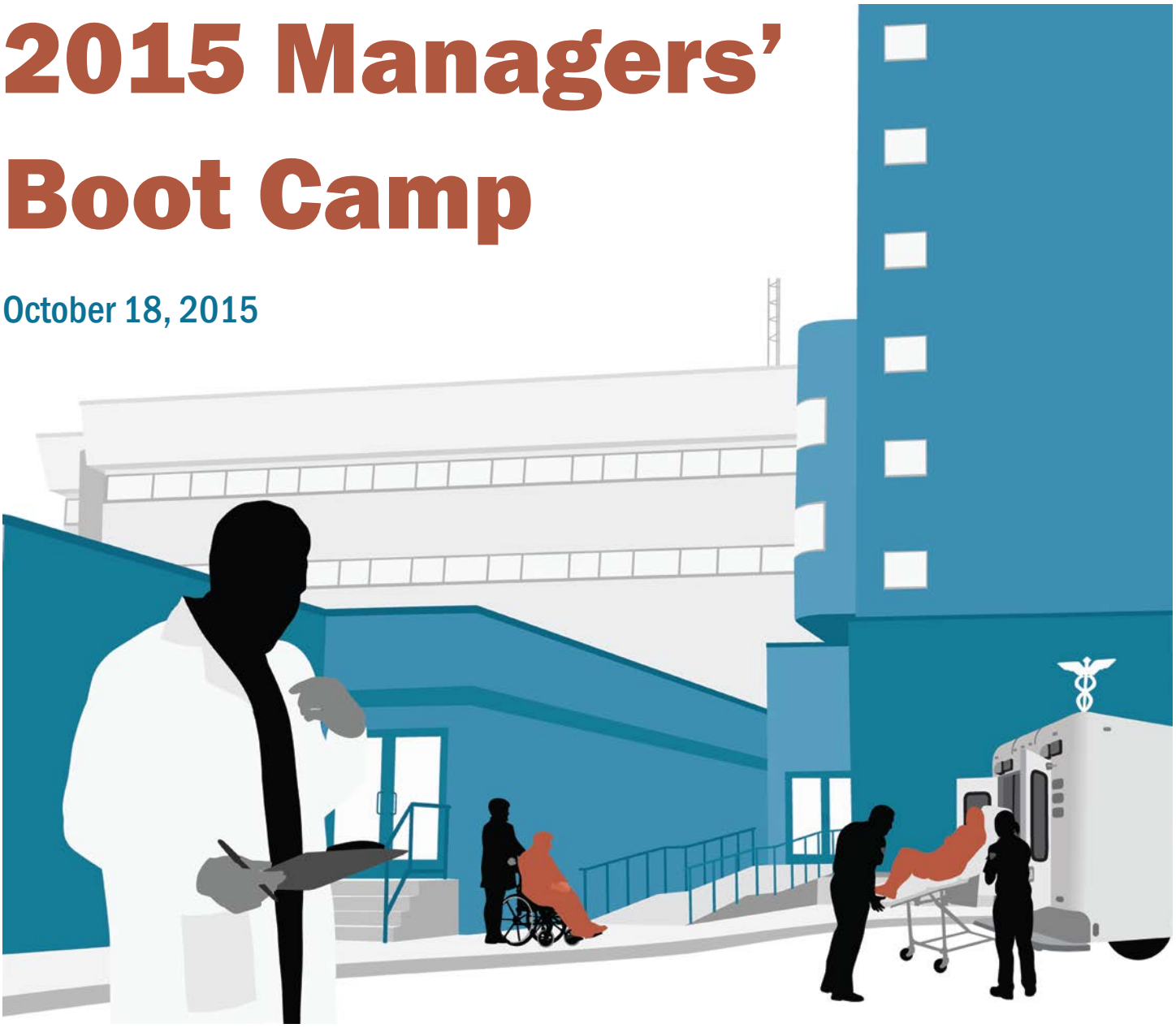
ASHP Section of Pharmacy Practice Managers

2015 Managers' Boot Camp

October 18, 2015



ashp™ | Pharmacy Practice Managers

Managers Boot Camp 2015

Table of Contents

October 18, 2015 – Sunday

Managers Boot Camp 2015

Speaker Bios

Samuel V. Calabrese, B.S.Pharm., M.B.A., FASHP
Associate Chief Pharmacy Officer
Cleveland Clinic

Samuel V. Calabrese is the Associate Chief Pharmacy Officer at the Cleveland Clinic, a 1300-bed academic medical center where he is responsible for over 400 FTEs. Mr. Calabrese holds an academic appointment at NorthEastern Ohio Medical University as an instructor in the Health System Pharmacy Administration program. He received his BS Pharm from The Philadelphia College of Pharmacy and Science, his MBA from Cleveland State University and is an ASHP Fellow.

Mr. Calabrese has chaired the Section Advisory Group (SAG) on Quality and Compliance and is currently a member of the SAG on Leadership Development. He also serves on the ASHP Council on Pharmacy Management, has been an ASHP delegate for Ohio, and is currently the Director at Large –elect for the Section of Pharmacy Practice Managers. Calabrese is an active faculty member with the ASHP Manager's Bootcamp and is a Past President of the Ohio Society of Health-System Pharmacists. He is a frequent invited lecturer who has published and presented on various management and leadership topics.

Samuel V. Calabrese can be e-mailed at sections@ashp.org.

Robert P. Granko, Pharm.D., M.B.A.
Director of Pharmacy
Cone Health | Moses H. Cone Memorial Hospital
Greensboro, North Carolina

Robert P. Granko, Pharm.D., M.B.A. is the Director of Pharmacy at The Moses H. Cone Memorial Hospital in Greensboro, NC, a 536-bed community teaching hospital and flagship hospital for the Cone Health Network. Dr. Granko is a past Gold recipient of the 2013 Leadership Excellence Awards in Pharmacy and received an American Society of Health-System Pharmacists (ASHP) Best Practice Model Award in 2011. Dr. Granko maintains an academic appointment as Associate Professor of Clinical Education at the University of North Carolina Eshelman School of Pharmacy.

Dr. Granko is a current faculty member with the ASHP Managers Boot Camp, is the past chair of the ASHP Practice Section Advisory Group on Manager Development, and has served as ASHP Delegate representing North Carolina. He also serves as member of the Board of Trustees of the North Carolina Center for Hospital Quality and Patient Safety. Dr. Granko has published several manuscripts and presented on topics related to leadership development, pharmacy operations management, and clinical benchmarking.

Dr. Granko received his Bachelor of Science degree in Pharmacy from Long Island University School of Pharmacy, his Doctor of Pharmacy from the University of North Carolina School of Pharmacy, and his Master in Business Administration from Pfeiffer University, School of Graduate Studies.

Lindsey R. Kelley, Pharm.D., M.S.
Assistant Director of Pharmacy, Ambulatory Care Services
University of Michigan Hospital and Health Systems
Ann Arbor, Michigan

Lindsey R. Kelley, Pharm.D., M.S., is Assistant Director of Ambulatory Pharmacy Services at the University of Michigan Hospitals and Health Centers. Areas of oversight include community pharmacies, outpatient infusion, a specialty pharmacy program, transition of care initiatives, 340b multi-pharmacy contracting and collaboration with Ambulatory Care Unit management on medication practices in outpatient clinics.

Dr. Kelley received her Bachelor of Science degree in chemistry from Northern Arizona University in Flagstaff and Doctor of Pharmacy degree from The University of Arizona in Tucson. She completed a postgraduate year 1 (PGY-1) pharmacy practice residency accredited by the American Society of Health-System Pharmacists (ASHP) at Abbott Northwestern Hospital in Minneapolis, Minnesota, followed by a two-year combined administrative residency and Master of Science degree in social, administrative, and clinical pharmacy at the University of Minnesota Medical Center, Fairview in conjunction with the University of Minnesota College of Pharmacy.

Dr. Kelley has been active with state and national professional societies. While in Minnesota, she served as secretary for the Central Minnesota Society of Health-System Pharmacists, as well as new practitioner liaison on the board of directors of the Minnesota Society of Health-System Pharmacists. She served a similar position on the board of directors for the Pennsylvania Society of Health-System Pharmacists (PSHP) and was chair of the PSHP membership committee. For the Western Pennsylvania Society of Health-System Pharmacists, Dr. Kelley served as chair of professional practice.

Dr. Kelley has served as a member of the ASHP Council on Pharmacy Practice and ASHP Section of Pharmacy Practice Managers Advisory Group on Manager Development. Previously she served as chair of the ASHP New Practitioner Forum Executive Committee, and in 2010 she was honored with the ASHP New Practitioners Forum Distinguished Service Award.

Adam Orsborn, Pharm.D., MS
Clemmons, North Carolina

Adam Orsborn, Pharm.D., M.S., is a forward-thinking pharmacist leader and entrepreneur with nearly 10 years of experience developing and implementing improved pharmacy systems and services, and working with leaders in all facets of health system pharmacy. Focus is on creating environments for innovative ideas to become a reality and bring value to patients, caregivers and organizations. Dr. Orsborn spent seven years at Wake Forest Baptist Health where he held the position of Assistant Director of Outpatient and Ambulatory Pharmacy, Director of Pharmacy; Operations and Finance, and Executive Director of Pharmacy. Additionally, Dr. Orsborn was the Program Director for the two-year Health-System Pharmacy Administration Residency at Wake Forest combined with a Master of Science degree from the University of North Carolina - Chapel Hill graduating five highly successful pharmacy leaders during his tenure.

Dr. Orsborn received his Doctor of Pharmacy from the University of Nebraska and Master of Science from the University of Wisconsin combined with the Health-System Pharmacy Administration Residency at the University of Wisconsin Hospital and Clinics.

Melissa Ortega, Pharm.D., M.S
Director, Pediatrics and Inpatient Pharmacy Operations
Tufts Medical Center
Boston, Massachusetts

Melissa Ortega, Pharm.D., M.S, is Director, Pediatrics and Inpatient Pharmacy Operations at Tufts Medical Center in Boston. As a member of the Pharmacy Department's leadership team, she oversees a combination of clinical and operational pharmacy services which includes central operations, the sterile products area, pediatrics and the emergency department. Additionally, she serves as preceptor for the PGY1 practice management rotation and oversees the Northeastern University's Bouve' College of Health Sciences School of Pharmacy cooperative education (Co-op) program.

Melissa received her doctorate of pharmacy degree from Nova Southeastern University in Fort Lauderdale, Florida and completed her pharmacy practice and health-system pharmacy administration residencies at the University of Wisconsin Hospital and Clinics. Melissa has contributed to several key initiatives within her department including her involvement in the implementation of our Carousel technology, facilitating the Pharmacy Council for Technician Advancement, the design and deployment of our Team-Based Technicians, the formalization of our Drug Selection Committee, enhancing the sterile products area services including expanashion of hours, iinsourcing as well as preparing more ready to administer doses, and the design and implementation of the pilot project evaluating the impact of the pharmacy services within our Emergency Department.

Melissa remains active in the Massachusetts Society of Health-System Pharmacists having served on the Early Careerist Committee and Chair of the Membership Committee. She is also an active member in the ASHP Section for Pharmacy Practice Managers on Leadership Development, has served as Chair of ASHP New Practitioners Forum on Public Affairs and Advocacy Advisory Group and as a member New Practitioners Forum Executive Committee.

Kate Schaafsma, Pharm.D., M.S., M.B.A., BCPS
Pharmacy Manager of Outpatient and Emergency Pharmacy Services
Froedtert Hospital and the Medical College of Wisconsin
Milwaukee, Wisconsin

Kate Schaafsma is a Pharmacy Manager of Outpatient and Emergency Pharmacy Services at Froedtert Hospital and the Medical College of Wisconsin in Milwaukee, WI. Kate received her doctorate of pharmacy from Butler University in Indianapolis, IN after which she completed the 2-year Master's and residency in pharmacy administration at the University of Wisconsin Hospital and Clinics. She is responsible for pharmacists, residents, interns and pharmacy technicians practicing in the outpatient pharmacy and emergency department settings. Kate serves as a clinical instructor for University of Wisconsin-Madison and Concordia University of Wisconsin pharmacy students in addition to serving as the Residency Program Coordinator for the PGY1 Community Residency Program. With Froedtert Hospital, Kate works side-by-side on a daily basis with leaders and providers from across ambulatory specialty clinics and emergency services to advance and expand the scope of pharmacy services. She also sits on the PSW Hospital advisory board in addition to working on ASHP SAG for Manager Development and UHC Professional and Workforce Development Committee.

Mark Sullivan, Pharm.D., M.B.A., BCPS
Executive Director, Pharmacy Inpatient and Clinic Operations
Vanderbilt University Hospital and Clinics
Nashville, Tennessee

Dr. Sullivan is Executive Director, Pharmacy Inpatient and Clinic Operations at Vanderbilt University Hospital in Nashville, Tennessee. He also has been either responsible for, or assisted with, implementation of a number of medication-related systems, including automated medication vending systems, "Smart Pump" medication infusion systems, the computerized prescriber order entry system and the bedside bar coding system. He has served as an invited member of the USP Safe Medication Use committee, vice chair of the ASHP Practice Managers section advisory group on communications, and chair of the manager development advisory group. He holds faculty appointments to the University of Tennessee, Belmont University and Lipscomb University Colleges of Pharmacy and served on the Admissions Committee for the inaugural class of the Lipscomb College of Pharmacy.

Managers Boot Camp 2015

October 18, 2015

0800 – 0815	**Greetings and Boot Camp Overview/Goals**
0815 – 0850	**Achieving service excellence – Defining success in today's new health care paradigm**
0855 – 0945	**Action oriented strategic planning- For managers to turn environmental changes into sustainable services and outcomes**
0945 – 1000	**Break**
1000 – 1035	**Case study Part One**
1035 – 1135	**Accountability –** • **Pharmacy Financial Basics - Building Blocks of Leadership Success** • **How to manage and measure to promote practice advancement your stakeholders will recognize and your patients will appreciate**
1135 -1210	**Case Study Part Two**
1210 – 1250	**Lunch**
1300 – 1340	**Alignment of skills and strengths – Building your team to meet the demands of tomorrow**
1340 – 1415	**Role Play Case Study - Human Resources**
1415 – 1430	**Break**
1430 – 1500	**Case Study Part Three**
1500 – 1615	**C-Suite and Group Presentations**
1615 – 1630	**Facilitated discussion of presentations**
1645 - 1700	**Wrap-up and finish**

2015 Manager's Boot Camp

Developed by the Section of Pharmacy Practice Managers

ashp

ashp LEADERS CONFERENCE

Manager's Boot Camp Program Overview

Lindsey R. Kelley, Pharm.D., M.S.
Assistant Director of Pharmacy,
Ambulatory Care Services
University of Michigan Hospital and Health Systems

Faculty Introductions

Relevant Financial Disclosure Information

- The faculty and planners report no financial relationships relevant to the content of this continuing education activity.

Who's in the Audience?

- Is this your first boot camp?
- Your leadership role:
  - ❖Is it formal or informal?
  - ❖Director, manager, clinical coordinator, other?
  - ❖Length in current leadership role?
  - ❖Desire to move up?

Pharmacy Leadership

- New managers and directors often promoted based on clinical leadership abilities
  - ❖ Lack advanced management training
- Skill set necessary to be an outstanding clinician differs from that needed to succeed as a clinical leader or manager
- New clinical leaders often struggle selling their ideas from an administrative perspective
  - ❖ Leads to frustration and eventual demise

Pharmacy Leadership – A New Paradigm

- Health Payment Reform & Shifting Reimbursement Targets
- Increasing number and size of multi-hospital health systems
- 24 hour patient care needs
- Workforce shifts with increasing number of pharmacists with residency training
- Broad scale EMR implementation
- Challenges and costs of HIT
- The growing complexity of the pharmacy enterprise

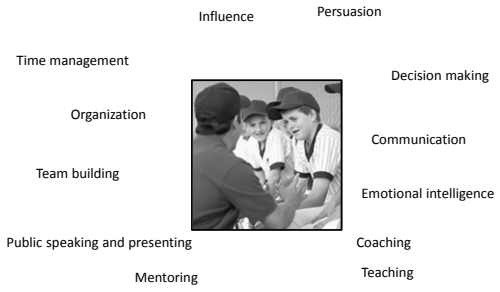
Pharmacy Leadership

"A lack of leadership will mean that health-system pharmacy will no longer be in a position to enhance patient safety, to optimize medication therapies across the continuum of care, to make a real difference in the lives of the patients that we serve"

-Mick Hunt (ASHP Past President)

Building Leadership Skills

General Leadership Skills



Influencing Change

- Establish a sense of urgency
- Form a guiding coalition
- Develop a compelling vision
- Produce short term results
- Prepare for and remove obstacles
- Institutionalize change

Adapted from: Kotter JP. Leading Change: Why Transformation Efforts Fail. *Harvard Business Review*. 2007.

Necessary Skills for Pharmacy Managers and Clinical Leaders

What is Managers' Boot Camp?

