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How Hospital Pharmacy Leaders Drive Transformation

Capturing New Sources of Revenue and Savings with a Hospital-Owned Outpatient Pharmacy:

A White Paper Providing Five Best Practices

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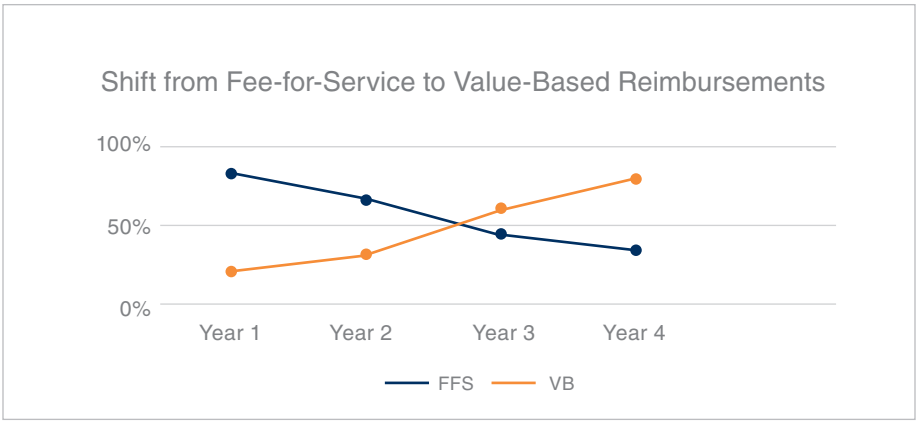
As healthcare shifts toward a focus on population health management and Accountable Care Organizations (ACOs), hospital C-Suite strategies are moving away from fee-for-service and toward value-based reimbursement. In order to maximize hospital revenues while navigating this change, C-Suite strategies are targeting the sweet spot that generates maximum revenues from both reimbursement models.



The transition toward value-based reimbursements means that, going forward, hospitals should adjust their approach to controlling cost rather than relying upon maximizing revenue, and a hospital-owned outpatient pharmacy can be an important part of that strategy.

Hospitals that do not operate their own outpatient pharmacy, or have one that is not reaching its maximum potential, are leaving savings and potential revenue sources on the table. Hospitals with their own outpatient pharmacy can capture new sources of revenue, increase quality, improve the patient experience, curb readmissions, and reduce medication costs for their hospital employees. An outpatient pharmacy allows the hospital to better serve their patients, their employees and the community. Having an outpatient pharmacy tells third-party insurance carriers that the hospital can take care of medical and pharmacy benefits for their own employees. By maintaining a lower than inflation benefit level year-over-year, the hospital can demonstrate to the insurance carrier that it is truly performing value-based healthcare.

Without its own in-house outpatient pharmacy, **A HOSPITAL CAN SPEND AS MUCH AS 12% MORE** on medications for its own employee health plan members.

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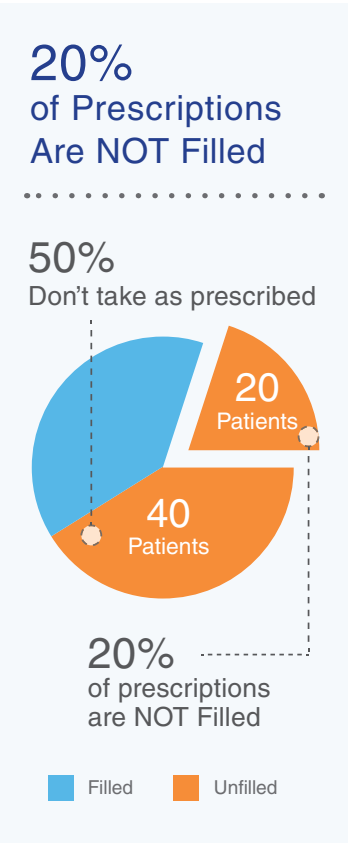

When patients are discharged from a hospital without medications in hand from a hospital outpatient pharmacy, an average of 20% of those prescriptions go unfilled.[1] Of those that get filled, only about 50% of patients typically take their medicines as prescribed, resulting in approximately $177 billion annually in direct and indirect costs to the U.S. economy.[2]

With an established outpatient pharmacy, the hospital can capture a portion of those prescriptions. There also are substantial quality issues at stake, that, without an outpatient pharmacy can result in a lack of control over care and outcomes, driving higher readmission rates and potentially costly penalties.

