ashp PHARMACY EXECUTIVE Leadership Alliance®

Models to Improve Patient Access and Capacity Optimizing Pharmacist-Provided Care

Strategies and Tactics for Multi-Hospital Health Systems

PELA® Virtual Conference Report

June 26, 2025

INTRODUCTION

Paul W. Abramowitz

Leigh Briscoe-Dwyer

On June 26, 2025, the American Society of Health-System Pharmacists (ASHP) Pharmacy Executive Leadership Alliance® (PELA®) convened for a virtual conference, *Models to Improve Patient Access and Capacity Optimizing Pharmacist Patient Care.* ASHP introduced PELA® in 2020 to create opportunities for pharmacy executives and chief pharmacy officers to share insights on critical topics through events that help advance pharmacy leadership and practice in multi-hospital systems and large hospitals. This PELA® virtual event provided health-system pharmacy executives and thought leaders an opportunity to discuss current experiences, challenges, opportunities, and innovative strategies to improve patient access, throughput, and capacity by integrating pharmacists into care delivery across all service lines and settings. This discussion is especially timely. Across the country, health systems are facing challenges including rising demand, limited workforce capacity, and tighter margins.[1] However, these challenges also present opportunities, and pharmacy leaders can shape how care is delivered moving forward. Strategies discussed align closely with the priorities outlined by the ASHP 2024 Commission on Goals: Primary Care Delivery Transformation, which emphasized the need for pharmacists to take on expanded roles within primary care teams and system-wide population health efforts.[1] The Commission identifies measures of success for a primary care model that aligns with those defined by the Agency for Healthcare Research and Quality and include equitable access to care, patient satisfaction, continuity of care, cost, quality, and workforce well-being and satisfaction.[1,2] Other recent publications have also described an important role of pharmacists in primary care and population health.[3-6] The National Academy of Sciences report, Implementing High-Quality Primary Care notes that "Pharmacist expertise is critical in guiding the team, person, and family in effectively assessing, planning, and managing medication use."[7] To fully utilize pharmacists, though, will require a transformation of primary care, including creating a delivery system that supports collaboration and team-based care and overcomes challenges to pharmacists' scope of practice.[8]

Welcoming and opening remarks were provided by **Leigh Briscoe-Dwyer PharmD, BCPS, FASHP**, ASHP president, and **Paul Abramowitz**, **PharmD, ScD (Hon),** chief executive officer, ASHP. Briscoe-Dwyer urged health-system pharmacy leaders to gain an understanding of trends influencing primary care delivery and explore the role of pharmacists and pharmacy technicians in new models and consider how to develop scalable and sustainable programs. With this in mind, and considering the implications of primary care transformation for ASHP members, partners, and ASHP's strategic direction, the PELA® Virtual Summit objectives were to:

- Identify models to improve access, patient throughput, and capacity for hospitals and health systems optimizing the role of pharmacists.
- Describe team-based primary care and population health models that support transitions of care (TOC) and medication adherence, and leverage the integration of all service lines of multi-hospital health systems; and
- Discuss the current challenges pharmacy executives face in leading the pharmacy enterprise and identifying solutions and opportunities with workforce and reimbursement structures.

Abramowitz stressed that pharmacy leaders are in a powerful position to meet the challenges as pharmacists take on greater leadership within primary care teams and system-wide population health efforts. He stressed that to realize a transformation of primary care, there is a need for health-system pharmacists to be agile and continue prioritizing patient needs and expectations, to work collaboratively across healthcare disciplines, and to safely and effectively leverage digital health technologies and tools.

Pharmacy executive leaders from over 150 multi-hospital health systems participated in the conference including chief pharmacy officers, directors of pharmacy, population health pharmacy leaders, ambulatory care pharmacy leaders, medication outcomes pharmacy leaders, and outpatient pharmacy leaders. These themes were explored by gaining insights from health care thought leaders on what is driving patient access transformation; an engaging panel discussion with four executive leaders representing PELA® peer organizations; and finally, small breakout discussion groups designed to broaden insights from all participants. The panel discussion and breakout groups focused on addressing challenges, redefining roles, and implementation strategies.

