**CARE TRANSFORMATION COLLABORATIVE (CTC)**

**COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK**

**Consisting of 8 pages**

**Pharmacy Quality Improvement Initiative**

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

1. Introduction/Purpose

The Rhode Island Department of Health (RIDOH), the Care Transformation Collaborative of Rhode Island (CTC-RI), in collaboration with faculty from University of Rhode Island College of Pharmacy, have selected your practice to participate in the clinical quality improvement initiative funded by UnitedHealthcare and Rhode Island Department of Health to improve the safe, effective and efficient use of medications in adults age 50 and older. 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 in improving patient care. Your Pharmacy Quality Improvement team will meet monthly with the on-site Clinical Quality Practice Facilitation over a 13-month time period and participate in quarterly peer learning collaborative meetings facilitated by content experts in the field. The Collaborative Agreement Scope of Work outlines the mutual responsibilities of each party as outlined in the Pharmacy Quality Improvement Initiative application process.

Strategic Goals:

The goal of this new statewide program is to improve the safe, effective and efficient use of medications in adults age 50 and older. There shall be an emphasis on de-prescribing harmful drugs when indicated, promoting adherence to evidence-based medication therapies, and addressing health-system inefficiency and coordination issues that contribute to sub-optimal medication use. The framework below will be used as a foundation for the quality improvement initiative:

|  |  |  |
| --- | --- | --- |
| **Safe (S)** | **Effective (E)** | **Efficient (C)** |
| **Avoiding use of:**1. Benzodiazepines
2. Multiple CNS depressants
3. NSAIDS, if using anticoagulants
4. Anticholinergics in dementia\*
5. Fluoroquinolones as initial therapy
6. Opioids in excessive quantities
7. Opioid in combination with benzodiazepine
8. Buprenorphine for OUD in combination with opioid or other Rx controlled substance
9. Prescribing of naloxone
10. Higher-risk drugs (PIMs)\*
 | **Patient adherence to:**1. Anticoagulants
2. Antihypertensive medications
3. Diabetes medications
4. Depression medications
5. Cholesterol medications
6. Respiratory inhalers
7. Buprenorphine for OUD

**Evidence-based therapies:**1. Statin use in diabetes
2. ACE/ARB use in diabetes
3. Overuse of inhaled short-acting beta agonists
 | **Health system use:**1. Limit number of prescribers
2. Avoid polypharmacy

**Use of generics:** 1. Overall
2. Diabetes medications
3. Mental health medications

**Other:**1. Low Value Drugs
2. Use of erythropoietin
 |

\* (PIM: potentially inappropriate drugs; apply only to adults age 65+ years; OUD = opioid use disorder

Pharmacy Quality Improvement Initiative Objectives:

1. Provide practices/SOC with an opportunity to select and implement a practice/SOC focus of medication management improvement 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 safe, effective and efficient medication management of older adults;
3. Improve provider and practice team confidence and skills in implementing evidence-based patient engagement and tools for optimizing medication use;
4. Improve patient medication management outcomes through pharmacy practice facilitation support, peer learning opportunities and applied team-based performance improvement;
5. Potentially enhance pharmacy scope and standardization of practice though use of collaborative practice agreements, as applicable to the practice selected area of focus;
6. Demonstrate the benefit of a pharmacy led quality improvement initiative.

Services to Be Provided

Participating SOC/Practices will receive: monthly on-site consultation and coaching from a Pharmacy Quality Improvement Facilitator; opportunity to improve provider and practice team efficacy in addressing patient pharmacy needs; professional education presented quarterly at peer learning network meetings with content expert consultation; option of obtaining URI CoP assistance in working with practice/SOC analysts to apply pharmacy algorithm codes to system of care pharmacy claims.

Assumptions:

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

Practice Responsibilities and Requirements:

Pharmacy Quality Improvement Practice quality improvement teams will participate from February 2020 through February 18, 2021 with expectation that practice will participate in February 20, 2020 Orientation Program, and quarterly peer learning collaborative meetings. Practice QI Team will participate in monthly meetings with Practice QI Facilitator. All Clinical Providers will complete Self-Efficacy Surveys at beginning and end of initiative. (*Please see Attachment A*). Practices/SOC will receive pharmacy performance reports that have been generated by URI CoP from APCD pharmacy claims data. Practices will use this baseline information, together with provider self-efficacy information, to identify areas of clinical focus that are specific to their practice/SOC needs and develop, implement and evaluate team based pharmacy performance improvement plans.

2-Month Preparation Period QI Initiative Activities (February -March 2020): Identification and Planning for What Matters Most to the Practice/SOC and What Matters Most to the Patients

Practice QI team:

* Completes the provider self-efficacy survey prior to the orientation “kick off” meeting (2/20/20);
* Participates in kick off learning network meeting (2/21/10);
* Participates in monthly meetings with the practice QI facilitator;
* Uses the APCD practice/SOC pharmacy performance reports and practice self-efficacy survey results to select metric(s) for improvement based what matters most to the practice/SOC;
* Identifies and submits performance improvement plan (Plan-Do-Study-Act) including rationale, practice performance improvement measurement plan, target, and clinical and patient engagement strategies that will be used to improve care.

