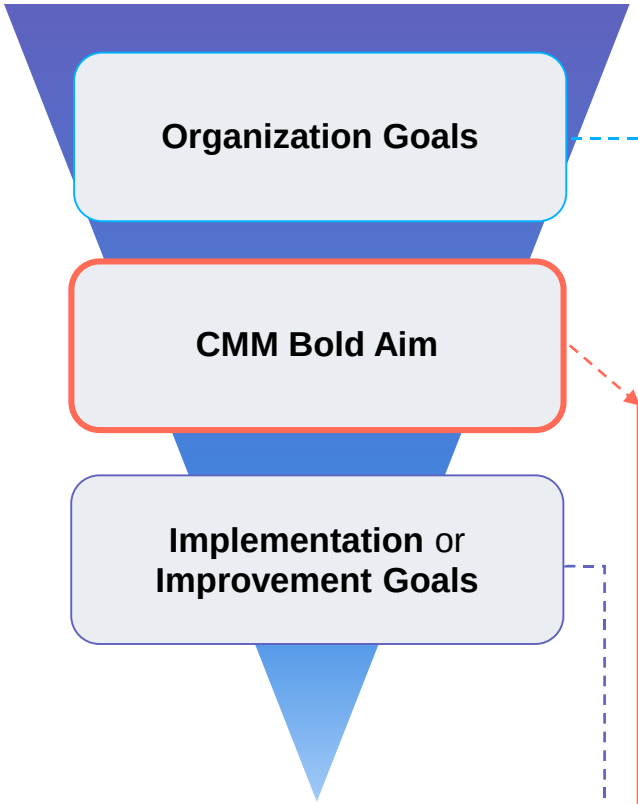
Creating Your CMM Bold Aim Statement

Creating a **Bold Aim Statement** for your comprehensive medication management (CMM) implementation or improvement effort should be a team-based endeavor. You should ultimately seek organizational buy-in for your Bold Aim, especially once you start making the business case for why CMM is important for your practice.



Organization Goals are the key priorities of your organization and the outcomes they are most interested in improving. These outcomes can be clinical or cost-related and are the 'metrics that matter' the most to your organization.

Examples:

- *Improving chronic disease quality metrics (e.g., HEDIS measures, UDS measures)*
- *Improving access*
- *Reducing readmission rates*
- *Closing clinical care gaps (e.g., decreasing HbA1c to ≤9% in 70% of patients with HbA1c>9% within 18 months; meeting system BP goals in 80% of patients by Dec 2022)*

Your team's **Bold Aim** is the overarching aim of your CMM implementation or improvement effort. Your aim statement should be created by your team and should align with your organization's goals. Your team's Bold Aim will be the driving force for your CMM work.

Examples:

- *"By the end of 2022, our CMM program will increase the number of patients we see to 6,000 unique patients and our CMM clinical data will exceed clinical quality goals."*
- *"Reduce A1c from ≥9% to <9% and BP from ≥140/90 to <140/90 for 200 patients with uncontrolled DM and HTN by improving medication adherence to 70% within 9 months."*
- *"Decrease Medication Therapy Problems (MTPs) by 75% in our 1250 CMM patients from September 2021 through August 2022."*

An **Implementation** or **Improvement Goal** is a goal your team sets for a specific area targeted for implementation or improvement.

Examples:

- *"Within the next two weeks, develop a protocol for identifying patients who will be offered CMM services."*
- *"Schedule follow-up visits with 80% of our CMM patients over the next 3 months."*
- *"Follow-up on 60% of our documented Medication Therapy Problems (MTPs) over the next 6 weeks."*

CMM in Primary Care Research Team
UNC Eshelman School of Pharmacy Center for Medication Optimization
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Every goal your team sets – whether it's a **Bold Aim** statement or a goal for a given improvement cycle – should consist of (at least) the following 4 elements:

- ✓ **A Target Population:** Identify the Population of Focus or a group of patients or stakeholders that will be the focus of your intervention (e.g., patients with diabetes, all high-risk patients, patients scheduled for CMM appointments).
- ✓ **Specific Measure(s):** State/define the specific measure(s) you will be tracking (e.g., A1c, statins, readmissions, follow-up appointments made, clinical indicators).
- ✓ **Outcomes:** Establish a set of results that will stretch or improve the team's capacity (e.g., patients with diabetes brought to goal, patients scheduled a CMM follow-up appointment).
- ✓ **Timeframe**: Set a timeframe within which the goal can be achieved but which also stretches the capacity of your team.
  - Your Bold Aim should be measureable within months to years
  - Improvement goals should be measurable within weeks to months

Start here to begin defining your Bold Aim for your CMM implementation or improvement effort.