STRATEGIES IN OPTIMIZING PATIENT ACCESS: PRIMARY CARE, POPULATION HEALTH, AND MEDICATION MANAGEMENT

Jennifer Dauer, chief strategy and transformation officer, The Ohio State University Wexner Medical Center, kicked off the virtual event with a plenary session moderated by **Trisha A. Jordan, PharmD, MS,** chief pharmacy officer, The Ohio State University Wexner Medical Center, Assistant Dean for Medical Center Affairs, The Ohio State University College of Pharmacy. As chief strategy and transformation officer, Daur is responsible for organizational strategy and identifying key initiatives to guide enterprise transformation, including new clinical initiatives and business development opportunities. Dauer highlighted the critical importance of access and its impact on healthcare, described how a patient-centered culture can address systemic access challenges, and described pharmacy role evolution and how it can impact access. Dauer's background in the consumer goods field provides a unique view of healthcare, which is particularly important in the current environment where, more now than ever, patients are shifting to healthcare consumerism behaviors. Accessibility and patient preferences, including empowerment, digital transformation, and a focus on experience, are driving healthcare decision-making. When selecting a new provider or service location, patients ranked insurance coverage, clinical expertise, and availability of appointments as their top criteria.[9] Therefore, Daur suggested that when thinking about the value proposition for pharmacy services, consider where pharmacists can affect change when it comes to access and patient preferences. In order to meet (or hopefully, exceed) patient access expectations, the supply (capacity to provide the care) and a well-designed clinical and operating model needs to support the (patient) demands (Figure 1). It is recognized that there is considerable opportunity for improvement and Dauer shared that one way to do that is to benchmark and learn from others: "Search and reapply" or "Steal and improve." In other words, find inspiration from others, probe and gain insight, then reimagine it for what can be adapted to your organization. To this end, at Cleveland Clinic, they have implemented universal on-line scheduling, patient-centered care councils (that include patients), and expanded their Comprehensive Contact Center, which serves patients with unique needs. They are also piloting models for care redesign. Daur is hopeful that placing the patient at the center will not only ensure access to care but lead to transformation of the patient experience.

> "The pharmacy enterprise strategic plan helped me to understand pharmacy and how they can impact the organization's strategic imperatives.
>
> - **Jennifer Dauer,**
> The Ohio State University Wexner Medical Center

Dauer is enthusiastic about the potential for pharmacists to address access challenges and become part of the transformation to make an impact on patient lives. The pharmacy's strategic plan helped to understand and demonstrate how the pharmacy can impact the organization's strategic imperatives. She believes the pharmacy enterprise plays a pivotal role in access across the continuum of care note that, over the past several years, there has been a continued focus and growth in ambulatory care. Pharmacy's impact is broad, cuts across all settings and is critical to addressing gaps in care (Figure 2).

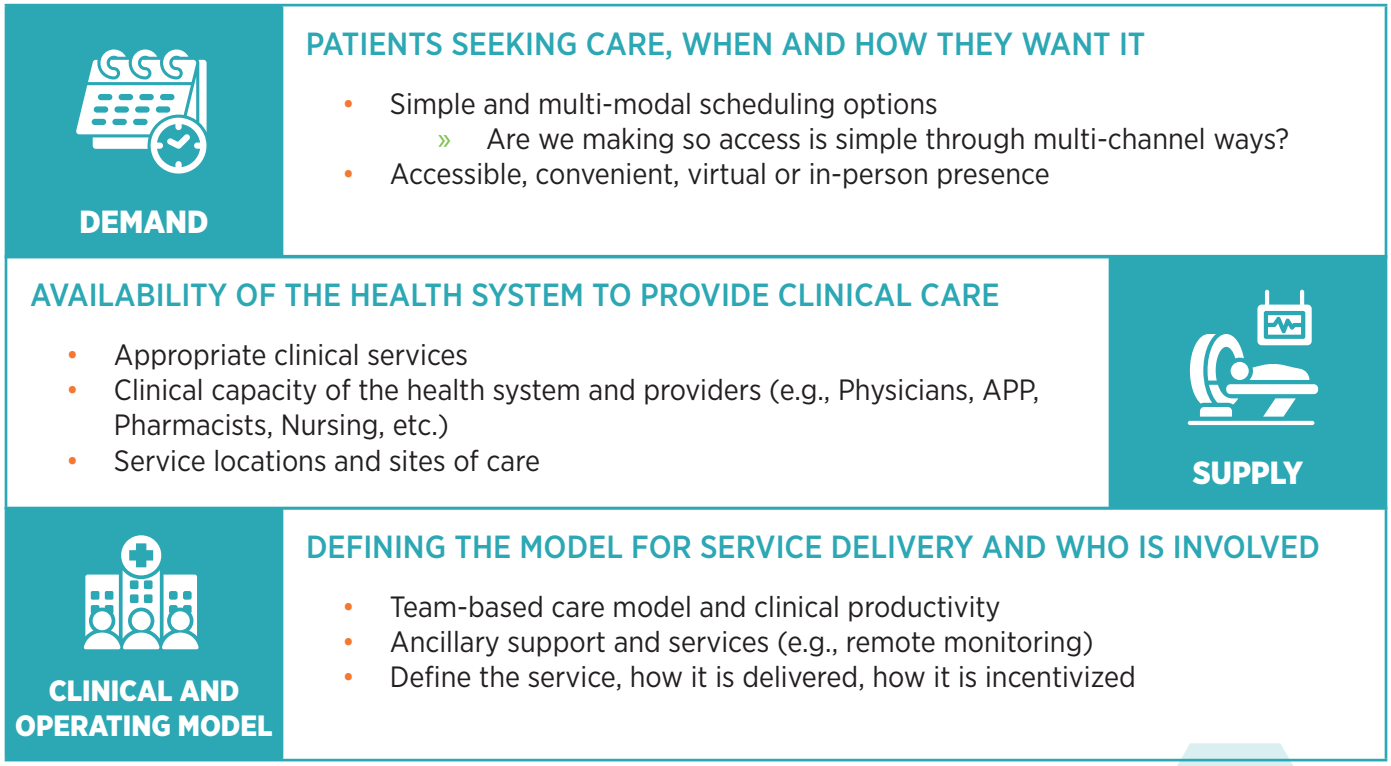
Jordan described four areas where pharmacy is addressing access including medication access initiatives (e.g., addressing pharmacy deserts, the prior authorization process, and substance use disorders treatment), empowering data-driven decision making (e.g., dedicated pharmacy analytics support and referral monitoring, advancing clinical practice and patient outcomes (e.g., TOC program and expansion of services across the care delivery model), and enhancing operational efficiency and risk management (e.g., supply chain risk mitigation and infusion referral navigation). For example, they are currently piloting a process with vendors to improve medication access through the prior authorization process and are proposing opening community pharmacies in pharmacy desert locations.