Additionally, a hospital outpatient pharmacy has certain advantages over retail or community pharmacies that include:

- A hospital outpatient pharmacy is another point of patient contact, not only following discharge, but on an on-going basis. The outpatient pharmacy is integrated into the patient's electronic medical records (EMR) which can be tied into the pharmacy dispensing system, making the hospital pharmacy connection even stronger. Retail and community pharmacies do not have access to the patient's EMR, typically do not see their customers on a regular basis, and therefore cannot make this full circle connection. From a HIPAA perspective, it is difficult for a non-hospital affiliated pharmacy to have access to the patient's EMR to deliver care.
- Hospitals are better able to deal with patients who consume the bulk of resources due to their diagnoses and/or regular emergency department (ED) visits.
- Hospitals understand the insurance world, payors and billing in a deeper way than retail pharmacy.

All of these factors help the hospital market its outpatient pharmacy with the pharmacy becoming an extension of the hospital brand, energizing brand loyalty and increasing HCAHPS scores.

Hospitals should also consider the significant costs of covering their own employees' medications. Without its own in-house outpatient pharmacy, a hospital can spend as much as 12% more on medications for its own employee health plan members.

Though an often-overlooked segment of a hospital's daily operation, a hospital-owned outpatient pharmacy represents real opportunities for increased revenue, savings, and clinical outcomes. In a time when every dollar counts and quality is more linked to cost and reimbursements than ever before, hospital outpatient pharmacies could generate millions to the bottom line across a number of fronts by leveraging five proven best practice techniques.

[1] NCBI. *Medication Use in the Transition from Hospital to Home.* Accessed April 11, 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3575742/

[2] National Council on Patient Information and Education (NCPIE). *Enhancing Prescription Medicine Adherence: A National Action Plan.* Accessed April 11, 2017. http://www.talkaboutrx.org/documents/enhancing_prescription_medicine_adherence.pdf

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FIVE BEST PRACTICES FOR OUTPATIENT PHARMACY SUCCESS

Best Practice #1: *Generate new revenue and savings*

If patients are leaving the hospital empty-handed without their prescriptions, revenue is walking away with them. With a well-positioned and well-run hospital-owned outpatient pharmacy, prescription revenue is captured before patients ever leave the hospital. It is not only good clinical practice, but it is good financial practice as well.

It would be hard to find another business model where a company was satisfied with providing part of a vital service to its customers, but sent the rest of the business out for a third party to fulfill. It would be especially concerning if the business was being held accountable and compensated based on the results of the service provided.

The lost patient revenue is significant. Each discharged patient, outpatient visit, and ED patient gets an average of 2 prescriptions[3] at a typical cost of $56 per prescription.[4]

To demonstrate the magnitude of lost revenue, we applied these figures to a sample 300-bed hospital system with 14,000 discharges; 50,000 emergency department visits and 161,000 outpatient visits. With 225,000 annual patient encounters requiring 450,000 prescriptions,[5] this example system sends more than $25 million of revenue and $750,000 (3%) in EBITDA out the door to offsite retail pharmacies.

(Please note that these numbers apply to the 300-bed example hospital system, and statistics may vary from population to population and whether the hospital is in an urban or rural setting. A thorough evaluation of all key variables, including but not limited to hours of operation, pharmacy proximity to the emergency department, staffing skills and model, tangible and intangible benefits by a team of experienced advisors, needs to be done before making any financial estimates or projections.)

