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HARVEY A. K. WHITNEY
LECTURE

Pharmacy's bucket list: Lean in

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I feel supremely honored to be standing before you tonight. I consider this a lifetime achievement award. This recognition, voted on by such a prestigious group of professional leaders who have gone before me, is truly an honor counted among the highest I have ever been awarded. In fact, I believe receiving the Harvey A. K. Whitney Lecture Award tonight completes my own professional “bucket list.”

Everyone is probably familiar with the 2007 comedy-drama film by that name directed by Rob Reiner and starring Jack Nicholson and Morgan Freeman. A blue-collar mechanic played by Morgan Freeman and a billionaire hospital magnate played by Jack Nicholson meet for the first time in the hospital after both have been diagnosed with terminal lung cancer. After a rocky start, they become friends as they undergo their respective treatments. Both write a list of things to do before they “kick the bucket,” and they begin an around-the-world vacation to complete the lists.

My own bucket list

My personal bucket list has some very important things on it:

- First, and always first, is raising children who make a difference. Jenna and Julia, I want to thank you for being such good seed for that one. You made my job easy and have grown and developed into people who can now coach me. I know you will make a difference in the world and leave it a better place than you found it. I am very proud of both of you.
- Second is expressing my love and thanks to my family often enough and sincerely enough through my actions that they believe it. My deepest gratitude and love go to my parents, my two sisters and their families, and my two daughters. The boundless support of my family has been the foundation of my life. I truly believe that the single most important career decision you can make is whether you choose to have a life partner and who that partner is. I don't know of one person in a leadership position whose life partner is not fully—and I mean fully—supportive of her career. Cary Parke, you are really the guy who makes my life work, my best friend, a dedicated advisor, and someone who meets me halfway on all our life goals to form that loving partnership. Thank you.
- And third is using my personal strengths to love, laugh, give, and care in this world. I am lucky to work every day with extraordinary people at the Department of Veterans Affairs (VA). My thanks to Bill Jones, Tim Stroup, Roger Pierce, and Lynnae Mahaney for nominating me and supporting my nomination for this award; Scott Mambourg and Beth Foster, who have worked by my side for 20 years at the VA in Reno as innovators and early adopters of clinical practice; and my staff at the Veterans Integrated Service Network (VISN) 21, Joy Meier, Bob Coleman, Diana Higgins, and Amy Furman, who challenge me to live up to their high standards to transform and improve our health care delivery every day. All of my work has been the result of collaboration with colleagues at the University of Iowa, the University of North Carolina, and the VA. The 75-plus residents I have coached over the years have taught me more than I can express and they keep me young.

In reality, most of our lives are spent “doing” so much that we don't stop to think about what our ideal life should look like in the beginning,

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Jannet M. Carmichael is Pharmacy Executive for Veterans Integrated Service Network (VISN) 21, where she coordinates safe and cost-effective use of medications through pharmacy services, formulary management, and health analytics in a network of Veterans Affairs (VA) health care systems in northern California, northern Nevada, and Hawaii.

During her 30-year career with the VA health care system, Dr. Carmichael has made significant contributions to the system's progressive pharmacy practice model, including the use of quality metrics to improve patient care and patient safety while lowering health care costs. She oversaw the development of pharmacist-run primary care and inpatient clinics at the VA Sierra Nevada Healthcare System, a program that received ASHP's Best Practices in Health-System Pharmacy Award in 2002. She provided direct patient care in this environment for 20 years and continues to be credentialed and privileged as a VA clinical pharmacy specialist.

In her current role, she leads clinical pharmacy management initiatives that contribute to optimal prescribing practices for a variety of conditions and coordinates initiatives to improve patient care and drug safety. She is also responsible for the VISN 21 clinical data warehouse, health analytics, pharmacoepidemiology programs. Dr. Carmichael is the pharmacy residency director for the VISN 21 postgraduate year 2 (PGY2) managed care system residency program. She has trained over 75 PGY1 and PGY2 residents during her career.

In addition to her VA leadership roles, Dr. Carmichael has authored hundreds of professional papers, book chapters, and research projects throughout her career. She is coauthor of the IMPROVE research project, a multicenter study of the clinical and economic benefits of clinical pharmacist interventions in VA medical centers.

