SOUTHWEST VIRGINIA
COMMUNITY HEALTH SYSTEMS

Opening Doors to Quality Healthcare

Implementing a new Clinical Pharmacy Service at SVCHS: CKD Management

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Objectives

- Describe how clinical pharmacists are integrated at SVCHS
- Discuss how clinical pharmacy programs are funded in FQHCs
- Introduce the grant that supported creation of our CKD service line
- Outline the real-world implementation, challenges, and early outcomes of this new service
- Summarize long-term sustainability of the CKD service through efficient workflows, measurable outcomes, and clear value to providers and patients

SVCHS - “Opening Doors to Quality Healthcare”

- 4 Primary Care Sites (FQHC/CHC)
  - Integrated Behavioral Health
  - Integrated Clinical Pharmacy
- 2 Dental Sites
- 1 Optometry Site
- 1 Entity-owned Pharmacy
- 3 New Day Recovery Sites
- Migrant Health Network
- School Based Health

SVCHS Clinical Pharmacy

- Integrated clinical pharmacy team across 4 primary care sites
- **Staffing:** 2 clinical pharmacists (1.4 FTE) + 2 certified pharmacy technicians
- **Focus areas:** Hypertension, diabetes, CV risk reduction, UDS & Aledade quality measures
- **Proven impact:** Pharmacist-led SMBP program improved HTN control 15–20% since 2021
- **Why CKD:** Natural extension due to overlap with HTN, diabetes, and SDOH barriers
- Supports SVCHS's mission by improving access to high-quality, team-based chronic disease care

Funding Justification for Clinical Pharmacy

- 340B Drug Pricing Program Savings
- Quality savings/Value Based Care contracts
- AWVs, TOCs, CCM
- Grant opportunities – federal, state, private
- Internal reinvestment from improved quality and reduction in unnecessary referrals and costs

Direct Relief Grant Opportunity

- Improve CKD screening rates in populations with hypertension and diabetes
- Optimize care for patients with established CKD, including improving BP and A1c control, avoiding nephrotoxins, and ensuring appropriate use of ACE/ARBs, SGLT2 inhibitors, and statins
- Address social determinants of health, especially medication access, using PRAPARE data
- Strengthen interdisciplinary care through provider education and integrated pharmacist workflows

CKD Service Design & Implementation

- Staff: Recruitment/Hiring/Onboarding
- Technology: Operations & Outcome Tracking, EMR Templates/Structured Fields
- Workflows: Outreach, Scheduling
- Training & Education: Patient Handouts
- Implementation
- Outcome Tracking and Reporting

CKD Management Program

Identify & Outreach

- Identify patients – Azara PVPs, or DRVS algorithms
- Provider referrals
- Outreach by phone or in clinic
- Schedule for enrollment visit with clinical pharmacist
- CKD screening recommendations for HTN and DM patients

Initial Enrollment Visit

- Clinical Pharmacist Office Visit w/ comprehensive medication review
- CKD education using standardized materials
- Recs for med optimization (BP, HTN, HLD, renal doses)
- NSAID/nephrotoxin avoidance counseling
- SDOH review and access interventions
- Optional pillbox with education

Follow-up

- Ongoing communication with PCPs
- Six-month focused follow-up visit with targeted education on CKD nutrition, HTN control, or diabetes depending on patient need
- Review labs/implementation of changes from initial visit

Implementation Timeline

Months 1-3

- Hiring processes, workflow development, building documentation tools, and creating educational material

