SPECIAL FEATURE

Pharmacy without walls

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Abstract: Attributes of excellence in pharmacy management are described: big-picture thinking, the ability to exploit change, and willingness to take risks.

Big-picture thinking means understanding trends that are shaping health care in order to determine where pharmacy fits. Health systems look beyond inpatient care and use case managers to maximize resource use; pharmacists might serve as case managers. Managed care has caused physicians to be more receptive to resource-management strategies, such as clinical pathways; pharmacists can collaborate in the development of clinical pathways. Pharmacists can serve as physician extenders; for example, by conducting anticoagulation or hypertension clinics. Pharmacists need flexibility to adapt to changes in the internal organization of acute care institutions; they will need to learn about the clinical, behavioral, operational, and fiscal aspects of managing the total patient. New reporting relationships give pharmacists the opportunity to demonstrate to other members of the health care team their role in preventing, managing, and resolving drug-related problems throughout the continuum of care. Risk-taking can mean setting ambitious goals. By setting and achieving ambitious goals for products and services, pharmacists can raise patients' and other health care providers' expectations for pharmacy services. Pharmacists' success will depend on their willingness to experiment with new services and discard services that do not substantially advance patient care.

Pharmacists must monitor changes in the provision of health care, determine the implications for their practice, and seek opportunities for participation outside the walls within which they have traditionally practiced.

Index terms: Administration; Administrators; Health care; Pharmacists, hospital
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We are at a crossroads with respect to the future of health care delivery in the United States. A number of us grew up in an era when health care was provided according to the "military metaphor" recently described in the *New England Journal of Medicine*:[1] a metaphor of medicine as a war against disease, a "medical arms race" based on the belief that all problems could be solved with more sophisticated technology. In recent years, that metaphor has been supplanted by a market metaphor, in which health plans and hospitals market their products to consumers and medical care is a business primarily motivated by profit. In this metaphor, "the goal of medicine becomes a healthy bottom line."[1]

In many parts of the country—certainly in the West, where I am from, and the East, especially here in Boston—we have seen the impact of market-driven changes on the structure and function of institutions and pharmacy departments. Merger mania, integration (and in some cases, disintegration), capitation (and in some cases, decapitation), managed care, and managed profit are all part of the lexicon of health care in the 1990s. Although the pursuit of quality has been a major theme in health care organizations over the past five years, our actual achievement of quality is dubious. In his 1989 Webb lecture, Bill Gouveia[2] described management excellence as the ability to "navigate permanent white water." Six years later, I beg to differ slightly with his assessment. At least one can see white water. I would use the metaphor of the Bermuda Triangle to describe the challenges we are currently facing. The corners of the triangle are managed care, quality, and profit, and the provider and patient are inside the triangle. As managed care becomes the predominant arrangement for health care delivery, we are seeing an attempt to juxtapose the disparate goals of quality and profit, and

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we find ourselves asking, "Will patients and providers find themselves lost within health care's Bermuda Triangle?"

To compete in the marketplace, institutions are implementing strategies to reduce operational expenses. Among these are the implementation of patient-focused care and the elimination of traditional departmental structures. In some situations, pharmacy staff members are reallocated to nursing units as part of a team of caregivers. In other instances, the pharmacy director position has been eliminated and the department reports to an individual who may not have any background in pharmacy. Internal competition among institutional departments for staff and resources will continue to intensify as institutions struggle to reduce their cost of providing care. How this all shakes out will have significant implications for the practice of pharmacy. Thus, we are at a critical juncture where sustaining the programs that we have worked so hard to develop and taking the necessary steps to continue to advance the practice of pharmacy will require stretching ourselves to the maximum. To characterize success in the 1990s, Popcorn[3] quoted the queen in *Alice in Wonderland*: "It takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run twice as fast as that!"[3] This is an apt characterization of the outlook for pharmacy.

