



American Society of  
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March 13, 2009

**Memorandum**

To: Henri Manasse

From: David Chen

Re: ASHP/ASHP Foundation Practice Model Summit Advisory Committee Meeting

The ASHP/ASHP Foundation Practice Model Summit Advisory Committee meeting held on February 23<sup>rd</sup> and 24<sup>th</sup>, 2009 was very productive and exciting. Daniel Ashby facilitated two days of the committee's time together and we were able to meet the core objectives identified for their work. The attached information provides the background leading up to the Advisory Committee meeting, the outcomes of their work, and the individuals that were involved.

The information provided and decisions made by the advisory committee have been immediately utilized in guiding decisions and developing additional background materials required to support this initiative. Key next steps include the securing of funding for the summit, continued provision of information utilizing ASHP resources to promote the advancement of the practice model, and the strategic planning on the integration of these and additional activities required to impact and stimulate long term change.

cc: David Witmer  
Steve Allen  
Dan Cobaugh  
Bill Zellmer

**TOGETHER WE MAKE A GREAT TEAM**

## ASHP/ASHP Foundation Practice Model Summit Advisory Committee Proceedings

### **Background**

The ASHP Board during the April 2008 meeting approved the action to create and fund an advisory committee to assist ASHP and the ASHP Foundation in initiating and guiding the plans for a Practice Model Summit. It was determined that the vision for this summit would be:

“The summit will create passion, commitment, and action among hospital and health-system pharmacy practice leaders to significantly advance the health and well being of patients by optimizing the role of pharmacists in providing direct patient care. By describing patient care services and activities that support the safe and effective use of medications, corresponding models can be adopted that optimize the full potential of pharmacist, technician, and technology resources.

The summit will be a key event in a comprehensive process that is designed to increase the value of the pharmacists and pharmacy enterprise in hospitals and health systems.”

President Kevin Colgan appointed the Advisory Committee members in November 2008. (Appendix A). In addition, Daniel Ashby was asked to serve as the facilitator for the committee. The Advisory Committee met at the ASHP offices on February 23<sup>rd</sup> and 24<sup>th</sup>, 2009. To facilitate their work the committee was provided background materials that included proceedings from past ASHP/ASHP Foundation consensus conferences results from the April 2008 ASHP strategic retreat, Council minutes, and benchmark papers on the practice model. Also provided were documents the committee members submitted. The charge created for the Advisory Committee was:

“This advisory committee is requested to assist ASHP in its planning of the summit. The Advisory Committee is requested to consider that pharmacists must continue to move towards a practice model that supports the use of their skills and abilities in caring directly for patients to their fullest potential. In addition, the Advisor Committee should consider the effect that information technology, expanding role of technicians, rising salaries of pharmacists, ever challenging payment systems, growing healthcare demand, and need for improved role delineation have on the possible hospital and health-system pharmacy practice models. The goals of this committee include:

1. Identify the key influencers impacting the future model(s) of pharmacy practice in hospitals and health systems to be addressed during the summit.
2. Assess if it is feasible and desirable for the Summit to address both the macro deployment of resources by the pharmacy department and the micro approach to practice by individual practitioners that have highly differentiated or specialized roles.
3. Decide on the objectives that will be established for the Summit.

4. Identify the types of individuals that should be considered for participant invitation and as observers in order to fully meet the decided objectives of the Summit.
5. Identify the best mechanisms for managing the Summit so that actionable outcomes that stimulate change are produced.
6. Determine mechanisms that should be considered for communicating the work of the Summit in order to ensure clear understanding and embracing of the envisioned outcomes.”

### **Advisory Committee Meeting**

The Advisory Committee met for two days of facilitated discussion led by Daniel Ashby. Also in attendance were ASHP and ASHP Foundation staff as well as members of the Practice Model Initiative Team (Appendix B). The meeting was initiated with a review of key publications followed by an open forum discussion. Following this the committee was separated into two workgroups and was asked to address the following topics:

- What questions need to be asked?
- What is ‘missing’ that the profession needs to move forward?
- Who are the invitees? (groups, character traits, and representative individuals)
- Who should be the leaders at the summit; plenary sessions and break out groups?
- What are best mechanisms to reach actionable outcomes?
- What actions need to occur pre-summit, currently with summit, and post-summit?

These topics were prepared to help identify what key issues are unresolved from past practice model change efforts and what are the influencers of success for the future practice model. It was important to reflect on lessons learned from past initiatives and identify what ASHP members and others would require to successfully fulfill the envisioned outcomes of the summit. In addition, the committee was asked to identify the types of individuals and character traits that would be necessary to have in leadership roles for this effort. Finally, with the vision that the summit would be one part of a larger initiative advice was needed on an ideal design of both a summit and the preceding and ensuing efforts to affect change.

