Practice Spotlight

Florida Hospital Orlando
Orlando, FL
www.floridahospital.com

Craig Coumbe, R.Ph., M.B.A.
Director of Pharmacy

Rania El-Lababidi, Pharm.D.,
BCSP (AQ-ID), AAHIVP
Assistant Director, Clinical Services

In YOUR VIEW, HOW WOULD YOU DEFINE THE IDEAL PHARMACY PRACTICE MODEL?

Florida Hospital Orlando, a 1,067-bed acute-care medical center that serves as Florida Hospital’s main campus, was founded in 1908. Florida Hospital Orlando houses one of the largest emergency departments and largest cardiac catheterization labs in the country. It is one of the busiest hospitals in the nation, providing service excellence to more than 32,000 inpatients and 125,000 outpatients each year.

Florida Hospital is operated by the Seventh-day Adventist Church. It serves as a community hospital for Greater Orlando and as a major tertiary referral hospital for Central Florida and much of the Southeast, the Caribbean and South America. Adventist Health System operates 37 hospitals in ten states making it the largest not-for-profit Protestant healthcare system in the United States.

We believe that ideal practice model is one that positions the pharmacist to provide safe, efficient and effective patient care. For our institution we envision an ideal practice model as
one that utilizes state of the art automation and technology in addition to highly trained pharmacy technicians, to allow pharmacists to practice more effectively at the patient’s bedside.

**HOW DO PHARMACISTS IN YOUR RE-DESIGNED PHARMACY PRACTICE MODEL PROVIDE CARE TO PATIENTS AND ENSURE SAFE AND EFFECTIVE MEDICATION THERAPY?**

In 2009, we changed our practice model from a centralized pharmacy practice model to a decentralized hybrid practice model. Florida Hospital’s previous practice model was a clinical specialist model with separate roles for clinical staff and distributive staff.

All clinical specialists attended rounds and spent the remainder of the day following up on their patients’ needs. Many had precepting and teaching responsibilities. Centralized pharmacists were responsible for medication order entry, checking drug products, and answering telephone calls. They had no patient interaction.

Our new practice model includes decentralizing as many pharmacists as possible in order to expand clinical coverage. Clinical coverage is patient-centered utilizing assignment by medical service and geographically by patient care unit. We also strategically position clinical pharmacy specialists to partner with generalist clinical pharmacists to help mentor, develop and train those pharmacists in their new decentralized roles.

Pharmacists practice in a hybrid model on patient care units providing both clinical and distributive functions and hence have accountability over both types of operations. This model now ensures that the pharmacist has ownership for patient outcomes within their area of practice. Pharmacists in our current practice model are active members of multidisciplinary healthcare teams practicing in various clinical specialties including: critical care, infectious diseases, bone marrow transplant, oncology, cardiology, neuroscience, and investigational drug services.

This re-designed practice model improved medication turn-around-time, physician and nursing satisfaction. The impact on our pharmacy department was improved employee job satisfaction as evidenced by a significant reduction in pharmacist turnover rates. In addition, this redesigned model expanded clinical pharmacy services by allowing us to implement an antibiotic stewardship program.
**WHAT SERVICES HAVE YOU DETERMINED TO BE ESSENTIAL TO SUPPORT YOUR PHARMACY PRACTICE MODEL?**

As we were introducing the decentralized practice model, we were also working simultaneously to ensure that major operations in the Central Pharmacy were optimized and made more efficient. For example, the dispensing rate from automatic dispensing cabinets was optimized from 65% to 90% over the course of a year. This ensured that pharmacists’ workflow in decentralized areas was not interrupted throughout the day to follow-up on medication requests from the nursing staff.

Since pharmacists in our new practice model own both the clinical and distributive functions for their units, they are responsible for all aspects of medication management, including order verification, clinical pharmacy services (e.g. pharmacokinetic dosing, renal dosing, intravenous to oral therapy conversion, automatic therapeutic substitutions, non-formulary management, monitoring of high-cost agents, and antimicrobial stewardship), as well as regulatory compliance.

