Bold goals for health-system pharmacy: Perspectives of a new practitioner

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My reflections on the goals for health-system pharmacy are rooted in my experiences as a young pharmacist in Ohio State’s health-system pharmacy administration residency and my learning from graduate classes in public health. I believe health-system pharmacy leaders have the skill and talents to drive the necessary change in healthcare. Much of the profession’s response has been reactive to the evolving healthcare landscape instead of a more-beneficial proactive approach. From my perspective, I see pharmacists shaping our systems of care, bending the cost curve, and filling the primary care gap.

Adapting to evolving systems of care

The Mirror to Hospital Pharmacy reflects on the 1964 healthcare environment. If we look at the current healthcare environment, most clinicians are witnessing a rapid rate of vertical and horizontal integration in their organizations. Health systems are acquiring or creating relationships with other health systems and expanding or consolidating their portfolio of services along with their geographic footprint. Consolidation creates many challenges for clinicians and leaders, such as working within new reporting structures and communicating across new departments. Consolidation also provides many opportunities to collaborate with pharmacists across care settings and leverage technology to gain new information about patients as they traverse the continuum of care. As a result, there is tremendous potential in data that must be unlocked by focusing efforts around transitions of care.

The systems of care that are created can have a lasting impact on how practitioners react to future problems. Pharmacists have expanded their scope of practice to fill gaps in the medication-use process, because we have the training and experience, making us effective in adapting to our organization’s needs. Pharmacy departments have taken very different approaches to common issues that have resulted in clinical practice variation. Systems have been created that rely on having the right person in the right place to prevent adverse outcomes instead of developing high-reliability processes. Many of the systems and pharmacy practice models that are present today were created in an era without the electronic tools currently available. How people interact and communicate with one another has changed dramatically since pharmacists left the basement of the hospital. The ASHP Pharmacy Practice Model Initiative (PPMI), initiated in 2010, is an important step in developing rational practice models that create consistent patient outcomes across the country. We must go one step further and work with our nursing and medical colleagues to develop high-reliability systems that do not rely on memory steps. Technology can take us part of the way, but pharmacists cannot do this as a professional silo—we must work with the other professional societies in other disciplines. As Clifton Latiolais said in 1972, “rhetoric and emotion are rampant, while deeds and action are scarce.” While Latiolais was referring to conflict within the pharmacy profession, I believe this statement holds some truth as healthcare disciplines are trying to figure out the Patient Protection and Affordable Care Act (PPACA).

Practice models can be too rigid, set unanticipated expectations on clinicians, and are not responsive to future changes. Caution must be taken when designing future systems so that unintended consequences are mitigated. We must be nimble
as future disruptive technologies are adopted, patients become informed consumers, and the way we relate to each other changes.

Economical pharmacy practice

The cost of care in the United States is not sustainable while falling short in quality of care and patient safety. Pharmacists cannot sit back and watch health reform happen. Pharmacists must help design meaningful reform that addresses the issue of the cost of healthcare. We must be proactive in bending the trajectory of the cost curve on the two items that we can influence: the cost of people and the cost of technology. We have been successful in attaining a professional wage, a goal laid out in the Mirror, but this means that we are an expensive resource. The answer to improving medication outcomes cannot always be adding more pharmacists. Instead, we need to prioritize activities so that the skill set required for a task is matched to the appropriate member of the care team. This means that pharmacists will need to hand over some tasks to pharmacy technicians, which was a goal of the PPMI, as well as to nurses, social workers, and midlevel providers.

We must transcend the politics of professional turf wars to ensure that pharmacists are focusing their efforts on the activities that have the highest impact on patient care.

Variations in clinical outcomes and the cost of healthcare throughout the United States have been described for over 40 years. Pharmacy and therapeutics (P&T) committees have created standardization and cost containment within organizations, but the cost of care across organizations can be very different. Some of this variation is due to gaps in research, when there is no good answer on how to treat a specific situation, and many times we will lean toward a more costly regimen because there is a theoretical benefit. To help control clinical outcomes and cost variation, one must look beyond national borders for solutions. Internationally, organizations and institutes have been developed to define cost-effective care within each country.

The National Institute for Health and Care Excellence (NICE) in the United Kingdom is the most highly regarded example of a technology assessment center that drives cost containment. This organization is not a part of the government and is therefore shielded from political processes. NICE encourages consistency, quality, and efficiency throughout the United Kingdom’s health system by providing guidance to the government, assessing new technologies, developing guidelines, and defining quality standards for health systems. The United States needs an analogous technology assessment center to evaluate new therapies so that innovation is incorporated into practice rationally, instead of incorporating such therapies based on how well they are marketed.

Our professional society can serve a function similar to that of NICE. ASHP is insulated from the government and can serve as an unbiased advisor to providers and payers alike. Based on the activity of a technology assessment center, such a center should probably be based in the ASHP Research and Education Foundation. The goals of this center would be to promote cost-effective medication use across the country, especially in areas where there may not be strong P&T committees. The guidance provided by the center could be used as evidence or supportive documentation by pharmacy departments across the country to drive cost-effective, appropriate care.

Innovation does cost money, but we are all responsible for controlling the costs of innovation by adopting technology only in those areas where it shows meaningful benefit.

Pharmacists in primary care

The PPACA aimed to restructure our healthcare system to prevent disease and high-cost hospital care through the growth of primary care. Before the PPACA was passed, there was a paucity of primary care providers; with more people gaining access to healthcare, this shortage will become even more pronounced. Pharmacists have already demonstrated value in primary care and can help fill the impending shortage of primary care providers. Consolidation of hospitals with primary care networks also provides a unique opportunity for pharmacy departments to develop primary care practices within our own health systems. Health systems must move quickly to expand pharmacist participation in ambulatory care teams before other models are adopted that do not include a pharmacist. While pharmacists have demonstrated value in ambulatory care, the niche that pharmacists should aim to fill is management of chronic diseases. Once a diagnosis has been established and a treatment modality selected, pharmacists can be effective in monitoring and adjusting medication therapy long-term under a practice agreement with a physician.

To foster the role of pharmacy in primary care, we must continue to develop training opportunities for pharmacists and credentialing structures to support quality. This could include further expansion of primary care pharmacy residencies and other formal training programs offered by ASHP. Credentialing should be included in the health-system quality-review processes that are already established for other prescribers.

We are aware of the importance of obtaining prescribing authority to create reimbursement structures that solidify pharmacists’ role in ambulatory care. ASHP has gained some positive momentum in generating this policy change, which has long been a goal of the profession.

Pharmacists are well positioned to help address inefficiencies in care...
processes, drive out waste in medication use, and fill the impending ambulatory care void. Pharmacists have the skill set, passion, and professional organization (ASHP) to influence reform. By setting bold goals, the profession can set a successful trajectory for future practitioners, much like our predecessors laid out in the *Mirror*.

References