What are you doing for others?

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Good evening, friends, and family. It is a great honor to stand before you this evening and accept the Harvey A. K. Whitney Lecture Award.

I thank the past recipients of this award for this recognition. You are a group that I greatly admire, and I am humbled to join you as a recipient of this distinguished award.

In my life it is important to me to work hard, help others, and continue to learn. Those values were instilled early in my life by my mom, Irma Scott, who as a single parent dedicated her life to raising 4 kids. Thank you, Mom.

I've been influenced by a strong family value that education is nonnegotiable. That value dates back to the early 1900s, when my great-grandfather Henry Watkins Sr. and his sister Zadie Watkins were graduates of Alcorn University. That legacy crossed generations and is represented tonight by my mom, my uncle George Watkins, and my aunt Mary Watkins. They are also graduates of Alcorn University and, with my aunt Linda Watkins, were educators in the Chicago public school system throughout their careers. They inspire me.

I am delighted that my brother Karl, his wife Jill, and daughter Karli are here, as well as my sister Lynda.

I also want to thank my brothers-in-law and sisters-in-law, Mike Anderson and his wife Renee and Steve Anderson and Linda Becker, for their support and for making the journey to share this moment with Cindy and me. And, of course, my wonderful wife, and best friend Cindy. You mean the world to me, and I thank you for your love and support.

Throughout my career, I have had the good fortune to work with people who have continually inspired me to be better.

My career as a pharmacist started at the University of Wisconsin, where I gained a pharmacy practice philosophy that continues to guide my thinking today.

During the master's degree and residency programs at the University of Kansas (KU), I gained a broader understanding of the scope of pharmacy and administrative practices in healthcare. You cannot go through the Kansas programs without learning that good leadership is required to achieve any goal. I valued that lesson and better integrated it into my professional core as a faculty member and assistant director at KU Medical Center upon completing the KU programs.

It was also during my residency that I found my professional home in ASHP, which provided me more growth and opportunities than I can ever repay.

Following my time at KU, I had the privilege to practice for almost 20 years in hospitals and health systems—specifically in various roles within Allina—before experiencing healthcare from the additional perspectives of a pharmacy management company and, later, the pharmacy benefit management industry: McKesson Medication Management, Medco Health Solutions, and EnvisionRx Options. These experiences provided unique insights into the broader business of healthcare in addition to those I'd gained in hospitals and health systems.

I share my journey because these experiences have shaped my thinking during my career. I have found that regardless of my practice environment, societal expectations of the pharmacy profession consistently include the provision of safe therapies that achieve the desired clinical outcomes and a standard of providing care consistent with what we would want for our loved ones. I believe our responsibility—the societal purpose of the pharmacy profession—is to fulfill the expectations of society. For me, there has always been a recurring question that has grounded me in our societal purpose. That question, inspired by Dr. Martin Luther King Jr., is this: What am I doing for others?

"What are you doing for others?"

In a sermon during the civil rights era, Dr. King[1] posed this question best as he stated, "Life's most persistent and urgent question is, 'What are you doing for others?'" This quotation is from his sermon "The Three Dimensions of a Complete Life," in which Dr. King described those dimensions as (1) the inward concern for one's own welfare that causes one to push forward to achieve his or her goals and ambitions, (2) the outward concern for the welfare of others, and (3) the upward reach for God.

I believe that at some point in our lives we will privately reflect on these 3 dimensions as they apply to our lives. But tonight I pose the question "What are you doing for others?" as an expression of the outward concern for the welfare of others, for the pharmacy profession, and for a profession that I am deeply proud of and to which I will forever remain committed.

I believe that the answer to the question "What are you doing for others?" is embedded in the mission of our profession and ASHP, our professional home. I always found inspiration in the simple but powerful ASHP mission: "Helping people make the best use of medications." The term *people* is a key word here. Patients and their families will always be

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He previously served in executive roles at Medco Health Solutions as president of Accredo Infusion Services, where he was responsible for the specialty pharmacy and home care infusion businesses. He also served as Medco's chief pharmacist and senior vice president of professional practice and was responsible for leading the practice of more than 3,500 pharmacists, nurses, dietitians, and other healthcare professionals.

Prior to joining Medco in September 2008, Mr. Scott was chief operating officer of McKesson Medication Management, a subsidiary of McKesson that provided pharmacy management services to hospitals and other health provider organizations. He also has more than 25 years of experience in hospitals and health systems, including serving in senior leadership positions at Allina Hospitals and Clinics and as assistant director of pharmacy at University of Kansas Medical Center.

Mr. Scott is passionate about participating in efforts to improve health care and has served in several leadership roles in professional and community organizations. He is a past president of ASHP and of the Ronald McDonald House Board of Directors Charities of Minneapolis and St. Paul. He is a board member of the Utilization Review Accreditation Commission and the Board of Visitors at the University of Wisconsin School of Pharmacy. He has also served on the University of Minnesota College of Pharmacy Deans' Board of Advisors and on the faculty of the ASHP Foundation Pharmacy Leadership Academy.

