2022 Pharmacy Chronic Disease Quality Improvement Project Ideas

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Introduction

This document provides ideas to the projects presented on the 2022 IPCP Application for pharmacies. Each project below includes a list of activities that are t**he main building blocks around a successful quality improvement project for each topic. The intent is not that each pharmacy must do all the activities listed, but to give an idea of all the places for quality improvement processes.** A SLCoHD staff member will sit down with you to talk through the quality improvement Plan, Do Study, Act (PDSA) cycle, assist in creating a plan of activities, and outline the requirements based on that plan. Our goal is to have more meaningful quality improvement projects that improve quality measures and are tailored to the pharmacy's priorities.

Definitions

Automated Office Blood Pressure (AOBP): a blood pressure machine that provides multiple sequential measurements when staff is not present to reduce "white-coat hypertension"

Collaborative Practice Agreement (CPA): a formal practice relationship between a pharmacist and a prescriber. The agreement specifies what functions (in addition to the pharmacist's typical scope of practice) can be delegated to the pharmacist by the collaborating prescriber. CPA's increase the efficiencies of team-based care and formalize practice relationships between pharmacists and prescribers.

Community Health Worker (CHW): The jobs and roles of CHWs are as varied as their titles (promotora, patient advocate, health navigator, peer support specialist, etc.). All CHWs, however, share trust and a connection with their communities. Community Health Workers are trained lay people who provide education and social support, while serving as a liaison with health care providers and social services. CHWs offer interpretation, provide culturally appropriate health information, assist people in receiving the care they need, help overcome barriers, give informal counseling and guidance on health behaviors, and advocate for individual and community health needs.

Diabetes Self-Management Education Support (DSMES): Diabetes Self-Management Education (DSME) is the cornerstone of care for all individuals with diabetes who want to achieve successful health outcomes and avoid complications. The ten-week program is conducted in health care settings, such as physicians' offices and clinics, pharmacies, and hospital outpatient settings. DSME is the active, ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. The overall objectives of DSME are to support informed decision-making and improved self-care behaviors, encourage effective problem-solving and active collaboration with the healthcare team, and improve clinical outcomes, health status, and quality of life.

Electronic Health Record (EHR): a digital version of a patient's paper chart; they are real-time, patient centered records that make information available instantly and securely to authorized users

Medication Therapy Management (MTM): a distinct service or group of services that optimize therapeutic outcomes for individual patients. These services are independent of, but can occur in conjunction with, the provision of a medication product. MTM encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's scope of practice. These services include but are not limited to the following: performing or obtaining

necessary assessments of the patient's health status, formulating a medication treatment plan, selecting, initiating, modifying, or administering medication therapy, monitoring and evaluating the patient's response to therapy, performing a comprehensive medication review, communicating essential information to the patient's primary care providers, providing verbal education and training to enhance patient understanding and appropriate use of medications, providing services designed to enhance patient adherence to therapeutic regimens.

National Diabetes Prevention Program (National DPP): The National DPP is a structured, evidence-based, year-long lifestyle change program to prevent or delay onset of type 2 diabetes in adults with prediabetes or at risk of developing type 2 diabetes. The National DPP lifestyle change program is founded on randomized controlled research studies which showed that making realistic behavior changes helped people with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). The program is group-based, facilitated by a trained lifestyle coach, and uses a CDC-approved curriculum. The curriculum supports regular interaction between the lifestyle coach and participants; builds peer support; and focuses on behavior modification through healthy eating, increasing physical activity, and managing stress. The program may be delivered in-person, online, via distance learning, or through a combination of these delivery modes.

Social Determinants of Health (SDOH): The economic and social conditions that influence individual and group differences in health status. Conditions in the places where people live, work, and play affect a wide range of health risks and outcomes. Addressing these conditions such as education, housing, income, access to healthy food, and neighborhood safety and greatly impact the health of an individual and community and advance health equity.

Improve Health Equity

- **Project Goal:** To identify and improve the medication adherence rates and overall management of hypertension, high cholesterol, and/or diabetes of the 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)
    1. If applicable, number of collaborative practice agreements implemented
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Analyze data - Stratify any data or reports the pharmacy can access by disparate and/or high burden subpopulations to identify patient populations with lowest medication adherence rate or another data factor. If working with a clinic, the pharmacy can use clinical control rates.
    2. Research the needs and barriers of identified under resourced patient populations to achieving higher medication adherence rates and chronic disease management. Activity options may include:
        - Implement or improve upon SDOH (social determinants of health) screening and referral process.

- Implement or improve upon risk stratification scoring of patients.
- Implement or improve upon a way to receive input from the identified patient populations on needs, barriers, and ideas for interventions (i.e. questionnaire, focus groups, patient boards, etc.).
- Utilize existing community and public health data to research key neighborhoods and/or communities' needs, resources, etc.

