

Addressing Key Issues in Health-System Pharmacy: Spotlight on Leadership

Thirteenth Annual ASHP Conference
for Leaders in Health-System Pharmacy

The premier conference on today's key pharmacy practice management topics

October 20–21, 2008

The Westin O'Hare

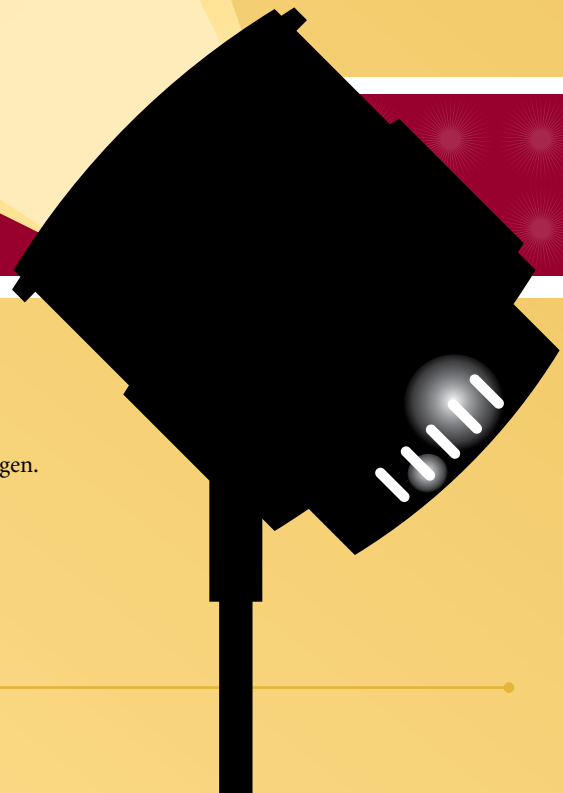
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At the 13th annual ASHP Conference for Leaders in Health-System Pharmacy, top health-system executives brought perspectives from the “C-suite” to plenary sessions. Five half-day workshops and two shorter “intensive” sessions were offered, addressing topics such as building effective partnerships, enhancing management skills, improving quality, implementing performance tracking, and strategic planning. “Addressing Key Issues in Health System Pharmacy: Spotlight on Leadership” was the theme of the October 20–21, 2008, conference, held in Chicago. Summaries of the sessions are presented here. The annual John W. Webb Award lecture given during the conference by Thomas S. Thielke, M.S., R.Ph., FASHP, will be published in the *American Journal of Health-System Pharmacy*.

Programs and Presenters

GENERAL SESSIONS

The New Role for Pharmacy Leaders: From Player to Conductor of the Hospital Orchestra

Charles R. Denham, M.D.
Chairman
Texas Medical Institute of Technology
Austin, Texas

The Future of Pharmacy Practice and Evolving Models

Burnis D. Breland, M.S., Pharm.D., FASHP
Director of Pharmacy and Clinical Research
Columbus Regional Healthcare System
Columbus, Georgia

Let's Leave a Legacy of Learned Leaders in Health-System Pharmacy

David A. Zilz, M.S., R.Ph., FASHP
Emeritus Professor of Pharmacy, University of Wisconsin
Senior Consultant, University of Wisconsin Health Systems
Madison, Wisconsin

Innovative Staffing Models: Spotlight on Meeting the Challenges of Pharmacy's Changing Demographics

Sara J. White, M.S., R.Ph., FASHP
Pharmacy Leadership Coach
Mountain View, California

Emily Alexander, Pharm.D., BCPS
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Envision Telepharmacy, LLC
Alpine, Texas

Gary S. Plank, Pharm.D.
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Marshfield Clinic
Marshfield, Wisconsin

Michael D. Sanborn, M.S., R.Ph., FASHP
Corporate Vice President
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Increasing the Leadership Impact of Pharmacists: Social Marketing Strategies for Leading and Accelerating Change

Dennis C. Wagner, M.P.A.
Deputy Director, Health Resources and Services
Administration Center for Quality
United States Department of Health and Human Services
Washington, DC

Programs and Presenters

INTENSIVE SESSIONS

Fitting High-Cost Pharmaceuticals into Reimbursement Guidelines: Spotlight on Specialty Pharmacy Drug Products

Bonnie Kirschenbaum, M.S., R.Ph., FASHP, FCSHP
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Informatics: Health Information Technology Impact on Safety and Quality—The Pharmacist's Role

Ann M. Bobb, B.S., R.Ph.
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WORKSHOPS

Spotlight on Building Effective Partnerships: Why Should the C-Suite Listen to You?

Susan Teil Boyer, M.S., R.Ph, FASHP
Vice President, Professional Services
Good Samaritan Hospital
Vice President, Pharmacy and Laboratory Services
MultiCare Health System
Tacoma, Washington

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University Health System, Inc. dba
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Clinical Managers: Enhancing Your Management Skills and Getting Things Done

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University of Minnesota Medical Center
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Improving Quality in Health Systems: Spotlight on Medication-Related National Quality Initiatives

Patricia C. Kienle, M.P.A., FASHP
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Cardinal Health Center for Safety and Clinical Excellence
Lafin, Pennsylvania

Darin L. Smith, Pharm.D., BCPS
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Norman, Oklahoma

Pharmacy Metrics: Implementing a Pharmacy Performance Tracking and Reporting Methodology

Howard S. Glazier, Pharm.D.
Senior Executive
Accenture, Pharmacy Practice Consulting
San Francisco, California

William W. Churchill, M.S., R.Ph.
Executive Director of Pharmacy Services
Brigham and Women's Hospital
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Strategies for Successful Strategic Planning: Developing Your Department's Five-Year Plan

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Steven Cano, M.S., R.Ph., FASHP
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Somerville, Massachusetts

The New Role for Pharmacy Leaders: From Players to Conductor of the Hospital Orchestra

CHARLES R. DENHAM

The opportunities for health care reform have never been better,” said Charles Denham, Chairman of the Texas Medical Institute of Technology in Austin. According to Denham, the next breakthroughs in health care will not involve devices, pharmaceuticals, software, or imaging techniques; rather, they will likely center around social innovations, leadership, and the last “mile” to the patient. Denham used the metaphor of an orchestra of finely tuned instruments to illustrate how pharmacists might rise in the organization to assume more leadership roles.

