SALT LAKE COUNTY
HEALTH DEPARTMENT

2022 PHARMACY CHRONIC DISEASE QUALITY IMPROVEMENT PROJECTS APPLICATION

Access online: **https://tinyurl.com/SLCOPharmacyApplication2022**

The Healthy Living Program at the Salt Lake County Health Department works with community pharmacies to improve patient care and practices in preventing and managing hypertension, high cholesterol, and diabetes. The overall goal of this funding opportunity is to improve hypertension control rates (NQF18), statin therapy rates (MIPS Measure #438; CMS 347), and uncontrolled diabetes rates (NQF59). **This funding opportunity is available from January 1st through December 31st, 2022**. **At least one PDSA cycle, per project selected, must be implemented by June 30th, 2022 for reimbursement. Pharmacies will continue to work on selected projects for the rest of the calendar year and turn in outcome measures by January 15th, 2023.** Please read the following application instructions and funding requirements for more details. **Applications are due January 15th, 2022 to healthpromotion@slco.org.**

Application Instructions

- All pharmacies that offer primary care services in Salt Lake County are eligible to apply.
- Priority areas include Glendale, Rose Park, West Valley, South Salt Lake, Midvale, Kearns, Taylorsville, and Magna.
- Clinic can apply for a **maximum of $4,750.**
- Pharmacy CANNOT receive funding for activities that are already implemented in the pharmacy.
- Applications will be accepted on a first come, first served basis until funds are exhausted.
- Once submitted, applications will only be approved after a staff member from the Healthy Living Program meets with the pharmacy to finalize project activities.
- Funding CAN pay for the time spent on planning, implementing, disseminating, and evaluating the projects. Funding CANNOT pay for research, equipment, incentives, or direct services such as patient care, co-pay fees, medication, or patient education.

Funding Requirements

- Meet with SLCoHD staff to go over the proposed projects and create a plan of how to execute the project(s) through a quality improvement Plan Do Study Act (PDSA) cycle. Fill out PDSA worksheets and work on project activities.
- **Due Dates:**
  - **March 31st**: Turn in baseline data for projects.
  - **June 30th**: Complete and turn in *at least* one PDSA worksheet per project with supporting documentation of project implementation.
  - **July 1st – December 31st**: Continue to work on PDSA cycles and projects.
  - **January 15th of the next year**: Turn in updates, supporting documentation, and outcome evaluation.
- Communicate regularly with assigned Healthy Living staff member including a minimum of a kick-off meeting, mid-point meeting, and wrap-up meeting.
- When possible, stratify data and control rates by these high burden subpopulation categories; race/ethnicity and uninsured/low-income status. See the document "Evaluation for High Burden Subpopulations" for more information.
- Provide follow-up data for up to 5 years, upon request.
- Submit at least one success story of how a project(s) has improved your pharmacy.

PHARMACY INFORMATION

Name of Pharmacy: _____

Pharmacy Address: _____

Applicant Name: _____

Applicant Job Title and Role in Application Projects:

_____

Applicant Phone Number: _____

Applicant Email: _____

Names and Roles of Other Staff Who Will Be Involved:

_____

_____

INSTRUCTIONS:

- **Choose up to $4,750 in projects**.
- The goal of this approach is to have meaningful quality improvement projects that improve quality measures and are tailored to each pharmacy's individual priorities.
- Mark the box of the projects your pharmacy would like to work on. You can choose two projects under the same topic area or choose one project from two different topic areas.
- Each pharmacy will create their own quality improvement project in the chosen area(s) with the guidance of a SLCoHD staff member. Ideas of activities for each project can be found in the Chronic Disease Quality Improvement Project Ideas document.
- Submit application and a SLCoHD staff member will meet with your pharmacy to tailor activities for chosen projects to your pharmacy's needs.
- Create a quality improvement plan by using the Plan, Do, Study, Act (PDSA) tool
- SLCoHD staff will create an outline of the project completion requirements based on the agreed upon project plan.

☐ Improve Health Equity – $2,000

- **Project Goal:** To identify and improve the medication adherence rates and overall management of hypertension, high cholesterol, and/or diabetes of pharmacy's disparate and/or high burden subpopulations. These are the patients that have lower rates of medication adherence compared to the general clinic population.
- **Evaluation:** Medication adherence rate (or other feasible data point) of patients taking medication for high blood pressure, high cholesterol, and/or type-2 diabetes stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status)
    - If applicable, number of collaborative practice agreements implemented
- **Summary of activities:** Use data reports to identify disparate patient populations, improve pharmacy staff training around health equity and implicit bias, and implement

appropriate interventions to improve medication adherence and chronic disease management of identified client populations.

☐ Team-based Care - $2,000

- **Project Goal:** To improve management and medication adherence of hypertension, high cholesterol, and diabetes through new or enhance approaches to team-based care. Team-based care is having multiple healthcare professionals working collaboratively with patient on shared goals in an effective, patient-centered, timely, efficient, and equitable way. It involves identifying who is part of your care team, who should be part of your care team, and ensuring all staff members are working to the highest level of their expertise and ability to meet the needs of your patient population.
- **Evaluation:** Medication adherence rate (or other feasible data point) of patients taking medication for high blood pressure, high cholesterol, and/or type-2 diabetes stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Number of non-physician team members included on clinic's care team
    - Number of collaborative practice agreements implemented
    - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with high blood pressure, cholesterol, and diabetes
    - Community Health Workers (CHWs) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with hypertension, high cholesterol, and/or diabetes that personally engaged with a CHW
- **Summary of activities:** Map out pharmacy workflows and roles of care team, identify and improve gaps in team's care plan. Choose to incorporate other team members such as community health workers and improve collaborations with clinics through collaborative practice agreements (CPAs).

