

How to Meet the Needs of Small and Rural Practitioner Members in Your State

September 21, 2017



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The screenshot shows the GoToWebinar control panel interface. At the top, there is a red banner that reads "Attendees Still On Hold" and "Press *1 to Start the Broadcast for all attendees." Below this, there are several expandable/collapsible sections: "Audience view" (100%), "Sharing", "Webcam", and "Audio". The "Audio" section is currently expanded, showing options for "Computer audio" and "Phone call" (selected). Below these options are fields for "Dial:", "Access Code:", and "Audio PIN:", each with a blue rectangular placeholder. There is also a note: "Already on the call? Press #77# now." and a link "Problem dialing in?". Below the audio section, there are sections for "Dashboard", "Attendees: 1 out of 1001", "Polls (0/0)", and "Handouts: 0 of 5". The "Chat" section is expanded, showing a message from "Me (to All - Entire Audience):" at 4:59 PM: "How can i submit a question?". Below the chat area is a text input field, a dropdown menu set to "All - Entire Audience", and a "Send" button. At the bottom, there is a "Webinar Now" section with "Webinar ID: 322-662-731" and the "GoToWebinar" logo.

Presenter

Erika L. Thomas, M.B.A., B.S.Pharm., is Director of the ASHP Section of Inpatient Care Practitioners. Previously, Ms. Thomas served as Scientific Project Director for ASHP Advantage and Director of Educational Programming in the ASHP Educational Services Division. Before coming to ASHP, Ms. Thomas practiced at The Methodist Hospital in Houston, Texas; Lutheran General Hospital in Park Ridge, Illinois; and Michael Reese Hospital in Chicago, Illinois. She completed her residency at Harper Grace Hospitals in Detroit, Michigan.



Erika Thomas

Presenter

- Future President-Elect (2018), Indiana Pharmacists Alliance
- Former Chair (2016-17), ASHP Small and Rural Hospital Section Advisory Group
- Past President (2015), Indiana Academy of Health System Pharmacists
- Former Board Member (2010-2016), Indiana Rural Health Association
- Former Director of Pharmacy (2004-2013) of a Critical Access Hospital in Rural Indiana



Denise Fields, PharmD, FASHP

Presenter

**PharmD: University of Minnesota College of
Pharmacy Class of 2016**

Duluth Campus

**Masters in Public Health: University of Minnesota
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**PGY1 Residency: Essentia Health-St. Mary's Medical
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Amber Soukkala

Presenter

Lindsay Massey is a pharmacy manager at Saint Luke's Hospital of Kansas City where she oversees the pharmacy services for the neuroscience, emergency, neonatal and medical intensive care areas. Lindsay also serves as the Chair of the Saint Luke's Hospital Medication Safety Team and precepts students, PGY1 and PGY2 residents in medication safety and administration. Lindsay graduated from the University of Kansas School of Pharmacy and completed a combined PGY1/PGY2 residency with a Masters of Science in Health-System Pharmacy Administration at The Ohio State University Medical Center.

Lindsay currently serves as President of the Kansas Council of Health-System Pharmacy and is a Kansas delegate for the ASHP House of Delegates.



Lindsay Massey

Presenter

Steve Glass, RPh is a 1981 graduate of the University of Georgia College of Pharmacy. He has over 30 years of association management experience including over twenty five years with Georgia Society of Health-System Pharmacists. He is also the Executive Director for the Virginia Society of Health-System Pharmacists and the Alabama Society of Health-System Pharmacists.

He has been recognized as an ASHP Fellow. He has received the Certified Association Executive (CAE) from the American Society of Association Executives and the Certified Meeting Professional designation from Convention Industry Council.

Mr. Glass is a member of American Society of Health-System Pharmacists, American Society of Association Executives, Georgia Society of Health-System Pharmacists, Georgia Pharmacy Association and Florida Society of Association Executives.

In his spare time, he love to play golf.



Steve Glass



**Inpatient Care
Practitioners**

Overview: Setting the Stage

Erika Thomas, M.B.A., B.S.Pharm.

