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INTRODUCTION

Marilyn K. Speedie, PhD
Dean, University of Minnesota College of Pharmacy, Center for Leading Healthcare Change

The timing of this symposium—“Improving Patient Care Through Research, Practice, and Leadership”—cannot be more urgent. The health care environment is undergoing tremendous change, as is the practice of pharmacy itself. Who will succeed the leaders from our generation of senior organizational managers and directors, and how will we guide the next generation to become the trailblazers who will help pioneer the next phase of patient care, one in which the pharmacist is an active participant if not a leader?

Owing to the fast pace of change in the health delivery system, leadership is more critical today than ever before. This is true across the pharmacy profession, including within managed care. Indeed, managed care organizations can play a critical role in shaping pharmacy practice and patient care, based on their ability to access and interpret the care data available along with the financial aspects

This article was summarized by S.M. Health Communications from a podium presentation and approved by the speaker.

of care delivery. If these components can be harmonized, health care delivery can indeed change for the better in the United States.

Yet, this can only occur if the new generation of pharmacy leaders surpasses us in terms of experience and knowledge. This implies that the leaders of tomorrow need to be nurtured, mentored, and encouraged to take risks to develop new ways to improve patient care and the care management process. How do we optimally utilize and infuse our pharmacologic knowledge into the team-based care concept? How do pharmacists secure compensation for their well-earned services? How do pharmacy leaders prove their value to the health care system’s

stakeholders, including patients, senior management executives, health care policymakers, and lawmakers?

This conference and these meeting proceedings are intended as a guide and a plan of action for current pharmacy leaders and for those who are passionate about the pharmacy profession, to help advance patient care and health system goals through the unique skill sets offered by pharmacists.

Leaders of tomorrow need to be nurtured, mentored, and encouraged to take risks to develop new ways to improve patient care and the care management process.

Everyone in this room is a leader, and we have a duty to be a mentor to a pharmacy student or another person who has recently started working for their organization. Give them the guidance, the direction, the tools to be leaders.

— Edith Rosato, RPh, IOM, Chief Executive Officer, AMCP



KEYNOTE ADDRESS

LEADERSHIP AND CHANGE: HOW LEADERSHIP HAS AFFECTED THE U.S. HEALTH CARE SYSTEM

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The U.S. health care system is a highly complex amalgamation of private, public (e.g., Medicare and Medicaid), and governmental (e.g., Veterans Affairs, TriCare) components, and as a result it suffers from significant inefficiencies as well as demonstrates surprising effectiveness in some areas and poor outcomes in others. Talk of health reform to address some of these problems is subject to highly divisive, partisan debate, and the U.S. Supreme Court plans to rule on the constitutionality of the reform components.

The evolution of the U.S. health care system has not necessarily been the result of leadership at the presidential or congressional levels but rather the result of reactive forces that have shaped the health environment. Health cost trends rise unabated; in 2010, 17.9% of the gross domestic product was spent on health care, or \$2.6 trillion.¹ A study from the Commonwealth Fund in 2010 found that 29 million Americans were underinsured,² and as of December 2011, 46.6 million were found to have no health insurance at all.³

However, it may take a healthy dose of true leadership to navigate the path to a system that can improve health care delivery while addressing the critical cost issues that face us today.

THE ACA: PROLOGUE AND DEBATE

Leaders in the White House and at the Capitol have wrestled with the problem for decades. In March 2010, the Patient Protection and Affordable Care Act (ACA)⁴ was signed into law to address the issues of cost, coverage, and quality. Some components of the ACA have already been implemented, such as the prohibition on pre-existing condition exclusions for children, the coverage of older children (up to age 26) through their parents' policies, and various other insurance reforms. The bulk of the ACA's provisions are to be implemented in 2014, pending

the U.S. Supreme Court's decision on the constitutionality of the individual mandate, and whether the rest of the ACA can stand if this is overturned. Although the Court's decision and its implications are as yet unknown, some major trends and changes will not be affected by it.

