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A primary care psychiatric pharmacist clinic for addressing hypertension and mental health disparities in black patients

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Abstract

A psychiatric pharmacist can play a critical role in addressing health disparities in black patients by managing both psychiatric and nonpsychiatric conditions. Black patients experience disparities in the treatment of both hypertension and mental health disorders, highlighting the need for innovative care models. This paper describes the integration of a psychiatric pharmacist into a primary care clinic to provide comprehensive medication management for hypertension, psychiatric disorders, and tobacco use disorder in black patients. The integration of this model faced challenges, including limited pharmacist funding and provider unfamiliarity with the psychiatric pharmacist's role. We describe how these barriers can be mitigated through relationship-building and demonstrating the pharmacist's value in patient care. This model highlights the potential for psychiatric pharmacists to provide whole-person care, addressing both psychiatric and nonpsychiatric conditions and working to reduce health disparities. The implementation of psychiatric pharmacists in primary care settings may serve as a strategy to improve equitable health care access and outcomes for black patients.

Keywords: psychiatric pharmacy, health disparities, hypertension, mental health, health equity, black Americans

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Introduction

Hypertension and mental health (MH) disparities increase the risk of morbidity and mortality in black Americans compared with non-Hispanic white Americans.[1,2] Patients diagnosed with MH conditions are at higher risk for being diagnosed with hypertension and other cardiovascular conditions.[3,4] To improve clinical treatment and outcomes of black Americans, a comprehensive approach that addresses the intersectionality of physical and mental health is needed. Because most psychiatric pharmacists complete a general pharmacy residency prior to specialized psychiatric training, psychiatric pharmacists are poised to meet this need.

To our knowledge, there have been no published descriptions of a psychiatric pharmacist providing comprehensive medication management (CMM) under prescriptive authority of hypertension and MH conditions in black patients in a primary care setting. Published studies focus on either pharmacists reducing hypertension health disparities in black patients or psychiatric pharmacists reducing MH disparities in a safety-net clinic and patients who are indigent.[5-10] Studies on psychiatric pharmacists within a primary care clinic mostly consist of pharmacists providing medication management of MH conditions with limited prescriptive authorities for other disease states.[11-15] Additionally, none of these studies focuses on the black population. The objective of this paper is to describe a psychiatric pharmacist integrated within a primary care clinic providing CMM under prescriptive authority of hypertension and MH conditions in black patients.

