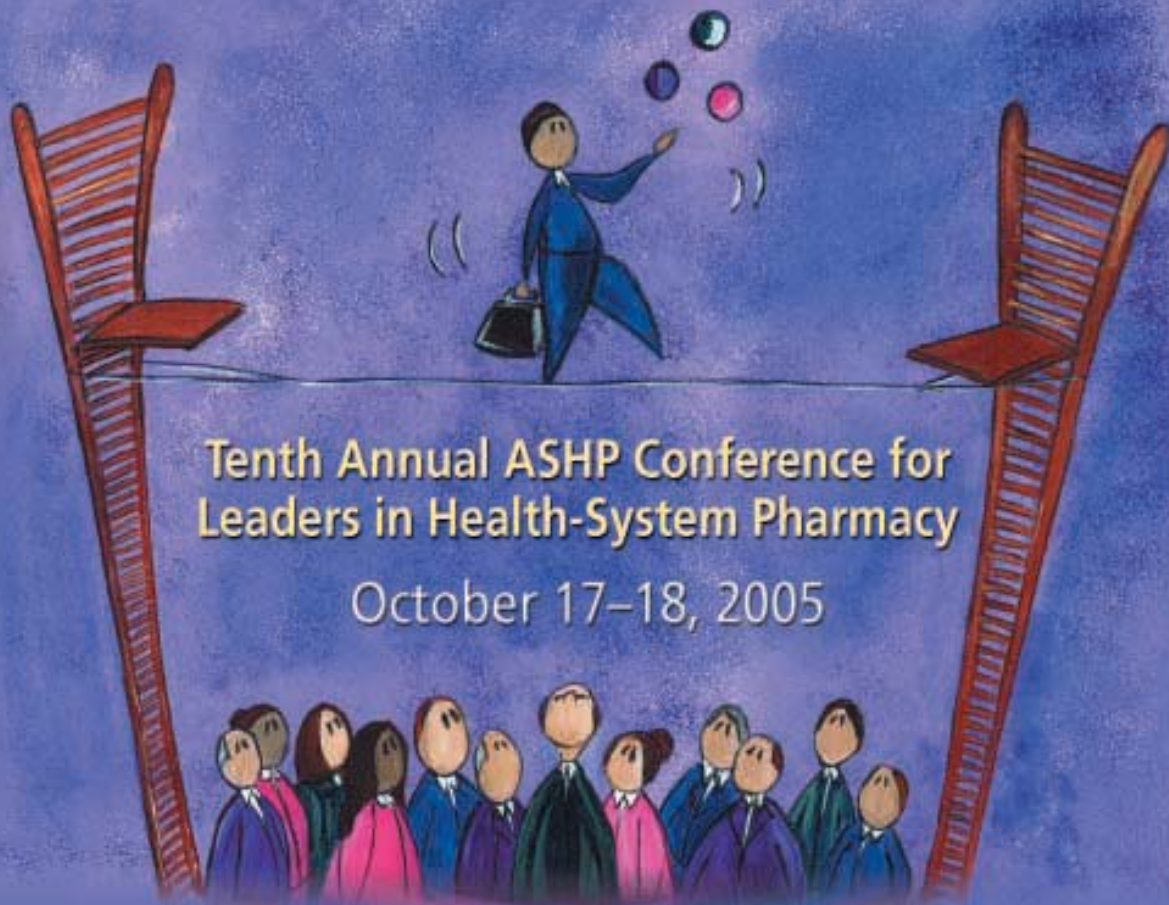


BALANCING COMPETING DEMANDS

*Practical Strategies for
Pharmacy Leaders*



Tenth Annual ASHP Conference for
Leaders in Health-System Pharmacy

October 17-18, 2005

The Westin O'Hare • Chicago, Illinois

*The premiere conference on today's key
pharmacy practice management topics*



Planned by the ASHP Section of Pharmacy Practice Managers.