Tactics Employed by the ACA to Increase Coverage. The Act employs six different strategies to reduce the number of uninsured and thereby increase coverage⁴:

- (1) It expands Medicaid dramatically (roughly one-quarter of the U.S. population will be covered by Medicaid, including the low-wage working class).
- (2) It encourages but does not require each state to form an insurance exchange or purchasing pool. The federal government would offer subsidies to help people afford premiums for health insurance purchased through it.
- (3) It requires that employers with more than 50 workers provide health insurance coverage or pay a penalty.
- (4) It provides tax credits to many small businesses with fewer than 25 employees to help them sponsor the necessary health coverage.
- (5) It implements federal efforts to regulate the private health insurance (e.g., prohibiting exclusions for pre-existing conditions for children, setting health plan medical loss ratios, and keeping younger people on parents' health policies), which were historically the states' responsibility.
- (6) It mandates that all individuals participate in the health insurance market—this does not carry punitive jail sentences but rather would have significant tax implications—in order to optimize the use of a community rating to lower premiums overall.

Tactics Employed by ACA to Improve Quality and Lower Costs. To understand how to control high health care costs, one must understand how and where the money is spent. In comparison with other western countries, physician utilization

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is relatively low. Americans go to the physician roughly four times each year compared with six to seven visits for Western Europeans.⁵ Americans also spend less time in the hospital and have fewer hospital beds per capita than in many western countries. Americans do have higher obesity rates but smoke less than residents of wealthier countries. Part of the reason that our health care costs are so high is that Americans are wealthier and choose to spend more of their discretionary income on health care. However, that is only one component.

Economists point out that the total cost of a health care good equals the cost per unit multiplied by the volume of units, plus the cost to administer it. The price per unit of health care paid by Americans is far higher than that paid by anyone else in the world (including for physician services, hospital services, and technology).⁵ For example, Germany has 7.5 magnetic resonance imaging (MRI) units per 1 million residents. The United States has 27 MRI units per 1 million people, and utilization is similar to that in Germany. Yet, in Japan, that ratio is 40 MRI units to 1 million population.^{6,7} The difference lies in the price paid per unit service. The McKinsey Global Institute reported that Germany pays \$216 on average per MRI procedure; the United States pays five times more (\$1,100) per MRI procedure. In Japan, this figure is only \$122 per procedure.⁷ This discrepancy has arisen because Japan and Germany regulate prices for these services. The United States does not regulate prices for private-sector health services like MRIs. Furthermore, other countries also regulate capacity and volume, including physician and hospital services.

How then to contain the costs of the American health care system? Clearly, price regulation across the board would have scuttled any possible chance to pass the ACA. The Obama Administration's tentative deal with the pharmaceutical industry to refrain from Medicare drug price regulation in exchange for phasing out the part D coverage gap supported this understanding—that any conversation about limits on care or spending is too easily associated with “rationing” in the American mind. Instead, the ACA tries to deal with cost control indirectly, by attempting to reduce prices and utilization, but doing it through provider incentives. That is, the Democratic Party's approach has been to include greater use of information technology, pay-for-performance schemes, capitation, and shared savings programs to affect how clinicians prescribe and utilize health care services. The federal government has promoted myriad pilot programs through Medicare primarily,

to encourage and test these incentive efforts, with the hope that these ideas will diffuse to the private sector.

The Republican Party's approach has been to not focus on the provider but rather on consumer behavior. Republican leadership seeks to increase competition, transparency, and to reduce moral hazard (i.e., by encouraging more high-deductible health plans to avoid unnecessary use of health services).

The opposing concepts have resulted in a clash over the final outcome, with implications for President Obama's re-election campaign, control of the Congress, and perhaps the survival of the ACA. Employers have sued in federal court that the individual mandate component of the ACA is not constitutional.

This is the primary issue of the case facing the U.S. Supreme Court at present. Does the federal government have the authority under the Constitution's Commerce Clause, Necessary and Proper Clause, or General Tax Clause

The price per unit of health care paid by Americans is far higher than that paid by anyone else in the world.

to enforce the mandate? Opponents of the ACA do not believe that individuals should be required to buy a commercial good.

The second issue facing the Supreme Court at present is whether the Medicaid expansion is constitutional. Twenty-six states have entered the case, claiming that they have been unlawfully coerced into financing and administering the proposed Medicaid expansion. The federal government countered that it has a history of attaching strings to federal grants (and that it expects to pay for 95% of the expansion of Medicaid rolls).

The third issue addresses a complicated question: If either the individual mandate or the Medicaid expansion is found by the Supreme Court justices to be unconstitutional, does it mean the whole ACA is unconstitutional or can other components be promulgated into law? Is the individual mandate integral to the survivability of the Act?