An active member of national and state pharmacy associations, Dr. Carmichael is a past president of ASHP, a past chair of the ASHP Research and Education Foundation, and a past member of the ASHP Commission on Credentialing, and she currently serves on the Pharmacy Practice Model Initiative planning and implementation groups. She has served as president of the Nevada Pharmacy Alliance and the Nevada Pharmaceutical Association. She was chair of the BCPS Pharmacotherapy Council and a member of the board of directors of the Board of Pharmacy Specialties, serving as 2007–09 board chair. Dr. Carmichael served on the Nevada Board of Pharmacy and is a member of the Accreditation Council on Pharmacy Education's site evaluation teams for accrediting schools of pharmacy. She served on the National Quality Forum's Medication Management Steering Committee and was a member of the technical expert panel for the Centers for Medicare and Medicaid Services' Maintenance and Development of Medication Measures initiative.

Dr. Carmichael received a bachelor of science in pharmacy degree from the University of Iowa and a doctor of pharmacy degree from the University of the Pacific. She is a past recipient of the Pharmacist of the Year award of the Nevada Society of Health-System Pharmacists and has also received the Bowl of Hygieia Award, the University of Iowa Distinguished Alumni Award, the American Pharmacists Association (APhA) Distinguished Federal Pharmacist Award, and the Robert G. Leonard Memorial Award. She holds the designations Board Certified Pharmacotherapy Specialist, Fellow of APhA, and Fellow of the American College of Clinical Pharmacy.

let alone identify the five things you must do so that on your deathbed you can honestly say that your life was a success. The essence of a good bucket list consists of overcoming fears, achieving goals, realizing dreams, and even simple pleasures. Fortunately, much of my bucket list has been accomplished while, out of necessity, earning a good living as a clinical pharmacist.

My professional bucket list includes lots of cool things you have

read about in my program biography, but what my bio *doesn't* say is that I have had the opportunity to spend most of my life in cutting-edge (my staff say "bleeding-edge") areas of pharmacy practice that continue to excite me each day. I have had the opportunity to make a difference to the patients I have served, the students and residents I have taught and whose lives I have helped shape, and the projects I have worked on. It has been a privilege to serve our nation's

heroes as a pharmacist in the VA health care system for 30 years. And I have had the opportunity to be a role model to other professional women.

This last item deserves a little more attention. When I set out in my professional life, I thought that women's movement leaders like Gloria Steinem had done the heavy lifting and my generation would be different. My sister Julie (who is counting her last days until retirement as dean of external relations for Western Iowa Technical Community College) recently sent gift cards to our daughters for a book titled *Lean In* by Sheryl Sandberg,¹ Facebook's chief operating officer (COO). Julie included an e-mail to the girls saying she wished someone had told her all this stuff when she was their age, 35 years ago.

While Sandberg's book has received controversial reviews, as a good COO she knows how to delegate, and her writing partners are experts on gender and social inequality who have helped produce a well-referenced book on current facts about gender gaps. The astonishing fact for me was that while Sandberg graduated from Harvard in 1995, a full 20 years after I graduated from pharmacy school, many of the societal gender issues today are the same as they were then. She asks a lot of important questions about why, after two or three generations of "liberated" women, the goal of true equality still eludes us. In the last 30 years, it turns out that women have made more progress in the work force than in the home. According to the most recent analysis, when a husband and wife are both employed full-time, the mother does 40% more housework than the father. She also spends more time with child care. A 2009 survey found that only 9% of people in dual-earner marriages said that they shared housework, child care, and breadwinning evenly. Sandberg invites women to "lean into" their chosen professional roles even when

society may tell us to lean back. All of us—men and women alike—have to understand and acknowledge how stereotypes and biases shape our beliefs and perpetuate the status quo.