Health-systems are betting on enhancing patient access as a core business strategy and the enterprise pharmacy can play a critical role in achieving goals across the continuum. Pharmacy leaders should consider expanding or implementing initiatives that will improve access.

Key Takeaways

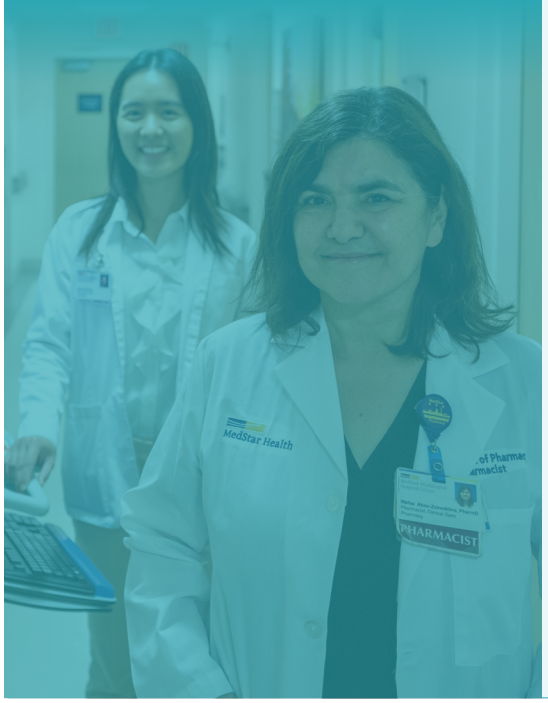
- "Access" is a **top 3 consumer criteria** when choosing healthcare
- Patient-centered culture **addresses the root causes of access issues**
- Health systems are making **big bets on addressing access**
- **Pharmacy practice and the role of pharmacists have rapidly evolved and shifted** to improve access across the care continuum

FIGURE 1: ALIGNING CAPACITY, CARE MODEL, AND OPERATIONS TO MEET PATIENT DEMAND AND PATIENT DELIGHT



Adapted with permission by Jennifer Dauer

FIGURE 2. PHARMACISTS WILL PLAY A CRITICAL ROLE IN ADDRESSING CARE GAPS AND ACCESS



IMPROVING QUALITY, SAFETY, EXPERIENCE

- Direct-to-consumer services
- EHR outreach
- Drone medication delivery
- Virtual monitoring of infusion care

COMPREHENSIVE MEDICATION MANAGEMENT

- Preventative health
- Population health
- Specialty/Retail
- Pharmacogenomics
- Ambulatory care clinics

CHRONIC DISEASE MANAGEMENT

- Remote patient monitoring
- Telehealth
- Oral therapies

ACUTE CARE AND TRANSITIONS OF CARE

- Precision prescribing
- Cell/Gene therapies
- Clinical trials
- Home infusion
- Medication access

PANEL DISCUSSION: MODELS TO IMPROVE ACCESS AND CAPACITY OPTIMIZING PHARMACIST PATIENT CARE

Note: Content has been modified for clarity and readability.

Four panelists (See Box) participated in a discussion on models to improve access and optimize pharmacist patient care, including new roles and settings. Panelists described their current responsibilities and experience in program development and expansion including ambulatory care, population health, TOC, and specialty pharmacy. Several of the panelists had experience with innovative ambulatory care models including growing primary and specialty care within an embedded pharmacist model (Papineau), a referral-based medication management clinic (Truelove), population health and care transition programs (Olson), and delivering pharmacy services through primary care (Malachowski). As innovators, pharmacy leaders must be strategic and find ways to overcome funding and resource challenges, identify opportunities in TOC and chronic disease management, and document outcomes that demonstrate value. In a discussion moderated by Boedecker, the panelists addressed a series of questions to gain insight into how to overcome challenges and implement strategies for successful innovation.