UNSTOPPABLE HEALTH DELIVERY TRENDS

Regardless of the outcome of the Supreme Court's deliberations and the implementation of health reform, many formative trends that are influencing the health care markets are expected to continue:

- (1) The number of integrated delivery systems will grow. This may be encouraged by the ACA's implementation but can be expected to occur in any case. Fewer clinicians will be in solo practices, and the number of multispecialty groups will increase.



- (2) Integrated delivery systems will become larger. Hospitals are buying practices and insurance companies to gain size and leverage. This may result in suboptimal competition in certain markets over time.
- (3) Within integrated delivery systems, the battles and conversation over scope of practice increase. This revolves around the expanding roles of the nurse, pharmacist, and the more defined role of the clinician. It also implies a battle as to who will take the role as team leader of the patient-centered medical home.
- (4) Mid-size to large employers are asking about wellness programs. They are seeking information on return on investment but perhaps with little response. Some evidence demonstrates that certain wellness programs save money, and employers will take risks to attempt to improve the health of the workforce.
- (5) More care management activity is likely as well as more aggressive care management programs.

Although managed care enrollment has leveled off (assuming a burst of Medicaid from the ACA implementation does not occur), what has remained steady has been the desire for more care management programs for patients with chronic diseases: Chronic disease care is one of the principal drivers of health care expenditures.
- (6) Efforts will likely focus on detecting high utilizers of services, particularly on a geographic level. Identification of “community hotspots” will spur research into why they require emergency room services on a more frequent basis and what services are inappropriate.
- (7) The trend toward greater collection of comparative- effectiveness research (CER) data and its use in determining the value of treatment will continue unabated. The American Recovery and Reinvestment Act of 2009⁸ budgeted billions of dollars for its encouragement and the institution of the Patient-Centered Outcomes Research Institute.
- (8) The health system will continue its movement away from traditional fee-for-service reimbursement, and toward more prepaid or risk-sharing mechanisms.
- (9) The uptake of health information technology will also be unaffected by the outcome of health reform efforts, with more widespread implementation of electronic medical records.
- (10) The information generated and stored by electronic medical record systems will speed the maturation of another movement—personalized medicine.

As a leader, one must set a vision or implement a priority list to help the organization go in the right direction.

These changes will occur even if the ACA were struck down by the U.S. Supreme Court. However, managing the changes that may occur associated with the ACA and the trends that will continue unabated will be critical. Leadership will be the key.

LEADERS AND THE FUTURE HEALTH CARE SYSTEM: LESSONS FROM OUR PRESIDENTS

Leaders are individuals who facilitate the work of others to reach mission-driven goals. How is this achieved? First, whether the President of the United States, a chief executive officer, or the head of an organization, that leader often has to deal with existing crises (or those they inherited). Successful leaders do not let the crisis define them.

As a leader, one must set a vision or implement a priority list to help the organization go in the right direction. That often means that the leader must be willing to surprise and/or compromise, and go against prevailing wisdom of what his or her goals should be (consider that President Richard M. Nixon was

the first to visit communist China or that President George W. Bush pushed through Medicare part D legislation). Sometimes, leaders must recognize that their best laid plans will not work (consider President Bill Clinton’s health care reform effort). That implies that the leader needs to be willing to change and compromise. Harry S. Truman was more passionate than any other President about implementing National Health Insurance for U.S. citizens, but he didn’t have the strategy or the votes to get it done.

Leaders facilitate the work of others. In developing the strategy for ACA, President Obama framed the large principles, but delegated to Congress the task of detailing the plan. This forced Congress to become invested in it. Even so, the ACA is widely referred to as “ObamaCare,” even though the Administration was careful to avoid its development as a White House plan.

Leaders have to learn how to lose. They do not win every battle (President Clinton won the enactment of the Children’s Health Insurance Program in 1997 even though he lost the health care reform battle in 1994).

Leaders must be effective communicators. This helps others become invested in the strategy. Successful leaders are those who can manage change. They must be able to create the vision, outline the plan, communicate it, and then direct others to frame it and complete it.

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LEADERSHIP AND PHARMACY: SIX LESSONS LEARNED ALONG THE WAY

Stuart Sowder, PharmD, JD, MBA
Vice President, External Medical Communications, Pfizer Inc.

People are not born leaders. We are shaped by our experience, our teachers, and the people who led us. Individual experience is crucial to our development; it evolves our outlook in unique ways.

