ASSESSING THE VALUE OF SERVICES PROVIDED BY PHARMACY FACULTY ON A CONTRACTUAL BASIS

THINK TANK

COLLEGE OF PHARMACY
The University of Tennessee Health Science Center
Memphis • Knoxville
In August, 2008, Dean Gourley announced the appointment of a College of Pharmacy “think tank” group to assess the value of services provided by faculty members on a contractual basis to affiliated clinical training sites. This action was taken in part upon the recommendation of Dr. Richard Helms, Chair of the Department of Clinical Pharmacy.

Members of the group included the following:

Max D. Ray, PharmD, MS, LHD, (Chair)
Professor of Pharmaceutical Sciences
UT College of Pharmacy

Alison Apple, M.S.
Assistant Professor, Clinical Pharmacy
Director of Pharmacy
Methodist University Hospital
Memphis, TN

James Cathey, BSPharm
Chief Executive Officer
East Tennessee Children’s Hospital
Knoxville, TN

Michael Christensen, PharmD
Professor, Clinical Pharmacy
Director of Pharmacy
LeBonheur Children’s Hospital

Peter Chyka, PharmD
Professor and Associate Dean
UT College of Pharmacy
Knoxville, TN

Brian Cross, PharmD
Associate Professor, Clinical Pharmacy
Kingsport, TN

Richard Helms, PharmD
Professor and Chair, Clinical Pharmacy

Kim Mason, PharmD
Assistant Professor, Clinical Pharmacy
Director of Pharmacy
University Hospital
Knoxville, TN

Steven R. Ross, M.S.
Assistant Professor, Clinical Pharmacy
Chief Executive Officer
University Hospital
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Kay Ryan, M.S.
Assistant Professor, Clinical Pharmacy
Director of Pharmacy
Regional Medical Center (The Med)
Memphis, TN

J. Aubrey Waddell, PharmD
Associate Professor, Clinical Pharmacy
Knoxville, TN

Robert Nolly, M.S., Consultant
Associate Professor, Pharmaceutical Sciences
Formerly Chief Executive Officer
William F. Bowld Hospital
Memphis, TN
It will be noted that the group included five hospital pharmacy directors, six faculty members from the College of Pharmacy (one of whom is also a hospital pharmacy director), representing both the Memphis and Knoxville campuses, one current hospital CEO, and one former hospital CEO (who served as a consultant to the group).

**CHARGE TO THE GROUP**

The following goal statement was provided to the members of the group at the time of their appointment:

*The College of Pharmacy needs to understand how health-system administrators and pharmacy directors think about the value of the services provided by clinical faculty members who work in their respective organizations on a contractual basis. In other words, what are they (directors and administrators) willing to accept as evidence of value? Although we have no reason to think that there are any difficulties with the contractual relations that currently exist between the College and individual health systems, we want to ensure that, as we move forward, we have a solid understanding of the expectations of those with whom we develop such contractual relationships.*

**Background**

In April, 2008, an earlier College of Pharmacy “think tank” group issued a report on the topic “The Ideal Framework for Building Good Relationships between Faculty Members and Clinical Training Sites.” The current report seeks to build on the findings and recommendations of that earlier report by examining the expectations of health-system administrators for faculty members whom they pay to provide services in their institutions under a contractual agreement.

The College has found that contract service models serve its needs very well. Such arrangements a) allow faculty members to maintain and improve their practice skills, b) provide experiential opportunities for our students in those sites, and c) provide an environment in which faculty members can engage in research and other forms of scholarship. We realize, on the other hand, that the hospital (or other clinical facility) has its own needs that must be met through such a contractual arrangement, if the arrangement is to endure. While we like to think that there is obvious value in the services that faculty members provide, we recognize that it is important to understand how health-system administrators view the value of such services.

Although the College has not yet experienced any major difficulties in establishing and maintaining such contractual relationships, we recognize that administrators and pharmacy directors in those institutions are under constant cost-containment pressures. We also recognize that costs of contracted services represent one (among many) targets for reduction, and that the value of such services comes under continuous scrutiny. In order to maintain the contractual relationships it currently has, and to develop new relationships in the future, the College seeks to
understand more clearly how the value of contract services provided by members of our faculty are perceived and assessed by our contractual partners.

**PROCESS**

The work of this group was conducted in two three-hour sessions: the first on October 30, 2008, and the second on January 23, 2009. Each member was asked to read two papers in advance of the first meeting (both of which were recommended by Dr. Chyka)\(^1,2\). These are listed in the Appendix. Those members of the group who are pharmacy directors were also requested to interview their CEOs in advance of the meeting, to get their thoughts on what they would accept as evidence of value of the services provided by contract pharmacy employees (e.g., pharmacy faculty members who work on a contractual basis for the hospital).

At the first meeting, following a brief orientation by the Chair, each member of the group was given an opportunity to speak without interruption for 15 minutes, to express opinions and ideas, to share experiences, or to raise questions for future discussion by the group. Following each presentation, time was allotted for discussion. There was rich conversation on each presentation, and by the end of the first session a number of general statements had been developed. These were compiled into a report and circulated to members of the group for study and reflection.

The principal purpose of the second meeting was to critically review the statements generated at the first meeting and to make appropriate changes and additions. By the end of the second meeting the group concluded that it had essentially completed its assignment. It was agreed that a draft of a final report would be compiled (by the Chair) and circulated to the group for approval.

