OptimaconHealth is a health system with services across two states, providing acute, ambulatory and managed care services to the community. The integration across the system is loosely structured, primarily at a strategy level, with less attention to functional alignment at the departmental level, as the system has grown quickly by acquisition and merger. The system includes a flagship 400 bed tertiary care center, 4 acute care hospitals and two specialty hospitals (pediatrics and cardiac care) as well as 15 regional ambulatory clinics providing outreach services, which represent a growing part of the system. The flagship hospital has been named in the top 100 hospitals for two of the last five years, and overall the organization has a reputation for excellence and has a history of unmatched communication and relationship with the community and patients and families.

Target care populations include:

- Digestive Diseases
- Emergency Medicine with a level 1 trauma center
- Endocrinology
- General Internal Medicine
- Heart/Cardiovascular Disease
- Cancer Care/Hematology/Oncology
- Human Motion/Orthopedics
- Interventional Radiology
- Neuroscience
- Ophthalmology
- Pathology
There is a large group practice of affiliated physicians associated with the flagship hospital, as well as multiple aligned individual group practices throughout Optimacon’s market area.

There is a large indigent care component and a significant teaching commitment, however OmptimaconHealth has maintained a relatively favorable payer mix over the past 6-8 years. Recent downturns in the economy are having negative effects on the organizational bottom line with significant shrinkage in margins, and there is growing pressure from
the CFO’s office for attention to reducing costs (and increasingly frequent questions about small items of monthly variance that sent the pharmacy leaders off chasing their tails for detailed, data driven answers.) Then there is always the periodic “benchmark” report, requiring research and response to justify variance with ‘similar’ organizations. More recently there have been rumors of a preemptive reduction in force, though no details have emerged.

Pharmacy leadership has been stable and the DOP at the flagship hospital is the most senior leader, and has been with the organization for 15 years. She is 50 years old, and her position with OptimaconHealth is her third job, having started as a cardiology specialist where she gained key medical and nursing staff support. Within 5 years she became the clinical coordinator, and four years later when the DOP was terminated, she was asked to serve as the interim director, and after 18 months and a failed national search, was asked to consider the permanent director position. She continues her success by building clinical services, especially in ambulatory settings, but has never taken the time to obtain advanced business training, and her skills are those she has learned on the job.

The leadership structure of the broader pharmacy enterprise is not clear, with overlapping responsibilities between the various DOPs at the multiple facilities (each reporting to their own COO) and, sometimes sending a confusing messaging to the C-suite senior leadership. Without a corporate pharmacy structure, there is no consistent scope of service across the enterprise and each facility operates fairly independently. Two of the Directors at the smaller acute care hospitals have completed PGY1 Residencies, one has a PGY2 residency and is working on his MHA and one DOP position has been open for 6 months. The Directors at the
Specialty hospitals are both pursuing executive MBAs. “Rules” and goals vary considerably among the various facilities, there is wide service and practice variability, formulary choice issues and decisions frequently conflict among the facilities (much to the confusion of physicians who practice at multiple sites), and different safety check practices create confusion and lack of practice consistency in the care patients can expect at various sites in the system.

There is a management to staff ratio of 1:14 (slightly worse than the national average), with a traditional Director, Manager, Supervisor, Lead Tech and Lead Pharmacist for specialty areas. The average length of employment is 8 years for the pharmacy and turnover rates of 18% for technicians and 12% for pharmacists; (evening and night shifts are difficult to fill and account for most of the turnover. The staff to occupied bed ratio is 1:16, slightly worse than the national average.

There are currently open positions at all of the hospitals. Resources to expand services are stretched and there is growing staff discontent. Additionally, some of the experienced pharmacists are unwilling to take on new responsibilities that require new competencies, which is creating a serious split between seasoned and newer pharmacists. There as been discussion among the Directors to establish a common recruiting effort and a team interviewing process across the system. There is also some early discussion of initiating a reward program for candidate referrals.

