In value-based care models, spurring greater physician-pharmacist collaboration can improve safety, cut costs, improve outcomes and provide a better patient experience.
EXECUTIVE DIALOGUE | Sponsored by Comprehensive Pharmacy Services | 2017

8 PANELISTS

MODERATOR

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EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER

Carilion Clinic | ROANOKE, VA.

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Virtua Health | MARLTON, N.J.

Jim West

PRESIDENT AND CEO

PIH Health | WHITTIER, CALIF.
As hospitals and health systems continue with the transition toward value-based care, leveraging pharmacy as a strategic asset can help to enhance patient engagement, improve quality and outcomes, and reduce costs. As key members of the clinical team, pharmacists ensure advanced medication management, and collaborate with patients and families, primary care providers and community pharmacists to ensure smooth transitions from the inpatient setting. The American Hospital Association’s Health Forum convened a group of hospital executives to explore the evolving roles of hospital and health system pharmacists. This panel highlights pharmacists’ roles across the continuum of care and how they are helping to improve organizational sustainability and enhance patient care.
MODERATOR (Bob Kehoe, American Hospital Association): How is pharmacy supporting value-based care delivery in your organizations today?

PATRICE WEISS, M.D. (Carilion Clinic): The key to what we’re doing is that the pharmacist assists physicians in developing a drug formulary that’s both cost effective and evidence-based. We no longer just view pharmacists as dispensing medications. They’re part of our clinical team. It’s worked and they enjoy it. We’re building that camaraderie where now you know the pharmacists and think nothing of picking up the phone and interacting with them.

We have pharmacists embedded in our emergency department, in surgery, as well as decentralized pharmacists who round daily with our physicians. We’ve incorporated pharmacists into our daily huddles and with many of our clinical teams because we realize their expertise is needed. We know that their role in both the clinical setting and medical homes is essential for care across the continuum. Pharmacists also aid in discharge planning and reducing readmissions.

PATRICK McGILL, M.D. (Community Health Network): We do all the things that Patrice described, but we have found that in a value-based world, a large portion of this is done in the ambulatory space. We have 20 pharmacists embedded in various clinics, based on the population or the panel size of the clinic. We try to get patients to discharge planning and to see the pharmacist in either the transitional care visit or when they come out of the hospital.

We’ve deployed pharmacists to perform annual wellness visits, including the Medicare annual wellness visit. Medicare says this visit can be done by any licensed professional, so we use residency-trained pharmacists. We started doing that because we found that 75 to 80 percent of the issues that come up in an annual wellness visit are medication-related – either cost, adherence, etc. – so, who better to manage that than the pharmacist? Pharmacists needed some training on the other aspects of an annual wellness visit – specifically, the risk-acuity coding and other areas, but that was an easy lift compared with training others on the medication aspect.
We also use pharmacists as physician extenders. In their treatment protocols, they manage diabetes, hypertension, cholesterol and asthma. In some cases, they run their own schedule in partnership with the physician. And we’ve found that pharmacists’ outcomes, especially in diabetes management, are better than those of the physicians.

Finally, the pharmacist in the ambulatory space will hold Medicare Part D education sessions, which are free to the patient. The pharmacist can do an individual assessment with the patient to help him or her figure out which is the best plan for the conditions they have and the medications they need. Those sessions have been hugely successful. I heard a calculation yesterday that this has saved $1 million to $1.5 million out of patients’ pockets for getting a more efficient, more comprehensive plan.

**SUSAN HERMAN** *(Adventist Health)*: In California, we have advanced practice pharmacists. In the ambulatory space in our oncology clinic, we have a pharmacy practitioner who sees patients after the doctor has visited with them. In a complicated case, the doctor may spend 10 or 20 minutes with the patient and then a pharmacist will spend another 30 minutes with the patient. That’s been a successful model.

**GENTRY HUGHES** *(Comprehensive Pharmacy Services)*: Are either of you getting reimbursed for any of those visits?

**HERMAN**: No, we do not.

**McGILL**: Yes, the pharmacists bill independently for the wellness visit. If it’s diabetes management, or if we use them in oncology as well, then they’ll usually bill one or two visits depending on the situation. That’s about all you can justify by the pharmacist because of the physical exam aspects that are needed for coding.

**GREG TEALE** *(Saint Luke’s Health System)*: At St. Luke’s, some sites are partnering with pharmacists to come in for 20 minutes of a 30-minute visit and will discuss what was learned with the provider, and then the provider will determine whether he or she agrees with the plan.

