Changing the pharmacy practice model: A health-system executive’s view

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Today’s health-system executives are faced with many challenges, including ensuring quality improvement and public reporting of quality measures, dealing with declining revenue and stagnation in the general economy, managing the growing numbers of uninsured and underinsured patients, finding opportunities to create new services and to serve new markets, investing in information technology, and ensuring employee and population wellness.

Reinventing acute care. The only way out of this conundrum is to reinvent acute care. There must be a new “home team” in the hospital that includes the hospitalist, the emergency care physician, and the intensivist partnered with nurses, pharmacists, case managers, social workers, and therapists. Members of this team will see the hospital as their primary workplace and will palpably see the need to transform the dysfunctionality of hospital systems of care.

The hospital of the future will need to be patient centered, defined by measurable quality, and delivered by teams of health care professionals. Measurement of success will need to be at the level of the team, not of the individual.

Teamwork. There will need to be a shift in hierarchy to allow all team members to be empowered to deliver best practices. Health care protocols, designed by the team, must be in place. A system for continuous quality improvement will need to be in place so that everyone can learn from past experiences. We will need to leave our silos and talk to each other.

There must be team education to ensure that all members know the same things, which is all the more difficult because we received our initial education separately. Real-time communication across shifts and professional disciplines is a prerequisite of best care. This involves much more than just an electronic medical record and may require multidisciplinary rounds and a culture that is open to criticism and transparency. We will need to overcome the geographic barriers within health systems and figure out how to integrate the many health care professionals who might be called on to care for each individual patient.

Conclusion. The status quo is not a tolerable solution, and many forces within and outside of health care are driving this imperative for change. It is time now for leaders in medicine, pharmacy, nursing, and elsewhere to set the direction for the hospital of the future.

This is a summary of a speech at the Summit. An audio recording of the full speech, synchronized with slides, may be accessed at www.ashp.org/ppmi/watch-taylor.

1. Sophisticated information technology systems. These systems enhance efficiencies, streamline services, and improve quality and include electronic health records that provide real-time outcome measures and foster continuity of care between inpatient and outpatient settings.
2. Physician integration. Strategic options for physician integration include independent medical staff membership, an administrative services contract, a clinical services contract, joint venture arrangements, and full-time employment. Additional new compensation models to attract and retain physicians should also be adopted.
3. Effective and efficient management of patient care quality and the continuum of care.
4. Pricing transparency. Hospitals must publicly report charges for diagnosis-related groups and ensure that pricing methodologies adequately address future changes in reimbursement.

Transition to the future. Hospitals’ transition to the future will be very challenging. One of the top priorities will be to find sufficient

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Health-system pharmacy’s imperatives for practice model change

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Redefining care models for pharmacists will not happen if we continue to simply do more of what we have been doing and deploying our scarce resources in the same way. It is time to be bold and forceful in our actions.

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Moral, ethical, and social imperatives. In order to foster effective change, we must reflect on the ethical, moral, and social imperatives facing pharmacists. Central to our professional ethos is caring about—not just providing services to—patients. There are at least four drivers in pharmacy’s ethical, moral, and social imperatives for new practice models.

The first driver is what I call “the sacred vessel.” Every human’s body for which we care is a sacred vessel in which we place toxic and otherwise dangerous chemicals and biological agents. We have an ethical and moral obligation to act as compassionately, safely, and effectively as possible in this realm.

The second driver is the concept of franchise. Given our unique education and knowledge about the use of medicines, we have been granted special privileges through licensure.

Given our franchise, we have an ethical and moral responsibility to maintain our knowledge and apply it on behalf of patients. And we must care for the franchise lest it be taken from us.

The third driver is the “doctrine of being your brothers’ and sisters’ keeper.” Pharmacists are expected to help protect patients from potential and preventable adverse drug events. Logically, this includes warning patients about potential adverse events. The legal term applicable to such professional behavior is “learned intermediary.” In litigation about whether pharmacists have a duty to warn patients about potential adverse effects, the courts have generally held that only physicians are accountable as learned intermediaries. However, it seems reasonable to anticipate that pharmacists in hospitals and health systems who care directly for patients will be found by future courts to be functioning as learned intermediaries.

The fourth driver is our professional covenant. We are subject to the ethical imperative passed down by Hippocrates: not just to do no harm, but to continuously strive to do only good. This is not always easy to do, as our profession is constantly tested by forces that focus on profit, speed, and corporate growth.

Collaboration. As we create new practice models, we must consider...