The list of women who lead countries is very small, as is the list of female top business executives. In pharmacy there exists a more gender-neutral workplace because of the relatively equal numbers of men and women in our field. This is probably why it has been so interesting for me to read *Lean In* and discover that, in society, women have not come very far in domestic and leadership roles. The face of pharmacy has changed as more women fill up the ranks of the pharmacy profession. Women have been graduating from colleges and schools of pharmacy at a higher rate than men for over 20 years, and men are retiring at a faster rate than women. These two trends combined have resulted in a practicing profession composed of a greater percentage of women than men. Yet despite these trends, a relatively smaller percentage of women hold upper management positions or tenured faculty positions or have risen to the level of dean in academia. Just as in other fields, family issues are felt to be a major factor. Women are still responsible for the majority of childcare and housework regardless of their employment, marital, or parental status.

From an early age, girls in all social environments get the message that they will have to choose between succeeding at work and being a good mother. A woman interested in having children starts to make decisions that affect her job performance long before she actually has children. Often without even realizing it, the woman stops reaching for new career opportunities. She not only doesn't become the "big L" leader that Sara White² referred to (in her 2006 Whitney address), she doesn't even raise her hand for the "little L"

Harvey A. K. Whitney Lecture Award

Past Recipients

1950	W. Arthur Purdum	1982	William E. Smith
1951	Hans T. S. Hansen	1983	Warren E. McConnell
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1956	George F. Archambault	1988	Joe E. Smith
1957	Sister Mary John, R.S.M.	1989	Wendell T. Hill, Jr.
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1960	Thomas A. Foster	1992	Roger W. Anderson
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1963	Vernon O. Trygstad	1995	Paul G. Pierpaoli
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1976	R. David Anderson	2008	Philip J. Schneider
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1980	Donald C. Brodie	2012	Rita R. Shane
1981	Kenneth N. Barker		

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."

leadership roles at work. She tends to fall back when opportunities are presented instead of “leaning in” to take on advancement opportunities and potential promotions prior to childbirth. These decisions affect many more years in a woman’s career path than is necessary. By the time the baby arrives, the woman is likely to be in a drastically different position in her career than she would have been in had she not leaned back. She may feel underutilized or less fulfilled when she returns to the workplace. If financially able, she may choose not to work.

The changing nature of pharmacy employment—the growth of large national pharmacy chains and hospital systems along with the related decline of independent pharmacies—has played a key role in the creation of a more family-friendly, female-friendly pharmacy profession. In fact, I found several reports calling pharmacy the most egalitarian of all U.S. professions today in term of hourly wages. The gap between how much women make compared with men (on average, they earn 82.2% of what men earn for the same job in the United States³) is narrower for women pharmacists, who earn 92% of what male pharmacists earn⁴; that is still not perfect but is a step in the right direction to labor market gender equity. However, even though male and female pharmacists earn a nearly equal hourly wage for equal jobs, after controlling for the relative lack of women in higher-paying leadership jobs, male pharmacists overall continue to earn higher income levels than female pharmacists.

Marianne Ivey and I were the “glass ceiling” breakers in the line of ASHP presidents. I was also the first female pharmacist on the Nevada State Board of Pharmacy. I have had lots of firsts for a woman in this profession. On more occasions than I can count, women in pharmacy have made me aware that they are looking and asking for my experienced help

as a mentor in the workplace. We struggle with many of the same social factors that impact the larger health care community.

So, maybe I do have one or two more things to add to my professional bucket list, but I have less time left to make a difference. Art Buchwald said, “I don’t know if it is the best of times or the worst of times, but I can assure you this: It’s the only time you’ve got.”⁵ We are all too soon reminded that our earthly time is very short to accomplish the items on our bucket list and that change is much slower than we think.

Thirty-eight years ago I graduated from the University of Iowa College of Pharmacy (go Hawkeyes) and took a clinical faculty position there; my practice site was in Mechanicsville, Iowa, just north of Iowa City. This was a town of 800 people that had lost its only medical doctor and pharmacist. Town leaders came to the university for help. A model family practice health clinic staffed by a family practice physician, clinical pharmacist, nurse, and receptionist was started.⁶ I arrived there in 1975, the fourth in a long line of amazing clinical pharmacists. The practice was unique in that the physician saw the patient in a traditional examining room, made a diagnosis, and then brought the patient down the hall to a small room that doubled as a pharmacy and a consultation office. The pharmacist and physician decided on a course of treatment together, and the pharmacist prepared the prescription for the patient, counseled him or her, and made a plan for follow-up. The physician diagnosed, and the pharmacist treated. That was 38 years ago; I thought we would be doing that everywhere by now. So, why haven’t we? What is still on pharmacy’s bucket list as I complete my own career bucket list? I would like to spend the rest of my time with you tonight discussing just three of the things still on pharmacy’s bucket list.