My career path includes 10 years in retail and clinical pharmacy settings, a law degree, and a position where I manage 500 pharmacists across the globe who answer research questions in every clinical area in which Pfizer has a role. I will share six lessons on how my experience and the people who shaped my learning molded how I would react to the challenges of leadership.

1. The Importance of a Mentor. Having a mentor, and preferably more than one, cannot be overemphasized. Experience cannot be bought—mentors pass on their knowledge, and the benefit of their experience is cumulative. I have had several mentors, including my father, who was a traditional community milkman. He worked in a pasteurizing plant overnight and delivered the fresh bottled milk to the families' doorsteps in the early morning. He was a hard-working family man who saw his profession fade away in front of his eyes. He decided to give each of his children three options for continuing their education: (1) go to pharmacy school, (2) join the military, or (3) pay for an education on their own. All of his children became pharmacists.

2. The Journey Is Often Circuitous. The path to a career is not always straight. much less obvious. I was unsure that I wanted to be a pharmacist, even after graduating with a pharmacy degree. I decided to enroll in law school and was accepted to one in New York City. I used my pharmacy license for a year to help pay for law school tuition. It was during that year that I fell in love with pharmacy.

As I didn't have a New York State Pharmacy license and needed an income, I started to work as a pharmacist inside the Veterans Administration (VA) system, which is regulated by federal not state law. Taking a position as a technician, I convinced the VA to hire me with the proviso that when a staff pharmacist position became available, I would be considered for it. After 8 months, I was hired as a pharmacist. Sometimes, you have to take a risk.

This article was summarized by S.M. Health Communications from a podium presentation and approved by the speaker.

3. Choose Jobs That You Are Passionate About. This is a basic although often overlooked lesson: One cannot be a leader without being passionate about the profession. People who become leaders love what they do.

4. Beware of the Comfort Zone. Having a long-term, secure position often leads to complacency. Taking risks is necessary for advancement and leadership. Mentors are good monitors for when it may be time to stretch your horizons or simply get more experience and knowledge by testing the waters elsewhere.

5. Focus on Facts not Feelings. When challenged, leaders use factual data or stories from experience, not emotion, to defend positions. Emotions, including anger, can get in the way of the conversation. When Pfizer's President asked me to cut my staff by one-half only weeks after starting my new position, I started researching the value of the department and its resources. Being able to share the details with Pfizer's senior management led them to change their position—no one was cut (but 5% of budget was).

6. Engender Trust. Trust is the most commonly cited characteristic of a leader. Trust is a climate created by a leader that empowers workers to make their own changes. To be a great leader, one must be trustworthy. It is indeed hard to gain trust, but it is very easy to lose it.

What is expected of leaders? (1) A leader must get business results; (2) a leader must have integrity, a strong, strict moral code of conduct (making the right decision), and be consistent and fair; and (3) a leader must exude genuine concern for his or her people, understand their strengths and weaknesses, and know what motivates them. A leader asks about personal issues and includes them in conversations.

Leadership is something that must be learned and gained through experience—one's own experience and that of the mentor(s). This affects how leaders react to certain situations or challenges and make decisions. Experience helps make better leaders. Leadership must be practiced everyday.



PHARMACY AND BEYOND: RESEARCH AND LEADERSHIP

This panel discussion was moderated by Gene Reeder, RPh, PhD,
Professor, Presbyterian College School of Pharmacy, and Director, Xcenda, Inc.

Kicking off this panel discussion was a presentation by Jan E. Hansen, BSPharm, PhD, Vice President, Global Health Outcomes Strategy and Research, Allergan, who pointed out that new treatments are increasingly evaluated using health technology assessment in the United States and abroad. The ability to apply “pharmaceutical technology assessment”¹ will require even more evidence. “We’ll need to challenge ourselves by incorporating elements of an ‘evidence package’ that is broader than what is attainable through traditional randomized, controlled trials,” she said. “It will need to include evidence of effectiveness versus the right comparator. It will need to answer the question ‘what is the economic value?’” It will need to determine if the new treatment fulfills an unmet need. It will also need to include the patient’s perspective and be more aligned with real-world practice.

She advised managed care pharmacy to get involved as early as possible in the product lifecycle to “collaborate and work with [pharma companies] to gather this evidence.” For example,





proactive collaborations in post-approval research help to gain real-world data on the experience and use of new products. Managed care pharmacy can enhance decision making through comparative-effectiveness research as the health care system shifts from “volume-based” to “value-based.” Managed care pharmacy can also play a leadership role, according to Dr. Hansen, through the use of health information technology, to support quality measurement, guideline development, pay-for-performance programs, and ultimately, to improve clinical processes.

