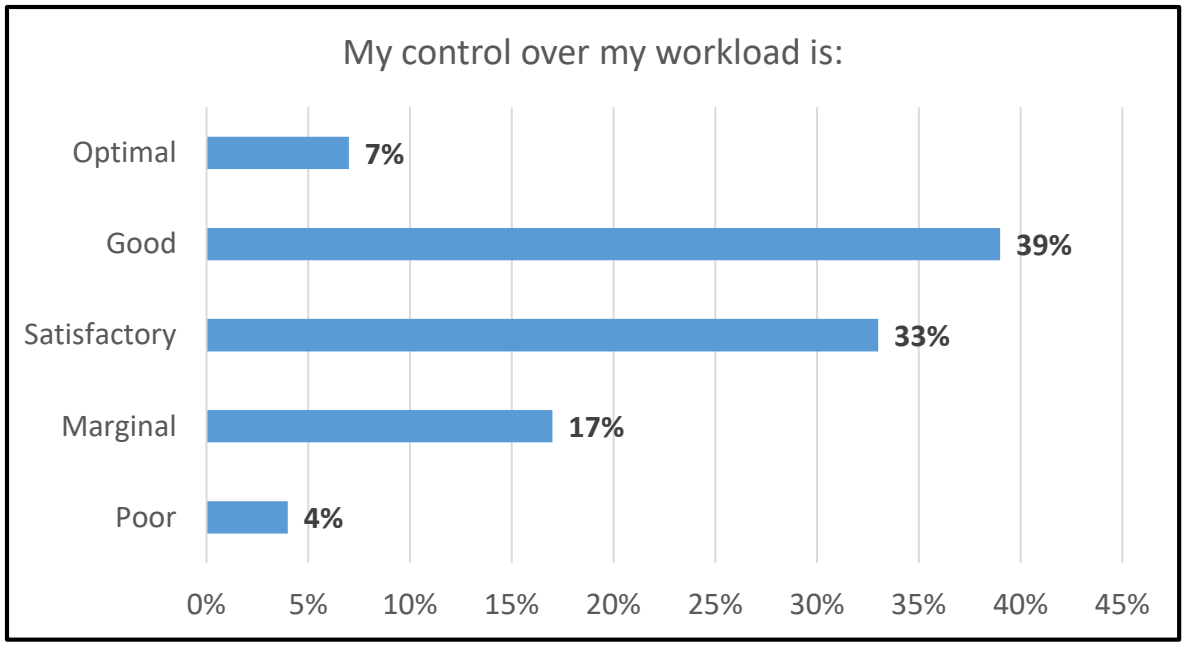
- 58% of respondents agree that they are satisfied with their current jobs
- 41% of respondents state “I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.”
- 31% of respondents spend a moderately high amount of time working on the EHR at home
- 62% of respondents noted they have a busy, but reasonable atmosphere at work