We’ve seen a shift from a focus on acute care. Over the last three to five years, it’s really been about how pharmacists assist with transitions in care and how we assist in the clinics. The biggest obstacle is trying to figure out how you can get integrated in the clinic with the providers to deliver that assistance. We are starting to get pharmacists in the clinics, primarily led through our specialty pharmacy. And since we have a return on investment with specialty, then you can get into certain areas – oncology, hepatology, dermatology, etc. Then you show that value in the clinic, not having to necessarily bill for those services. Once you show the value, then you can work into other areas.

**McGILL**: That’s difficult to do. In the ambulatory space, showing value is a barrier. At Community, we’re still primarily fee for service even though we have a few managed contracts. We’re in a Medicare Shared Savings Program. Pharmacists are the
most expensive ancillary service provider, so how do you show return on investment? We have this discussion frequently with our CFO and our financial and administrative folks. They’re looking at revenue and expense, and it’s hard to demonstrate ROI in value-based contracts.

Hughes: It’s about utilization, right? If they’re only 50 to 60 percent utilized for that type of service, then you’re going to get challenged. We see a lot of our clients looking at remote pharmacy solutions for these types of things – medication reconciliation, discharge planning and counseling. Then you’re able to do that on an episodic basis, and you’re getting 100 percent utilization out of the costs that you’ve applied to that effort. It’s something to consider. You’re talking about an expensive asset and it is difficult to show the direct return on it.

Tammy Huster (Virtua Health): We partner with our pharmacists during progressions rounds. A significant benefit, since we initiated this partnership a little over a year ago, was looking closely at a patient’s medication reconciliation to see how we could reduce our readmission rates. Through this process we found issues with accuracy and thoroughness, and now follow-up can be conducted throughout the course of their admission. That has been extremely beneficial. We’ve noted a reduction in our readmissions. Now, there’s a much more collaborative relationship between our nursing staff and the pharmacists. That’s where our value is.

Sheena Ferguson, R.N. (University of New Mexico Hospitals): We’ve seen that getting patients to a steady state through therapeutic targets significantly improves when we have pharmacists dedicated to that purpose. Our pharmacists are an integral part of our antibiotic stewardship initiatives and that extends to the outpatient setting.

A major focus for us has been on venous thromboembolism and pulmonary embolism and getting to those steady states and targets quickly. It has been good for us to have the pharmacist there. Some other areas in which we really excelled by having a pharmacist on the team is documentation and making sure that it is coded correctly. Our pharmacists also do a significant amount of patient education so they understand the goals and why you’re trying to get there. That’s been invaluable.

Jim West (PIH Health): We’re doing a lot of what everybody else is doing, but we’re nowhere near as developed on the ambulatory side. Our pharmacists set up our coumadin clinic, but then we handed it over to a physician assistant for billing reasons. We’re hoping that California gives pharmacists provider status, which would allow us to do a lot more.

About 20 percent of our business is capitated, and we have our own self-insured employee plan. Our chief medical officer runs our self-insured plan, along with our past pharmacy manager. Our focus is to
move people out to our home health agency, and patients have a lot of conversations with our clinical pharmacists to keep them from being readmitted.

We’ve done a lot of work around benefit design to keep our employees on the right meds at the lowest cost and to keep them out of the hospital. We were just told that we’re about 20 percent below the benchmark in cost per member because of that. All of the work Pat’s been doing on the ambulatory side makes sense. Economically in California, it’s not feasible right now to stay in business and do it. And we do not have enough global-risk contracts to make it of value, but I think it’s coming.

**MODERATOR:** How are your pharmacists working with patients to improve outcomes, particularly in those with complex diseases?

**HERMAN:** One of the things we do to prevent readmissions is to assign pharmacists to each of the units. We also started Meds-to-Beds so that our pharmacists work with outside pharmacies for outpatient drugs. If drugs come to the patient while they’re in the hospital, then the pharmacist engages in discharge planning and education. Pharmacists make sure that patients understand their medications and that they have them in their hands, because readmissions come from people not adhering to their medication regimens. In our community, transportation is often a problem, so we thought, “Let’s bring the drugs to the patients.”

This is part of Meds-to-Beds. Upon discharge, the pharmacists place follow-up calls to patients to make sure they’re taking their medications and to see if they have any questions. There’s a lot of patient-centeredness activity going on to make sure patients — especially those with complex conditions — understand their medications.

**McGILL:** For our value-based contracts, we partner with a team. It’s a three-party joint venture called Care Navigation. These teams interact with the top 5 percent of complex patients, and pharmacy is a member of that team. When patients come in for care navigation or chronic care management, they see a pharmacist for the first visit, along with a nurse and social worker, and a dietitian if necessary. If there are other pharmacy issues, then the patient will continue with the pharmacist afterward.