The theme of the Webb lecture series is achieving management excellence in hospital pharmacy practice. I will outline the attributes that I believe represent management excellence in the current and near-future health care environment: big-picture thinking, the ability to exploit change, and a willingness to take risks. The ability to thrive in this environment will require that pharmacy managers and practitioners apply these principles of excellence in their daily practice. Before I present my thoughts on these attributes, I will briefly explore the evolution of our profession in this century.

Changes in practice setting and clinical role

For most of this century, pharmacy has been practiced in structured settings, evolving from the soda shop to the community pharmacy and from the basement hospital pharmacy department to decentralized services including satellite pharmacies. The clinical role of the pharmacist has also evolved within these structured settings. As early as the 1921 APhA annual meeting, Krantz challenged pharmacists "to look beyond the mere filling of prescriptions to the great promising field of 'clinical services.'"[4] The clinical pharmacy movement began in the 1960s. In 1966, Brodie identified drug-use control as "the mainstream component of pharmacy practice."[4] Also in 1966, the University of California at San Francisco, under the leadership of Bill Smith, initiated the "ninth-floor project" to demonstrate the role of the decentralized pharmacist in providing clinical services to patients and members of the health care team.[5] Ten years ago, the leaders of hospital pharmacy convened at Hilton Head to assess the status of clinical pharmacy and identify methods for advancing clinical practice. The conference stimulated the entire profession to identify means of eliminating barriers to clinical practice.[6] More recently, in 1990, Hepler and Strand defined "pharmaceutical care" as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life."[7] The provision of pharmaceutical care has been embraced throughout the profession as the goal for pharmacy practice.[8]

An examination of our history over this century reveals two key elements. The first is that pharmacy practice has existed primarily within structured environments. I'll come back to this subject a little later. The second relates to the mission or core ideology of the profession. If we examine the terms associated with the aforementioned milestones in pharmacy practice—clinical practice, drug-use control, services to patients, responsibility for drug therapy, and improving patient outcome—it is evident that a core theme has existed for the profession for a large part of this century. This theme is responsiblity for patient outcomes through the provision of clinical services. Having such a unifying theme or core ideology is a key characteristic of companies that have withstood the test of time, according to Collins and Porras[9] in their book, *Built to Last*. The authors describe companies that have been in existence for at least 50 years, "have made an indelible imprint on the world," represent "premier organizations within their industry," and have been through "multiple product (or service) life cycles." These companies' core ideologies—their values and purpose—have enabled them to evolve to meet and in many

The John W. Webb Visiting Professorship in Hospital Pharmacy was established in 1985 at the College of Pharmacy and Allied Health Professions at Northeastern University, Boston, Massachusetts. Webb was Director of Pharmacy at Massachusetts General Hospital from 1959 until his retirement in 1983. After receiving Bachelor of Science and Master of Science degrees from the Massachusetts College of Pharmacy in 1949 and 1951, respectively, Webb was Director of Pharmacy at Hartford Hospital and worked at the University of Connecticut before returning to Massachusetts General Hospital in 1956 to become Assistant Director. Webb also served as director of the graduate program in hospital pharmacy at Northeastern from its inception in 1964 until his retirement, and he is the author of numerous contributions to the pharmaceutical literature.

A hospital pharmacy practitioner is appointed to the visiting professorship each year in recognition of his or her commitment to hospital practice, experience as a practitioner and educator, and dedication to publishing management-related articles. The visiting professor presents a lecture on excellence in management to students in the graduate program.

instances anticipate the needs of the markets that they serve, rebound after setbacks, and stimulate progress. It is apparent that the core ideology of the pharmacy profession has enabled us to advance our practice and achieve recognition of the pharmacist as a member of the health care team, but are we "built to last"? To answer this question, we need to explore attributes that characterize contemporary pharmacists and compare them with the attributes that will enable us to succeed in the future.

