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ASHP White Paper: Hospitalist–Pharmacist Teams Could Boost Patient Care

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Increased collaboration between two key hospital clinicians—hospitalists and pharmacists—would help improve medication safety, treatment protocols and discharge counseling, among other tasks, according to a draft white paper now being finalized.

The white paper, which describes the importance of hospitalist–pharmacist collaboration, is the result of conversations between the American Society of Health–System Pharmacists (ASHP) and the Society of Hospital Medicine (SHM), which represents hospitalists. The draft, which ASHP officials shared this spring with *Pharmacy Practice News*, is slated to be finalized by year’s end, according to Daniel Cobaugh, PharmD, FAACP, director of research for ASHP’s Research and Education Foundation.

Dr. Cobaugh and Mark Williams, MD, an SHM past president who helped develop the paper, agree that limited reimbursement has stymied collaboration. But it’s high time, they said, to promote some of the emerging efforts at the nation’s hospitals. By tracking results, both in terms of cost savings and improved patient care, they hope that the money will naturally follow.

“Hospital medicine is a relatively new specialty,” Dr. Cobaugh said. “It’s not surprising that there are not universally established systems where hospitalists and hospital pharmacists are collaborating in a team fashion. That’s one of the goals of this white paper—to drive this type of collaboration.”

Dr. Williams, director of the Emory Hospital Medicine Unit at Atlanta’s Emory University, agreed. “There’s increasing recognition that we need to take a teamwork approach to care delivery in the hospital. And an essential component of that team is pharmacists.”

Hospitalists, a nascent specialty a decade ago, are becoming a growing presence in the nation’s acute care hospitals. The term was coined in 1996 in a *New England Journal of Medicine* article (335:514-517) to describe physicians who specialize in the treatment of hospitalized patients. Within the next year, a handful of physicians had joined together to launch the SHM, then called the National Association of Inpatient Physicians.

By specializing in hospital care, hospitalists have the benefit of being onsite, rather than coming in for brief rounds, and thus become expert at providing high-quality and cost-effective care, advocates say. According to a study published 2004 in *The American Journal of Managed Care* (10:561-568), the mean length of stay for patients treated by hospitalists was a full day shorter than that for patients treated by a conventional healthcare team (5.5 vs. 6.5; $P=0.009$). There was an economic benefit as well—the total mean costs for patients treated by hospitalists ran \$917 less than for those treated by nonhospitalist physicians, although the difference was not statistically significant ($P=0.08$). Mortality also did not differ significantly between the two groups.

About 40% of the nearly 5,000 community hospitals in the United States have hospitalist programs, according to an analysis of the 2005 American Hospital Association survey data by the SHM.

The Yuma Regional Approach

Although formal collaborations are still relatively scarce, some pharmacists are striving to improve that situation, according to interviews with *Pharmacy Practice News*. At Yuma Regional Medical Center in Arizona, Tom Van Hassel, RPh, MPA, and his colleagues provide a tour of the pharmacy to all new hospitalists, along with the gift of a palm pilot loaded with medical software, physician pager numbers and other useful information. “We establish the two-way street right off the bat,” said Mr. Van Hassel, director of pharmacy at Yuma Regional and a member of the *Pharmacy Practice News* editorial advisory board. Charles Redfern, RPh, a Yuma Regional pharmacist, and Tsehaye Seare, MD, a hospitalist at the facility, often collaborate to improve patient care, Mr. Van Hassel noted.

At other facilities, such as Wesley Medical Center in Wichita, Kan., a designated pharmacist reviews charts and makes rounds at the bedside to clarify drug-related questions and concerns.

For the greatest benefit, hospital pharmacists should get out of the central pharmacy and interact with hospitalists on the floor, Dr. Williams said. “I think what’s most beneficial is the collaborative dialogue that can occur at the patient’s bedside to discuss medications that might be given.”

For example, he said, pharmacists can be helpful in determining optimal dosing for older patients, given the slower metabolism involved. Or, they can advise about potential drug interactions, particularly when adding a new medication to a regimen that may already include seven or more drugs.