Months 3-4

- Training providers and clinical staff; refining screening workflows

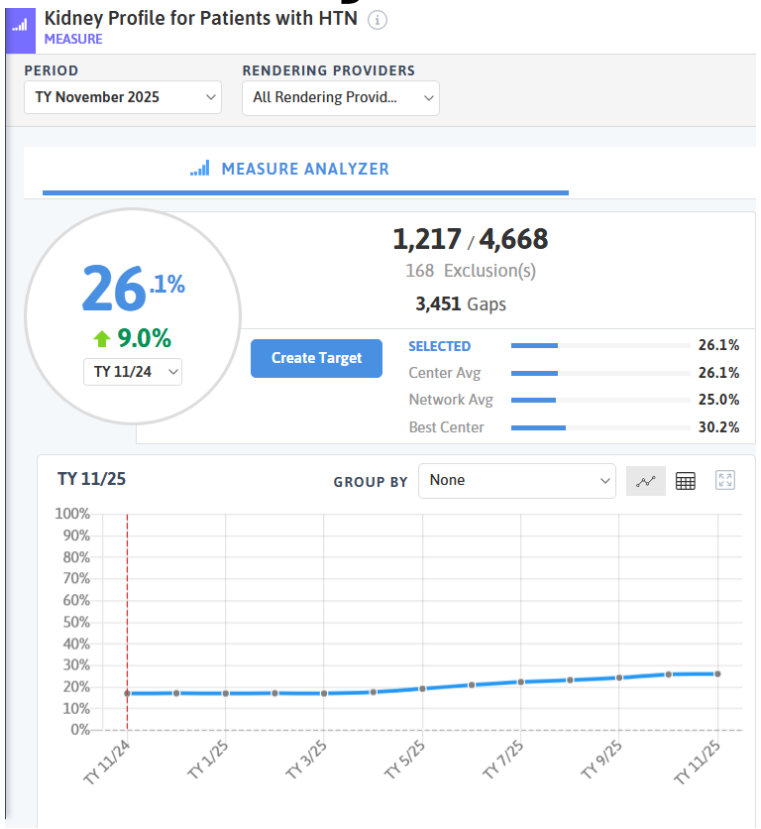
Months 4-6

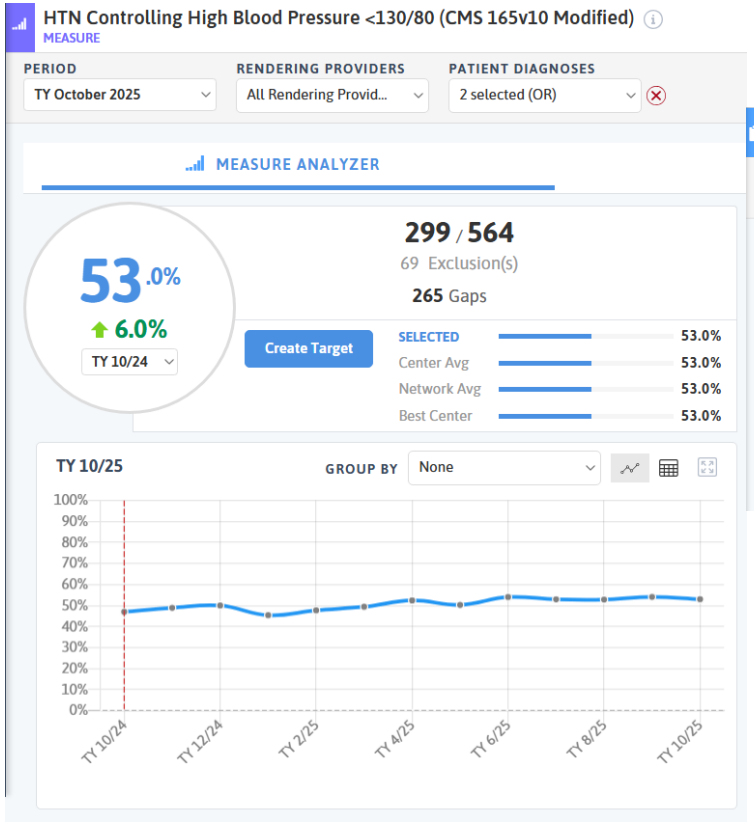
- Launch of patient visits, outreach campaigns, and use of PRAPARE for SDOH interventions