Series of didactic and workshop programming to help pharmacy managers build practical skills in the following areas:

- Administrative lingo
- Developing relationships with key stakeholders
- Leveraging quality and safety mandates to advance services
- Business planning for new services
- Strategic planning principles
- Leadership qualities and business acumen
- Navigating the healthcare organization
- Financial management principles
- Project management and implementation
- Promoting value through pharmacy services
- Leading teams and change

Focus of this Boot Camp

- **Achieving service excellence – Defining success in today's new health care paradigm**
- **Accountability: Understanding key financial management tools and principles. How to manage and measure to promote practice advancement your stakeholders will recognize and your patients will appreciate**
- **Action Oriented Strategic Planning: Methods for Managers to Turn Environmental Changes into Sustainable Services and Outcomes**
- **Alignment of Skills and Strengths: Building Your Team to Meet the Demands of Tomorrow**

Program Overview

- *Greetings and Boot Camp Overview*
- *Part 1*
  - Achieving service excellence – Defining success in today's new health care paradigm
  - Action Oriented Strategic Planning: Methods for Managers to Turn Environmental Changes into Sustainable Services and Outcomes
- *Break*
- *Part 2*
  - Workshop #1 (interactive case study)
  - Accountability: Understanding key financial management tools and principles. How to manage and measure to promote practice advancement your stakeholders will recognize and your patients will appreciate
  - Workshop #2 (interactive case study, continued)
- *Lunch*

Program Overview

- *Part 3*
  - Alignment of skills and strengths – Building your team to meet the demands of tomorrow
  - Role Play Case Study - Human Resources
  - Case Study Part Three
- Break
- Part 4
  - Groups Present
  - Facilitated discussion of presentations
  - Wrap-up and finish

Learning Objectives

- Analyze the impact of health-care reform and how it will change necessary financial skills that pharmacy leaders will need to measure and communicate business outcomes.
- How do pharmacy managers effectively lead in the evolving pharmacy enterprise.
- List key financial and quality indicators that influence health-system administrators' decisions and how pharmacy leaders can align strategic planning to impact institutional goals.
- Develop and apply strategies for advancing pharmacy services through staff engagement and effective personnel management.
- Identify the steps required to communicate the value of pharmacy to senior leadership and other key stake holders in the hospital and health system.
- Demonstrate the steps to successfully organize and implement a business plan for new or expanded services

ashp LEADERS CONFERENCE

Achieving Service Excellence -
Defining Success in Today's New Health Care Paradigm

Adam Orsborn, Pharm.D., MS
Clemmons, North Carolina

If you don't know where you are going…

…any road will get you there

Objectives

1. Define: Why do we need to change how we deliver care?
2. Assess: What are the **key needs** of the **people that care** most about what you do?
3. Develop: What is your definition of **success**?
4. Innovate: What **solutions** does your community have to offer for solving problems?
5. Achieve: What **factors** will help you reach your goals?

DEFINE:
factors creating change in healthcare

What is important to CEOs

Issue	2014	2013	2012
Financial challenges	2.5	2.4	2.5
Healthcare reform implementation	4.6	4.3	4.7
Governmental mandates	4.6	4.9	5.0
Patient safety and quality	4.7	4.9	4.4
Care for the uninsured/underinsured	5.5	5.6	5.6
Patient satisfaction	5.9	5.9	5.6
Physician-hospital relations	5.9	6.0	5.8
Population health management	6.8	7.6	7.9
Technology	7.3	7.9	7.6
Personnel shortages	7.4	8.0	8.0

http://www.ache.org/pubs/research/ceoissues.cfm

What is important to CEOs

Financial Challenges (n = 388)[1]	
Government funding cuts	85%
Medicaid reimbursement (adequacy and timeliness of payment, etc.)	81%
Medicare reimbursement (adequacy and timeliness of payment, etc.)	71%
Bad debt	67%
Decreasing inpatient volume	64%
Increasing costs for staff, supplies, etc.	50%
Competition from other providers	40%
Inadequate funding for capital improvements	39%
Revenue cycle management (converting charges to cash)	37%

http://www.ache.org/pubs/research/ceoissues.cfm

"The Triple Aim"

Safe
Effective
Patient Centered

Quality ⟺ Access

Timely
Equitable
Localized

Efficient
use of
resources

Cost = Value

Payment Transformation: Move to Value

The Old System

- Fee for service model
- Patients "discharged"
- Disease Management focus
- Addressing Sickness
- Measuring Mortality/Harm

The New System

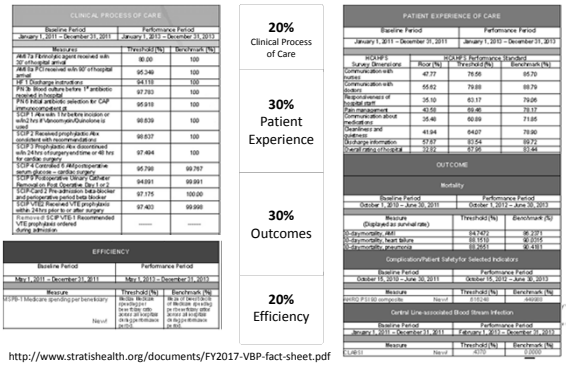
- Value-based payment
- Patients "transitioned"
- Care Coordination & Navigation
- Addressing Health
- Measuring Risk of Harm

Value Based Purchasing

- CMS payments at risk, 2015 Projection
  - 2% for Value Based Purchasing
  - 3% for readmissions
- VBP Domain (risk/reward):
  - Clinical Process of Care
  - Patient Experience of Care
  - Outcomes
  - Efficiency

FY2014 Value Based Purchasing Domain Weighting

(Discharges from 10/1/2014 – 9/30/2015)



20% Clinical Process of Care

30% Patient Experience

30% Outcomes

20% Efficiency

http://www.stratishealth.org/documents/FY2017-VBP-fact-sheet.pdf

ASSESS:
key needs of key stakeholders

The Patient's point of View

1. Use your smartphone
2. Play Doctor
3. Crayons for the table paper
4. Bring pipe cleaners
5. Have a freeze-dance party

http://www.yourmodernfamily.com/waiting/

General information | Survey of patients' experiences | Timely & effective care | Readmissions, complications, & deaths | Use of medical imaging | Medicare payment | Number of Medicare patients

http://www.medicare.gov/**hospitalcompare**/search.html

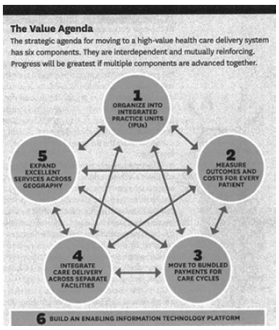
Publicly Reported Outcomes

General information	Survey of patients' experiences	Timely & effective care	Readmissions, complications, & deaths	Use of medical imaging	Medicare payment

Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival *Higher percentages are better*	Rate of unplanned readmission for heart attack patients
	Death rate for heart attack patients
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival *Higher percentages are better*	Rate of unplanned readmission for heart failure patients
	Death rate for heart failure patients
Heart attack patients given fibrinolytic medication within 30 minutes of arrival *Higher percentages are better*	Rate of unplanned readmission for pneumonia patients
Heart attack patients given aspirin at discharge *Higher percentages are better*	Death rate for pneumonia patients
	Rate of unplanned readmission after hip/knee surgery
Heart attack patients given a prescription for a statin at discharge *Higher percentages are better*	Rate of unplanned readmission after discharge from hospital (hospital-wide)

http://www.medicare.gov/hospitalcompare/search.html

The Value Agenda



Porter ME, Lee TH. The Strategy That Will Fix Healthcare. Harvard Business Review, October 2013; 50-70

Typical Patient Populations

- Oncology
- Metabolic Disorders
- Heart & Vascular
- Neuroscience
- Pediatrics
- Primary Care
- Musculoskeletal
- Women's Health
- Digestive Health
- Respiratory
- Trauma & Acute Surg
- Transplant
- Ophthalmology
- Urology
- Spine
- Kidney & Dialysis
- Head and Neck
- Behavioral Health

Clinical Services for all populations

- Pharmacy
- Nursing
- Rehabilitation
- Clinical Engineering
- Radiology
- Ambulatory Operations
- Critical Care
- Perioperative
- Lab
- Transition of Care
- General Medicine
- Food and Nutrition
- Emergency Medicine
- Reconstructive Surgery

The Value Agenda

1. Organize care into sub-populations with more specific needs

Oncology	Hematologic Malignancy	GI	Thoracic
Heart & Vascular	Acute Coronary Syndrome	Heart Failure	Cerebro-vascular

2. Create strategies to improve specific outcomes and financial issues for each
   - **<u>What can Pharmacy Services impact?</u>**

Porter ME, Lee TH. The Strategy That Will Fix Healthcare. Harvard Business Review, October 2013; 50-70

DEVELOP:
your definition of success

Pharmacy Solutions to Drive Value

Financial	• *Specialty Pharmacy Growth* • *Service Line Medication Utilization Reduction* • *Ambulatory Medication Net Revenue*
Access	• Ambulatory Pharmacist Clinical Practice • Specialty Clinic Medication Prior Authorizations • Key Performance Indicators Related to Pharmacy Systems (critical medication delivery time, medication related readmissions) • Decentralization and Expansion of Pharmacist Clinical Services
Quality	• Identify and prioritize OUTCOMES for each Service Line that pharmacy services can impact • Pharmacy Services at Discharge • Sterile Production Automation (IV Robotics) • Medication Distribution Automation

Pharmacy Solutions to Drive Value

- Value to the whole population

Quality and Safety	Operational Excellence	Financial Performance	Strategy and Growth
Days Since Last Medication Serious Safety Event	Percent of Discharges with RPh Medication Reconciliation	Total 340b, GPO Direct Savings Per Stat	Specialty Prescriptions
Barcode Medication Administration Compliance	Percent Medications Available Prior to Due Time	Drug Expense per Stat (320000)	Discharge Pharmacy Service Prescriptions
Pharmacist Managed IV to PO Medication Conversion	Percent Missing Medication Requests	Specialty Pharmacy Contribution Margin	Percent of Chemotherapy Preparations Through Automation
Retail Pharmacy Patient Satisfaction			

Pharmacy Solutions to Drive Value

- Incredible wealth of information regarding each of the possibilities from your peers
- The key is to identify the most impactful **wins for today** while developing systems for **tomorrow**


INNOVATE: solutions for your problems

Disruptive Innovation

- "Disruptive innovations create new markets for products or services, or they reshape existing markets" - Clayton Christensen
- Transforms high cost and complexity with
  - Simplicity
  - Convenience
  - Affordability
  - Accessibility

"Uber, the world's largest taxi company, owns no vehicles. Facebook, the world's most popular media owner, creates no content. Alibaba, the most valuable retailer, has no inventory. And Airbnb, the world's largest accommodation provider, owns no real estate. Something interesting is happening."

- Tom Goodwin, SVP of Strategy and Innovation, *Havas Media*

Disruptive Strategies: Transformation of Pharmacy Practice From a Dispensing Model to a Patient Care Model, 2012 NCPO Annual Meeting; January 2012; : Pharmacy Today; May 2012

Disruptive Innovation in Healthcare

- Drug Therapies!!
- Blood Glucose results appear in EMR in real time
- APPs in your driveway
- Retail Clinics



Disruptive Innovation in Healthcare

- Digitalizing a Human Being
  - Mobile/personal diagnostics, imaging, wireless bandwidth, networked information systems, computing power, social networking, **everything you do with your phone**
- Health Systems
  - Shift patients to lowest cost care setting
  - Prevention and individualized outcomes
- Pharmaceutical Companies
  - Partner with providers and health plans in network development
- Health Plans
  - Early diagnosis
  - Preventative care models
  - Total cost of care

Topol, Eric (2012). *The Creative Destruction of Medicine: How the Digital Revolution Will Create Better Health Care*. New York: Basic Books

Blue Ocean Strategy

The Four Actions Framework

- What aspect of your services are taken for granted, but not adding value? These should be eliminated
- What aspect of your services should be greatly reduced?
- What aspect of your services should be raised well above current standards?
- What has never been offered before that should be created?

Not only is it valuable to consider this for your own pharmacy services, but which industry partners are already doing this?

Kim, W. Chan; Mauborgne, Renee (2015). *Blue Ocean Strategy: How to Create Uncontested Market Space and Make the Competition Irrelevant.* Boston, MA: Harvard Business Review Press

Where Will Your Next Solution Come From?

- Don't underestimate the power of your community
  - Peers in your region
  - National Pharmacy Organizations
  - Non-Pharmacy Organizations
  - Technology Companies
- Focus on todays **needs** and **resources**

ACHIEVE: your goals

How to Achieve

- Stop attempting to influence change by educating people & start utilizing disruptive innovation (Example: policymaking, process change, new roles)
- Focus on what we do best: drug therapy
  - We are the medication experts and have opportunity to improve chronic conditions
- Start small & expand when pharmacy impact has proven valuable

How to Achieve

- Extend, do not imitate physician activities
  - Focus on activities physicians do not desire or have the time to do
- Provider status = paid for services = improved patient outcomes
- Shift in mindset: Define a performance measure that sets us apart from other health care professionals

How to Achieve

- Develop a service that is specifiable, measurable, & predictable (this will provide a strong argument for standards & accreditation)
- Consumers seek the help of those who provide a more effective, convenient & affordable approach to accomplishing tasks
  - Identify consumers who welcome pharmacy disruptive innovation

Objectives

Define:	Why do we need to change how we deliver care?
Assess:	What are the **key needs** of the **people that care** most about what you do?
Develop:	What is your definition of **success**?
Innovate:	What **solutions** does your community have to offer for solving problems?
Achieve:	What **factors** will help you reach your goals?

Success is more attitude than aptitude

Diplomacy is the
Diplomacy is the
some one else
some one else get
your way

Well done is better than well said

Failing to prepare, we prepare to fail

Acknowledgements

- ASHP
- David Chen
- Lindsey Kelley
- Steve Rough
- Scott Knoer
- Boot Camp contributors and faculty

Adam Orsborn, Pharm.D, MS
Adam.orsborn@gmail.com

References

1. American College of Healthcare Executives. (September 2014). *Top Issues Confronting Hospitals: 2013*. Retrieved from http://www.ache.org/pubs/research/ceoissues.cfm
2. Stratis Health. (September 2014). Understanding Value-Based Purchasing. Retrieved from http://www.stratishealth.org/documents/FY2017-VBP-fact-sheet.pdf
3. Medicare.gov Hospital Compare. (September 2014). Retrieved from http://www.medicare.gov/hospitalcompare/search.html
4. Porter ME, Lee TH. The Strategy That Will Fix Healthcare. Harvard Business Review, October 2013; 50-70
5. Disruptive Strategies: Transformation of Pharmacy Practice From a Dispensing Model to a Patient Care Model, 2012 NCPO Annual Meeting; January 2012; : Pharmacy Today; May 2012
6. "High Reliability Organization". *Wikipedia: The free encyclopedia. (September 2014). Retrieved from* http://en.wikipedia.org/wiki/High_reliability_organization
7. Topol, Eric (2012). *The Creative Destruction of Medicine: How the Digital Revolution Will Create Better Health Care.* New York: Basic Books

ashp LEADERS CONFERENCE

Action Oriented Strategic Planning

Kate Schaafsma, Pharm.D, MS, MBA, BCPS
Pharmacy Manager
Froedtert & the Medical College of Wisconsin
Milwaukee, Wisconsin

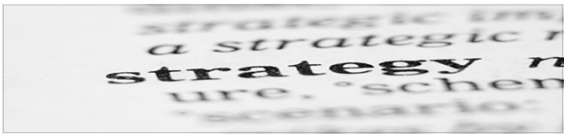
Objectives

- Define the terms
- Know why strategic planning is critical to success
- Develop a framework for strategic management
- Review a case of pharmacy strategic planning
- Reflect on secrets of success

ashp

Definitions

- **Strategic management** is the continuous process to maintain on target
- **Strategic planning** is an activity that is used to set priorities
- **Strategic plan** is a document with goals, objectives, and tactics

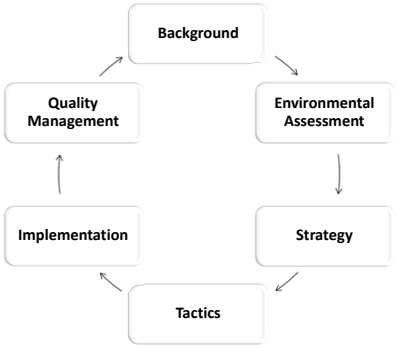


Where does Strategy Fit?

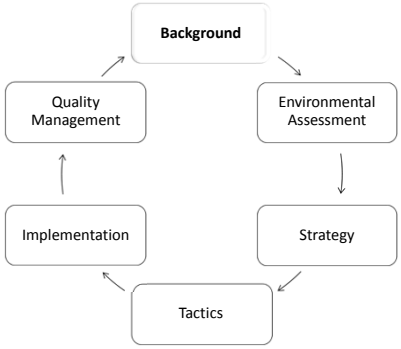
Benefits of Strategic Planning

- Clearly defines the purpose
- Establish practical goals and objectives consistent with that mission
- Means to communicate the goals and objectives in action
- Develop a sense of ownership of the plan
- Ensure the most effective use is made of the organization's resources
- Provide a base from which progress can be measured and establish a mechanism for informed change when needed
- Provides consistent focus
- Increases productivity from increased efficiency and effectiveness
- Solves major problems in the organization

Strategic Planning Process: BEST-IQ



Strategic Planning Process: BEST-IQ



Background

- ❖ Form a planning team
- ❖ Develop a timeline
- ❖ Prepare background information
- ❖ Review the corporate strategic plan
- ❖ Develop communication plan

Mission

❖ Mission statement – reason for existence

- Examples
  - ❖ Apple is committed to bringing the best personal computing experience to students, educators, creative professionals and consumers around the world through its innovative hardware, software and Internet offerings.
  - ❖ The Walt Disney Company's mission is to be one of the world's leading producers and providers of entertainment and information. Using our portfolio of brands to differentiate our content, services and consumer products, we seek to develop the most creative, innovative and profitable entertainment experiences and related products in the world.
  - ❖ Wal-Mart's mission is to help people save money so they can live better

http://onstrategyhq.com/resources/developing-your-strategy/

Vision

❖ Vision statement – aspirational description of what you ***want*** to achieve

- Example:
  - ❖ Amazon's vision is to be earth's most customer centric company; to build a place where people can come to find and discover anything they might want to buy online.
  - ❖ Wal-Mart's vision is to become the worldwide leader in retailing
  - ❖ Toyota's vision is to aim to achieve long-term, stable growth in harmony with the environment, the global economy, the local communities it serves, and its stakeholders
  - ❖ General Electronics' vision is to bring good things to life

http://onstrategyhq.com/resources/developing-your-strategy/

Values

❖ Values - the important, lasting beliefs or ideals that guide thoughts and actions

- Examples
  - ❖ The Walt Disney Company's Values - Dream, Believe, Dare, and Do
  - ❖ Toyota Values - Genchi Genbutsu, Kaizen, Challenge, Teamwork, and Respect
  - ❖ Google's Values – Fast is better than slow, You can make money without doing evil, Its best to do one thing really, really well, etc.