Dr. Hansen suggested that managed care pharmacy should be asking how they will drive these changes in research through leadership (see Figure) and penultimately, “Are you equipped to apply these new levels of evidence to the benefit of your patients?”

A presentation by Louise J. Sargent-Heuer, MS, RPh, Senior Director Healthcare Alliances, AstraZeneca, LP, elaborated on

Figure: What role can and should managed care pharmacy play?

Are YOU ready to drive research through leadership?

-  Are you ready to commit your time, energy, and availability for providing early and ongoing input?
-  Are you ready to “partner with the enemy” (i.e., industry and others) and collaborate on research initiatives?
-  Are you ready to expand the available evidence base by conducting relevant, rigorous research?
-  Are you ready to analyze, interpret, and apply the research to your practice setting for the benefit of your patients?

YOU can drive transformation and improve health care...

- Express an ongoing willingness to learn
 - Seek help from the experts
 - Gain understanding of research tools, methods, and techniques
- Challenge traditional notions
- Collaborate with others
 - Offer your input
 - Embrace research opportunities with “unlikely” partners
- Care about quality
- Embrace and drive change



the theme of “Collaborating to Build Real-World Evidence.” In the United States, her organization is primarily collaborating with HealthCore (a subsidiary of Wellpoint) to achieve this objective. Announced in February 2011, this partnership “helps increase AstraZeneca’s capabilities to generate real-world evidence” by analyzing how available medications work, providing insights into new therapies, and identifying unmet needs. “With more pressure on better spending of available health care dollars,” said Ms. Sargent-Heuer, “we need to ensure our medicines provide value. Our collaboration with HealthCore will help us provide that evidence of value.”

Kim A. Caldwell, RPh, Director, PBM Legislation and Public Policy, Humana Pharmacy Solutions, Humana, Inc., commented that when he was first hired by the managed care organization, “my focus was to do research. Senior leaders determined that the organization shouldn’t be wasting the high-quality data we have at Humana (particularly with our Medicare Advantage and Part D lives).” The result is Competitive Health Analytics (CHA). Mr. Caldwell discussed the progressive collaboration model involving Humana and CHA—where the payer and manufacturer (presently Pfizer) are at the same table to decide “What can we do together to change and improve population health?” Mr. Caldwell commented, “The industry needs to prove why a product costs as much as it does to determine what value should be attached to the product. But research is not only about the cost of pharmaceuticals, it’s about leadership. If we, together, don’t ask the right questions of the data, we’ll never get the right answers.”

Key Issues. *Considering Individual Patients Versus the Populace.* The question was raised how individual pharmacists can balance efforts on behalf of single patients and population-based health. Mr. Caldwell noted that this is really a question of how to make decisions that are meaningful to the end users—the patients. “When I was at [the Centers for Medicaid and Medicare Services],” he said, “we always referred to the hypothetical 80-year-old woman with multiple comorbidities and how our decisions would help or affect her.” This was an effective method for balancing the two considerations.

The Most Important Characteristic of Collaborative Partnerships. In order to make progress on multipartner collaborations and obtain valuable real-world evidence, Ms. Sargent-Heuer stated that having a champion or leader who has the same vision is critical.

Overcoming a Disjointed System. Dr. Hansen believes that leadership will be needed to utilize the evidence arising from today’s health care system. “We have a long way to go,” said Dr. Hansen, but AMCP is spearheading an effort with the International Society for Pharmacoeconomic and Outcomes Research and the National Pharmaceutical Council.

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LEADERSHIP AND CHANGE

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HEALTH CARE SYSTEMS AND FUTURE MODELS OF PHARMACY CARE

This panel discussion was moderated by Nancy E. Stalker, PharmD, Vice President, Pharmacy Services, Blue Shield of California

How can pharmacists create change and prove the effectiveness and value of medications in the pharmacy benefit? Part of the answer lies in new models of care and purchasers' expectations of pharmacists in these new models.

Nancy E. Stalker, PharmD, Vice President, Pharmacy Services, Blue Shield of California, stated, "Pharmacists can and must create change to improve effectiveness of medications and improve the outcomes and health of our member populations. We have a unique opportunity, with the advent of new and different models of care and financing mechanisms. We need to rethink how we do our business, and all of us must act."