PHARMACY EXECUTIVE PANEL

Ashley Boedecker

PharmD, MBA; Director, Member Relations; Section of Ambulatory Care Practitioners, ASHP *(Moderator)*

Matthew Malachowski

PharmD, MHA, BCPS; System AVP, Population Health and Ambulatory Care; Ochsner Health Pharmacy

Jeff Olson

PharmD, MBA, BCACP, FASHP; Director, Ambulatory Clinical Pharmacy; Intermountain Health, Canyons/Desert Regions

Emily Papineau

PharmD; Executive Director of Ambulatory Pharmacy Services; Community Health Network

Daniel B. Truelove

PharmD, AAHIVP, BCACP, BCPS, FASHP; Director of Pharmacy, University Health Network; University of Tennessee Medical Center

Q: WHAT LESSONS HAVE YOU LEARNED IN NAVIGATING FINANCIAL AND REIMBURSEMENT BARRIERS WHEN BUILDING SUSTAINABLE AMBULATORY PHARMACY MODELS ACROSS SERVICE LINES?

Truelove: Sustainability requires diversification. To this end, seek out fee-for-service opportunities, optimize 340B, align outcomes to achieve shared savings. I would layer different approaches while staying focused on the patient outcomes. You can also seek grant funding to support elements of the program. Framing initiatives in financial terms that resonate with the C-suite helps overcome barriers and strengthen organizational support.

Malachowski: To navigate financial barriers, be able to track work and impact that shows value. Also, consider "downstream value" (e.g., time to physician visits) and be comfortable to go across service lines to show impact of the pharmacist-delivered services to the patients and organization. For example, aligning pharmacy tracking measures with other key stakeholders, such as capturing Relative Value Units (RVUs), documentation and Evaluation and Management (E&M) coding. Alignment is key.

Q: CAN YOU TELL US MORE ABOUT HOW YOU ARE POSITIONING PHARMACISTS TO LEAD OR SUPPORT TRANSITIONS OF CARE AND/OR CHRONIC DISEASE MANAGEMENT IN A WAY THAT MEASURABLY IMPROVES OUTCOMES?

Papineau: As it was a measurable area for clinical optimization, we started with diabetes by asking for referrals and also making suggestions for patient referrals by running reports to identify patients with uncontrolled diabetes. We have recently augmented this by using an electronic health record (EHR) best practice alert to directly prompt providers to place a pharmacy referral with a click of a button during their patient's appointment, if a patient has a persistently elevated or grossly elevated A1c. Our pharmacists do face-to-face or virtual visits, both of which have demonstrably improved diabetes' outcomes. We are also getting ready to launch a patient-facing campaign where a message is sent directly to patients who meet certain criteria, providing information about the pharmacist, and inviting them to click and schedule an appointment.

Olson: At Intermountain Health, we are involved in chronic disease management as well as TOC. We do a post-discharge medication reconciliation and engage directly with patients. The initiative started small and demonstrated positive results, so was expanded to all our hospitals. We found there were three keys to success; first, identify pain points and organization priorities, then align efforts around those; align with a physician champion; and lastly, document value. We are also working to develop a broad scope of practice for multiple conditions and have tested various models such as virtual pharmacist visits and pharmacists embedded in clinics. Most importantly, identify how to deliver care in the best way possible to meet goals of patient engagement.

Papineau: We have a multi-pronged approach to TOC. Women's health services refer patients with hypertensive disorders with pregnancy to the pharmacist. Also, we have a COPD transition of care clinic that is supported by digital technology. The pharmacist uses a device to evaluate if patients are using their inhalers optimally and modifies therapy as appropriate. This has lowered readmission rates by about 12 percentage points. We also have a centralized pharmacist model for TOC that includes post-acute discharges, not just acute care discharges.

Q: WHAT HAS BEEN MOST EFFECTIVE IN ENGAGING EXECUTIVE LEADERSHIP, MEDICAL STAFF, AND PAYERS IN EXPANDING PHARMACIST ROLES ACROSS THE ENTERPRISE?

Papineau: We use a "buffet" model when proposing a new service or initiative, have something for everyone. We connect with stakeholders. For example, we have used vision-casting for providers as to how pharmacists can provide collaborative care, and for other executives, aim to align with their goals, like how to improve access to care (such as reducing time to visit). Sometimes also proposing a service as a "pilot" tends to reduce initial resistance or concerns. In addition, it's important to identify a physician champion. And lastly, we tell a good story or have some patient testimonials to complete the meal, so-to-speak.

Olson: It's critical to connect with the CFO, in a language they can understand and by telling compelling stories. It's marketing; we have a marketing workgroup.

Malachowski: We've taken a unique approach. To ensure physician engagement, we hired a pharmacist into the clinic cost center. I'd describe it more as a collaboration. The pharmacist is seen more as a partner, as a "pharmacy

asset" in the clinic. We knew we had hit a turning point when one of the physicians said, "When do I get my pharmacist?" It's important to learn the language of each stakeholder, then use that language to describe the great work you are doing.