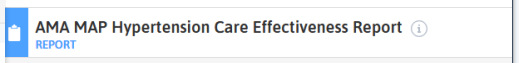
Challenges & Opportunities

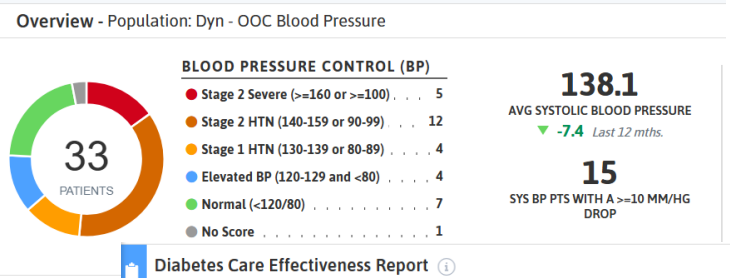
- Primary Care Provider engagement
  - CMO/Leadership Support, Workflows, Education
- CKD patient diagnosis, communication, and education
  - Provider education by CMO, Pharmacy Services Director
- SDOH Assessment & Intervention with PRAPARE form at SVCHS
  - Workgroup initiated to work on the health system processes for SDOH assessments, interventions, and intervention tracking

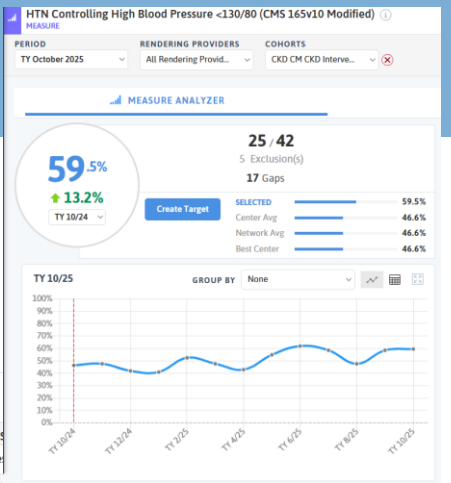
Early Wins & Successes

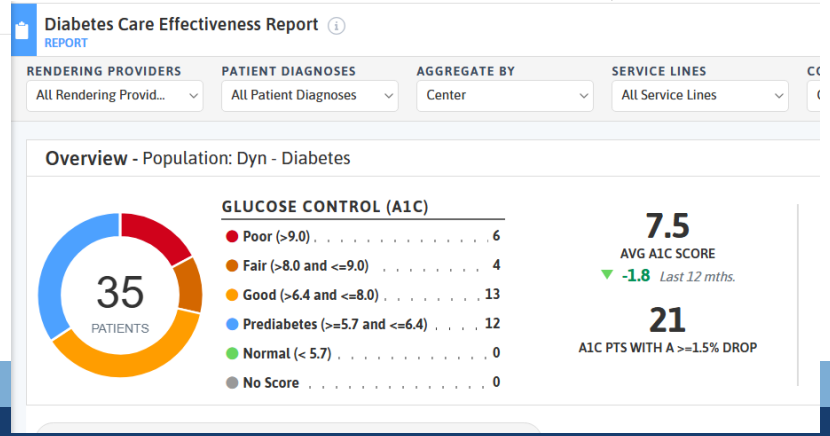












Honesty | Professionalism | Teamwork | Communication | Continuous Improvement | Accountability