Becoming visible and audible. The term "invisible" has often been used to characterize the role of the pharmacist in patient care. In 1981, the American Association of Colleges of Pharmacy, along with six national pharmacy practitioner organizations, identified communication training as an area of major deficiency in pharmacy school curricula.[10] The authors of a paper entitled "The Quiet Pharmacist" estimated that 20–30% of pharmacists try to avoid communication whenever possible.[10] In 1984, ASHP created a videotape entitled "The Invisible Ingredient" for the purpose of educating other health care providers about the role of the clinical pharmacist. Sadly, the perception of the pharmacist as the invisible ingredient still exists today. In a recent commentary entitled "Invisible Care," *AJHP* manuscript editor Stephen R. Kepple[11] noted that, except for patient counseling, the role of the pharmacist is largely invisible. He admonished that "pharmaceutical care should be something that patients openly demand, like clean sheets and board-certified surgeons." In the current environment, we cannot afford to be invisible.

Accepting change as the norm. An analysis of the attitudes, values, interests, and opinions of 409 clinical pharmacists was conducted in 1988.[12] Some characteristics of the clinical pharmacists were as follows:

- Hold beliefs tenaciously
- Difficult to change their minds
- Ideas and values are usually traditional
- Concern for helping people
- Need lives to be orderly and make sense
- Need to feel independent
- Set high goals for themselves and others
- Lack creativity
- Prefer strong leadership

The analysis concluded that clinical pharmacists are hard-working professionals committed to patient care and somewhat resistant to change. Yet, in the current marketplace, change appears to be the only consistent norm. Zilz acknowledged this in his keynote address at the Pharmacy in the 21st Century III conference held in October 1994: "There is no middle ground," he said. "You either will change to thrive or you will remain static and decay."[8]

What's out? What's in? A look at some of the key differences between traditional health care delivery and managed care can help define the changes that are needed. Hospitals have been one of the principal settings in which pharmacy practitioners could demonstrate their contributions to patient care. In the current context of health care delivery, however, hospitalization is considered a systems failure or, in the words of Paul Pierpaoli,[a] a "mistake." A list of elements of health care that are considered "out" and "in" would read as follows:

- Episodic care is out; continuum of care is in.
- Hospitals are out; integrated health care delivery systems are in.
- Departments are out; re-engineered processes with teams and case managers are in.
- Admissions are out; wellness is in.
- Specialist physicians are out; primary care physicians and physician extenders—nurse practitioners, physician assistants, . . . and maybe pharmacists—are in.
- The art of medicine is out; the business of health care is in.

Clearly, this new model for health care provides both opportunities and risks for pharmacists. Pharmacists' role as physician extenders has not been fully realized. Some pharmacists may have a problem with this title, believing that it eliminates some of their autonomy and identification as a professional. Personally, I believe we need to exploit the opportunities afforded by this newly evolving model for health care delivery. Doing so will require us to apply the principles of excellence to our practice.

Big-picture thinking

From my perspective, excellence in our ever-changing environment requires "big-picture thinking." This means understanding the trends that are shaping health care in order to determine where pharmacy fits and what actions are needed. An awareness of these trends is critical at a time when changes are occurring in such a frenetic manner. Popcorn[3] refers to "trendbending"—using emerging trends to shape strategies, products, and services for companies. She notes that trends may start small, and one needs to "connect the dots" to see the total picture. What are some "dots" that can help us determine where pharmacy fits in the evolving model for health care delivery?

Understanding the business of health care. Many of us have spent our careers focusing only on five to seven days of a patient's life, uninvolved in the patient's care before admission and after discharge from the hospital. In the past, hospitals were not motivated to develop mechanisms to manage patients outside the acute care realm, largely because reimbursement practices lacked incentives for institutions and practitioners to look at the big picture. The new focus on keeping patients out of the acute care setting has resulted in the creation of case managers. The case manager is responsible for managing patients across the continuum of care to prevent unnecessary office visits and admissions to the emergency room or hospital. When a patient is

admitted, a case manager works with the caregivers and family to facilitate the patient's discharge. What are the implications of this trend for pharmacy? Could pharmacists serve as case managers for patients with diseases for which medication is a major component of treatment? A pharmacist case manager could interact with the patient and family members during the acute care episode and then follow up with the patient after discharge. Another pharmacist case manager could be responsible for ongoing follow-up outside the hospital.