According to N. Marcus Thygeson, MD, Vice President, Medical Services, Blue Shield of California, San Francisco, "Physicians are inadvertently doing a bad job of managing medications. That is, they are good professionals but working within a bad system." He pointed to overuse of certain drugs, like proton-pump inhibitors,^{1,2} and the underuse of others, like antihypertensive agents.³ Furthermore, we have evidence of a great deal of misuse of medications, simply based on the prevalence of unrecognized adverse drug reactions sending patients to the hospital or resulting in the need for other preventable health services.⁴ "Too often, prescriptions are used to usher patients out the door to maintain the doctors' appointment schedule," said Dr. Thygeson. This is not how the system was designed, he emphasized, but these behaviors have emerged nonetheless. Part of the reason is that "compensation has been tied to throughput, not to health outcomes," he stated.

Leaders are trying to change the current system, through efforts like building accountable care organizations (ACOs) and patient-centered medical homes, where, coupled with different compensation systems, the incentives of the individual parties are better aligned (Table). Others are encouraging pharmacist participation in patient care teams, which has been proven to work. Dr. Thygeson emphasized that the key to changing poor physician prescribing behavior and to improving efficiency of the health care system is to "stop paying for throughput instead of outcomes or value." The new rules leaders must stand by in order to change the system effectively are simple: (1) pay for health created or maintained, not services rendered and (2) seek health and functional status improvement as the goal (not the number of patients seen or hospital bed census).

Ann Woo, PharmD, Director, Clinical Support, Hill Physicians Medical Group, San Ramon, California, reminded attendees in her remarks that medications are key to the management of nearly all chronic conditions. "As pharmacists at Hill Physicians Medical Group, we get to look at patient care longitudinally, across surgical, medical, and pharmacy components." Hill Physicians' pharmacists actively participate in different aspects of care, in a way that is much more expansive than managing medication use in isolation. "In our daily activities, we have access to laboratory, pharmacy, and claims data," Dr. Woo stated.

She outlined a partnership between Hill Physicians Medical Group and Blue Shield of California regarding its ACO. "In this pilot program," said Dr. Woo, "we integrate the pharmacist into one- and two-doctor practices in Sacramento, to remind clinicians daily to switch drug X to drug Y, to conduct medication reconciliation (particularly with discharge lists), and to call patients who might need help. This is being applied to asthma and hypertension today.

"What do we look for in a pharmacist? Our pharmacists rarely do only one thing at a time. We seek pharmacists who can multitask.

Table: New Care Models

ACO

- **Organization (actual or virtual) that is accountable for cost, quality, and experience of care**
- **New payment models (some combination of global payment, shared risk, bundled payment and P4P)**

PCMH

- **A prepared practice team providing evidence-based, preference-sensitive, patient-centered care in the setting of a continuous healing relationship.**

ACO = Accountable care organization; P4P = pay for performance; PCMH = patient-centered medical home.

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We also look for someone who is not looking for the routine but rather someone who is interested in expanding his or her clinical knowledge, which is not limited to drugs, said Dr. Woo.

This is a primary opportunity for pharmacists to show leadership, according to Dr. Woo. She was the first pharmacist hired by Hill Physicians Medical Group; the more leadership she displayed, the more she did, and the more she was asked to do. “This opportunity puts pharmacy in a different light,” she said. “I was the first hired in this venture, but today we have 6.5 full-time equivalent pharmacist positions. The role is ever evolving.”

Lisa Ghotbi, PharmD, is Chief Operating Officer of the Health Service System of the City and County of San Francisco. In this position, Dr. Ghotbi manages the \$700 million budget for city employees’ health services. “As an employer,” Dr. Ghotbi remarked, “we feel we’ve done everything we can do to push and pull the cost of health benefits. We’ve done everything we can do in terms of copays and deductibles, outside of high-deductible plans.” At present, 92% of all members of the system are in HMOs, and the other 8% are in PPOs. “The ACO is the next logical step,” she believes. The City of San Francisco is involved with two ACOs today (including the venture with Hill Physicians Medical Group).

The program is in its infancy, Dr. Ghotbi explained, and “we’re working on year 1 success factors. First, we must get better coordination between inpatient and outpatient pharmacists. Second, pharmacists must be part of the case management team. Third, we must consider using pharmacists in urgent-care settings, home visits, employee wellness programs, and on [phone-in] advice lines.”

