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HARVEY A. K. WHITNEY  
LECTURE

## Permission granted

DANIEL M. ASHBY

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Let me begin with a few words of thanks. First, to David Zilz, let me offer a sincere note of appreciation, not just for your kind words but for your friendship and contributions to my career over the years as well as your willingness to be a part of this year's Whitney Lecture program.

I would also like to express my appreciation to Debra Devereaux and Steve Sheaffer for their support of my nomination. Your conviction and perseverance that I was deserving of this special recognition are, in themselves, an award. Thank you for your support and, more importantly, your friendship.

To the Southeastern Michigan Society of Health-System Pharmacists, ASHP, and the Harvey A. K. Whitney Lecture Award Committee, thank you for this honor. I am humbled to be among the list of award recipients, all of whom I respect and admire.

Permit me to acknowledge the contributions of former team members at Grace Hospital and Harper Hospital in Detroit, Methodist Healthcare in Memphis, and The Johns Hopkins Hospital in Baltimore and to express my thanks for what

they have given me and what we were able to achieve collectively.

I have been fortunate also, as I moved around the country, to have friendships that have been sustained. To Richard Lucarotti, Margo Farber, William Greene, Mick Hunt, and Sister Mary Louise Degenhart: Thank you for everything you have given me. Your friendship is very important. My thanks also to colleagues I have worked with on the ASHP Commission on Credentialing, the ASHP Board of Directors, and the ASHP staff, including Henri Manasse, William Zellmer, and Stephen Allen. My thanks, also, to my preceptor and mentor, Ronald Turnbull, for the advice and counsel you have afforded me during my career and your kindness to attend this event tonight. Thanks, Ron.

Two people who can not be here this evening contributed significantly to who I am. They are my father, Loris Ashby, and my uncle, Meredith Ashby. My dad was a person with significant patience who routinely offered encouragement and support. My uncle, the eternal optimist, had a passion for life, family, and people. I would like to think I cap-

tured some of the traits of these very special family members. When I was 12 years old, my uncle presented me with a prized possession—a baseball autographed by Mickey Mantle. Mantle once said that he wished that everyone in America could hit a home run at Yankee Stadium to understand what it feels like to run around the bases as 50,000 people cheered.

I know exactly what it feels like to hit a home run at Yankee Stadium because of the next three people I would like to recognize: my wife of 41 years, Barbara, and our children Timothy and Bryce. Barb, your love and support have been constant sources of encouragement: Thank you. As for my sons, Tim and Bryce, I would only say that as a dad, I couldn't be more proud of you—who you are, and what you have accomplished with your lives. I know that the future is bright for both of you and your families. You are a constant source of pride for your mom and me.

Although excited and honored to receive this recognition, my excitement is tempered with the understanding of the responsibility that comes with it. Marianne Ivey,<sup>1</sup> in

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Daniel M. Ashby

Daniel M. Ashby is senior director of pharmacy for The Johns Hopkins Hospital. Mr. Ashby's current faculty appointments include those at the University of Maryland School of Pharmacy and the College of Notre Dame of Maryland School of Pharmacy. Mr. Ashby received his Master of Science in Hospital Pharmacy Administration and his Bachelor of Science in Pharmacy degrees from Wayne State University.

A native of Pennsylvania, Mr. Ashby began his career at Grace Hospital in Detroit as a pharmacist assigned to critical care. In 1972, he became the coordinator of drug information services, and in 1974, he was promoted to assistant director. Mr. Ashby continued his career as associate director of pharmacy at Harper Hospital, and in 1981, he was promoted to director of pharmacy. While in Michigan, Mr. Ashby served as an original member of the task force that

wrote the Pharmacy Certified Technician examination and training manual and served as a member of the Michigan Pharmacy Certified Technician Board of Examiners.

From January 1991 to January 1999, Mr. Ashby served as the director of pharmacy at Methodist Healthcare in Memphis. He had faculty appointments at the University of Tennessee College of Pharmacy and the University of Mississippi School of Pharmacy.

Mr. Ashby has held numerous offices in professional organizations including the Southeastern Michigan Society of Health-System Pharmacists, the Tennessee Society of Health-System Pharmacists, and the American Society of Health-System Pharmacists. Mr. Ashby served on the ASHP Commission on Credentialing and was ASHP President and Chairman of the Board of Directors from 2003 to 2004.