**HUSTER:** Our patients are afforded the opportunity to have their medications filled by a retail pharmacy prior to being discharged. It’s been a great help to our patients. When the medications are delivered directly to the bedside, the pharmacist reviews the medications with the patient who has the opportunity to ask questions. And then on discharge, the nurses can reinforce what the pharmacist previously covered with the patient.

**WEST:** We have a partnership agreement with a health plan called CareMore that provides physician extensivists to help keep patients out of the hospital post-discharge. Upon discharge, patients go to a multidisciplinary clinic for follow-up care and interact with pharmacists there. CareMore essentially micromanages the patient population to make sure they get their visits. We’ve done a little of that ourselves and it works well. It keeps patient bed days per thousand in the low 800s, which is pretty spectacular for a very sick senior population. CareMore does a lot of the pharmaceutical protocols from a corporate level because the resources are hard to come by.
TEALE: All of these efforts make the most of our resources. We have the same pharmacists taking care of acute care patients and then transitioning them to the ambulatory setting. It’s using the electronic health record to identify at-risk patients and developing post-acute solutions.

FERGUSON: In terms of programs that span the continuum, we have that in some of our high-risk populations, but not for everybody. The number of folks that never fill prescriptions is shocking. It’s been really nice when we’ve had that acute-to-clinic span on some of the more complicated disease conditions.

WEST: That’s a really important point. One of the things we’ve found is that patients aren’t filling prescriptions because of cost. Through our work with CareMore, we found that our endocrinologists were prescribing the higher-cost insulins, and they didn’t recognize the challenges that this may cause patients. There is a financial aspect. Health plans don’t see that they might be setting up benefits in a way that preclude people from being able to afford their medications, and it’s costing them on the back end on readmissions, extended hospital days or ED visits. It’s a big problem that needs to be solved.

WEISS: It’s challenging in many areas of medicine to be able to truly tie and correlate an intervention to a direct clinical outcome. In all of our institutions, we think we can make a difference through certain interventions. In one area we’ve seen this by incorporating pharmacists into the continuum of care, particularly in those high-risk patients with hypertension or diabetes that’s hard to control. By having pharmacists involved in that continuum, they can begin to understand each person’s daily living activities at home and help with therapeutic adjustments.

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“The number of folks that never fill prescriptions is shocking. It’s been really nice when we’ve had that acute-to-clinic span on some of the more complicated disease conditions.”
- Sheena Ferguson, R.N., University of New Mexico Hospitals
HUGHES: A lot of this discussion has been about discharge planning, ambulatory care and starting to follow a patient further downstream in the continuum. What we see with many clients is that these are additive services for an already slim and diluted pharmacy staff. So, I think you must be a little more highly evolved when you say, “we’ve got it” from an acute care perspective, because many health systems still haven’t completely figured it out due to challenges in recruiting pharmacists.

We see this push to try to move from production – dispensing medications – to a stronger, clinically oriented pharmacy department. There is an opportunity to look at adding resources, particularly clinical resources, and do that in a risk-type environment.

“We see this push to try to move from production – dispensing medications – to a stronger, clinically oriented pharmacy department.”
- Gentry Hughes, Comprehensive Pharmacy Services

MODERATOR: How are you facilitating collaboration among physicians and pharmacists to build consensus around standardized pharmacy care and drug optimization?

HERMAN: Physicians work with pharmacists on what drugs should be in the order sets. There are also guidelines and protocols for the best drugs for some of the complex, chronic conditions. Antibiotic stewardship is a huge piece, and we extend into the community as well. We have a collaborative in our community to talk about antibiotic stewardship as a city and as a community concern.

WEISS: We’re incorporating pharmacists into rounds and across the continuum of care. The other thing we’ve done is to put the appropriate pharmacists on selected committees. We ensure that there are providers on the committees as well so that the two groups are constantly interfacing. We also put into place a systemwide pharmacy and therapeutics committee covering our seven hospitals.

We actively engage the pharmacists in our order sets, our protocols and use evidence-based medicine. It’s really about having multidisciplinary conversations and multidisciplinary communication and

“We actively engage the pharmacists in our order sets, our protocols and use evidence-based medicine.”
- Patrice Weiss, M.D., Carilion Clinic
getting the right people at the table where things aren’t being siloed by a physician or nurse but truly having a mixed group around the table.

HUGHES: I see a lot of upfront collaboration in developing and building the order sets. My question is, what about the collaboration in terms of adhering to what’s in the order set? What we see in terms of the challenge with our clients is they did all this work and invested millions and millions of dollars in time and infrastructure and development, but then you start to veer away from adhering and complying to what’s in the order set.