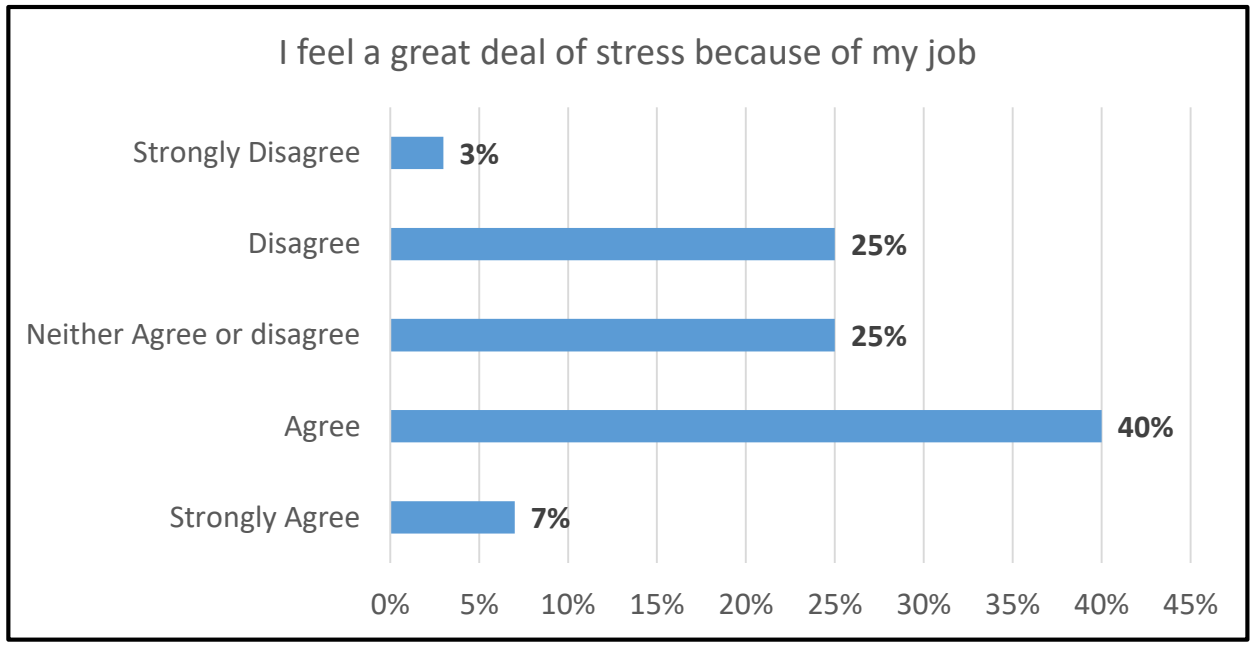

Overall, I am satisfied with my current job:
Strongly Disagree
1%
Disagree
2%
Neutral
14%
Agree
58%
Strongly Agree
25%
0%
10%
20%
30%
40%
50%
60%
70%

