**Care Management Recognition Awards**
**Best Practice Submission Template**
**May 2019**

**Overview:** Recognition for excellence in best practice will be given to practices and/or POs that have a **demonstrated track record of strong results related to care management**. One award will be given per category, each worth $125,000.

A physician organization can only submit for a total of **three** best practice awards; because of this limit we encourage thoughtful selection of practices for submission. The categories are **Care Management Workflow, HIE/ADT Implementation, Reduction in Utilization, Palliative Care, Behavioral Health Interventions,** and **Addressing Social Determinants of Health.**

Submissions are due by **5p.m. on Friday, August 30th, 2019** by emailing both lrajt@bcbsm.com and ldavis7@bcbsm.com. Deadline extensions will not be granted. Winners will be notified in **early November 2019** and awards will be disseminated in the **January 2020** PGIP incentive payment.

Files must be submitted in Microsoft Word using the following naming convention:
<PO Name>_<Practice Name>_BestPractice_<Category>_2019

Submissions may not exceed **three pages** using 10 point font or larger; submissions longer than three pages in length will not be considered (applicants may submit up to an additional **two pages** of appendices if essential to fostering progam understanding).

Any submission collected as part of this process may be used as an exemplar by MICMT, the CPC+ Care Intervention Subcommittee, or BCBSM, regardless of whether the submission received funding. Additionally, tools/processes/resources that were created for an intervention/program that receives funding must be shareable with other physician organizations.

Submissions are only valid if submitted by a PGIP physician organization; submissions from individual practices will not be considered.

If you have any questions please contact:

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Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): **Numbers reflect Primary Care only**
Medical assistants: 360
Physicians (MD, DO): 286
Mid-level providers (NP, PA): 37
Clinical Pharmacists (PharmD): 14

**Executive Summary (5-8 bullet points, must include summary of results)**


- University of Michigan Medical Group (UMMG) blood pressure control rates were relatively stagnant below the 90th percentile HEDIS blood pressure control measure.
- Patients with an elevated blood pressure (BP) were leaving a primary care visit without a follow-up visit within the clinically recommended timeframe of 2-4 weeks, 68% of the time.
- Implemented a hypertension best practice advisory in our electronic medical records by creating an automated visual when an elevated blood pressure is documented.
- By creating a workflow to properly identify patients with elevated BP, automate an order within electronic medical record to follow up with a pharmacist and scheduling them for their follow-up appointment before they leave their primary care visit, we achieved better follow-up timeframes and overall BP control improvements.
- The intervention workflow engaged the care team including physicians, pharmacists, medical assistants, and scheduling staff.
- UMMG partnered with two Meijer pharmacy locations to expand patient access into the community for hypertension follow-up visits with a Michigan Medicine trained community pharmacist.
- UMMG BP control improved from **72% in January 2017 to 76% in December 2018 (~40,000 patients in HTN Registry).** Intervention began in February 2017.
- Percent of patients with a follow-up scheduled within 1 month increased 30% in the same timeframe.
- The Centers for Disease Control and Prevention recognized Michigan Medicine's hypertension program as a model of innovation, which is replicable nationally for reducing hypertension through team-based pharmacy care.


**Category of Submission (see page 1):** Care Management Workflow

**Title of Submission: Improving Blood Pressure Control Utilizing Pharmacist and Electronic Medical Record**

**When did the intervention start and end? (1-2 sentences)**

The intervention began in February 2017 and still continues to help sustain improvements achieved in BP control of our hypertension population.

**Goal of the Program/Intervention: (1-2 sentences)**

We had two main goals for this hypertension intervention. The first was to improve and sustain BP control rates above the HEDIS 90th percentile benchmark (74% in 2017 and 75% in 2018) within the UMMG. The second was to increase the percent of patients with an elevated BP with a follow-up appointment scheduled within 1 month from 32% to >50% by December 2018.

**Who developed the program/intervention, and how? (2-4 sentences)**

This intervention was led by the Chief Quality Officer of the University of Michigan Medical Group, Hae Mi Choe, PharmD. Together with two project managers and input from the Ambulatory Care Leadership, UMMG Hypertension Quality Committee, the intervention was rolled out in a phased approach. We started with the clinics that had the most opportunity for improved BP control. We then expanded the intervention to eventually include all primary care clinics, regardless of their BP control rates.

**Description of the Program/Intervention (2-3 paragraphs):**

Blood pressure control in patients with hypertension and diabetes were two of the Medical Group's ambulatory Quality Focus Measures in 2017. The UMMG's BP control had consistently been below national and insurance payer standards at 72% (hypertension). Through data analysis, we discovered that nearly 40% of patient were walking out of a primary care visit with an elevated BP and no follow-up scheduled. This was where we identified our target population.

Identifying and following up with the hypertensive patient was a workflow improvement that we knew would involve a care team management approach. A protocol was developed to systematically identify patients with high BP and refer them for follow up at either their Patient-centered Medical Home (PCMH) or community pharmacist for hypertension management. All adults had a BP reading obtained by a medical assistant (MA) as part of the routine intake process when they presented for an appointment at a participating PCMH. If the BP was elevated, the MA rechecked the BP after at least 5 minutes and if the abnormal reading persisted, the MA attached a standing order for a referral to a pharmacist for BP follow up in the electronic health record. If the primary care physician signed the order, the check-out staff were instructed to schedule the visit with the pharmacist within the clinic or community pharmacy depending on patient preference.

