Pharmacy Management

Disposition of Illicit Substances (1522)
Source: Council on Pharmacy Management
To advocate that healthcare organizations be required to develop procedures for the disposition of illicit substances brought into a facility that ensure compliance with applicable laws and accreditation standards; further,

To advocate that healthcare organizations be required to include pharmacy leaders in formulating such procedures.

Pharmacy Department Business Partnerships (1416)
Source: Council on Pharmacy Management
To recognize that a key objective of pharmacy departments is to provide comprehensive medication management across the continuum of patient care, and that pharmacy leaders should proactively evaluate potential business partnerships against this objective; further,

To recognize that hospitals and health-system pharmacy leaders must ensure that business partners meet all applicable patient safety and accountability standards; further,

To provide education and tools for pharmacy leaders to aid in the evaluation of and development of business partnerships; further,

To educate health-system administrators on the importance of pharmacy leadership in evaluating and developing pharmacy-related business partnerships; further,

To encourage health-system pharmacy leaders to consider evolving health care financing systems when evaluating and developing business partnerships.

Integration of Pharmacy Services in Multifacility Health Systems (1417)
Source: Council on Pharmacy Management
To advocate that pharmacists are responsible for organizational efforts to standardize and integrate pharmacy services throughout the entire pharmacy enterprise in multifacility health systems and integrated delivery networks; further,

To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications; further,

To advocate for the regulations and resources needed to support efforts to achieve optimal patient health outcomes in multifacility organizations.

This policy supersedes ASHP policy 1210.

Proliferation of Accreditation Organizations (1303)
Source: Council on Pharmacy Management
To advocate that health care accreditation organizations include providers and patients in their accreditation and standards development processes; further,

To encourage health care accreditation organizations to adopt consistent standards for the medication-use process, based on established principles of patient safety and quality of care; further,

To encourage hospitals and health systems to include pharmacy practice leaders in decisions about seeking recognition by specific accreditation organizations.

Workload Monitoring and Reporting (0901)
Source: House of Delegates Resolution
To strongly discourage the use of pharmacy workload and productivity measurement systems ("pharmacy benchmarking systems") that are based solely upon dispensing functions (e.g., doses dispensed or billed) or a variant of patient days, because such measures do not accurately assess pharmacy workload, staffing effectiveness, clinical practice contributions to patient care, or impacts on costs of care, and therefore these measurement systems are not valid and should not be used; further,

To advocate the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care; further,

To define pharmacy workload as all activities related to providing pharmacy patient care services; further,

To continue communications with health-system administrators, consulting firms, and professional associations regarding the value of pharmacists' services and the importance of using valid, comprehensive, and evidence-based measures of pharmacy workload and productivity; further,

To encourage practitioners and vendors to develop and use a standard protocol for collecting and reporting pharmacy workload data and patient outcomes; further,

To advocate to health-system administrators, consulting firms, and vendors of performance-measurement services firms the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care.

This policy was reviewed in 2013 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Pharmacist Leadership of the Pharmacy Department (0918)
Source: Council on Pharmacy Management
To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,

To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,

To recognize the supporting role of nonpharmacists in leadership and management roles within pharmacy departments.

This policy was reviewed in 2013 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Pharmacy Staff Fatigue and Medication Errors (0504)
Source: Council on Administrative Affairs
To encourage pharmacy managers to consider workload fatigue, length of shifts, and similar performance-altering factors when scheduling pharmacy staff, in order to ensure safe pharmacy practices; further,

To oppose state or federal laws or regulations that mandate or restrict work hours for pharmacy staff; further,

To support research on the effects of shift length, fatigue, and other factors on the safe practice of pharmacy.

This policy was reviewed in 2014 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

ASHP Policy Positions 2009–2017 (with Rationales): Pharmacy Management

1522
DISPOSITION OF ILLICIT SUBSTANCES
Source: Council on Pharmacy Management

To advocate that healthcare organizations be required to develop procedures for the disposition of illicit substances brought into a facility that ensure compliance with applicable laws and accreditation standards; further,

To advocate that healthcare organizations be required to include pharmacy leaders in formulating such procedures.

Rationale

Hospitals and health systems often treat patients that have in their possession illicit substances (e.g., Schedule I drugs, or other illegal or illegally possessed substances), which requires the facility to make decisions about how to secure the substances, ensure the appropriate chain of custody, and document possession in the patient's medical record, as well as decide whether to inform law enforcement. Such decisions benefit from the organization's legal counsel making a determination for the organization, in consultation with pharmacy leaders who can help interpret the pharmacist-in-charge's legal requirements and related accreditation standards.

1416
PHARMACY DEPARTMENT BUSINESS PARTNERSHIPS
Source: Council on Pharmacy Management

To recognize that a key objective of pharmacy departments is to provide comprehensive medication management across the continuum of patient care, and that pharmacy leaders should proactively evaluate potential business partnerships against this objective; further,

To recognize that hospitals and health-system pharmacy leaders must ensure that business partners meet all applicable patient safety and accountability standards; further,

To provide education and tools for pharmacy leaders to aid in the evaluation of and development of business partnerships; further,

To educate health-system administrators on the importance of pharmacy leadership in evaluating and developing pharmacy-related business partnerships; further,

To encourage health-system pharmacy leaders to consider evolving health care financing systems when evaluating and developing business partnerships.