He is the recipient of numerous awards for his service to the profession, including the Hugh F. Kabat Award for Service to Pharmacy in Minnesota, the Harold N. Godwin Leadership Legacy Award, and ASHP's John W. Webb Lecture Award.

Mr. Scott earned a bachelor of science in pharmacy degree from the University of Wisconsin School of Pharmacy. He received a master of science degree in pharmacy administration from the University of Kansas, where he also completed an ASHP-accredited pharmacy residency.

the focus of the term *people*. Throughout my career, my perspective of the term *people* has continued to evolve and expand. For example, you quickly learn in hospital practice that *people* includes physicians, nurses, and other healthcare professionals whom we help to make the best use of medications as they treat patients. Through our advanced practices, we are serving many others as members of interprofessional health teams, and we are responsible for medication use and related outcomes.

As my career advanced, it also became clear that *people* included legislatures as we worked to shape policies that addressed various aspects of medication use at the state and national levels. This advocacy lifts us toward societal expectations of safety and desired clinical outcomes.

So today, when the question "What are you doing for others?" is asked of our profession, I am proud of our shared progress and accomplishments. Within our health systems we have made great strides over the years to help others make the best use of medications and advance healthcare. This is evident in the safety of our drug distribution processes, the appropriate utilization of medications, the continued evolution of our clinical services, and practice models that continue to adapt to meet the needs of patients treated in health systems.

Today—given my career experiences—I also believe that the scope of pharmacy practice is too narrow and that we must expand our thinking beyond the boundaries of our practice settings and better manage the health of the populations we serve. I believe that outside the boundaries of our health systems, pharmacist care is fragmented and dysfunctional. It is fragmented in that our organizations, including health-system pharmacy, community pharmacy networks, insurers, and pharmacy benefit managers (PBMs), are stuck in individual realities of control and influence. As a result, transitions across care continuums become risk points for patients and their medication use. In our communities, patients have multiple uncoordinated pharmacy providers who often do not have access to complete information to provide optimal patient care and thus focus mostly on dispensing medications. Pharmacist care is dysfunctional in that this system does not operate according to most acceptable business norms and people's experiences as consumers. Patients do not purchase health products and services as they buy products and services in other industries; this often leads to confusion among patients and their caregivers. The patient experience differs in the pharmacy industry, as we have third-party payers, formularies, in-network and out-of-network providers, prices that vary for reasons most patients do not understand, and services that vary depending on your pharmacy provider.

Fragmented and dysfunctional care also contributes to poor adherence and a lack of continuity of care. Consider the well-known adherence statistics:

- Thirty percent to 50% of adults with chronic conditions do not take their medications as prescribed,[2,3] and
- Increased morbidity and mortality due to medication nonadherence account for as many as 125,000 deaths and 10% of hospitalizations annually.[4,5]

Further, think about the patient experience. We tell patients the following:

- In the hospital, your medications are prescribed according to the health-system formulary. On discharge, you are prescribed medications to continue your treatments. But those medications have to comply with the formulary of your insurance company, a different formulary that can lead to a change in your medications.
- Your discharge prescriptions are forwarded to your community pharmacy of choice. It will fill them and inform you that your benefit plan requires you to get your refills from your mail pharmacy—unless, that is, you'd like to pay the entire cost out of pocket, which in some cases is the same or less than your copay.
- But if you have a specialty medication, you may have to use a different pharmacy. Yes, that's correct. You have a health-system pharmacy, a community pharmacy, a mail pharmacy, and a specialty pharmacy, and we rarely talk to each other.
- And no, not all medications are special, because for specialty medications we have to first get prior authorization from your benefit manager for you to receive the medication, and that could take a week. But you may have to repeat all of your information to the specialty pharmacy because, remember, we don't talk with each other about your care.
- I will get back to you in a week or so—just hang in there. Hope you are feeling better.

I have often thought that the foregoing scenario would fit perfectly in my favorite cartoon strip, *Dilbert*. It would be very funny. But the truth is that it is *not* funny, because it is reality for patients in our communities.

Fragmented and dysfunctional care also results in slow recognition of and response to problems affecting the safe and effective use of medications. Consider the opioid crisis. The result: Our ineffective systems of pharmacist care do not do enough for others. They don't meet society's needs for optimal medication use consistent with what you would want for your loved ones. We must do more for others!