**WHAT TECHNOLOGIES HAVE YOU IMPLEMENTED WITHIN YOUR PRACTICE SITE TO FACILITATE YOUR PRACTICE MODEL?**

Although we were able to decentralize pharmacy services prior to the introduction of computerized-provider order entry (CPOE) to our institution, its implementation nine months ago afforded a more efficient pharmacy operation. Pharmacists are now better able to assess and intercept medication orders in a more “real-time” fashion and able to make a bigger impact in ensuring compliance with the institution’s medication-use policies, evidence-based practice, and regulatory requirements.

We also utilize the electronic surveillance tool within the electronic medical record to identify opportunities for clinical pharmacy interventions based on pre-established criteria.

As the hospital is focused on meaningful use, bar coding will be shortly implemented which will afford a safer medication management system.

**HOW WOULD YOU SHARE THE SUCCESSES OF YOUR PRACTICE MODEL WITH OTHER PHARMACY DIRECTORS AND ADMINISTRATORS?**

We have shared our successes through poster presentations, on-site visits, and corporate presentations. We take every opportunity to discuss the successes and lessons learned from implementing a new practice model. We recently presented the outcomes of our antimicrobial stewardship program and how it was implemented within a decentralized practice model at this...
year’s summer ASHP meeting. We also seek out opportunities to share our experience both nationally and internationally.

**WHAT ARE SOME KEY CONSIDERATIONS TO GAIN EMPLOYEE ACCEPTANCE AND BUY-IN TO IMPLEMENT A NEW PRACTICE MODEL?**

Including the early adopters and innovators as part of this practice model change ensures its success in the early phases of implementation. Any change does not happen without some resistance and skepticism especially in the early phases. Positioning pharmacists who are flexible and likely to be successful with this change affords a more successful roll-out. Sharing success stories and celebrating this success helps dissuade any negativity associated with this change. We seek every opportunity to share our success stories utilizing various venues including, our weekly departmental newsletter, monthly staff meetings, the hospital’s newsletter as well as hospital’s town-hall meetings. In addition, soliciting feedback through staff meetings or “feedback sessions” about changes within the Department helps with staff engagement and obtaining buy-in.

To build consistency to the feedback process, we recently implemented “Pharmacy Practice Councils”, centered on the priorities of the PPMI summit recommendations. These practice councils create a framework for consistent bi-directional feedback between front-line staff and management and provide a platform for engaging the front-line in making decisions and providing their opinion on a consistent basis.

**HOW DID YOU GAIN SUPPORT OF HOSPITAL ADMINISTRATORS, PHYSICIANS, AND NURSING TO IMPLEMENT YOUR NEW PRACTICE MODEL?**

In the early stages of implementation we engaged hospital administrators, physicians and nursing leadership in this practice model change by sharing our plans and the gains achieved from this change. We were fortunate to have the full support of senior and medical staff leadership in implementing this practice model change. As we rolled-out the new model we continued to share pre-and post-implementation data associated with this model change which lend further support for it. Metrics of success that were shared with medical staff and senior leadership pre- and post-implementation included medication order entry turn-around-times, chemotherapy dispensing turn-around times, and clinical pharmacy interventions. All of those metrics improved significantly post-implementation of the decentralized pharmacy practice model.
WHAT ARE SOME LESSONS LEARNED WHILE IMPLEMENTING YOUR PRACTICE MODEL THAT YOU WOULD LIKE TO SHARE WITH OTHER PHARMACISTS?

Ensuring the involvement of early adopters of the practice model facilitates a successful model change. Routine reporting pre- and post-implementation data and successes to hospital administrators, medical staff leadership and nursing ensures continued support for the practice model change. Finally, engaging the staff with this change and utilizing the feedback from staff to fine-tune the model change helps not only sustain this change but also develop it.