Define Your Bold Aim		
Organization or Clinic Name:		
Target Population	Clinical condition(s)	
	Manageable number	
Specific Measures	Clinical measures	
	Frequency of measurement	
Goal Outcomes		
Timeframe for achieving your Bold Aim		

Create a Bold Aim Statement for your team's CMM implementation or improvement effort

Bold Aim Statement

- ✓ As a team, use the information listed in the previous chart to create your Bold Aim Statement
- ✓ Share your Bold Aim with key stakeholders to facilitate buy-in and support for your CMM-related work
- ✓ Keep track of progress towards your team's Bold Aim throughout your implementation or improvement effort, in order to remind you of the end goal of all your work

Document and track data related to your CMM Bold Aim

Bold Aim Measurements			
Timeline (when was the data collected?)	**Indicator Data** (what data was collected?)	**Sources of Evidence** (where did the data come from?)	**Interpret Data** (what is your interpretation of the data?)
Baseline Date:			

➢ For information on how to track your data via run charts, see our document titled ***Using Run Charts to Track Your Data*** in Step 8.

Bold Aim Statement Examples

Bold Aim Statement Example #1

2021-2022:

Bring 650 of the 1000 highest medication risk patients (DM, HTN, opioids) to specified goals from July 2021 to May 2022.

	CMM Referral Criteria	Goal
DM	A1c ≥ 9%	A1c < 9%
HTN	BP ≥ 150/90 mmHg	BP < 150/90 mmHg
Opioids	Concomitant use of opioid, BZD, and muscle relaxant	Discontinuation of at least one agent

2022-2023:

RESOLVE 70% of MTPs by December 31, 2023 for all patients seen for CMM within our health system.

Bold Aim Statement Example #2

Reduce A1c from ≥ **9%** to **< 9%** and BP from ≥ **140/90** to **< 140/90** for **200** patients with uncontrolled diabetes and hypertension by improving medication adherence to **70%** within **9 months**.

Bold Aim Statement Example #3

AIM #1:

Medication Reconciliation

- 90% of admitted patients will have home medication lists verified by pharmacy within 24 hours of transfer to the acute care floor to ensure complete accuracy
  - **Baseline: 20%** of admitted patients had accurate home medication lists when pharmacy not involved
- Tracking: Bi-monthly data analysis

AIM #2:

Discharge Counseling

- High-risk patients will be counseled by a pharmacist prior to discharge
- Goal: **90%** on **Q25 HCAHPS** score
  - **Baseline:** 2018 average HCAHPS score for **Q25 = 60%**

Bold Aim Statement Example #4

For 2020/2021, our bold aim consists of 3 core focus points.

Aim #1 – Bringing Diabetes Populations of Focus to goal (Goal= HbA1c to 8 or under)

Improvement
40% to goal in 6 months
80% to goal in12-month

Engaged Patients *(*1)*
50% to goal in 6 months
95% to goal in 12-month

All Diabetic Populations of Focus,
25% of patients show a reduction in BMI by **6 months** and
50% of patients show a reduction in BMI by **12 months**.

Aim #2 – Comprehensive Medication Management and Nutrition Services

We have a goal to offer CMM to **all PoF Patients**. Our goal is to offer face-to-face consults to **60%** of patients by **6 months** and **100%** by **12 months**.

Aim #3 – Reduction in Medications

We have a goal to reduce the **# of Medications** of our **Polypharmacy PoF** by **10%** at **6 months** and **20%** by **12 months**.

**1 - Engaged Patient is defined as a patient who has had a face-to-face encounter with our Clinical Pharmacist, Nutritionist, or Clinical PharmacyTechnicians.*