3. Learn and apply health equity principles to pharmacy's current processes and implicit bias.
    - Train staff on implicit bias.
    - Review pharmacy policies and processes to see how certain races, ethnicities, languages, and/or communities are adversely affected or at a disadvantage due to existing policies. Make revisions where indicated.
    - Review and update health education materials so they are culturally appropriate and/or fit the health literacy levels of common patients demographics.
    - Review and update hiring practicing so that the pharmacy is hiring staff that reflects the patients/communities it serves.
4. Implement interventions to improve the medication adherence rates and chronic disease management of identified patient populations.
    - Offer behavior and community program referrals related to SDOH such as Parks Rx (prescribing physical activity outside in parks/green space), Produce Rx (prescribing fruits and vegetables), affordable housing, etc.
    - Improve coordination and integration of social services and healthcare. Consider referral processes, bi-directional feedback, policies and systems in place.
    - Incorporate Community Health Workers (CHWs) or patient navigators into connecting patients with resources and education to improve chronic diseases.
    - Improve team-based care that will improve the care of identified disparate populations and will increase health equity. Consider working with pharmacists, nutritionists, CHWs, health coaches, peer educators, nurses, mental health professionals and others to provide the needed culturally appropriate coordination and support that affects chronic diseases.
    - Improve patient trust and access to culturally appropriate care for chronic diseases. Consider hiring health professionals and trusted staff from the communities the clinic serves, assessing and addressing health literacy, screen for and meet the barriers and needs of patients, etc.
    - Invest and partner with other organizations and coalitions that works on social determinants of health and health equity such as investing in community infrastructure, access to resources, and increasing patient and community advocacy.
5. Create and improve upon written pharmacy policies and processes that reflect the changes made from previous activities.

Team-Based Care

- **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 ensure all staff members are working to the highest level of their expertise and ability in order 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 the 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 (MTM) 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
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**)
    1. Identify and make improvements to the pharmacy team. Ensure all staff members are working to the highest level of their expertise and ability. This may include changing workflows, roles of the pharmacy team, and hiring or contracting with other healthcare professionals. The pharmacy teams' roles may address the following key areas: patient engagement, care team communication, social determinants of health, and analysis of data. (Refer to Flip the Pharmacy Domain 3 Change Package Example)
    2. Improve communication and trust among the care team. This may include regular team huddles, improved utilization of software and alerts for communication, identifying and matching strengths of each team member to their duties, and staff training.
    3. Work with clinics to become part of their team-based care model:
        i. Identify clinics who could benefit from having your pharmacist(s) as part of their care team for patients with hypertension, high cholesterol, and/or diabetes.
        ii. Establish a Collaborative Practice Agreement (CPA) with a clinic to do MTM with patients on hypertension, statin, and/or diabetes medications with the goal of increasing medication adherence rates, improving health outcomes and providing lifestyle modification counseling.
        iii. Work with the clinic to pull reports and create registries of patients diagnosed with hypertension, high cholesterol, and/or diabetes that are not well controlled and review medication adherence; then have clinic refer those patients to your pharmacy for MTM.
        iv. Track data such as improved clinical and qualitative outcomes resulting from the CPA, develop a return on investment (ROI) calculations, or another way to show the success of such collaborations.
        v. Work with a clinic/clinical provider to reduce patients' out-of-pocket costs by prescribing generic/cheaper version, one-pill therapy, and promoting resources (Good Rx app).

vi. Work with a clinic to implement a Self-Monitored Blood Pressure (SMBP) program tied with clinical support either through offering monitors at cost or through a lending program.

4. Integrate Community Health Workers (CHWs) into the care team:
    i. Identify internal or external CHWs who can become part of the pharmacy team to help improve medication adherence and management of hypertension, high cholesterol, and/or diabetes.
    ii. Create or improve a workflow process to integrate the internal or external CHWs into the care team which may include assessing social determinants of health (SDOH) and other needs, referring to services, and providing education.
    iii. Train the CHWs appropriately on the duties they will provide. Possible trainings include the CHW Core Skills/Competency Training (offered by Utah Department of Health), high blood pressure and other chronic disease management training, and motivational interviewing/health coaching training.
    iv. Have CHWs or supervisor join the Utah CHW Coalition.
    v. Utilize the CHWs as a patient advocate and allow them to provide input to the care team on patient needs, barriers, and possible solutions to improve medication adherence and the management of chronic diseases.
5. Create and improve upon written pharmacy policies and processes that reflect the changes made from previous activities.