Hypertension – $2,000 each

☐ IMPROVE HYPERTENSION CARE

- **Project Goal:** To improve medication adherence and management of hypertension.
- **Evaluation:** Medication adherence rate (or other feasible data point) of patients taking medication for high blood pressure.
    - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with high blood pressure
    - If applicable, number of collaborative practice agreements implemented
- **Summary of activities:** Implement or improve pharmacy processes and policies around hypertension care, utilize technology to pull reports to identify patients and follow-up through a more appointment-based model, provide Medication Therapy Management and other supports, implement, or improve Self Monitored Blood Pressure (SMBP) programs, and improve educational materials.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing hypertension work in your pharmacy.

Cholesterol – $2,000 each

☐ **IMPROVE CHOLESTEROL CARE**

- **Project Goal:** To improve medication adherence and management of patients with high cholesterol.
- **Evaluation:** Medication adherence rate (or other feasible data point) of patients taking medication for high cholesterol.
    - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with high cholesterol
    - If applicable, number of collaborative practice agreements implemented
- **Summary of activities:** Implement or improve pharmacy processes and policies around high cholesterol care, utilize technology to pull reports to identify patients and follow-up through a more appointment-based model, provide Medication Therapy Management and other supports, implement, or improve point-of-care testing, and improve educational materials.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing cholesterol work in your pharmacy.

Diabetes – $2,000 each

☐ **IMPROVE DIABETES CARE**

- **Project Goal:** To improve medication adherence and management of patients with type-2 diabetes.
- **Evaluation:** Medication adherence rate (or other feasible data point) of patients taking medication for type-2 diabetes.
    - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with type-2 diabetes
    - If applicable, number of collaborative practice agreements implemented
- **Summary of activities:** Implement or improve pharmacy processes and policies around high diabetes care, utilize technology to pull reports to identify patients and follow-up through a more appointment-based model, provide Medication Therapy Management and other supports, and improve educational materials.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing diabetes work in your clinic.

☐ **BECOME A NATIONAL DIABETES PREVENTION PROGRAM SITE**

- Refer to the separate National DPP application for $3,500
    - https://tinyurl.com/SLCONDPPApplication2022

☐ **BECOME A DIABETES SELF MANAGEMENT EDUACTION AND SUPPORT SITE**

- Refer to the separate DSMES application for $2,500 (plus possible funding to pay $1,100 DSMES application fee).
    - https://tinyurl.com/SLCODSMESApplication2022

Education & Referrals - $250 each

☐ **CHRONIC DISEASE POPULATION MANAGEMENT**

- **Project Goal:** To develop pathways to neighborhood/community-based resources that support patient health goals and maintain referral links to community-based chronic disease self-management support programs, exercise programs, and other wellness resources.
- **Evaluation:** Number of referrals
- **Summary of activities:** Read the arthritis burden report, identify insurance reimbursement options for referrals, establish or improve referral processes to Living Well programs, and set goals to increase referrals.

☐ **NATIONAL DPP REFERRALS**

- **Project Goal:** To identify patients with prediabetes, provide education, and refer them to the National Diabetes Prevention Program (NDPP) and other behavior change services and goals.
- **Evaluation:**
    - Number of patients referred to the National DPP
    - If applicable, number of patients that completed the National DPP
- **Summary of activities:** Screen for prediabetes, implement alerts and workflows to flag patients with prediabetes to refer to the National DPP, and identify and provide referrals to other behavior change services.

☐ Join the Community Pharmacy Enhanced Services Network (CPESN) - $500

- **Project Goal:** To join with other high performing pharmacies to improve the quality of care offered to patients and to offer value to plan sponsors and other non-PBM payers through enhanced services and lower costs. http://join.cpesn.com
- **Evaluation:** Attend 75% of meetings

☐ Healthy Retail - $500

- **Project Goal:** To improve access to healthy food choices to patrons who come into the pharmacy.
- **Evaluation:** Follow an evaluation plan with pre- and post-assessments along with providing any data available for financial impact and purchasing behavior.

Healthy Living – $250 each

☐ BECOME A HEALTHIER WORKSITE FOR EMPLOYEES

- ✓ Fill out the CDC Worksite Wellness Scorecard and/or apply for the Utah Worksite Wellness Council's Healthy Worksite Award
- ✓ Choose at least 2 total activities to improve worksite wellness offerings in the areas of physical activity, nutrition, and/or breastfeeding.

☐ BECOME A COMMUNITY PARTNER FOR IMPROVING HEALTHY FOOD ACCESS

- ✓ Choose a project or event that will increase access to healthy food such as holding a healthy food drive, creating a community garden, or partnering with a food pantry, farmer's market, or other organization.

☐ IMPLEMENT PARK RX

- ✓ Use the Park Rx America database to prescribe physical activity at a park with walking paths to combat chronic diseases. SLCoHD will train and assist with implementation.

Total Amount of Chosen Activities (CANNOT exceed $4,750) = $_____

By signing below, the pharmacy agrees to complete the chosen activities and submit the required documentation to healthpromotion@slco.org by June 30, 2022. To receive payment contingent upon ongoing federal government funding for this program, the pharmacy agrees to submit a supplier vendor form, if one is not already on file. The pharmacy agrees to contact SLCoHD staff by May 1, 2022 if the pharmacy will not be able to complete the chosen activities by the June 30th deadline.

Signature _____

Approved by SLCoHD _____