

“Keys to Unlocking the Past, Present and Future of Health-System Pharmacy”



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American Society of
Health-System Pharmacists®

TOGETHER WE MAKE A GREAT TEAM

Historical Perspective on Hospital and Health-System Pharmacy in the United States

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Why is an Understanding of the History of Our Field Important?

- **Part of what it means to be a professional person**
 - ❖ **Pride in the leadership and achievements of our predecessors**
- **Foundation for shaping the future**
- **Understand how change happens—basis for practice leadership**
 - ❖ **Distinction between external and internal factors in our development as a profession**

Major Changes over 50 Years

- **Hospitals have recognized universally that pharmacists must be in charge of the acquisition, distribution and control of medicines**
- **Hospital pharmacy departments have a major role in patient safety**
- **Hospital pharmacy departments have assumed a major role in promoting rational drug therapy**
- **Hospital pharmacy departments have come to see their mission as fostering optimal patient outcomes from medication use**

Major External Factors in Growth of Hospital and Health-System Pharmacy

- 1. Social factors: hospitals changed from housing “exiled human wreckage” to centers of diagnosis and intense treatment**
- 2. National health reform: hospital construction; health insurance; Medicare**
- 3. Problems in hospital control of medicines (Am. Hosp. Assn. 1937: handling of medicines “chaotic”; ignored)**
- 4. Revolution in health care technology (medicines, imaging, surgery)**
- 6. Escalating cost of medicines**
- 7. Accreditation requirements (quality concerns)**



Major Internal Factors in Growth of Hospital and Health-System Pharmacy

1. **Visionary leadership**
2. **Professional associations**
3. **Pharmacy education**
4. **Postgraduate residency education and training**
5. **Practice standards**



Visionary Leadership

- **Recognition of special opportunities to advance the whole profession by developing hospital pharmacy**
- **Stories of leaders:**
 - ❖ **Arthur Purdum**
 - ❖ **Edward Spease**
 - ❖ **Harvey A. K. Whitney**
 - ❖ **Donald E. Francke**
- ***Mirror to Hospital Pharmacy***
- **Goals for Hospital Pharmacy**



Professional Associations

- **Hospital pharmacists began to organize to advance their professional needs**
 - ❖ **Local, regional, state societies (beginning 1925)**
- **APhA Subsection on Hospital Pharmacy (1936)**
- **American Society of Hospital Pharmacists (1942)**
 - ❖ **Nurturing professional ideals**
 - ❖ **Tools for advancing practice**
 - ❖ **Concentrated focus on a limited number of goals**



Evolution of U.S. Pharmacy Education

1907	2-year Graduate in Pharmacy
1925	3-year Graduate in Pharmacy or Pharmaceutical Chemist
1932	4-year Bachelor of Science
1960	5-year Bachelor of Science
2004	6-year Doctor of Pharmacy



Postgraduate Residency Education and Training

- **Early priority of ASHP was to improve hospital pharmacy internships, stemming from great disappointment in pharmacy education's lack of attention on hospital pharmacy**
- **Hospital pharmacy residencies began in the 1930s**
- **ASHP accreditation program began in 1962**
- **Residencies create change agents for the profession**
- **Height of mentorship in professionalism**

Practice Standards

- **Authoritative advisory document on the optimal method for addressing an important issue or problem**
- **Minimum Standard for Pharmacies in Hospitals**
 - ❖ **First promulgated by American College of Surgeons in 1936**
 - ❖ **Revised since by ASHP**
- **Today, nearly 90 ASHP documents that deal with the most critical aspects of hospital pharmacy department operations and controversies in therapeutics**
- **Source of Joint Commission standards on the hospital medication use process**

Lessons from Our History

1. **Fundamental change requires leadership and time**
2. **Important to build consensus about a vision for the future and about the changes that are needed to achieve that future**
3. **Capitalize on changes in the environment**
4. **Periodically reassess and reinvigorate**

For Further Study

1. **Higby GJ. American pharmacy in the twentieth century. *Am J Health-Syst Pharm.* 1997; 54:1805-15.**
2. **Zellmer WA. Overview of the history of hospital pharmacy in the United States. In: Brown TR (ed). *Handbook of institutional pharmacy practice*, 4th ed. Bethesda, MD: American Society of Health-System Pharmacists; 2006.**
3. **Harris RR, McConnell WE. The American Society of Hospital Pharmacists: a history. *Am J Hosp Pharm.* 1993; 50 (Suppl 2): S1-45.**
4. **Francke DE, Latiolais CJ, Francke GN et al. *Mirror to hospital pharmacy*. Washington, DC: American Society of Hospital Pharmacists; 1964.**
5. **Harvey A. K. Whitney Award Lectures (ASHP). www.harveywhitney.org**

Current Perspectives on Hospital and Health-System Pharmacy in the United States

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Current Issues Affecting Pharmacy Practice: Some Things Don't Change

But they may become more important:

- **Prioritization**
- **Integration**
- **Adaptation**



Clinical Practice

- **If you don't like the term "clinical," give me an alternative**
 - ❖ **Then let's get to work**
- **One pharmacist demonstrating his or her value to one health professional or patient at a time**
- **Individual pharmacists with cognitive-based practices recognized by peers**
 - ❖ **Ambulatory setting**
 - ❖ **Home care setting**
 - ❖ **Academic medical care setting**
 - ❖ **Community hospital setting**



Pharmacy Now – Glass Half Full

- **Implementing expensive technologies that will free up pharmacist's time**
 - ❖ **Good news: More expansive roles for pharmacists until implemented**
- **Leadership (vision) to develop and maintain excellent sites and free up preceptors for advanced practice roles**
 - ❖ **Good news: excellent pharmacists willing and able to step into preceptor role**



Pharmacy Now – Glass Half Full

● Continuity of care

- ❖ As it relates to pharmacy, inconsistent access to the care of a pharmacist
- ❖ If we are needed so much, how can we not be available the vast majority of time
- ❖ As with other issues, particularly a concern in small systems
- ❖ Good news: more health professionals demanding continued access to pharmacist



Pharmacy Now – Glass Half Full

- **Numbers of generalists versus specialists in pharmacy realizing:**
 - ❖ **We are all specialists to some degree**
 - ❖ **Diversity of roles for pharmacists likely to continue to increase**
 - ❖ **Specialization naturally follows biotechnological advancements**
 - ❖ **Goal shouldn't be “equality” by cognitive-based practice aimed at lowest common denominator**



Pharmacy Now

- **Constantly changing roles (the one constant – change)**
 - ❖ **What is a patient care team?**
- **Increasing inter-disciplinary, inter-professional, or inter-whatever**
 - ❖ **“Our knowledge of the external world”**
 - ❖ **Deans’ Teaching Scholars Program at University of Arizona**



Institute of Medicine

- *To Err is Human: Building a Safer Health System*
- *Crossing the Quality Chasm: A New Health System for the 21st Century*
- *Preventing Medication Errors*
 - ❖ **Interdisciplinary effort with interdisciplinary recommendations for education and practice**

“Just give what I ordered...”

“Physicians who need me the least...”



Intra- and Inter-Disciplinary Hierarchies

- **Has usefulness but may be overstated (e.g., code with trained health care professionals)**
- **Barriers tend to be broken down through sustained interactions**
 - ❖ **Research**
 - ❖ **Service (e.g., professional meetings, committee work, inter-organizational collaborations)**



Example of Interdisciplinary: Critical Care Medicine

- **Inter-organizational collaborations**
 - ❖ **ASHP with Society of Critical Care Medicine (SCCM) and American College of Chest Physicians (ACCP)**
- **SCCM**
 - ❖ **Offices**
 - ❖ **Guidelines**
 - ❖ **Publications**
 - ❖ **Education**
- **ACCP**



I Believe in my Profession

- **Example: infusion clinic**
- **Example: intensive care unit**
- **Example: emergency department**
- **Example: nutrition support**



“A View from the Other Side of the Fence”

Cindi Brennan, Pharm.D., MHA, FASHP



Pharmacy Practice Model

At least three distinct practice models in hospital pharmacy:

- **Drug Distribution Centered Model**
- **Clinical Pharmacist Centered Model**
- **Patient Centered Integrated Model**



Pharmacy Practice Model

Drug Distribution Centered Model

- **Reactive order processing role**
- **Minimal pharmacist involvement with healthcare team**
- **Minimal accountability for patient outcomes**
- **Minimal leadership in medication use process**



Pharmacy Practice Model

Clinical Pharmacists Centered Model

- **Pharmacists practice exclusively in clinical or distributive roles**
- **Only clinical pharmacists involved with healthcare team and impact patient outcomes**
- **Clinical pharmacists rarely provide leadership in overall medication use process**



Pharmacy Practice Model

Patient Centered Integrated Model

- **Pharmacists accept responsibility for clinical and distributive functions**
- **Well-trained Technicians handle drug distribution functions**
- **Pharmacists proactively engaged in medication selection, use and outcomes on interdisciplinary team**
- **Pharmacists provide leadership and ownership for the medication use process**



Pharmacy Practice Model

People do not know what to expect from a pharmacist

- **Non-standardized services**
- **24/7/365 coverage?**
- **Different models of care at different institutions**
- **Patients probably do not know they have a pharmacist**

Do pharmacists know what to expect of themselves?