He has been recognized as a Fellow of ASHP and as Michigan Pharmacist of the Year and has been awarded the Wayne State University Distinguished Alumni Award, the Maryland Society of Health-System Pharmacists Board of Directors Award (for "significant, consistent and ongoing contributions to the Maryland Society of Health-System Pharmacists"), and the Association of Black Health-System Pharmacists President's Award ("in appreciation of significant, unselfish service to the Association"). Mr. Ashby is the 2010 recipient of the ASHP Distinguished Leadership Award in Health-System Pharmacy Practice, presented to "recognize individuals who have achieved excellence in health-system pharmacy practice leadership having led progressive improvements in pharmacy services within specific U.S. hospitals or health systems."

Mr. Ashby has published numerous articles and made over 100 presentations on a variety of topics. He is most proud to have served as a preceptor for more than 165 pharmacy residents. Dan lives in Baltimore with his wife, Barbara, and golden retriever, Gracie.

her Whitney address, established the context for my remarks with her suggestion that this lecture is a chance to "review our culture, our traditions, our storytelling, . . . our networking and our benchmarking" to "make us strong and enable us to deal with current situations and those in the future."

I will share a few stories and observations and identify a few best practices or strategies that may be useful to our profession. Former residents would offer a word of caution about my storytelling. They would say that although there is always a point being made, Dan can get so wrapped up with the story that he may forget the reason for the story. I will do my best to avoid that problem.

### Permission granted

On occasion, I will hear a comment or statement and have those words "stick." I keep thinking about the statement and, over time, the statement takes on additional meaning. One such example is the phrase "permission granted." So, how did that expression become special to me?

In 2000, Max Ray<sup>2</sup> was kind enough to serve as the keynote speaker for the Eastern States Resident and Preceptor Conference. The theme of his remarks focused on leadership. In one section of his remarks, Max shared numerous pieces of correspondence between pharmacy residents and a famous pharmacy leader, Dr. T. N. Ediser. The typical letter would seek guid-

ance to resolve a patient care problem confronting the pharmacy resident. Dr. Ediser offered excellent words of advice and on occasion confirmed that the resident already knew the right thing to do, encouraging action with the simple response "permission granted." Max eventually explained that "T. N. Ediser" was *resident* spelled backwards. The letters were actually being written by, and answered by, the resident. The letters existed in concept only as the residents worked through the issue, deciding what they should do. As a result, *permission granted* took on an entirely different meaning.

The expression *permission granted* is not about asking for and receiving permission; it is not about a higher authority granting permission. It instead conveys a strong message about motivation, empowerment, responsibility, and accountability. I started thinking about Daniel Goleman's<sup>3</sup> work on emotional intelligence and the importance of motivation as one of the major contributors to a leader's success. Motivation, common to virtually all effective leaders, is the drive to achieve beyond expectations. The key word is *achievement*. The leader is driven to achieve not by external factors, such as personal recognition, but instead to achieve for the sake of achievement. Motivation represents a passion for the work itself as the individual seeks out creative challenges, takes pride in a job well done, and assumes responsibility to see that the task is completed. Highly motivated individuals typically are not satisfied with the status quo and work to achieve best practices. Within the context of the letters to T. N. Ediser, individuals feel empowered to bring about change. They recognize their responsibility and feel accountable for assuming a leadership role for change and improvement. They are not asking permission but instead giving themselves permission to take action.

During the past year, ASHP and the ASHP Research and Education

Foundation supported two important initiatives that will help shape the future of our profession. The Pharmacy Practice Model Initiative (PPMI) Summit in November 2010 identified beliefs and assumptions and offered specific recommendations to advance the role of the pharmacist in providing direct patient care.<sup>4</sup> The Pharmacy Residency Capacity Stakeholders Conference (PRCSC) in February 2011 addressed training capacity needs for pharmacy residents and provided guidance for the profession to increase the number of pharmacy residency training programs and positions.<sup>5</sup>

The recommendations and strategies from those initiatives may have practitioners wondering, “Where do I begin?” ASHP staff are formulating ways to help answer that question. Included is a tool to support a gap analysis for the PPMI Summit recommendations. As we start this process, we should begin with a vision of our future. That vision should include the following key elements:

- Pharmacists should spend the majority of their time in direct patient care activities that will be performed consistently for all patients.
- The practice model for each pharmacy department should be “comprehensive,” with an appropriate mix of generalist and specialist pharmacist practitioners to provide needed services and with assurance of the competency of each provider.
- Drug distribution activities should be delegated to licensed pharmacy technicians.
- Technology supporting the medication-use system should add value to the roles of pharmacists, pharmacy technicians, and pharmacy students in supporting a safe, effective, and efficient medication-use system.
- Activities for pharmacy students and pharmacy residents should support the educational goals for both groups though their active involvement in the care of patients.

## Harvey A. K. Whitney Lecture Award

### Past Recipients

1950	W. Arthur Purdum	1981	Kenneth N. Barker
1951	Hans T. S. Hansen	1982	William E. Smith
1952	Edward Spease	1983	Warren E. McConnell
1953	Donald E. Francke	1984	Mary Jo Reilly
1954	Evlyn Gray Scott	1985	Fred M. Eckel
1955	Gloria N. Francke	1986	John W. Webb
1956	George F. Archambault	1987	John J. Zugich
1957	Sister Mary John, R.S.M.	1988	Joe E. Smith
1958	Walter M. Frazier	1989	Wendell T. Hill, Jr.
1959	I. Thomas Reamer	1990	David A. Zilz
1960	Thomas A. Foster	1991	Harold N. Godwin
1961	Herbert L. Flack	1992	Roger W. Anderson
1962	Grover C. Bowles	1993	Marianne F. Ivey
1963	Vernon O. Trygstad	1994	Kurt Kleinmann
1964	Albert P. Lauve	1995	Paul G. Pierpaoli
1965	Sister Mary Berenice, S.S.M.	1996	William A. Zellmer
1966	Robert P. Fischelis	1997	Max D. Ray
1967	Paul F. Parker	1998	John A. Gans
1968	Clifton J. Latiolais	1999	William A. Gouveia
1969	Leo F. Godley	2000	Neil M. Davis
1970	Joseph A. Oddis	2001	Bernard Mehl
1971	Sister M. Gonzales, R.S.M.	2002	Michael R. Cohen
1972	William M. Heller	2003	James C. McAllister III
1973	George L. Phillips	2004	Billy W. Woodward
1974	Louis P. Jeffrey	2005	Thomas S. Thielke
1975	Sister Mary Florentine, C.S.C.	2006	Sara J. White
1976	R. David Anderson	2007	Henri R. Manasse, Jr.
1977	Herbert S. Carlin	2008	Philip J. Schneider
1978	Allen J. Brands	2009	Paul W. Abramowitz
1979	Milton W. Skolaut	2010	Charles D. Hepler
1980	Donald C. Brodie		

Harvey A. K. Whitney (1894–1957) received his Ph.C. degree from the University of Michigan College of Pharmacy in 1923. He was appointed to the pharmacy staff of University Hospital in Ann Arbor in 1925 and was named Chief Pharmacist there in 1927. He served in that position for almost 20 years. He is credited with establishing the first hospital pharmacy internship program—now known as a residency program—at the University of Michigan in 1927.

Harvey A. K. Whitney was an editor, author, educator, practitioner, and hospital pharmacy leader. He was instrumental in developing a small group of hospital pharmacists into a subsection of the American Pharmaceutical Association and finally, in 1942, into the American Society of Hospital Pharmacists. He was the first ASHP President and cofounder, in 1943, of the *Bulletin of the ASHP*, which in 1958 became the *American Journal of Hospital Pharmacy* (now the *American Journal of Health-System Pharmacy*).

The Harvey A. K. Whitney Lecture Award was established in 1950 by the Michigan Society of Hospital Pharmacists (now the Southeastern Michigan Society of Health-System Pharmacists). Responsibility for administration of the award was accepted by ASHP in 1963; since that time, the award has been presented annually to honor outstanding contributions to the practice of hospital (now health-system) pharmacy. The Harvey A. K. Whitney Lecture Award is known as “health-system pharmacy’s highest honor.”