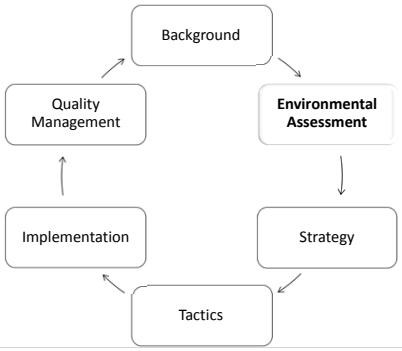
http://onstrategyhq.com/resources/developing-your-strategy/

Tips for Success

- ✓ Involve everyone in development
- ✓ Clear and easily understood
- ✓ Specific, short, and memorable
- ✓ Keep it simple – realistic – practical
- ✓ Focus on the customer
- ✓ Reflect core competencies

http://onstrategyhq.com/resources/developing-your-strategy/

Strategic Planning Process: BEST-IQ



SWOT Analysis Template

State what you are assessing here _____

(This particular example is for a new business opportunity. Many criteria can apply to more than one quadrant. Identify criteria appropriate to your own SWOT situation.)

criteria examples	strengths	weaknesses	criteria examples
Advantages of proposition? Capabilities? Competitive advantages? USP's (unique selling points)? Resources, Assets, People? Experience, knowledge, data? Financial reserves, likely returns? Marketing - reach, distribution, awareness? Innovative aspects? Location and geographical? Price, value, quality? Accreditations, qualifications, certifications? Processes, systems, IT, communications? Cultural, attitudinal, behavioural? Management cover, succession? Philosophy and values?			Disadvantages of proposition? Gaps in capabilities? Lack of competitive strength? Reputation, presence and reach? Financials? Own known vulnerabilities? Timescales, deadlines and pressures? Cashflow, start-up cash-drain? Continuity, supply chain robustness? Effects on core activities, distraction? Reliability of data, plan predictability? Morale, commitment, leadership? Accreditations, etc? Processes and systems, etc? Management cover, succession?
criteria examples	**opportunities**	**threats**	**criteria examples**
Market developments? Competitors' vulnerabilities? Industry or lifestyle trends? Technology development and innovation? Global influences? New markets, vertical, horizontal? Niche target markets? Geographical, export, import? New USPs? Tactics: eg, surprise, major contracts? Business and product development? Information and research? Partnerships, agencies, distribution? Volumes, production, economies? Seasonal, weather, fashion influences?			Political effects? Legislative effects? Environmental effects? IT developments? Competitor intentions - various? Market demand? New technologies, services, ideas? Vital contracts and partners? Sustaining internal capabilities? Obstacles faced? Insurmountable weaknesses? Loss of key staff? Sustainable financial backing? Economy - home, abroad? Seasonality, weather effects?

Internal Assessment

- ❖ Seek out strengths and weaknesses
- ❖ Resources, people, culture and information systems
  - Department structure and facilities
  - Partnerships
  - Employee competency
  - Teaching environment
  - Med use process
  - Clinical services
  - Automation and technology

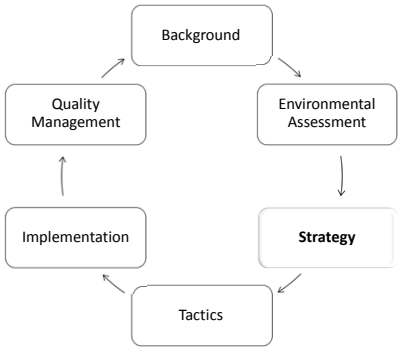
External Assessment

- ❖ Seek out opportunities and threats
  - Identify key industry trends
    - ❖ Sterile product compounding
    - ❖ Credentialing and privileging
    - ❖ Marketplace competition
  - Identify changes at a local and national level
    - ❖ Board of Pharmacy
    - ❖ Regulating bodies - The Joint Commission
    - ❖ Payers - Centers for Medicare and Medicaid Services

Environmental Assessment

- ❖ Complete SWOT analyses
  - Internal environment analysis
  - External environment analysis
- ❖ Gather input from all stakeholders
- ❖ Consider organizational and political implications

Strategic Planning Process: BEST-IQ

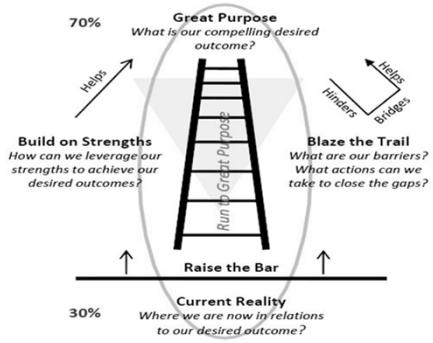


Strategy Formulation

- Define strategic priorities based on risk and reward
- Identify strategic opportunities that align with the mission, vision and values
- Identify what external factors need to be addressed
- Prioritize focus areas
- Develop goal statements
- Develop specific objectives for goals

Force Field Analysis

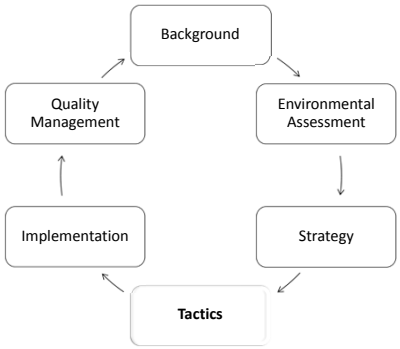
Structural Tension



Strategy Formulation

- Define strategic priorities based on risk and reward
- Identify strategic opportunities that align with the mission, vision and values
- Identify what external factors need to be addressed
- Prioritize focus areas
- Develop goal statements
- Develop specific objectives for goals

Strategic Planning Process: BEST-IQ



Develop Tactics

- Develop strategic plan tactics
- Identify measurable imperatives
- Develop action plans (SMART goals)
- Determine the required metrics

SMART Tactics

SPECIFIC
- State what is to be achieved, clear and well defined

MEASURABLE
- Capable of measurement, progress is monitored and definitive end point

ACHIEVABLE
- Realistic given the circumstances in which it is set and the resources available to the business

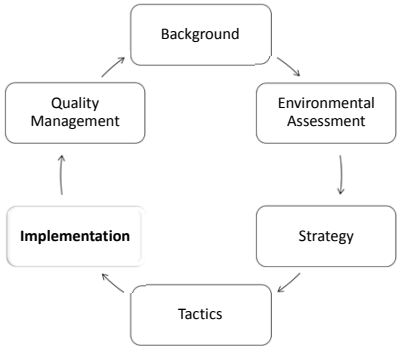
RELEVANT
- Relevant to the people responsible for achieving them

TIMELY
- Detailed timeline with milestones

Determine Metrics

- Operational metrics
- Process metrics
- Fiscal metrics
- Quality or safety metrics
- Visual summary of metrics - dashboard

Strategic Planning Process: BEST-IQ



Strategic Implementation

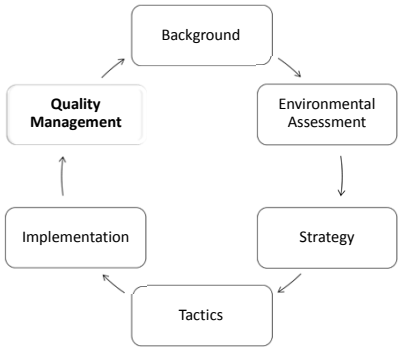
- Finalize the timeline
- Monitor implementation
- Enlist support
- Communicate the plan to stakeholders
- Execute the strategic plan
- Incorporates short term wins with rewards

Keys to a Successful Implementation

Must Do's
- Leadership presence
- Employee with knowledge and experience
- Resources
- Strategic goal – management structure

Pitfalls
- No one knows who is in charge
- Last minute or lack of communication
- Il-defined goals
- Lack of accountability
- Lack of tracking progress

Strategic Planning Process: BEST-IQ



Quality Management

❖Strategic Control, Evaluation, or Quality Management
- Develop a monitoring plan to measure progress
- Monitor, evaluate, and adjust the plan as needed
- Set-up annual review to determine progress
- Taking corrective action, if necessary

Levels of Evaluation

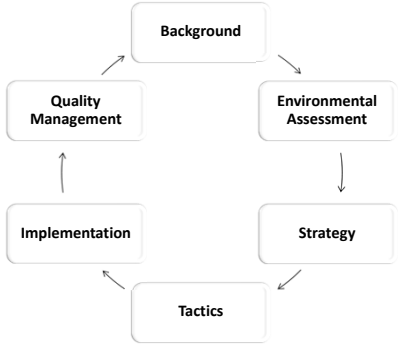
❖ Strategic level
- Does the consistency of the strategy align with the environment?

❖ Operational level
- How well is the organization doing in pursuit of strategy?

Tools to Assist in Evaluation

❖Dashboards
❖Balanced scorecard
❖Scheduled meetings
❖Software packages
❖Project progress reports
- Charters, Gant Charts, etc.

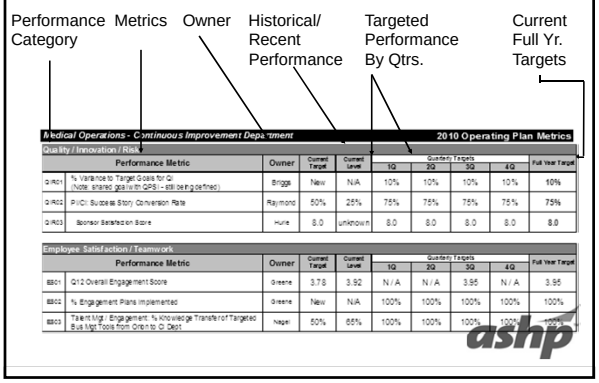
Strategic Planning Process: BEST-IQ



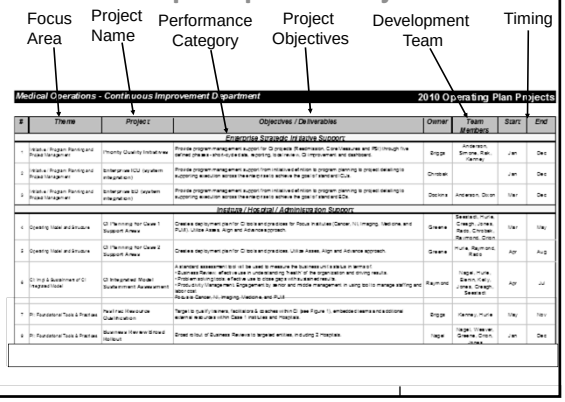
ashp LEADERS CONFERENCE

Strategic Management Tools

Example for Developing Op Plan Metrics



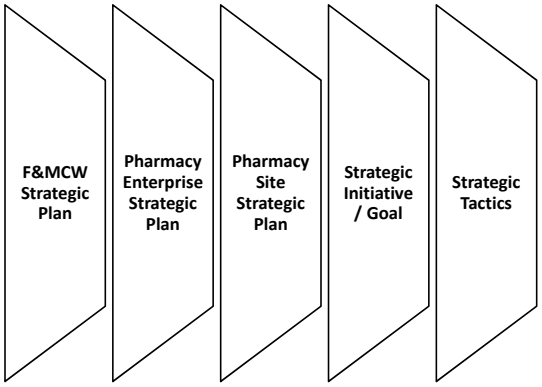
Example Op Plan Projects



ashp LEADERS CONFERENCE

Pharmacy Enterprise Strategic Planning

Case Study

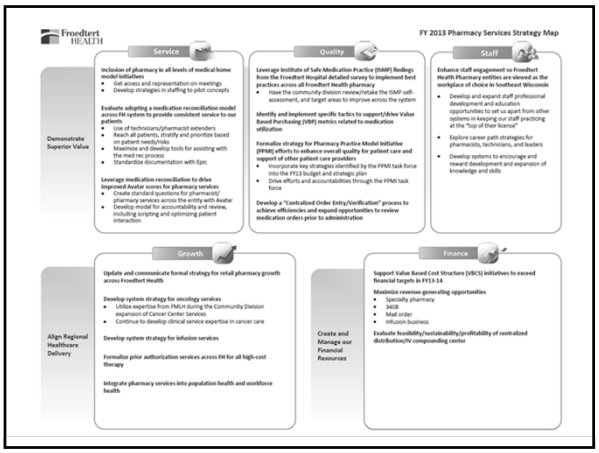


Pharmacy Enterprise Mission Statement

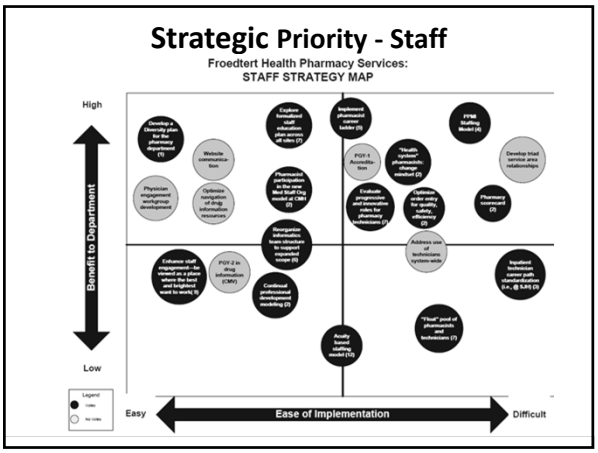
- *The Froedtert Pharmacy is a health care team committed to:*
  - ❖ *High quality, safe, cost-effective, evidence-based, and patient centered care in an atmosphere of communication and shared respect;*
  - ❖ *Life-long learning through education of patients, students, residents, staff, and other health care professionals; and*
  - ❖ *Researching and investigating cost-effective delivery models designed to enhance the quality and safety of medication use.*

Pharmacy Enterprise Vision Statement

- *To be recognized as a national pharmacy leader, offering patients evidence-based options throughout the continuum of care to achieve high quality outcomes while advancing the practice of pharmacy*



Strategic Priority - Staff



Strategic Priority - Staff

Staff

We will distinguish Froedtert Health as a workplace of choice in health care with emphasis on an environment that values health, wellness, dignity and respect.

Froedtert Health Major Initiative: Staff and Physicians

- Continue to develop Performance Excellence model to enhance staff engagement and leader accountability for results
- Define needed leadership capabilities and identify current gaps
- Educate leaders on diversity and inclusion best practices and establish accountability for implementation at each entity
- Use the results of our entity-based medical staff surveys to create and implement action plans to improve physician-engagement throughout Froedtert Health
- Complete an analysis and recommend a workforce development plan to support future patient care models

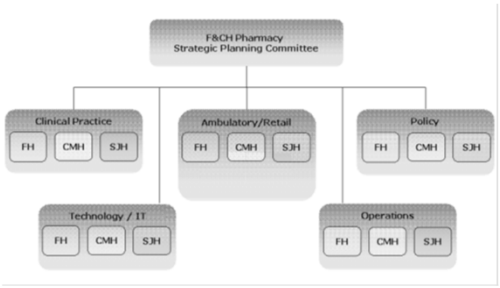
Goals

1) Increase staff engagement
2) Improve performance on the annual staff survey Diversity Index

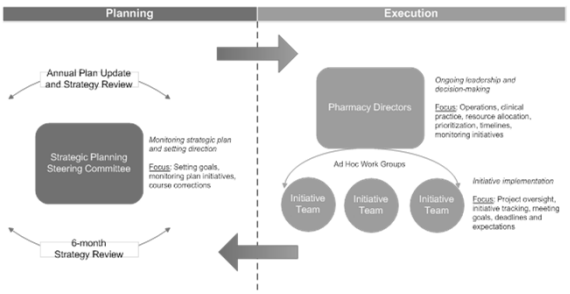
Pharmacy Services Annual Action Plan / Tactics — **Accountability**

1. Acuity based staffing model (12 votes)
2. Enhance staff engagement – be viewed as a place where the best and brightest want to work (9)
3. Evaluate progressive and innovative roles for pharmacy technicians (7)
4. Explore formalized staff education plan across all sites (7)
5. "Float" pool of pharmacists and technicians (7)
6. Re-organize informatics team structure to support expanded scope (6)
7. Implement pharmacist career ladder (5)
8. PPMI staffing model (4)
9. Inpatient technician career path standardization (i.e., @ SJH) (3)
10. Pharmacy scorecard (2)
11. Continual professional development modeling (2)
12. "Health system" pharmacists: change mindset (2)
13. Optimize order entry for quality, safety, efficiency (2)
14. Pharmacist participation in the new Med Staff Org model at CMH (2)
15. Develop a diversity plan for the pharmacy department (1)

Pharmacy Enterprise Strategic Plan



Implementation Framework



Secrets for Success

- ✓ Connect with your pharmacy team
- ✓ Communicate, communicate, communicate
- ✓ Develop communication tool
- ✓ Manage the resources entrusted in your care
- ✓ Deliver on your promise through results
- ✓ Never go on a journey unprepared
- ✓ Stay focused on your plan
- ✓ Stay connected with events in the profession & industry
- ✓ Continue learning and longing for improvement

References

- Zuckerman, AM (2012). Healthcare Strategic Planning. Healthcare Administration Press.
- Mindtools.com
- Porter, ME (1996). "What is Strategy", Harvard Business Review, Nov/Dec 1996.
- The Serving Leader Toolkit. Accessed via http://www.theservingleaderacademy.com/toolkit.html

ashp LEADERS CONFERENCE

Questions?

ashp LEADERS CONFERENCE

Pharmacy Financial Basics

Building Blocks of Leadership Success
October 18th, 2015

CONE HEALTH
The Network for Exceptional Care

Robert P. Granko, PharmD, MBA
Director of Pharmacy
Moses H. Cone Memorial Hospital