According to Denham, “transparency is a given for the future.” System failures will get worse, patients receiving treatment will be sicker, and resources will be fewer than today. Care is getting more fragmented. System failure rates and inpatient safety and quality of care are growing log metrically, while improvement programs have grown mathematically. He predicted that this gap will continue to increase until leadership finds a way to close it. The current system is built on a micro transaction economic model. As Denham pointed out, there are no CMS codes for teamwork or leadership, even though these are vital to the success of health care.

Denham conceded that it is not easy to be a leader. Leadership is the fastest growing root cause of sentinel events, and the Joint Commission is going to focus more on leadership. Questions that might be posed include the following: Do people really understand what they are doing? Do they understand what they are supposed to be doing? Has leadership continually reinforced the things that need to be done? Compliance with the national patient safety goals is down. Denham was not surprised by this because health care staff are being asked to do more with fewer resources.

According to Denham, three things are needed to change the current environment: (1) leadership, (2) resources, and (3) systematic implementation. Resources and leadership are tied together—resources come from leadership. A shift from pay for performance to pay for improvement is occurring. Denham predicted that if health care reform proceeds, CMS will “move from a passive transactional organization to an active value purchasing organization.”

The pharmacist’s new role in the leadership circle was described. Pharmacists will be acknowledged and recognized for their understanding of what goes on beyond the walls of the pharmacy and will be in direct contact with the hospital board and the C-suite. The 2009 practice standards are still under revision. When they become available pharmacy leaders will need to understand all of the measures that apply to medication therapy management and incorporate them into the institution’s safe practices.

Denham described the term, “values genetics.” He defined it as a failure of leaders many of whom have focused too much attention on the bottom line and who have defied the “business laws of gravity, which are cost, performance improvement, speed, and trust.” These laws of gravity are interlocked and tightly coupled. Said Denham, “The core values of our leaders are like genes; the genes are expressed in traits similar to how core values are expressed as behaviors.”

Current leaders in health care lack knowledge with regard to how the enterprise runs as a system. Denham believes that the “breakthrough leaders” will include pharmacists and physicians who have terrific values and who understand financial and operational sides of the health care business. All of these changes will be necessary to develop a disciplined culture of excellence.

The Future of Pharmacy Practice and Evolving Models

BURNIS D. BRELAND

Burnis Breland defined the pharmacy practice model as “the operational structure that defines how and where pharmacists practice, including the type of drug distribution system used, the layout and design of the department, how pharmacists spend their time, practice functions, and practice priorities.” Said Breland, establishment of an effective working practice model is essential for pharmacists to provide effective patient care. To be successful, this model should accommodate a broad range of pharmacy services and give priority to pharmacist functions that provide the greatest value to the patient. He quoted an observation by William E. Smith that essentially “drugs are being prescribed extensively and haphazardly, and distributed by a system which is so complicated and inefficient that it defies description.” Noted Breland, this statement appeared in the journal, *Drug Intelligence*, back in 1967, but it is clearly relevant to 2008.

Breland traced pharmacy practice models from 1967 to today and into the future, and noted some striking similarities. Beginning with the 9th Floor Project at the University of California, San Francisco Medical Center, pharmacists participated in the following activities on a 24-hour basis: interpreting physician orders, challenging each order for correctness for a specific patient, and being available on the floors to physicians and nurses. Smith summed up the pharmacist’s role in 1967 as “...improving drug therapy when he is a part of the patient care team is to guarantee the patient the proper use of the best pharmacological agents available.” Pharmacy practice in the 1980s involved decentralized pharmacy services (i.e., satellite pharmacies), which lessened nurse responsibility for drug-related matters and put the pharmacist in a position in which his or her knowledge could be used effectively. The 1990s saw the introduction of the pharmaceutical care concept. ASHP defined the concept as follows: “Pharmaceutical care is the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient’s quality of life.” Breland then projected what pharmacy practice in the future will involve. He cited the Joint Commission of Pharmacy Practitioners’ (JCCP) Future Vision of Pharmacy Practice in 2015 vision statement as the goal for the future. Said Breland, pharmacy practice in 2015 will focus on

patient-centered care and JCCP anticipates that “pharmacy will have the authority and autonomy to manage medication therapy and will be accountable for therapeutic outcomes.”

Breland explained that pharmacy should have a written policy on pharmaceutical care, which should serve as a philosophical and practice-based guide. The policy should explain how clinical, drug information, and other traditional pharmacist functions are integrated and prioritized. All functions should take into account value to the patient, the health care staff, and the institution. Breland cautioned that pharmacists risk overload as they are being asked to do more with less citing the fact that pharmacists at his institution have noted a significant increase in requests to initiate and manage therapy (e.g., starting and managing heparin therapy, dosing vancomycin, dosing in pediatric, renal, and obese patients).

