Integrated, Hands-on Hennepin Clinical Pharmacists Meet Patients Where They Are

Serving a largely Medicaid population, Hennepin County Medical Center's CMM program helps reduce readmissions and emergency department visits by taking a whole-person approach and working collaboratively with the rest of the clinical team.

Hennepin Healthcare operates a hospital, primary care clinics, specialty clinics and retail clinicals throughout the county. It's a teaching hospital and a safety net provider with 10 community pharmacies. The system has a robust and integrated pharmacy system where the inpatient, CMM and community pharmacy program work together for the whole patient.

AT A GLANCE

Hennepin County Medical Center
Minneapolis, MN

Person in charge: Mark Holtan, Pharm.D., BCACP, AAHIVP, Ambulatory Pharmacist Manager

Organization type: Safety net health system

Year CMM launched: 2007

Payment and funding sources: Medicaid fee- for-service and self-pay; ACO contracts; grants; 340B savings

CMM/DS-MTM staff:

- 16 pharmacists (10.8 FTE)
- 2 pharmacy residents (about 1.4 FTEs)
- 5 pharmacy students (.4 FTE) over the course of the year
- 2 clerical staff (1.1 FTE)

Number of CMM/DS-MTM sites: 16

Unique CMM patients served in last 12 months: 2,722

Unique DS-MTM patients served in last 12 months: 1,349

Can patients self-refer? Yes

Notable findings:

- Extending beyond the traditional walls of the clinic, pharmacists meet patients where they are, including homeless shelters and skilled nursing facilities—and as part of transitional care teams.
- Patients in the transitions-of-care unit who received CMM services had a 10% lower rate of 30-day readmissions and 12.3% reduction in ED visits compared to a control group.

Comprehensive care, everywhere

Clinical pharmacists are embedded at a wide range of sites varying from internal medicine to specialty sites. Regardless of the primary condition of the patient, the philosophy of the team is whole patient care—looking at every medication and every disease state and how they interact. The team-based care model at HHS means that non-medication patient issues can also be addressed. If the patient is asked to take a medication with food, and they don't have access to food, the team can utilize the social worker to help address those needs. Socioeconomic issues can have a huge impact in a patient's ability to adhere to medications, and sometimes those are the most important to address.

In many instances, a patient's primary care condition is able to be managed even when seen at a specialty clinic by a pharmacist. For example, they are often able to manage a patient's blood pressure and cholesterol in psychiatry clinic through a collaborative practice agreement (CPA) for a patient who doesn't often present to their PCP. CPAs are linked to provider referrals and can be easily initiated and tracked through the EMR. In primary care clinics, many of us are working shoulder to shoulder with providers and can make changes through direct recommendations to the patient's care team.

Return on Investment can sometimes be difficult to define with CMM. Direct payments for services provided often don't offset the pharmacist's salary. Health systems are constantly looking for areas to cut costs, and pharmacist expenses often stand out. Integrating pharmacists into specialty medication initiation within the CMM model has been valuable to the institution financially while working to reduce readmissions, ED visits and other medical spending. Tying the department to increased revenue and decreased costs is especially important at a 340B institution.

Success factors

Holtan identified three critical elements for success:

1. **Integrated, interdisciplinary care team:** Pharmacists in the hospital, in community pharmacy and in clinics work alongside providers and other members of the care team. Pharmacists are an integral part of each team, accessible by pager, EMR and in person. For clinics that don't have a pharmacist presence, there is a centralized consult pharmacist available for any questions that arise.
2. **EMR integration:** Important data is accessible to all members of the care team. This can be patient specific data that is essential to the care of the patient you are seeing but can also be aggregate data to evaluate outcomes and identify specific areas to target.
3. **Funding:** Funding and reimbursement come from several sources, including some Medicaid fee-for-service, self-pay, ACO contracts and 340B savings reinvested into program. Seeking out grant funding with clinical partners has also been valuable.

Lessons learned

1. **Consider sustainability when starting or maintaining a practice.** Simply placing a pharmacist in a clinic and hoping for success rarely works. Ensure that medical providers in that clinic and ancillary staff are aware of the role of the pharmacist and the care provided. And make sure that there is enough pharmacist coverage. It's often tempting to expand out to new clinics without enough coverage to succeed rather than increasing existing clinic coverage to improve services.
2. **Meet the patients where they are.** During this time of reduced clinic access and COVID-19, they've pivoted care to providing phone and video services, in addition to in person visits. Many patients have lost accessibility to their primary care provider, so clinical pharmacists have been paramount to connecting with patients, arranging medication access and addressing health needs. They have worked hand in hand with mail services to ensure patients maintain control of chronic disease with consistent access to medications.
3. **Consider the finances.** Without losing sight of the CMM model, ensure that ambulatory clinical pharmacists are involved with health system initiatives. By aligning with primary care and transition of care initiatives and a large part of the specialty pharmacy strategy, Hennepin ensures it is valuable part of cost saving and revenue initiatives.

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Get the medications right

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