Pharmacy’s bucket list

Creating demand for clinical pharmacy services. First on my pharmacy bucket list is creating a demand for clinical pharmacy services as essential health care services. In our efforts to make health care more affordable, to include 51 million Americans who lack sufficient health coverage, and to improve the quality of health care, many Americans will soon be offered new insurance coverage options through “healthcare marketplaces” (formerly called health exchanges). Even while states debate and consumer polls find that a substantial proportion of Americans are unaware that “it’s law,” new provisions of the Patient Protection and Affordable Care Act will go into effect in October 2013 and for many years to come. Qualified health plans will offer bronze, silver, gold, and platinum coverage—but all must cover 10 categories of essential benefits and services. These services include hospitalization, ambulatory care, and emergency care. They include maternity and newborn care and treatment of mental health and substance use disorders (with the same deductible as for other services). The law includes preventive and wellness care, pediatric services, laboratory and rehabilitative services and devices, and prescription drugs. Our society has determined that prescription drug coverage is one of the essential health benefits that must be included in health plans; however, clinical pharmacy services *are not included*. Pharmacists’ direct patient care services are known by a variety of terms, including medication therapy management, comprehensive medication management, collaborative drug therapy management, and pharmaceutical care. Since I am never sure which of these terms is meaningful to people, for the rest of my presentation I will refer to these services as “clinical pharmacy” or “pharmacist direct patient care” services.

Most pharmacists will continue to work for large organizations or corporations. New incentives to share cost savings will expand accountable care organizations. As more people enroll in health care marketplaces in future years, there will be requirements for reporting of clinical quality measures and accreditation of health plans to participate, and a much bigger need for data-driven health care. Instead of fee for service, more and more providers will be paid by value-based reimbursement. Our *hope* is that in these efforts to improve care, pharmacists who provide direct patient care will find a niche.

While we also all *hope* the total cost of care will decrease, the number of prescriptions filled will very likely increase, especially for those patients who are new to this essential health benefit. Pharmacists and the public must determine if the services of clinical pharmacists are an essential health care benefit and, if they are, how pharmacists will be reimbursed for these services. All of us in this room know this looks like the “perfect storm”: an increase in the number of Americans with prescription coverage, an increase in accompanying preventable drug-related morbidity and mortality, and no clinical pharmacy services. For those of us with the greatest ability to have an impact on and understand this area, this should be of great concern.

Note that dental and optometry services are not “essential” services, and those professions have developed plans for consumers to pay for their services (those who can afford them). Should pharmacist clinical services also be available only as add-on services for those who can pay? Should medication management be available only in health systems or only on some inpatient wards or only for some specific patient populations as part of value-based reimbursement?

Even those of us who boast the best clinical pharmacy services know

we cannot provide that level of quality care to all our patients; there is great variability. As our country works toward a universal vision of health care coverage throughout the continuum of care, pharmacy should be defining the core clinical functions and defining the pharmacist staffing ratios necessary to provide every patient with these services. There simply are not enough of us now employed to do the job. We see that more pharmacists are graduating annually from colleges of pharmacy and worry about an oversupply, yet we have only scratched the surface to solve drug-related problems and improve medication outcomes for patients. What’s more, we have data that support these activities as cost-effective in all health care systems. Many critical reviews have been done to demonstrate the median ratio of benefit to cost is that for every dollar spent on clinical pharmacy services, \$4.80 is returned to the health care system.⁷ We are far ahead of other professions in our ability to show value.