When designing a pharmacy model Breland explained that it is important to determine which pharmacy functions are needed and are most valuable, how pharmacist care is delivered, and how pharmacists prioritize their time and work functions. Breland presented the following 7 basic principles to follow in the process:

1. Each patient deserves to have a pharmacist.
2. Patients should be provided consistent care by the same pharmacist or by another pharmacist who is knowledgeable about the patient’s case.
3. All patient care areas of the hospital should be served by a pharmacist to oversee drug therapy at all times and staffing must be adequate to meet those needs.
4. Pharmacists must identify the patient’s care needs and prioritize their work to meet those needs based on urgency and value to the patient.
5. Pharmacists cannot spend inordinate amounts of time performing functions they like while neglecting functions that are more valuable to the patient.
6. Pharmacists’ schedules should be arranged to allow them to consistently work in specific patient care areas to advance their knowledge and skills in those areas.
7. The pharmacist is first responsible to the patient.

Let's Leave a Legacy of Learned Leaders in Health-System Pharmacy

DAVID A. ZILZ

Leadership is a verb, not a noun, pronoun, or preposition,” said David A. Zilz. It is an action word than means “doing something.” According to Zilz, leadership is whatever action you take that influences somebody to do something differently, and, hopefully better. Zilz explained that the topic of leadership is important because excellence in leadership will lead to the largest number of best decisions for every organization, now and in the future. All decisions are equally important, meaning the day-to-day decisions are as meaningful as a few “wow” decisions. Leadership decisions in critical areas, such as deciding whether to develop a new program, hiring and promoting the right person at every juncture, and disciplining, reprimanding, and releasing inept performers, are especially important.

Zilz presented several definitions of legacy (i.e., historically something that is handed down from one period of time to another period of time). He asked the audience to reflect on what they thought their legacies were at several important junctures in their lives (e.g., as a student, as a resident, in pharmacy, in life). Zilz explained how legacies are tied to leadership and presented characteristics of great leaders. Among these characteristics are the following: integrity, knowledge, vision, commitment, and expectations for positive results. These characteristics are necessary in a learned legacy, and he explained that one will never become a leader until he or she first learns to follow and be led. Likewise, it is impossible to be an excellent teacher if you lack the maturity to want your student to be more accomplished than you.

Zilz stressed the importance of learning from others on a daily basis. Zilz said he learned from the hospital and health system leadership, association executives, elected officials in associations, community service contacts, and others. He advised participants to be or have a mentor at all times because these relationships will have a lasting impact. Zilz said he believes that there is no greater opportunity to establish a legacy of learned leadership than in a residency program.

Zilz did a consulting project for community hospital several years ago and presented a case study of what he described as a learned pharmacy department. Zilz explained how the experience inspired him to think differently about being involved. During the consulting project, the director of the pharmacy department mentioned that he attends at least

one pharmacy meeting a year so he will not miss “what’s new in pharmacy.” In this director’s view, “Associations exist to see that I gain during the good times and to help me survive gracefully and comfortably during the bad times.” This pharmacy director worked hard at ensuring that people from the pharmacy department were always positioned to be “in the know.” One way he achieved that was to monitor every pharmacy organization with involved individuals from his department (e.g., ASHP, state health-system pharmacy association, state board of pharmacy, group purchasing organization members and officers). He claimed this strategy paid off because he remained knowledgeable about trends in all sectors of pharmacy practice and was able to prepare the department for such changes.

Powerful messages from influencers in the profession are also important in legacy development. Zilz cited some of the simple truths from previous recipients of health-system pharmacy’s most prestigious award, The Harvey A. K. Whitney Lecture Award. Zilz said many of the stories leave a powerful message in legacy development within departments.

Given the complexity of hospitals, Zilz advised that future learned pharmacy leaders should consider expanding their expertise in areas such as industrial engineering, architecture, and “futuresology.” Pharmacy leaders will need to branch out to manage many of the changes that Zilz anticipates. Some of these changes include the expansion of proteonomics, genomics, and ergonomics; automation and informatics; supply chain management; rationing as a part of daily decision-making; communication with patients via multiple media; disease management; quality improvement and evidence-based practice; comprehensive medication reconciliation; scheduling and length of stay, which will be measured in hours and minutes, not days; new practice models; and expectations of young pharmacists.

Pharmacy’s leadership will face new challenges. Zilz said it is imperative that future pharmacy leaders have extraordinary vision, charisma, perseverance, and networking to handle a growing number of increasingly complex issues simultaneously. Zilz could not say what kind of leadership would be needed in that environment, but he did conclude by saying “The leadership in pharmacy will step forward. It always does.”

Innovative Staffing Models: Spotlight on Meeting the Challenges of Pharmacy's Changing Demographics

SARA J. WHITE, EMILY ALEXANDER, GARY S. PLANK, MICHAEL D. SANBORN

Sara J. White served as a moderator of this session. Staffing models used at three health care systems were described.

Remote Order Entry Electronic Supervision of Technicians.

Emily Alexander, Director of Envision Telepharmacy, LLC, in Alpine, Texas described how they supervise technicians who perform order entry remotely. The remote order entry follows the traditional pharmacy process: the order is transmitted from the hospital and is reviewed and entered into the system by a pharmacist. The technicians fill the order and an image of the order is transmitted to a pharmacist, who checks it. After the order is checked, the technician receives notice to process the order. The following technician duties are supervised electronically:

- Medication and drug distribution entry,
- Work pursuant to a medication order,
- Compounding sterile products,
- Accessing and restocking automated medication distribution systems,
- Distributing routine orders for stock supplies to patient care areas,
- Unit dose and multiple dose prepackaging.
- Bulk compounding and batch preparation.