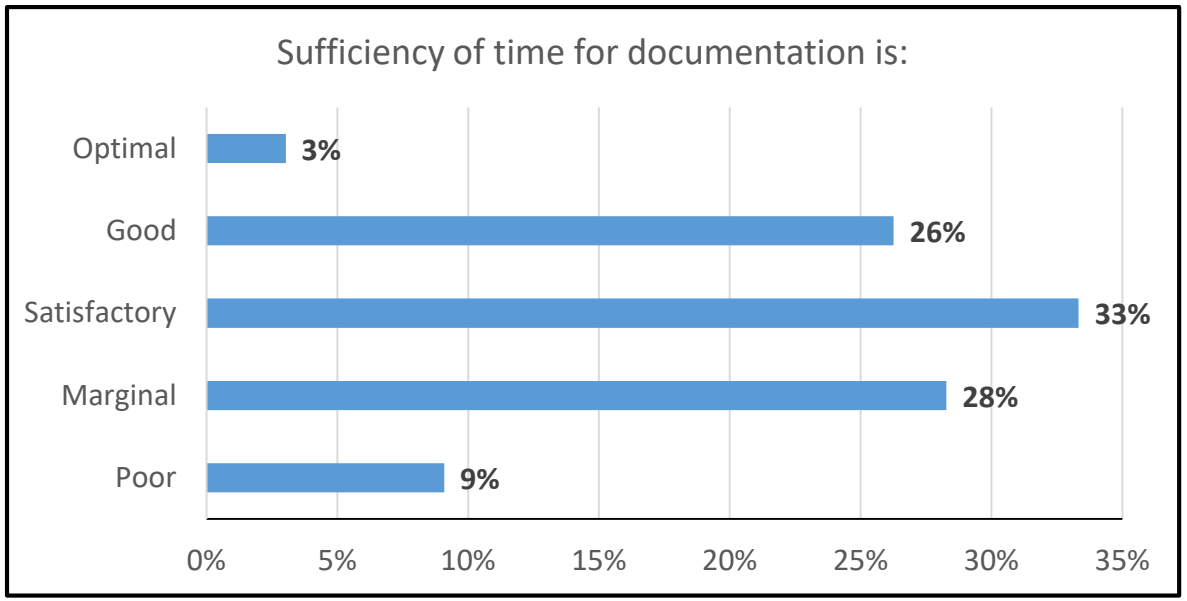

Using your own definition of "burnout", please choose one of the answers below:
I feel completely burned out. I am at the point where I may need to seek help.
1%
The symptoms of burnout that I am expierencing won't go away. I think about work fustrations a...
10%
I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion
30%
I am under stress, and don't always have as much energy as I did, but I don't feel bruned out
41%
I enjoy my work. I have no symptoms of burnout
17%
0%
10%
20%
30%
40%
50%

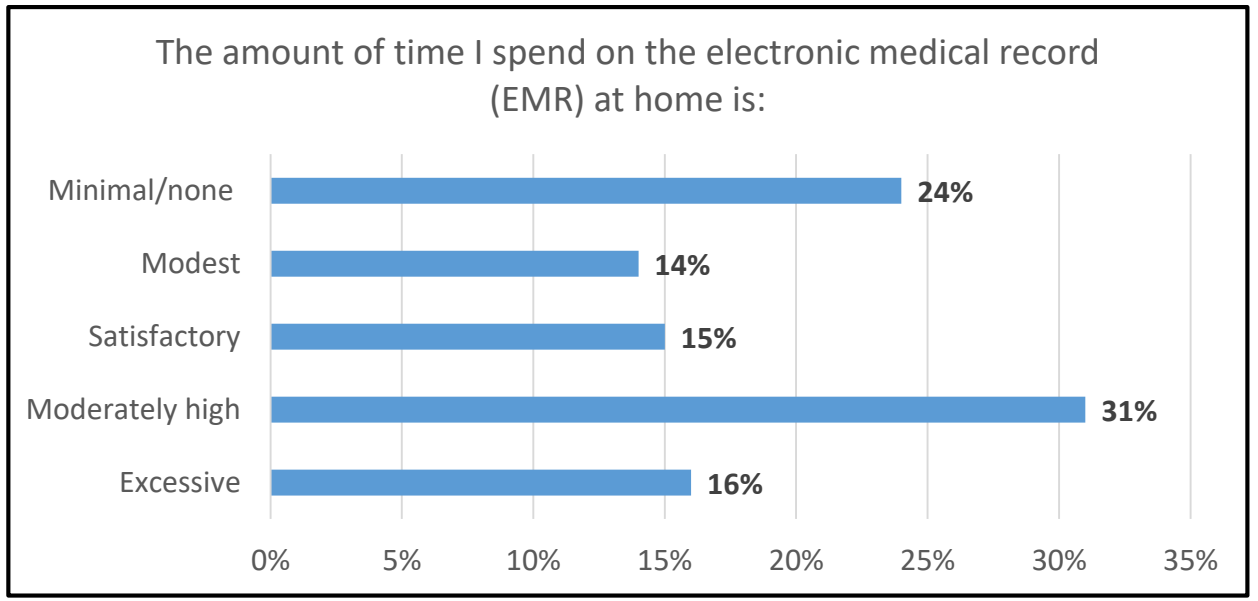

My professional values are well aligned with those of my clinical leaders:
Strongly Disagree
0%
Disagree
4%
Neutral
9%
Agree
54%
Strongly Agree
33%
0%
10%
20%
30%
40%
50%
60%