Hypertension

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 (MTM) services to promote medication self-management and lifestyle modification for patients with high blood pressure
    - If applicable, number of collaborative practice agreements implemented
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:** (Refer to Flip the Pharmacy Hypertension Change Packages)
    1. Leverage an appointment-based model for pharmacies instead of a dispensing model. This includes optimizing the utilization of technology and electronic care plans for patient care. Refer to Flip the Pharmacy trainings and materials for how to accomplish this.
    2. Create data reports to identify patients taking anti-hypertensive medication. This may include adopting a new software of system with the ability to run more specific reports and analyze data. From those reports, identify patients the pharmacy care team can follow-up with to provide MTM and/or other pharmacy supports.
    3. Provide MTM and other pharmacy supports such as medication synchronization, generic/cheaper versions of medications, and/or combined/one-pill therapy for patients on anti-hypertensive medication.
        i. Use a plan of care form for patients not adherent to medication.
        ii. Contact family members to provide support for medication adherence.
    4. Train and evaluate direct patient care staff on accurate blood pressure measurement and documentation.

5. Implement or improve Self-Monitored Blood Pressure tied to clinical support through implementing a home blood pressure machine lending library, providing regular free walk-in blood pressure check opportunities for patients, offering monitors at cost, or another method (i.e. using existing resources such as senior centers, clinics, etc.).
6. Educate patients on their ASCVD risk. This may include implementing the use of the consumer-facing ASCVD risk calculator.
7. Implement or improve the use of patient educational materials on nutrition ("DASH" diet), physical activity, medication adherence, etc.
8. Provide other patient education and referrals for comorbidities and other risk factors (i.e. create registries of patients diagnosed with hypertension that are also smokers and provide follow-up education including offering a referral to the Utah Tobacco Quit Line and other resources).
9. Work with a clinic, community partner or other stakeholder to conduct a community screening to identify people with undiagnosed and/or uncontrolled hypertension and connect them to a clinic for follow up care.
10. Create or update a written policy(ies) to reflect changes made from previous activities.
11. Partner with National Diabetes Prevention Program sites to have blood pressure checks and refer those with hypertension to the clinic.
12. Set up a lending library to give blood pressure monitors to National Diabetes Prevention Program sites for participants to monitor their blood pressure.

Individual QI/PDSA Cycle Project

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

Cholesterol

Improved 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 (MTM) services to promote medication self-management and lifestyle modification for patients with high cholesterol
  - If applicable, number of collaborative practice agreements implemented
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:** (Refer to Flip the Pharmacy Hypertension Change Packages)
  1. Leverage an appointment-based model for pharmacies instead of a dispensing model. This includes optimizing the utilization of technology and electronic care plans for patient care. Refer to Flip the Pharmacy trainings and materials for how to accomplish this.
  2. Create data reports to identify patients on cholesterol-lowering medications. This may include adopting a new software of system with the ability to run more specific reports and analyze data. From those reports, identify patients the pharmacy care team can follow-up with to provide MTM and/or other pharmacy supports.

3. Provide MTM and other pharmacy supports such as medication synchronization, generic/cheaper versions of medications, and/or combined/one-pill therapy for patients on cholesterol-lowering medications.
    i. Use a plan of care form for patients not adherent to medication.
    ii. Contact family members to provide support for medication adherence.
4. Provide point-of-care testing directly at the pharmacy to evaluate cholesterol levels and provide counseling and/or referral to provider.
5. Educate patients on their ASCVD risk. This may include implementing the use of the consumer-facing ASCVD risk calculator.
6. Provide or improve patient educational materials on topics such as nutrition, physical activity, and medication adherence for high cholesterol.
7. Work with a clinic, community partner or other stakeholder to conduct a community screening to identify people with high cholesterol and connect them to a clinic for follow up care.
8. Create or update a written policy(ies) to reflect changes made from previous activities.

Individual QI/PDSA Cycle Project

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

Diabetes

Improved 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 (MTM) services to promote medication self-management and lifestyle modification for patients with type-2 diabetes
    - If applicable, number of collaborative practice agreements implemented
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:** (Refer to Flip the Pharmacy Hypertension Change Packages)
    1. Leverage an appointment-based model for pharmacies instead of a dispensing model. This includes optimizing the utilization of technology and electronic care plans for patient care. Refer to Flip the Pharmacy trainings and materials for how to do this.
    2. Create data reports to identify patients on diabetes medications. This may include adopting a new software of system with the ability to run more specific reports and analyze data. From those reports, identify patients the pharmacy care team can follow-up with to provide MTM and/or other pharmacy supports.
    3. Provide MTM and other pharmacy supports such as medication synchronization, generic/cheaper versions of medications, and/or combined/one-pill therapy for patients on diabetes medications.
        i. Use a plan of care form for patients not adherent to medication.
        ii. Contact family members to provide support for medication adherence.
    4. Educate patients on their ASCVD risk. This may include implementing the use of the consumer-facing ASCVD risk calculator.

