Health-system pharmacy’s imperative for practice model change

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Redefining care models for pharmacists will not happen if we continue to simply do more of what we have been doing and deploying our scarce resources in the same way. It is time to be bold and forceful in our actions.

Moral, ethical, and social imperatives. In order to foster effective change, we must reflect on the ethical, moral, and social imperatives facing pharmacists. Central to our professional ethos is caring about—not just providing services to—patients.

There are at least four drivers in pharmacy’s ethical, moral, and social imperatives for new practice models. The first driver is what I call “the sacred vessel.” Every human’s body for which we care is a sacred vessel in which we place toxic and otherwise dangerous chemicals and biological agents. We have an ethical and moral obligation to act as compassionately, safely, and effectively as possible in this realm.

The second driver is the concept of franchise. Given our unique education and knowledge about the use of medicines, we have been granted special privileges through licensure.

Given our franchise, we have an ethical and moral responsibility to maintain our knowledge and apply it on behalf of patients. And we must care for the franchise lest it be taken from us.

The third driver is the “doctrine of being your brothers’ and sisters’ keeper.” Pharmacists are expected to help protect patients from potential and preventable adverse drug events. Logically, this includes warning patients about potential adverse events. The legal term applicable to such professional behavior is “learned intermediary.” In litigation about whether pharmacists have a duty to warn patients about potential adverse effects, the courts have generally held that only physicians are accountable as learned intermediaries.

However, it seems reasonable to anticipate that pharmacists in hospitals and health systems who care directly for patients will be found by future courts to be functioning as learned intermediaries.

The fourth driver is our professional covenant. We are subject to the ethical imperative passed down by Hippocrates: not just to do no harm, but to continuously strive to do only good. This is not always easy to do, as our profession is constantly tested by forces that focus on profit, speed, and corporate growth.

Collaboration. As we create new practice models, we must consider...
our duty to colleagues in medicine, nursing, and others. We are part of a team with the common goal of ensuring optimal patient outcomes. Our best future is one in which pharmacists work collaboratively with other members of the patient care team to provide a continuum of care.

**Economic imperatives.** A critical issue is the intensity of human resources used in the medication-use process and the rationale for how those resources are applied. Society will not be served well if we do not get the effectiveness and efficiency equation right. We must use technology and task shifting to improve pharmacists’ effectiveness and efficiency.

**Health policy imperatives.** Policymakers are increasing their interest in linking payment with performance measures for safety and quality. Health-system pharmacists have long been accustomed to quality measurements, but these measurements are likely to become more intensive and pervasive.

Medication errors and inappropriatey prepared medications will likely be included among the facets of health care that are excluded from payment. We must step up to the leadership challenge of ensuring that our institutions avoid such events.

**Evidence-driven models.** In creating optimal practice models, we should be driven by evidence, and we should be examining pharmacists’ impact on therapeutic outcomes, safe preparation and use of medications, health-related quality of life, and economic outcomes of care.

**Recommendations.** In order to refine care models for pharmacists,

- Pharmacy departments should move toward requiring technicians to be certified and pharmacists to be residency trained and board certified in the specialties that relate to their areas of practice,
- Pharmacist associations and state boards of pharmacy should identify the competencies that health-system pharmacists and technicians will need in the future,
- Pharmacy practice models must ensure that pharmacists are accountable for outcomes on a personal level and an institutional level, and
- Pharmacists must stop doing work that can be done by nonpharmacists.

### Implementing practice model change: Opportunities and challenges in a changing environment

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Over the past 50 years, hospital and health-system pharmacy has been on an evolutionary spiral, moving continuously toward greater accountability for patient safety and optimum outcomes from the use of medicines. These advances occurred through the application of three facets of leadership—the same elements that the Institute for Healthcare Improvement (IHI) has identified as keys to improving health care:

- Will—necessary change supported by professional leadership with courage and commitment,
- Ideas—shared vision for improvement, combining new thinking with creativity, innovation, and enthusiasm, and
- Execution—combining process change with logical use of technology, along with organizational skills to make change happen. (This is usually the most challenging aspect of fostering change.)

**Pharmacy’s scorecard.** We have made progress in some areas of practice and have struggled in others. Here is how I would score our performance:

- Patient-specific drug distribution: A
- Unit dose drug distribution: A–
- Drug-use control: B
- Drug information services: A–
- I.V. admixture services: A–
- Clinical practice: globally, C; selected areas and patients, A+
- Pharmaceutical care: implementation, C–; rhetoric, A+
- Medication safety: related to product handling, B; related to clinical care, C–

**Lessons from IHI.** IHI teaches that neither single nor multiple proj-