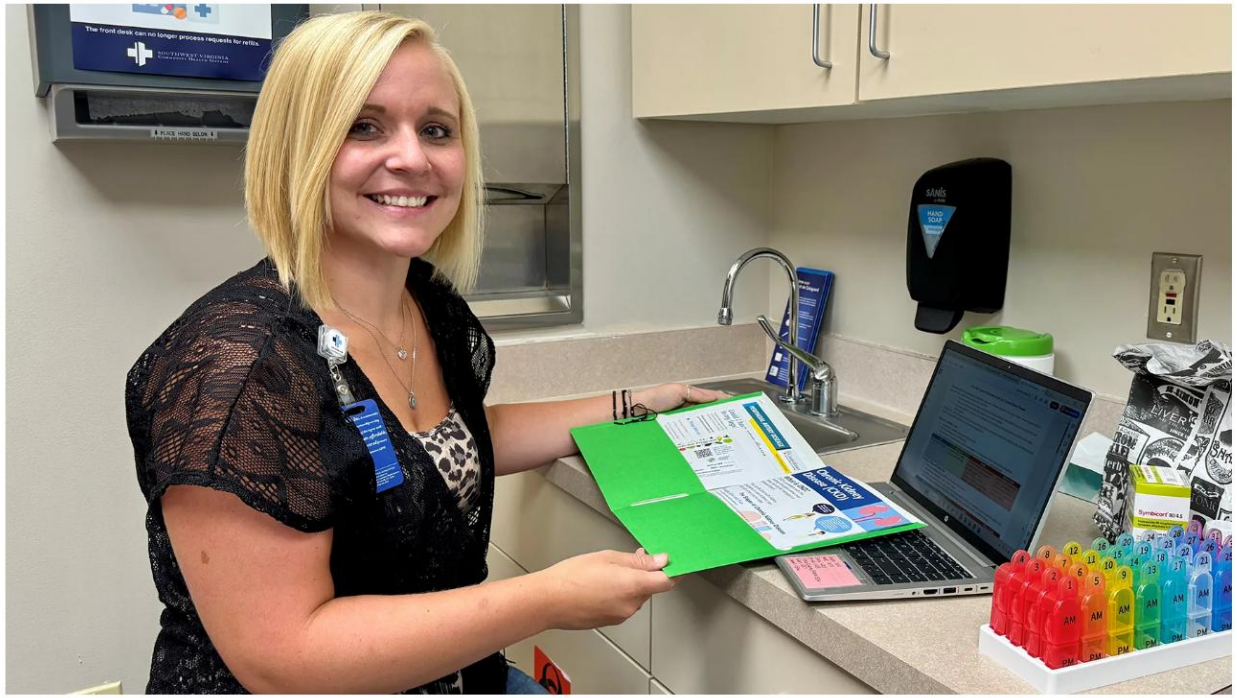
Patient Impact

“Many patients enter the program unaware they have low kidney function or have never had a thorough discussion about their CKD diagnosis. Pharmacists are filling this gap with individualized education, therapy optimization, and close monitoring—reducing risk of CKD progression and strengthening interdisciplinary care.”

— Jasmine Clevinger, PharmD

BD, Direct Relief, and NACHC Award Four U.S. Community Health Centers for Innovation in Care

In collaboration with Direct Relief and the National Association of Community Health Centers, BD invests $900,000 to advance medication management programs for vulnerable patients.



Jasmine Clevenger, PharmD, of Southwest Virginia Community Health Systems, which received financial support to expand clinical pharmacy services to better support patients with chronic kidney disease. (Courtesy

Sustainability & Next Steps

Sustain

- Continuing 340B pharmacy savings
- Value-based care incentives tied to BP, A1c, and CKD screening
- Internal reinvestment tied to demonstrated improvements in quality metrics
- Integration with our existing DM and HTN service lines for shared workflows and efficiencies

Next Steps

- Increasing provider referral consistency
- Improving early CKD diagnosis and staging practices
- Strengthening SDOH workflows across the system
- Expanding to earlier-stage CKD patients for prevention
- Continuing to scale outreach to meet population needs

Conclusion

- Integration of clinical pharmacist into the primary care team can improve patient outcomes and drive system level improvements in quality measures
- Targeting interventions based on quality measures, funding sources, gaps in care, or services that require significant provider time can ensure the highest-impact use of clinical pharmacy resources and support efficient, mission-aligned service expansion

Questions?

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SVCHS Clinical Pharmacy

Scheduled Appointments

- Anticoagulation Management
- HTN Management SMBP Enrollment
- CGM Set-Up
- DM Management/Education

Collaborative Visits with PCP

- Identify patients during pre-visit planning (focus on uncontrolled DM, HTN)
- See in same visit before or after PCP

PharmD Consults

- Telephone encounters for any medication related issue, question, concern, or access barrier
- Patient telephone outreach for follow ups between office visits

Collaborative Practice Agreements

- Anticoagulation Management, Diabetes Management

Targeted Interventions

- Statin use, aspirin use, anticoagulation monitoring, Hep C treatment monitoring/follow up, antibiotic stewardship
- RPM Programs: HTN SMBP Program, DM CGM Monitoring