Virtual private networks were set up to access orders and electronic medical records. All orders are scanned and loaded into electronic image queues. The servers are located in a data center in Dallas.

Most of the pharmacists who participate in the program are women, 30–50 years old, with one or more dependents living at home. The scheduling is very flexible, and they are allowed to work from home. The pharmacists work on teams, with each team having between 3 and 12 pharmacists.

Alexander admitted to facing several challenges, both internal and external. Internal challenges included a lack of face-to-face time, difficulty with team building, and scheduling. External challenges included regulatory issues that involved data collection several years in advance, pilot testing the project, presenting data to a task force for review, and rule changes to allow this practice model to be implemented.

Alexander reflected on key lessons that have been learned. First, it is important to build relationships. Second,

the feedback she received from satisfaction surveys was useful. Pharmacists who are good matches for this type of work are those who are both experienced and motivated.

Leveraging Pharmacy Staff Expertise Using Telemedicine Technology. Gary S. Plank of the Marshfield Clinic, a physician group practice covering 40,000 square miles in Wisconsin, described how they have used telemedicine technology to provide pharmacy services. Pharmacy services provided by the Marshfield Clinic include a clinical pharmacy services unit, 8 oncology practice sites, 15 “own use” dispensing pharmacies (including 1 340(b) pharmacy), and a health maintenance organization pharmacy benefit management program.

The Marshfield Clinic has been exploring the possibility of providing remotely supervised pharmacy services since 2002, when a new oncology services practice opened in Wisconsin Rapids. Physicians and nurses at the new site considered on-site i.v. admixture services to be critical in the clinic’s success, and they realized that they needed a pharmacist to run the program. However, difficulty in recruiting a pharmacist coupled with a small practice site was not economically feasible. They were able to secure the clinical expertise of a pharmacist using telemedicine. Full two-way tele-video communication between a pharmacist and the i.v. technicians, physicians, and nurses has provided the clinic with necessary pharmacist expertise. A couple of conditions of licensure—the requirement that a pharmacist can only dispense from a location that is licensed as a pharmacy and the requirement that a pharmacist be present for dispensing to occur—precluded pharmacist dispensing at the clinic. In addition, the Wisconsin Examining Board would not allow “remote supervision” by a pharmacist. As a result, physicians at the clinic dispense in consultation with pharmacists.

Currently, 6 pharmacists staff the Marshfield Clinic’s 10 regional oncology practice sites using telemedicine technology. Efforts to change the legislation to allow telepharmacy are in process with the support of the Pharmacy Society of Wisconsin, Wisconsin Pharmacy Examining Board, Aurora Health Care, and the Marshfield Clinic. A new law allowing for two years of demonstration projects to support the Pharmacy Examining Board’s determination of specific rules to allow telepharmacy is under consideration.

Employee Retention and Staffing. Michael D. Sanborn of the Baylor Health System in Houston, Texas led off by stating that “the best recruitment strategy is a great retention strategy.” Sanborn said his goal is to be the pharmacist employer of choice. According to Sanborn, to become the employer of choice, you need to provide the following:

- Progressive and efficient operations,
- A focus on employee satisfaction and retention,
- Effective communication and motivation,
- Meaningful employee recognition, and
- Adaptive scheduling and work options.

Sanborn explained that pharmacy operations must be organized to the extent possible through a reduction in waste and an increase in efficiency. Automation, information technology, sterile and non-sterile compounding services, and use of pre-made and ready-to-use products can streamline the workload. In addition, the department’s culture should foster an environment in which everyone is able to contribute. Sanborn noted that it is much easier to retain current employees than it is to hire new ones. He mentioned several strategies for retaining employees, including focusing on

the orientation program, providing equity and camaraderie among staff members, and instilling a sense of achievement in staff. Sanborn explained that effective recognition programs are those that are long-lasting and are individualized, immediate, somewhat random, and meaningful.

At Baylor, several workforce accommodations aimed at attracting and retaining employees have been implemented. Some staff work on a compressed schedule involving shifts of 10–12 hours. Highly customized self-scheduling and part-time work are also available to staff. Some pharmacy staff participate in job sharing or work half-shifts or a flex schedule. Some remote work is available and several retired pharmacy staff are called into service when necessary. Sanborn said scheduling to accommodate these work arrangements can be challenging, although he said employee self-scheduling can be effective and it eliminates many management headaches.

Sanborn closed by reflecting on some lessons learned. To implement alternative scheduling effectively you need to be open minded regarding employee requests and changes need to be communicated to staff effectively. In the end, Sanborn said the scheduling has been a morale booster and has been an effective tool for recruiting and retaining staff.

Increasing the Leadership Impact of Pharmacists: Social Marketing Strategies for Leading and Accelerating Change

DENNIS C. WAGNER

Social marketing has been used successfully to drive change in national health care measures, and many of these principles can be applied to pharmacy. Wagner explored how the powerful discipline of social marketing might be applied to “our work of pharmacy leadership, our work of fostering adoption of best practices, and our work of promoting good medicine-taking behavior by consumers.”

Wagner defined social marketing as “an organized way of asking from and giving to individuals and organizations in order to achieve individual and social benefits.” To be successful social marketing principles must

- Have clear aims and measure results.
- Use offers and requests to create *action*.
- Improve the offers and requests.
- Generate momentum and keep moving.
- Go after “low hanging fruit.”
- Sell the *benefit*, not the *problem*.