P F B

Objectives

1. Describe the current financial opportunities and challenges facing Hospitals and Health-Systems
2. Provide an overview of basic financial terms
3. Assist in navigating example financial and productivity reports
4. Provide an overview of developing budgets and monitoring performance
5. Identify the necessary elements of a successful business plan and ways to promote Pharmacy's brand

P F B

Moses H. Cone Memorial Hospital

P F B

Moses Cone Hospital and Cone Health Department of Pharmacy

MCH Department of Pharmacy Stats	Cone Health Pharmacy Stats
❖ 135 employees (110 FTEs)	❖ 275 employees (250 FTEs)
❖ Staff:	❖ Staff:
❖ 35 Pharmacists	❖ 100 Pharmacists
❖ 50 Technicians	❖ 130 Technicians
❖ 14 Administrative Staff	❖ 14 Administrative Staff
❖ 11 Pharmacy Residents (FY16)	❖ 17 Pharmacy Residents (FY16)
❖ FY16 Expense Budget: $30M	❖ FY16 Expense Budget: $70M
❖ Salary Expense: $7.2M	❖ Salary Expense: $17M
❖ Drug Expense: $21M	❖ Drug Expense: $43M
❖ FY15 Revenue Budget: $100M	❖ FY15 Revenue Budget: $220M

P F B

Introduction

- ❖ All Healthcare organizations are and will continue to face challenges
  - Constant headwinds
- ❖ There are emerging and game-changing strategic implications
- ❖ We need to be better educated on the Business of Pharmacy and its effect on the enterprise
  - Improved financial decision-making, having a basic understanding of the basic principles of healthcare
  - Improved decision making reflecting financial experiences

P F B

ashp

Continuous Challenges and Opportunities

- ❖ 2014/5 Outlook – US Not-for-Profit Hospitals – Moody's
- ❖ Increasing consumer and employer pricing sensitivity and transparency
  - Longstanding negative outlook - since 2008
  - Seeing some hope – extensive cost reduction strategies and revenue form the Affordable Care Act
    - Declining payments
    - Rising costs
- ❖ Nontraditional competitors
- ❖ Shift of care to the ambulatory care setting
  - ❖ 2 Midnight Rule

P F B

Continuous Challenges and Opportunities

- Generate sufficient operating margin to support our clinical, education and research mission
- Completing Epic and other core information system implementations, and switch to ICD-10
- Evolving "systemness" and operating model
- Clinical integration and care delivery transformation
- Stabilizing new Affiliate operations and developing model for future success
- **Sustained pressure to contain costs, ensure clinical and operational efficiencies and search for new revenue sources**
- Keeping pace with evolving population health landscape (in multiple locations)

P F B

Two-Midnight Rule

- Effective October 2013, the "two-midnight rule" for acute care hospitals classifies most hospital visits under 48 hours as outpatient cases.
- Genesis:
  - PRE:
    - Inpatient admissions standard relied on the physician's judgement on who should be admitted
    - Led to increased contractor reviews
    - Backlog of Medicare appeals
  - POST:
    - Provide clarity to admission standards
- Previously, inpatient status was largely determined by medical necessity.
  - Weaken hospital operating profitability because it will lower Medicare reimbursement for these cases.

P F B Moody's Investor Service March 12th 2014

ashp

Two-Midnight Rule

- **Reimbursement difference between inpatient and outpatient cases will decrease profits**
  - On average, the rule could cause revenue reduction averaging $3,000 to $4,000 per case.
- **Two-midnight rule will accelerate trend of inpatient care shifting to outpatient**
  - The rule will result in significant growth in observation stays in 2014, pressuring hospital revenues.
- **Hospitals with short lengths of stay will be most affected**
  - Smaller community hospitals with low average lengths of stay and less complex cases are most at risk.
- **Reimbursement change will impact hospitals with high proportion of inpatient care**
  - Profitability will suffer as the high fixed costs of inpatient care are spread over a smaller base of inpatients.
- **Small hospitals lack adequate staff to adapt to new rule**
  - More resources are needed to implement administrative and operating changes caused by the rule.
- **Fewer RAC claims provide a silver lining**
  - The rule could reduce recovery auditor contractor (RAC) reviews of hospital admissions practices, offering some financial relief.

P F B Moody's Investor Service March 12th 2014

ashp

ashp LEADERS CONFERENCE

Key Terminology

Key Terminology

- Case Basis
  - Also called prospective payment - common
  - Paid a set fee for the care of a patient who has a certain condition (MS-DRG)
  - Regardless of how long the patient stays or number of resources consumed
- Bundled Care
  - This arrangement is where the provider is paid a fixed amount during an entire care episode and may include multiple care sites such as post-acute care facilities
- Per Diem
  - Agreed amount per patient day
  - Contractual per diem – payer sets the price

A Primer on Hospital Accounting and Finance 5th edition

P F B

ashp

Key Terminology

- Capitation
  - Hospital or health system receives a fixed amount per enrolled individual per month—often indicated as per member per month (PMPM)
  - To cover a specified scope of medical services.
  - The provider is paid regardless of whether medical services are used and conversely bears all cost overruns from services provided.
- Pay-for-Performance (P4P) and Shared Savings/Risk Arrangements
  - Movement to reward providers for increasing care value.
  - Providers receive bonus payments or have a portion of their pay withheld based on whether they meet preset performance targets. Targets may relate to quality, cost effectiveness, efficiency of care, or other factors.
  - *Shared savings* arrangements offer incentives for providers to reduce healthcare spending for a defined patient population by offering them a percentage of net savings realized

A Primer on Hospital Accounting and Finance 5th edition

P F B

ashp

Key Terminology

- Charge Data (Drug) Master
  - List of all hospital procedures, services, supplies, and drugs used for patient care services
  - Code # for each line item in the Charge Data Master
- HCPCS Codes:
  - Medicare/Medicaid billing codes for all procedures, items, and services used by a provider
  - Some NDCs tied to HCPCS codes "Natural HCPCS"
  - Revenue Codes: Denotes where and what types of services are provided

P F B

ashp

Key Terminology

- 3 main financial statements
  - Balance sheet
    - Summary of all account balances, including assets, liabilities and equity – as of a specific date (e.g. quarterly or year end)
  - Income statement
  - Cash flow statement
- Gross revenue
  - Payer payments
  - Accrual – revenue recognized when its earned
- Expense
  - Supplies and labor (There are others!)
- Profit/Contribution Margin
  - Revenue – expense
  - Many organizations' goal is 4-6%

Different Reports for Different Audiences

Recipients	Period	Provided
Public	Annually*	Annual report (based on audit) includes: • Statement of Operations and Changes in Net Assets • Balance Sheet • Statement of Cash Flows • Audit Certificate
Directors	Monthly or quarterly	Periodic package includes: • Statistics • Statement of Operations and Changes in Net Assets • Balance Sheet • Statement of Cash Flows (often quarterly) • Variances from Budget
Management	Monthly, weekly, and as required	Periodic package in greater detail: • Departmental analyses • Product line analyses

*Some public reporting is done quarterly, as in the case of publicly placed financial transactions.

Source: Kaufman, Hall & Associates, LLC

P F B

ashp

Measuring Revenues and Expenses with Accrual Accounting

- Accountants measure profit or loss by applying a concept called *accrual accounting*.
- Accrual accounting entails deciding when patients have received services for which the organization is entitled to income, as well as how and when the cost of these services is measured.
  - Income (revenue) is earned when services are provided. A patient in a bed is receiving a service.
  - Expenses are the costs of providing material and service to the parties that receive the service, when the service is being provided.

P F B A Primer on Hospital Accounting and Finance 5th edition

ashp

Measuring Revenues and Expenses with Accrual Accounting cont.

- The timing of when an organization gets paid for the services it renders, or when it pays for the materials and services it purchases.
- The accurate measurement of profits or losses depends upon the correct matching of services provided and the costs of providing these services.

- Payment for services and materials that have been provided may occur long after they have been received and consumed.

P F B A Primer on Hospital Accounting and Finance 5th edition

ashp

Key Terminology - Summary

Liabilities	future sacrifices of economic benefits arising from present obligations to transfer assets or provide services to others as a result of past transactions or events
Charity of uncompensated Care	care rendered to patients without the expectation of compensation for such services
Contract Allowance	accounting adjustment required to reflect uncollectible differences between established charges for services rendered to insured persons and rates payable for those services under contracts with third-party payers
Cost Center	responsible for providing services and controlling costs
Operating Margin	total operating revenues minus total operating expenses
Contribution Margin	revenue from services minus all variable expenses
Management Discuss & Analysis	section of the annual report that is written by management to identify highlights of financial results and discuss the risks to the organization. It is not audited.
Bad Debt	amount not recoverable from a patient or an entity that may have the ability to pay but does not following exhaustion of all collection efforts
Recovery Audit Contractor	program created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers
Variable Costs	cost whose unit value remains relatively constant but whose aggregate value changes, usually proportionately to changes in volume
Statement of Net Assets	financial statement that presents the financial position of the organization at a point in time
Fixed Costs	type of cost that stays approximately the same in total over a particular range of activity
Medicaid	federally aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care; benefits, program eligibility, rates of payment for providers, and methods of administration of membership and payment to providers
Assets	probable future economic benefits obtained or controlled by an entity by virtue of past transactions or events
MS – DRG	patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed; provides a framework for specifying hospital case mix
Variance	difference between and expected value and the actual value
Accrual	basis of accounting whereby revenue is recognized when it is earned and expenses are recognized when they are incurred
Flexible Budget	Budget that, when prepared, recognizes that expenditures are a function of activity levels and are adjusted accordingly
Net Assets	residual interest in the organization's assets remaining after liabilities are deducted
Medicare	U. S. health insurance program generally for people aged 65 and the disabled

P F B

ashp

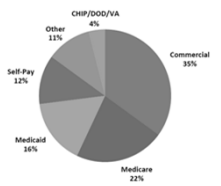
ashp LEADERS CONFERENCE

Charging

Payer Types

- Payer types:
  - Private - BCBS
  - Government – Medicaid – indigent or low income
  - Self-pay
  - Charity Care - Care rendered without the expectation of payment
- Bad Debt
  - Amount not recoverable from a patient or entity
- Payers negotiate contracts with health care organizations based on
  - Quality, Service, and Outcomes

U.S. Payer Mix



Source: Centers for Medicare & Medicaid Services, National Health Expenditures, by Source of Funds Table, 2013 data.

P F B

ashp

How Medicare Severity DRG-Based Payment Is Determined

- MS-DRGs are based upon acuity and are "weighted," according to the severity of the patient's illness, which can indicate the intensity of care or services needed.
- Sicker patients require more of the hospital's care and resources
- Patient or "case" with a weight of 2.0 is deemed to be double the intensity and hence require double the costs (and payment) of a case with a weight of 1.0, which is the baseline weight.
- Each hospital has a unique MS-DRG distribution.

Number of Discharges	MS-DRG Number*	Description	Percent of Total Discharges
1,376	795	Normal newborn	16.7
1,098	775	Vaginal delivery w/o complicating diagnoses	13.4
161	194	Simple pneumonia and pleurisy age >17 w/o complications/comorbidities	2.0
150	391	Esophagitis, gastroenteritis, and misc. digestive disorders age >17 w/o complications/ comorbidities	1.8
136	292	Heart failure and shock	1.7

*First three digits of MS-DRG code.

Source: Kaufman, Hall & Associates, LLC

If the MS-DRG weight is 2.0	And the base rate or the value of a case with a weight of 1.0 is $5,000	Then the value of a specific case is 2.0 X $5,000 = $10,000

P F B

Pharmacy Financial Basics

- How we bill
  - Charge master – bill for each line item
  - Each payer has its own rules – usually complicated
  - DRGs, bundles and outlier payments
    - MS – DRG (Medicare Severity-Diagnosis Related Groups) : patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patient length of their inpatient stay and amount of resources consumed
    - Case mix
- How we get paid (simple version)
  - Inpatient encounter (cost center) - we are paid what is in the contractual agreement - not what it actually costs to care for patients
  - Outpatient encounter (revenue maker) - typically fee for service that is "discounted" based on contractual agreements

P F B

ashp

Pharmacy Revenue Routing

- Dispensing Pharmacy's Cost Center
  - Pharmacy revenue is routed to the dispensing pharmacy's cost center
  - For example:
    - Medications dispensed from pharmacy A will have charges routed to "PHARMACY A"
    - Medications dispensed from another pharmacy (B) will have charges routed to "PHARMACY B.
    - Cost Center Defined
      - E.g., 10500, 10501, respectively – Inpatient Operations, Sterile Products

P F B

ashp

Pharmacy Revenue Routing

- Possible exceptions:
  - <u>Investigational Drugs</u>:
    - Any investigational medications that have a billing type of "investigational drug".
    - The revenue for these meds will be routed to the "INVEST DRUGS" cost center, regardless of where they are dispensed from.
  - <u>Contrast Media:</u>
    - Contrast medications follow a different logic.
    - Their cost center routing is not based off of the pharmacy that they are dispensed from, but the department that the user is logged into.
    - E.g.: If a user is logged into one of the imaging departments or other departments that buy and dispense their own medications, the revenue will be routed to that department's cost center.
    - If a user is logged into one of the other hospital departments or the pharmacy department, the revenue will be routed to the "PHARMACY INPATIENT OPERATIONS" cost center.

P F B

ashp

Risk Mitigation Strategies

- Currently, the Pharmacy Revenue Cycle infrastructure functions as manual, risk prone, single-individual, review process.
  - Pharmacy has been asked to invest into reducing the medication liability associated with RAC audits and incorrect medication billing units, which this software addresses.
  - 1) capture missing HCPCS codes, 2) monitor NDC code integrity, 3) identify purchased drugs not in your formulary, 4) alerts on incorrect unit multipliers, 5) pricing variances, 6) volume reconciliation comparing drug spend to charge capture activity.
  - Improved pricing consistency and transparency
  - Ensure accurate medication formulary multipliers are correct and uploaded
- Pharmacy revenue cycle void that has received much attention over the past few months with the RAC audits.
  - Addresses revenue leakage and compliance risks
  - Due to the increased scrutiny of compliance issues related to billing units and multipliers by OIG, it has become increasingly significant to maintain oversight and accurate data in both your new and existing systems.

P F B

ashp

Revenue Codes – Sample Guidance

REVENUE CODE AND CPT/HCPCS Coding by Payer

DRUG TYPE	H-Default CPT/HCPCS	A-Default RC	D-Medicaid HCPCS	BS Indicator Medicaid	B-OP Medicare HCPCS	X-OP Medicare RC	IC	GL KEY	XXX RC	XXX ALT CPT	XXX STD CPT
INJ, IV DRUGS **W/ REAL HCPCS**	REAL HCPCS	636					6	371	636	REAL HCPCS	REAL HCPCS
INJ, IV DRUGS **W/ NO HCPCS**	J3490	250		5			6	371	250	J3490	J3490
INJECTIBLES SELF ADMINISTERABLE -On the Medicare Self Administered List	REAL HCPCS	636			A9270 GY	637	6	371	636	A9270 GY	REAL HCPCS
IV SOLUTIONS W/ REAL HCPCS	REAL HCPCS	258					6	371	258	REAL HCPCS	REAL HCPCS
IV SOLUTIONS W/NO HCPCS	J3490	258		5			6	371	258	J3490	J3490
BLOOD CLOTTING FACTOR / Hemophilia	REAL HCPCS	636					9	884	636	REAL HCPCS	REAL HCPCS
CHEMO INJ, IV W/ **REAL HCPCS**	REAL HCPCS	636					6	378	636	REAL HCPCS	REAL HCPCS
CHEMO INJ, IV DRUGS **NOC**	J9999	250	J3490	5			6	378	250	J9999	J9999
ORAL CHEMO W/ **REAL HCPCS**	REAL HCPCS	636					3	378	636	REAL HCPCS	REAL HCPCS
ORAL CHEMO DRUGS W/ **NO HCPCS**	J8999	250	J3490	5	A9270 GY	637	3	378	250	J8999	J8999
ORAL ANTIEMETICS W/ **REAL HCPCS**	REAL HCPCS	636					3	378	636	REAL HCPCS	REAL HCPCS
OPHTHALMIC Drop/Solution/Cream/Ointm	BLANK	250	J3490	5			3	371	250	J3490	J3490
ORAL, Oral Syringes, Tabs, Caps, Creams, Ointments, Powders, Supp, Solids, UD or UDC, OS(oral-solution) (usually no HCPCS)	BLANK	250	J3490	5	A9270 GY	637	3	371	250	A9270 GY	J3490
CONTRACEPTIVE DEVICE IMPLANTABLE	REAL HCPCS	278					10	371	278	REAL HCPCS	REAL HCPCS
INHALATION SOLUTIONS (don't use J codes that describe "Admin.thru.DME"	J3490	250		5			3	371	250	J3490	J3490
TAKE HOME Drugs (usually no real HCPCS)	BLANK	253	J3490	5	A9270 GY		3	371	253	BLANK	BLANK
Drugs Incident to Other DX Services	REAL HCPCS	254					6	371	254	REAL HCPCS	REAL HCPCS
Drugs Incident to Radiology	REAL HCPCS	255					6	371	255	REAL HCPCS	REAL HCPCS
Investigational Drugs (REAL HCPCS)	REAL HCPCS	256					3	371	256	REAL HCPCS	REAL HCPCS
Investigational Drugs (NO HCPCS)	BLANK	256	J3490	5			3	371	256	J3490	J3490
Non-Prescription Drugs (RC 257)	BLANK	270					10	371	270		
Supplies (meters, strips, creams, containers)	BLANK	270					10	371	270		
Supplies STERILE	BLANK	272					10	371	272		
Supplies TAKE HOME	BLANK	273			A9270 GY		12	371	273		
Supplies IMPLANTED	C HCPCS	278	(RC 272)				19	371	278	C HCPCS	C HCPCS

P F B

Reimbursement

- Fee For Service
  - Paid according to the volume of services that are provided
  - Traditional model – still common today
  - Disadvantages: Overutilization of services
- Pay for Performance
  - Also known as Incentive Payments
  - Eligible to additional payments by meeting or exceeding negotiated criteria
    - Demonstrated lower cost of care
- Shared Risk
  - Established benchmark of medical expenses
- Bundled Payment
  - Hospitals receive one payment for a discrete set of services
- Capitation
  - Hospital receives specific payment per patient, per month and must provide necessary services
  - What if hospitals cost of care exceed payments?