TEALE: That’s something that we struggle with. Who holds the provider accountable for following the order set? What’s the escalation plan? We’re trying to map that out right now through our system pharmacy and therapeutics committee. We have nine pillars with nine different individuals who are in charge. If an oncologist goes outside of an order set and is not working with the pharmacists, who does that route to so that you have a provider-to-provider conversation rather than one from a pharmacist to provider?

WEISS: That’s where physician leadership is key. We’re an integrated clinic system, and we pride ourselves on physician leadership, whether it be that person’s division chief, section chief or department chair. Clearly, we need buy-in at the top to adhere to these standards. And if there is a reason not to adhere, it had better be a good reason. There is a process, and physicians must effectively demonstrate the need before we go outside of the order set. Physicians need to hold physicians accountable. It’s not fair to put other people in that spot.

HUSTER: We’ve had success in implementing our orthopedic order set. It’s helped with other initiatives by being able to show success among a group of surgeons from our joint-replacement institute, showing how they are following a really concise set of instructions for their patients and the medications that those patients will be taking. We’re slowly being able to extend that into other areas, like urology.

To the point about the pharmacy and therapeutics committee, I think that’s one thing that we do really well. We have a collaborative group that holds active discussions, and they often debate about the medications that we are trying to implement and the benefits of certain medications.

Having our pharmacist at various meetings, such as with our divisional surgical leadership, generates good dialogue, which helps. These meetings are well-attended by our orthopedic surgeons. But now, we are seeing greater attendance by those from other surgical specialties, such as bariatrics, general surgery and urology. Being able to share the success is gaining interest and will lead to sustainability.

MODERATOR: Are you considering a strategy or have you already crafted one to manage specialty pharmaceuticals in your organization?

FERGUSON: As an academic medical center, we have internships or residencies that give students an opportunity to see if they’re interested in a specialty area that they may not have been attracted to otherwise. When they have these great clinical experiences, they see an amazing team and realize how satisfying it could be, and that we’re developing the next group of people who may want to be part of that specialty. And that includes the physicians, who have done that for a while in their rotations. We’ve also done that with advanced practice nurses and with pharmacy residencies or pharmacy internships in specialty areas. That’s worked really well for us. Again, if teams are going lead the way, we’re going to have better outcomes.
WEST: We have a partnership agreement with the University of Southern California. It has a specialty pharmacy and we’re looking to USC to help us. USC has a strong pharmacy presence and a good pharmacy program. Their residents have always come to our hospital, so that’s our approach.

TEALE: About three years ago, we started to work on this with our employee plan through our retail pharmacies. We opened our specialty pharmacy in September 2016 that focused on oncology and hepatology. We’ve got a big cardiology group, so we’re looking at some initiatives in that area. I’m pretty passionate about this because the three big pharmacy benefit-management companies control this market. And I see that these are our patients and there needs to be continuity of care. We’re all talking about transitions of care. How does that translate with taking large, expensive drugs and outsourcing their management to somebody in Florida or New York or wherever the big specialty pharmacies are. The only reason that it’s set up that way is because of the cost. From a patient care perspective, it’s not there. There has to be a better way.

HUGHES: This is a hot topic right now across the country. I don’t walk into a single meeting in a C-suite where this doesn’t come up. There’s a tremendous lack of awareness and understanding of specialty pharmacy. In the C-suite, for those who are making these decisions, it’s incredibly complex. But Greg hit on the most important part. We sit here and talk about value-based care, managing a patient across the entire care continuum. You’re effectively handing over this patient to a third party when you as a health system are in the absolute epicenter and should be the one managing this clinical episode with a, generally, high-cost patient.

KEY FINDINGS

1. Identifying ways to foster greater collaboration among pharmacists and clinical teams in both the acute care and ambulatory settings can improve results throughout the care continuum, including discharge planning, medication reconciliation and reducing readmissions.

2. Although there are complex factors to consider, there is great value in taking the time and devoting the resources to developing and implementing a specialty pharmacy strategy. Executive leadership and involvement in this process is a critical success factor.

3. Pharmacists can play a valuable role in helping patients understand their medication regimens and the goals of the overall treatment plans. Likewise, pharmacists can extend value to the clinical team by helping patients with chronic conditions to understand which coverage plans may be the best choice from both a cost and value perspective.

4. Facilitating collaboration among physicians and pharmacists to build consensus around standardized pharmacy care and drug optimization can lead to improved outcomes and improved levels of patient engagement.
Comprehensive Pharmacy Services

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