To maximize the effectiveness of social marketing, the following questions might be posed:

- What *benefits* do we sell to get people to take the actions we want them to take?
- What are our *aims*? How can we make them big, powerful, and attractive?
- What are our *requests*? Who do we make them to? What offers do we make?
- What is our “*low hanging fruit*?” What’s already working? Where do we already have momentum?

Wagner used the “Organ Donation Breakthrough Collaborative” to illustrate the process. This initiative was spearheaded by Tommy Thompson, Secretary of the Department of Health and Human Services (HHS). The collaborative began in September 2003 and ran through April 2004. The answer to the first question regarding the benefits of organ donation is obvious: organ donation saves lives. Thompson committed to a measurable aim of achieving organ donation rates of 75% or higher in hospitals. HHS requested assistance from the Joint Commission to help mobilize hospitals and their administrators to participate in the collaborative. The Joint Commission took actions such as having surveyors include

the question “What is your donation rate?” during their interviews with hospital chief operating officers (CEOs). CEOs who responded with a number less than 75% are urged to join the collaborative. In addition the Joint Commission’s executive vice president serves on the National Organ Donation Alliance, which expands the work of the collaborative. The collaborative has been very successful. Before the collaborative fewer than 50 large hospitals had rates of donation of 75%; by May 2005 that number had increased to 185, and, by October 2007, that number grew to 392 hospitals. An example of “low hanging fruit” was identified as donation after cardiac death. Donation after cardiac arrest has increased significantly over the past few years. At one hospital the number of donations after cardiac death has increased from a total of 268 in 2003 to 647 in 2006.

Wagner concluded by challenging the conference participants to use the information provided at the conference as a means to create action in the workplace. Such actions might include commitments to self and others, deals, practices to try, events to convene, and requests and offers to be made. Action-generating questions for such activities included the following:

- Who could you engage to transform learning from this conference into action? What requests or offers would you make to them?
- What events could be convened to activate others on this work?
- What deals could be made to rapidly increase pharmacy leadership?
- What *three* actions could you take by the end of the week?

Wagner concluded by explaining how requests and offers lead to real work. Work, he explained, involves making commitments, delivering on those commitments, and securing commitments from others. Work is not about talking about commitments. He provided a script for leadership, action, and results. Attendees were asked to list at least three actions they planned to take from the Leaders Conference and to complete the following open-ended statement: “I am committed to increasing the leadership of pharmacy and pharmacists to improve healthcare for the patients we serve. I personally and professionally care about this because...”

Fitting High-Cost Pharmaceuticals into Reimbursement Guidelines: Spotlight on Specialty Pharmacy Drug Products

BONNIE KIRSCHENBAUM

According to health care consultant, Bonnie Kirschenbaum, health care dollars spent on specialty pharmaceuticals are expected to double by 2010. Specialty pharmacies are typically under contract with a third-party to provide a limited number of high-cost pharmaceuticals (e.g., injectable biological therapies, oral chemotherapy agents). Kirschenbaum noted that pharmacy leaders are struggling with issues regarding patient safety, institutional liability, and reimbursement with these products.

Kirschenbaum said it is important for pharmacy leaders to develop a position statement on how specialty pharmacy products are to be handled in the inpatient, outpatient, and long-term care settings. Specialty pharmacy products currently account for >20% of pharmacy costs in many health plans. Specialty pharmacy products are biotechnology and gene-based therapies that have one or more of the following characteristics:

- Use for treatment of chronic or rare diseases.
- Annual cost exceeding \$5000.
- Administration by a route other than oral.
- Product delivery to patients by mail or at home, possibly requiring special handling, such as refrigeration.
- Administration outside a hospital setting (e.g., physician's office, specialty clinic, or patient's home).

- Managed outside traditional outpatient prescription drug benefits.
- Requirement for complex care, patient education, or continuous monitoring.

Specialty pharmacy products are drawing attention for a couple of reasons. More than \$50 billion per year is currently spent on these products, and that number could rise to \$100 billion by 2010. Use of specialty drugs for long-term conditions increases the long-term cost impact to payers.

Specialty pharmacy medications provide highly sophisticated treatment for patients with rare or chronic conditions who previously had no viable therapeutic options. The challenge is how best to manage use of these drugs in a manner that achieves their therapeutic potential at a cost that allows patients to have access to them. An integrated approach to achieving this will likely be required because of the safety and handling concerns associated with their use (e.g., short-shelf life, refrigeration in many cases, need for overnight delivery, clinical services to reduce incidence of adverse effects and increase compliance).

Specialty pharmacies have been successful in marketing their services, such as care management for complex cases, simplified administration (e.g., electronic billing and reporting), and a single source for service. Many health systems have begun to look into the possibility of taking on the role of a specialty pharmacy.

Informatics: Health Information Technology Impact on Safety and Quality—The Pharmacist’s Role

ANN M. BOBB

Ann M. Bobb described how health information technology has been employed at Northwestern Memorial Hospital (NMH) in Chicago, Illinois to reduce prescribing errors. In 2002, clinical staff pharmacists at NMH collected all orders that contained a prescribing error for a one-week period. A total of 1,111 prescribing errors were identified. Of these, 31% were classified as causing potential harm to patients, 48% were related to dose, 15% to frequency, and 6% to drug allergies. Of all of the verified prescribing errors, 64% were rated as likely to have been prevented by computerized prescriber order entry (CPOE), with 43% of these errors having the potential to cause harm in patients. Bobb described another evaluation at NMH that determined the likelihood that smart pump technology without an interface to other systems could have prevented errors and found that only one error would have been prevented.