Truelove: We've emphasized to payers how accessible our clinical pharmacists are, especially when their priority is ensuring patients can engage with a clinical provider. We try to position the conversation so that the pharmacist is viewed as an added benefit, not an additional cost.

Q: HOW ARE YOUR PHARMACY SERVICES DEMONSTRATING VALUE FOR YOUR ORGANIZATION AND STAKEHOLDERS (E.G., FINANCIAL, ACCESS, COST SAVINGS, REVENUE GENERATION, ETC.)?

Olson: We also take the "buffet" approach that Emily mentioned. How to define and demonstrate value depends on priorities of your organization: the payer mix, patient population, clinical outcomes, patient and provider satisfaction; know the organization's highest priorities. On the financial side, we have focused on billing for services, optimizing 340B savings, cost avoidance, prescription capture, and provider access. The organization is shifting to a value-based care (VBC) model and now we have a pharmacist presence in every primary care clinic. We've also developed a cost avoidance calculator where we assign value to medication therapy problem interventions and report that out monthly. This information has served as a catalyst for expanding services.

Papineau: We have taken advantage of TOC billing opportunities and been able to optimize enhanced reimbursement using pharmacist engagement and allow for more efficient visits for the providers. We have also optimized annual wellness visits, strategically focusing on patients with the most medications. While these annual wellness visits are revenue-generating, they have also created many positive downstream effects, including providing an opportunity for the pharmacist to identify patients who would benefit from additional chronic disease appointments. Another area for demonstrating value to the organization is that our pharmacy technicians manage the medication assistance programs and identified $64 Million in cost savings for patients last year. This can also be used as an example of how 340B dollars can be used to fund these positions and give back to the community.

Malachowski: There is so much value-added to the services we have implemented. For example, the population health pharmacy team can identify care gaps and work with pharmacy resources in the clinic to close the gaps. As an incentive, we also have a shared savings program in population health with both upside and downside risk.

Q: HOW CAN PHARMACIST MODELS OF CARE BE ADAPTED TO BETTER ADDRESS THE NEEDS OF RURAL POPULATIONS?

Malachowski: Ochsner and Geisinger have similar models for their rural populations; there is centralized physician who conducts virtual patient visits, and we have pharmacists out in the community, creating a ring around the physician. In between physician visits, patients are managed virtually, and the physician notified if an issue is identified.

Truelove: Many patients in rural areas can't access telehealth visits from home, so we're equipping our rural clinics with telehealth "rooms" to help patients connect with more services and specialists within our network. We're also beginning conversations with community pharmacies in rural areas to offer similar telehealth rooms, enabling patients to have virtual clinic visits while at the pharmacy.

Olson: We have done similar. We're using nurses in the home for highest risk patients, and they bring technology into the home, connecting patients to physicians and pharmacists.

Q: WHAT DO YOU SEE AS THE ROLE OF PHARMACISTS IN ADVANCING PATIENT VALUE?

Malachowski: Whatever we can take off the physicians' plate will be critical to address the shortage. But it's critical that pharmacists are viewed as partners. For example, revenue generated remains in the cost center. Sometimes there are concerns about "slicing up the pie," but if done right, increasing access makes the pie bigger and you should see an overall increase in provider RVUs as a result. Unfortunately, panel sizes vary depending on the practice, so there is no magic number for expected increase.

Olson: It's important for pharmacists to be financial stewards but also prevent problems in patients.

Truelove: Pharmacists are medication specialist providers and should be more proactive. To unlock potential, pharmacists will need provider status. Success will come from showing pharmacists are not just dispensing or "managing" medications, but leading medication use to achieve outcomes.

Papineau: To boost patient-pharmacist connectivity, we must develop an 'easy button' utilizing direct-to-patient advertising and EHR integration for seamless appointments and physician referrals. Our challenge now is how to increase pharmacists' capacity to see more patients.

BREAKOUT SESSIONS: THE PULSE ON PRACTICE

The PELA® conference attendees were invited to participate in virtual breakout sessions designed to build on the panelist discussion and gain broader insight into current strategies and practice. Facilitators posed several questions to participants to generate discussion about the current state of primary care and population health program development, challenges, and successes. Five strategic themes emerged from the discussions, which are summarized below: Creating the Value Proposition; Organization Alignment, Integration, and Collaboration; Building Capacity to Improve Patient Access; Leveraging Technology; and Redefining the Pharmacy Workforce.

CREATING THE VALUE PROPOSITION

The value proposition for both medication management and population health programs is revenue-or quality-based, and most commonly a combination of the two. In a value-based environment, most health systems have a process to identify high-risk patients or gaps in care and dashboards to review key performance indicators (KPIs). [SEE Table 1] In addition, some organizations capture operational benefits of the pharmacy-based services that may yield collateral quality or financial improvements such as increased prescription capture for retail and specialty pharmacy, optimized 340B savings, and decreased wait times for a physician visit. Funding complexities and a lack of direct revenue streams present challenges. A significant challenge is how to align the quality measures and billing opportunities when there are multiple payers.