Pharmacists can collaborate and assist hospitalists in a number of ways, according to the draft paper. Among the examples:

- Provide drug information consultation to doctors, nurses and other clinicians.
- Assist in the development of treatment protocols.
- Monitor patient therapeutic responses.
- Manage adverse drug reactions.
- Provide patient and caretaker education, including discharge counseling.

Pharmacists also can assist with patient care indirectly, such as by participating in quality improvement initiatives and the development of institutional guidelines and protocols, according to the draft paper. Hospital pharmacists could be particularly helpful in making sure certain national quality indicators are followed, such as discharging heart attack patients with aspirin and β -blockers, Dr. Cobaugh said.

For pharmacists, the benefit of working with a hospitalist is that they have a vested interest in learning the various nuances of how that particular hospital works, Mr. Van Hassel said. “They get a real sense of ownership of what’s going on in the hospital,” he said. “And they are available. For them to do their job quickly, they have to understand pharmacy protocols and procedures. It improves the communication piece so much.”

At Wesley Medical Center several years ago, it was the hospitalists who requested a designated pharmacist, said Joan Kramer, PharmD, BCPS, a clinical research and hospital medicine specialist at the 760-bed hospital. “They felt like they needed more drug regimen review, patient interaction and patient education,” she said.

At about 8 a.m. daily, Dr. Kramer reviews medical charts that the hospitalists have earmarked. On a typical day, she’s heading up to the patient floors within an hour. Outside of a lunchtime break, she typically works until mid-afternoon visiting each patient. Dr. Kramer used to round with the

hospitalists. But the patient volume has gotten so large that it's more efficient to round separately, she said, and then compare notes with the hospitalists late in the day.

Improving Patient Discharge

At the University of California, San Francisco (UCSF), pharmacists work with the hospitalists to make sure all medication issues are resolved during the patient discharge process, said Thomas Bookwalter, PharmD, a clinical pharmacist in general medicine and palliative care at UCSF. Pharmacists even touch base with the patient by phone after they are discharged. In a study about the telephone follow-up, published in *The American Journal of Medicine* (2001;111[9B]: 26S-30S), Dr. Bookwalter and other researchers found that the patients who received the phone calls were less likely to return to the emergency room within 30 days—10% compared with 24% in the no-phone call group.

"You can't follow the [discharge] plan if you don't have the tools," he said. "And one of the tools is the medication. It's intuitive that if they got the medications they would come back less and that turned out to be true."

Improving collaboration, however, isn't cheap, said Dr. Bookwalter. He's quick to point out that UCSF's affiliated hospitals benefit from its pharmacy residency program when it comes to staffing such efforts. To achieve reimbursement, he said, more effort needs to be made to develop bottom-line analyses. "I do think we need more data. We need to publish the things that we do and the results of what we do."

One financial argument that would get hospital administration's attention is if pharmacists could demonstrate that collaboration with hospitalists reduces length of stay, said Indu Lew, PharmD, director of corporate pharmacy, education and research at Saint Barnabas Health System, Livingston, N.J. "Certainly a lot of decreasing the length of stay involves medication management. I think that's where pharmacists can work with hospitalists."

As Dr. Kramer completes her rounds at Wesley Medical Center, she does document her results in dollars and cents. When she discontinues an unnecessary medication or reduces costly lab work, she makes a note in her progress report. Those savings, she said, get compiled over time and sent to the hospital's administration.

In the years ahead, the move toward collaboration will be assisted by technology—from personal digital assistants to electronic medical records, according to the ASHP draft report. Dr. Bookwalter, one of the white paper's contributors, has been pushing for a formal statement for several years. He said he is elated that this discussion is taking center stage.

"I think hospitals often perceive pharmacists as dispensers in running the pharmacy and storing drugs and keeping drug costs down," he said. "The culture generally is that's just what pharmacists do. But it's an exciting time to be working in hospital pharmacy because that [perception] is changing."

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