Best Practice #2: *Reduce hospital employee medication costs*

Another significant financial benefit of a hospital-owned outpatient pharmacy is the potential savings on the cost of medications for its own employees and their dependents through their prescription benefit plans. Under the “own use” definition, hospitals can purchase drugs for their inpatients, hospital staff, auxiliary, and retired employees at inpatient GPO prices. In this class of trade, drug prices are typically 5% to 12% lower than retail prices at big box chains and community pharmacies. In order to qualify for this pricing, the hospital must demonstrate that it is using those drugs for this limited population only.

Annually, the average cost of providing prescription drugs to an employee is $700 to $800 when accessing retail pharmacies.[6] By utilizing the lower inpatient GPO pricing, the annual per covered member medication costs could be reduced by $35 to $84.[7]

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[3] AHRQ MEPS Statistical Brief #245, May 2009. Accessed April 11, 2017. https://meps.ahrq.gov/data_files/publications/st245/stat245.pdf

[4] National Community Pharmacist Association Digest, 2013. Accessed April 11, 2017.http://www.ncpanet.org/pdf/digest/2013/2013digest_financials.pdf

[5] Billian’s Health Data 2013-2014.

[6] Kaiser Family Foundation/Health Research & Education Trust 2016 Annual Employer Health Benefits Survey. Accessed April 11, 2017. http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey

[7] 2013-2014 Prescription Drug Benefit Cost and Plan Design Report

Our sample 300-bed system might have 1,800 employees totaling 4,500 benefit members, costing the hospital about $3.25 million annually. The purchase cost of these medications is approximately $2.6 million. By purchasing medications at inpatient GPO prices and facilitating employee access to the hospital-owned pharmacy, the system could save $130,000 to $312,000 per year. Some hospitals set up their own employee pharmacies in order to take advantage of these savings as well as enhanced revenue from prescriptions filled in-house.

Because the hospital manages the employee prescription benefit as well as the medical benefit, the pharmacy has more control over where the patient receives their medications. This is particularly important as oncology medication reimbursements are being stripped from the medical benefit and moved over to the pharmacy benefit. Though reimbursements are lower under the pharmacy benefit, the hospital still retains some of those dollars. If the hospital does not have an outpatient pharmacy, those dollars will be lost.

FOR 340B COVERED HOSPITALS, prescription medication costs potentially could be reduced by more than 50%, **SAVING THE FACILITY AN ESTIMATED $1.3 MILLION PER YEAR.**

Best Practice #3: *Enhance patient experience, improve medication adherence, reduce readmissions*

Filling medications onsite is generally more convenient for patients and improves their experience with the healthcare provider. The inconvenience of filling a prescription offsite may contribute to the 20% of prescriptions going unfilled as previously noted. Approximately 45,000 patients would not receive their prescriptions using our sample 300-bed system.

Providing access to medications onsite makes it easier for patients to get and take initially prescribed drugs. An outpatient pharmacy can deliver prescriptions directly to the patient's bedside prior to discharge, and provide counseling to ensure that the patient understands how and when to take their medication. The patient leaves the hospital with medications in hand, increasing the probability of medication adherence, improved outcomes, and reduced readmissions.

Once the patient leaves the hospital, with an outpatient pharmacy in place, the patient has access to on-going consultation, increasing the likelihood that the patient is taking their medications correctly, is not experiencing adverse drug events, and understands that within 30 days they need to access their primary care physician to continue their therapy. An integrated pharmacy is able to accomplish these transitions of care tasks that lead to improved clinical outcomes, better adherence, reduced readmissions, and patient satisfaction. A retail or community pharmacy is not equipped to handle such transitions of care.

Best Practice #4: *Stock specialty drugs*

By 2020, it is estimated that over 60 percent of drug spend will be for specialty medications.[8]

[8] Levine, Sharon, MD. *Specialty drugs: It's about health, value and price.* Accessed April 11, 2017. http://www.pharmedout.org/pdf/R3DSlides/Levine.pdf

Without an outpatient pharmacy, the hospital will not be able to claim a piece of the rapidly growing specialty drug market.

