

**Call for Applications: “Implementing Primary Care and Pharmacy Strategies to Improve Care for Patients with Diabetes”**

The Care Transformation Collaborative of Rhode Island (CTC-RI), in partnership with University of Rhode Island (URI) College of Pharmacy and Rhode Island Department of Health (RIDOH) is pleased to offer seven primary care practices the opportunity to apply for funding to join a two year pharmacy quality improvement initiative that has been funded by United Healthcare and RIDOH to improve screening rates and management for patients with diabetes for earlier detection of diabetes-related eye and kidney disease.

Over the two-year period, practices will be eligible to receive up to \$20,000 (\$15,000 infrastructure payment; \$5,000 incentive payment for meeting targets/improvement thresholds). Funds are intended to support health care practices in their efforts to participate in a data driven pharmacy quality improvement initiative to improve their knowledge, awareness, and competency with implementing screening treatment strategies in the care of patients with diabetes and to provide earlier detection of important microvascular complications including retinopathy and nephropathy. The selected primary care practice teams will work to:

- Improve eye exam screening rates
- Improve kidney health evaluation screening rates
- Improve glycemic control for patients with diabetes
- Incorporate pharmacy directed interventions within primary care
- Implement a coordinated academic detailing approach with outreach to selected specialists (such as ophthalmologists, nephrologists, and endocrinologists)

Applications are due on **May 22, 2024.**

Project activities will **begin June 11, 2024**, and will continue for 24 months.

**Benefits of participation:**

Opportunity to:

- Develop, implement and/or enhance a sustainable team based structured approach to improve care for patients with diabetes with a particular focus on earlier detection of eye disease and kidney disease, informed by state-wide data analysis of RI All Payer Claims Data (APCD).
- Leverage pharmacists, technology, data, and best practice sharing to better utilize resources, to intervene in a timely manner to improve diabetes care.

- Obtain practice infrastructure payments (\$7,500 each year for two years: total \$15,000), for team time to develop and implement pharmacy and health equity strategies and obtain \$5,000 in incentive payments for meeting target screening rates/improvement thresholds. Targets for incentive payment will be set in year 2.
- Access monthly coaching from pharmacy practice facilitator.
- Learn from peers and subject matter content experts at quarterly peer learning collaborative meetings and plan spread and sustainability based on best practices.
- Position practice for ongoing value-based care payments based on performance.

### Prerequisites:

- Outpatient primary care practice that has pharmacist support embedded within the primary care team or other access to pharmacist expertise as described by the applicant.
- Uses an electronic medical record system and is able to report diabetes population screening rates at baseline and follow up intervals.
- Agrees to principle of transparency for performance improvement information that will be shared with learning network members. Participant performance in this project may be detailed in reports and other media disseminated by CTC-RI which may identify the name of the practice/system of care.
- Submits a completed application and cover letter from practice team **May 22, 2024**, by 5pm indicating commitment and capacity for meeting the project expectations detailed below
  - Application link: <https://www.surveymonkey.com/r/pharm2024>
  - Practice cover letter: <https://ctc-ri.org/file/practice-letter-support-pharmacy-20241docx>
- Submits a letter of support from the system of care (if applicable) by **May 22, 2024** (*Please see Appendix C for template*).
  - System of care/leadership cover letter: <https://ctc-ri.org/file/system-careleadership-letter-support-pharmacy-2024docx>

### Quality Improvement Initiative Objectives

- Improve team knowledge, awareness, and competency with implementing screening strategies in the care of patients with diabetes and to achieve earlier detection and management of important microvascular complications including retinopathy and nephropathy.

- Support primary care practice teams in the identification and implementation of data-driven performance improvement action plans to improve screening rates (eye exam and kidney health evaluation) and improve glycemic control/HbA1c for patients with diabetes.
- Improve provider and practice team wellbeing through effective use of high functioning team-based care.
- Improve patient access to care and patient outcomes through pharmacy practice facilitation support, peer learning opportunities, and applied team-based performance.
- Conduct Pharmacist-led academic detailing to targeted providers (PCP, endocrinologists, ophthalmologists, nephrologists) highlighting therapeutic recommendations for patients with CKD (eg: anti-proteinuric therapies) or retinopathy (ie: anti-VEGF agents). Academic detailing is defined as an interactive educational outreach to prescribers to provide unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions, with the goal of improving patient care and optimizing resources.
- Collect patient feedback to assess for health disparities and gaps in care and incorporate findings into risk stratification and performance improvement plans.
- Develop and implement a plan for best practice sharing, spread, and sustainability.
- Enhance pharmacy scope and standardization of practice through use of collaborative practice agreements, compacts, and e-consulting, where/if appropriate.
- Demonstrate the benefit of a pharmacy led quality improvement initiative.
- Inform policy and best practices for diabetes screening and management.