P F B

Pharmacy Financial Basics

Healthcare's Alphabet Soup: Selected Definitions

ACO	**Accountable care organization.** An ACO is a legally structured arrangement between hospitals, primary care and/or specialty physicians, and other providers (such as post-acute care or inpatient rehab facilities, home health care, skilled nursing) to coordinate and deliver efficient and effective care for a defined patient population for a specified period of time. An ACO assumes accountability for improving quality and slowing the growth of costs.
CI	**Clinical integration.** The purposeful fostering of collaboration among independent doctors, other providers, and hospitals in a way that increases both the quality and efficiency of patient care.
HIPAA	**Health Insurance Portability and Accountability Act.** Enacted in 1996, HIPAA intends to improve the portability and continuity of health insurance coverage in the group and individual markets; combat waste, fraud, and abuse in health insurance and healthcare delivery; simplify the administration of health insurance; and other purposes. Its Privacy Rule regulates the use and disclosure of "protected health information" held by "covered entities," a key consideration for hospitals and health systems.
HMO	**Health maintenance organization.** A managed care plan that integrates financing and delivery of a comprehensive set of healthcare services to an enrolled population. HMOs may contract with, directly employ, or own participating healthcare providers. Enrollees are usually required to choose from among these providers and in return have limited copayments. Providers may be paid through capitation, salary, per diem, or pre-negotiated fee-for-service rates.
IPA	**Independent practice association.** An entity that contracts with individual physicians or small physician groups to provide services to HMO or other plan enrollees at a negotiated per capita or fee-for-service rate. Physicians typically maintain their own offices and can contract with other HMOs and see other patients.
PHM	**Population health management.** PHM occurs when a healthcare system or network of providers works in a coordinated manner to improve the overall health, health outcomes, and well-being of patients across defined care settings under risk-bearing arrangements.
PHO	**Physician–hospital organization.** An organization that contracts with payers on behalf of one or more hospitals and affiliated physician groups to provide healthcare services. The PHO also may undertake utilization review, credentialing, and quality assurance. Physicians typically retain ownership of their own practices and maintain significant business outside the PHO.
POS	**Point-of-service.** A managed care plan that offers health plan enrollees the option of using network or non-network providers at the time care is needed; enrollees typically have significantly larger copayments for selecting the latter.
PPACA	**The Patient Protection and Affordable Care Act, or ACA.** Signed into law in 2010, the ACA aims to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. Its primary mechanisms are mandates, subsidies, and insurance exchanges.
PPO	**Preferred provider organization.** A health plan that offers a network of providers whose services are available to enrollees at lower cost than the services of non-network providers. Access is broader and looser than with an HMO; enrollees may go to an out-of-network provider for an additional cost and self-refer to any network provider at any time.

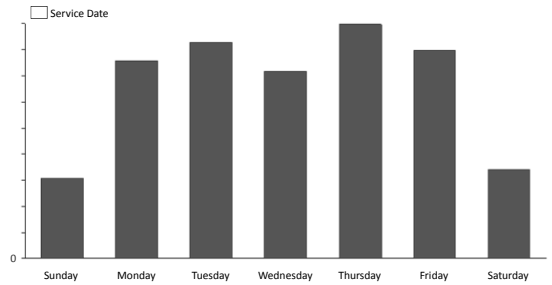
Sources: American Hospital Association, *Accountable Care Organizations: AHA Research Synthesis Report*, June 2010; T.J. Babbo et al., "Clinical Integration: A Physician and Hospital Strategy for Better Quality, Enhanced Competition, and Collective Contracting"; University of Washington School of Public Health and Community Medicine, *Glossary of Health Care and Health Care Management Terms*; and G. Hill et al., "Population Health Management—Hill's Handbook to the Next Decade in Healthcare Technology," Citi Research, May 14, 2013.

P F B

LEADERS CONFERENCE

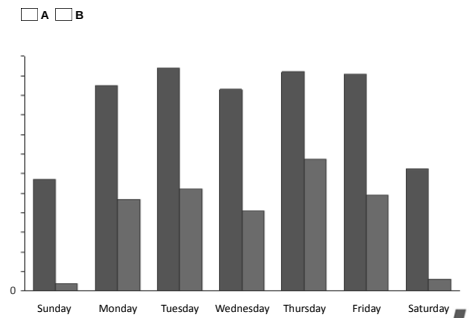
Financial Reports and Assessing Operations

Average Daily TOTAL Revenue for Cost Centers
Revised DSS Data

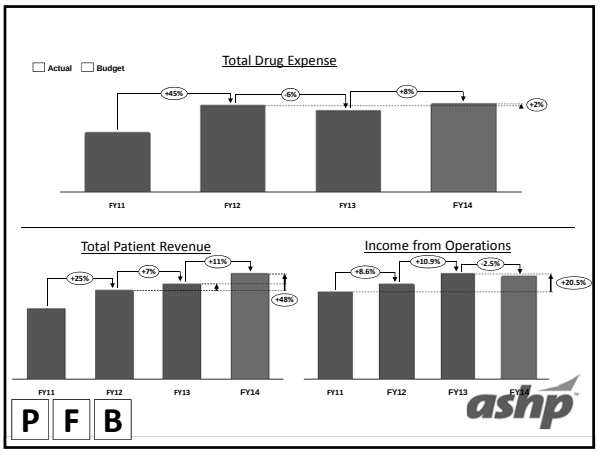


P F B

Average Daily Revenue for Cost Centers A and B

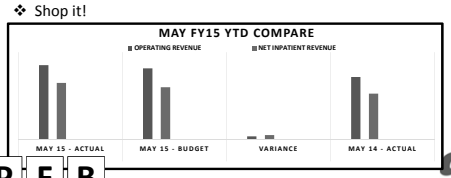


P F B



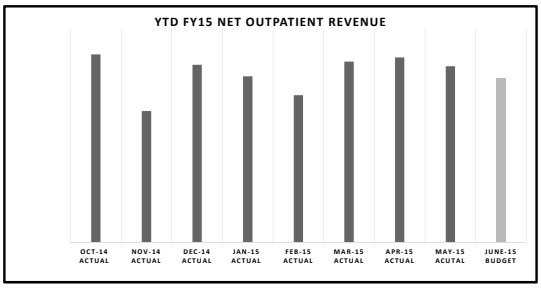
Financial Summary Steps

- Get access to some data – Departmental or Cost Summary Data
  - Ask someone
  - Go back and make sure you understand the embedded assumptions and caveats
- Build out your data in Excel – Understand what you are building out and what is says
- Place graphs in a PowerPoint slide 8x11
- Shop it!



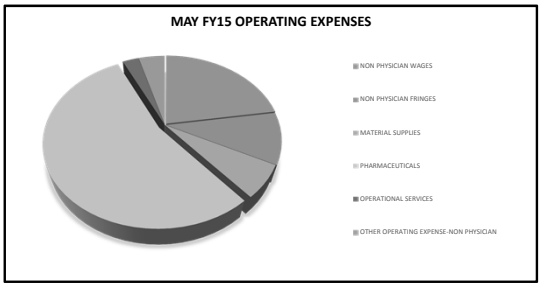
P F B ashp

YTD FY15 NET Outpatient Revenue



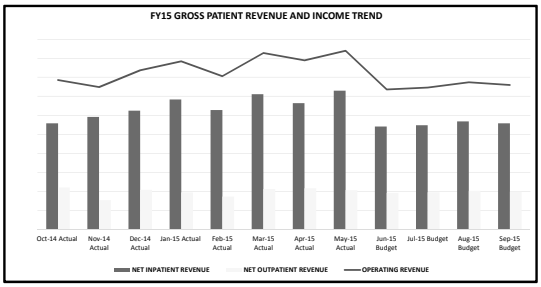
P F B ashp

MAY FY15 Operating Expenses



P F B ashp

FY15 Gross Patient Revenue And Income Trend

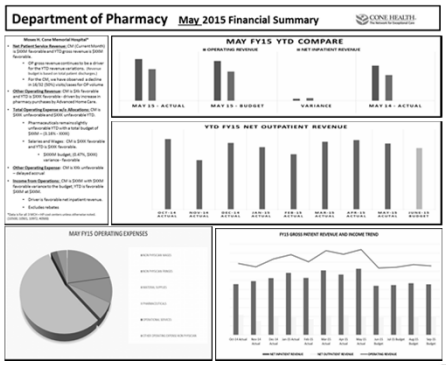


P F B ashp

Current Month (CM) Explanations

- **Net Patient Service Revenue (10-500):**
  - CM (Current Month) is $XXXK favorable and YTD gross revenue is $XXXK favorable.
  - OP gross revenue continues to be a driver for the YTD revenue variations. (Revenue budget is based on total patient discharges.)
  - For the CM, we have observed a decline in 12/32 (38%) visits/cases for OP volume
- **Other Operating Revenue:**
  - CM is $XXK favorable and YTD is $XXXK favorable - driven by increase in pharmacy purchases by XXX.
- **Total Operating Expense w/o Allocations (10-500):**
  - CM is $6K favorable and $XXK unfavorable YTD.
  - **Pharmaceuticals remains YTD on-budget with a total budget of $XXM – (0.49% -40K)**
  - **Salaries and Wages: CM is $XXK favorable and YTD is $XK unfavorable.**
  - **$XXM budget; (0.26%, $8K) variance**
- **Other Operating Expense:**
  - CM is at budget
- **Income from Operations:**
  - CM/YTD is $XXM with $XXK favorable variance to the budget
  - Driver is favorable net inpatient revenue.

P F B ashp



P F B

ashp

ashp LEADERS CONFERENCE

Productivity and Benchmarking

Pharmacy Financial Basics
Productivity

- Report Categories
  - Statistics and Hours
    - Inpatient and Outpatient Days
  - Key Ratios
    - Non Productive
    - Volume Adjusted
  - Variance Analysis
    - Total Gross Revenue Variance
    - Total Salary Variance
    - Total Medical/Surgical Supply/Pharmacy Variance

- Benchmarking

"It is not enough to be busy... The question is: what are we busy about?"
— Henry David Thoreau

P F B

ashp

Department Performance Report
40500 - MC-PHARMACY
Moses H. Cone Memorial Hospital

OPERATIONSADVISOR®

Reporting Period: 06/14/2015 - 07/25/2015

Pay Period Detail

	05/16/2015	05/30/2015	06/13/2015	06/27/2015	07/11/2015	07/25/2015	Reporting Period Avg	FYTD Avg
Volume (Calendar Days)	14.00	14.00	14.00	14.00	14.00	14.00	14.00	14.00
Budget Volume	14	14	14	14	14	14	14	14
Worked Hours Data								
Actual Worked FTE	72.77	71.15	73.36	74.37	74.16	77.36		76.89
Actual Worked Hours per Unit	415.8285	406.5785	419.1752	424.9963	423.7573	442.0786	430.2774	439.3994
WH Primary Target								
Target Worked Hours per Unit	436.2469	436.2469	436.2469	436.2469	436.2469	436.2469	436.2469	436.2469
Total Target Worked FTE	76.34	76.34	76.34	76.34	76.34	76.34	76.34	76.34
Target FTE: Fixed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Target Worked FTE: Variable	76.34	76.34	76.34	76.34	76.34	76.34	76.34	76.34
Worked Hours Productivity Index	104.91%	107.30%	104.07%	102.65%	102.95%	98.68%	101.39%	99.28%
Worked FTE Variance	(3.57)	(5.19)	(2.99)	(1.97)	(2.19)	1.02	(1.04)	0.55
WH Budget								
Budget Worked FTE	76.34	76.34	76.34	76.34	76.34	76.34		76.34
Budget Worked Variance FTE	(3.57)	(5.19)	(2.99)	(1.97)	(2.19)	1.02		0.55
Paid Hours Data								
Actual Paid FTE	79.78	81.16	82.94	83.85	86.28	85.55	85.23	84.27
Actual Paid Hours per Unit	455.9001	463.7929	473.9252	479.1215	493.0251	488.8823	487.0096	481.5708

Productivity Analysis for Department of Pharmacy Cost Centers

- The pre-assigned workload statistic for each cost center in the Department of Pharmacy can be either daily Average Adjusted Patient Days (APD) or Calendar Days (CD). APD is a variable metric while CD is a fixed metric.
  - APD is a Decision Support endorsed organizational metric that often considers gross revenue, inpatient revenue, and volume of inpatient days.
  - This figure is selected for a large number of organizational departments. While APD or CD may not be an exact match to determine volume in your area, it is the standard, in most cases. E.g. FY 14, the budgeted daily Average Adjusted Patient Days is 1245.5.
- In reviewing your Cost Center's most recent Productivity for the Pay Period, please note the following:
  1. Budgeted Hours = Budgeted FTE's x 80 Hours (# of hours per FTE in a pay period).
  2. For the costs centers who are on CD, the budgeted workload is 14.
- To calculate your productivity %, you can take your Targeted Worked FTE (Budget)/ Actual Worked FTE. This will closely approximate your Productivity Index.
  - To calculate the number of worked FTEs for the pay period, simply take your Total Worked Hours/80 (80 hrs in a pay period)
- To calculate how much the addition (or reduction) of an FTE in a given pay period can be accomplished by adding or subtracting 80 hours (# of hours a FTE would work in a PP, regardless of position) to Actual Hours Worked. To re-calculate your NEW productivity %, you can take your Budgeted Hours/Actual Hours.
  - FTE (1.0)/PP = FTE across the pay period

P F B

ashp

Department of Pharmacy Benchmarking

- Value Leader
  - Cone Health and Moses Cone Hospital and Premier Benchmarking Report
- Knowledge Driven
  - Premier Benchmarking Reporting Methodology
  - Moses Cone Department of Pharmacy FTE Updates since November 2014
  - The Lazarus Report
- Healthy Communities
  - Moses Cone Department of Pharmacy Opportunities for Improvement
- Innovation and Transformation
  - Opportunities with the Premier Benchmarking Report and Conclusions

P F B

ashp

ashp LEADERS CONFERENCE

Developing the Budget and Monitoring Performance

Annual Budgeting

- ❖ Goal of the budget: forecast of revenue and expenses
  - Describes the hospital's/department's specific financial goals for each account for the fiscal year (July-June or October-September)
- ❖ You see those values on the budget summary
- ❖ Timeline – 1 year horizon and reflects planned objectives in the "short-term"
- ❖ Integration of planning and budgeting
  - Volume trends, payment arrangements, new ventures/business opportunities
- ❖ Timely, considerable involvement in staff from all levels – careful attention and planning

P F B

ashp

A Primer on Hospital Accounting and Finance 5th edition

Annual Budgeting

- ❖ Budgets are always changing depending on the environment
- ❖ Annual budgets "may be" changed in the beginning part of the year, if ever
  - Fixed
- ❖ Often, we are left explaining variances throughout the year
  - Variance analysis – positive and negative
    - Quantifies the difference between actual and budgeted values for resources, revenues or expenses
- ❖ Larger the variance – the greater the attention
  - Also need to look at trending as well
- ❖ Lets take a look!

A Primer on Hospital Accounting and Finance 5th edition

P F B

ashp

FY 2016 Budget Calendar

- ❖ Finance populates department budgets into system
  - Throughout June – ***This is a KEY date!***
- ❖ Program changes due to Finance
  - June 30
- ❖ Division Presidents, VPs, and Directors review budgets with their designated Finance Director as needed
  - July 13 – 31
- ❖ Budget updates/revisions approved by EVPs
  - August 3 – 13
- ❖ Budget document delivered to Board Finance Committee
  - August 21

P F B

ashp

Annual Budgeting Summary

- ❖ Budget – description of a financial plan
  - ❖ List of estimates of expenses and revenues for a stated period of time
  - ❖ Predictive plan, describes a period in the future
- ❖ Budget importance
  - ❖ Adherence to budget is a predictor of financial stability
  - ❖ Financial implications - Health Care System Level
    - ❖ Financial bond rating
    - ❖ Affects ability to borrow money, amounts, and rates

P F B

Supplements to Annual Budgeting

- ❖ Flexible Budgeting
  - Used on a monthly basis
  - Effectively measures budget to actual variances
  - Expense categories are based of estimated activity from month to month
    - Retroactive change as each month is finalized
  - Allows leaders to see the results that reflect the actual level of department activity for each line item
    - E.g., Patient days, Outpatient visits, etc.
- ❖ Rolling Forecasting
  - Helps identify gaps in performance
  - Often a quarterly process
  - Used from for budget planning – long range (3-5 years)
  - Compares quarters of projections to the strategic financial plan assumptions and expected trajectory
  - Focuses on forecast grouping rather that line item variances

A Primer on Hospital Accounting and Finance 5th edition

P F B

ashp

Budget Process

- October 1 – September 30 – Fiscal Year
- Budget upload in June (ish)
- Current FY financial data used to project upcoming FY budget
- Annualized data
  - Start with
  - Commonly 9 months, but not always
  - Convert a rate of any length into a rate that reflects the rate on an annual (yearly) basis
    - (9 month total/9 * 3) + 9 month total

P F B

ashp

Operating Budget (Expenses)

Key Pharmacy Expense Classes:

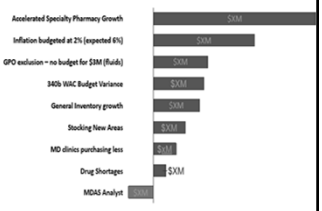
- **Drugs Chargeable – TOTAL DRUGS**
  - FY16 ~$17M
  - Drugs, blood products (Albumin, Factors)
    - Blood Factors(FY14) ~ $1M
  - Fluids – Expense Increase
  - Solutions and Sets (CSTD, IV Sets)
  - Anesthesia Gases
  - Lease and Rental
- **Labor**
  - People (Salaries and Wages) – FY16 $7M
    - Productive Time – worked hours
    - Non Productive Time – PTO/PAL
  - Employee benefits
- **Other**
  - Travel, Software, Drug Information References and Subscriptions

P F B

ashp

FY Drug Budget Drivers

- Patient volumes
  - Seasonality
- Contracts
  - IV Fluids
- Inflation - First to go
  - 4-6%
- New Entities
  - Specialty Pharmacy
  - Biologic and oncology agents
  - Antifungals
  - Other key items (CV drugs)
- Generics
- *Projecting Future Drug Expenditures – Annual*



P F B

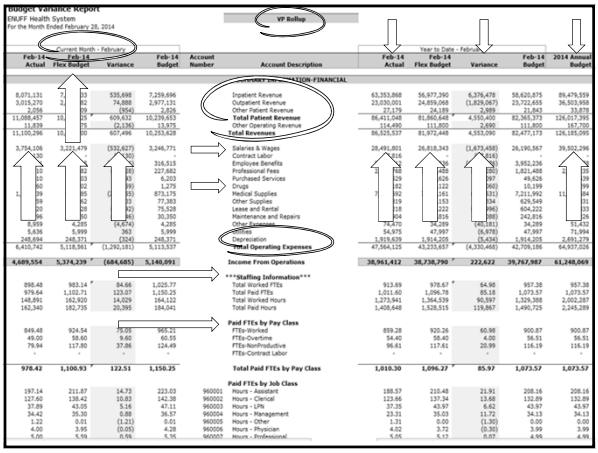
ashp

Pharmacy Financial Basics
Budget Tactics and Takeaways

- Start preparing early
  - You and your staff
  - Learners
- Don't pad
  - Lose credibility
- Use data & be accurate
  - National benchmarks
  - Organizational historical data
- If you take a risk, make it known
  - Transparent
- If changes made, document!
- Specialty budget – WOW!

