NEW PHARMACY PRACTICE MODELS  Implementing practice model change

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 inappropriately 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

BILLY WOODWARD

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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-
Table 1. Contrasting Implications of a Clinically Accountable Pharmacy Practice Model

<table>
<thead>
<tr>
<th>Facet of Practice Model</th>
<th>Traditional Practice Model</th>
<th>Clinically Accountable Practice Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared vision of preferred practice</td>
<td>Clear</td>
<td>Less clear</td>
</tr>
<tr>
<td>Practice scope</td>
<td>Traditional and pharmacy centric</td>
<td>Patient focused and shared with other team members</td>
</tr>
<tr>
<td>Locus of responsibility</td>
<td>Pharmacist</td>
<td>Interdependent team</td>
</tr>
<tr>
<td>Number of variables</td>
<td>Small</td>
<td>Large</td>
</tr>
<tr>
<td>Economic base</td>
<td>Clear</td>
<td>Cloudy</td>
</tr>
</tbody>
</table>

Take full advantage of external catalysts for change. Examples of such catalysts include:

- Evidence about improved economic and clinical outcomes when pharmacists are part of the patient care team,
- Endorsement of pharmacist engagement in patient care by groups such as the Joint Commission and the National Quality Forum, and
- Practice standards and professional education by ASHP.

Address the “untouchable” issues that have plagued us in the past. Examples of these issues include:

- The leadership vacuum related to clinical practice,
- Cultural and competency divisions between clinical and traditional practitioners,
- Pharmacists’ deficiency in people skills,
- The limited role for technicians, and
- The preponderance of pharmacy-centric thinking.

Challenge the traditional pharmacy practice paradigm with new concepts and expanded ways of thinking to fully integrate distributive and clinical pharmacy roles and pharmacists with the patient care team.

- Pharmacy practice models must be built on effective direct relationships with patients, caregivers, and the patient care team.
- Pharmacists must become an essential member of the patient care team, with specific clinical accountabilities without sacrificing traditional product-related accountabilities.
- Pharmacists must integrate their practice as an interdependent member of the interdisciplinary team, with all team members sharing common objectives for the care of the patient.

Table 1 shows the contrasting implications of full integration of clinical care into a clinically accountable pharmacy practice model.

Conclusion. There is already a good foundation in hospital and health-system pharmacy for pharmacists to become fully accountable members of patient care teams. It is urgent that we build on this foundation with an expanded new practice paradigm and become patient-centered practitioners.

Reference