2023 CHRONIC DISEASE QUALITY IMPROVEMENT PROJECT REQUEST FOR APPLICATIONS (RFA)

PHARMACIES

1.0 Introduction:

The Chronic Disease Prevention Team at Salt Lake County Health Department (SLCoHD) would like to collaborate with community pharmacies to improve patient care and clinical practices. Through quality improvement projects, pharmacies will implement interventions intended to improve outcomes for the residents of Salt Lake County specific to diabetes, high cholesterol, hypertension, and related risk factors. Funding will be granted upon completion of these projects and as described throughout the RFA and resulting contract. Funding is provided by the Centers for Disease Control and Prevention (CDC).

2.0 Program Goals – Prevent, identify, and manage chronic diseases:

a. Identify and Improve Hypertension Control Rates (NQF18)
b. Identify and Improve Statin Therapy Rates (MIPS Measure #438; CMS 347)
c. Identify and Decrease uncontrolled Diabetes (NQF59)

3.0 Application Instructions:

a. Select One (1) Chronic Disease Focus Project for $2,000
b. Select One (1) or more Community/smaller Project(s) for $500 total
c. Email completed application form to healthpromotion@slco.org
    i. Application due date: January 15, 2023

4.0 General Expectations for Pharmacies:

a. Complete an improvement plan, using the Plan, Do, Study, Act (PDSA) worksheet.
b. Implement improvement plan, evaluate effectiveness of strategies, and adapt accordingly.
c. Have regular contact (in person, virtual, phone or email correspondence) with a member of the Salt Lake County Chronic Disease Prevention Team.
d. Submit one success story of how your project has improved your pharmacy.
e. Provide pre and post data corresponding to your chosen project.
f. Provide follow-up data for up to 5 years, upon request.
g. Follow Timeline as listed in this application.
h. See project specific details for additional requirements.

5.0 Eligibility and Selection Criteria:

a. All pharmacies that offer services in Salt Lake County are eligible to apply.
b. We are eager to support and work with several pharmacies in Salt Lake County and to the extent that is feasible we will accept and work with all pharmacies that apply, however, funding is limited. If more applications/funding requests are submitted than can be accommodated by funding, recipients will be chosen primarily based on pharmacy location and populations served, with some consideration given to potential impact and feasibility of projects chosen. The funding request may also be reduced to a single project proposed in the application.
    i. Priority areas include Glendale, Rose Park, West Valley, South Salt Lake, Midvale, Kearns, Taylorsville, and Magna.
    ii. Priority populations include those who are low income, Native American, Black/African American, or do not speak English as their primary language.
c. Once submitted, applications will only be approved after a staff member from the Salt Lake County Chronic Disease Prevention Team meets with the pharmacy to finalize project activities.
d. If desired, pharmacies may select more than one community/smaller project to work on with SLCoHD, however funding for the community/smaller project(s) will still be $500, whether one or more than one project is selected.
e. If received, funding CAN pay for time spent on planning projects, implementing projects, disseminating projects and/or evaluating projects.
f. Funding CANNOT pay for research, equipment, incentives, direct services such as patient care, co-pay fees, medication, and/or patient education.

6.0 Timeline/Due Dates:

a. January 15, 2023: Complete and email 2023 Application to SLCoHD
b. By February 15, 2023: Meet with the SLCoHD Chronic Disease Prevention Team

Applicants will be notified of the funding decision no later than February 24, 2023

c. February 28, 2023: Complete and email formal contract to SLCoHD
d. March 15, 2023: Baseline Data Due (for the year 2022)
e. April 15, 2023: PDSA Cycle Worksheet Complete
f. April 15 – August 15, 2023: PDSA Cycle in Progress
g. April 15 – August 15, 2023: Midpoint Meeting (Specific Date: _____)
h. September 30, 2023: Success story collected and given to Health Department

Payment will start being processed upon satisfactory progress of improvement plan implementation, utilizing the PDSA process.

i. November 1 – December 15, 2023: Final Meeting (Specific Date: _____)
j. January 15, 2024: Post Data Due (for the year 2023)

2023 CHRONIC DISEASE QUALITY IMPROVEMENT PROJECTS APPLICATION

PHARMACY

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Address: _____

Applicant Name: _____

Applicant Job Title and Role in Projects: _____

Applicant Phone Number: _____

Applicant Email: _____

Name and Roles of Other Staff Who Will Be Involved: _____

_____

_____

Additional Staff Contact:

Name: _____

Role: _____

Email: _____

Phone: _____

Specific Populations Served:

If applicable, please provide a brief explanation of any of the priority populations you serve. This includes Native American, Black/African American, those who do not speak English as their primary language, or those who are low income.

_____

_____

_____

Do you serve those covered by Medicaid?_____ Medicare? __ Select __

Chronic Disease Focus Project

Please select one (1) chronic disease quality improvement project.

Hypertension ~ Cholesterol ~ Prediabetes/Diabetes

Through SLCoHD, the CDC will provide **$2,000** for completion of one (1) chronic disease focus project.

☐ IMPROVE HYPERTENSION (HTN) CARE

- **Project Goal:** Improve medication adherence and management of HTN.

- **Project Activity Options:**
  - Improve pharmacy processes around HTN care.
  - Utilize technology to identify patients and deliver follow up.
  - Provide Medication Therapy Management (MTM) and other supports.
  - Implement or improve Self Monitored Blood Pressure (SMBP) programs.
  - Improve patient education materials.
  - Administer surveys to track medication adherence of patients and related factors

- **Evaluation:**
  - Medication adherence related measures (depending on available data) of patients taking medication(s) to treat HTN.
  - Number of pharmacists who provide MTM services and lifestyle modification for patients with HTN.
  - Number of collaborative practice agreements (CPA) implemented, if applicable.
  - Number of patients utilizing SMBP at home.