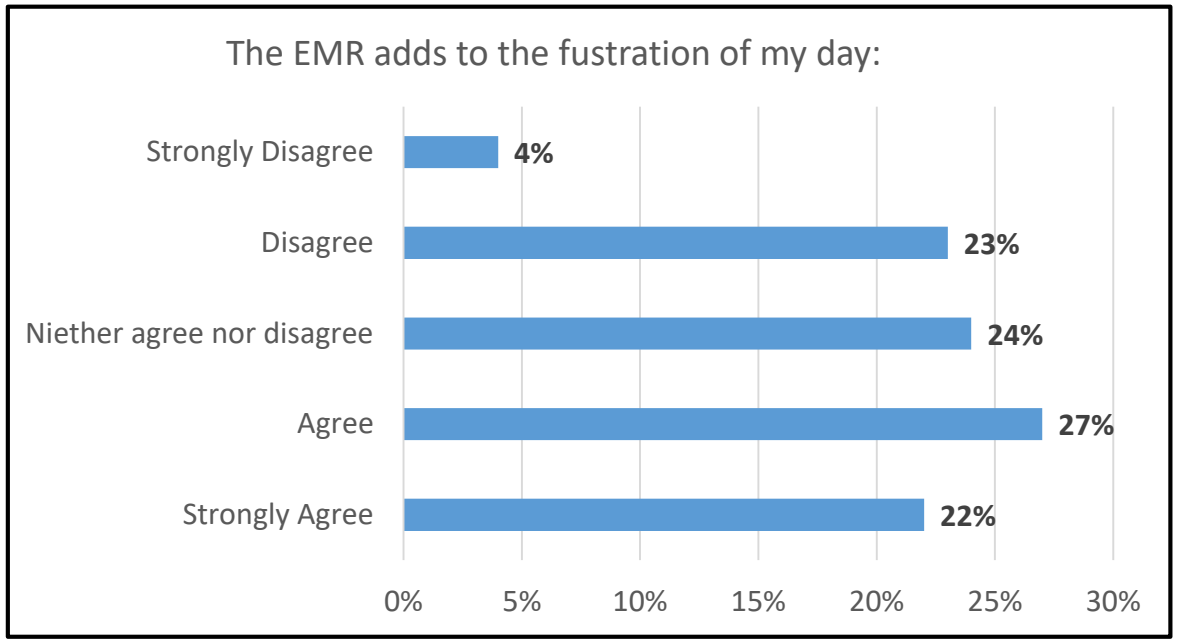

The degree to which my care team works efficiently together is:
Optimal
17%
Good
55%
Satisfactory
21%
Marginal
4%
Poor
3%
0%
10%
20%
30%
40%
50%
60%