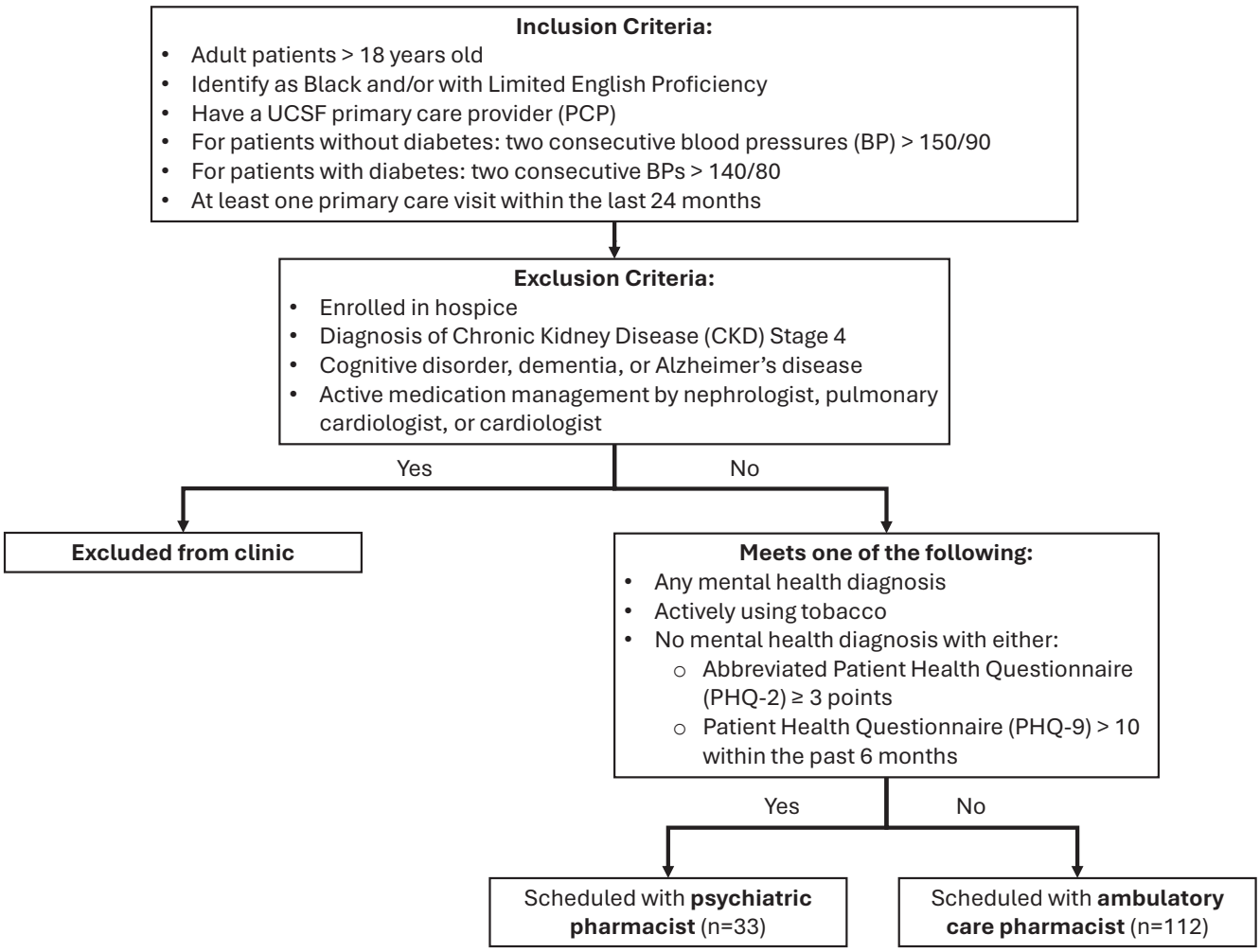

FIGURE: Patient inclusion/exclusion criteria and clinic scheduling workflow

Description

In September 2020, the University of California, San Francisco Health System (UCSF) identified a disparity of more than 10% in blood pressure (BP) control between all empaneled black (67.6%) and nonblack patients (77.8%). To address this, UCSF Health, in collaboration with the UCSF School of Pharmacy, created a telehealth pharmacist clinic embedded within primary care focused on black patients. A model was created with a Board-Certified Psychiatric Pharmacist and ambulatory care clinical pharmacist. Both pharmacists had full prescriptive authority under a collaborative practice agreement to adjust or manage medications, set follow-up schedules, and order laboratory monitoring related to hypertension. The psychiatric pharmacist was additionally scoped for all medications related to MH diagnoses and substance use disorders. The clinic was staffed by 2 pharmacists with 0.3 full-time equivalents (FTEs) and 2 health care navigators (HCN). The psychiatric pharmacist was a faculty member at the affiliated school of pharmacy and provided 1 half-day (0.1 FTE), whereas the other pharmacist provided a full day (0.2 FTE) of clinic.

Enrollment was initially restricted to black patients with 2 consecutive BPs > 150/90 mmHg for patients without diabetes and 2 consecutive BPs > 140/80 mmHg for patients with diabetes. Patients were primarily identified through the electronic medical record dashboard. The inclusion and exclusion criteria and clinic scheduling are shown in the Figure. HCNs conducted outreach to patients identified through the dashboard, conducted an intake, and enrolled the patient in the program if the patient agreed. Patients with MH diagnoses, Patient Health Questionnaire (PHQ-9) scores > 10, or who were actively using tobacco were scheduled with the psychiatric pharmacist (Figure). All other patients were scheduled with the generalist pharmacist. When clinic capacity increased, we began enrolling patients with limited English proficiency as this was another priority population for UCSF.