Other large social issues, such as marriage between same-sex couples, immigration reform, and even emergency contraception availability to young females, receive heavy media coverage. As social awareness grows, you can feel the pendulum of public opinion changing social norms on these issues. However, the need to provide a mandatory safety net of pharmacist services for the inevitable drug-related problems that will follow is not high on the list of societal concerns yet. We need to “lean into” any opportunity we have to create a sense of urgency and to publicize and market this disparity as a public health concern. The public, corporate leaders, hospital and health-system leaders, and public policymakers must understand that pharmacists can expand their role to assist with this problem. We must communicate in clear terms the adverse impact of a product-only prescriptions benefit

without services to assure effective, safe, and cost-effective patient use of that benefit.

Provider status for pharmacists. Obtaining provider status for pharmacists has been on the profession’s bucket list for as long as I can remember. Many pharmacy organizations have made this their top legislative priority and allocated resources to the cause. We know there is a shortage of primary care providers that will reach critical proportions in the coming years as baby boomers age. It has been estimated that if a primary care physician with a panel size of 2500 followed the recommendations found in the most common clinical guidelines, he or she would spend 7.4 hours per day doing recommended preventive care, 10.6 hours per day doing recommended chronic care, and 3.7 hours doing acute care^{8,9}; that would amount to almost 22 hours a day taking care of patients. No wonder few physicians have chosen to go into this practice environment. We also know that management of chronic disease consumes the majority of health care resources. And we know that pharmacists providing direct patient care can assist in resolving both issues.

In 2011, VA provided approximately 80 million outpatient visits and 692,000 inpatient admissions to over 6 million patients in our nearly 1,000 outpatient clinics and 152 medical centers. VA is currently the largest health system in the United States. To deal with these impossible primary care expectations, teams have organized into medical homes that we in the VA call patient aligned care teams, or PACTs. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has been a widely accepted model of how primary care should be organized and delivered throughout the health care system.

VA's vision of the clinical pharmacy specialist (CPS), a credentialed pharmacist provider, in a PACT is to have one pharmacist per 3600 patients (that means one CPS for three teams of 1200 patients). While this is our working ratio, it may be inadequate to care for all our patients. The CPS is assigned to and actively participates in primary care teams, providing chronic disease state management for patients between visits with their primary care provider and assisting with meeting disease state goals. Have we met these CPS ratios for all patient teams? No. However, we are working hard to increase the number of pharmacists involved in direct patient care to meet the needs of our patients.

VA currently employs 7100 pharmacists (10% of all U.S. health-system pharmacists), and we have the largest number of ASHP-accredited residents—560. More than 2700 of our pharmacists (about 38%) now practice with an advanced scope of practice within the VA. Their duties include performing physical and verbal assessments, ordering and interpreting drug-related tests, referring patients to other health care providers, prescribing medications, and many other provider-level functions. Last year these pharmacists logged almost 4 million patient encounters. In the VA, we have moved far beyond collaborative drug therapy management and have expanded core pharmacist privileges, which are granted under an advanced scope of practice. Pharmacists with this scope of practice are credentialed similarly to other prescribers in the health care system.

I am extremely proud to be part of this group. It is probably the most highly credentialed group of pharmacists in the world. Over 72% of VA CPSs have completed a residency or fellowship or are certified by the Board of Pharmaceutical Specialties (BPS). While we have been able to advance efforts to secure provider

status within the VA, we still cannot be considered licensed independent practitioners because such designation is governed by state law. We need to put this on our bucket list after provider status. Right after that we need to start working on our clinical pharmacy referral network, but I'm getting ahead of myself again.

In most states, pharmacists can apply for collaborative drug therapy management (CDTM) status to their state board of pharmacy. CDTM is a team approach to health care delivery whereby a pharmacist and a prescriber establish written guidelines or protocols authorizing the pharmacist to initiate, modify, or continue drug therapy for a specific patient. Many pharmacists now wish to provide these and other direct patient care services more independently.

The official "provider" list for fee-for-service care is maintained by the Centers for Medicare and Medicaid Services (CMS). This list governs what services a profession can provide, as well as payment for those services. Our approach has been a legislative effort to add pharmacists to this list as providers of cognitive services. Although current Medicare Part D law reimburses pharmacies for pharmacists providing some cognitive services, including medication therapy management for a select subset of patients, the program is restrictive and encompasses only a small set of the services pharmacists are capable of undertaking. Having pharmacists on that all-inclusive list of CMS providers for this essential health care service has eluded us. We need to lean into this one.