**SUMMARY**

The output of this group’s efforts is a set of statements, or observations, rather than an action plan. These are summarized below. The intent is to help those in leadership positions in the Department of Clinical Pharmacy understand more clearly the reality of the world of health-system administrators and pharmacy directors insofar as contractual relationships are concerned.

1. It is important that colleges of pharmacy (deans, department chairs, and individual faculty members) understand the financial basis of hospital operations (both inpatient and outpatient). Points to keep in mind are:

   - It is in the hospital’s best financial interest to reduce patient length of stay.
   - Preventing an admission does not benefit the hospital financially, except in the case of uninsured or under-insured patients.
   - Preventing an ED visit does not benefit the hospital financially.
   - Increased use of ambulatory care facilities **does** benefit the hospital financially (in cases where the hospital operates an outpatient division).
- Reducing costs is more important to a hospital CEO than introducing services aimed at increasing revenues. Labor costs and drug costs are both major targets for reduction.
- Increased efficiency is one way to reduce labor costs.
- The financial basis of hospital operations changes continuously, a point which those in colleges of pharmacy need to be aware of.

2. Related to #1, it is important that colleges of pharmacy understand the patient mix and the payer mix of individual hospitals, and how these factors affect the need for pharmacy services. For example:

- A hospital with an organ transplant program has quite different needs than a hospital without such a program. (Numerous other examples could be cited).
- Hospitals have to contend with a number of payers: Medicare, Medicaid, commercial insurance, managed care, etc. Hospitals with a preponderance of patients covered by any one of these payment sources will look different from those with a majority covered by another plan. The impact of DRGs and fixed-rate reimbursement must be borne in mind by the colleges.

3. It is also important that colleges of pharmacy recognize the fundamental differences between university hospitals (or other teaching hospitals) and community hospitals. The type of medical staff structure that exists in teaching hospitals is not typically seen in community hospitals.

4. While everyone supports the concept of improved outcomes (improved quality), the definition of “quality” varies from one setting to another. College of pharmacy presentations that are based on quality improvement, without a corresponding reduction in cost, will not be viewed very favorably by hospital CEOs. Such presentations must be tailored to the specific quality metrics used by the specific institution.

5. Anything pharmacists can do to “keep the medical staff happy” is viewed by hospital CEOs as having value. Hospitals (obviously) depend on physicians for patient admissions, and it is very important to maintain their (physicians’) good will. The medical staff can be one of pharmacy’s strongest allies.

6. Pharmacists (including clinical faculty members) can gain great support from the medical staff in hospitals through service on key committees.

7. Hospitals are under perpetual pressure from accrediting and regulatory bodies to improve quality. To the extent that contract pharmacy employees can help the hospital meet the standards set by such organizations, they will be viewed as valuable. (Three current “pressure points” are medication safety, medication reconciliation, and computerized physician order entry.) However, it is often difficult to show how pharmacy services impact quality, as measured, for example, by Leapfrog outcomes.
8. There is a need for a general, well-agreed-upon set of metrics for evaluating the quality of services provided by clinical pharmacy faculty (or pharmacists employed full-time by a hospital). The clinical “report card” system used at Methodist University Hospital is one example of such a set of metrics. In this system, a dollar value is assigned to each clinical pharmacy intervention.

9. It is important to hospital CEOs that there is continuity of care in any service offered in that institution. Pharmacy faculty members who work for hospitals on a contractual basis must understand that any service they propose to provide must be provided on a continuous basis, and not just during hours when the faculty member may want to be in the hospital. Continuity of care is also important from a patient satisfaction perspective and a physician perspective. To that end, it is important (to hospital administrators and pharmacy directors) that contract employees (e.g., clinical faculty) become integrated into the total service delivery program of the pharmacy department (including both distribution and clinical services).

10. Pharmacists (including clinical faculty members) must take responsibility for calling key papers on value of pharmacy services to the attention of hospital CEOs. It should not be assumed that the CEO will have already seen such reports.

11. Not all services that pharmacists or clinical pharmacy faculty members tend to think of as being valuable actually prove to be valuable. A frequently-cited paper by McLaren et al\textsuperscript{3} challenges the value of specific pharmacy services in the critical care setting.

12. Hospitals expect that a pharmacy faculty member who joins the organization (on a contractual basis) will be there long enough to justify their (the hospital’s) investment in this arrangement. Similarly, it is expected that in cases where a faculty member does leave, the College will replace that individual quickly.

13. It might be useful to know how some hospitals think about the value of pharmacy residents. At Methodist University Hospital, the pharmacy residency program is justified based on specific services the residents provide, which are seen by the hospital as having value:
   - applications of evidence-based protocols (which result in a shortened length of stay)
   - contributions to the hospital’s ADE program
   - participating on the code team
   - medication reconciliation
   - drug information/discharge counseling/inservice education
   - impact on various quality indicators

14. Because of the ability to recoup much of the costs associated with conducting a first-year (PGY1) pharmacy residency program (through Medicare pass-through funding), some hospitals view pharmacy residency programs as being particularly valuable. Contract faculty
members may be instrumental in helping a hospital establish a pharmacy residency program, and this may be perceived by some hospitals as a valuable contribution.

15. Some of the service needs that hospitals have, which clinical pharmacy faculty could provide, include:

- helping pick up the slack in pharmacy workload in the case of staff lay-offs
- increased participation in a variety of interdisciplinary patient care services
- training the permanent pharmacy staff to become better clinicians

Zhang JX. Where does high-quality research in economic evaluations come from? (Ed.) Pre-publication draft, obtained from Dr. Zhang at the School of Pharmacy, Virginia Commonwealth University, Richmond, VA; 2008.