- To achieve desired outcomes, the practice model should be team based, with a representation of specialist and generalist pharmacists, pharmacy residents, pharmacy students, and pharmacy technicians.

A team-based practice for pharmacy will support communication, problem identification, and problem resolution, an approach consistent with Albert Einstein's<sup>6</sup> caution that problems cannot be solved at the same level of thinking with which we created them. Starting with a new model in mind and applying creative thinking will support the achievement of our vision.

That being said, I would like to explore three specific topics that, I believe, are core to implementing our vision and represent the groundwork for our future success: (1) the redesign of the pharmacy residency model, (2) the competence and quality of the pharmacist work force, and (3) the role of students and the need to make students indispensable.

I have selected these three issues, perhaps in part, because of my own interest and commitment to residency training. These three items also represent initiatives over which pharmacists in hospitals and health systems have significant control and are in a position to facilitate change quickly. The benefits of change for these items would be significant and represent "quick wins" that support our future practice model vision and the recommendations of the PPMI Summit and PRCSC.

### Residency model

During his 1988 Whitney address, Joe E. Smith<sup>7</sup> recognized the silver anniversary of ASHP-accredited residency programs. With 2013 on the horizon, we are approaching our 50th year of residency accreditation. Pharmacy residency training programs have supported change and the advancement of clinical practice,

operational improvements, and medication-use safety in hospitals and health systems. Residency programs continue to support the development of future leaders for the profession. A key to our success has been the voluntary accreditation process directed by the ASHP Commission on Credentialing and supported by the ASHP Accreditation Services Division. Without the profession's participation in and commitment to a voluntary accreditation process, we wouldn't have realized the advancements made over the past 50 years. Accreditation standards raise the bar of expectations higher with each revision.

Although the *content* of residency training has changed significantly over the past 50 years, the residency training *model* has not. If we are to achieve the established goals of ASHP<sup>8</sup> and the American College of Clinical Pharmacy (ACCP)<sup>9</sup> that all pharmacists entering practice and engaged in direct patient care will have completed postgraduate year 1 (PGY1) residency training by 2020, we need to increase our capacity for residency training. Strategies to increase capacity were explored during the PRCSC and included the development and implementation of a new model for residency training. This need for a change in the model is supported not only by the issue of capacity but also by the recommendations of the PPMI Summit. The support from the Summit rests within the recognition of the value of an integrated practice model and the need to develop practitioners' skills for this role.

The pharmacy residency training model for most programs today relies on rotational experiences in specialty practice areas and the one-on-one preceptor-resident relationship. Certainly, the "M" factor represents a significant component of the value for residency training and should be protected. The M factor, in this case, refers to the mentor-protégé rela-

tionship. At the same time, is it reasonable to expect that pharmacy residents, having completed rotational experiences in specialty practice areas within a specialist model, will somehow magically make the transition to an integrated practice model or want to? Shouldn't some portion of the residency training program provide experience in a team-based integrated practice model to ensure competency and a smooth transition to this model of practice?

During a residency preceptor committee meeting at Johns Hopkins, the question was asked: "How efficient are we with our residency training model compared with the Department of Medicine or other training programs?" That question had me visiting with the medical residency program leaders at Johns Hopkins to review their model and subsequently reviewing the standards of the Accreditation Council for Graduate Medical Education to see if there were other strategies we might consider. At the PRCSC, Michael Adams,<sup>10</sup> the program director for the medical residency at Georgetown University, provided a review of that institution's model, further supporting the idea that changes could be made to the pharmacy residency model to increase our efficiency and capacity. There was agreement by PRCSC attendees that elements of the medical model provided strategies for pharmacy to improve our process.

As we thought through the development of a new residency training model at The Johns Hopkins Hospital, our first step was to identify assumptions. These assumptions represented overarching principles of the residency program, were largely consistent with those identified by PRCSC attendees, and included as examples the following:

- Outcomes and competency developed during residency training should not be compromised.

