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OPTIMIZING PHARMACY SERVICES

Managing your hospital pharmacy during
the COVID-19 pandemic and beyond

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How Hospital Pharmacy Leaders Drive Transformation



OPTIMIZING PHARMACY SERVICES: MANAGING YOUR HOSPITAL PHARMACY DURING THE COVID-19 PANDEMIC AND BEYOND



COVID-19 continues to dramatically impact the short- and long-term strategies of hospitals and health systems, leaving much uncertainty regarding future financial stability and the ability to maintain excellent care for patients. Cancellation of non-elective procedures put facilities behind, reducing inpatient census and critically impacting hospital revenues. About two-thirds of hospital pharmacies have reduced staff as a result. Leading health system and hospital executives gathered for a virtual executive dialogue to discuss the challenges they face and explore how the pharmacy can serve as a value driver in this difficult time. They shared insights into how optimizing pharmacy services can deliver clinical and operational benefits while also reducing costs and revealing new revenue opportunities, including those offered by telepharmacy and specialty pharmacy. ●

KEY FINDINGS

- 1** **Supply shortages** continue to challenge hospital pharmacy departments.
- 2** The biggest staffing concern for hospital pharmacies is the **ongoing shortage of pharmacy technicians**.
- 3** Some hospitals see **specialty pharmacy operations** as a potential win for patient care and hospital finances, although they can be difficult to establish.

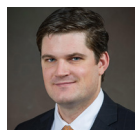
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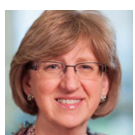
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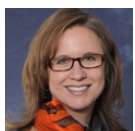
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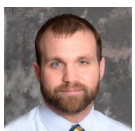
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AMERICAN HOSPITAL ASSOCIATION | CHICAGO

MODERATOR: (Bob Kehoe, American Hospital Association): **What are some of the biggest pharmacy-related challenges your organization faces as the pandemic continues to unfold?**

AL PATTERSON (*Boston Children's Hospital*): Boston Children's is a teaching hospital for Harvard Medical School and we have close working relationships with some of the other big hospitals in the Boston area. The biggest challenge we have had has been securing supplies. In the early days of the outbreak, the challenge was focused on neuromuscular sedatives. Any time there was an anecdotal report of any medication having some sort of benefit, within the next six hours it was in short supply from every wholesaler. It was a knee-jerk reaction — you don't want to be the last to the well — and unfortunately it got to be pretty ugly at times.

I'm in pediatrics so we have not been impacted with the patient loads to the same extent that our adult counterparts have. Luckily, we have been able to find supplies that have really helped to sustain some of our adult counterparts in our region. But supplies continue to be a problem.

One issue is that even before the pandemic, we were already in a widespread drug shortage — particularly for us in pediatrics — regarding intravenous immunoglobulin (IVIG). That almost became instantaneously unavailable for some IVIG products. That has created a significant impact because of the multisystem inflammatory syndrome associated with COVID-19 for some children. We are a regional center for most of the Northeast and we have handled now about 65 cases that have used incredible amounts of IVIG. So that has been a real supply issue for us.

JULIA ILYIN (*Hackensack Meridian Health Mountainside Medical Center*): My hospital is part of Hackensack Meridian Health, which has 13 hospitals and more than 200 ambulatory care centers, fitness and wellness centers, home health services, rehab centers and

skilled nursing centers in New Jersey. My biggest challenge during the surge was operationalizing the IV-room compounding. Compounding the medications by hand for an average of 35-40 intubated patients on a daily basis took a tremendous toll on my staff. Each of the vented patients probably needed on average five or six drips and these drips needed to be made daily because they are not commercially available.

PHYLLIS LANTOS (*New York-Presbyterian Hospital*): Our system has more than 4,500 beds in 10 facilities, and at the peak of the surge here in New York, we had about 2,600 patients in the system who were COVID-positive. Between 800 and 900 were in intensive care units, and most of them were on ventilators. When the Northeast was one of the first hot spots in the country, we felt that we were able to get the drugs we needed. But now that it's spread throughout the country and there are many markets that are going to be in need, I think we will be challenged to get access to supplies if New York becomes a hot spot again.

JULIE YAROSH, D.O. (*ProMedica*): ProMedica has 12 hospitals in Ohio and Michigan. When COVID-19 hit, we had the luxury of being in a multistate system — if we were short on propofol or albuterol at one hospital, we could obtain it from some of our regional hospitals that did not have as many COVID-19 patients. Our Michigan hospitals took overflow patients from Detroit, and we were able to acquire some medications through some of the state organizations that were put in place. That helped us significantly, particularly in our rural and critical access hospitals that were treating COVID-19 patients.