Quantifying and attributing pharmacists' contributions to VBC outcomes is also challenging in team-based care models, despite evident impacts on quality measures like diabetes control. One organization described demonstrating value from a multi-pronged approach and translated interventions into an estimated dollar amount that could be attributed to the pharmacist's interventions. Also, in addition to demonstrating positive outcomes (e.g., dashboard with clinical outcomes or being able to show measurable improvement in quality measures, shared savings criteria, and STAR ratings), having a physician champion is a key driver for gaining approval to expanding access to pharmacist-delivered care.

> "In addition to fee-for-service, our pharmacy ambulatory care footprint is largely based on improving physician access."
>
> - **Breakout group participant**

VALUE PROPOSITION FOR POPULATION HEALTH

Revenue generated from billing for services is unlikely to offset the costs of a pharmacist, thus other benefits need to be articulated to leaders including increasing access and improved quality and safety of populations. There is generally a focus on patients with chronic diseases including hypertension and diabetes. In one model described, the population health pharmacist team focuses on highest need areas. The pharmacist is virtual and has a collaborative practice agreement (CPA) through primary care offices but are not physically in the practice.

> "Typically, populations with quality measure gaps (when there is a financial link to improved quality measure performance) are prioritized."
>
> - **Breakout group participant**

Priorities are often driven by financial incentives built into payer contracts if certain metrics are achieved, and the most common example discussed were the CMS STAR measures or other criteria that drive shared savings. One participant noted that their population health team was established because of engagement in risk-based contracting. Patients are often identified by the payer and dashboards created that show medication-related gaps in care, such as compliance or meeting health-related measures. The pharmacist population health team then works to close those gaps.

LESSONS LEARNED

- Align population health priorities with organizational priorities and where there are financial and quality opportunities.
- Understand metrics defined in value-based payment models and related contracts.
- Create clinical dashboards showing the impact on clinical quality measures such as HbA1c and blood pressure.
- Document value by using a multi-pronged approach, based on not only revenue, but also improvement of metrics that drive value-based incentives.

TABLE 1. EXAMPLES OF KEY PERFORMANCES INDICATORS (KPIS) USED IN PHARMACY-BASED PRIMARY CARE AND POPULATION HEALTH SERVICES

KPI	Value Measures (From Panel)
Cost savings	• 340B savings/optimization • Cost avoidance from resolving drug therapy problems • Medication assistance program savings
Provider Access	• Provider RVUs • Time to initial and follow-up visits
Quality	• Avoidable readmissions • Emergency department visits • Improved patient outcomes • Time for patients to reach therapeutic goals (i.e., BP, A1C, etc.) • STAR adherence measures
Revenue	• Annual wellness visits • Transitions of care encounters • Prescription capture
Satisfaction	• Patient satisfaction • Pharmacist utilization rates • Provider satisfaction

ALIGNMENT, INTEGRATION, AND COLLABORATION

One challenge in value-based payment models, including those with shared savings incentives, is that there are often competing interests; for example, there may be added drug costs to meet guideline-directed therapy recommendations, but the savings are seen in the overall cost of care. Making the case to expand access to pharmacist-provided services requires aligning the organization or service line strategic priorities (e.g., reducing readmissions, improving transitions of care). Demonstrating the value of pharmacist services to those key service line stakeholders early in the collaboration process was seen as key to gaining buy-in and sustaining long-term involvement in population health initiatives.

Pharmacist-based care delivery models can include primary care/clinic-based medication management provided by pharmacists or segregated and decentralized population-based health services. Participants expressed a challenge with the centralized model is building trust with clinic teams compared to the clinic-embedded model. In the primary care model, pharmacists are most commonly patient-facing and embedded in clinics, but some participants described regional integration or a combination with centralized, telehealth-based service delivery. Embedding pharmacists into clinics can also increase capacity by allowing physicians to offload visits like those for refills and focus on more complex care or new patients.

> Building relationships and trust through strong connections with the clinical team and leadership is critical.
>
> - **Breakout group participant**

Integration and coordination of services is critical. The work of embedded pharmacists should align with the population health team, particularly for chronic diseases where there is overlap, such as diabetes, and cardiovascular disease. For example, many services including medication reviews (e.g., MTM Part D) and diabetes care are being performed in outpatient pharmacies and also by population health teams. Participants expressed a challenge with the centralized model, commonly used in population health models, is building trust with clinic teams compared to the clinic-embedded model.

One organization described creation of "stand-alone" medication management clinics that focus on diabetes and hypertension management. (Although it wasn't stated, this model most likely would require a collaborative practice agreement to be in place to thrive.)

Finally, aligning costs with the service entity for pharmacy services is a consideration for some organizations. For example, for one organization, there is a centralized pharmacy reporting structure (recruitment and oversight is by the pharmacy) but pharmacy labor costs are funded out of the entity (e.g., primary care clinic.). Similar cost structures were described for population health pharmacists.