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Gaining greater influence on institutional policies, encouraging leadership in a changing work force, using the first 100 days in a new position to set the stage for success, ensuring reimbursement for potential revenue, implementing technology to improve patient safety, providing medication therapy management services under Medicare Part D, motivating staff, communicating to build relationships and encourage behavior change, and overcoming barriers to creative thinking were themes addressed at the 10th Annual ASHP Conference for Leaders in Health-System Pharmacy, held October 17–18, 2005, in Chicago. This year's conference theme was "Balancing Competing Demands: Practical Strategies for Pharmacy Leaders."

Six concurrent programs were held on Monday afternoon and repeated Tuesday morning, allowing each registrant to choose two programs. New this year was an informal roundtable session during the Monday evening reception, at which participants talked with experts about USP Chapter <797>, emergency preparedness, leadership succession planning, Medicare 340B safety net services, activities of the Joint Commission on Accreditation of Healthcare Organizations®, and the changing demographics of the profession.

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PROGRAMS AND PRESENTERS

General Sessions

How the Best Leaders Build Talent and Value

Joe Healey
Joe Healey Performance, Inc.
Pittsburgh, Pennsylvania

Executive Pharmacy Leadership: The Role of the Chief Pharmacy Officer

Marianne F. Ivey, Pharm.D., M.P.H., FASHP
Corporate Director
Health Alliance Pharmacy Services
Cincinnati, Ohio

David A. Kvanetz, M.S., FASHP
Chief Pharmacy Officer
The Cleveland Clinic Foundation
Cleveland, Ohio

Medication Therapy Management Services: Advancing Patient Care

Steven M. Riddle, BCPS
Lead Pharmacist, Medication Utilization and Quality Improvement
Harborview Medical Center, Pharmacy Services
Clinical Assistant Professor
University of Washington School of Pharmacy
Seattle, Washington


Bridging the Pharmacist Generational and Gender Gap

Sara J. White, M.S., FASHP
Pharmacy Leadership Consultant
Mountain View, California

Part-time Pharmacists/Full-time Professionals: The Changing Work Force

Craig Kirkwood, Pharm.D.
Manager, Pharmacotherapy Services
Virginia Commonwealth University Health System/Medical College of Virginia Hospitals
Associate Professor
Virginia Commonwealth University School of Pharmacy
Richmond, Virginia

Kelly Rogers
Pharmacy Manager
Clarian Home Care
Clarian Health Partners, Inc.
Indianapolis, Indiana



James A. Eskew, M.B.A.
Director of Pharmacy
Clarian Health Partners
Indianapolis, Indiana

Whose Life Are You Leading, Anyway?

Jeffrey B. McMullen, CSP
CEO, The McMullen Group, Inc.
Appleton, Wisconsin

Breakout Sessions

The New Leader's First 100 Days: Key Strategies for Success

Mick Hunt, Jr., M.S., M.B.A., FASHP
Senior Director, Pharmacy Services
Novation, LLC
Irving, Texas

Daniel M. Ashby, M.S., FASHP
Director of Pharmacy
The Johns Hopkins Hospital
Baltimore, Maryland

Bruce E. Scott, M.S., FASHP
Chief Operating Officer
McKesson Medication Management
Brooklyn Park, Minnesota

Reimbursement 101: Understanding and Improving the Process

Anne T. Jarrett, M.S.
Assistant Director of Pharmacy
Wake Forest University Baptist Medical Center
Winston-Salem, North Carolina

RoseMarie Babbitt, M.A.
Associate Director of Pharmacy
Parkland Health and Hospital Systems
Dallas, Texas

Rita R. Shane, Pharm.D., FASHP
Director, Pharmacy Services
Cedars-Sinai Medical Center
Los Angeles, California

Application of New Technology to Improve Patient Safety

Leslie R. Mackowiak, M.S.
CPOE Program Director
Duke Health Technology Solutions
Durham, North Carolina

William W. Churchill, M.S.
Director of Pharmacy Services
Brigham and Women's Hospital
Boston, Massachusetts

Effective Communication Skills: Techniques for Pharmacy Leaders

Stephanie Barnard
Communication Consultant
Business Image Consulting, Inc.
Wilson, North Carolina

Developing Tomorrow's Leaders

Scott M. Mark, Pharm.D., M.S., FASHP
Director of Pharmacy
Director, Pharmacy Practice Management
Residency Program
University of Pittsburgh Medical Center
Assistant Professor
University of Pittsburgh School of Pharmacy
Pittsburgh, Pennsylvania