However, we continue to struggle with staffing concerns, particularly pharmacy techs. This has been an ongoing issue for us but particularly during this pandemic when we turned a 72-bed hospital in Toledo into a full COVID-19 hospital. Staffing was a huge issue because we needed to staff 24/7 when typically we use after-hours pharmacy solutions for

our smaller hospitals. But we couldn't do that when we were treating coronavirus patients. Typically, we might have three critical care patients in a 72-bed hospital but, during the surge, we went to as many as 34 at one time on ventilators.

MODERATOR: Has the impact of COVID-19 motivated your organization to evaluate the state of your pharmacy more closely or look at how your operations might need to change?

YAROCH: I don't think we're doing anything drastic from an operational standpoint, but we are going back to enforce certain procedures that were in place that maybe our teams have not been following. We are working with our purchasers now so we will be better prepared for future events.

When you go through a pandemic, it can point out how siloed some of our facilities may be and how we really need to take advantage of that systematization. For example, we typically wouldn't react to a drug study of 50 people or fewer. But when we heard of a solution to help care for people on ventilators with high-flow oxygen, we bought a lot of drugs that we ultimately did not use. Even though we could return some purchases, we couldn't return everything.

BRIAN CHERRY (*CalvertHealth*): Calvert Health is a 100-bed hospital about 45 minutes southeast of Washington, D.C. We were able to see our pharmacy department transition from a valued support department of the care continuum to taking a significant leadership role in how the hospital was treating patients during the pandemic. We quickly developed a COVID-19 treatment team that comprised pulmonologists, hospitalists, ED and infectious disease providers. Our lab, ICU, community wellness, chief nursing officer and chief medical officer were also on the team. Our pharmacy team facilitated

the discussions and decisions regarding what treatment regimens we'd utilize and how we'd adjust based on the most current information available. It was remarkable and inspiring to see this leadership transition.

RANDY BALL (*Texas Health Resources*): Texas Health Resources serves the Dallas-Fort Worth area and surrounding counties. We have 14 wholly owned hospitals and quite a few joint ventures and an affiliation

with the University of Texas Southwestern Medical Center. There are a couple of things that we already had put in place that would have been hard to implement during the crisis but have shown a lot of benefit. Prior to the onset of COVID-19, we had centralized some of the order-verification processes, which allows us to support all of our different entities from a central location. There have been times when we have been short of employees in various hospitals because of exposure to the virus and, by having the central order verification, this has allowed us to support those hospitals.

We had also centralized a major portion of our purchasing. So, as we have fought through the different shortages, staff members at every hospital are not having to try to deal with the problem because we have a small team of experts working on it. Then we can move product among our different entities based on need. That has been a big benefit for us.

We also used our central pharmacy team to coordinate all the various research projects related to COVID-19 with which pharmacy is involved. This includes not only the development of treatment protocols, but keeping those up to date and communicating with everybody who needs to know.

GENTRY HUGHES (*Comprehensive Pharmacy Services*): Challenges that pharmacy leaders were experiencing

"Challenges that pharmacy leaders were experiencing before the pandemic have been magnified, and we are seeing that priorities continue to shift because the environment is so dynamic."

— Gentry Hughes —

riencing before the pandemic have been magnified, and we are seeing that priorities continue to shift because the environment is so dynamic. Leaders are trying to build new contingency plans in preparation for another potential resurgence in the short term or even the longer term. We see a lot of focus on inventory optimization due to cash flow concerns.

LANTOS: We are in a multiyear transition of moving to a uniform medical record system across all our sites. In anticipation of that, we are moving away from separate formularies at each of the institutions to having a single formulary. There was enormous progress on this before COVID-19, but the pandemic has made clear the importance of centralization and standardization for our pharmacies. So, we are doing a lot of work in that area across the sites.

THOMAS YEAGER (*Penn Highlands Clearfield*): Penn Highlands Healthcare is a five-hospital system in central Pennsylvania. Our hospitals are all rural and we haven't had a large influx of coronavirus cases at this time. We haven't had to deal with many drug shortages or personal protective equipment shortages, so we are trying not to be complacent and prepare for possible shortages this fall and winter.

We have been talking with our other local health care providers and the other hospitals in our system — we are all within 30 minutes of each other — about how we will support one another if one of us has a surge of cases.