Director

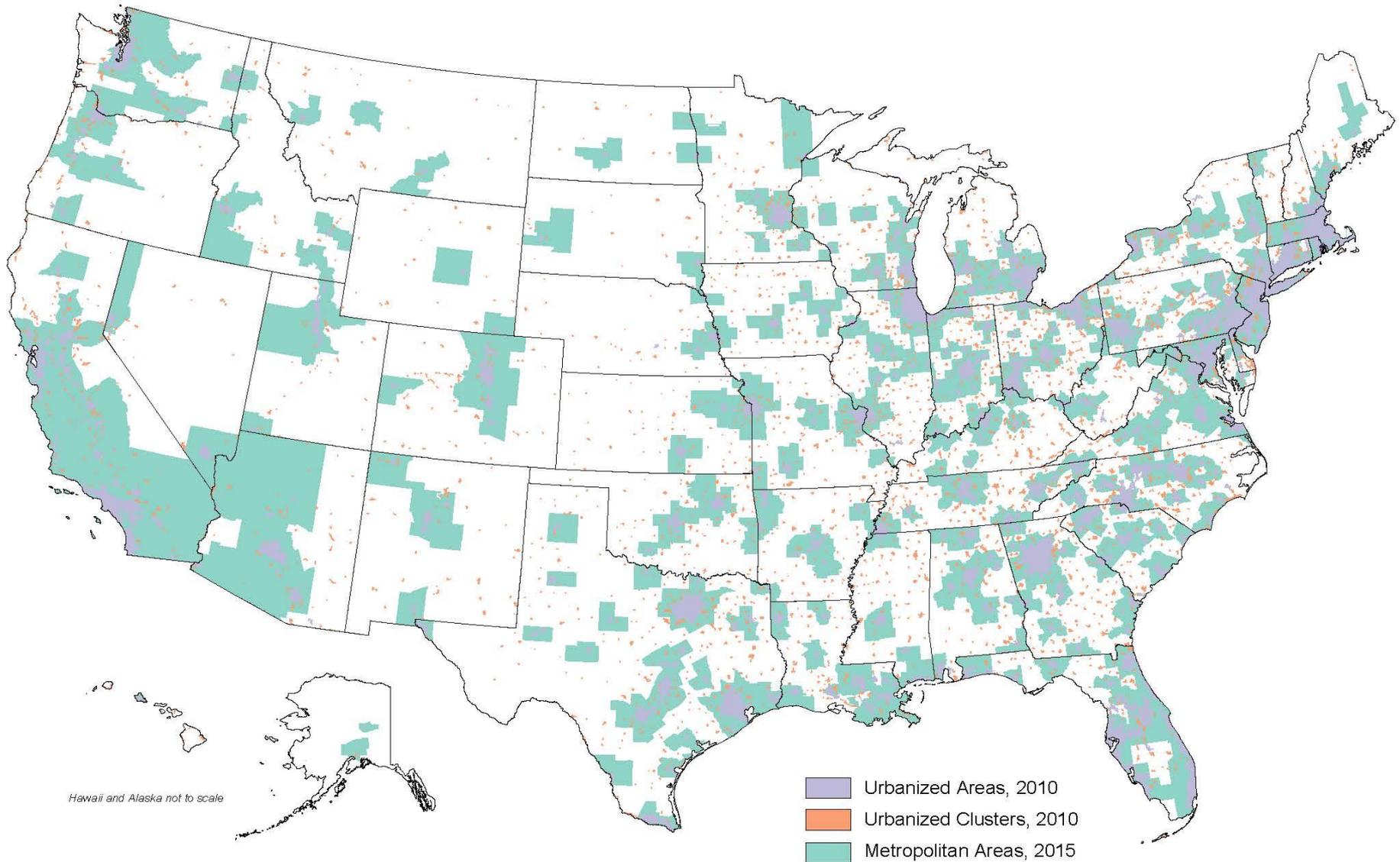
Section of Inpatient Care Practitioners



Rural America

- Approximately 18% of U.S. population
- Approximately 84% of the geographic area of U.S. is rural
- Population in rural America is decreasing

Urbanized Areas and Urbanized Clusters 2010



Hawaii and Alaska not to scale

Overview of U.S. Hospitals

Total Number of All U.S. Registered Hospitals	5,564
• Number of U.S. Community Hospitals	4,862
• Number of Urban Community Hospitals	3,033
• Number of Rural Community Hospitals	1,829

Characteristics of Rural Hospitals and Patients

Rural-specific challenges include:

- Rural residents are older, poorer, and more likely to have chronic diseases than urban residents.
- Rural hospitals are typically smaller than urban hospitals.
- Rural hospitals provide a higher percentage of care in outpatient settings and are more likely to offer home health, skilled nursing and assisted living; all of which have lower Medicare margins than inpatient care.
- Rural hospitals rely more heavily on reimbursement from public programs whose payments fall short of costs.

Prominent Challenges Faced by Rural Hospitals

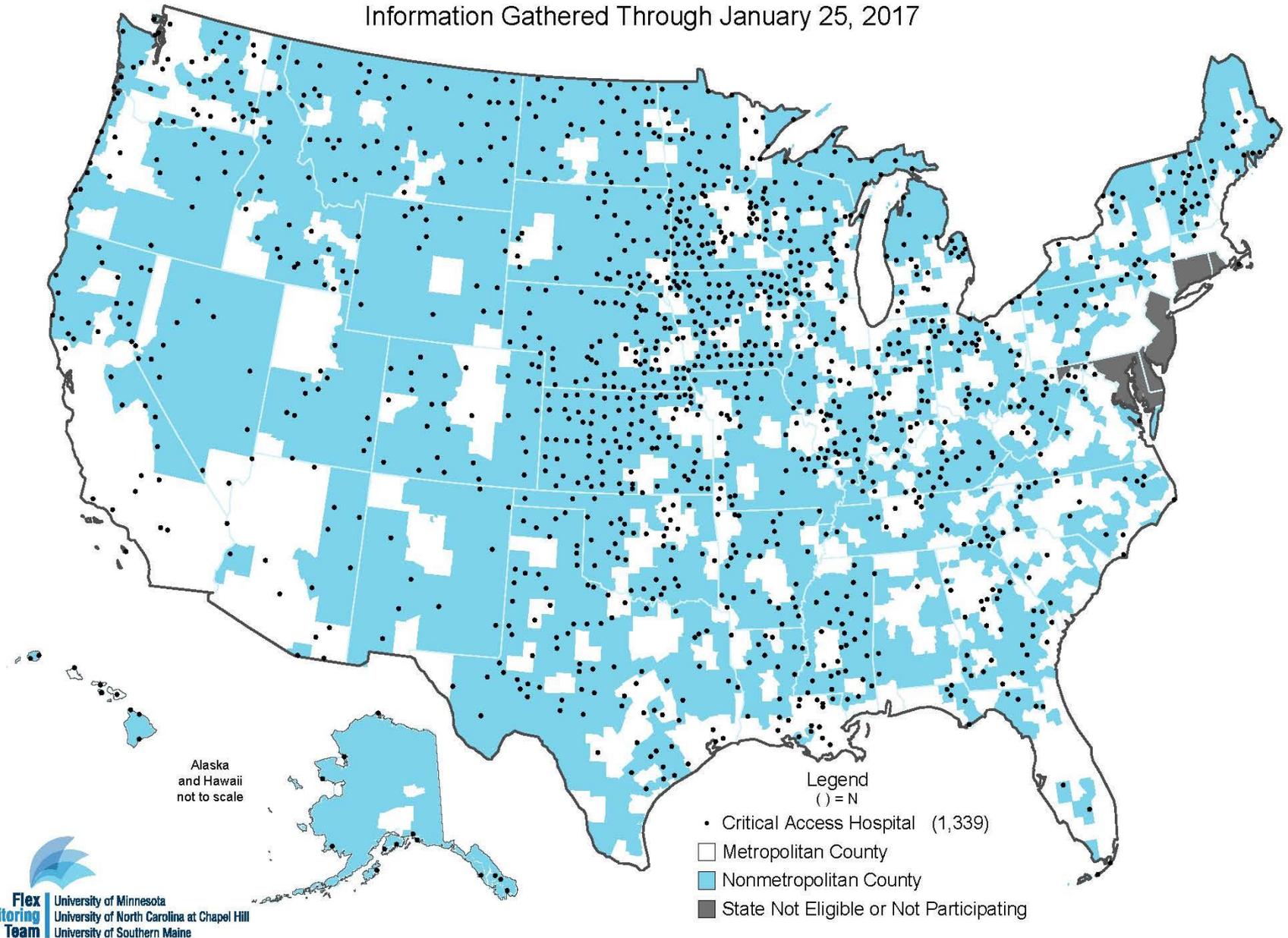
- **Remote geographic location**
 - Low population density and distance from other providers result in low volumes and high relative operational costs.
- **Modest budgets**
 - Low population density tends to keep hospital size small and patient volume low, thereby keeping hospitals' budgets modest. Lean budgets with limited flexibility in cash flow make necessary capital investments in the facility or equipment difficult
- **Workforce recruitment and retention**
 - Workforce is an ongoing challenge closely linked to the remote geographic location of the healthcare facility.
- **Demographics of rural America**
 - Rural residents are older, poorer, and have more chronic conditions. This can lead to additional challenges and unique pressures to the healthcare facility providing care for these individuals.