Rationale

Hospitals and health-system pharmacy leaders have to increasingly assess and engage with external business partners in order to facilitate continuity of care for their patients and optimize outcomes. Hospitals and health-system leaders must be positioned to provide the most comprehensive care for their patient populations. As these external entities expand their market share and become more engaged across the health care continuum, a significant number of hospitals and health systems are dealing with how to best evaluate potential business partnerships. In some cases hospital or health-system pharmacy leaders are seeking to create a network of pharmacy locations and services for their patients that the health system cannot build itself. In other cases hospital and health-system pharmacy leaders need to engage with external business partners to provide services they cannot provide or to improve the efficiency of services provided by the hospital or health system. Additionally, a number of business entities see changes in value-based purchasing and readmission payment as an opportunity to contract with health systems. Finally, there are also business partners (e.g., data management, automation, compounding, and consulting organizations) that pharmacy leaders need to engage with in order to manage their pharmacy enterprise. These changes have posed a political, logistical, and professional challenge for pharmacy leaders.

1417

INTEGRATION OF PHARMACY SERVICES IN MULTIFACILITY HEALTH SYSTEMS

Source: Council on Pharmacy Management

To advocate that pharmacists are responsible for organizational efforts to standardize and integrate pharmacy services throughout the entire pharmacy enterprise in multifacility health systems and integrated delivery networks; further,

To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications; further,

To advocate for the regulations and resources needed to support efforts to achieve optimal patient health outcomes in multifacility organizations.

This policy supersedes ASHP policy 1210.

Rationale

Data from a 2011 American Hospital Association annual survey of hospitals indicate that at the time of the survey, 4432 of 5724 hospitals were part of either a system or a network, reflecting the evolution of the health care enterprise from single hospitals to integrated systems and networks. Multiple hospitals organized and owned by the same system have been in the United States marketplace for decades, but the rapidly changing marketplace in the past 2–3 years seems to foreshadow a future in which every hospital in the country will be part of a system. These systems have become increasingly complex as they also delve into non-hospital based businesses and seek to standardize and gain economies of scale across the organization.

These new organizations and the recognition of the importance of medication management to the overall health of these organizations have led to new roles and new

challenges for pharmacy leaders. The pharmacy enterprise of the future will be more sophisticated and corporate in its nature. Pharmacy leaders both at the local hospital and at the corporate level have to more so than ever look at their pharmacy services in the context of the overall goals and needs of the organization or health system and determine the most efficient and effective means to provide these services. Leadership of the pharmacy must evolve from a department leader in a single facility to an effective corporate leader of medication use across a wide array of business units, care settings, and organizations. Centralization of medication management services is no longer confined to drug distribution but also includes human resources management, integrity of the electronic health record and related patient-care information, and oversight of various business partners. Pharmacy leaders within these evolving health systems will have many challenges, ranging from communication among the pharmacy management team, decisions on pharmacy infrastructure purchases and contracting, identification of critical services and standardization, succession planning and workforce development, supply chain management, human resource coordination, and strategic planning across diverse hospitals within the system. Further challenging health system pharmacy leaders are coordinating pharmacy services across larger geographical regions.

The nature and culture of decision making will be changed as some decisions become more centralized and corporatized and new practice models are developed to capitalize and adapt to the changing market place. Especially as merged systems extend beyond local and regional markets, health care will likely become even more business-like in its decision-making and fewer decisions will be made at the local facility level. The pharmacy enterprise will need to adapt to this changing environment. Many important decisions that influence medication-use policy will be made at the level of corporate leadership, and it will be critical that pharmacists provide leadership in this corporate decision-making. The ability to demonstrate the financial impact of pharmacy services will be critical and the development and implementation of effective drug-use policy across the enterprise will be crucial to success.

Along with increasing consolidation and integration of health systems, the business model for health care is also evolving. Pharmacy leaders will need to become familiar with changing business imperatives and align the pharmacy business plan with that of the health system. Planning must integrate at both the strategic and tactical level. Pharmacy needs to be envisioned as a service rather than a department. These changes have resulted in the need to evaluate best practices, legal and regulatory requirements, and leadership structure.

1303

PROLIFERATION OF ACCREDITATION ORGANIZATIONS

Source: Council on Pharmacy Management

To advocate that health care accreditation organizations include providers and patients in their accreditation and standards development processes; further,

To encourage health care accreditation organizations to adopt consistent standards for the medication-use process, based on established principles of patient safety and quality of care; further,

To encourage hospitals and health systems to include pharmacy practice leaders in decisions about seeking recognition by specific accreditation organizations.