There are two current PGY1 residents completing a residency in 6 months, and one is interested in a PGY2 Medication Safety residency.
Pharmacy Services By the Numbers and Challenges

Ambulatory Pharmacy Care Services are staffed by 132 FTEs and the drug budget totals $19.6 million. Leadership challenges for the ambulatory pharmacy team include:

- Justification and reimbursement/cost justification for clinical services
- Decentralization
- Acceptance of pharmacists new roles in the clinics: are they physician extenders or practice pharmacy and by practicing pharmacy can they make the physician more productive
- Cost of drugs and billing/reimbursement and the pharmacist’s involvement in drug authorization and finding cost offsets through safety net programs if funding is not improved

Pharmacist clinics, which include 340b, are managed as a separate cost center with 60 FTEs ($4.9 million in salaries) and an annual drug budget or $2.6 million. Leadership challenges include:

- Reimbursement/cost justification for clinical services
- Proving value and being self-sustaining
- Building a patient care practice

A staff of 32 FTEs, with an annual budget of $16.3 million, provides home Intravenous Services. Leadership challenges include:

- Reimbursement/billing & collections
- Market competition
- Coordination with discharge planning
**Acute Pharmacy Care Services** includes a staff of 225 FTEs, with a drug budget of $26.8 million. Leadership challenges include:

- Medication safety and quality of care
- Leading and managing The Business of Pharmacy
- Recruiting, training and retention
- Decentralized services 24/7
- Controlling drug costs balanced with patient outcomes
- Clinical – distributive staff ‘gap’
- Communicating with C-suite regarding value of pharmacy services
- Implementing and supporting technology

The Sterile Prep Lab has a staff of 41 FTEs and includes IV preparation and an OR pharmacy, and is budgeted as part of the central pharmacy. Leadership challenges:

- Quality/safety
- Regulatory compliance
- 24/7 service
- Staff training/competence

The Pharmacy Patient Care Team is comprised of a 17 FTE team integrated with medicine and nursing teams. Services include clinical rounds, coagulation clinics, medication therapy management and participation in medical clinics and the HIV clinic. The budget tracked separately but part of overall acute care pharmacy budget. Among the leadership challenges:

- “Separation” from pharmacy team
- Acceptance by medical staff
Managed Care Services

OptimaconHealth managed care pharmacy services include at-risk insurance plan, a PBM and 9 retail pharmacies owned by the plan, with a prescription volume range of 150 – 1500 prescriptions per day. Managed Care Services includes 240 FTEs, including retail pharmacy staff and a $200 million budget, approximately 80% of which is the cost of drugs. Among the leadership challenges:

- Balancing at risk insurance vs provider business
- Geographic decentralization (100+ mile radius)
- Highly regulated insurance business
- Cost of drugs vs PMPM cost vs cost of prescription rider
- Building physician support for prescription benefit strategy
- Leaders that can stand alone and run a business and professional service
- Satisfying payer, patient/member, physician and C-suite
- Claims adjudication/data
- Outcomes data and ROI

Despite the fact that financial performance of the pharmacy has been essentially sound, there is a lingering misunderstanding and doubt about
effectiveness on the part of C-suite leadership. Clinical pharmacy services are viewed favorably – often as exemplary – by most medical staff where clinical teams practice, however there is both push and pull pressure to expand services to new areas with simultaneous resistance from some medical staff.

Medical staffs in hem/onc and the heart center are strong proponents of the clinical pharmacy services, but there is spotty clinical activity in other clinical acute care areas. There is only one pharmacist with oncology experience and when he is not there, the responsibility falls to other staff that have adequate but not optimal competency. The physicians expect the pharmacist to “flesh out” protocols with correct doses and supportive care. The pharmacy oncology specialist does this routinely, but physicians need to do it themselves in his absence. This is time consuming for them and typically requires an extra three hours per physician per day. There are strong pockets of clinical service in some clinics, but there has been little effort to link and duplicate these services in acute care or across the continuum of services.

There is strong support from at least some of the nursing leadership and unit supervisors, particularly for clinical services. A lingering issue with nursing leadership and line managers is the consistency of pharmacy services including a plaguing issue with late and missing doses.