Various Rural Hospital Designations/Provider Types

- Critical Access Hospital (CAH)
Rural hospitals maintaining no more than 25 acute care beds. CAHs must be located at least 35 miles, or 15 miles by mountainous terrain or secondary roads, from the nearest hospital
- Disproportionate Share Hospital (DSH)
A special reimbursement designation under Medicare and Medicaid that is aimed at supporting hospitals at which care is provided to a large proportion of low-income patients. Although not a rural-specific designation, the DSH programs allow some rural facilities to remain financially viable.
- Rural Referral Center (RRC)
Rural tertiary hospitals that receive referrals from surrounding rural acute care hospitals. An acute care hospital can be classified as an RRC if it meets several criteria pertaining to location, bed size, and referral patterns.
- Sole Community Hospital (SCH)
A designation from the Centers for Medicare and Medicaid Services (CMS) based on a hospital's distance in relation to other hospitals, indicating that the facility is the only like hospital serving a community.

Location of Critical Access Hospitals

Information Gathered Through January 25, 2017



Sources: US Census Bureau, 2015; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2017.

Note: Core Based Statistical Areas are current as of the July 2015 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

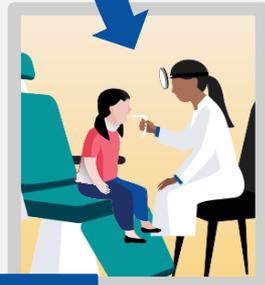
Rural Hospitals: A Community's Anchor

DID YOU KNOW?

- Rural America includes approximately **57 million people**, about 18% of the population and **84% of the geographic area of the USA**.
- There are **1,855 rural hospitals** that support nearly **2 million jobs**.
- Every dollar spent by a rural hospital produces another **\$2.29 of economic activity**.
- A typical critical access hospital **employs 141 community members**.
- Rural hospitals handle more than **21.5 million emergency visits**.

Access to
primary care

Safe haven in times
of emergency



Jobs



EMERGENCY

24/7 care



COMMUNITY CLINIC



Community Partnerships
to ensure wellness and
total health

Tell Congress to protect health care in rural communities.