According to Bobb, health information technology will be an integral part of progress that needs to be made in preventing medication errors, which she noted contribute to somewhere between 44,000 and 98,000 deaths each year. Noted Bobb, an integrated electronic health record that incorporates CPOE and clinical decision support could have a significant impact on improving safety and quality of care. Such a system would allow health care practitioners to have access to legible patient information anytime, anywhere. In addition, clinicians would have information in real time, which would allow physicians to be alerted to hazards according to a patient’s medical history and current medications. Other benefits include the elimination of order transcription, improved turnaround times for medications, radiology procedures, and laboratory reports, and a decrease in medication errors.

Bobb conceded that there are a number of barriers when adopting widespread implementation of health information technology. Physicians and nurses may resist the change because of a perception that additional time will be required to enter orders into the system and that additional time will be needed to pass medications. Cost is another potential barrier, especially if there are competing priorities for capital budget items. An initial investment for CPOE can cost upward of \$1 million. When adopting health information technology, Bobb explained that adoption and innovation can only happen when there is buy in from the organization’s leadership in addition to a well-defined deployment strategy, well-conceived design, and strategy for optimizing use of the technology.

Patient safety should be the guiding principle when using health information technology. Bobb listed the following as guiding principles:

- The safest thing to do is the easiest thing to do.
- Standardize and simplify processes.
- Reduce reliance on memory.
- Enhance access to complete and timely information.
- Use fail-safe systems and forcing functions.
- Reduce stress in the work environment.

How do you define success? According to Bobb, success can be defined by use of the system, user satisfaction, decrease in medication errors, decrease in adverse events, and public reporting (e.g., core measures).

Bobb closed by explaining where pharmacists fit into the process. Pharmacists should be willing to offer assistance, adhere to patient safety principles, and provide clinical expertise, and keep the patient’s safety as the top priority.



Spotlight on Building Effective Partnerships: Why Should the C-Suite Listen to You?

SUSAN TEIL BOYER, STEVEN R. ROSS, SARA J. WHITE

Susan Teil Boyer and Steven R. Ross explained how learning to communicate effectively with the C-suite is imperative for pharmacy leaders. They discussed how the ability to move items on the pharmacy department's agenda is vital for effective development and implementation of efficient medication-use systems and for providing optimal patient care.

The director of pharmacy is charged with representing the department in the health system. To work effectively with the C-suite executives, it is important that he or she understand the style of these individuals. For example, knowing the type (e-mail, face-to-face conversations, standing meetings) and frequency of communication this individual prefers is key. Understanding differences in style is also important; every organization is made up of a variety of personality types. There are decision makers, who view the big picture as well as people persons who thrive on relationships. Some administrators are process oriented and slow to make decisions while others are detail oriented and like to see more data. Ross also explained that it is important to keep in mind that new programs do not always have a price tag.

When asked to describe the ideal department head, Ross said he or she should be credible and decisive with a “can do” attitude. Boyer views the ideal department head as being a team player or someone who collaborates with other departments and is able to look outside to see how one department can help another. Managers need to take the high road and work with their peers to solve problems. Sara White provided the following words of wisdom when dealing with management: “Take responsibility, do not place blame, and do not take problems to your boss, take solutions.”

The panel explained that the pharmacy department will always face challenges. Staff is generally overworked and seldom are there enough people to do all the work. Pharmacy managers are constantly being asked to cut, but even within such an environment it is possible for the director of pharmacy to continue the department's development.

Pharmacy directors who have the most impact in the C-suite are those who have a comprehensive understanding of how decisions are made and work within those parameters. These individuals also understand how priorities are established and do everything they can to assist their organizations when they are called upon to do so.

Clinical Managers: Enhancing Your Management Skills and Getting Things Done

JOHN D. PASTOR, SAMANEH T. WILKINSON

John D. Pastor and Samaneh T. Wilkinson led workshop participants through a series of exercises aimed at improving communication skills. They began by explaining how important communication is in the workplace. Relationships are of utmost importance, and communication should be proactive. They advised participants to provide colleagues with a “heads-up” when appropriate, to deliver bad news right away, and to always make your boss and the staff look good. Communication, they said, should be patient-centered, not pharmacy-centered. Do what you say you will do are words everyone in the department should adhere to.

Pastor provided an overview of the following five communication basics:

1. Know your audience.
2. Find and support your main point.
3. Choose the right channel.
4. Anticipate and prepare for questions.
5. Listen.

Pastor explained how to address communication basics 1 and 2. He stressed that you will not be effective without a solid relationship with your audience. Key stakeholders need to be identified. Supporters and opponents as well as their agendas need to be identified. That way you can identify common goals.

When tackling basic number 2, the audience was reminded that pharmacists are naturally detail oriented and often the main point gets lost in the details. To avoid that scenario, they explained that getting to the main point can be as simple as creating a one-sentence goal statement. The main point should be tailored to fit the audience, identify key supporting facts, and be focused and simple.

Choosing the right channel or basic number 3 began with a discussion of the various options for communication—e-mail, meetings, face-to-face conversations, phone conversations, voice mail messages, instant messaging, and conference calls. E-mail messages, because they are used so frequently, were discussed at length. E-mail messages were deemed to be appropriate for communication with “bad” listeners, when a written record is needed, or when what is being communicated is too complicated for an oral exchange. E-mail should not be used as a substitute for a phone call or

conversation, for communicating confidential information, or as a means to deliver bad news.