- Interactions with preceptors would change but should still protect the mentor–protégé relationship.
- The preceptor model should evolve to an “attending pharmacist” role that delegates patient care responsibility but is still accountable for outcomes.
- The role of the resident should evolve to a “practitioner-learner,” a licensed pharmacist practicing under the guidance of the attending preceptor.
- Residents, as practitioner-learners, should participate in some rotations structured as an integrated practice model.
- Simulations and other forms of technology should be used to support residency training and minimize preceptor time for orientation and explanations of routine or repetitive functions.
- Performance measures should be developed to ensure the quality of patient care as well as the quality of the learning experience.
- The residency model should embrace the concept of a team-based learning environment including clinical pharmacy specialists, decentralized pharmacists, pharmacy students, and pharmacy technicians.
- A progression of autonomy should be developed and defined for students in introductory and advanced pharmacy practice experiences, residents, pharmacists, and preceptors that includes student educational responsibilities.

Attendees at the PPMI Summit recognized the value of an integrated practice model as an effective strategy to support a breadth of pharmacy services as PGY1 residency-trained pharmacists provide clinical services in a generalist practice model. At the same time, we realize that for our organization and many organizations, patient care demands support the need for specialized practice knowledge only developed through the completion of a postgraduate year 2 specialty residency. The combination of specialists and generalists sup-

ports what Kevin Colgan<sup>11</sup> described during a presentation at the 2010 ASHP Midyear Clinical Meeting as a “comprehensive practice model.” Additional elements required for a comprehensive practice model are described within the recommendations of the PPMI Summit.

I do not know what the ideal number of residents is for The Johns Hopkins Hospital or for your hospital or health system. My preceptor, Ronald Turnbull, established a minimum of 2 when he explained to me many years ago that if you didn’t have 2 residents, you didn’t have a residency program. Donald Letendre, a graduate of the Kentucky program when it was a three-year program with 12 residents each year, suggested to me that 36 was the ideal number of residents. Toby Clark suggested that 8–12 PGY1 residents for every 325 beds is a reasonable ratio. Janet Teeters, thinking about our current model, has encouraged each program to “just add 1” to address the capacity issues facing the profession. They would all agree that the pharmacy residency program must be accredited. The need for a new model is supported by not only the issues surrounding capacity but also the needs identified within our vision of the future and the recommendations of the PPMI Summit. PGY1-trained pharmacists, practicing in an integrated practice model, are core to the establishment of a comprehensive model.

The time has come for change. As we begin to think through the process of implementing a new residency training model, we may find ourselves confronted with a number of questions:

- Should we implement changes to the residency training model for our organization?
- Would a reasonable strategy be to convene a group of preceptors to identify assumptions or overarching principles for a new practice model?

- Should we develop a list of specific questions or operational procedures to achieve and support for each of these assumptions?
- Should we convene a planning retreat within our department to define the model and a strategy for implementation?

If these questions were directed in a letter to ourselves, just as residents did when writing to T. N. Ediser, I suspect that the answer we would receive would be “permission granted.”

### **Competence and quality of the pharmacist work force**

The competence and quality of the pharmacist work force are not new issues, and you may be wondering why I have included them in my remarks.

Henri Manasse<sup>12</sup> discussed the issue of the competence and quality of the pharmacy work force in his 2007 Harvey A. K. Whitney Lecture. He spoke about “self-examination of the quality, safety, efficiency, and cost-effectiveness of our health care services system.” Certainly, the competence and quality of the pharmacy work force support the achievement of a safe, effective, and efficient medication-use system. This connection validates our concerns with the issues of competence and quality of the pharmacy and pharmacist work force.

In terms of our continued efforts to improve the competence and quality of the pharmacist work force, Manasse recognized, as do each of us as practitioners, the “significant gains” that had been achieved “through the expansion and revision of the curricula in our schools and colleges of pharmacy.” We have all benefited from these changes and the leadership, support, and collaboration from our colleagues at the American Association of Colleges of Pharmacy and the Accreditation Council for Pharmacy Education (ACPE). Despite these gains, Manasse

encouraged that “we still need to do some deep thinking about the level and scope of competence required of our practitioners in hospitals and health systems.” Although it took me a while, I now better understand this message and why, with the changes we are experiencing in the balance of the supply and demand of pharmacists, the competence and quality of the pharmacist work force should be revisited. We have had little experience understanding and dealing with the implications of an improved supply of well-trained pharmacist practitioners. How does this change affect our practice model and how workforce decisions are made within our organizations?