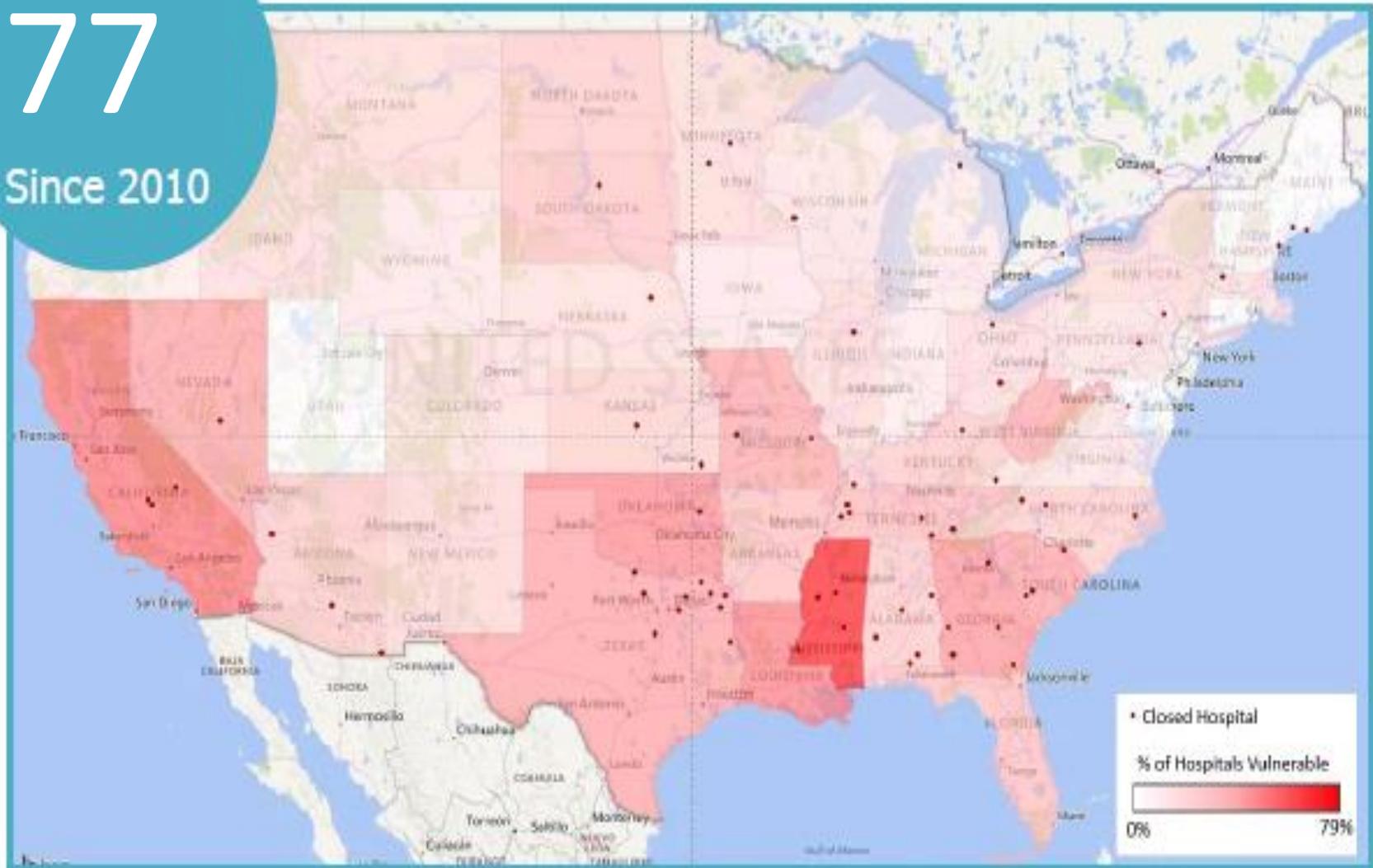
Another Wave?

Rural Hospital Closures and Risk of Closures

Closures Escalating

77

Since 2010



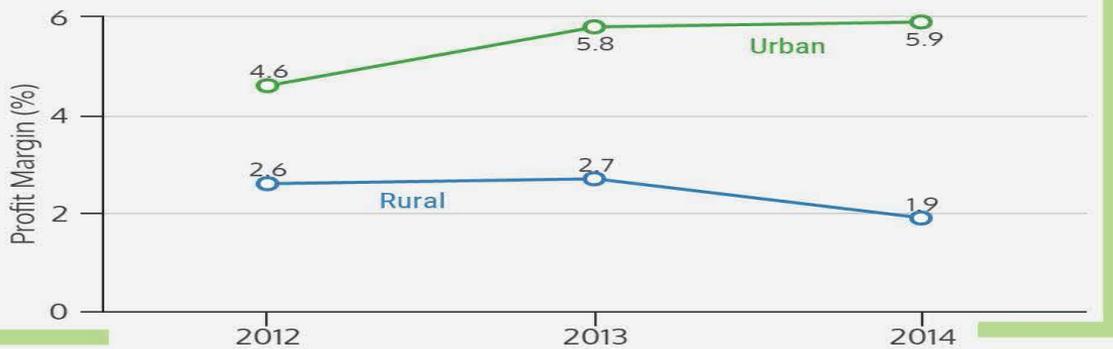


Profitability of Rural and Urban Hospitals

Rural hospitals are much less profitable than urban hospitals, which puts them at higher risk of closure. This infographic compares time trends on the profitability of urban and rural hospitals and illustrates geographic variation of profits across states.

August 2016

Median Profit Margin for Urban & Rural Hospitals



profitability of urban hospitals has increased



profitability of rural hospitals has decreased



Profit margin expresses the profit a hospital makes as a proportion of its revenue. Between 2012 and 2014, the median profit margin for urban hospitals went up, but the median profit margin for rural hospitals went down, revealing a widening urban-rural gap in hospital financial performance.



Causes of the gap between rural and urban hospital profitability may include declines in patient volume, changes in Medicaid and Medicare reimbursement, and other factors that affect rural hospitals more than urban hospitals.



WHY IT MATTERS: Poor profits can result in hospitals not having the money they need to purchase new technology, hire providers, and maintain buildings. Over time this can result in financial problems or even closure of the hospital. Understanding where some hospitals are succeeding, compared to those that are not, is important as policy makers try to craft sustainable models of health care for rural areas.