## Statement of Need

[Read the statement of need document here](#), including information on Chronic Kidney Disease, Retinopathy, and the risks to those with Diabetes diagnoses.

## Practice/team expectations

- Meets monthly with the practice facilitator.
- Attends quarterly learning collaborative meetings. Participates in kick off learning network meeting on June 11, 2024.
- Generates, utilizes, and submits performance measurement data quarterly, using HEDIS measure specifications for: Estimated glomerular filtration rates, urine albumin-creatinine ratio, eye exams and HbA1c control/Glycemic Status Assessment.
- Identifies, submits, and presents performance improvement plan (Plan-Do-Study-Act) at quarterly meetings.

- Develops and implements action plans, staff training and workflows to support the project goals.
- Develops risk stratification strategy to identify and address gaps in care associated with factors such as insurance status, socioeconomic status, race, ethnicity, sex and/or other equity measure.
- Identifies providers using internal data and conducts academic detailing for at least 85% of targeted providers.
- Conducts care team surveys, once after the kickoff meeting and a second time at completion of the quality improvement initiative (survey instrument to be provided by CTC-RI).
- Submits final QI results using story board template, including plan for sustainability, and spread and presents at the final learning peer learning network meeting.

#### **Milestone Document:**

Please see Appendix A: Milestones Summary Document, to review details on performance expectations and project activities for the 24-months initiative.

#### **QI Initiative Measures**

##### Qualitative Measure: Provider/practice team survey.

A provider/practice team survey link will be sent to pharmacist leads who will be responsible for dissemination within their practice setting. The survey elements will address:

- Reporting the top barriers to better performance on the screening measures.
- Notions and insights about patient and practice-related factors associated with screening rates
- Effects of the initiative on vulnerable patient groups
- Effects of the initiative on the well-being of the care team members

##### Quantitative Measures: Practice facilitator will work with practices to review and apply HEDIS measure specifications.

1. Estimated glomerular filtration rates
2. Urine albumin-creatinine ratio
3. Eye exams
4. HbA1c control

## Payment Schedule

### Year 1

- Practices will receive \$5,000 with execution of Participative Agreement, attendance of the kickoff meeting (June 2024)
- Practices will receive \$2,500 for submission of staff survey, submission of baseline data (due 8/16/24), continued submission of quarterly data, attendance at monthly practice facilitator meetings, attendance at quarterly peer learning collaboratives, and the submission of April 18, 2025, PDSA (April 2025)

### Year 2

- Practices will receive \$5,000 for complete risk stratification of all 4 measures, continued practice facilitation meetings with practice facilitator, and submission of July 12, 2025, PDSA (July 2025)
- Practices will receive \$2,500 for academic detailing plan submission, completion of staff survey, data stratification, spread and sustainability plan submission. (May 2026)
- Practices may receive a \$5,000 incentive payment at the end of the program. Performance targets will be set in the beginning of Year 2. (May 2026)

## Timeline for Selection Process

Step	Activity	Date
1	Launch Call for Applications	May 1, 2024
2	Conference call with interested parties to answer any questions.  Join Zoom Meeting <a href="https://ctc-ri.zoom.us/j/85328279752?pwd=E1ZaHmNSGTVboEkTSbdABd8NvAGAvh.1">https://ctc-ri.zoom.us/j/85328279752?pwd=E1ZaHmNSGTVboEkTSbdABd8NvAGAvh.1</a>  Meeting ID: 853 2827 9752 Passcode: 646876	Wednesday May 8th, 8:00-9:00am Friday May 10th, 12:00-1:00pm
3	Submit application via online survey  <a href="https://www.surveymonkey.com/r/pharm2024">https://www.surveymonkey.com/r/pharm2024</a>	May 22, 2024
4	Selection Committee scores submitted applications and selects practices	June 1, 2024
5	Notification to selected practices	June 9, 2024

ADVANCING INTEGRATED HEALTHCARE

6	Orientation Kick Off meeting for newly selected practices	June 11, 2024, 7:30-9:00
7	Deadline for baseline data submission (more info to be sent to practices)	Screening Data from July 1, 2023-June 30, 2024) submitted by August 16, 2024
8	Monthly meeting series begin	To be scheduled by practice facilitator with practice