☐ IMPROVE DIABETES AND PREDIABETES CARE

- **Project Goal:** Improve medication adherence and management of diabetes and prediabetes.

- **Project Activity Options:**
  - Utilize technology to identify patients with diabetes/prediabetes and offer follow up services.
  - Provide MTM and other supports.
  - Improve patient educational materials.
  - Screen for prediabetes, implement alerts and workflows to flag patients with prediabetes to refer to the National Diabetes Prevention Program (NDPP), and/or other behavior change services.
  - Set up or improve process of referring patients with diabetes to the Diabetes Self-Management Education and Support (DSMES) program.
  - Administer surveys to track medication adherence of patients and related factors.
  - Improve pharmacy processes for diabetes care.

- **Evaluation:**
  - Medication adherence related measures (depending on available data) of patients taking medication(s) for diabetes or prediabetes.
  - Number of pharmacists who provide MTM services and lifestyle modification for patients with diabetes.
  - Number of CPAs implemented, if applicable.
  - Number of referrals made to NDPP, DSMES, or other behavior change services.

☐ IMPROVE CHOLESTEROL CARE

- **Project Goal:** Improve medication adherence and management of high cholesterol.

- **Project Activity Options:**
  - Improve pharmacy processes around care for high cholesterol.
  - Utilize technology to identify patients and follow up with an appointment-based model.
  - Provide MTM and other supports.
  - Improve patient educational materials.
  - Administer surveys to track medication adherence of patients and related factors.

- **Evaluation:**
  - Medication adherence related measures (depending on available data) of patients taking medication(s) for high cholesterol.
  - Number of pharmacists who provide MTM services and lifestyle modification for patients with high cholesterol.
  - Number of CPAs implemented, if applicable.

☐ IMPROVE HEALTH EQUITY

- **Project Goal:** Identify and improve medication adherence rates and management of chronic disease in disparate and/or high burden subpopulations. These are the patients that have lower rates of medication adherence compared to the general population.

- **Project Activity Options:**
  - Use data reports to identify disparate client populations.
  - Administer surveys or use other mechanisms to track medication adherence of patients and related factors, and identify disparities among subpopulations.
  - Improve staff training around health equity and implicit bias.
  - Implement appropriate interventions to improve the medication adherence rates of identified client populations.
  - Create and improve upon written pharmacy policies and processes to improve health equity.

- **Evaluation:**
  - Medication adherence related measures (depending on available data) of patients taking medication(s) for treatment of chronic disease.
  - Trainings done and number of staff members trained in health equity related skills/topics.

☐ TEAM-BASED CARE

- **Project Goal:** Improve management and medication adherence through new or enhanced approaches to team-based care.

- **Project Activity Options:**
  - Map out pharmacy workflows and roles of the care team.
  - Identify and improve gaps in team's care plan.
  - Choose to incorporate other professional team members into the patient care model such as community health workers and improve CPAs.

- **Evaluation:**
  - Medication adherence related measures (depending on available data) in patients taking medication(s) for treatment of chronic disease.
  - Roles and number of non-pharmacist team members included on care team for patients with chronic disease.
  - Number of CPAs implemented.
  - Number of pharmacies and number of full-time equivalent pharmacists who provide MTM services to promote medication self-management and lifestyle modification for patients with chronic disease.

Community Project

Please select one (1) community project.

Through the SLCoHD, the CDC will provide **$500** for completion of one (1) or more community project(s).

The Chronic Disease Prevention Team will connect you with individuals at SLCoHD that will help you with these projects.

☐ **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 two (2) total activities (provided specifically for your workplace at the end of filling out the application) to improve worksite wellness offerings.

☐ **BECOME A COMMUNITY PARTNER FOR IMPROVING HEALTHY FOOD ACCESS**

- ✓ Choose a project or an event that will increase access to healthy foods. Projects could include holding a healthy food drive, creating a community garden, promoting awareness of local food resources, partnering with a food pantry, farmer's market, or other organization.

☐ **IMPROVE YOUR FOOD RETAIL/VENUE ENVIRONMENT AND PRACTICES**

- ✓ Complete the Eat Well Utah environmental scan to identify and address areas of improvement in your food/beverage retail and/or venue. These include aspects related to greater availability and easier identification of healthy options, making the healthy choice the easier choice, minimizing waste, etc.

☐ **REFER TO LIVING WELL CLASSES**

- ✓ Become set up or refine the process to refer patients to Living Well classes to address certain chronic conditions. This includes identifying insurance reimbursement options for referrals, establishing or improving referral processes, setting goals, tracking referrals, and reporting the number of referrals to SLCoHD.

☐ **INCORPORATE TOBACCO CESSATION REFERRALS**

- ✓ Invite the Salt Lake County Tobacco Education Program to present to your pharmacy staff about cessation best practices.
- ✓ Referral tobacco users to the Utah Tobacco Quitline (made by the provider at waytoquit.org).
- ✓ Track referrals made by the pharmacy through the electronic health record and reports from the Utah Tobacco Quitline. Submit this tally for grant reporting.

☐ 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.

☐ JOIN THE COMMUNITY PHARMACY ENHANCED SERVICES NETWORK

- ✓ 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 (Pharmacy Benefit Manager) payers through enhanced services and lower costs. http://join.cpesn.com. Attend 75% of Community Pharmacy Enhanced Services Network (CPESN) meetings.