LOWEST: Florida -3.3%

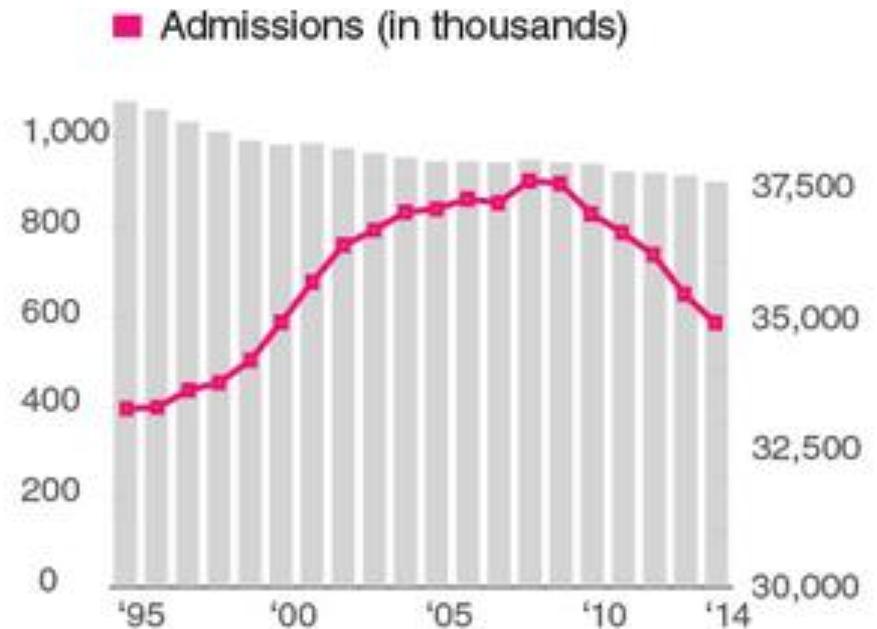
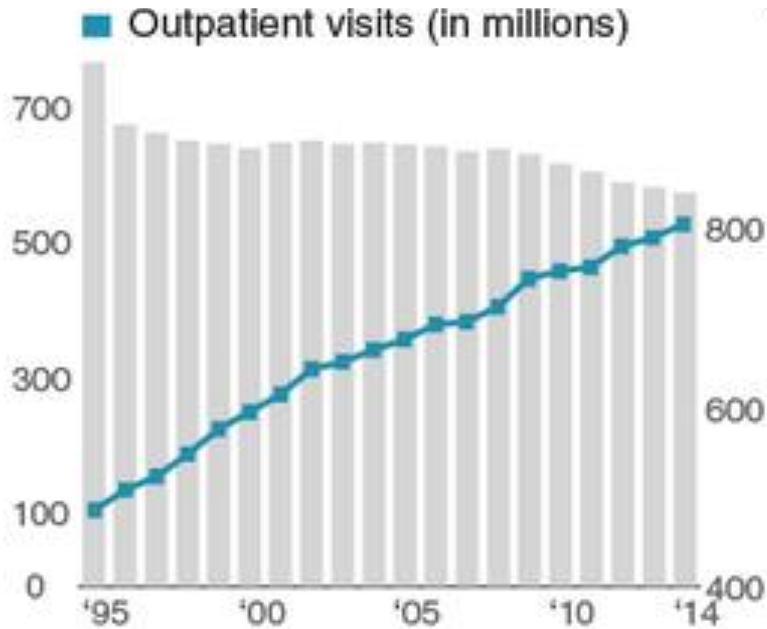
MEDIAN PROFIT MARGIN FOR RURAL HOSPITALS BY STATE (2014)