LESSONS LEARNED

- In an integrated, team-based model, it is important to clearly define the role and responsibilities of the pharmacist and to build relationships that foster trust/credibility.
- Pharmacy leaders should ensure that pharmacy is integrated into key stakeholder groups (e.g., care management team, ACO operating committee).
- Pharmacy leaders should reach out to physicians and ask how pharmacy can help; see to understand barriers to providing high-quality, efficient care.
- Pharmacy leaders should engage payers and highlight how pharmacists can impact population health management.
- Standardizing documentation across all platforms would be a crucial first step to improving transparency, promoting collaboration, and reducing duplication of work.

BUILDING CAPACITY TO IMPROVE PATIENT ACCESS

There are several driving forces enabling the pharmacy enterprise to build capacity to see patients. Financial incentives include fee-for-service (FFS) payments or shared savings from VBC models. However, with the shortage of primary care providers and long appointment delays, patient access needs are now a priority. One organization noted that their pharmacy ambulatory care footprint is largely based on physician access in addition to FFS. Technology, for example, using AI to identify high-risk patients, is needed to improve efficiency

and access. Also, several organizations described the use of technicians to support medication access and other functions. For example, having pharmacy technicians focus on medication access and issues impacting adherence quality measures has freed up pharmacist time. One organization noted that they had been so successful with their embedded specialty pharmacists, that they are going to expand to primary care.

LESSONS LEARNED

- Incorporate virtual visits to align service delivery with optimizing 340B and access to medications like GLP1s and SGLT2s.
- Build on prior successes and continually describe the benefit of utilizing pharmacists to increase patient access to care.
- To improve efficiency, leverage the ancillary staff in the clinic.
- Implement collaborative practice agreements to reduce provider burden and enable pharmacists to manage therapy more efficiently.

LEVERAGING TECHNOLOGY

Artificial intelligence, including enhanced documentation within the EHR, and digital health technologies, such as remote monitoring tools and telehealth, are transforming pharmacy practice. Several participants noted that telehealth has helped with small and especially, rural practices that have a need but it is difficult to have a pharmacist there on regular basis (and practices are sometimes so small that more limited pharmacist presence is all that is needed). Several organizations are also utilizing artificial intelligence (AI) in their work, for example, one site applied AI to prescription fill data to identify care gaps based on standard protocols and metrics. This also allows work to be centralized to a refill and prior authorization center. Organizations are also using AI for documentation and ambient listening for notetaking during patient encounters. Other areas for leveraging AI include processing prior authorizations and improved medication adherence. For example, one organization is in the process of implementing an automated phone outreach system that connects patients with medication needs to pharmacists or technicians This will hopefully create efficiencies by having less “cold calling” and more escalation of patients with issues AI outreach can’t address. There is also technology that will let patients more easily identify the most affordable medication options.

The use of e-consults and AI is helping to decrease time spent on certain tasks. For example, at one organization, e-consults are sent to the pharmacist based on payer criteria for infusion center patients. The pharmacist then makes a therapy plan which is sent to the infusion suite. It should be noted that integrating third party technology with the EHR can also improve efficiency, the quality of documentation and recall bias in primary care. Digital technologies being used include continuous glucose monitoring and remote blood pressure monitoring. However, integrating these technologies into the EHR requires oversight and a vendor evaluation process to ensure HIPAA compliance, data flow, and ongoing validation. Also, some organizations’ population health strategies are emphasizing the integration of technology, such as EHR-integrated blood pressure tracking, continuous glucose monitoring (CGM), and AI documentation tools to enhance efficiency and care quality. To improve access to practice providers, one organization has the capability now for physicians to send e-consults to off-site pharmacists (whose primary practice may be within a certain specialty) for clinical input or questions.

LESSONS LEARNED

- Leveraging technologies can improve access to care, including the reach of rural populations.
- Effective applications of new technologies, including AI, will change how work is performed, and can improve efficiency.
- Application of technology requires oversight and monitoring to ensure safe and reliable performance.

REDEFINING THE PHARMACY WORKFORCE

Roles and responsibilities of the pharmacy workforce are rapidly changing, and this can pose challenges in some states, particularly when regulations haven't caught up with new technologies. When evaluating program expansion or implementation, the emphasis is placed on ensuring that pharmacists are positioned to prioritize care for high-risk or high-need patients. This includes ensuring adequate support by non-pharmacy personnel, pharmacy technicians, and leveraging technology. Support for scheduling patient visits, for example, requires collaboration with the clinic or physician practice, and may be a challenge depending on the organization structure and funding/revenue streams. Similarly, it can be stressful for pharmacists to work with expectations from both clinic and pharmacy leadership, thus there needs to be clear role definition and expectations for accountability. Defining roles and responsibilities or scope or practice, such as in a collaborative practice agreement, can help to maintain consistency and protect role integrity across care settings.