The psychiatric pharmacist conducted visits via telephone or the video conferencing platform Zoom (San Jose, California) and provided CMM of hypertension, MH conditions, and/or tobacco use. Initial appointments were 40 minutes, and follow-up visits were 20 minutes with the

psychiatric pharmacist seeing 4 to 6 patients per week. Patients were mailed an electronic BP cuff, which was funded by the Office of Population Health, and instructed on proper BP management technique by the pharmacists and HCNs. The pharmacists collected home-measured BPs from patients and assessed in-clinic BPs measured at in-person primary care or specialty visits to assess hypertension. The psychiatric pharmacist assessed MH conditions through mental status examinations, validated psychiatric scales, a psychiatric interview, assessment of adherence, and laboratory monitoring. Tobacco use disorder was assessed through smoking history, current smoking status, the Heaviness of Smoking Index, and assessment of triggers and previous quit attempts.[16] Both pharmacists identified as Chinese American and spoke clinical Spanish and Mandarin Chinese. For all other non-English languages, a translator was used.

The psychiatric pharmacist provided CMM of hypertension, MH conditions, and tobacco use disorder, including initiating, adjusting, and discontinuing medications; addressing drug-drug interactions; providing motivational interviewing; assessing adherence techniques; ordering and monitoring laboratory tests; providing diet/lifestyle and behavioral counseling; connecting patients with nonpharmacologic resources (eg, psychotherapy); coordinating care (eg, contacting providers for other patient needs); and assisting with insurance coverage issues. When the clinic started, pharmacists provided detailed notes with their thought process and collaborated on decision making to establish credibility and clinical rapport with new providers (described below). Within 3 months of clinic initiation, the pharmacists transitioned to independent practice.

On average, patients were seen every 1 to 3 months. The HCNs provided health coaching and care coordination 1 to 2 weeks after each pharmacist visit. Patients were eligible for graduation from the program if their BP was at goal for at least 3 consecutive months. BP goals were individualized based on patient comorbidities and age and according to American Heart Association/American College of Cardiology guidelines. Upon becoming eligible for graduation, patients could continue participation in the program if they had uncontrolled MH or wished to remain with the clinic.

Results

From September 2020 to July 2022, 112 patients were enrolled in the pharmacy clinic. Of these patients, 24 patients had at least 50% of their visits with the psychiatric pharmacist, and 22 of those patients identified as black (the remaining 2 were patients with limited English proficiency). The Table summarizes the demographics of the 22 patients. After 1 year, the clinic patient population was expanded to black patients with diabetes and patients with limited English proficiency. With the success of this clinical model, the primary care leadership funded 3 full-time primary care clinical pharmacists to expand this model across other disease states and priority areas in primary care.

TABLE: Demographics of included patients

Characteristic	n (%)
Age (Mean ± SD)	58 ± 10 years
Race/Ethnicity	
Black or African American	22 (100)
Gender	
Female	11 (50)
Male	11 (50)
Psychiatric Diagnoses[a]	18 (82)
Major Depressive Disorder	12 (55)
Generalized Anxiety Disorder	3 (17)
Posttraumatic Stress Disorder	8 (36)
Schizoaffective Disorder	2 (9)
Substance Use Disorders	13 (59)
Tobacco Use Disorder	11 (50)
Alcohol Use Disorder	2 (9)
Encounter Diagnoses	273
Encounters per patient (Mean ± SD)	12 ± 8
Hypertension and MH[b]	129 (47)
Hypertension and Tobacco Use Disorder[c]	27 (10)
Hypertension, MH, and Tobacco Use Disorder[d]	12 (4)
Hypertension[e]	95 (35)
MH	8 (3)
Substance Use	2 (1)

[a]Values do not add up to 100% due to some patients having more than 1 psychiatric diagnosis.
[b]Number of encounters that included hypertension and at least 1 MH diagnosis as reasons for visit.
[c]Number of encounters that included hypertension and at least 1 substance use diagnosis as reasons for visit.
[d]Number of encounters that included hypertension, at least 1 MH diagnosis, and at least 1 substance use diagnosis as reasons for visit.
[e]Patients declined making changes to their psychiatric regimen, had stable MH symptoms, or had psychiatric medications managed by an outside provider.