There is also a rules-based (not legislatively driven) provider list that is maintained for the value-based reimbursement process. I would recommend that the time is right to also petition the Secretary of Health and Human Services to be added to this list of health care providers so that pharmacists working in accountable-care organizations and other value-

based systems can apply for credentialing and privileging more easily.

Both California and Massachusetts have bills seeking legislative authority to establish pharmacist provider status in those states. We all need to lean into this continued legislative effort in any way we can. For decades, we have focused on giving women the choice to work inside or outside the home. We have celebrated the fact that women have the right to make this decision, and rightly so. In the same way, we have two very important processes of patient care that pharmacists fulfill. We have many pharmacists who are deeply entrenched in order-fulfillment activities and function well within their current scope of practice. Just as it is time to cheer on men and women who want to sit at the table, seek leadership challenges, and lean into their careers, it is also time to do the same for pharmacists who want to evaluate patients, prescribe medications, and assist in ensuring optimal outcomes of medication therapy. There are certainly enough drug-related problems to be solved and too few of us to do it.

Pharmacists have spent many years preparing for provider status. We have revamped and upgraded our educational and academic programs to require doctoral-level education for all. Pharmacy school graduates must pass the standardized North American Pharmacist Licensure Examination to demonstrate the basic knowledge needed to practice. Boards of pharmacy also require candidates to demonstrate knowledge of state and federal law and require a number of internship hours as a requisite to licensure. Postgraduate education includes postgraduate year 1 and postgraduate year 2 programs. Fellowships and master of science and Ph.D. degrees are also available, as are traineeships and certificate programs in specified areas of pharmacy practice. If additional demonstrated proficiency is needed, BPS certification is avail-

able. BPS has now credentialed nearly 16,000 pharmacists¹⁰—that number is expected to double in the next five years (Ellis B, BPS, personal communication, 2013 May)—and after 2013 we will have trained 32,400 ASHP-accredited pharmacy residents (Teeters J, ASHP, personal communication, 2013 May).

Pharmacy has always been concerned about *which* pharmacists should be providers. Should we allow all pharmacists to prescribe medication or only those with certain additional credentials? I sometimes think we are our own worst enemy in our ability to endlessly argue about this process. Let us apply the same principles we accept in society—that there is not just one way to cross the road. Which credentials will be needed will be determined by the type of direct patient care service provided.

While it is difficult to explain all this credentialing to others outside of pharmacy, the current pathway for achieving, demonstrating, and maintaining competence as clinical pharmacists is not an obstacle to attaining provider status. As pharmacists, we are capable and competent as providers. However, it is probably not a “one-size-fits-all” approach. Some combination of all these credentials is sufficient to secure provider status that allows an advanced scope of practice that will improve medication outcomes for patients.

Creating a framework for credentialing and privileging for all practice sites. In addition to answering the age-old question of which pharmacists should be providers, we seem to continually ask what services these pharmacists will provide. As pharmacy has evolved, we have always talked about two parallel processes of patient care—both centered on the patient and the medication-use process. At first, it was “pharmacist” and “clinical pharmacist.” Even in the VA we have “clinical pharmacists” and “clinical pharmacy specialists.” There will be pharmacists who want to be

providers and those who don’t. There are still environments where pharmacists who want to be providers shouldn’t or can’t. Could all pharmacists be providers? Yes, maybe eventually, but right now many practice environments are not ready for them. Issues of access to health records and patient information, as well as practice model support and acceptance by teams and patients, will limit this activity for many. However, just as societal biases shape our view of gender issues, so we must resist the temptation to continue to allow our pharmacy biases to perpetuate the status quo.