The acute need for big-picture thinking has been precipitated by the evolution of managed care and the implications the corporate practice of medicine holds for our careers. Paul Pierpaoli,[13] in his 1986 Webb lecture, stated that "business people are now considered to be the chief architects of redesign of the health care system." Although we pharmacists may not characteristically be enthusiastic about the business aspects of our practice, an understanding of the principles governing the changes in health care reimbursement can help identify opportunities for our involvement in organizational initiatives. Capitation gives physicians incentives to work with hospitals to reduce resource consumption, since the dollars saved remain in the health care system to be used for salary bonuses, acquisition of new technology and so on. As a result, physicians become more receptive toward participation in resource-management strategies. One such strategy is the development of clinical pathways; this strategy provides an excellent opportunity for pharmacist collaboration in the development of guidelines to ensure appropriate medication management.

Along with understanding the business of health care, big-picture thinking also means looking beyond traditional roles and settings to see how various functions depend on each other and how changes in one function affect the other. In the non-acute-care environment, we are witnessing increased use of physician extenders such as nurse practitioners and physician assistants. These individuals free up the physician's time to see more patients. In a managed care environment, the goal is to increase the number of members to bring in a steady stream of revenue and to spread the risk of catastrophic illness across a larger number of members. Increasing physician panel size, defined as the number of patients that can be managed by a physician, enables the physician group or the integrated system to add more members. When physician extenders free up physician time, physicians can see more patients. This concept offers a number of opportunities for pharmacists. For example, pharmacists can establish anticoagulation, hypertension, or cholesterol-monitoring clinics, which can allow the physician to see more patients. Pharmacists can also participate in developing practice guidelines, monitor medication use, and educate patients and other health care providers. One can also envision pharmacists practicing in specialty medical groups, such as in oncology or infectious diseases, in which patients are receiving complex medication therapies. Thus, knowledge of the business aspects of the current health care environment enables one to strategically plan for pharmacist positions in nontraditional practice settings.

Studying the environment. In preparation for the Battle at Little Bighorn, Sitting Bull carefully studied not only the physical terrain but the actions—both purposeful and inadvertent, the characteristics, and the behaviors of Custer and his soldiers during the months preceding the battle.[14] Similarly, pharmacists can study the elements of change occurring in health care to create our future. For example, with the new emphasis on wellness and preventing hospitalization, how can pharmacists make a contribution? Recently, Johnson and Bootman[15] estimated the cost of drug-related morbidity and mortality at $76.6 billion annually. What actions can we take to identify and prevent drug-related problems in our own practice settings? In an integrated health system, could pharmacists staff a hot line to answer patients' questions about their drug therapy and possibly prevent unnecessary visits to the emergency room or the physician? Should pharmacists periodically call patients at home who have been identified as at risk for noncompliance, to determine if they are taking their medications as prescribed?[16]

To attract and maintain members, health plans and providers are placing increasing emphasis on patient satisfaction. One tool for measuring patient satisfaction and other aspects of care is the Health Employer Data Information Set (HEDIS), developed by the National Committee for Quality Assurance.[17] Some employers have decided to use only health plans that report annual HEDIS data. The categories evaluated by HEDIS include quality, access and patient satisfaction, membership and utilization, and finance. What are the implications of this increased emphasis on patient satisfaction and quality? Could increased interaction between patients and pharmacists through a hot line or pharmacist-run clinics result in increased patient satisfaction and ultimately influence a patient's choice in selecting a health plan? Although HEDIS currently does not specifically measure quality relating to pharmacy services, readmissions of patients with asthma are evaluated as an indicator of quality. Can pharmacists play a role in the development of practice guidelines to prevent asthma readmissions? As future versions of HEDIS are developed, what opportunities will exist for pharmacist involvement in improving the quality of care?

