

Dr. Gerald Meyer Emphasizes “Courage” at the American Society of Health System Pharmacists

The following is an excerpt of an inaugural address given by Gerald E. Meyer, PharmD, MBA, FASHP, new President of the American Society of Health System Pharmacists (ASHP), at the Opening Session of ASHP’s Summer Meeting in Minneapolis, MN, June 4, 2013. Included in this excerpt are highlights from questions submitted from ASHP members. Dr. Meyer is Director of Experiential Education at the Jefferson School of Pharmacy.

I would like to begin by acknowledging you—our members. I want to personally thank all of the members who have participated in ASHP’s state societies. ASHP could not fulfill its mission without the support and inspired leadership of our affiliates. Yes, being president of ASHP involves a lot of time and travel. But it also comes with a large support staff.

The volunteer leaders in our affiliates, on the other hand, *do it all*. You are the membership committee, the program committee, the finance committee, the professional advocacy committee, the strategic planning committee, and so much more. So, to all of you, a great big thanks!

A Rich Pharmacy History

Many of you may know that I am from Philadelphia. And I am *proud* of it.

Philadelphia has a very rich pharmacy history. We have the first hospital in the United States—Pennsylvania Hospital—founded by Benjamin Franklin in 1751. We have the first college of pharmacy in the United States—the Philadelphia College of Pharmacy, which opened in 1821. And we had the first hospital pharmacist in the United States. His name was Jonathan Roberts.

We also lay claim to the first Hospital Pharmacy Residency Program to be surveyed for ASHP accreditation and the first accredited Pharmacy Technician Training Program, both at Thomas Jefferson University Hospital.

We have four past-presidents of ASHP currently working in Philadelphia and a fifth in retirement nearby. I have been truly fortunate to have had access to so many health-system pharmacy leaders.

I am most appreciative for the inspiration, support, and encouragement that I have received from numerous professional colleagues – including more than 230 pharmacy residents – at Thomas Jefferson University Hospital and Thomas Jefferson University with whom I have had the privilege to work. And, most importantly, I am thankful for the wonderful personal support from my wife, Cheryl, my sons Kevin and David, and many family members and friends.

Top Priorities

In writing this speech, I definitely had a lot of people to call upon. Yet, as much as I value their wisdom, I did not ask a single one of them for guidance on what I should talk about today. Rather, I asked you, the members. ASHP is a membership organization. It is owned by you, its members. So I felt it was appropriate to focus our discussion today on those issues that are of greatest importance to you.

We sent out a survey to a random sample of ASHP members and asked: “What question would you like to ask Gerry Meyer?” Well, you did not disappoint. We received 130 questions, many of which spoke to the concept of courage.

“What will be your top priorities as incoming president of ASHP?”

I have a list of priorities to share with you. But *my* priorities are of little value unless they become *our* priorities. My top priority, therefore, is to be the best leader I can possibly be. And you can’t lead without a vision.

What makes a good leader?

- The ability to articulate a vision,
- The ability to motivate others toward that vision, and
- The ability to remove obstacles to promote achievement of the vision.

Now, who among you can recite ASHP’s vision? ASHP’s vision is that medication use will be optimal, safe and effective for all people, all of the time. There’s no mention of “hospitals” or “health systems.” There’s not even mention of “patients.” It says “all people, all of the time.”

Here is my list of priorities for the year. I would suggest that we view most of the individual items on this list as obstacles confronting us in our efforts to accomplish ASHP’s vision:

- Build coalitions
- Implement the recommendations of the Pharmacy Practice Model Initiative
- Pursue provider status
- Promote interprofessional education and practice
- Expand training and certification for pharmacists and pharmacy technicians

- Position ASHP to be as nimble as possible in a rapidly changing environment, and...
- World peace!

There's a reason for the last item on the list. Creating an environment in which medication use will be optimal, safe and effective for all people, all of the time is a bold and expansive vision. And just because it is hard to conceptualize, we cannot be deterred from putting our energies towards its achievement. (So, in that respect, our vision is a bit like world peace.)

Antagonism vs. Synergism

"We see a push to work collaboratively with other health care providers but seem to have a difficult time putting this into practice. Are there ways to accelerate this interprofessional practice? Perhaps through pharmacy education and post-graduate residency programs?"

By definition, interprofessional activities clearly cannot be accomplished by one profession. Each profession must be willing to participate.

The good news is that in May 2011, a group called the Interprofessional Education Collaborative—consisting of educators representing pharmacy, medicine, nursing, dentistry, and public health—released a report that summarized the core competencies needed for interprofessional collaborative practice. Those core competencies fell within four domains:

1. Values and ethics
2. Roles and responsibilities
3. Interprofessional communication
4. Teams and teamwork

What this report says is that to build an efficient and effective health care system, health care providers need to:

- Have a common understanding of health care ethics and values
- Understand one another's roles and responsibilities
- Learn how to communicate with one another, and
- Learn how to be part of effective teams and how to play well together in the sandbox.

For two years, we have had this guidance document that delineates the curricular components that should be taught to health care students, interprofessionally. Our profession needs to take a leadership position in incorporating interprofessional competencies into our formal education and training standards. These changes cannot occur fast enough. Furthermore, to develop this set of skills and knowledge within *practicing* pharmacists, ASHP must incorporate this critical content within our continuing professional development offerings.