P F B

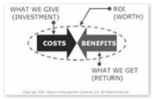
ashp



Tools

Return on Investment (ROI)

- A ratio that divides the net benefit by the total amount of the investment
- A straightforward financial tool that measures the economic return of a project or piece of equipment
- Amount of bang for your buck
- Templates



$$ROI = \frac{\text{(Gain from investment – Cost of investment)}}{\text{Cost of investment}}$$

P F B

ashp

Return on Investment (ROI)

- Why is an ROI analysis needed?
  - Competing needs for limited capital/ operating resources forces us to choose between various projects/investments
  - Increases the likelihood of optimal financial results from investments
  - Helps determine if the implementation of the service or technology will result in positive or negative financial return
- Templates - $39.95

P F B

ashp

Return on Investment (ROI)

Choosing a particular ROI method will depend on the preferences of senior management (usually the CFO). The method used is not as important as the consistent application of the methods.

FOUR WAYS TO CALCULATE ROI

Method	Answers the question…	Expressed in…	Typically used for…
Breakeven Analysis	How many sales do we need to recoup the investment?	Units sold	Market-focused projects, such as product development; entrepreneurial endeavors
Payback Period	How long will it take to recoup the investment?	Months or years	Projects with a heavy upfront investment, such as facilities projects; productivity projects that accumulate benefits over time
Net Present Value (NPV)	How much is this project worth to the business?	Dollars	Projects with large expenditures
Internal Rate of Return (IRR)	What rate of return will this project deliver over its lifecycle?	Percentage	Projects that the company reports on externally, especially those that require you to borrow money

P F B

ashp

Pharmacy Financial Basics - Lessons

- Work with a leader in Finance
- Adhere to financial standards and partner with finance and decision support to know what they expect
  - Enhances credibility
- Email colleagues for good external and internal templates
- Develop a standard template for use within your department
  - If you don't have one, develop one – or ask someone
- Understand the difference between hard and soft savings

P F B

ashp

Pharmacy Financial Basics - Lessons

- Always include ROI in business case for any new program or service
  - Shop your draft – understand it from others perspective
- Become savvy with spreadsheets
  - Better yet…hire a business manager skilled in ROI analysis
- Show to your boss prior to presenting
- Be creative
- Don't leave it until the end – they take time!

P F B

ashp

Building a Business Plan

- Agenda
- Executive Summary
  - Document that should be written to the level of the audience (administration vs. clinical)
  - SBAR
- Business Need Statement
  - Why is this important
  - Document outlining the external services you are trying to provide for a potential "business" partner (stakeholder)

P F B

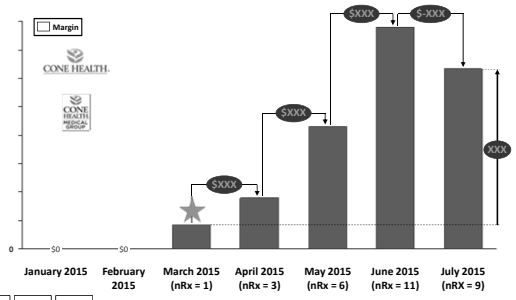
ashp

Building a Business Plan

- Business need – Analysis
- Project Overview – Options
- Schedule
  - Timelines – Gantt Charts
- Impact
- Risks
- Financials
- Summary of Options
  - Remember… this can be thought of as a marketing guide (stress the positive aspects of plan, work to clear any potential roadblocks)
  - References
- Stakeholders
  - E.g., Contracts and IT

P F B

Hepatology (RCID Clinic) Specialty Prescription Margin - Example



P F B

ashp LEADERS CONFERENCE

Value-Based Care

The Impact of an Emerging New Business Model - Elements of Change in the Old/New Business Model

- Healthcare industry has started a transition to a value-based business model from an activity or volume-based, fee-for-service model that has been in place since the 1960s
- The new model is profoundly different than the traditional model in almost every respect.
- The value-based model will shift how providers deliver and are paid for services, as described in this section.

Element of Change	Today	Future
Care focus	Sick care	"Healthcare," wellness and prevention, disease management
Care management	Manage utilization and cost within a care setting	Manage ongoing health (and optimize care episodes)
Delivery models	Fragmented/silos	Care continuum and coordination (right care, right place, right time)
Care setting	Office/hospital	Ambulatory, home, virtual
Quality measures	Process-focused, individual	Outcomes-focused, population-based
Payment	Fee for service	Value-based (outcomes, utilization, total cost)
Financial incentives	Do more, make more	Perform better on measures, make more
Financial Performance	Margin per service, procedure (bed, physician, etc.)	Margin per life

Source: Kaufman, Hall & Associates, LLC

P F B

Pharmacy Financial Basics

- Cost reduction (elimination of direct expense)
  - Drug costs
  - Personnel/FTE removed from budget
  - Reducing cost of harmful medication errors
  - Reduction in agency nurse use
- Cost avoidance (avoiding future expense)
  - Slowing the drug cost trend curve
  - Preventing inappropriate use of a new drug
  - Adding robotic dispensing technology that will enable you to grow volume without adding new personnel
  - Preventing cost of harmful medication errors

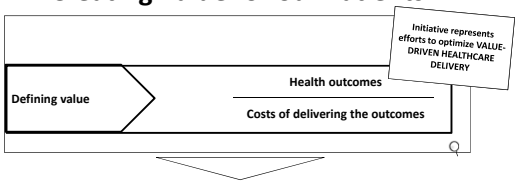
P F B

Pharmacy Financial Basics

- Patient safety
  - Reduced error, preventing cost of harmful medication errors
- Improved operational efficiency
- Improved throughput
  - MD efficiency
- Saved nurse/physician time
- Reallocation of FTE
  - More nurse time at the bedside

P F B

Creating Value for our Patients

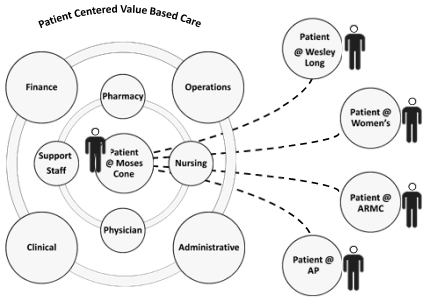


- **Health outcomes** = the full set of patient health results over the care cycle
- **Costs of delivering outcomes** = the total costs of care for a patient's condition over the care cycle
  - ✓ **Better health is the goal, not more treatment**
  - ✓ **Better health is inherently less expensive than poor health**

P F B

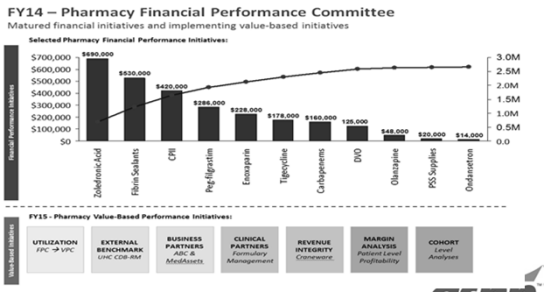
Source: Value-Based Health Care Delivery; Michael E. Porter, June 22, 2011: Slide courtesy of Andy Nelson UNC Medical Center

Value-Based Care



P F B

Financial Performance Committee → Value Performance Committee



P F B

Pharmacy Financial Basics

Common Hard Saving

- Reduction in unit cost of operations
- Reduction in unit cost of production
- Reduction in transaction cost
- Reduction in overhead cost
- Reduction in transportation cost
- Reduction in manpower
- Increased throughput, resulting in increased sales or revenue

Common Soft Savings

- Reduction in cash flow
- Reduction in need for working capital
- Avoidance of capacity enhancement
- Conformation to changes in the law
- Increased safety in the workplace
- Increased employee satisfaction
- Increased customer satisfaction

P F B

www.isixsigma.com/implementation/financial-analysis/hard-and-soft-savings-what-counts-can-be-counted/

Pharmacy Financial Basics

- Metrics that matter
  - Transitions of Care
  - Readmission Reduction
  - Core Measure Compliance
    - Value-Based Purchasing
  - HCAHPS / Patient Satisfaction
  - Cost Reduction
    - Yes, that you'll take out of your budget
  - NEW Revenue Streams
    - Clinic Revenue
    - Add expense to your budget
  - Medication Error and Quality Metrics

P F B

Pharmacy Financial Basics References

- *Financial Intelligence* by Karen Berman and Joe Knight
- Wilson AL. *Financial Management for Health-System Pharmacists*. ASHP 2009

- *Healthcare Finance: An introduction to Accounting and Financial Management*, 5th edition.
- Journals:
  - Healthcare Financial Management
  - Harvard Business Review

P F B

ashp LEADERS CONFERENCE

Departmental Operating Reviews

Departmental Operating Review

- To culturally embed the Pharmacy Departmental Operating Review series, the department and its leadership created 5 central governing and anchoring series tenants:
  - Defining area-specific goals as a means to improve operational standards under the Organization's pillars of excellence: Value Leader, Knowledge Driven, Healthy Communities, Innovation and Transformation
  - Provide pharmacy leadership with routine performance reports for defined operational groups while promoting and demonstrating connectivity across all cost centers housed within the Department
  - Promote the creation of dashboards that illustrate best practices and current standards within the Department
  - Serve as a venue to plan and discuss future avenues for revenue growth and expansion of the Medical Center's Department of Pharmacy practice model
  - Encourage staff involvement in operational objectives and initiatives by having them take part in the DOR series presentation, both in assembly and conveyance of the final presentation deliverables, thus supporting and upholding the employee crafted values of our Department

P F B

Granko RP and Lamm M. Promoting pharmacy business success through the implementation of a Departmental Operating Review Series. *Am J Health Syst Pharm* 2015; 72:610-613.

Departmental Operating Review Planning Phase

- The Departmental Operating Review series will require a planning phase prior to a scheduled go-live month. The following phases will take place for each management area prior to go-live.
- **Phase I**: Preparatory Meeting with Teams (May 2013)
  - Associate/Assistant Directors meet with teams to discuss/perform mock DOR
  - Build DOR for area based on 6 pillars of excellence
  - Develop area-specific dashboard
  - Provide recommendations
- **Phase II**: Presentation to Team 1 (June 2013)
  - Report area-specific DOR objectives
  - Display area-specific dashboard
  - Receive and incorporate recommendations from Team 1
- **Phase III**: Finalize Area-specific DOR (July 2013)
  - Finalize area-specific DOR
  - Finalize area-specific dashboard
  - Prepare for Departmental DOR go-live based on schedule below (August 2013)

P F B

DOR Schedule and DRAFT Agenda

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Hospital	X			X			X			X		
Administrative Services and Acute Care Core Operations		X			X			X			X	
Ambulatory Care Services			X			X			X			X
Acute Care Services and Medication Use Advancement (pre-Hospital)	X			X			X			X		
Departmental Overview (post-Hospital)	X			X			X			X		

- Value Leader
  - Department of Pharmacy Finance
  - Department of Pharmacy Productivity
- Knowledge Driven
  - Employee Partnership Survey
  - Performance Scorecard
  - On-going Quality Projects
- Healthy Communities
  - Joint Commissions Readiness Plan
  - PGY1 Residency Program and Publication History
- Innovation and Transformation
  - 4 North Pilot
  - Specialty Pharmacy – Ambulatory Strategy

P F B

Conclusion

- Enhance your financial vocabulary
  - References
- Work to understand the breadth and depth of your Pharmacy's business
  - Acquire different types of pharmacy reports
  - Understand and work to implement fundamental concepts of budgeting and its process
- Build up more efficient clinical operations and improve quality of patient care
  - Sustainable modeling for now and the future
- Domain knowledge in financial management improves your communication with financial team
  - In and outside of your Department - Finance and Non-Finance staff
  - Educate others
- Use these tools to build and further promote the brand of pharmacy
  - Dashboards and Department Operating Reviews

P F B

Acknowledgments and Questions

- ASHP
- David Chen
- Rick Couldry
- John Pastor
- Steve Rough
- Scott Knoer
- Past Boot Camp Contributors and Faculty
- Attendees

Robert P. Granko, PharmD, MBA
Robert.Granko@conehealth.com

P F B

ashp LEADERS CONFERENCE

Alignment of Skills and Strengths: Building Your Team to Meet the Demands of Tomorrow

Sam Calabrese, B.S.Pharm, MBA, FASHP
Associate Chief Pharmacy Officer
Cleveland Clinic
Cleveland, Ohio

Objectives

- Describe the difference between change and transition
- Identify strategies to manage change and transitions
- Describe methods to maintain employee engagement during change

Definitions

- Change – situational
  - ❖ Focus on the outcomes
- Transition – psychological
  - ❖ Process that people go through as they come to terms with a change
- Terms are not interchangeable

Phases of Transition

"Transitions start with an ending and ends with a beginning."

ENDINGS	NEUTRAL ZONE	BEGINNINGS
• Loss • Letting go • Getting closure • Saying good-bye	• In-between time • Chaos • Clean slate	• Being "with it" • The new chapter • Renewal

Getting people through the three phases is essential to achieving change

Mutual Dependence

Badly planned or implemented change creates painful transitions

TRANSITION

CHANGE

Unmanaged transition makes change less likely to work

Create A sense of Urgency

- Make the status quo seem more dangerous than launching into the unknown
- "Sell" the problem
- Identify and discuss major crises or opportunities

How do you get people to let go?

- Identify who's losing what
  - ❖ Describe the change in as much detail as possible
  - ❖ What are the secondary changes that will result
  - ❖ Who is going to lose what
  - ❖ Notice that losses may not be "concrete"
  - ❖ Is there something that will be over for everyone

Resistance

- It's the transition, not the change that people often resist
  - ❖ Loss of their identity and their world
  - ❖ Disorientation in the neutral zone
  - ❖ Risk of failing in the new paradigm

Strategies to manage endings

- Don't argue with what you hear
- Don't be surprised by overreaction
- Acknowledge loss openly and sympathetically
- Expect and accept signs of grieving
- Compensate for their losses

Form a guiding coalition

- Engage your informal leaders
- Small/medium group that believes in the change
- Work as a team with formal leaders to move change forward

Provide a Vision

- A picture of the future
  - ❖ Help direct the change effort
- Easy to communicate
- Appeals to the end users
- Should be able to communicate in 5 minutes

Communicate the Vision

- Over communicate information
  - ❖ Define what is over and what isn't
  - ❖ Define the end
- Use all vehicles possible
  - ❖ Meetings
  - ❖ Emails
  - ❖ Newsletters
- Treat past with respect

Leading through the Neutral Zone

- Old ways over and new ways not working well
- Anxiety rises and motivation falls
- Productivity suffers
- Old weaknesses may reemerge
- People become polarized
- More open to new ideas

Empower others to act on the Vision

- Capitalize on the chaos by encouraging folks to innovate
- Remove obstacles
  - ❖ Change systems/people that undermine the vision
  - ❖ Organizational structure
  - ❖ Negative employees
  - ❖ Negative leaders

Enhancing the Neutral Zone: Assisting with empowerment

- Capitalize on doing things differently
  - ❖ Restraints of innovation are weakened
- Question the usual way
- Provide training in innovation techniques
- Encourage experimentation
- Brainstorm new answers to old ideas

Enhancing the Neutral Zone: Assisting with empowerment

- Create temporary systems
  - ❖ Protect people from further changes
  - ❖ Review policy and procedures
  - ❖ Reporting relationship changes
  - ❖ Set short range goals
- Use the neutral zone creatively

A New Beginning

- Will take place only when individuals are ready to make an emotional commitment to do things a new way
- Resistance
  - ❖ Reminds them the old way is ending
  - ❖ Possibility that new way won't work
  - ❖ Reminder of old failures
  - ❖ End of Neutral Zone flexibility

Create Short term wins

- Keeps the urgency level up for long term projects
- Plan for visible performance improvements
- Recognizing and rewarding employees
- Begins the "hard wiring" of new processes

Reinforce the New Beginning

- Provide consistency
  - ❖ Policies and procedures
  - ❖ Own actions
  - ❖ Rewards
- Hire, promote, and develop employees who can implement the vision
- Celebrate success / Maintain engagement

Engagement Drivers in Times of Change

1. Build trust through communication
2. Seek team participation to manage change
3. Display Serving Leadership qualities

Engagement Drivers in Times of Change

1. Build trust through communication
   - Proactive, timely and transparent
   - Be specific - include "what," "why," and "how" details
   - Repeat via multiple communication channels
   - Have crucial conversations

Crucial Conversations

- What makes a conversation "crucial" vs. typical?
  - ❖ First, opinions vary
  - ❖ Second, the stakes are high
  - ❖ Third, emotions run strong

Crucial Conversations

- How do we typically handle crucial conversations:
  - ❖ We can avoid them
  - ❖ We can face them and handle them poorly
  - ❖ We can face them and handle them well

Crucial Conversations

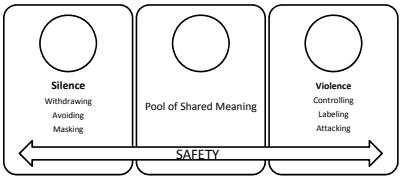
- Why don't crucial conversations tend to go well?
  - ❖ Emotions tend to rule
  - ❖ Your body physically reacts
  - ❖ We are under pressure
  - ❖ We are stumped
  - ❖ We act in self-defeating ways

The Principles of Crucial Conversations

Get Unstuck
How to spot the conversations that are keeping you from what you want.
Start with Heart
How to stay focused on what you really want.
Learn to Look
How to notice when safety is at risk.
Make it Safe
How to make it safe to talk about almost anything.
Master My Stories
How to stay in dialogue when you're angry, scared, or hurt.
STATE My Path
How to speak persuasively, not abrasively.
Explore Others' Paths
How to listen when others blow up or clam up.
Move to Action
How to turn crucial conversations into action and results.