Two communication tools, the SBAR technique (situation, background, assessment, recommendation) and elevator speech, were demonstrated. The SBAR technique is useful for oral and written communication within a department to solve emerging issues in the work setting (e.g., potential heparin shortage). The elevator speech, which is a quick (30–60 seconds) and short (100–150 words) overview of a service, proposal, or project, is useful when communicating new initiatives to others outside the pharmacy. Participants were instructed to also focus on basics 4 and 5, anticipate and prepare for questions, and listen.

Pastor also reminded participants of the importance of engaging staff and providers. Key partners and allies outside the department were identified (e.g., physicians, nursing managers, nurse clinicians, cardiopulmonary services, and dieticians). Examples of how to engage physicians included identifying and building relationships, knowing the medical literature, discussing issues proactively, and following up on all requests in a prompt and complete fashion.

Engaging Staff. Samaneh Wilkinson then led participants through some exercises on how to engage staff. She began by leading the group through 8 tools for engaging staff (communicating, gathering information for continuous improvement, setting goals, rewarding and recognizing staff, asking questions and requesting feedback, preparing employees for change, setting clear expectations, and instilling a culture of mutual respect and trust). Using these tools, the following 10 items were reviewed as ways of engaging staff:

1. Conducting weekly pharmacy meetings, including time for discussion at the end.
2. Developing goals (team, department, and personal).
3. Developing a department task force.
4. Celebrating wins and losses with staff.
5. Encouraging external involvement.
6. Making the staff experts.
7. Promoting teamwork.
8. Being involved.
9. Building confidence.
10. Socializing with staff.

Improving Quality in Health Systems: Spotlight on Medication-Related National Quality Initiatives

PATRICIA C. KIENLE, DARIN L. SMITH

Introduction to Quality Initiatives. Patricia Kienle led off the workshop with the Institute of Medicine's (IOM) definition of quality, "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Quality initiatives came to the forefront in the 1990s with a flurry of articles in the medical literature about the prevalence of errors in health systems. Publication of the IOM's report entitled "To Err is Human" in 1999 brought even more attention to the issue. Since then, the government's role in health care has increased along with efforts of key organizations that have initiated effort to improve quality through means such as public performance and pay for performance. These key organizations include the Joint Commission, Centers for Medicare and Medicaid Services (CMS), IOM, Institute for Healthcare Improvement, National Quality Forum, the Leapfrog Group, and quality alliances. Measures that each of the aforementioned organizations are responsible for were explained in detail.

The Joint Commission's initiatives toward improving quality have included creating standards, National Patient Safety Goals, certification programs, and performance measures. Likewise, CMS has instituted no-pay conditions and will not reimburse for certain conditions. Examples include foreign objects retained after surgery, air embolism, blood incompatibility, manifestations of poor glycemic control, catheter-associated urinary tract infections, and surgical site infections. Other conditions under consideration for no-pay include Legionnaires' disease, iatrogenic pneumothorax, delirium, ventilator-associated pneumonia, *Staphylococcus aureus* septicemia, and *Clostridium difficile*-associated disease.

Health-System Pharmacy 2015 is ASHP's landmark initiative to significantly improve the practice of pharmacy in health systems. Launched in 2003, the initiative's goals include increasing the extent to which health-system pharmacists actively apply evidence-based methods to the improvement of medication therapy and to increase the extent to which pharmacy departments in health systems have a significant role in improving the safety of medication use.

Improving Quality of Evidenced-Based Medication Use in Health Systems: Leveraging the Role of the Pharmacist. Darin Smith made the case for pharmacist participation in quality initiatives. He noted that the major-

ity of the CMS indicators are medication-related. He also noted CMS recognizes the role of the pharmacist in its Core Measures Specification manual for conditions such as acute myocardial infarction and heart failure.

Smith, who is Director of Pharmacy Services and Performance Improvement at the Norman Regional Health System in Norman, Oklahoma, described how pharmacists have been involved in core measures and the Surgical Care Improvement Project (SCIP). A clinical pharmacist full-time equivalent was assigned to a pneumonia project and was responsible for ensuring appropriate antibiotic selection, and concurrent inpatient order reviews, which were identified using pneumonia CareMaps. Pharmacist interventions included ordering pneumococcal vaccines, ensuring timely administration of antibiotics, and contacting the smoking cessation nurse when indicated. This pharmacist took the lead in the vaccination program and helped to build a comprehensive program that has grown to include a drive-thru clinic. Between December 1999 and December 2007, more than 66,000 patients were screened and more than 9,900 vaccines were administered. Pharmacists at the Norman Regional Health System have similar roles in the treatment of acute myocardial infarction, heart failure, and deep vein thrombosis.

New Quality and Safety Measures. Several new measures are currently in development. Cholesterol assessment and lipid-lowering therapy at discharge have been added to the treatment of acute myocardial infarction. Likewise, global vaccination measures have been expanded to include all eligible patients and not just pneumonia patients.

New SCIP measures include antibiotic re-dosing in the operating room, continuation of beta-blocking agents in postoperative patients, and postoperative removal of urinary catheters. Measures for patient safety as well as the inpatient and outpatient management of chronic obstructive pulmonary disease are also in development.

The CMS's Office of Clinical Standards and Quality began the Quality Improvement Organization's 9th Scope of Work project on August 1, 2008. This three-year program will target work components in hospitals, nursing homes, and physician offices. The three core areas of work under review are beneficiary protection and public reporting, patient safety, and prevention.