### **Consensus Process:**

The advisory committee and selected ASHP staff were divided into two workgroups. Each group was led by a facilitator (Appendix B) to address each of the questions noted above. After each group generated ideas, the entire advisory committee then discussed and collectively added to the results. ASHP staff compiled the lists of ideas for key questions to resolve and topics for the plenary sessions. Participants were then asked to rank their top 5 in each category.

For the summit objectives the Advisory Committee facilitator led an open discussion on what the objective should be for the summit/initiative which was followed by each workgroup member ranking their top 5.

The consensus process was not used for the sessions on what is missing to move practice model forward (Appendix C), character traits and types of individuals that should be invited and lead

the summit (Appendix D), the best mechanisms to reach actionable outcomes, and ideas generated for actions that need to occur pre-summit, currently with summit, and post-summit. The information from these discussions will be utilized by ASHP and ASHP Foundation staff and the Advisory Committee in subsequent planning sessions. It was noted that summit/initiative planning decisions should take into account the need to create a) PASSION – to energize the attendees; to create a sense of urgency b) COMMITMENT – to define what the new practice model should look like and c) ACTION – to identify strategies for implementation of the new model.

### **Advisory Committee Meeting Results:**

The following are the results of top choices for objectives identified for the practice model summit/initiative, the key questions that need to be resolved, and the topics that should be considered for the plenary sessions.

#### *Objectives Identified for Initiative: (Top choices with more than 50%)*

1. Create a vision for a pharmacy practice model that ensures provision of safe, effective, efficient, accountable, and evidence-based care for all hospital/health system patients;
2. Determine patient care-related services that should be consistently provided by departments of pharmacy in hospitals and health systems and increase demand for pharmacy services by patients/caregivers, healthcare professionals, healthcare executives, and payers;
3. Identify the available technologies that should be leveraged to support implementation of the practice model, and identify emerging technologies that could impact the practice model;
4. Support the optimal utilization and deployment of hospital and health-system pharmacy resources through development of a template for a practice model which is operational, practical, and measurable; and
5. Identify specific actions steps pharmacy leaders and staff should take to implement practice model change including determination of the necessary staff (pharmacy leaders, pharmacists, and technicians) skills and competencies required to implement this model.

#### *Key Questions to Resolve at Summit: (Top choices with more than 50%)*

1. What is the ideal practice model? What are the minimum components that all models should have regardless of practice setting?
2. What is the implementation strategy for the practice model?
3. What are the current expectations of our stakeholders (patients, payers, and the public)? How should we change expectations? What should these new expectations be?

4. What core activities should be included in the practice model? Considerations: clinical versus distributive, priorities of functions versus flexibility, uniformity across settings
5. What is the scope of the practice model definition? Considerations: applicability to small and rural hospitals, applicability beyond inpatient services, impact of COC, relationship between preventive, treatment and palliative care.
6. What will the workforce needs be? Considerations: role definitions, accountability, competency measurement, impact of technology, educational change required, a 24x7 workforce, technicians)
7. What is the imperative for changing the practice model? Why should it be a top priority for the profession?

*Topic Ideas for Plenary Sessions: (Top choices with more than 50%)*

1. What is the imperative for changing the practice model? Why should it be a top priority for the profession?
2. What are the external factors influencing the need for the development of a new practice model?
3. What is the ideal practice model? Where the pharmacist is best utilized in the medication use process?
4. What are the short-term and long-term strategies for implementing the practice model?
5. Why is the development of a new practice model important and necessary to providing proper patient care?
6. What are the minimum components that all practice models should have regardless of practice setting?
7. Session on technology – current, limitations and future
8. Evolution of pharmacist care
9. Career sculpting and leadership

**Next Steps for Practice Model Summit and Initiative**

ASHP and the ASHP Foundation staff will provide the ASHP Board with these proceedings and continue with its fund raising efforts to support the summit. Pre-summit education and advocacy activities will continue utilizing the information and ideas obtained from the Advisory Committee's discussions and decisions.

## Appendix A

### ADVISORY COMMITTEE ON ASHP'S PRACTICE MODEL SUMMIT ROSTER - 2008-2009

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## Appendix B

### ASHP/ASHP Foundation Practice Model Initiative Team

- Cynthia Reilly
- David Chen
- Daniel Cobaugh
- David Witmer
- Douglas Scheckelhoff
- Ellen Wilcox
- Karl Gumper
- Kasey Thompson
- Kristin Banek
- William Zellmer