LESSONS LEARNED

- Prioritize high-risk or high-need patients to assure pharmacist access to those who are most likely to benefit.
- Ensure adequate support staff, including scheduling support and pharmacy technicians, to perform technical functions and free up time for more complex functions that require a pharmacist.
- Create clear lines of accountability and defined responsibilities for pharmacists in collaborative practice settings/models.
- Seek out opportunities to leverage technology to improve pharmacist efficiency and expand access to pharmacist-based care.

EXAMPLE PHARMACY ENTERPRISE PRACTICE MODEL INNOVATIONS

- Created positions that are more aligned with care process across transitions than siloed inpatient vs. outpatient roles, for example, in transplant services the same pharmacist that sees the patient as an inpatient, follows the patient as an outpatient.
- Piloted a population health approach for patients on Medicare Advantage, working to address gaps including adherence, to improve STAR ratings.
- Embedded a clinical pharmacist in care management teams and when contracting with payers, "sell" care delivery as a team-based "package."
- Shifted to an e-consult process to support provider questions to increase efficiency.
- Embedded pharmacists into population health teams.
- Deployed pharmacy technicians for medication adherence outreach.
- Assigned a pharmacist to each primary care clinic with a focus on chronic diseases. It is a hybrid model of telehealth and in-person. For the smaller practices, there is always virtual availability, but the pharmacists are in clinic once a week or once a month to establish a presence.
- Conducted a successful telehealth pilot and are currently expanding to other clinics. The in-person and telehealth visits are billed incident-to and include evaluation and management (E&M), chronic care management, and wellness visits.
- Built a population health program for ACO patients and teams of pharmacists and technicians are organized by service lines (Medicare, Medicaid, employee health plan, commercial payers, etc.). Patients are identified by an established pharmacy risk score.
- Created a population health pharmacy team (pharmacists and technicians) that is supported by the health system's Population Health Management Office. Technicians support medication access and adherence quality measures, and medication regimen confirmation. Pharmacists focus on provider & care management referrals, quality measures, and interdisciplinary virtual rounds for various specialties. Virtual rounds involve a pharmacist, specialty physician, and care management staff reviewing patients identified with care gaps.
- Established a telehealth program for patients recently discharged to skilled nursing facilities, and also a hospital Follow Up Clinic to support patients recently discharged who are unable to see a PCP in a timely manner.
- Integrated prescription refill programs or created incentive programs into their employee prescription benefit to increase prescription capture.
- Implemented pharmacists to help navigate patients through infusion center care. The pharmacy team handles some pre-infusion services and assists in documentation and the revenue cycle process.

CLOSING REMARKS

Health-system pharmacy leaders are implementing innovative programs in response to the evolving transformation of primary care. While there are challenges, approaching program growth strategically can bring value to the organization and improve patients' access to care. Key strategies include creating the value proposition, ensuring alignment with organizational strategic priorities, building capacity, and redefining roles within the pharmacy workforce.

REFERENCES

1. Executive Summary of the 2024 ASHP Commission on Goals: Primary Care Delivery Transformation. Am J Health Syst Pharm. 2025;82(8):497-503. doi:10.1093/ajhp/zxae324
2. Agency for Healthcare Research and Quality. Defining the PCMH. Accessed May 11, 2025 https:// www.ahrq.gov/ncepcr/research/care-coordination/pcmh/define.html
3. DiPiro JT, Hoffman JM, Tichy E, et al. ASHP and ASHP Foundation Pharmacy Forecast 2025: Strategic Planning Guidance for Pharmacy Departments in Hospitals and Health Systems. *Am J Health Syst Pharm*. 2025;82(2):17-47. doi:10.1093/ajhp/zxae280
4. Sanborn MD. Population health management and the pharmacist's role. *Am J Health Syst Pharm*. 2017;74(18):1400-1401. doi:10.2146/ajhp170157
5. Smith M, Bodenheimer T, Robb K. Health Affairs Forefront. November 13, 2024. Building The Primary Care Workforce with Pharmacist Clinical Services. Accessed August 22, 2025. https://www.healthaffairs.org/content/forefront/building-primary-care-workforce-pharmacist-clinical-services
6. Dodd MA, Haines SL, Maack B, et al. ASHP Statement on the Role of Pharmacists in Primary Care. *Am J Health Syst Pharm*. 2022;79(22):2070-2078. doi:10.1093/ajhp/zxac227
7. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care, Robinson SK, Meisnere M, Phillips RL Jr., McCauley L, eds. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington (DC): National Academies Press (US); May 4, 2021.
8. Robb K. Primary care must transform. Am J Health Syst Pharm. 2025;82(8):387-388. doi:10.1093/ajhp/zxaf014
9. Kyruus Health. 2023 Care Access Benchmark Report for Provider Organizations. Accessed on September 5, 2024. https://kyruushealth.com/resource/2023-care-access-benchmark-report-for-provider-organizations/

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