Darker shades = Lower profit margins



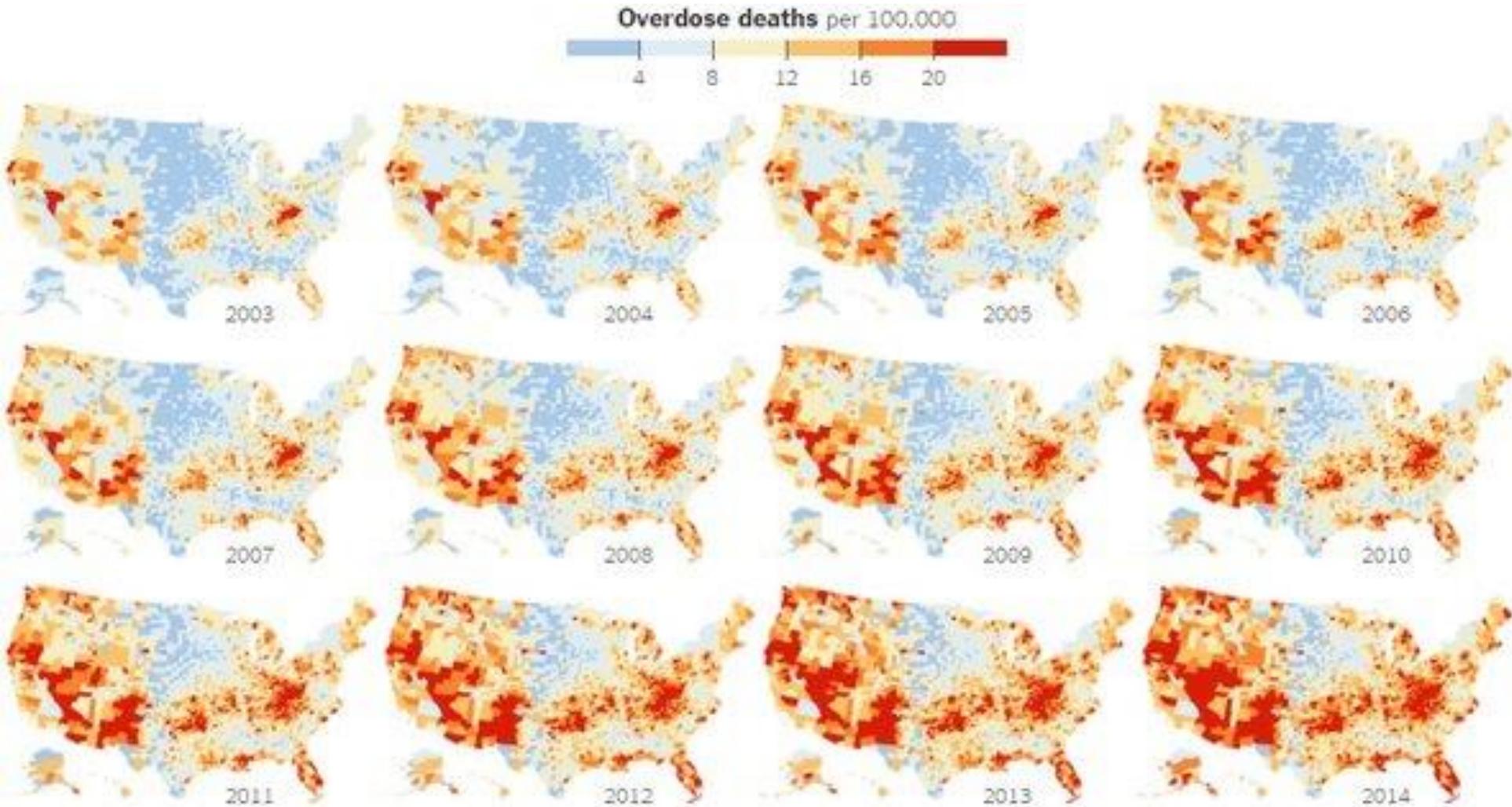
Utilization Trends

More outpatient, less inpatient = overcapacity



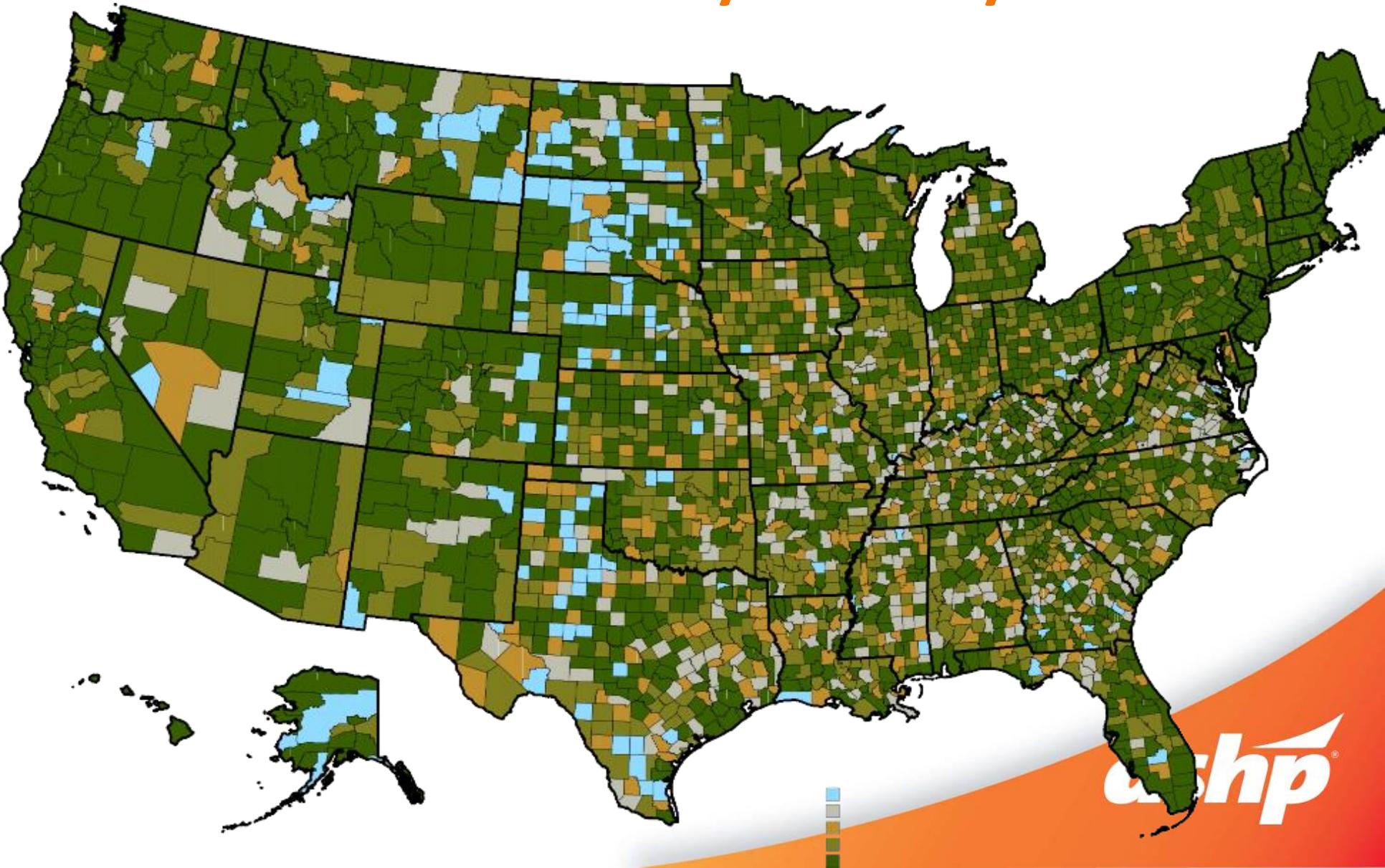
Source: AHA hospital statistics

Opioid Crisis in Rural America



All states have demonstrated an increase in nonmedical prescription opioid mortality during the past decade, however, the largest areas of abuse are concentrated in states with large rural populations, such as Kentucky, West Virginia, Alaska, and Oklahoma.

Distribution of Primary Care Physicians





ashp[®]

Denise Fields, Indiana

A STATE PERSPECTIVE





**INDIANA
PHARMACISTS**

Advancing Our Profession Together

How to Meet the Needs of Small/Rural Practitioner Members

Dr. Denise Fields, PharmD, FASHP

Dr. Denise Fields, PharmD, FASHP



- Future President-Elect (2018), Indiana Pharmacists Alliance
- Former Chair (2016-17), ASHP Small and Rural Hospital Section Advisory Group
- Past President (2015), Indiana Academy of Health System Pharmacists
- Former Board Member (2010-2016), Indiana Rural Health Association
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Indiana Pharmacists Alliance

Mission & Vision:

To be the voice and advocate for the profession of pharmacy in Indiana. Lead the advancement of Indiana Pharmacy by promoting legislation and innovations that optimize patient care, safety, and the health of our communities.