The pharmaceutical industry is in the process of reinventing itself with the many mergers, acquisitions, and joint ventures that seem to occur almost weekly. The most thought-provoking model has been the purchase of pharmacy benefit management companies (PBMs) by pharmaceutical companies. What are the implications of these changes for pharmacy practice?

PBMs provide access to patient and provider utilization data that will enable the drug companies to provide disease management programs to health plans and providers. Disease management is defined as "a comprehensive, integrated approach to care and reimbursement based fundamentally on the natural course of disease, with treatment designed to address the illness with maximum effectiveness and efficiency."[18] A number of organizations are designing disease management programs to determine what factors and interventions in the management of a given disease will improve effectiveness and efficiency. Although these programs are in their infancy, it is not unlikely that a company could approach an integrated health system and offer to manage a number of chronic diseases on a shared-risk basis. Is the pharmacist practicing in the health system positioned to participate in this program, or will the program be managed by the drug company's internal staff? By studying the changes in industry, pharmacists can offer to assist their institution or health system in the development of a disease management program. Alternatively, if the decision is made to partner with a commercial disease management company, pharmacists can offer to participate in the program.

One of the trends for the 1990s described in *The Popcorn Report* is cocooning, defined as "the impulse to go inside when it just gets too tough and scary outside."[3] The uncertainties in the current health care environment foster a desire in all of us to stay in the cocoon. However, our ability to promulgate the role of the pharmacist in patient care will require the opposite kind of behavior. To succeed we will need to diligently monitor the changes occurring around us, determine the implications of these changes for pharmacy practice, and maintain a proactive approach.

Exploiting change

In his 1992 Webb lecture, Bernard Mehl[19] stated that "excellence must be defined to include flexibility or the ability to adapt to differing situations." Changes in our practice environments will continue as institutions restructure, reengineer, and reinvent themselves in order to compete in the marketplace. The changes we are seeing within hospitals parallel the evolution from institutions to integrated delivery systems that provide seamless care. Shortell et al.[20] described the transition in the internal organization of acute care institutions as a "new management culture" that emphasizes "managing across boundaries . . . thinking beyond the boxes . . . and acting outside the bricks and mortar." Many of our organizations are eliminating traditional departmental structures in order to manage services and processes that are focused on the care of the patient instead of the management of an individual department. Consistent with this change, patient management is provided by a team of health care providers rather than staff from multiple independent departments. As traditional roles, relationships, and practice environments change, the new culture will require a tremendous amount of flexibility and willingness to move beyond the walls within which we have practiced.

The uncertainty associated with these changes means that our work life will have "fuzzy edges" for some time. Although this may be difficult for pharmacists who have traditionally "needed their lives to be orderly and make sense,"[12] we need to learn how to take advantage of this ambiguity to position the pharmacist as an integral member of the health care team. Paul Pierpaoli[13] said in 1986 that pharmacy leaders need to be able to "tolerate and transcend ambiguity." He also cited the need for the "bilingual pharmacy director" who could manage the business and operational aspects of the department as well as its professional role in the provision of clinical services. Today, it will be the "multilingual" pharmacy leaders and practitioners who will be able to thrive.

Pharmacists will need to develop a number of skills to succeed within this new framework for health care delivery. Managers and practitioners will need to learn about the clinical, behavioral, operational, and fiscal aspects of managing the total patient. Pharmacists' successful integration into the team will require an understanding of what each member does for the patient, how each member's role affects the care and outcome of the patient, how each role relates to the roles of the other team members, and how the care affects the "bottom line." To achieve this new way of thinking, pharmacists and other health care providers will need to commit to learning as a team to break down the traditional compartmentalized approach to patient care. Turf battles will probably be an inherent part of this process but will also afford pharmacists the opportunity to educate other disciplines about their unique role in optimizing drug therapy. Pharmacists will need effective communication skills to work with team members and patients. Wright and Manasse[21] recently wrote that pharmacists need to develop skills in the social and behavioral sciences in order to communicate and care for the whole patient "in the context of a partnership of prescriber, pharmacist, and patient." The focus on treating the whole patient will necessitate that pharmacists learn the language of outcomes management and collaborate with other team members to determine which factors in the care process result in the most cost-effective outcomes.

