Clinic Coordinates with University, Brings CMM to the Underserved

The Center for Healthy Hearts, a free clinic, partners with the Virginia Commonwealth University School of Pharmacy and its Center for Pharmacy Practice Innovation.

The clinic is a medical home for the uninsured in Richmond and houses the CMM program with the university providing faculty and expertise. "In return, we have a site where we can be innovative and develop new clinical models as well as have a great learning environment for pharmacy students and others," said Dave L. Dixon, Pharm.D., FACC, FCCP, FNLA, BCACP, BCPS-AQ Cardiology, CDCES, CLS, of the Center for Healthy Hearts.

Today, the CMM team includes five pharmacists (0.5 FTE) and two pharmacy residents (0.8 FTE). Roughly 20 to 24 advanced pharmacy practice experience (APPE) students are involved each year, plus numerous service-learning students (512 hours per year).

AT A GLANCE

Center for Healthy Hearts
Richmond, VA

Person in charge: Evan M. Sisson, Pharm.D., MSHA, BCACP, CDCES, FADCES

Organization type: Free clinic—501(c)3

Launched: 2008

Payment sources: Grant, public and private contract funding

Funding sources: Pharmacy school pays for pharmacists and PGY-2 residents

Number of pharmacists: 0.5 FTE among 5 volunteer pharmacists

Number of sites: 1

Unique patients served in last 12 months: 525

Can patients self-refer? Yes

Notable findings:

- Collaborations between safety-net clinics and schools of pharmacy can be a "win-win," providing experience for pharmacists and students while offering otherwise unavailable resources to the clinic.
- Board certification is becoming important.
- A study of 250 patients (six months before and after CMM intervention) revealed CMM was associated with an 86% reduction in inappropriate emergency department use.

Professional advancement: board certification and residency

Board certification is only going to become more important for pharmacists practicing CMM, Dixon predicted. "If you asked me a few years ago, I would have had a different answer." But now, he thinks it will be important in terms of billing and credentialing. "So from a CMM standpoint, it's really important." He plans to pursue board certification in ambulatory care this year.

Similarly, he sees residency training as important for CMM. Even though he believes schools of pharmacy are moving in the direction of preparing students to provide CMM, "by and large, I think CMM requires post-graduate training."

"You must be able to demonstrate the value of your CMM program to various stakeholders."

Making a difference

A review of 250 patients referred to the Center from local emergency departments (six months before and after CMM intervention) revealed CMM was associated with an 86% reduction in non-emergent emergency department use. Dixon noted part of this success relates to connecting uninsured patients with chronic conditions to a medical home. Its recently published evaluation of this model reported that reduction in blood pressure was durable over the four-year study period with a mean blood pressure control rate (68%) that exceeded the NCQA reported mean control rates (57% for Medicaid) for the same time period.[1]

A second retrospective study evaluated the time to blood pressure goal compared with usual care using data from existing medical records in uninsured patients with hypertension. The primary outcome was time from the initial visit to the first follow-up visit with a blood pressure <140/90 mm Hg. The study included 377 patients (259 = Center; 118 = usual care). Median time to blood pressure goal was 36 days at the Center vs 259 days in usual care ($P < .001$). At 12 months, blood pressure control was 81% and 44% in the Center and usual care cohorts, respectively ($P < .001$). The authors concluded that collaborative models involving pharmacists should be considered to improve blood pressure control in all high-risk populations.[2]

Adding CMM services had a major impact on how the clinic served its patients, he said. Before 2008, the Center was primarily a nurse-driven clinic with physician support. Patients received refills on their medications and assistance by completing the patient-assistance paperwork; however, chronic disease management through medication management was not formally performed. "Integrating pharmacists into the care model and allowing them to provide CMM via collaborative practice agreements with the medical director allowed for expansion of services to include diabetes education and management and improved management of hypertension and dyslipidemia," he said.

Success factors

Dixon identified two factors contributing to his program's success:

1. **Support from the board of directors and the clinic medical director:** For the medical director, it was a "no brainer," Dixon said. But they encountered some uncertainty from the board—not all of whom are health care professionals. "There was a little bit of 'pharmacists doing what?'" Having the medical director on board—and on the board—made a big difference. "I think for the board it was more a function of necessity, to be honest, but at the same time, a great opportunity to try something new. Timing and need will drive these things."
2. **Ability to initiate therapy:** He attributes this to two factors: broad collaborative practice agreements and scope-of-practice regulations. "In Virginia, pharmacists can initiate drug therapy as long as the condition has been diagnosed by one of our physician or nurse practitioner colleagues."

Lessons learned

1. **Be patient with administrators and physicians.** It takes time to build trust, but once they see the results of CMM, they will buy into what you're doing.
2. **Be proactive in developing a way to make it financially sustainable.** "Being a free clinic helps in some ways but hurts in others." Public monies only provide a portion of the annual operating expenses. "That's why we're working on referral agreements to diversify our revenue streams, using a capitated approach," he said.
3. **Demonstrate results.** "You must be able to demonstrate the value of your CMM program to various stakeholders, and that requires developing an ongoing data collection process that demonstrates the pharmacists' impact."

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1. Sisson EM, Dixon D., et al. "Effectiveness of a Pharmacist-Physician Team-Based Collaboration to Improve Long-Term Blood Pressure Control at an Inner-City Safety-Net Clinic" Pharmacotherapy 2016;36:342-347
2. Dixon DL, Sisson EM, et al. Pharmacist-physician collaborative care model and time to goal blood pressure in the uninsured population. J Clin Hypertens. 2017;00:1–8. doi.org/10.1111/jch.13150.

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