## Application Checklist

Application Checklist Item	Check if complete
<p>1. Application form filled out completely: <a href="https://www.surveymonkey.com/r/pharm2024">https://www.surveymonkey.com/r/pharm2024</a></p> <p>a) See questions before completing the application here:  <a href="https://ctc-ri.org/file/application-survey-items-diabetes-pharmacy-quality-improvement-429docx">https://ctc-ri.org/file/application-survey-items-diabetes-pharmacy-quality-improvement-429docx</a></p>	
<p>2. Practice cover letter indicating the practice's commitment and acceptance of the conditions stated in the application, signed by all members of the quality improvement team and by a practice leadership representative.</p> <p>– <a href="https://ctc-ri.org/file/practice-letter-support-pharmacy-20241docx">https://ctc-ri.org/file/practice-letter-support-pharmacy-20241docx</a></p>	
<p>3. System of Care/leadership (i.e., accountable care organization or accountable entity) cover letter indicating, the level of support provided for the lead practice for participating in this initiative including information if SOC would like to include multiple practices. If yes, other information (practice(s) name and providers) needs to be included. Letter is not required if practice is not part of a system of care.</p> <p>– <a href="https://ctc-ri.org/file/system-care-letter-support-pharmacy-2024docx">https://ctc-ri.org/file/system-care-letter-support-pharmacy-2024docx</a></p>	
4. Response to questions	

### **CTC-RI Selection Committee Policy and Procedure**

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

**Selection Committee Process for Review of Applications:** The CTC-RI Selection team will convene in May - June 2024. All reviewers will read and score each application independently using the scoring criteria below. **Questions:** A total of 10 points is possible for each essay question. 2 points if question is answered; an additional 2-3 points if response demonstrated organizational interest/commitment and moderate degree of readiness; additional 4-5 points for above average response suggesting that the practice has high degree of readiness, has begun pharmacy transformation work and is making progress towards medication optimization. The CTC-RI team may request interview applicants if further information is needed. The applications will be ranked by final scores. In the event of a tie, the following criteria will be used:

1. Priority may be given to practices/SOC that have an interest in practice standardization through collaborative practice agreement or other method of improving pharmacy impact
2. Priority may be given to practices that reside in the core cities (West Warwick, Central Falls, Pawtucket, Providence, and Woonsocket).
3. Priority may be given to practices that have a higher percentage of Medicaid enrollees or patients with income below the poverty level.
4. Priority may be given to practices that have a higher percentage of patients with diabetes.
5. Successful completion of a prior CTC-pharmacy learning collaborative initiative.

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

## Rating Scale

Impact area	Scoring	Refers to application question:
<b><u>1. Identification of Data to Improve Care</u></b> <ul style="list-style-type: none"> <li>Practice is currently collecting Kidney health evaluation (a) estimated glomerular filtration rates and (b) urine albumin-creatinine ratio (c) eye exam on patients with diabetes; (d) HbA1c control and screening data</li> </ul>	<b><u>Max = 4</u></b>  Practice is currently collecting data	1. Refer to question (18)
<b><u>2. Impact</u></b> <ul style="list-style-type: none"> <li>Number of patients with diabetes</li> </ul>	<b><u>Max = 8</u></b>  Add 1 point: 50-100 patients with diabetes. Add 2 points: 101-300 patients with diabetes. Add 3 points: over 300 patients with diabetes.	2. Refer to (3, 10, 11 and practice letter)
<ul style="list-style-type: none"> <li>Practice team has demonstrated ability to determine gaps in care based on race/ethnicity/gender/insurance status and or other factors</li> </ul>	Add 1 point	3. Refer to (21)
<ul style="list-style-type: none"> <li>% of Medicaid enrollees or uninsured or income below the poverty level</li> </ul>	1 point: 30% 2 points: 31-50% 3 points: above 50%	4. Refer to (11)
<ul style="list-style-type: none"> <li>Practice is in Providence, Pawtucket, Central Falls, West Warwick, and Woonsocket, with a higher diabetes disparity</li> </ul>	Add 1 point	5. Refer to (2, 10, 11), practice letter
<b><u>3. Patient Engagement</u></b> <ul style="list-style-type: none"> <li>Practice team identifies patient engagement strategy to better understand what matters most to the patient.</li> </ul>	<b><u>Max= 2</u></b>  1 point	6. Refer to (24)