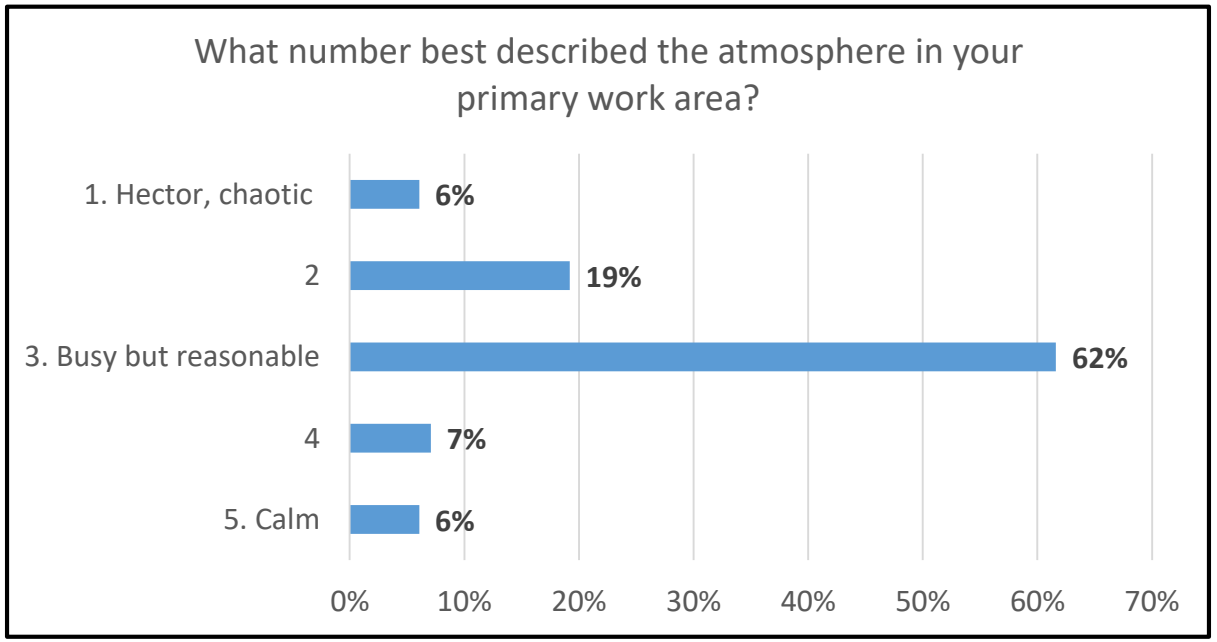

My control over my workload is:
Optimal
7%
Good
39%
Satisfactory
33%
Marginal
17%
Poor
4%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%


I feel a great deal of stress because of my job
Strongly Disagree
3%
Disagree
25%
Neither Agree or disagree
25%
Agree
40%
Strongly Agree
7%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%


Sufficiency of time for documentation is:
Optimal
3%
Good
26%
Satisfactory
33%
Marginal
28%
Poor
9%
0%
5%
10%
15%
20%
25%
30%
35%


The amount of time I spend on the electronic medical record (EMR) at home is:
Minimal/none
24%
Modest
14%
Satisfactory
15%
Moderately high
31%
Excessive
16%
0%
5%
10%
15%
20%
25%
30%
35%


The EMR adds to the fustration of my day:
Strongly Disagree
4%
Disagree
23%
Niether agree nor disagree
24%
Agree
27%
Strongly Agree
22%
0%
5%
10%
15%
20%
25%
30%


What number best described the atmosphere in your primary work area?
1. Hector, chaotic
6%
2
19%
3. Busy but reasonable
62%
4
7%
5. Calm
6%
0%
10%
20%
30%
40%
50%
60%
70%

Please tell us more about your work stresses and/or what this collaborative might do to reduce them (Selected responses)

- " There is no compensation for out of office time like doing charting/notes, prepping for visits, reviewing records or portal messages which are becoming excessive! This somehow needs to change, in every other profession these things would be billed. They are increasing burnout and providers are sadly leaving primary care."
- "Improve leadership training. Advocate for increase reimbursement for longer PCP and therapy sessions: 20 minutes for a PCP apt is not sufficient."
- "Due to COVID, workflows and policies constantly change and staff are not on the same page, there's inconsistency."
- "Time is the biggest factor - creating work efficiencies and improving ability to delegate would be of most use"

How might reducing preventable hospitalizations and ED visits impact your professional well-being? (Selected responses)

- "Patients would be healthier and there would be fewer documents to read."
- " It would cut down on everyone's workload and increase patient satisfaction. It's better care and saves money. Sometimes I have guilt in not managing something outpatient that really could be if I had a few hours to spend doing it, and so I send to ER, so hopefully this would help with that!"
- "Making an impact in these areas would be personally rewarding as this would demonstrate an improvement in patient care and total cost of care."
- " It would allow for improved health care quality at our clinic. It helps save time by shifting from reactive to more proactive approaches. It would help save time as well by frontloading our efforts in order to prevent the necessary follow-ups that would normally occur post hospitalization."

Next steps

- **September:** Team identifies plan to implement test for change: Roles and responsibilities, Work flow, Measurement collection, Staff training, Obtaining input on what is important to the patient
- **October:** Team tests change, measures results including feedback from staff and patients: team updates PDSA based on experience
- **November:**
  - PDSAs due 11/5
  - Next Learning Collaborative 11/18