An understanding of the importance of competency comes from a review of the list of expected pharmacist services in a comprehensive practice model. One list was developed as part of the University HealthSystem Consortium’s review of the pharmacy practice model for academic medical centers, led by Paul Bush.<sup>13</sup> Through Paul’s leadership and the active participation of task-force members, a list of services that should be provided by all academic medical center hospital pharmacies was developed. These efforts occurred in parallel with the ASHP PPMI Summit. A review of the recommended services for all patients makes a strong case for competent pharmacist personnel to deliver these services. Most telling was the universal support by task-force members of the list of direct patient care services.

The PPMI Summit also identified essential activities that should be provided in any optimal pharmacy practice model.<sup>4</sup> The list of activities is extensive and includes

- Daily patient-specific medication review,
- Monitoring of patient response to medication therapy,
- Adjustment of medication dosages based on patient response or pharmacokinetic characteristics of the medication,
- Adjustment of medication regimens based on genetic characteristics of the patient,
- Monitoring of critically important serum medication concentrations and other clinically important laboratory analyses,
- Authority to adjust dosage for selected medications,
- Participation in antimicrobial stewardship,
- Medication reconciliation in the emergency department, on patient admission, during hospital transfer, at patient discharge, and in ambulatory care settings,
- Establishment of processes to ensure medication-related continuity of care for discharged patients,
- Provision of education to patients at discharge,
- Participation on the rapid-response team, and
- Participation on resuscitation teams.

This list of activities was supported by PPMI Summit attendees to ensure the quality, safety, efficiency, and cost-effectiveness of the medication-use system. The question I started to consider was, “Does every pharmacist in a position to provide direct patient care services possess the knowledge, skills, abilities, and competencies to provide these services?”

The PRCSC afforded the opportunity to review our current landscape of residency training, trends in the delivery and financing of health care, work-force trends, and policy issues. Several times during the conference, the policy statements of ASHP and ACCP that support the requirement for PGY1 residency training for entry into clinical practice by 2020 were discussed.

While thinking about this long list of essential drug therapy management services that would be expected of pharmacists practicing in either a specialist or generalist model and our vision for the future, we might be asking ourselves several questions:

- Is it 2020 at our organizations today?
- Should the completion of a PGY1 residency be required and a part of the job description to provide clinical services?
- Should we take steps to ensure that pharmacists providing essential drug therapy management services have the required knowledge, skills, abilities, and competencies?

If these questions were directed in a letter to ourselves, I know the answer we would receive would be “permission granted.”

### Making students indispensable

It seems to me that as we go about implementing the recommendations of the PPMI Summit, much of our focus will appropriately center on the utilization of pharmacists, pharmacy technicians, and technology. And, although included in the recommendations made during the Summit, I wonder if we could be overlooking the importance and significance of pharmacy students?

During a visit to Detroit, I found myself speaking with Douglas A. Miller backstage at the commencement ceremony for the Wayne State University College of Pharmacy. We spoke about Wayne State’s strategies to address the needs of student experiential training.<sup>14</sup> I recalled Doug’s comment that “our goal is to make pharmacy students indispensable to the training site.” During my return flight to Baltimore and several times during the days that followed, I thought about his comment and wondered if our preceptors would consider students indispensable.

As early as 2004, many people understood, with the growing number

of pharmacy schools and pharmacy students needing quality experiential training, that a “perfect storm” was on the horizon. That storm is now being picked up on the local radar for most hospital and health-system pharmacies around the country. If our vision is that every student should have quality introductory and advanced experiential learning experiences, collaboration between colleges of pharmacy and the training sites will be needed to ensure success.

A return visit to Detroit, through the hospitality of Doug Miller; Edward Szandzik, the Director of Pharmacy at Henry Ford Hospital; and Richard Lucarotti, a faculty member at Wayne State University, increased my understanding of what I believe is a “best practice” supporting experiential training of students. There are a number of “best practice” models in place around the country that are effectively supporting the experiential training needs of students. The elements that seem common to successful programs include

- A strong commitment from the program to match the students’ interests with the scheduled experiential experience,
- Support for students to make career decisions earlier in the educational process,
- The availability of educational tracks for experiential training that match the students’ desired career path,
- The availability of a traditional track for students who have not yet identified a career path and desire a variety of experiences to support their career goals and objectives, and
- Extended rotational experiences within the desired career track for students at a single site.