Pharmacy Metrics: Implementing a Pharmacy Performance Tracking and Reporting Methodology

HOWARD S. GLAZER, WILLIAM W. CHURCHILL

Howard S. Glazer and William W. Churchill explained the role of pharmacy leaders in performance monitoring, analysis, and reporting. They began by explaining why there is a strong need for pharmacy leaders who can make the case that health system pharmacy is a continuously evolving practice with an emphasis direct patient care. Pharmacy leaders are needed to help change management's perception of the pharmacy department as the "pharmaceutical materials management department" with its clinical focus viewed as secondary in importance. It will be up to pharmacy leaders to define and demonstrate the broad values pharmacists bring to patients and institutions.

Managers should not be confused leaders, noted Glazer and Churchill. Managers have subordinates, display an authoritative style, and are risk averse and work focused. On the other hand, leaders have followers, a charismatic style, and are people focused and risk seeking. Managers and leaders are also vastly different in their approaches. For example, managers plan details, while leaders set directions. Likewise, managers take existing roads; leaders pave new roads.

Mission and Vision Statements. Pharmacy leaders will increasingly be called upon to create a strategic direction for the pharmacy department. Mission and vision statements are a way to show the organization a roadmap to a successful future. Mission and vision statements define who you are as a department as well as what you do as a department. They also explain the values and principles on which the department's visions are based.

Strategic Plans. Departmental strategic plans are another means of setting the department on a course for success. A well conceived strategic plan is one that defines exactly what needs to be done to achieve success as well as provides everyone in the department with specific goals and an action plan to guide actions on a daily, weekly, and monthly basis. A departmental strategic plan is far more than a simple task list. Rather, it is a robust outline of the actions to be taken and the results to be achieved.

Benchmarking. Benchmarking is another useful performance tool. Following are some of the strengths of benchmarking:

- Allows the organization to compare its performance with best practice sites.
- Identifies key areas of performance excellence.
- Identifies areas in need of improvement.
- Identifies potential areas for new services.

On the other hand, it can be difficult to find comparable organizations (i.e., apples to apples comparisons are often hard to find). In order to make meaningful comparisons, all of the details included in the data need to be understood.

Annual Reports. Annual reports are tools used by some pharmacy leaders to communicate key information to targeted audiences within the organization. These reports typically include updates on pharmacy activities, strategic initiatives, and medication use issues. Glazer and Churchill offered the following suggestions for developing the pharmacy department's annual report:

- Become familiar with developing effective annual reports (i.e., read the literature on the subject).
- List key objectives and keep the report concise.
- Include relevant information and examples.
- Mention in the report how the department's goals and objectives align with the institution's goals and objectives.
- Choose a reader friendly format that will make it easy to update future reports.
- Use the report as an educational and marketing tool.
- Use the report to educate the pharmacy team, senior administration, and other health care teams.
- Involve pharmacy employees and managers in the development of the report.

Balanced Scorecard Report. The balanced scorecard is a tool that translates the organization's mission and strategy into a comprehensive set of performance measures that provide the framework for a strategic measurement and management system.

Strategies for Successful Strategic Planning: Developing Your Department's Five-Year Vision

MICHAEL D. SANBORN, STEVEN CANO

Sanborn and Cano led the workshop by providing several definitions of strategic planning, the simplest being “the formal consideration of the pharmacy department’s future course.” Strategic plans should be designed to answer the following three questions:

1. What should we be doing?
2. For whom should we be doing it?
3. How can we do it better?

Strategic plans are important because they provide a means to assess the pharmacy department’s position, role, and future state. It provides the department with the opportunity to give deliberate consideration to the resources and needs of the department, such as personnel and services, facilities planning, technology, and budget. There are benefits to creating and following a strategic plan, which include setting a clear direction, driving innovation, focusing resources, incorporating benchmarking and best practices, accelerating culture change, reducing time spent on low-priority work, and improving services and quality of care. Sanborn and Cano said that a good strategic plan is fact-based, goal-oriented, focused, based on broad thinking, aligned, engaging, implementable, adaptable, and agreed upon.

The pharmacy’s strategic plan should be aligned with the health system’s plan and initiatives, although pharmacy-specific goals and metrics should also be developed. Strategic thinking involves deliberately thinking about assessing and creating the future for yourself and the department. Strategic thinking should take into consideration staff competence and skills, products (medications) and services, customers, environmental and regulatory factors, and competitors.

Strategic plans include the following general components:

- The department’s true mission.
- Documentation of service, safety, quality, finances, and growth.
- SWOT (strengths, weaknesses, opportunities, threats) analysis.
- Needs assessment.
- Action plans.
- Alternatives.
- Assignment of priorities.
- Implementation timelines.
- Ongoing updates.

The strategic plan should include specific, time-bound statements of intended future results, including goals, objectives, and tactics. Goals are the broad outcomes to be achieved, objectives are the measurable tasks that will be undertaken to realize the goal, and tactics are the tools that will be used to achieve the objectives. It is often helpful to rank each in order of importance and to select those to be addressed in the short-, medium, and long-term views.

Using a formal approach, such as strategic planning, to performance excellence will facilitate overall improvement in the department. Many examples of best practices are available (e.g., Malcolm Baldrige National Quality Improvement Act of 1987, U.S. Department of Commerce, National Institute of Standards and Technology, criteria for performance excellence, and national and statewide assessment and award processes), and they should be evaluated for applicability and possibly incorporation into the pharmacy department’s strategic plan.