For example, the electronic health record has changed practice in any system that has one. My VISN 21 pharmacy benefit management group has spent the last 10 years developing a clinical data warehouse to do pharmacoepidemiology and pharmacovigilance in populations of patients on medications. To me this has been a very rewarding practice—it’s like clinical pharmacy on steroids, in fact. Our group is defining what the role of the health analytic pharmacist is in our practice model and training future pharmacists to fill this void with our postgraduate year 2 residency. When I started my career 38 years ago, I could not have imagined a practice of “patient population management by health analytics.” But here it is. And, as a result, we have created what is yet a third parallel pharmacy process of patient care. It is now common for pharmacists to use health analytics to identify high-risk patients who do not achieve a variety of performance, safety, or quality goals and to assist in coordinating and providing disease management, alone or with teams, to achieve therapeutic outcomes. These pharmacist-run programs have now demonstrated reductions in 30-day readmission rates and overall hospital admissions. So now we have pharmacist roles that include primarily order fulfillment, primar-

ily direct patient care, and primarily population management. We need to encourage all new role-development efforts as long as they contribute to advancing our practice model. The point is that practice models change and evolve; so should the scopes of practice and credentialing of pharmacists.

I may have been one of the first to be granted a VA pharmacist scope of practice and have held one continuously since 1981. Performing patient care functions at the “top of your scope of practice” is a concept that has advanced in complexity over the past 30 years. For many years, VA had pharmacists in hypertension clinics, diabetes clinics, and lipid outpatient clinics or pharmacists who focused only on pharmacokinetics, total parenteral nutrition, discharge counseling, or dosage adjustments in inpatient settings. Many of these practitioners have evolved into higher-functioning pharmacists who support the team’s vision of patient-centered care and have become proficient in helping to manage multiple disease states. Medication reconciliation (e.g., discharge, transitions of care, evaluation of new patients), disease and medication management (e.g., anticoagulation, antimicrobial stewardship, pharmacokinetic drug management, parenteral nutrition, PACT involvement, geriatrics), medication safety (e.g., improving adherence, formulary management), academic detailing, and health analysis are now among the services that VA pharmacists routinely provide. But tomorrow . . . who knows.

I urge all practice sites to develop a framework to standardize credentialing and scope-of-practice oversight of pharmacists who provide direct patient care. Employers (chain pharmacies as well as university hospitals) who agree to allow pharmacists the necessary access to patients and health information—and the time to provide direct patient care—should set up a standardized credentialing

process as practice models evolve. Employers have the opportunity to proactively develop this framework now, or it may be left to payers or regulatory bodies later.

A high-performing pharmacy must be able to determine what a pharmacist provider does and what credentials are needed to do it based on feasibility, financial return, the strategic focus of the organization, and the effect on quality and safety. However, we need to continue to be able to recognize high performance and make sure we do not hang a new banner over an old practice. What is good for business may or may not always be good for patients.

Conclusion

Many years ago I was told that, as a woman, I could “have it all.” I wish, instead, I would have been advised to lean in. Don’t select professional options already looking for the exit. Don’t put the brakes on—but rather accelerate—through life’s transitions. Keep your foot on the gas pedal until a decision must be made. That is the only way to ensure that when that day comes, there will be a real decision to make. As pharmacists, we are ready to take on a bigger role in direct patient care to improve drug therapy outcomes. All of us have to understand and acknowledge how stereotypes and biases shape societal beliefs and perpetuate the status quo, whether we are

talking about gender or pharmacy services. During this unprecedented transition of health care reform, I challenge you to remember that we are the health professionals with the strongest knowledge, skills, and ability to manage and reduce the sea of drug-related morbidity and mortality we see in our daily professional lives. Harvest innovative clinical practices, share your experiences (within the pharmacy organization and beyond), and encourage your health care teams to talk and publish the roles of clinical pharmacist’s impact on patient care. While we all have to ensure we speak the same language within pharmacy, we also need to ensure that others can sing our praises.

Closer to the end of my career than the beginning, my bucket list is thankfully pretty short. Pharmacy, however, has a couple of age-old items on its bucket list on which I would like to see some transformational progress before I fade into the sunset. Regardless of your personal choice of career path, it is really time for all pharmacists to lean into provider status, to establish a credentialing process in all pharmacy environments so we can make direct patient care services essential health care services for all our patients, even when society might be telling us to lean back. Progress often depends on taking risks, advocating for ourselves, and agreeing on the necessary steps

and framework needed to get there. This is an unprecedented time for us all to lean in together.

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