In these new delivery models, practitioners and managers will likely be reporting to individuals who have varying degrees of experience working directly with pharmacists and therefore may not be fully aware of the pharmacist's contributions to patient care. An individual's expectations are based on past interactions and experiences. One of the keys to achieving excellence is creating expectations by demonstrating what is

possible. New reporting relationships afford an opportunity to educate other team members about the role of the pharmacist in the prevention, management, and resolution of drug-related problems across the continuum of care. By demonstrating their "multilingual" understanding of the changes occurring in health care, pharmacists can take the next step by offering to develop programs and services in both the acute and nonacute settings that reflect the goals of the institution or health system. Excellence will be achieved by using change to advance the practice of pharmacy within the health care system.

A few words must be said about pharmaceutical care in the new context of health care delivery. Pharmaceutical care has served as a unifying goal for the profession. However, it is *patient* care and not medical, nursing, or pharmaceutical care that is the prevailing theme in health care organizations today. Efforts to promulgate pharmaceutical care may actually jeopardize the ability of pharmacists to fully develop their role as key members of the health care team. Team members who do not understand the intent of pharmaceutical care may interpret the term as serving only the profession of pharmacy and not the patient. Ironically, pharmacists who have integrated themselves into the patient care team will be in the best position to provide pharmaceutical care.

Taking risks

One characteristic of visionary companies cited in the book *Built to Last*[9] is the establishment of Big Hairy Audacious Goals (BHAGs). In 1924, Thomas Watson, the president of the Computing Tabulating Recording Company, decided to change the company's name to International Business Machines (IBM). Watson's BHAG was to transform his average company that sold time clocks and weighing machines to a company with a global presence. The authors of *Built to Last* state that BHAGs stimulate progress and move organizations outside of the "comfort zone." BHAGs also require a certain level of unreasonable confidence; a willingness to take risks is a prerequisite to establishing these goals.

Risk is defined in *Webster's New Riverside University Dictionary* as "the possibility of suffering harm or loss"; synonyms for risk-taker include gambler, entrepreneur, and experimenter. Year after year our profession has achieved the status of the most trusted professional in polls of consumers.[22] I would venture to guess that none of the voters who selected us as number 1 would characterize pharmacists as risk-takers. Yet we are all aware of examples in which pharmacists have taken risks and ventured into new areas of practice. The ninth-floor satellite pharmacy at UCSF in 1966, the establishment of anticoagulation clinics, and the development of home care programs are all examples of risks that pharmacists have taken. The individuals who initiated these programs probably had a BHAG in mind, which they then translated into reality. What began as an experiment led to advancement of the practice of pharmacy. Had these pharmacists asked the other members of the health care team if they wanted these services, they probably would not have received a definitive response. Xerox Corporation had a similar experience when it developed its first copying machines. The company offered to sell some of the patents to IBM but IBM, seeing no major market for copiers, decided against buying the patents. Since businesses had never had large-scale copying capability, IBM did not see a large market for the copiers.[9] Remember, expectations are based largely on experience. Therefore, once products and services are created, expectations are also created. Most of us could not imagine life today without a copying machine.

Have you ever discontinued a pharmacy service? What happens? My experience is that when we discontinue services, we receive complaints. We experienced this recently when we had to close a retail pharmacy where we had an outstanding pharmacist who worked closely with patients and physicians. The pharmacy was not fulfilling the desired revenue goals. After we announced the closure, I was overwhelmed with calls from patients and physicians who were distraught about no longer having "their pharmacist" available.

Our BHAG as a profession should be to create an expectation on the part of patients and health care providers that pharmacists are integrally involved in ensuring the appropriate use of medications in all health care settings. I believe Bill Smith[23] had this in mind when he indicated in his 1987 Webb lecture that the "measurement of management excellence has to be that all patients who need clinical services receive them." I already raised the possibility that patients' decision to select one health plan over another might be influenced by their level of satisfaction with the services provided by the pharmacist. This is one of my own personal BHAGs. The challenge we face is how to achieve these BHAGs for the pharmacy profession.