Solution : Dialogue

- Free flow of meaning between two or more people



Get Unstuck

- Recognize crucial conversations
  - ❖ What conversations am I not holding or not holding well
  - ❖ How do you feel when in a crucial conversation
  - ❖ What emotions are you feeling regarding the discussion
  - ❖ How do you control your emotions
  - ❖ Identify someone to role-play

Start with Heart

- Work on me first
- Focus on what you really want
- Refuse the Fool's Choice

Work on me first

- Winning
- Punishing
- Keeping the peace

- What effect do they have on the pool?

Focus on the wants

- What do I really want for myself
- What do I really want for others
- What do I really want for the relationship

- How would I behave if I really wanted these results

Avoiding the fools choice

- Silence vs Violence response
- Search for the "and"
  - ❖ What do you really want
  - ❖ What you really don't want

Learn to Look

- Look for when a conversation becomes crucial
- Look for content and conditions
- Look for silence and violence
- Learn to look for your own Style Under Stress
  - ❖ Physical
  - ❖ Emotions
  - ❖ Behavioral

Mutual Purpose

- Common Objectives
- Need to have an open dialogue
- Mutual purpose is the foundation of trust
- Incorporate mutual respect

Master My Stories

- How to stay in dialogue when you're angry, scared, hurt
- You and only you create your emotions
- The stories we create generate our emotions

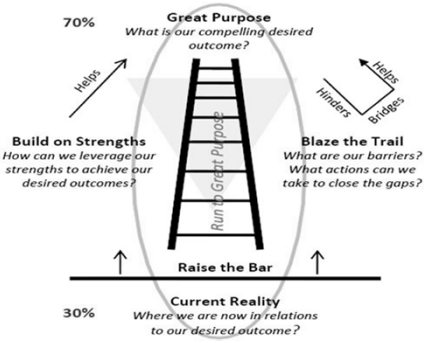
Master My Stories

- Am I pretending not to notice my role in the problem?
- Why would a reasonable, rational, and decent person do this?
- What should I do right now to move toward what I really want?

Engagement Drivers in Times of Change

2. Seek team participation to manage change
   - Get team feedback and suggestions
   - Create a process for collecting ideas
   - Ask team for their communication preferences

Structural Tension



http://www.servingleaderacademy.com/toolkit.html

THINKING ENVIRONMENT

- Explore an idea with a group
- Slow down a conversation
- Hear from everyone

THINKING ENVIRONMENT

- OPENING ROUND
  - ❖ Up to 2 minutes each
  - ❖ Ask the group: *"What is your current thinking about ____?"*
- OPEN DISCUSSION
  - ❖ 5 minutes total
  - ❖ Ask the group: *"What do you notice now that you've heard everyone's thinking? Is anything present that wasn't before?"*
- CLOSING ROUND
  - ❖ Up to 2 minutes each
  - ❖ b. Ask the group: *"What is your freshest thinking about _____? "*

Engagement Drivers in Times of Change

3. Display Serving Leadership qualities

"The ripple effect of a leader's enthusiasm and optimism is awesome. So is the impact of cynicism and pessimism.

Leaders who whine and blame engender those same behaviors among their colleagues.

Spare me the grim litany of the 'realist.' Give me the unrealistic aspirations of the optimist any day."

Engagement Drivers in Times of Change

3. Display Serving Leadership qualities

- "Own" the enterprise-wide decisions
- Use your emotional intelligence
- Be visible with the team
- Balance empathy with channeling team energy

Summary

- You have to end before you begin
- Between the ending and the beginning there is a gap
- The gap can be creative
- Emotional responses can occur during transition
- New beginnings occur when individuals are emotionally ready to commit
- New beginnings must be reinforced

Reference

- Bridges, W. Managing Transitions, Making the Most of Change. 2nd ed. New York, NY: Da Capo Press, 1991.
- Kotter, John P. "Leading Change. Why transformation efforts fail", Harvard Business Review, January 2007, pp 92-107.
- Patterson, Grenny, McMillian, Switzler. (2012). *Crucial Conversations.* New York: McGraw Hill.

Managers Boot Camp 2015

Human Resources Management Case Study

Case:

Melissa is the Director of Pharmacy at Anytown Hospital, a 150 bed community hospital. Melissa has been in her role for 8 months, following completion of her PG2 Administrative residency and MBA. She was hired on by Jim, the Administrator of Professional Services, shortly after he terminated the previous director due to three years of declining employee engagement scores. Melissa's main priority is staff development and focusing on areas of concerns determined by past surveys. Jim asked Melissa to prioritize the concerns of "my work unit provides high-quality care" and "my work unit want to go above and beyond what's expected of them".

This morning, Jim called Melissa to let her know that Chief, Division of General Surgery Anesthesia, Dr. Smith paged him to report a medication error made by the OR pharmacy. Dr. Smith reported that the heparin drip that was provided for his patient had apparently been made incorrectly and that patient received a 10 times overdose. The patient had significant bleeding post op and required both additional treatment and time in the OR to address this. Dr. Smith expressed to Jim that he is grateful that his team's quick response saved the patient's life.

During Melissa's review of the incident she discovered that Jerry was the pharmacist staffing in the OR. Jerry was the Assistant Director of Pharmacy and Interim Director of Pharmacy prior to her arrival. She had asked him to step back into staffing due to his caustic nature of his interpersonal skills. She assigned him to the OR Pharmacy to keep him away from the other staff. Jerry has about 6 months till he can retire.

Human Resources Management Case Study (continued)

Melissa was also meeting with Jerry biweekly for the last three months due to complaints from Anesthesia providers about his communication skills. Jerry received verbal warnings and now is on a written performance improvement plan drafted by HR and Melissa. The next step is a final reminder, followed by termination if improvement can't be documented.

Melissa scheduled an appointment with Jerry at 2:30pm tomorrow to review her findings.

Assignment:

You are asked to put yourself in Melissa's role and answer the following questions to prepare for the crucial conversation tomorrow.

1. What are the goals for meeting with Jerry tomorrow?
2. What background information do you need to gather before you talk to Jerry?
3. What strategies are you going to use to communicate with Jerry in spite of his caustic nature?

Role play by facilitators:

The scenario you observed between Melissa and Jerry demonstrates an interaction where (1) stakes are high, (2) opinions vary, and (3) emotions run strong.

Reflection Assignment:

Please answer the following questions to critique Melissa's discussion with Jerry.

1. What factors lead to the negative exchange between Melissa and Jerry?
2. What did Melissa gain by having this conversation? Did she reach her goal for the meeting?

Managers Boot Camp 2015

Interactive Workshop Case Study

The Case: A fictional, but realistic organization described below has the goal of elevating pharmacy services in a manner which maximizes the quality of patient care and overall cost efficiency. This organization will serve as the basis for an interactive case workshop exercise throughout the program. Below is a brief summary of the organizational background, pertinent pharmacy department information, and political landscape which provides essential information to assist with completing the workshop exercises. **It is necessary that you read this case prior to attending the workshop**.

**NOTE: It is not necessary that participants memorize every fact about this organization. Rather, it is important that all workshop participants read the case once or twice to develop a basic understanding prior to the workshop.

Organizational Background

This facility is a community teaching hospital (700-bed, tertiary-care, not-for-profit facility) located in a city of 250,000 people, providing acute care to both adult and pediatric patients throughout the greater geographical region. Approximately 3/4 of the hospital beds are allocated for adult patient care (550 beds), and of these, 80 are ICU beds and 100 are dedicated to "The Women's Center", a well renowned maternity service. The 150 pediatric beds are recognized as the facility's children's hospital and treated as a separate institution within the hospital, including a 20-bed pediatric ICU and a 25-bed neonatal ICU. The hospital has a network of 25 clinics that were recently acquired and incorporated as "Provider-Based Clinics" of the hospital. This network includes 4 oncology clinics that combine for a total of 60 oncology infusion chairs. The remaining clinics provide a variety of ambulatory services including a non-oncology infusion center, dialysis, cardiac rehab, radiology, same-day surgery, pediatric special procedures, and several primary care and specialty physician office clinics.

The hospital considers pediatrics, maternal & fetal medicine, oncology, and cardiology to be its four "Centers of Excellence".

Pertinent Pharmacy Department Information

The pharmacy department has approximately 100 FTE's (53 technical and support staff, 25 unit-based decentralized clinical pharmacists, 8 clinical specialists, 8 managers, 6 operations pharmacists and 3 PGY1 pharmacy residents) and is centrally located in the basement of the hospital. The pharmacy functions in a decentralized medication distribution model with automated dispensing cabinets located on all of the nursing units and procedure areas and satellite pharmacies in the OR and children's hospital. The department has a USP <797> compliant clean room serving adult and pediatric patients. The pharmacy has an annual inpatient drug budget of $33 million and an outpatient (clinic, procedure area, infusion) drug budget of $42 million. The pharmacy salary and benefits budget for all areas is $9.2 million annually. Top drug expenditures by therapeutic class include anti-infective agents, blood products and hemostasis agents, immunosuppressive medications, chemotherapy agents, anticoagulants, and blood stimulation agents. Chemotherapy and anti-infective drug expenses have

risen at a rate of 15% per year over the past 5 years, while anticoagulant and hemostasis agent drug expenses have been remarkably low over the past five years when compared to peer-group hospitals.

Clinical pharmacists practice in a decentralized model [M-F two 8-hour shifts per day (1st and 2nd shift) and Sa-Su one 8-hour shift (1st shift)]. They rotate to the decentralize area 80% of their time while the remaining 20% of their time is spent covering the central pharmacy and the pediatric satellite. Decentralized pharmacists review and verify all inpatient medication orders (CPOE is used), and provide some targeted clinical services such as IV to oral conversions, renal dosing, and supporting the pharmacotherapy consult service including pharmacokinetic dosing and medication reconciliation on admission. In addition, technicians are deployed throughout the hospital, working with pharmacists to obtain medication admission histories and facilitating the medication reconciliation process. Pharmacists also participate on patient care rounds when they have time and as requested by medical staff. 14 of the 25 decentralized pharmacists have completed PGY1 practice residency training programs within the past 5 years, and six are board certified.

The Department of Pharmacy also offers a ASHP-accredited residency training programs dedicated to developing clinical practice competencies. The three PGY1 pharmacy residents provide decentralized clinical coverage during the week (M-F), including patient care rounds participation, and provide staffing coverage every third weekend and one evening shift every 3rd week.

In addition to the three PGY1 residents, approximately 14 pharmacy students complete advanced hospital experiential rotations during their fourth year, but they all have to travel over an hour from their school each day or find housing in the area for the rotation. Two months ago, a new school of pharmacy initiated its inaugural class at a renowned local university. The Dean of the school has requested meetings to discuss opportunities for his students to engage within the department.

A dedicated preceptor works closely with each resident as well as the pharmacy students and is ultimately responsible for all pharmacotherapy related outcomes and student/resident education. Learning is not handled in a layered fashion from pharmacist to resident to student.

Of the 8 clinical specialist pharmacists, all have specialty residency training (PGY2) as follows – one each in critical care, cardiology, pediatrics, and infectious diseases; two each in oncology and internal medicine. All are board certified and provide weekday clinical services in select areas of the hospital; they routinely participate in patient care rounds in their areas of specialization, precept student clinical rotations, and provide teaching for medical students and residents. They review medication orders entered in CPOE when they have time and they rarely interact much with patients. The infectious disease and oncology specialists spend part of each week providing pharmacotherapy reviews and patient education in their respective clinics.

Lastly, the hospital operates an outpatient pharmacy which fills about 250 prescriptions per day. Prescription volumes have been flat for the past five years, presumably due to a poor location and lack of marketing. Margins are on the decline with last year's financial performance being at break even. A recent study indicates that only 20% of inpatient discharge and clinic prescriptions are being filled in the outpatient pharmacy, and only about 10% of hospital employees use the outpatient pharmacy as their primary pharmacy provider. The pharmacy accepts the large majority of prescription insurance plans and about 70% of the volume is billed to a third party plan (including the plan carried by hospital employees), about 10% through Medicaid and the other 20% is cash and other miscellaneous accounts (i.e. local workman's compensation plan, charity fund, and others).

Political Landscape and Impact of Health Care Reform on the Health-System's Future

Medicare reimbursement and pay-for-performance private insurance agreements make up the vast majority of the hospital revenue sources. Most of the private insurance agreements utilize recognized ambulatory care measures to set quality standards for reimbursement. In 2011, the clinics' chronic care scores were below the regional averages (17% of patients have uncontrolled cholesterol [regional average is 8.5%], 32% of hypertensive patients are meeting blood pressure goals [regional average is 45.7%], and 19% of diabetic patients have uncontrolled hemoglobin A1c [regional average is 11.3%]). As a direct result of these publicly reported performance indicators, 4% of the clinics patients transferred out of the clinics' care in the last fiscal year, and the clinic did not receive maximal reimbursement from insurers. Pharmacist involvement in ambulatory practice is limited to partial coverage of the infectious disease and oncology clinics. The organization also provides the majority of services for a local self-insured company (ACME, Inc). This self-insured company is the largest in the area, employing 15% of the community's residents, and has noticed a 13% increase in health-related absenteeism over the last year.

Also, the organization is reeling from the impact of the 2012 CMS health care payment reform system based on readmissions, value-based purchasing and hospital acquired conditions. The hospital is currently 7th in their regional 8-hospital peer group on their Hospital Compare Report in most quality measures. Their HCAHPS scores have not improved in the past two years, and their medical readmission rates are currently 22% (with a cost per readmission of $22,000) with 2,900 readmissions documented in the past year. The statewide average readmission rate for peer hospitals is just 11.3%. Patient satisfaction scores continue to fluctuate (25% decrease in the last three months)—the lowest performing areas include the ED and outpatient clinic units.

Medicare reimbursement reductions, private insurance payment reductions, lower-than-expected patient volumes in all care settings (except for surgeries), poor investment returns and a major information technology system downtime left the hospital with a 40 million dollar shortfall in operating margin compared to budget at the end of FY 13.

The Senior Executive Team has been constantly changing over the last 5 years; the CEO of the organization has been in healthcare for 40 years (3 at this hospital) and has publicly announced that he "took this job to retire from it in the near future". The pharmacy director reports to the Vice President of Operations (who is also the CNO) with a joint accountability (dotted-line reporting) to the Associate Vice President of Resource Management. Both of them report to the Executive Vice President of Operations who reports to the President/CEO of the hospital. In response to the budget shortfall, the hospital instituted a plan for a reduction in labor force (RIF) of 8% across the organization beginning with this fiscal year. Ancillary and central services were the most affected as they are seen to be inefficient and often redundant. Pharmacy services are considered a "clinical service" and thanks in large part to the support an advocacy of the VP/CNO, clinical services bore a much smaller portion of the FTE cuts. The pharmacy department was given targets for 10% reduction in drug expenditures, 6% reduction in operating expense from the in-patient budget and only a 4% reduction in workforce. All cost centers have been challenged to find creative ways to increase revenue on both in-patient and outpatient areas. Along with the focused cuts, executive leaders have made it clear that support of new programs will be given to safety initiatives, programs with measurable outcomes improvements (readmission rates, Core Measure scores, Ambulatory Care Measure scores, patient satisfaction), and programs supporting the

"Centers Of Excellence".