- **Advance** Indiana Pharmacy Provider Legislation and Service Reimbursement
- **Grow** Your Professional, Business, and Leadership Skills
- **Expand** Your Professional Resources and Network
- **Strengthen** Professional Outreach

IPA Members

- *Serving over 1,000 Pharmacists, Technicians and Student Pharmacists.*
- *In 2016, bylaw changes for the Alliance led to a reorganization of the structure*



Where to begin

- Identify Needs
 - Survey members
 - Recognize established networking avenues
 - Recruit representation from small/rural practice setting
- Develop and/or Link to Resources
 - Education opportunities
 - Collaboration opportunities
 - Toolkits
 - Best Practices
- Represent Members
 - State and national level
 - Pharmacy and non-pharmacy organizations
 - Public policy/legislation

Survey Opportunities



Live Meetings

Virtual
Connections



Focus Group

Established networking groups to consider

- State Rural Health Association
- State Hospital Association
- Electronic Medical Record Vendor
- Wholesale Vendor
- Group Purchasing Organization

Collaboration Example

- Remote pharmacy service vendor contract with Indiana Rural Health Association
 - Bargaining power enhanced as prices lower than individual line item pricing/hospital
 - Service concerns escalated more quickly and to a higher level speaking with a collective voice
 - Sharing of policies and order sets as the vendor helped identify best practices among our group

Best Practice Examples

- Antidote stock sharing
 - State poison control center established “recommended stocking levels of antidotes”
 - Surveyed 3 rural hospitals within 60 mile radius to see if they would like to “share” burden of recommended stocking levels
 - Created stock level form with quantities at each location with pharmacy and ER contact numbers to expedite request in an emergent situation

Representation Example

- Board of Pharmacy testimony on behalf of small and rural hospitals
- Electronic Health Record vendor concerns brought before ASHP and ISMP
- Telepharmacy Bill needed to meet the needs of small and rural pharmacists within hospitals and community pharmacies

Networking within established groups

- Ask InSRN round table groups (Pharmacists, Hospital CEOs, et) to provide input regarding state-wide legislative pursuits
- Suggest topic ideas/speakers for group purchasing organization pharmacist meetings
- Ask wholesale vendor representatives to distribute surveys/information from your group
- Legal interpretation through Automated Dispensing Machine (ADM) vendor

Future plans and ideas

- New Website Platform
 - Virtual networking groups
 - Enhanced polling capabilities
- Statewide Policy Caucus for ASHP Delegates to interact with state ASHP members
 - Live event - Pharmacist Day at the Statehouse
 - Networking call(s)

Considerations for All of Us

- “The capacity of 1”
 - How much can be done with limited resources?
 - Start with identifying needs
- Micro-Volunteering opportunities
 - Engagement opportunity for someone looking for short term volunteer assignments
 - Leadership development
- Engaging non-pharmacists
 - Pharmacy technician and student members
 - Small and rural pharmacy supporters
 - Population health/public policy leaders



**INDIANA
PHARMACISTS**

Advancing Our Profession Together

VISIT US ONLINE TO JOIN NOW!

indianapharmacists.org



Amber Soukkala, North Dakota, Minnesota

A STATE PERSPECTIVE



Amber Soukkala, PharmD, MPH

ASHP Small and Rural Virtual Panel Discussion: A New Practitioners Perspective

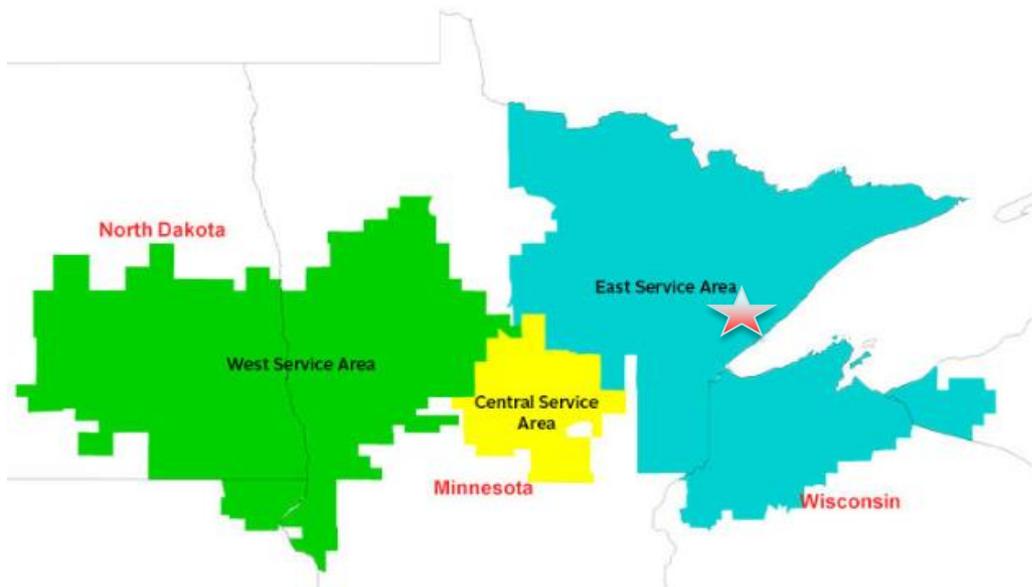


Essentia Health
Here with you

Biography

Amber Soukkala (amber.soukkala2@essentiahealth.org)

- PharmD: University of Minnesota College of Pharmacy Class of 2016
 - Duluth Campus
- Masters in Public Health: University of Minnesota School of Public Health
- PGY1 Residency: Essentia Health-St. Mary's Medical Center
 - Duluth, Minnesota
- Current Practice: Essentia Health
 - Main practice site is at Miller Dwan Medical Center



Essentia Health
Here with you

Questions

- What do you do in your position that you need additional networking and education to accomplish? Are these unique to small and rural health-care providers or do they apply to all practitioners?
- How can your state affiliate help you with these needs?
- What mechanisms can your state organization use to optimally provide you with this information or service?
- What 3 pieces of advice would you offer your state organization on how to meet your needs?
- Any other information that they feel would be useful for all state organizations to know to meet their needs.