Patient access to specialty drugs is a growing concern. Drug distributors are narrowing the networks for specialty medications, making it difficult for independent or community pharmacies to stock a broad spectrum of specialty products. With connection to the patient's EMR, the hospital outpatient pharmacy is ideal for offering these specialty medications to patients who often have complex conditions. Though some specialty medications are covered by Medicare Part D, it can be limiting, and it is critical for patients that hospitals and health systems offer specialty medications in-house.

Best Practice #5: *Explore the 340B Drug Discount Program*

The 340B Drug Discount Program provides an opportunity for hospitals to generate savings on drug purchases for medications that are made available to an underserved patient population. For 340B covered hospitals, prescription medication costs potentially could be reduced by more than 50%, saving the facility an estimated $1.3 million per year.

It is important to note that 340B hospitals must have carefully controlled processes and appropriate systems in place to ensure that they meet the strict patient eligibility criteria as defined by the Federal Health Resources and Services Administration (HRSA). In addition, HRSA requires that 340B covered entities demonstrate that they are using savings from the program to expand care for their underserved patients.

PRACTICES TO RECONSIDER OR PITFALLS TO AVOID

There are certain practices that may keep hospitals from achieving advantages such as new revenue, additional savings, and improved quality. So, hospitals should keep the following in mind when determining the best way to meet their pharmacy needs. Avoiding these common pitfalls can contribute to ensuring objectives are achieved:

- **Executive and Key Stakeholder Support** – It is critical to get all internal stakeholders committed to the single vision and advantages of a hospital-owned outpatient pharmacy. Everyone from an executive sponsor to physicians, bedside nurses, discharge planners, and inpatient pharmacy team need to have a seat at the table in the planning and implementation process of an outpatient pharmacy.
- **Establish Clear Goals for the Project** – Goals should be set with defined metrics where possible: revenue, return on investment, reducing readmissions and revisits, patient satisfaction with discharge process, percentage prescription filled by patients and employees.

ALIGNMENT AND CONTROL – A hospital-owned outpatient pharmacy provides the hospital with better control over the health and care outcomes of the patient across the entire continuum of care. An externally-owned pharmacy's interests and a hospital's interests may not be in alignment. In an ACO, alignment is of particular importance because the hospital is in a capitated arrangement for healthcare. If the hospital does not have an outpatient pharmacy or has no

control over an outpatient pharmacy, it is difficult to monitor a contractual arrangement with an external pharmacy in order to deliver the same type of pharmaceutical care services that the hospital pharmacy can provide, and the hospital may be at risk related to that capitation.

- **Engage the Entire Hospital Team** - Strategic alignment from the C-Suite on down or pharmacy on up is critical, financially and clinically, to ensure that everyone in the hospital is moving in the same direction in order to make the pharmacy successful. Engage physicians, nurses, case managers, discharge planners, care coordinators, social workers, and pharmacy staff to move business into the pharmacy in order to make it successful.
- **Clarify Required Skill Sets** – The skill set needed to manage an outpatient pharmacy significantly differs from managing an inpatient pharmacy department. Retail pharmacy policies and procedures, staff training and education, interfacing with customers, understanding and managing third party insurance requirements, and maintaining inventory varies significantly from inpatient to outpatient settings.

CONCLUSION

Establishing a hospital-owned outpatient pharmacy or optimizing an existing one can deliver new sources of revenue, decrease costs, improve clinical quality, and extend coordinated care to patients. With the right subject matter expertise, following a few established best practices, and avoiding some well-traveled pitfalls, hospital systems can achieve a number of financial and clinical benefits.

About the Authors

Tracy W. Becker, PharmD, MBA, CDE, is the *Divisional Vice President* of Outpatient Pharmacy Services for Comprehensive Pharmacy Services, applying his 37 years of pharmacy experience to support outpatient pharmacy services through outpatient unit development, the 340B Drug Discount Program, medication therapy management, and accountable care strategies. He earned his PharmD from Duquesne University, MBA from Waynesburg University, and Certified Diabetes Educator designation through the National Certification Board of Diabetic Educators.

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