Overall, medical staff groups are extremely "pro-pharmacy" and routinely embrace the role of the pharmacist within their services. A notable exception are the internal medicine and cardiology physicians who are known for a change resistant culture and do not feel that they have received a consistent high level of service and the focus that they are due from the clinical pharmacists or pharmacy distributive services. They are, however, united with all hospital physicians in their respect and appreciation for the technicians who perform admission medication histories. In addition, the ED Medical Director is the chair of the Hospital Safety Committee and routinely contacts the pharmacy leadership team and clinical pharmacists to discuss medication errors, need for drug use evaluations, and patient care scenarios within the emergency department. Recently, there have been a few high-profile adverse medication events which he has discussed with the Senior Executive Team as well as research indicating that medication misuse is prevalent in the community:

- Patient presented to the ED with a bag of prescriptions bottles that included 3 different beta-blockers from two different pharmacies that they took regularly.
- A patient seen in the primary care clinics was prescribed metformin despite a calculated creatinine clearance of 26 mL/min (serum creatinine = 1.4 mg/dL). The patient later presented to the ED with severe acidosis.
- Patient presented to the ED with multiple Pulmonary Embolisms. The medication history technician discovered an unfilled prescription for Lovenox folded up with the list of medications they take and printed materials from a recent visit to the pre-op assessment clinic.
- Patient was admitted via the ED to a critical care unit for sepsis. Review of the previous admission (only 3 days ago) in the electronic medical record showed that a prescription for IV vancomycin was e-prescribed to a local 24-hour Wally's World Pharmacy.
- Patient seen in the ED for acute abdominal pain and was sent home with TMP/sulfa for UTI. Patient returned in 48 hours and was admitted with significant bleeding and an INR of 10.5. Medication history did not note the patient was taking warfarin 5 mg daily.
- A recent study has indicated that 20% of hospital admissions through the ED are due to inappropriate drug therapy management (non-compliance, wrong drug, preventable adverse drug events, etc) in the home setting.

The hospital has recently undergone a reaccreditation site visit by The Joint Commission and issues were noted with the nurses' ability to answer surveyor questions related to medication reconciliation and documentation of patient education. During one of the patient tracers, a surveyor observed a problem with the discharge medication list, patient education materials, and communication to the next care provider. The hospital has had a nursing-driven discharge process for as long as anyone can remember. The Joint Commission Surveyors also commented on very inconsistent practices within the organization for patient medication teaching.

Pharmacy Department Leadership Retreat

The pharmacy department recently held a strategic planning retreat to brainstorm enterprise-wide advances in pharmacy services which if implemented would provide optimal value to the organization. Consensus was reached that many unprecedented opportunities existed for pharmacy to help lower cost, improve reimbursement, and maximize quality of patient care and customer service within the inpatient and ambulatory settings with particular emphasis on transitions in care. It was recognized that the organization's future financial sustainability is going to be very closely tied to its' ability to improve

quality and efficiency while at the same time lowering costs, and that this presents great opportunity for the pharmacy department to expand its practice model and provide value to the organization like never before. Specific discussion occurred about opportunities for the pharmacy department to assist at a higher level with the organization's ambulatory care drug therapy management and discharge pharmacy services. At this retreat, consensus was reached that implementing the following new pharmacy programs would help to transition the department into a high performance pharmacy, optimizing its value equation to the organization and to patients.

1. **Develop a new pharmacy intern <u>training</u> program** in collaboration with the local School of Pharmacy that supports both the integration of pharmacy students (without straining existing resources) and the **expansion of the department's pharmacy resident <u>training</u> program** to provide leadership within the program in addition to advancing the pharmacy practice model.
2. Establish **a pharmacist led chronic disease management program** associated with the primary centers of excellence within the health-system.
3. Develop a more efficient and value-added **discharge pharmacy service** with the goal of ensuring that patients are set up to be successful with their therapy post-discharge.
4. Create a new pharmacy service to provide **specialized preventative care** in every setting (including the home) for **patients at high-risk for readmission** to the hospital.

Managers Boot Camp 2015

2015 Manager's Boot Camp Interactive Workshop Exercise Instructions

Total Workshop Duration: 3 hours, 10 minutes

Based on the fictional hospital case, each table will be assigned one of **four** proposed new pharmacy services for which they will develop a business case framework with the goal of obtaining hospital senior leadership approval of the resources required to implement this new service.

The workshop is divided into **four interactive components**. Each workshop component builds upon prior components as well as didactic materials presented throughout the workshop.

Attached is a series of worksheets corresponding to each of the four workshop components. These worksheets will serve as your table's template for completing the business case in a stepwise fashion throughout the workshop, resulting in the creation of a construct for a successful business case for a new pharmacy service.

Title of Business Case Assigned to Your Table:

_____

_____

Get to Know Your Team Members:

_____

Name Place of Employment

_____

Name Place of Employment

_____

Name Place of Employment

_____

Name Place of Employment

_____

Name Place of Employment

_____

Name Place of Employment

Workshop #1

1. Identify topic, introductions.

2. Select a table timekeeper:_____

3. Everyone at the table takes notes on their worksheet

4. Briefly discuss the case and opportunities surrounding the implementation of this new service at your table.

5. Begin creating your business case by working through the following exercise as it relates to your assigned new service:

Proposal Description Summary:

a) Write a 1-2 sentence proposal succinctly describing the service you wish to implement.

Background Information:

Utilize information from the case and your personal knowledge of healthcare to describe in bullet point format answers to the following questions.

a) Why is this issue important (consider changing healthcare landscape, hospital goals)?

b) Briefly describe how the service for which you are developing the business case is currently being provided at the hospital:

c) What internal factors (e.g.; baseline data to demonstrate that a problem exists) and external factors (e.g.; regulatory standards, payment reform measures, etc) will you collect/include with your business case to support your proposal?

.

Stakeholders:

a) Identify at least 6 key stakeholders in the organization related to the service you wish to implement who will either support and/or resist you along the way, and for each list their wins and/or losses as related to the new service; for the opponents propose at least one strategy for overcoming their resistance.

Supporters:

Opponents:

b) List the top-3 key people whom politically you need to align with to support your proposal to maximize your chance of success:

Benefits:

a) Describe at least six benefits to the organization if your new service is implemented (think both "non-financial" and "financial" institutional value). For each financial benefit, indicate whether it is considered "hard" or "soft" by the hospital.

b) Describe metrics that you will measure to determine the impact and success of this project following its' implementation. Describe "how" you will measure each outcome, any resources required to obtain the data, and indicate the timelines for measuring each metric.

You have completed workshop #1.

Workshop #2

Resources Required:

Identify specific resources required (personnel, equipment, space, etc) to implement and maintain the new service, estimate the expected up-front and/or annual cost for each resource) – these serve as inputs into your ROI.

Return on Investment (ROI). – Financial Institutional Value

Using the attached ROI template, develop a basic ROI framework to include in the business case (up-front costs, annual operating costs, hard and soft savings, and net benefits to the organization).

Project Management and Implementation Plan (if time permits)

Starting with the day this project is approved by senior leadership, develop a high-level project implementation plan indicating the top 5-10 major project milestones or key deliverables (actions steps required for success of the project) and timelines for each.

You have completed workshop #2.

Workshop #3

<u>Developing Your 5 Minute Sales Pitch to Senior Leadership</u>

Next, each table should select 1-2 individuals who will deliver a 5 minute sales pitch to Senior Leadership to advocate for support of your new service project proposal and approval of the resources necessary to successfully implement this project. Take the next 30 minutes and use the form on the next two pages to record the key points you wish to make in your 5 minute sales pitch (the individuals selected to deliver the sales pitch should do the recording). This presentation format is a guideline only, you may use it, or you may be creative in developing your own 5 minute sales pitch template and work outside of this structure if you wish. **Creativity counts!!!**

Here is how the 5 minute sales pitch presentations will work (in Workshop #4):

1. 4 tables (one working on each new service being proposed) will be randomly selected to present their 5 minute sales pitch to Senior Leadership. 2 representatives from the selected tables will present this sales pitch to all workshop participants.

2. The assumption is that the written business case developed throughout this workshop will be provided to Senior Leadership for officially considering this proposal. However, due to politics and the short attention span of most members of the Senior Leadership team, the decision on whether or not to support this project will be based on the quality of the 5 minute presentations.

3. While only one table will be selected to present each business case, participants at every table will have a chance to participate in this session. Workshop participants at tables not presenting a sales pitch will have the opportunity to serve as a c-suite panel who will react to the presentation. Following the presentation, the c-suite panelists may ask questions of the presenters, challenge them, and react to the presentation (e.g.; they can play the part of the non-supportive CNO, the dissenting CFO, etc). Their role is to challenge the presenters and have them defend their position to the group.

4. Pay attention, every workshop participant will have the opportunity to vote on the best 5-minute sales pitch and the best c-suite panel reaction during our workshop wrap-up session. **Members of the winning sales pitch and c-suite panel teams receive a prize at the conclusion of the workshop**.

5 Minute Sales Pitch Summary Worksheet

Introduce Yourself
Proposal (succinctly describe the service you wish to implement)
Why is this important? (describe what is currently broken, or why the changing healthcare landscape makes this proposal important for the organization)
Benefits/Outcomes of your proposal (think many stakeholders**)**
Resources Required and estimated total cost of the project

Sell key aspects about the ROI of your project (expect to be challenged here)
Summary of Project Milestones (high level plan for implementation)
Concluding Statement (convincing 30 second wrap-up)

You have completed workshop #3.

Sales pitches will be presented in workshop #4

Managers Boot Camp 2015

Self Assessment Questions

1) Accountable care organizations
    a. Will just involve hospitals
    b. Is another term for pay for performance
    c. Addresses total care through continuum and encompasses pay for performance and cost savings sharing

2) Components of Value Based Purchasing Include:
    a. Process of Care (where the right interventions implemented)
    b. Outcome of Care (unplanned readmission or patient death within 30 days of discharge)
    c. Patient Experience (satisfaction survey results)
    d. All of the above

3) Managers engage in several strategic management processes including:
    a. Situational analysis
    b. Strategy formulation
    c. Strategic implementation
    d. Strategic control
    e. All of the above

4) Elements of a Return on Investment include:
    a. Costs
    b. Financial return
    c. Benefit calculations
    d. Non-financial benefits
    e. All of the above

5) Which is NOT a characteristic of a high power team:
    a. Purpose
    b. Process
    c. Communication
    d. Minimize member participation
    e. Commitment
    f. Trust

Self Assessment Answer Key:

1) c
2) d
3) e
4) e
5) d

ROI Template Worksheet - 2015

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Net Revenue						
Capital Expenses						
Total Capital Expense						
Operating Costs	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
Total Operating Costs	xxxxxxxxxxx					
Hard Savings	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
Total Hard Savings	xxxxxxxxxxx					
Soft Savings	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
	xxxxxxxxxxx					
Total Soft Savings	xxxxxxxxxxx					
Annual Net Benefit (Loss) with hard savings only	xxxxxxxxxxx					
Cumulative Net Benefit (Loss) with hard savings only	xxxxxxxxxxx					
Annual Net Benefit (Loss) with hard & soft savings included	xxxxxxxxxxx					
Cumulative Net Benefit (Loss) with hard & soft savings included	xxxxxxxxxxx					

Note: Organizations may require ROI calculations on Net Present value (NPV), Internal Rate of Return (IRR) and Payback Period in Years. These calculations are not represented here and should be performed with your Finance Department.

Thinking *inside* the Box – How to be Innovative

Posted by Kayley Lyons, PharmD, MS, BCPS on August 27th, 2014

As healthcare changes faster than ever, innovation will play an even more important role for individual pharmacists, departments and our profession. How can you, as a leader, develop creative teams and lead healthcare innovation? Start by busting these three innovation myths.

Myth 1: Certain people are more creative than others

A creativity gene does not exist. We all have the same capabilities and cognitive processes to be creative.[1] Maybe the problem in pharmacy is that we don't see ourselves as creative but as conventional. People will not think of a creative idea until they believe in themselves that they can.

In Dr. David Owens' Theory of Innovation Constraints he explains four constraints the individual faces to come up with a creative idea.[2] These barriers can be countered (Table 1) by practicing the "5 Discovery Skills", skills which emerged from Dyers' research on great innovators and should be practiced by all pharmacists.[3]

Table 1: Individual strategies for innovation

Individual Innovation Constraints[2]	The 5 Discovery Skills of Great Innovators[3]	Apply today[4]
Perception We are limited to what we pay attention to, gather data or no data from, the distance we are from the data, and how we stereotype the data	**Observing** Detecting small behavioral details of your customers that suggest new ways of doing things	Spend time observing the problem from the end users vantage point
Intellection How we frame the problem, problem-solve, come to an answer, and ability to carry it through	**Associate** Connecting seemingly unrelated questions, problems, or ideas **Questioning** Asking "why", "why not", and "what if" – challenging the status quo	Read, listen to, or experience outside of the "pharmacy bubble" Spend time asking these questions and thinking about what would challenge the status quo?
Cognitive Lack of persistence or overusing a single strategy	**Experimenting** Trying new experiences and exploring the world	Use a hypothesis testing mindset to implement new strategies and evaluate the results
Motivation Apathy or lack of an interesting problem	**Networking** Diversifying your network to gain radically different perspectives	Contact interesting people you know to meet and bounce ideas off of.

Myth 2: Creativity comes from one person with a bright idea

In his book "Group Genius", Dr. Keith Sawyer counters the common belief that creative ideas come from a lone genius.[5] More appropriately, creativity comes from creative collaboration (group genius) and hard work. Ideas incubate and iterate over time until we step

away from the problem to have that “aha” moment. The “aha” moment is a popular visualization but the hard work and right kind of creative collaboration is not. Table 2 reviews constraints groups face to innovate and strategies to overcome them.

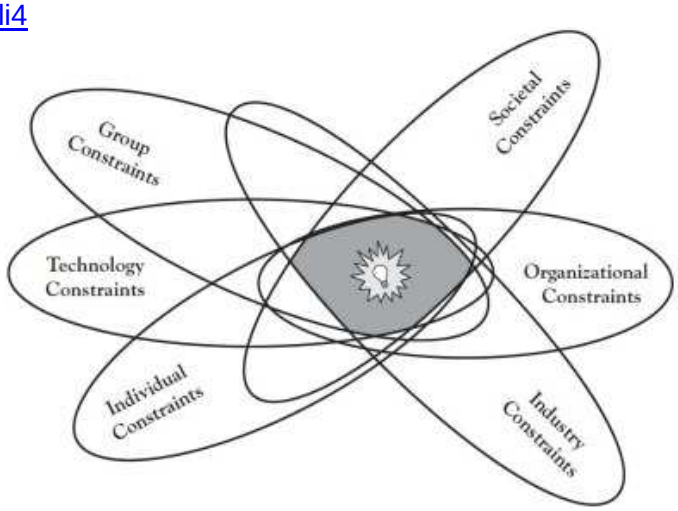
Table 2: Group strategies for innovation

Group Innovation Constraints[2]	Strategies to overcome group constraints[2,5]
Emotion constraints Emotions such as pride, fear of conflict, and judgment can stop creativity in groups	• Support a safe culture that does not differentiate between my idea and your idea • Have good task and process conflict without relationship conflict • Celebrate success *and* failure, punish inaction • Share ideas early and often, even if they are not formulated yet
Culture constraints We tend to choose groups most like ourselves and each group has its own decision making culture.	• Prize new problem solving methods • Increase the variety and diversity of your groups • Immerse yourself in creative networks and groups
Environment constraints Does your workspace impede group interaction? Do you have all the right resources your team needs?	• Reconfigure your workspace like Apple® or Google® for innovation. See this new article in Academic Medicine[6] • Build a team playground to share and document insights in a team space or technology
Process constraints Using a creative process is vital to spark innovation. If a process is too structured or not structured enough, creativity will fall through the holes	• Develop, master and use a process • In the early stages leave time for learning and work with the same intensity as you would at the end of the project • Brainstorm as many ideas as possible and then trim these down after this step is complete (not during) • Know creativity can be inefficient and know when to cut your losses

Myth 3: You have to think outside the box

Innovative people think outside the box right? Wrong. Innovation is creating value for your customers. Dr. David Owens claims innovation comes from inside the box of what stops creativity as depicted by the grey box in Figure 1. Our role then becomes not “thinking outside of the box”, but expanding the size of the box by eliminating different constraints. This article already reviewed how to fight individual and group constraints. Now watch this video to learn more about organizational, technological, societal, and industry constraints. https://www.youtube.com/watch?v=1RlhEhZBli4

Figure 1: Thinking inside the box of constraints



Questions to think about

- What are healthcare's industry constraints and how can we diminish them?
- What habits can you and your group employ today?

Further reading - Build off the "Group Genius" of ASHP and AHA with these links:

- http://www.ashpadvantage.com/leaders/proceedings.html
- http://www.ashpfoundation.org/MainMenuCategories/CenterforPharmacyLeadership/INNOVATION
- http://www.aha.org/advocacy-issues/initiatives/innovation.shtml

Further Reading and References:

1. Sawyer, R. K. (2011). *Explaining creativity: The science of human innovation*. Oxford University Press.
2. Owens, D. A. (2011). *Creative People Must be Stopped: 6 Ways We Kill Innovation (without Even Trying)*. John Wiley & Sons.
3. Dyer, J., Gregersen, H., & Christensen, C. (2013). *The innovator's DNA: Mastering the five skills of disruptive innovators*. Harvard Business Press.
4. Gubbins, P. O., Micek, S. T., Badowski, M., Cheng, J., Gallagher, J., Johnson, S. G., ... & American College of Clinical Pharmacy. (2014). Innovation in Clinical Pharmacy Practice and Opportunities for Academic–Practice Partnership. *Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy*, *34*(5), e45-e54.
5. Sawyer, K. (2007). *Group genius: The creative power of collaboration*. Basic Books.
6. Ricciotti, H. A., Armstrong, W., Yaari, G., Campion, S., Pollard, M., & Golen, T. H. (2014). Lessons From Google and Apple: Creating an Open Workplace in an Academic Medical Department to Foster Innovation and Collaboration.*Academic Medicine*, *89*(9).

Post author:

Kayley Lyons, PharmD, MS, BCPS
PhD Student, Learning Sciences and Psychological Studies
University of North Carolina School of Education

Research Assistant, The Academy
UNC Eshelman School of Pharmacy
Twitter @Kayleylyons
Personal Blog: http://kayleylyons.wordpress.com/

http://www.ashpadvantage.com/ppmitoolkit/