Additional Networking and Education Needs

- Small and Rural Needs
 - Easy and simple ways to get involved
 - Focus on topics important to those who practice in these sites
 - Telemedicine
 - 340B
 - Drug Shortages and Expenses
 - **Training the next group of small and rural pharmacists/technicians**
 - Supporting Internship Programs
 - Residency Program/Rotation Development
 - Pharmacy Technician Role Advancement
 - Legislation Impacting Small and Rural Hospitals
 - Pair up with other rural focused organizations (NRHA)
 - Include these issues in your states “Legislative Days”
 - “Regional Societies”
 - AKA: Local “Sub” Chapters



Providing Networking/Education to Small and Rural Members

- Use Technology
 - Efficiency and Accessibility is **key**
 - Communication needs to be effective and to the point
 - Recordings and live streams
 - Use your website to reach us
 - Come to us!
 - Move your annual meetings and gatherings around the state to include new faces
- Call in Back Up
 - Local chapters of the National Rural Health Association (NRHA) or state public health groups
 - Team up with the pharmacy schools in your area
- Split up!
 - Regional Societies
 - Why? Provides more opportunity for leadership roles and to focus on topics import to those in the area (i.e. rural/small hospital topics)



Advice and Summary

- Make it easy and simple for students and new practitioners to *get* and *stay* involved
 - Annual and Midyear planning committees
 - Invite them to speak or present (either online or in person!)
 - Resident projects
 - Resident/Student Pearls
 - Make a point to expose them to small and rural leaders in your organization
- Use technology to reach us
 - Making your content accessible to those who are in small and rural locations is critical
 - Record webinars and meetings, use conference calls, and Skype/Lync
 - Keep your website up to date and user friendly
 - An easy place to start? Have your new practitioners help!
- Don't be afraid to call us out!
 - Make a point to create committees/subcommittees and projects focused in on small and rural practices
 - Development of “regional societies”



Lindsay Massey, Kansas

A STATE PERSPECTIVE





Kansas Council of
Health-System Pharmacists
www.kchponline.com

KCHP Rural Hospital Pharmacy Summit



President:

Lindsay Massey, PharmD, MS, BCPS

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Rural Health in Kansas

- 32% of Kansans live in rural areas
- 84 Critical Access Hospitals
 - most of any state
 - 64% of hospitals
- Non-pharmacy personnel performing pharmacy functions





Summit History

Networking with peers identified common questions and challenges

Outreach to hospital pharmacists

First Rural Health Summit (2013)

Official KCHP Event (2017)



KCHP Rural Hospital Pharmacy Summit

- **Location**
 - Salina Regional Health Center
- **Cost**
 - \$100 per facility
 - Scholarships available upon request
 - Free KCHP Membership for one individual
- **Topics**
 - Keynote Speaker
 - Clinical updates
 - USP 800
 - Medication Safety
 - Law – Representation from Boards of Pharmacy & Nursing
 - 340B & Hospital Billing
- **CE**
 - 6.5 CEU Hours
 - Pharmacists, Technicians, Nurses





KCHP Rural Hospital Pharmacy Summit

- **Planning**
 - Responsibility of Director of Education
- **Funding**
 - Registration
 - Considering complimentary registration for KCHP members
 - KCHP
 - Vendors
 - Hospital Foundation
- **Further Benefits**
 - Quarterly phone call
 - Future educational programming at annual meeting

Steve Glass, Georgia

A STATE PERSPECTIVE



How to Meet the Needs of Small/Rural Practitioner Members in Your State

Steve Glass

Georgia Society of Health-System Pharmacists



Objectives

- To provide monthly continuing education to members
- To provide an avenue for residents and other to present

Nuts and Bolts

- Webinars are held on the second Thursday of the month at 12 noon
- Goto Meeting is the platform we use
- There is no charge to members to participate
- One hour of CE
- Call for presenters is done early in the residency year
- Normally get 50-70 attendees at each one

Conclusion

- Members from throughout the state participate.
- We have been able to attract new members because of this.

DOP calls

Objectives

- To provide a venue for DOPs to discuss common issues

Nuts and Bolts

- DOP conference call is held the fourth Friday of each month at 11am
- All DOPs are invited but you must be a GSHP member to attend
- Part of the registration process includes a required field for agenda items
- Two DOPs serve as moderators for the call
- DOPs discuss the agenda items that are submitted
- Normally around 20 DOPs are on each call

Conclusion

- **DOPs like to be able to discuss common issues with each other**
- **Resources and ideas are shared**
- **We have attracted some new DOP members**
- **Side benefit-easier to ask them to assist with Reverse Expo**

Clinical Call

Objective

- To provide a venue for Clinical managers, etc. to discuss common issues

Nuts and Bolts

- Clinical conference call is held the third Monday at 3:30pm
- All clinical coordinators are invited but you must be a GSHP member to attend
- Part of the registration process includes a required field for agenda items
- Two members serve as moderators for the call
- Submitted agenda items are discussed

Conclusion

- Able to discuss common issues with each other
- Resources and ideas are shared
- We have attracted some new members because of it

Questions