The nomenclature for the program at Wayne State supports our understanding of the program structure and the options available to students.

Rotations offered include “LAPPs, TAPPs, and CAPPs.” A LAPP is a longitudinal, hospital-based experience supporting five to seven required rotations at one health-system site, while a TAPP is a traditional model with a series of rotations at multiple sites, and a CAPP is a community pharmacy experience with three consecutive experiences completed at one practice site.

Key elements of the program were discussed during our visit. Students are oriented to the options available to them during programs held in the third professional year. Each participating LAPP and CAPP practice site presents an overview of the experiential opportunities they provide, and additional information about each of the sites is made available to students through websites. In addition, students can gain insight and perspective about the program options from various faculty members, academic advisors, and from senior students currently completing the advanced pharmacy practice experiences. Many sites hold an open house for prospective students hosted by current or former students, pharmacy residents, and preceptors.

Students sign up for onsite interviews for LAPP or CAPP programs in which they have an interest. After the interview process, the students and practice sites participate in a match program that operates long the same lies as the ASHP Resident Matching Program. This process helps ensure that students’ interests and abilities are matched with the opportunities available at the various sites. Regardless of whether a student chooses a LAPP, CAPP, or TAPP, each receives comparable training experiences in accordance with ACPE standards. However, with this system, those who desire to do so have the opportunity to advance their career within a specific area of pharmacy practice. The advantage to the practice site is that students who complete multiple rotations at that single site become

much more familiar with the professional and support staff and with pharmacy operations at that site. As a result, it is much easier for them to be integrated into the process of patient care.

I was able to observe this integration during our visit to Henry Ford Hospital. Students do not simply “shadow” a pharmacist but instead are assigned to and develop a relationship with a rounding team. As skills develop and experience permits, students are given progressively increasing levels of responsibility for drug therapy outcomes for patients under their general care. A typical patient load is about 10–15 patients. Pharmacist preceptors provide oversight of student performance and ensure quality patient care (much like an attending physician supervises residents and students on service). Student projects designed to improve the scope and quality of pharmacy services and patient care are encouraged.

Participating LAPP sites have increased the number of rotations they offer, reversing a previous trend where hospitals and preceptors typically wanted fewer, not more, students on rotation. Students are now contributing to the process of patient care. They are seen as assets rather than liabilities. At Henry Ford Hospital, students have become indispensable.

This structure represents a win-win-win. Students receive a more meaningful experience (“doing” rather than just “watching”), which helps better prepare them for the next stage of their career. Participating sites benefit as the integration of students into their practice model permits expansion and enhancement of patient care. The college benefits because it has a greater number of high-quality rotations to offer its students. Interviews with faculty, preceptors, pharmacists, residents, and former and current students validated the success and value of this program.

The strategy utilized by Wayne State University represents only one method to meet the experiential training needs of students. Around the country, schools and colleges of pharmacy are collaborating with experiential training sites to change our model of introductory and advanced experiential training. The time to act is now. As we begin to think through the process of implementing new models for experiential training, we are once again confronted with questions. It really comes down to one basic question: Should we pursue strategies to make students indispensable? Asking ourselves the question, our answer, once again, is “permission granted.”

### Final thoughts

In the time we have had this evening, we have been able to explore three topics representing areas where pharmacists in hospitals and health systems have a significant level of control and could quickly bring about changes that would benefit the profession and our ability to provide patient care services. As you consider strategic planning activities for your hospital and health system in the future—if you haven’t done so already—I would encourage you to develop and implement changes to the pharmacy residency model to increase our ca-

capacity and decrease the cost of care for patients. In addition, we should take a hard look at what we are asking our clinical pharmacists to do and ensure that they possess the knowledge, skills, abilities, and competencies needed. Last but certainly not least, we should review the structure for student experiential training and develop strategies to make students indispensable to the training sites.

Finally, as we go forward from this evening, when you ask yourself questions about what to do, remember the strong message of motivation, empowerment, responsibility, and accountability within the simple expression “permission granted.” Give yourselves permission to assume a leadership role to implement change.

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