Discussion

One major challenge was building trust and relationships with the primary care providers (PCPs). When the psychiatric pharmacist began adjusting medications, some PCPs, having never worked with a psychiatric pharmacist before, were unsure whether the pharmacist had the expertise and training to adjust and manage MH medications and conditions. Other PCPs were not comfortable themselves with managing MH conditions and preferred to defer management to psychiatry. To build trust and a relationship, the psychiatric pharmacist first dialogued with the PCP about recommendations for treatment before prescribing directly. They did this by messaging the PCP after each visit with a nontemplated summary, detailing their thought process, assessment, reasoning, and suggestions for medication

therapy adjustments. PCPs would either respond by indicating their agreement or initiate a discussion with the pharmacist if they had a question about the recommendation. This process helped to build a relationship and collaborative approach between the PCP and pharmacist. As the PCPs saw the positive outcomes on the patient's conditions and heard directly from their patients the benefit of working with the pharmacist, they trusted the pharmacist more and soon turned management of those conditions over to them. In a few months, the psychiatric pharmacist was prescribing and managing medications directly without first suggesting the recommendation to the PCP. It became a very collaborative relationship with PCPs messaging the pharmacist asking for advice on how to manage the patient, requesting follow-up areas for the pharmacist visit, and consulting them on other patients with MH concerns. Even after prescribing independently, the psychiatric pharmacist continued to send summarized updates from each patient visit and dialogued frequently with PCPs to ensure continuity of care and a continued relationship.

The focus on a historically marginalized population also afforded unique challenges. Many of the clinic patients shared their negative experiences and mistrust in the health care system and providers. The psychiatric pharmacist in this clinic received training in relationship-centered communication skills for racial equity, which was a virtual synchronous session offered through the psychiatric pharmacist's institution, and has experience creating diversity, equity, inclusion, and antiracist pharmacy curricula and pedagogy. Utilizing these skillsets, the psychiatric pharmacist provided culturally humble care and empowered the patients to engage in and take charge of their own health. For many patients, the psychiatric pharmacist was the provider they saw most frequently and consistently. Several patients remarked how they felt they could trust the psychiatric pharmacist and that the psychiatric pharmacist truly cared about their well-being. For practitioners creating clinics to address health disparities in specific populations, especially those who are historically marginalized, we recommend that they receive training in providing relationship-centered, culturally humble care and, above all, value the patient's perspective and autonomy in their health; possible sources of training include continuing education from professional pharmacy organizations, the Academy of Communication in Healthcare, and programs/presentations from affiliated schools of medicine. Another consideration is patient-provider racial concordance. Whereas there was no racial concordance in this clinic, the pharmacists were still able to establish strong patient-provider relationships. In black patients, some studies suggest improved patient experiences and outcomes, whereas others show neutral effects with patient-provider racial concordance. There is conflicting evidence for other racial groups for patient-provider racial concordance, and this should be considered in designing interventions for specific populations.[17]

Another learning point from this clinic was the opportunity to create a new ambulatory care psychiatry pharmacy practice from a primary care need. Though the focus of the clinic was on hypertension management, by including a psychiatric pharmacist, we were able to demonstrate the value of psychiatric pharmacists in primary care. In an institution in which providers are unfamiliar with psychiatric pharmacists, it can be difficult to obtain provider buy-in for funding a position. There are several aspects that helped our clinic model to be successful in obtaining sustainable funding. First, we focused on an institutional priority tied to an objectively measurable outcome and financial incentives. UCSF Primary Care needed to meet a benchmark of 73% of black patients having controlled hypertension within the fiscal year to receive funding for the subsequent year. We reached that goal and demonstrated the impact of our clinic specifically by showing that the patients to target were those who reached their BP goal after enrolling in the clinic. The psychiatric pharmacist requested that MH outcome data be collected and presented at each monthly clinic team meeting, further highlighting their impact. Finally, we had physician champions with whom the pharmacists worked closely in the creation, implementation, and evaluation of the clinic. These physician champions were PCPs themselves who were able to directly see the impact of the pharmacy clinic on their patients and advocated for continued funding and expansion of ambulatory care pharmacy services to health system leadership.

Conclusion

Through collaboration with physician partners, establishment of trust with PCPs, and alignment with institutional priority metrics linked to funding, we successfully demonstrated the value of a psychiatric pharmacist in a primary care clinic focused on addressing both physical and MH conditions in black patients. This approach secured sustainable funding and facilitated the expansion of pharmacy services. This model highlights the critical role psychiatric pharmacists can play in improving health equity by integrating comprehensive medication management into primary care settings.

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