She added, “With the expected surge of new patients seeking primary care with Medicaid expansion, physicians will need to use every resource at their disposal to meet the demand for primary care.”

Key Issues. *The Move to ACOs.* How do pharmacy tools need to change to meet the demand for pharmacy services in more integrated, coordinated care models? Dr. Stalker responded that “we need to begin to engage new pilots and models, to expand, and to engage pharmacists to work more closely with the physicians. That means having better access to the health

records (including electronic health records, and medical and pharmacy claims data). We’re beginning to talk with pharmacies about working on these models.”

The panel also discussed how to stimulate pharmacists to get involved in these burgeoning ACOs. Dr. Woo remarked that a pilot program starting in June 2012 features a home health nurse visit

for targeted patients (those identified as taking certain high-risk medication regimens). “The Hill Physicians pharmacist will back those nurses up; the pharmacists will do the outbound calls.” She acknowledged that this is only a start, and at this time, pharmacist services will be uncompensated.

Dr. Thygeson added that nurses cannot fill all the gaps. “We need more team-based care, with pharmacists lending their expertise on medical management issues. Pharmacists have a huge role to play in these new delivery models,” he said. “We need to discover how the team models will look and how it will be compensated.”

Employer Initiatives to Reduce Medication Overuse. Dr. Ghotbi commented that employers are returning to a focus on wellness. “Every department will be required to have a wellness plan for its employees. We see nurses trying to do the work of pharmacists. We definitely need more pharmacists in our organization. We’re looking to partner with pharmacy schools to have wellness clinics to educate employees on-site. This is something from the 1980s that is coming back again.”

“We need to begin to engage new pilots and models, to expand, and to engage pharmacists to work more closely with the physicians. That means having better access to the health records.”

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IMPROVING PATIENT CARE THROUGH LEADERSHIP

This panel discussion was moderated by Marilyn K. Speedie, PhD, Dean, University of Minnesota College of Pharmacy, Center for Leading Healthcare Change; and Mary Anne Koda-Kimble, PharmD, Dean, University of California, San Francisco, School of Pharmacy

“Everyone in this room needs to be a leader,” said Mary Anne Koda-Kimble, PharmD, Co-moderator. “The cost of not changing is greater than the cost of changing to the benefit of the whole.” This panel discussion focused on how the pharmacy profession can expect to change both proactively and in reaction to the evolution of the health care system.

Key Issues. *New Opportunities for Pharmacists.* In a world beyond product dispensing, pharmacists offer a great deal of expertise to the health delivery system. Paul W. Abramowitz, PharmD, Chief Executive Officer of the American Society of Health-System Pharmacists, stated that the “the majority of pharmacists will be considered direct care providers, and should be part of every health care team.”

Thomas E. Menighan, BSPHarm, MBA, ScD, Chief Executive Officer, American Pharmacists Association, added, “We see patients working with their pharmacists to understand how to optimize their medication use. We see major opportunities for pharmacists in managed care, and in particular, we see great promise in pharmacist-led improvements in transitions in care. How these services are paid for is still a question, but we’ll figure it out,” he said.

Edith A. Rosato, RPh, IOM, Chief Executive Officer of the Academy of Managed Care Pharmacy, explained, “How I was taught 30 years ago is far different than how students are taught today. They are taught to be more than dispensers of medications. The foundation is being set for where pharmacy practice will head in the future. We anticipate a more active role in public health and population health (e.g., consider how community pharmacy became a point of contact and distribution for H1N1 and seasonal flu vaccine), and a more active role in evidence-based medication management.” Ms. Rosato emphasized, “Whatever practice setting you are in, we have certain principles we use to manage patients, guided by our oath, which is focused on optimal patient care. These principles can be applied in any practice setting.”

Ms. Rosato added, “The patient is at the center of care. We need to change our focus from dispensing medications to patient care by practicing pharmacy care. These are exciting times for pharmacists.”

Others on the panel agreed. “The pharmacist should be the first point of entry into the health care system for many,” according to Dr. Michael Sparer from Columbia University. Richard A. Zabinski, PharmD, Vice President, Pharmaceutical Solutions, OptumHealth Care Solutions, added that most people have a great level of access to local pharmacists. “This access means a great deal of influence,” he said, and “this influence can only be exercised if there is a good level of trust.” Dr. Zabinski suggested that we should consider new terminology for pharmacists as the first access point for primary care, i.e., “primary care pharmacists” or “health care concierges.”