<b><u>Rating Scale</u></b>		
<ul style="list-style-type: none"> <li>Practice has described an approach for collecting and integrating feedback from patients</li> </ul>	1 point	7. Refers (26)
<b><u>4. Practice Team Readiness</u></b>	<b><u>Max = 3</u></b>	8. Refers to (6)
<ul style="list-style-type: none"> <li>Practice has pharmacist or access to a pharmacist supporting practice with sufficient capacity to lead the project.</li> </ul>	1 point	
<ul style="list-style-type: none"> <li>Practice has provider leadership committed to the project</li> </ul>	1 point	9. Refers to (22)
<ul style="list-style-type: none"> <li>Practice has identified other practice team members to support the project</li> </ul>	1 point	10. Refers to (22)
<b><u>5. Practice Sustainability</u></b>	<b><u>Max = 3</u></b>	11. Refers to (25)
<ul style="list-style-type: none"> <li>Practice team has articulated anticipated barriers and plan to address</li> </ul>	1 point	
<ul style="list-style-type: none"> <li>Practice team is interested in/already using standardizing care using collaborative practice agreements</li> </ul>	1 point	12. Refers to (22)
<ul style="list-style-type: none"> <li>Practice has explained the sustainability plan for expanding screening efforts</li> </ul>	1 point	13. Refers to (26)
<b><u>6. Practice/System of Care Readiness</u></b>	<b><u>Max = 2</u></b>	14. Refers to (22) and practice letter
<ul style="list-style-type: none"> <li>Practice/System of care has IT capacity and functionality to assist with this project</li> </ul>	Add 1 point	
<ul style="list-style-type: none"> <li>System of care is interested in multiple practices being involved in initiative or has a plan to spread to other providers</li> </ul>	Add 1 point	15. Refers to (10, 11, 29)

## Appendix A:

Implementing Primary Care and Pharmacy Strategies to Improve Care for Patients with Diabetes Initiative Milestones Summary Document Pharmacy Milestone Summary		
Deliverable	Timeframe Due Dates	Notes
Kickoff meeting	June 11th, 2024	
Monthly practice facilitation meetings	June 2024-May 2026	
Quarterly learning collaboratives	October 2024 February 2025 May 2025 August 2025 November 2025 February 2026 May 2026	
Submit PDSA, and aggregate results for HEDIS measures <ul style="list-style-type: none"> <li>- Kidney Health Evaluation</li> <li>- Eye Exams</li> <li>- A1C &lt; 8%</li> </ul>	Baseline measure results: (July 1, 2023-June 30, 2024) submitted by August 16, 2024  Submit quarterly updates on: October 11, 2024 (initial PDSA plan due) January 17, 2025 April 18, 2025 July 12, 2025 October 17, 2025 January 16, 2026 April 17, 2026	
Review open gaps for each of the measures. Strategies include but are not limited to: <ul style="list-style-type: none"> <li>- Conducting chart reviews</li> <li>- Interviewing patients and conducting SDoH screening</li> <li>- Categorizing reasons for not meeting the measure</li> <li>- Collecting demographic data</li> <li>- Evaluating for co-morbidities</li> </ul>	One measure must be completed by October 11, 2024. All measures prior to April 18, 2025.	
Using internal data, identify providers and conduct academic detailing for up to 85% of targeted providers (PCP, endocrinologists, nephrologists, ophthalmologists). Review list of specialist providers with practice facilitator prior to any outreach in order to ensure a	November 2024- February 2026	

ADVANCING INTEGRATED HEALTHCARE

coordinated approach. Measure and report impact of academic detailing initiatives.		
Survey care team members (survey instrument to be provided by CTC-RI)	Baseline (Within 3 months of kickoff) and at Completion (May 2026)	
Stratify patients at risk by race, ethnicity, and payer all others are optional. (consider the following) (consider the following) <ul style="list-style-type: none"> <li>- A1C/GMI</li> <li>- Presence of medical comorbidities</li> <li>- Presence of behavioral health comorbidities</li> <li>- Language preference</li> <li>- CKD Stage</li> <li>- # of specialists involved in care for patient</li> <li>- Other to be determined by practice</li> </ul>	Determine which other variables to collect during months 1-4. Submit plan for high-risk priority population by July 12, 2025.	
Submit and implement plan for spread/sustainability	January 16, 2026	
Final storyboard submission	May 2026	