It's important to consider what this report does *not* say. Nowhere does it say that interprofessional education should encompass getting health care students into the same classroom to teach them pathophysiology, pharmacology, diagnosis, or treatment. So, if those are not our commonalities, then those must be our differences. *Exactly.*

Let's look at this in pharmacologic terms. Sometimes, we administer two very effective drugs that may compete for the same receptor, and the result is that they become less effective. We call that phenomenon "antagonism." On the other hand, sometimes we prescribe two drugs and the positive effect is greater than the

anticipated sum of their individual effects. We call that "synergism."

Let's move past interprofessional antagonism. Let's have the courage to promote an efficient and effective health care system comprised of *interdependent, synergistic* health care providers.

The Future of Residency Training

Among the questions I received, more related to residencies than to any other topic. Two members asked: *"How does ASHP plan to help grow the number of residency programs and the number of available positions? And, how can the accreditation process be simplified?"*

Although it sometimes may *feel* like we are making little progress in this area, the numbers tell a different story. From 1995 to 2006 (a 12-year period), the number of available accredited residency programs and the number of available positions in those programs doubled. From 2006 to 2012 (a subsequent 6-year period), the number of accredited residency programs and number of positions doubled again.

Part of the reason for this rapid growth is that the value proposition for residencies is easily developed for residents, employers, patients, and the profession. The ASHP website contains a number of documents that can assist practitioners in justifying, designing, and conducting residency training programs.

However, one of the greatest barriers to increasing the number of residency training programs cannot be overcome with guidance documents alone. A good training program requires a *solid infrastructure.*

Pharmacy services must meet contemporary standards of practice. Preceptors must have the ability to impart knowledge and develop critical reasoning skills. Residency program directors

must be able to mentor and inspire those entering the profession. And an organization's culture must be supportive of the training mission. We cannot, and we should not, compromise on these foundational pillars.

While ASHP's residency policy is aspirational in nature and the decision about whether to pursue a residency is a career decision and you do not need a residency to obtain a pharmacist license; you *do* need a residency to pursue and advance along certain career paths and the number of those career paths continues to grow every year.

There are four stages to the education and continued training of a pharmacist: pre-pharmacy undergraduate education, professional doctorate education, formalized training, and continuing professional development. *Coordinating the outcomes* of each of these four stages is a professional imperative. Yes; the requirements for the pre-pharmacy and pharmacy curricula will continue to evolve; but, we must recognize that there is only so much that we can accomplish in the classroom because (1) contact time is limited, and (2) students do not have pharmacist licenses.

At some point in time, the profession will need to address the question: Should residency training be *required* for pharmacists to meet their obligation to their patients? At some point, that answer will be "yes." Whether this happens by 2020 or not, it is far better for the profession to prepare for that future than to be unprepared when that future arrives.

Gaining Provider Status

"When are pharmacists finally going to be recognized as providers, and what will it change?"

Many of you may have attended the Provider Status Town Hall at this Summer

Meeting where this very issue was discussed. Much of what we heard, we already knew:

- The health care environment is changing.
- Emerging practice models are focused on integrated health care delivery systems.
- Policymakers are seeking ways to make health care more affordable for more people.
- Payment will be focused on quality, not quantity, of care.
- Consumers will demand transparency in the cost of their care.

So, what will happen when pharmacists are recognized as health care providers?

- Pharmacists' patient care services will *improve access*.
- Pharmacists' patient care services will *improve quality*.
- Pharmacists' patient care services will *help control costs*. Access—quality—cost. There is substantial documentation to support the positive impact of pharmacists on access, quality and cost of care. We know it. Now we have to sell it. We must have the courage of our convictions.

The first step towards achieving provider status is to ensure that the profession moves forward with this *common message* by solidifying these basic principles within the existing coalition of pharmacy organizations. Then, we need to expand the coalition to include other critical stakeholders, including health care provider groups, payers, and patient advocates. We need to draft legislation and seek support by educating legislators, both on a state and national level.

ASHP will serve as your collective voice in formulating the message. ASHP will develop the materials needed to deliver that message. ASHP will tailor those materials

for different audiences. And ASHP will train you. But, *we need you to deliver the message* to your legislators, to your C-suite, to your health-system's lobbyists, to your health care colleagues, to your complacent pharmacist colleagues, to your local media, and to your patients. Access—quality—cost. The message is clear. The message is focused. The message meets society's needs.

Gaining provider status will ensure that pharmacy is at the table when regulators and other policymakers invite *health care providers* to help construct new delivery models. And that is why ASHP, the American Pharmacists Association (APhA), the American College of Clinical Pharmacy (ACCP), and other health care organizations have committed significant resources to achieving provider status for pharmacists.

While no one can predict when we will finally succeed, I am confident that we *will* succeed if we have the courage to stand strong and united on this issue and if our members get personally involved.

I call upon all pharmacists who believe they are health care providers, on all student pharmacists who believe they are training to become health care providers, on all people who want their medication use to be optimal, safe and effective all of the time. I call on everyone to send the message: *"Pharmacists are medication-use experts. Pharmacists improve access, improve quality, and control the cost of health care. Pharmacists are health care providers."*

In closing, I want to thank everyone who took the time to submit questions. I invite you to continue to send me your comments and suggestions over the next year. Send your emails to: prez@ashp.org.

Finally, I want to thank you for the courage you show every day toward advancing ASHP's vision: that medication use will be optimal, safe and effective for all people, all of the time. ■