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## SMALL AND RURAL HOSPITAL DISCUSSION GROUP

### Summary

June 13, 2005      Boston, Massachusetts

**Moderator: George Hatfield, M.S., Pharmacy Director - Island Hospital, Anacortes, Washington.**

Mr. Hatfield welcomed the members to the meeting. Approximately 75 members were in attendance.

Teresa Rubio, ASHP Staff, gave an overview of ASHP's work for small and rural hospitals (attached.) Members were encouraged to participate via the listserv, give suggestions to the new web resource center for small and rural hospitals, and in programming for the Midyear Clinical Meeting.

The following topics were discussed:

- After hours services
- USP 797
- 340 B
- Residency Programs
- Patient's own meds
- Medication Reconciliation

#### After Hours Services

- Meditech is commonly used in small hospitals.
- Cardinal RxE Source is commonly used, comment to check with your BOP first
- (Maine) Group of 20 small hospitals have one pharmacist who contracts with them to provide 7 day coverage. Pharmacist is an independent contractor.
- Cerner used to provide services.
- (WI) Comment that pharmacist lives far away, and RN cannot enter pharmacy per JCAHO. How should this be handled?
- (NH) Night supervisor used Pyxis Med Administration check, Pyxis Connect from home. Almost everything is kept on the floor.
  - Another member commented that this would not improve patient safety.
  - Later clarified that for 2006, there is no change in JCAHO requirements. RN will still have access to the pharmacy, and that the issue with JCAHO was that unlimited access to the pharmacy is not desirable. There are very few small hospitals that have more than 2 entries/night.
- (MN) Omnicell used- decreases amount of time RN enters the pharmacy (less than 1 time/month.) Pharmacist accesses system from home.
- (NE) From a small hospital- cannot justify cost of consulting. Does not have a computer system. Suggests that first priority is implementing an electronic MAR.

- Another comment that this hospitals should first focus on CMS conditions of participation to justify new services which are not limited to critical access hospitals.

## USP 797

- Question arose: how do barrier isolators compare to a clean room?
  - (KS) After site visits to larger hospitals, found that outsourcing was not necessary. Currently using 2 isolator (paid \$70K for both.) May consider a clean room in the future.
  - (WA) Currently remodeling the pharmacy- has more space, but being taken up by the anteroom/anteroom. Are considering barrier isolators.
- (CA) Hospital has more chemo inpatient vs. outpatient. What are others' plans for chemotherapy, meeting 797/NIOSH requirements? Needs negative pressure/vent to the outside.
- (NE) Comment that barrier isolators can be used for simple compounding (no TPNs, dialysis.) May be cumbersome if doing a lot of preparations (due to crowding.)
  - Comment from a member that isolators exist for TPN compounding, although they outsource TPNs. They do have occasional patients on renal replacement therapy, which is difficult to compound in the barrier isolator.

## 340B and drug costs in general

- Comment that the Western North Carolina alliance has grouped 16 small hospitals together to get Premier discounts (all work with the same GPO)
- (RI) Southern NE Hospitals- have banded together with other hospitals (Amerinet.)

## Residency Programs

- (RI) Considering co-sponsoring a program
- (WI) Has residency program. Includes critical access hospitals, 2 nursing homes. Residents have primary care and staffing responsibilities.

## Patient's Own Meds

- Member shares their policy that if patient is an observation patient, can use their own meds.
- (Maine) Promotes patient using their own meds for cost effectiveness.
  - Comment from another member over medication integrity.
  - Another comment that pharmacist must identify medication/RN administer.
- (NE) Small surgical hospital- cannot maintain formulary if patient does not bring in their meds. Many hospitals buy in small quantity or borrow.
- (CA) Some patients will not accept formulary substitutions
- (KS) Therapeutic interchange with medication reconciliation is a problem because patient may be sent home on new drugs and continues using the previous drug, there is no medication reconciliation. Not much cost saving seen.
- (WA) Hospital does not do automatic interchange- community drives what is on the formulary

## Medication Reconciliation

- Pharmacist taking admission history in the ED gives the biggest "bang for buck"