Question	Subject Matter Expert		
	Tripp Logan	Deborah Bowers	Randy McDonough
Describe where in the workflow the patient's blood pressure gets measured a) What staff role is responsible for taking the blood pressure, and who documents it?	Depends on the service/program. • General screenings – kiosk (no staff) • Grant projects – Community Health Workers (CHWs)/Students • Pre-pharmacist meeting – Techs or CHWs or Students • Interpretation of BP readings – PharmD or Students	Depends on the service/program. • All b/p patients done at time of pick up by the pharmacy technician • Grant projects – Lifestyle coaching classes done before the class by pharmacy tech • Interpretation of BP readings – Pharmacist on duty • I don't have students often but when I do they help with all of the above	Patients are identified using the Appointment-Based Model and when they have their scheduled visit, their blood pressure is taken. In the 2nd scenario, patients are identified during the normal prescription workflow by the dispensing pharmacist who is reviewing each patients regimen looking for medication-related problems. A patient who is taking antihypertensives is identified and referred to our "slack pharmacist" who performs the blood pressure. We are starting to train technicians to help with this Currently it is mostly done by our clinical staff which include two pharmacists, a resident, and students on rotation. These individuals are our slack personnel. We utilize our technicians to manage our dispensing functions including Technician Product Verification. We are starting the training of our technicians for triaging and blood pressure monitoring of patients. Currently, pharmacists, resident, students do the documentation of blood pressures
How do staff determine whether the pharmacist needs to review the blood pressure reading? (Does the pharmacist review every blood pressure reading that is taken, or only the ones that are out of normal range & need some type of action to be taken?)	1. If the patient has a question -> PharmD 2. If the CHW/Tech recognizes the reading is outside of practice guidelines -> PharmD	1. If the patient has a question -> pharmacist 2. Have a guidance sheet and if the reading is outside of practice guidelines -> pharmacist 3. Pharmacist do review all readings also after the fact to make sure nothing got missed.	It is our philosophy that pharmacists should review all blood pressures, review medications, consult & provide any education to patients. Technicians can triage and do the blood pressure measurements, but pharmacists need to look at all vitals/lab values to evaluate and make decisions (if needed).
In terms of hypertension management, what information does your pharmacy regularly communicate to physician practices? a) How is the information transmitted (fax, secure electronic messaging, other)?	1. BP Readings, transportation status, health insurance status, drug copay status, if they have a BP monitor 2. Phone, fax, secure messaging in that order	1. BP Readings, any other issues that might be impacting the patient (during workflow only send if intervention is needed) 2. Lifestyle coaching usually fax for informational reasons but will call if need intervention 3. Phone, fax in that order (usually always by phone because faxes tend to not get responded to in a timely manner), would like to check into secure messaging in the future.	We provide a SOAP note along with the blood pressure measurements in the objective section. Mostly fax, some secured portals, and some shared EMRs

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As part of your hypertension-related communication to medical providers, do you include recommendations to change drug therapy in order to improve blood pressure control? If so, can you give an example of how those communications are worded? What type of response rate do you receive to those recommendations?	1. Only a small percentage of the time…our recommendations are typically based on out of pocket cost barriers unless it's an obvious drug-disease conflict 2. If so, can you give an example of how those communications are worded? What type of response rate do you receive to those recommendations? 3. Re: out of pocket cost reduction---------over 90% response rate a. Click here to view template.	We usually do and most all is done by phone.	Yes, always. If we see that someone is not at goal, then we make a clinical recommendation via SOAP note. FF has made positive lifestyle changes and he is adhering to his medications since enrolling in our medication synchronization program. His blood pressures continue to be elevated. He is taking the maximum dose for his lisinopril/HCTZ 20/12.5 = 2 tablets every morning. He is taking amlodipine 5 mg QAM. Given his current medication regimen and his elevated blood pressures, can we increase his amlodipine 5 mg to 10 mg QAM, 1 month supply, 11 refills. ☐ Yes ☐ No • We will continue to monitor FF's blood pressure and response to medications and continue to encourage his lifestyle changes. • We will follow up with FF in 1 week, if dose is changed to determine if dose increase was effective in improving his BPs
Describe any additional processes you've had to integrate into workflow to meet the needs of your payer opportunity (for Blood Pressure)?	Regular follow up with patients by a CHW to ensure proper technique, they understand the BP monitor, what the readings mean, and for patient accountability	We follow up with patients once a week during the Lifestyle coaching classes then once a month on their sync date there after	Flagging patients with hypertension. Reviewing adherence, blood pressure goal attainment. Identifying patients not at goal. Making clinical recommendations. If recommendation is accepted, becomes a new prescription to change therapy (if that was the accepted recommendation). Patient is contacted about med/dose change.
Share one reason you believe you have been successful in securing a payer for blood pressure management.	High incidence of untreated hypertension in the area	High incidence of untreated hypertension in the area from our FTP reported bp's in SC incidence was 40% uncontrolled.	Our documentation to demonstrate types of medication related problems (MRPs) identified, clinical interventions to resolve MRPs, and outcome of intervention (how did the prescriber respond). So it was the development of our patient care processes and the generation of data from those processes to demonstrate our ability to collect this data, provide patient care, make clinical interventions, and improve patient outcomes (clinical and total cost of care).