In Dr. Sparer’s community, the local chain drug store has become like a general store—he goes there regularly for items or services other than medications. “The sign out front says, ‘Get your flu shot here.’ If the large chain drug stores will play that role in communities, there is a real opportunity for pharmacists to play that role in public health.”

Increasing Time of Engagement at the Chain Drug Store. In order to take advantage of the pharmacist’s position as a health care concierge, pharmacists behind the counter must have more time to engage the patient. Dr. Zabinski pointed out that “the business case does not currently exist to convince a chain drug store chief financial officer that this makes sense. We need to create the business case and communicate it.”

Dr. Menighan added that “businesses cut costs where they can when there is not enough revenue. On the pharmacy level, this means fewer technicians, which results in dissatisfied pharmacists.” He said, “We have to keep the faith and build up the services we can offer patients. These types of services are on the rise.”

If ACOs gain traction, according to Dr. Abramowitz, they may demand that pharmacies offer a portfolio of different services. This may compel the creation of different practice models for all pharmacy sites, including their linkage with each other, to insure continuity of care.

Perhaps something can be learned from our colleagues to the north. Dr. Menighan described his experience meeting with the Canadian Pharmacists Association and learning about regulatory successes they’ve experienced. Although there has not been great



uptake by Canadian pharmacists on their prescriptive authority opportunities (which he believes lacks critical mass at this time), “it is a good start, and we expect that to accelerate. We’re on the path to creating pharmacy standards for community practice, which will lift the patient’s clinical experience.”

Training Tomorrow’s Leaders Today. The burden of training pharmacists to take positions of leadership should not fall entirely onto the pharmacy schools, said Dr. Abramowitz. “It should be complemented by residencies and fellowships,” which can emphasize aspects of leadership.

Dr. Menighan noted that “we invest a good deal in student programs, and we’re coaching pharmacists that they don’t need to be ‘the boss.’ They can lead from where they stand. You don’t need a title to lead. New services are often started by new practitioners. Find the things that are working and lift them up. Don’t necessarily search to fix things that are broken.”

Dr. Koda-Kimble stated, “We look for students who show that they care enough about something outside of themselves, making a commitment (e.g., church, athletics, and the underserved); it doesn’t have to be in academics. We preselect them. I find that students lead me, not *vice versa*.”

SUMMARY

In Malcolm Gladwell’s book *Outliers: The Story of Success*,¹ he points to four characteristics of being a leader: (1) luck, (2) skill and intelligence, (3) hard work, and (4) mentorship. Dr. Menighan pointed out that each of us may have some of these characteristics, but we depend on others for the rest.

Ms. Rosato reminded the attendees that “everyone in this room is a leader, and we have a duty to be a mentor to a pharmacy student or another person who has recently started working for their organization. Give them

the guidance, the direction, the tools to be leaders,” she said.

“To achieve our vision,” said Dr. Zabinski, “we need to train all students to be leaders. At the patient care level, we need to teach communication techniques to help pharmacists be that health care concierge, to redirect the patient to proper care.

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Creating the Next Generation of Leaders

To help train the next group of young pharmacists to lead pharmacy practice to 2020 and beyond, today’s pharmacy executives must take at least the following steps:

- (1) Mentor at least one young pharmacist, providing the guidance, moral compass, and/or work environment, with continual positive reinforcement, to enable that person to become passionate about their profession.
- (2) Encourage young pharmacists to expand their horizons beyond the dispensing of medications and to consider new practice environments, including on physician-led care teams.
- (3) Focus on the importance of trust to building credibility that is vital to leadership.
- (4) Understand the multiple health care trends that will continue to shape the health delivery system (e.g., more integrated systems and accountable care organizations, increasing scope of practice and patient care roles for pharmacists, greater need for comparative-effectiveness research (CER), greater consumer share of the health cost burden) regardless of the upcoming Supreme Court decision on the constitutionality of provisions of the Accountable Care Act.
- (5) Train them to lead through the use of health information technology to support quality measurement, pay-for-performance, and to improve clinical processes.
- (6) Encourage multipartner collaborations to obtain valuable real-world evidence
- (7) Train young pharmacists to lead by utilizing current and future CER results in decision making to the benefit of patients.
- (8) Balance considerations of population health versus that of the individual patient.

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