Challenges For The Profession

Internal Drivers

- **Pharmacists are “shy”**
 - ❖ **New pharmacists not trained or not confident in demonstrating skills or establishing new services**
- **Comfortable, afraid of change; enjoy status quo**
 - ❖ **Many academic centers eat “change” for breakfast**
- **Inability to communicate**
 - ❖ **Audience cannot hear what you are saying because of how you are saying it; it is not resonating with audience**



Challenges For The Profession

External drivers

- **Technology**
 - ❖ **Pharmacy linked to its mastery of technology (Epic/Cerner) not for their clinical expertise**
 - CPOE: pharmacy is generally the leader because we know and understand the system, thus we get overlooked for the clinical knowledge provided and are linked to “systems analysts”
- **Accreditation (TJC) and Payers (CMS)**
 - ❖ **Med rec/anti-coag/abx management**
 - ❖ **Pay-for-performance (P4P)**
- **C-suite expectations**
 - ❖ **C-Suite evaluating widgets and not service**
 - ❖ **Traditional pharmacy benchmarks don't always reflect patient care activities**
- **Economy**
 - ❖ **Doing more with less**



“To Infinity and Beyond”



Together we make a great team



Leadership Traits

- **“Can do attitude”**
 - ❖ We hire for attitude, train for skills
- **Accountable, takes responsibility and has high integrity**
- **Makes the right decision, not easiest decision**
- **Works collaboratively with formal and informal leaders**
- **Change champion**
- **Can think outside the box**
- **Making changes that can influence the overall practice of pharmacy**
- **Title does not constrain actions**



Care Model Considerations

- **Increased ambulatory visits due to decreased hospital length of stay**
- **Preventative medicine vs. reactive medicine**
- **Fewer treatment options due to a drying pipeline of traditional medications**
- **Increasing number of biologics/gene therapy**
- **Replacement of clinical pharmacist by mid-levels**
 - ❖ **PAs and NPs are less expensive**
 - ❖ **Can bill as “providers”**



One Vision

Pharmacy Practice in the Future

- **Cognitive**
- **Interdisciplinary**
- **Increased credentialing**
- **Diverse pharmacists to match diverse population**
- **Increased (but fairly stable) numbers of general pharmacists**
- **Increased responsibility and expectations in all areas of practice**
- **Increased numbers of specialized pharmacists in parallel with increased technological advancements**



The Future- Threats

- **Increasing demand for health care services by aging and ethnically diverse population**
- **Increasing use of sophisticated medications and technologies; increased specialization**
- **Pharmacy education will need to change in conjunction with changing system**
 - ❖ **Projections regarding numbers and types of pharmacists are only projections**
- **Need for postgraduate education and training (e.g., residencies) will only increase**



The Future- Opportunities

- **Positive attributes of increasing diversity**
- **Pharmacist focus on cognitive skills with increased use of technology and increased potential for enhanced job satisfaction**
- **Technology will allow for enhanced ability to deliver pharmacy education to a wide variety of students in a wide variety of settings**
- **Improved postgraduate education and training likely to foster expanded roles for pharmacists**



The Key Question

Which paradigm will become dominant?:

The pharmacist is responsible for ensuring that a patient receives the medicine ordered by the physician and that the medicine is safe to use.

The pharmacist is responsible for helping a patient make the best use of medicines.

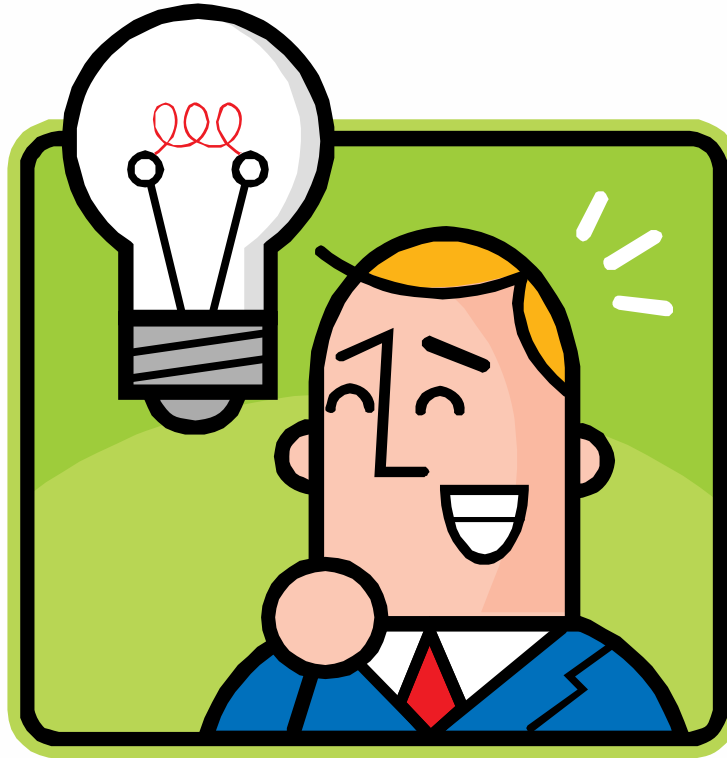


Factors that Will Influence the Answer

- **Health reform, including payment**
- **Leadership in the profession**
- **Pharmacist practice-model reform**
- **The forces of corporatization**
- **Provider status**
- **Pharmacy technicians**
- **Public demand for clinical pharmacist services**
- **The hearts and minds of pharmacists**



Final Thoughts.....



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