Rationale

Hospitals and health-system pharmacy leaders have years of experience in managing the demands and challenges of ensuring that pharmacy services meet the standards of accreditation organizations. In order to be a qualified provider for the Centers for Medicare & Medicaid Services (CMS), hospitals need to be certified and meet the standards of an approved accreditation organization, or be accredited through the CMS state-based survey process. Until recently, this accreditation was predominantly performed by The Joint Commission (TJC). Hospitals with additional ambulatory care services (e.g., home infusion and durable medical equipment) have also had to manage the accreditation process for those business units. If a hospital is accredited by TJC, it is required to have the nonhospital-based business units surveyed by TJC if TJC has a corresponding accreditation process.

Accreditation of hospitals and health systems has improved the quality of and enhanced the services provided by those organizations. ASHP has participated for many years in the TJC standards development process, and TJC medication management standards have supported strong pharmacy services.

Until recently there were relatively few accreditation organizations that hospital and health-system pharmacy leaders needed to be familiar with. Three phenomena in recent years have created challenges for pharmacy leaders: (1) TJC is no longer the only accreditor for hospitals and health systems, (2) health systems are building or acquiring new business units with accreditation processes that need to be integrated into those of the broader health system, and (3) new accreditation processes are being established for operations or entities that pharmacy leaders may be responsible for or are considering.

Outsourcing of pharmacy services and the receipt and handling of prescription drugs for specialty pharmacy patients (“white bagging”) is another facet of the challenges that changes in accreditation have created for hospital and health-system pharmacy leaders. Many of these pharmacy providers may require accreditation, and hospital pharmacy leaders need to consider means to ensure the pharmacy provider is preferably or properly accredited.

The expansion of health systems and the growth of the pharmacy enterprise are creating a new need for pharmacy leaders to manage multiple accreditors and raising the potential challenge of managing overlapping accreditors (e.g., whether a hospital’s URAC-accredited specialty pharmacy also requires TJC review). Another concern is that when new accreditation processes become established as a requirement for providing pharmacy services, they can become a barrier to the creation or expansion of pharmacy servicing, restricting organizations’ growth. For example, it has been reported that four payers require URAC accreditation to be a specialty pharmacy provider. In addition, accreditation processes and standards for community pharmacy are being developed, and pharmacy leaders will need to consider those as well.

0901

WORKLOAD MONITORING AND REPORTING

Source: House of Delegates Resolution

To strongly discourage the use of pharmacy workload and productivity measurement systems ("pharmacy benchmarking systems") that are based solely upon dispensing functions (e.g., doses dispensed or billed) or a variant of patient days, because such measures do not accurately assess pharmacy workload, staffing effectiveness, clinical practice contributions to patient care, or impacts on costs of care, and therefore these measurement systems are not valid and should not be used; further,

To advocate the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care; further,

To define pharmacy workload as all activities related to providing pharmacy patient care services; further,

To continue communications with health-system administrators, consulting firms, and professional associations regarding the value of pharmacists' services and the importance of using valid, comprehensive, and evidence-based measures of pharmacy workload and productivity; further,

To encourage practitioners and vendors to develop and use a standard protocol for collecting and reporting pharmacy workload data and patient outcomes; further,

To advocate to health-system administrators, consulting firms, and vendors of performance-measurement services firms the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care.

This policy supersedes ASHP policy 0406.

Rationale

Although the practice of health-system pharmacy has evolved and changed significantly over the past two decades, benchmarking systems used to gauge the value and productivity of health-system pharmacy have remained largely unchanged. Productivity measures based solely on dispensing functions or a variant of patient days are not valid tools to assess current health-system pharmacy practice. These outdated measures do not reflect ASHP's aspirations for health-system pharmacy (e.g., ASHP best practices and the 2015 Initiative) or evolving Joint Commission requirements. Use of these inappropriate productivity recommendations may result in inadequate staffing, which increases stress on pharmacy leadership, discourages pharmacists from becoming pharmacy directors, and contributes to the leadership gap in health-system pharmacy.

Alternative benchmarking systems that more accurately reflect true health-system pharmacy productivity have been developed. The ASHP Section of Pharmacy Practice Managers has made recommendations for the effective use of workload and productivity systems in health-system pharmacy that elaborates the types of metrics that should be used.

0918

PHARMACIST LEADERSHIP OF THE PHARMACY DEPARTMENT

Source: Council on Pharmacy Management

To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,

To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,

To recognize the supporting role of nonpharmacists in leadership and management roles within pharmacy departments.

This policy supersedes ASHP policy 0606.

Rationale

The ASHP Long Range Vision for the Pharmacy Work Force in Hospitals and Health Systems sees a growing role for nonpharmacists in management and leadership positions in hospitals and health systems. Many factors are fueling this expansion, including a shortage of pharmacists, pharmacists' salaries, and the growing complexity of the pharmacy enterprise. There are many functions in the pharmacy department that can be led or managed by nonpharmacists, including management of technological, business, or financial matters. Although nonpharmacists fill many important supporting leadership and management roles within pharmacy departments, a pharmacist should lead the pharmacy enterprise, supervise and manage all pharmacy personnel, and be responsible for the administrative, clinical, and operational functions of pharmacy departments in hospitals and health systems. Use of specialized nonpharmacist expertise will vary, depending on the size and complexity of the pharmacy enterprise. These roles will be more prevalent in large facilities and less so in small or rural facilities, where there is likely to be less specialization in pharmacy functions.