Pharmacists within the PCMH clinics have a collaborative practice agreement allowing for titration, initiation and discontinuation of medications to help patients achieve target outcomes. Within the community setting, the pharmacists have access to the medical record, are able to enter notes and vitals from their patient visits, and are able to 'pend' orders for providers. Once the patient is seen by the pharmacist for follow-up on an elevated BP, the patient is typically not discharged from care by the pharmacist until the patient has two consecutive visits with controlled BP.

**How were patients identified for the program/intervention? (1-2 paragraphs)**

We started by analyzing the entire hypertension population in September 2016. Out of those patients who had uncontrolled BPs documented in our medical record system, 33.4% had no follow-up on that elevated BP 3 months later (December 2016). To fully utilize our clinical pharmacist's time in the PCMH setting, we decided to automate the process for a patient to follow-up with a pharmacist for BP management.

The second part of the identification process came from the development of the hypertension best practice advisory (BPA) within our electronic medical record system When a medical assitant is rooming a patient, the BP is typed into the patient's chart. If the BP is elevated, an advisory to take a second BP interrupts the workflow. If the patient's second BP is still elevtaed, they are identified as a patient for this intervention.

**How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)**:

Success was measured in two main ways; improved BP control rates in primary care, where the BPA is live and increased percent of patients with follow-up within one month with a signed order from the BPA.

Improved blood pressure control rates is an outcome based measure of success. We analyzed pre-intervention data by pulling patient primary care visits where an elevated BP was their most recent BP recorded. Of these patients, we also pulled their next follow-up appointment to determine timeframe of which follow-up occurred and by what type of provider. Measuring the time between the initial elevated BP appointment and the next follow-up pre and post-intervention was our process based measure of success. By doing this, we were able to see that only 32% of patients were scheduled to be seen within the clinically appropriate 2-4 week timeframe to follow-up on an elevated BP reading. In December of 2018, we did the same data pull of patients with an elevated in-clinic BP to see if we saw an increase in patients with a follow-up occurring within one month.

UMMG BP control rates are measured on a monthly basis for our hypertension population. Patients who fall in the denominator meet the following criteria: patient is alive and has been seen in an ambulatory care setting at least twice in the past two years by Primary Care (Family Medicine, General Medicine, General Pediatrics, Geriatrics, or Adult Medicine/Pediatrics) or relevant specialty, with one of those visits completed in the past 395 days. Relevant specialty clinics for this report include Cardiology, Endocrinology, and Nephrology.

The numerator are the patients, ages 18-85, whose BP is in control based on the most recent BP value in the past year, adjusted for age and diabetes status. Per the HEDIS 2017 specifications, BP control is defined as: 1) BP < 140/90 mm/Hg for patients 18 - 59 years of age; 2) BP < 140/90 mmHg for patients 60 - 85 years of age with diabetes; and 3) BP < 150/90 mm/Hg for patients 60 - 85 years of age without diabetes. Of note, the HEDIS 90$^{th}$ percentile benchmark changed from 74% to 75%. Definition of control did not change between the two calendar years.

**What were the program results? Include qualitative data/graphs (2-3 paragraphs):**

We were able to improve and sustain BP control rates above the HEDIS 2017 90$^{th}$ percentile of 74% and continued sustainability above the 90$^{th}$ percentile when the HEDIS benchmark was increased to 75% in 2018. The graph in appendix 1 illustrates primary care hypertension control for the years 2017 and 2018. The BPA was turned on at 3 pilot primary care sites in February 2017. From there, we rolled-out the BPA to all other primary care sites (14 total) and was completed with the rollout by August of 2017. Sustainability was ensured by monitoring and providing feedback on workflow adherence to each clinic, so they were aware of their opportunities to improve.

The percent of patients with a follow-up appointment scheduled within 1 month increased 30% with a signed order from the hypertension best practice advisory. Prior to the intervention, we found that only 32% of patients with an elevated in-clinic BP had a follow-up scheduled within 30 days. Following the BPA intervention, the percentage jumped to 62%, with an additional 18% having a follow-up appointment within 60 days.

**Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)**:

Yes, the best practice advisory was a new process that we rolled out to all 14 ambulatory care clinics. To supplement care for our hypertension population, we also developed a new patient education hand-out and an interactive voice response (IVR) system for patients to report home BPs into their medical chart for their pharmacist to assess.

Once the patient was identified in their primary care physician visit with elevated BP and scheduled with a clinical pharmacist for follow-up, the clinical pharmacist could enroll them into IVR system. The patient can choose their preferred time of day/day(s) of the week to be called by the system. They are called at those chosen times and prompted to dial in their systolic, diastolic and pulse readings. These readings are immediately available in the patient's chart and if they are above or below specified thresholds, the pharmacists receive a message to alert them of the out of range BP.

**What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)**

Hypertension is one of the leading causes of heart disease and death in the United States. Helping our patients achieve better BP control is of extreme importance. To help us tackle this large and important problem for our patients, it was important for us to include everyone who is involved in the patient's clinic experience.

We are most proud of the teamwork this intervention demands and the way that all members of the patient care team involved in the hypertension workflow really made this a success.

**How will your organization use the funds if your submission wins? (1 paragraph)**

The funds from this award would aid in ongoing support of our community pharmacy partnership, in current state UMMG is providing financial support for community pharmacist's effort. Support from this award would allow for continuation and potential expansion of this model.

Appendix 1.

University of Michigan Medical Group Hypertension Control 2017-2018