QI Initiative Performance Period (April 2020 – February 2021):

Practice QI team:

* Continues to participate in monthly meetings with the pharmacy QI facilitator to review implementation of the performance improvement plan including results of “tests of change” for process and outcome measures;
* Develops, implements and refines action plans and workflows to support use of evidence based clinical and patient engagement strategies (if applicable to the selected metric) and performance results compared to identified target;
* Submits updated Safe-effective-efficient performance improvement plans (S-E-E) P-D-S-A (April);
* Attends 2nd learning network meeting (May);
* Optional\*: Identifies 2nd quality improvement activity (P-D-S-A) based on practice/SOC area of interest which could include but not limited to: applying QI algorithm codes to practice/SOC pharmacy claims, identifying opportunity to standardize care using collaborative practice agreement, identifies an outreach strategy to improve care using community pharmacy approach, identifies an outreach strategy with a skilled nursing facility to improve transitions of care and medication reconciliation (June);
* Submits updated S-E-E: PDSA (July);
* Attends 3rd Learning Network meeting and reports out on progress/outcomes including results of patient engagement strategy (August);
* Submits results of optional\* practice identified P-D-S-A (December);
* Submits results of final S-E-E using a storyboard template (January 2021); and
* Attends final learning network meeting (February 2021)

\*Pending confirmation of additional funding for this optional activity

Practice Compensation:

Practices will be eligible to receive:

* Infrastructure payment of $10,000 that practices can use to offset costs associated with measuring, reporting and monitoring data needed for improving the selected quality improvement metric, and staff time (pharmacist, provider champion, nurse care manager, practice manager) for participation in monthly and quarterly quality improvement activities and SOC support;
* First infrastructure payment of $5,000 will be provided to practice with receipt of signed collaborative agreement, provider self-efficacy survey information and team attendance at orientation kick off meeting (payable: February 2020);
* Second infrastructure payment of $5,000 will be provided to practice with submission of updated S-E-E performance improvement plan (including update on patient engagement strategy and team attendance at the 3rd peer learning network meeting (payable: August, 2020);
* $5,000 of incentive payments based on meeting quality improvement target that team identifies as part of the Plan-Do-Study-Act (P-D-S-A) performance improvement plan; Note: As part of the service delivery requirements, in month two, the expectation is that the practice team will identify and submit a PDSA which identifies a pharmacy measurement metric that needs improvement per the baseline APCD practice report, a practice identified meaningful improvement target, and rationale (payable: February 2021);
* Option\* of applying for and obtaining an additional $4,000 for successful submission of practice identified P-D-S-A on a pharmacy project of special interest to the practice/SOC; Topics could include but not limited to: applying QI algorithm codes to practice/SOC pharmacy claims, identifying opportunity to standardize care using collaborative practice agreement, outreach to community pharmacy, outreach to SNF to improve transitions of care and medication reconciliation (payable February 2021 with completion of P-D-S-A for selected optional initiative).

\* Pending confirmation of additional funding for this optional activity

CTC-RI reserves the right to delay/withhold/pro-rate payments if Practice fails to meet any of the practice requirements as outlined in Milestone Document *(Please see Attachment B).*

Care Transformation Collaborative of RI Practice name:



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Signature: Debra Hurwitz, Signature of authorized staff:

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

**Attachment A: S-E-E Self-Efficacy Survey Due February 17, 2020**

Survey Link/ Virtual Version: <https://www.surveymonkey.com/r/SCFY3WJ>

**Demographic questions**

Q. Gender

Q. Years of practice experience: A. 0-5/6-10/10-15/15+

Q. Role: A. Internists/Geriatrician/Family Physician/Nurse Practitioner/Physician’s Assistant/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Q. Practice setting: A. Adult Primary Care / Health Center / Other

Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescribing Efficacy (general questions)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Considering the use of medication among older adults:*  | Strongly disagree | Disagree | Neutral | Agree | Strongly Agree |
| **DEPRESCRIBING** |  |  |  |  |  |
| 1. I have no difficulty deprescribing higher risk medications among my older patients
 |  |  |  |  |  |
| 1. I feel confident in my ability to determine the risks versus benefits of **continuing** higher-risk medications
 |  |  |  |  |  |
| 1. I feel confident in my ability to determine the risks versus benefits of **DIScontinuing** higher-risk medications
 |  |  |  |  |  |
| 1. I am able to effectively incorporate patient goals and values when deciding to initiate or discontinue a medication
 |  |  |  |  |  |
| 1. I feel confident in my ability to engage with patients who demonstrate a strong desire to continue a medication that I want to deprescribe
 |  |  |  |  |  |
| 1. I am confident in my knowledge of non-pharmacological alternatives to potentially harmful medications
 |  |  |  |  |  |
| 1. I am confident in my ability to ensure that my patients understand the potential harms of their medications, and when to seek medical care.
 |  |  |  |  |  |
| 1. When deprescribing a medication, I am knowledgeable of appropriate dose reduction and tapering approaches.
 |  |  |  |  |  |
| 1. When deprescribing a medication, I am confident in our system’s ability to monitor patients for adverse outcomes
 |  |  |  |  |  |
| **PROMOTING ADHERENCE TO MEDICATION**  |  |  |  |  |  |
| 1. Medication adherence is a significant challenge for many of my patients
 |  |  |  |  |  |
| 1. When initiating a medication therapy, my discussions with patients are effective in promoting optimal patient adherence
 |  |  |  |  |  |
| 1. I am confident in my ability` to ensure that my patients understand the indication for their medications and how to take them
 |  |  |  |  |  |
| 1. I can effectively address patient barriers to medication adherence *pertaining to medication cost*
 |  |  |  |  |  |
| 1. I can effectively address patient barriers to medication adherence *pertaining to health literacy*
 |  |  |  |  |  |
| 1. I can effectively address patient barriers to medication adherence *pertaining to patient motivation*
 |  |  |  |  |  |
| 1. I can effectively address patient barriers to medication adherence *pertaining to regimen complexity*
 |  |  |  |  |  |
| **OTHER** |  |  |  |  |  |
| 1. I am confident in my ability to effectively address polypharmacy
 |  |  |  |  |  |
| 1. It is difficult to coordinate patient medication regimens because of the number of prescribers involved
 |  |  |  |  |  |
| 1. I am pressured to prescribe newer brand name drugs when an older generic medication may be suitable
 |  |  |  |  |  |
| 1. My ability to effectively manage a patient’s medication regimen is benefited by the expertise of the other practitioners in my care setting
 |  |  |  |  |  |
| 1. My ability to effectively manage a patient’s medication regimen is benefited by the technical resources available in my care setting
 |  |  |  |  |  |
| 1. My ability to effectively manage a patient’s medication regimen is benefited by accurate medication lists and information pertaining to medication history
 |  |  |  |  |  |
| 1. My ability to effectively manage patients’ medication regimen is benefited by having the necessary time to address medication-related issues.
 |  |  |  |  |  |

Attachment B: 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  |   |
| Completes provider self-efficacy survey | Due February 14, 2020  | Survey Monkey Link: https://www.surveymonkey.com/r/SCFY3WJ Email: CTC-ri@ctc-ri.org |
| Option of identifying optional QI Project  | Identify as part of the application  |  |
| Practice QI team participation in monthly meetings with the practice QI facilitator | Starts the month after the kick off March 2020  | Sign-up sheet will be available at Kick off meeting 2/27/20  |
| Practice QI team attendance and participation at in-person kick-off learning session | Presentation on APCD baseline data and provider self-efficacy survey results  |  |
| Team reviews APCD Claims Data and provider self-efficacy data and identifies domain area of focus for quality improvement together with potential plan for patient engagement; Identifies if practice/SOC wants to work with URI around having codes applied to practice/SOC pharmacy codes  | Month 2APCD Information serves as baseline pharmacy performance report; Provider self-efficacy report services as provider baseline information  | PDSA to include rationale for selection of performance measure and plan for patient engagement  |
| In conjunction with the Pharmacy practice facilitator, identify quality improvement activities to optimize performance, completes a Plan do study act QI Plan, including how practice will capture and report information, incorporate patient engagement strategy and evidence based clinical strategy and target;  | Month 3: Due: April 30, 2020  | PDSA to be submitted to CTC-ri@ctc-ri.org |
| Team attends quarterly meetings, present QI work plan and data results with content expert as applicable  | Month May 21, 2020 , August 20,2020 November 19, 2020 February 18,2021 |  |
| Identifies optional\* QI plan activity (PDSA) together with goal, strategy, data collection plan and evaluation  | Month Due June 30, 2020  | Submit to CTC: to CTC-ri@ctc-ri.org |
| Submits updated P-D-S-A (S-E-E measure)  | Due July 31, 2020  | Submit to CTC: to CTC-ri@ctc-ri.org |
| Quarterly learning: report out on barriers and challenges with implementation of QI, quarterly results data  | Quarterly learning: August 20, 2020  |  |
| Submits updated P-D-S-A (S-E-E measure) QI action plan with emphasis on patient engagement outcomes | Due October 31, 2020  | Submit to CTC: to CTC-ri@ctc-ri.org |
| Quarterly Learning: Reports out on results of patient engagement activity  | November 19, 2020 |  |
| Submits results of 6 month option action plan  | Due: December 16, 2020  | Submit to CTC: to CTC-ri@ctc-ri.org |
| Submits final QI results for P-D-S-A (S-E-E measure) using story board template | Due: January 31, 2021 | Submit to CTC: to CTC-ri@ctc-ri.org |
| Submits updated provider self-efficacy survey  | Due February 11, 2021  | Submit via survey monkey  |
| Final learning collaborative  | February 18, 2021  |  |

\* Pending confirmation of additional funding for this optional activity