5. Provide or improve patient educational materials on topics such as nutrition, physical activity, and medication adherence for diabetes.
6. Work with a clinic, community partner or other stakeholder to conduct a community screening to identify people with diabetes and connect them to a clinic for follow up care.
7. Create or update a written policy(ies) to reflect changes made from previous activities.
8. If applicable, implement a bi-directional referral system to exchange information with organizations implementing National DPP.
    i. You may create a National Diabetes Prevention Program cohort. Begin by filling out Salt Lake County's funding agreement.
    ii. Creating a National Diabetes Prevention Program cohort does not count as a CDQIP project, and must be a fully separate project, however separate funding is available.

Individual QI/PDSA Cycle Project

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

Education & Referrals

Chronic Diseases 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
- **Training:** A pharmacy champion will meet with a SLCo staff member to learn about Living Well workshops for asthma, diabetes, prediabetes, falls prevention, arthritis, and pain management
- **Activities:**
    1. Read the Arthritis Burden report
    2. Work with SLCoHD staff to determine if Providers can bill through the reimbursement referral process. Options may include:
        - Glycemic management services
        - Chronic care and preventive care management for empaneled patients
        - Practice improvements that engage community resources to support patient's health goals
        - Engagement with QIN-QIO to implement self-management training programs
        - Participation in a QCDR, that promotes use of patient engagement tools
        - Implementation of condition-specific chronic disease self-management support programs
        - Improved practices that disseminate appropriate self-management materials
    3. Establish or improve a patient referral method for Living Well Programs
    4. Pull a registry report to identify patients who have been diagnosed with specific chronic diseases (such as arthritis, prediabetes, or diabetes) and refer them to the Living Well self-management and physical activity programs

5. Establish or update a policy with workflow to routinely query registry for newly diagnosed patients with specific chronic conditions (such as arthritis, prediabetes, or diabetes) and refer them to the Living Well self-management and physical activity programs
6. Track and set goals for patient referrals

National Diabetes Prevention Program Referrals

- **Project Goal:** To identify patients with prediabetes, provide education, and refer them to the National Diabetes Prevention Program (National DPP) 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
- **Training Resources:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
  1. Create a workflow process to identify patients with prediabetes through the risk test, educate patients, refer to National DPP, and follow-up with patients with prediabetes.
  2. Implement a prediabetes awareness campaign to educate patients about prediabetes and National DPP (if possible, tailor to underserved patient populations).
  3. Work with community partners, clinic partners, and/or stakeholders to conduct a community screening to identify people with elevated blood glucose and connect them to a clinic for follow-up for management and diagnosis.
  4. Create or update a written policy(ies) to reflect changes made from previous activities.

Join the Community Pharmacy Enhanced Services Network (CPESN)

- **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 Living

Healthy Retail

- **Project Goal:** To improve access to healthy food choices to patrons who come into the pharmacy.
- **Required evaluation** – Evaluate the effectiveness of the projects with pre and post assessments. Provide the agreed upon data points related to the financial impacts of the project and changes in patron purchasing behaviors.
- **Activities:**
  - ✓ Ensure at least 25% of all packaged food choices meet the following healthy product criteria:
    - Limit all snack items (not refrigerated meals) to ≤200 calories per item (excluding nuts and seeds without added fats, oils, or caloric sweeteners).

- Limit total calories from saturated fat to ≤10% (excluding nuts and seeds without added fats or oils).
- Limit calories from sugars to ≤35% of total weight (excluding fruits or vegetables without added caloric sweeteners).
- Ensure ALL packaged snacks have 0 grams of trans fat.
- Ensure the first ingredient is a fruit, vegetable, dairy product, or protein food; or is a whole grain-rich grain product; or a combination food that contains at least ¼ cup of fruit and/or vegetable.

✓ Ensure at least 50% of available beverage choices contain ≤ 40 calories per 8 fluid ounces (excluding 100% juice with no added sugars and unsweetened fat-free or low-fat [1%] milk).

✓ Place two healthy products, such as fresh fruit or packaged snacks, at the checkout counter. (See the healthy product criteria above).

✓ Price one brand of bottled water equal to or below the price of all other beverages of the same volume. Display this low-priced bottled water option at eye level or just below eye level in refrigerator.

✓ Post at least two signs or shelf labels promoting healthy eating or healthy products in the store.

✓ Remove all advertising for alcohol, tobacco, sugar-sweetened beverages, and junk food from one area of store: checkout counter, a single window, or the front door.

Healthy Worksites

☐ **BECOME A HEALTHIER WORKSITE FOR EMPLOYEES**

✓ Fill out the CDC Worksite Wellness Scorecard and/or apply for the Utah Worksite Wellness Council's Health Worksite Award

✓ Choose at least 2 total activities to improve worksite wellness offerings in the areas of physical activity, nutrition, and/or breastfeeding.

Healthy Food Access

☐ **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.

Park Rx

☐ **IMPLEMENT PARK RX**

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