Our opportunities

While the challenges can be daunting, the healthcare landscape is undergoing significant change, and I believe health-system pharmacy is positioned better today than at any time in history to improve medication use in our communities. Consider the current healthcare landscape:

- Between 2010 and 2018 there were 870 hospital and health system acquisitions or mergers, creating vast regional and national networks, and indications are that this trend will continue.[6-9]
- Hospital-owned physician practices have increased 128%, from 35,400 in 2012 to 80,000 in 2018, thus increasing the capabilities of health systems to provide acute and chronic care for their service area.[10]
- Disruptive moves in the insurer and pharmacy markets—with CVS acquiring Aetna, Cigna acquiring Express Scripts, and UnitedHealth Group expanding the capabilities of Optum—are likely already affecting the delivery of pharmacist care in our communities.
- Government and commercial payers continue to be concerned with the increasing cost of healthcare.[11-13] And numerous employer healthcare coalitions have emerged in the country with the broad intent of improving quality and better managing costs, including making prescription medications more affordable.[14]

As a result, in most communities healthcare is now provided by a few large health systems. And with this market domination, our health systems are asked to not only treat incidents of illness but to fulfill the triple aim of simultaneously improving the experience of care, improving the health of populations, and reducing the per capita cost of healthcare.[15] Improving the experience of care and reducing the per capita cost of health care are very important and well-understood initiatives. However, improving the health of populations seems to be less clear. I think it is commonly understood that we are referring to improving the overall health of defined populations. Defined populations may include patients with specific diseases such as diabetes, patients with complex medication regimens, and patients with diseases that are impacted by environmental determinants of health—such as childhood asthma and the quality of the air they breathe. Improvements are focused on prevention as well as direct and indirect determinants of health and are assessed by appropriate metrics in populations defined by the needs of the community. And as our health systems pursue the triple aim, health-system pharmacy must take a leadership role and improve the use of medications in defined populations so that we improve the health of our communities.

In addition to health systems, insurers, PBMs, and employers are stakeholders in improving the health of populations. Insurers and PBMs have expanded their capabilities as pharmacist care providers, and employers continue to express dissatisfaction with a healthcare system that they view as failing to meet their expectations regarding the quality and cost of care. As we endeavor to improve the use of medications, our scope must expand to include all stakeholders concerned with improving the health of populations within the communities we serve. We cannot do this alone.

My ask of the profession of pharmacy—as we consider the persistent and urgent question of "What are we doing for others?"—is that we place patients and population health at the center of our societal purpose. I ask that we consider all pharmacy organizations and resources at work in our communities as we develop strategies to improve medication use. Although some organizations may be providing

duplicate and competitive services, we must aim to better coordinate our services to provide better care for our communities. I ask that health-system leadership bring together stakeholders and reimagine how pharmacist care is provided, with a focus on better managing the health of populations in our communities.

Several health systems and their pharmacy enterprises have developed population health management strategies.[16] I applaud their progress and urge them to continue collaborative efforts to maximize the resources of health-system pharmacy, insurers, PBMs, and community pharmacy networks to better manage medication use in various populations.

Of course there is a lot of work to be done, and all of us have a role to play. That work may include initiatives such as these:

- Developing shared medication-use criteria for select medications, potentially eliminating the need for prior authorization. Although there is pride in authorship of utilization criteria, it is my observation that the process of creating utilization criteria is similar among organizations (i.e., health-system pharmacy, insurers, and PBMs): pharmacists with similar education and training use the same published evidence to arrive at similar utilization criteria.
- Developing methods to share appropriate patient information throughout a preferred or defined pharmacy network that is coordinating and maximizing resources to better serve patients.
- Sharing population data and metrics regarding performance with respect to accepted proven standards of care so that all stakeholders interested in the health of a population are aware of opportunities for improvement.
- Creating avenues to respond quickly to emerging medication safety issues or risks in our communities.
- Helping patients, one patient at a time, navigate our fragmented and dysfunctional care and advocating for your ideas to improve care.

I am not proclaiming to have the answers, nor do I believe that improving our medication is easy. But this is comfortably within the influence and skill set of health-system pharmacists. It is similar to work that you have done in getting a seat at the executive table of health systems and managing complex organizations to achieve better clinical outcomes. It includes understanding and owning the problem, creating a vision, exercising leadership and innovation, knocking on the door of opportunity, and stepping up when opportunity knocks on your door. But just as Dr. King spoke to "life's most persistent and urgent question" being "What are you doing for others?" we must act with persistence and urgency in pursuit of improving medication use in populations and improving the health of our communities.

My ask is that you develop a pharmacy population health management vision and strategy for your community and execute it.