Drug cost controls are in place, but poorly documented and communication is spotty and inconsistent, often a trigger for firedrills. Financial data are typically not accessible to pharmacy leadership for proactive response to variance inquiries and pharmacy reports don’t seem to effectively communicate to c-suite leadership timely and critical
messages that reflect the logic behind the actions that pharmacy leaders are taking. The DOP is not involved at many C-suite meetings where decisions about pharmacy and medication use related issues are discussed and decisions are made. Pharmacy business processes are adequate but need clarification and updating (eg invoicing practices and pricing analysis), better documentation and consistent execution and reporting. Recently there have been some questions from the CFO regarding the CDM and charge processes, and whether a need for updating might be influencing some of the negative revenue trends. Are we charging and billing timely and accurately?

The flagship hospital and two of the acute care hospitals are 340b qualified. System DSH numbers are close to 340(b) qualification for the pediatric hospital and for the other acute care hospitals, but no initiatives to evaluate DSH qualifications or firm up numbers have been initiated. The question of some new retail and contract services has been tossed around among a few pharmacy thought leaders, but no action has been taken to qualify the opportunities. There has been limited discussion with the C-suite and HR to consider pulling eligible employee prescriptions into the 340 b program.

The Pharmacy Department is currently in process with implementing a new pharmacy information system, part of an enterprise wide system, and it is presumed that will resolve all of the organization’s integration issues. Unfortunately, the system installation has been delayed twice and the most recent pending deadline in 60 days is looming large. The vendor has failed to meet multiple deadlines, but the new – 30 days new – COO has indicated that this WILL HAPPEN ON DEADLINE or heads will roll (not hers.)
Priorities for IT implementation are not always clear, and seem to change frequently. There have been 3 CIOs over the last five years and with each change, a shift in priorities and philosophy. CPOE and Clinical Decision Support have emerged as critical priorities at the C-suite level. The CPOE system is in place however, the output is a paper-based report distributed to the pharmacy designated areas for manual reentry into the pharmacy system. BCMA, eMAR, ADE monitoring, EMR integration, PHR integration all have their key supporters and have been discussed, but little consensus has evolved about the priorities and queuing for implementation, and a system wide strategy. There is a core disagreement about how to address the ROI of each implementation, what is the “biggest bang for the buck”, what is most critical – installing on time and on budget OR impacting other system goals. The DOPs at the acute care hospitals have been discussing more operational and procedural standardization, but the discussion has not reached of level of priority.

Automated dispensing cabinets (ADC) are interfaced or profiled to the legacy pharmacy information system, with technicians managing the refill process and only ordered, pharmacist-verified medications should be available fro dispensing from the ADCs with the exception of committee approved “override” medications, including emergency meds, antidotes, and some narcotics. Inventory control carousel technology is used in the flagship hospital. While the hospital has a system-wide standing contract for offsite unit dose packaging, but there are persistent issues with manufacturer/distributor substitution and non-scanning items that are typically (hopefully?) in quarantine before they fail ADC fill.
Quality and Safety

The organization has a Medication Safety Officer (MSO), an RN who reports through the Quality Assurance and Performance Improvement group. The MSO leads the monthly meeting of the Medication Safety Committee, which reports to the Pharmacy and Therapeutics Committee. The primary agenda items include review of adverse drug event and medication event reports, and occasionally a physician will speak up during a meeting to indicate that one of his patients had experienced a significant medication error that is not included in the report presented. A recent sentinel event in the ICU was related to a medication event and a Root Cause Analysis (RCA) is underway.

Although the CEO vocally supports a strong focus on safety, a recent employee culture of safety survey demonstrated that more than 50% of staff felt that if they reported an error, there would be retribution.

Pharmacy has recently been asked to improve the medication reconciliation process due to a Joint Commission finding. Pharmacy has recently taken an active role in National Patient Safety Goal 03.05.01 – anticoagulation – and is struggling with the process and pharmacy time involved. The Director of Quality has approached several of the Directors of Pharmacy about getting more involved in the Core Measure work, and there has been discussion about an initial project focused on SCIP: antibiotic timing.