### ASHP/ASHP Foundation Practice Model Funding Team

- Colleen O'Malley
- Julie Webb
- Susan Cantrell
- Stephen Allen

### Facilitators for Advisory Committee Meeting

- Daniel Cobaugh
- Deborah Perfetto
- Karl Gumper
- Kristen Banek

## Appendix C

### **Summary of Key Points on What's Missing to Move Practice Model Forward**

1. Lack of a true sense of professionalism among individual pharmacists (ownership and accountability of patient care related to medication management).
2. Lack of resources (funding, well trained technicians, legislative and regulatory change) to allow pharmacists to practice according to an alternative practice model.
3. Realignment of incentives (pharmacy) with those of hospital leadership to encourage pharmacists' accountability for safe and effective patient care.
4. Lack of resources related to the proper training and education of pharmacy students and technicians (funding, rotation preceptors, practice sites, pharmacists to train technicians, etc.).
5. Inability of patients to truly recognize the risks associated with medication use (can also be associated with the increased need for patients to take an active role in their health care).
6. Need to recognize the academically trained specialty pharmacist as a "leader" (leading based on clinical knowledge and expertise instead of management ability).
7. Lack of a cohesive/formal plan to communicate the importance of the clinical pharmacist in the hospital/health system and the public/patients.
8. Universal acceptance of responsibility for patient outcomes to define
9. Competency of pharmacy leadership and leadership at individual level that is prepared to affect change
10. Level of technology that is available, understood, and optimally utilized
11. True interdisciplinary care model – pharmacist as a professional equal
12. Sufficient quantity of pharmacy educators

## Appendix D

### Invitee Groups and Characteristics

<ul style="list-style-type: none"> <li>• Health System Executives – Kaiser Permanente, AHA, ACHE, Providence, Institution’s/System’s Vice Presidents or DOP’s Direct Report (CEO from Virginia Mason)</li> <li>• Hospitalists – SHM – Check current BOD</li> <li>• Patient advocates – David Swann, AARP, Art Levin</li> <li>• CMO’s – Jeff Collins (Sacred Heart – Providence), Keith Martin (Providence), Review large organizations as well as UHC Institutions.</li> <li>• CIO/CMIO’s – AMIA, HIMSS, Regenstrief, VA System, Vanderbilt, Intermountain Health, and Mayo.</li> <li>• Human Resources/Healthcare workflow Development – Academics, Recruiting Agencies, IOM reports, need individual who can focus on credentials and training.</li> <li>• PhRMA – Need to forecast on new innovations and pipeline</li> <li>• Alliances – Premier, VHA, Catholic, etc.</li> <li>• Pharmacy Educators – Need good communicators – Deans and Practice Chairs, Collaborate with AACP and ACPE.</li> <li>• Health IT Leaders – Not necessarily the following individuals, but people like Newt Gingrich or David Brailer – Pharmacist Leaders in this area? Possibly vendors.</li> <li>• State Government Representatives (Innovative Medicaid) – Massachusetts</li> <li>• PGY-2 Pharmacy Specialty Program Directors</li> <li>• Lead Surveyors from ASHP Residency Accreditation</li> <li>• Pharmacy Technician Leaders – Active State Organizations, PTEC, PTCB</li> <li>• Change Engineers/Workflow systems engineers/Social Sciences experts – deal with re-design and cultural changes.</li> <li>• Public/Private Payers – CMS, Aetna, AHIP, etc.</li> <li>• Publicist/Public Relations – ASHP PR firm? Review other companies work, J&amp;J example of campaign towards nursing.</li> <li>• Experts on Personalized Health Care</li> <li>• Others: FDA, HHS, HRSA</li> </ul>	<ul style="list-style-type: none"> <li>• HRSA</li> <li>• Managed care</li> <li>• Academia</li> <li>• VA system</li> <li>• Mail order</li> <li>• Hospitalists</li> <li>• Internists</li> <li>• Emergency med</li> <li>• ACP</li> <li>• Payers – private and public</li>   <li>• ACPE president</li> <li>• AACP rep</li> <li>• Nursing health system</li> <li>• Magnet Hospital person</li> <li>• Innovative hospital directors</li> <li>• CMO</li> <li>• Small hospital reps</li> <li>• Healthcare executives</li> <li>• AAFP</li> <li>• QIO organizations ( TJC, NQF, AHRQ, IHI, QIO)</li> <li>• Clinical practitioners</li> <li>• Health IT Leaders – Not necessarily the following individuals, but people like Newt Gingrich or David Brailer – Pharmacist Leaders in this area? Possibly vendors.</li> <li>• Pharmacy Associations</li> <li>• Business Innovations/Large Business/Venture Capitalists – Examples of Wal-Mart or Fed-ex – supply chain automation and standardization. Group used Izod, Avon, and 3M as companies re-defining their brand. Possibly Google and/or Microsoft to discuss EHR potentials.</li> <li>• Pharmacy Leaders (Current Practitioners) – ACCP, State affiliates willing to lead local initiatives, Past Presidents and BODs.</li> <li>• Health Policy Experts – Writers/editors of Health Affairs Journal.</li> <li>• Nursing/Nurse Practitioners/CNO’s – AONE, ARNP, search for CNO similar to CMO search.</li> <li>• State Affiliates</li> <li>• Accreditation Bodies - TJC</li> <li>• Credentialing Bodies</li> <li>• Safety and Quality Organizations – Leapfrog, IHI, NQF, AHRQ</li> </ul>
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