MODERATOR: What kind of staffing issues have you been dealing with because of the pandemic?

HUGHES: Many hospitals have had to quarantine key members of their team and, frankly, didn't have a plan to fill that gap. Staffing contingency plans are a new area that I don't think has really been evaluated previously.

BALL: Our primary staffing issues have been around technicians, not pharmacists. We went into this with some technician shortages — and we still have some shortages in this particular market right now, especially for higher-level job functions like IV compounding. In March, I hired some pharmacy students as interns to create an additional staffing pool and we have utilized them intermittently to fill in for technicians as needed.

MODERATOR: Were you using remote pharmacy services before the pandemic? Are you currently looking into telepharmacy as a potential way to increase bandwidth or generate additional revenue?

YAROCK: Our larger facilities — 250 beds and up — have 24/7 in-house pharmacy teams, while our smaller facilities use remote pharmacy services after hours. The after-hours services have been a huge advantage for us and helped us from a cost perspective, particularly in our critical access or smaller rural hospitals.

LANTOS: We have had telemedicine at the forefront for a number of years and have been working to grow it. As a result of the pandemic, we went from maybe 2% to 3% of outpatient volume up to probably 20% to 25% of outpatient physician activity now on telemedicine.

Telepharmacy is a component of that.

YEAGER: We have never used telepharmacy here. Our hospitals are all small, but not critical access. We each have a 12-hour pharmacy, and we have integrated all of our processes and all of our order plans. This standardization across the system simplifies things. Our nighttime verification comes from our main hub hospital in a hub-and-spoke model. If we had a staffing problem, our plan would be to utilize a lesser-hit hospital to allow us to provide order verification for the other facilities in our system.

“As a result of the pandemic, we went from maybe 2% to 3% of outpatient volume up to probably 20% to 25% of outpatient physician activity now on telemedicine.”

— Phyllis Lantos —

MODERATOR: Does your organization own a specialty pharmacy? If so, what insights can you share?

PATTERSON: We are in the process of building it out right now. We have a partner because this is not for the faint of heart. We have been trying to do this for 12 years and finally, with the impact of COVID-19 and the drop in revenue, it received attention. One of the drivers is that insurers are looking to white bag everything they possibly can and, for our infusion group, that is a huge challenge. [White bagging means that a specialty pharmacy ships a patient-specific drug to a provider's office for administration, removing the physician's control over the drug's preparation and reducing the payment the physician practice receives.] We are hopeful that this will give us an opportunity to recapture not just the medical benefit but the pharmacy benefit levels as well for those patients. The other issue is the continuum of care for our pediatric patients, who have a fragmented care protocol when they get most of their care here [at Boston Children's] and then have to go to CVS or some other organization.

We are simultaneously trying to work out the logistics of getting our own home-infusion program up and running. As long as the 340B [drug pricing program] benefit lasts, that is economically viable. The margins will not be quite the same without 340B, but it's still the right thing to do from a patient care perspective. We expect to have this up and running by the middle of 2021.

YAROCK: We have a specialty pharmacy program, and I think it makes sense in some communities and not in others. Our program is based in metro Toledo, where a higher percentage of patients is being treated for HIV and hepatitis and rely on those specialty meds. This is cost-efficient for us because we have a dense population so, when

we courier those meds straight to our patients' homes, we can do actual routes. This has been successful and we have been able to grow. We also do our own medication packaging because we have robots that do our blister packs for us. But you definitely need a certain volume threshold to make this work for your organization. It might not work as well in more rural areas.

MODERATOR: What are the lessons learned during the pandemic that you would share with other pharmacy organizations that are looking for ways to improve operations?

ILYIN: The biggest thing is to be prepared for medication shortages and supply chain problems. There is a fine balance between how much you want to stockpile versus how much you think you will use, and we are definitely watching that closely. We are also watching closely all the new protocols for potential treatments that are in the pipeline.

CHERRY: One thing we learned, or maybe were simply reminded of, was the importance of recognizing our staff. The events of the last few months gave me an opportunity to frequently thank

our pharmacy team for everything they were doing amidst the myriad changes our organization and the pandemic threw at them. They did a tremendous job and it was great to continually remind them of that and thank them.

LANTOS: Having an overarching view of the pharmacy across your system is important. A key thing for us is centralization — getting standardization and management of a single formulary and metrics to monitor various sites. ●

"There is a fine balance between how much you want to stockpile versus how much you think you will use, and we are definitely watching that closely."

— Julia Ilyin —

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