Paradigm shifts

As you explore improving patient care within your community, it will require openness to new ideas. Throughout my career, some of my old paradigms kept me stuck in my thinking. For example, I once thought of insurers and PBMs only as healthcare gatekeepers who decided who could provide care and be reimbursed for the care provided. That was the totality of my experience with insurers and PBMs, so that shaped my thinking. Through my subsequent career experiences, my paradigm changed. I now understand that an important responsibility of insurers and PBMs is to act as value shoppers for medical and pharmacy benefit plans on behalf of their clients. Their clients are employers and payers in search of medical and pharmacy benefit plans that meet the needs of their employees or members at the best price. Another example of my paradigm shifts relates to communication with patients. I grew up in an era in which conversations with patients were face-to-face and you established a relationship with the patient. So, as you might imagine, in 2008 when I started at Medco, I didn't really understand how pharmacists could possibly have a meaningful relationship with patients in a call center receiving tens of thousands of calls a day. Then I spent time visiting with the pharmacists and listening to their calls. One particular call still stands out to me today. It was late at night, about 11 PM, when a pharmacist answered a call from a lady saying, "Thank you for taking my call." After the normal authentication process, the caller said her son was just discharged from the hospital. He had medications dispensed by Medco and new medications dispensed from the hospital. Someone at the hospital had explained the new medications to her, and since getting home she had looked up the new medications but still had questions. That conversation went on for almost 40 minutes and addressed duplicate medications, the purpose of the medications, adverse effects, administration times, and many other questions. Why was this such a rich conversation? This was a mom who had gotten home from a hectic few days at the hospital, the kids were now asleep, and she had time and was ready for this conversation. She had questions, needed answers, and the call center pharmacists were available and ready at 11 PM to talk with her. Throughout my tenure at Medco, I listened to that scenario play out many times. I came to understand that there is value in being available when the patient is ready and that meaningful dialog can happen telephonically. Furthermore, the call center model was repositioned in my thinking to be an extremely valuable tool for patient outreach, follow-up, and management.

Today, with virtual communication, improved technology, and a generation of people who are of the opinion "Why talk when you can text?" we must be prepared to further adjust our patient communication paradigms.

I offer my experiences only to say that as you continue the journey of providing healthcare in our evolving world, you will also be asked to confront paradigms you may hold. It is important that you ask yourself, "Is my current paradigm allowing me to take full advantage of opportunities to advance healthcare, improve the health of populations, and do all that I can for others?"

A note of caution

Before I end, I do have one note of caution regarding protecting our culture. I believe that improving the health of our communities could become a competitive strategy among health systems. Thus, our efforts to work with others and improve the use of medications in our communities may result in strategies that compete with those of other regional health systems. I urge you to protect the collaborative culture of health-system pharmacy and ASHP. Avoid the competitive urges of classifying practice information as competitive intelligence or intellectual property, because that is not where we compete. We share practice information that will help others, no matter who they are, to make the best use of medications. Health-system pharmacy has an incredibly supportive and collaborative culture that we should value and protect even in competitive situations.

Summary

Our health systems have evolved into large organizations and are increasingly concerning themselves with the triple aim of simultaneously improving the experience of care, improving the health of populations, and reducing the per capita cost of healthcare. Health-system pharmacy enterprises must take a leadership role in improving the use of medication in defined populations so that we improve the health of our communities. But our scope has to expand and include other stakeholders interested in the health of populations. I ask that you develop and embrace population health management strategies for your community.

So, when health-system pharmacy is asked what it is doing for others, the answer will be that not only are we doing a great job of caring for patients treated in our health systems, we are also improving the health of populations and our communities.

Closing

And as I close, I know that if many of you in this room were personally asked the question "What are you doing for others?" one answer would be that you mentor and help young leaders grow and develop. I know this because I benefited from the help of many of you, and I thank all of you.

I especially thank David Zilz, who has been present during my entire career providing much-needed guidance. David always had a plan for me before I knew I needed a plan.

And, of course, Tom Thielke and Pam Ploetz, who hired me as a pharmacy technician, intern, and pharmacist and taught me how to practice pharmacy.

And I am also very grateful to Pam Ploetz for seeing potential in me that I didn't see myself and for changing the course of my career over a pizza as she encouraged me to go to graduate school. Thank you, Pam, and thank you to my Wisconsin family.

And thank you to my Kansas family. Thank you to Harold Godwin and Sara White, who continually demonstrated excellence in leadership and were always there with guidance and support. And Sara, thanks for more than 30 years of breakfast at ASHP meetings. I always look forward to our conversations.

And Henri Manasse, who, as ASHP chief executive officer, took it upon himself to make sure that as an ASHP presidential officer, I grew as a person and as a leader. Thank you, Henri, for making that such a special time in my life and for continuing to help me grow.

And finally, a special thanks to Lisa Gersema and Jill Boone for nominating

Harvey A. K. Whitney Lecture Award

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me for this award and to all who supported my nomination.

And although I am extremely proud of this award, I know that there is nothing that I have accomplished during my career that I did alone. Thank you to the leadership teams I have worked with throughout my professional journey. You are very special to me and will always be.

Thank you for your time and attention this evening, and thank you for all that you do for others.

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."

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