Collins and Porras[9] described the belief of visionary companies in experimentation, as illustrated in 3M's philosophy: "Let's try a little stuff and keep what works." Post-it Notes are certainly an example of something that worked beyond everyone's expectations. Visionary companies are known for experimenting and allowing products and services to evolve based on the needs of the marketplace. Initiative is fostered in order to promote creativity and progress. If we adopt this premise from successful companies, then our own success in the current and future environment will be determined by our willingness to experiment with new services and discard those that do not appear to significantly contribute to patient care. This means that we need to be willing to take the risks associated with trying out new programs and services. Given the economic constraints that we are all experiencing, these

experiments will most likely need to be accomplished with existing resources. Therefore, we will need to evaluate our operations and determine what changes to make in order to allocate staff to new programs. Changes that increase efficiency, such as automation, outsourcing, and increasing the use of technicians, can help support these experiments. It may also be necessary to prioritize programs and services in order to determine which ones to retain and which ones may need to be sacrificed. One thing appears to be certain: If we don't conduct our own analysis, our institutions will bring in consultants to do the analysis for us.

We also need to recognize that with the rapid rate at which change is occurring, we do not have time to engage in lengthy planning for these experiments. We should take a lesson from the military theorist Karl von Clausewitz who, according to Collins and Porras,[9] observed that detailed plans usually fail because circumstances change. And we need to accept mistakes as an inherent part of the experimentation process that enables us to learn. If we are willing to move beyond the traditional walls within which we have practiced, there are a number of opportunities to make a difference. Consider some of the possibilities:

- Case management
- Preventive care
- Discharge planning for patients admitted for drug-related problems
- Patient follow-up to assess compliance
- Pharmacist-run clinics
- Participation in disease management and outcomes management
- Pharmacist hot line

If we can demonstrate that these experiments contribute to the cost-effective management of patients across the continuum, we will not only be able to sustain these positions but we will have taken steps towards achieving our BHAGs.

Adjuncts to excellence

One could not achieve excellence without a commitment to lifelong learning and mentoring. John Webb[24] described the importance of both of these attributes in his Harvey A. K. Whitney Award address. With respect to learning, he stated that "diligence in pursuing a 'labor of love' will allow you to grow intellectually and you will be able to see exciting new horizons." This statement is particularly compelling at a time when a commitment to learning about changes in the environment is essential for our future. To keep abreast of the many health care and clinical issues affecting our profession, we will need to exercise extraordinary discipline.

The importance of making a commitment to human resources planning and focusing on the growth of the pharmacy practitioner was addressed in Joe Smith's[25] 1988 Webb lecture. Creating an environment that fosters the development of the individual and making a personal commitment to mentoring are prerequisites for advancing the practice of pharmacy. The lead article in a recent issue of *Modern Healthcare*[26] indicated that mentoring could become a casualty of the lack of time in the "hectic world of health care." Although the article's focus was health care executives, the danger applies to pharmacists as well. At this juncture, mentoring is an essential investment in the future of our profession.

Conclusion

The changes occurring in health care demand that we take a proactive approach toward demonstrating the pharmacist's contribution to patient care. We can no longer afford to be perceived as "quiet pharmacists" who provide "invisible care." If we are "built to last," we will move outside the walls within which we have created the practice of pharmacy. Applying the principles of excellence that I have described—big-picture thinking, exploiting change, and risk-taking—will enable us to become an integral component of the evolving model of health care delivery. We have many exciting opportunities ahead of us, and we must face the possibility that we may not succeed in each endeavor we undertake. But, in the words of Helen Keller, "Life is either a daring adventure, or it is nothing."[27]

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[a]Developing a program to prepare hospital pharmacy directors for success in integrated health care systems. Used at a focus group held at ASHP headquarters in May 1994.

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