Scott Knoer, Pharm.D., M.S.
Director of Pharmacy
Fairview-University Medical Center
Minneapolis, Minnesota

Alison Apple, M.S.
Administrative Director—Department of Pharmacy
Administrator—Methodist Cancer Center
Associate Professor
College of Pharmacy
University of Tennessee
Memphis, Tennessee

Motivating Staff to Improve the Medication Safety Process

Virginia W. Barnes, Ed.D.
Coordinator, Continuing Education and Outreach
Missouri University Extension
University of Missouri—St. Louis
St. Louis, Missouri

HOW THE BEST LEADERS BUILD TALENT AND VALUE

Joe Healey

In the opening session, motivational speaker Joe Healey offered insights on creating positive change from the careers of well-known leaders and his personal experience.

Health-system pharmacy wants a seat at the table—greater influence on institutional policies. Healey challenged pharmacists to think in terms of “helping them lead at the table.” Even if pharmacy leaders do not have a seat, they can approach those at the table in a way that has an impact.

When medications account for 10% of a health system’s costs, pharmacy is in the spotlight and pharmacy leadership is crucial. If not enough pharmacists step up, nonpharmacist managers could be hired. Being a successful leader requires a sustained effort. In contrast to strong management, or micromanagement, leadership requires gaining the trust and participation of the whole team. Leaders must communicate that they care about people’s input and want their involvement. They must partner with people to encourage them to take ownership.

Performance Ideas from the Best and Brightest

Pharmacists can learn from biographies of great leaders. For example, Wal-Mart founder Sam Walton recognized that to have a seat at the table, he needed to spend more time on relationships and less on tasks. Leaders learn that they can accomplish more through other people than they would alone, through networking, politicking, mentoring, and coaching. Walton spent 60% of his time with people, 20% on tasks, and 20% in “management by walking around,” or observing. Pharmacy leaders need to spend some of their observation time outside their departments.

Colin Powell noted that it is not always necessary to have 100% of the information on an issue before making a decision. A

successful leader knows which decisions require perfection (having all the data, and thus minimizing risk) and which can be made on the basis of only 30%, or 70%, of the information. This mode of decision-making requires thinking intuitively: trusting one’s instincts and pulling up knowledge based on experience and stored in the subconscious.

Leaders with intuitive thinking are able to keep the proper focus on what is important. Lee Iacocca said the most important step in his leadership development was choosing to review weekly the organization’s long-term plans, roles, goals, and mission.

Leadership requires not only competence but willingness to assert oneself. Some pharmacists may be too “nice” to be at the table, Healey cautioned. Harry Truman learned this lesson well and went on to become the most trusted political leader of his time. Truman was known for being deliberate; his approach was “say what you mean and mean what you say.”

Paradigms Matter

A person’s paradigm, or view of the world, drives how the person approaches issues and solves problems, or fails to solve them. Paradigms are shaped early by a person’s history and experiences. Effective leaders constantly allow their paradigms to be molded; they refuse to allow them to become cemented. Peter Drucker, a well-known expert on management and leadership development, said effective leaders see the world the way it is, rather than the way they want it to be.

Leaders who work on their paradigms have greater candor. To help others shift their paradigms so the team can move to a higher level of performance, the leader needs to understand the others’ paradigms, which can be done only through relationships. “The ability to shape someone’s paradigm is based on how much the person trusts you,” said Healey.

Trusted leaders can change people’s thinking so that they perform at a higher level on their own, without being micromanaged. Moreover, the trust of those outside the pharmacy team is essential for influencing those at the table.

Healey used personal stories to illustrate key points on creating influence and building, through trust, a high-performing team:

- The leader who observes a paradigm problem must call it to the person's attention and ask permission to talk about it; a good relationship is a prerequisite to influencing another's paradigm.
- Vision can be learned. Successful organizations such as Southwest Airlines empower their teams to share a vision and thus contribute at a higher level.

Building Influence

Healey challenged pharmacy leaders to help people share their vision. If even 5% or 10% of the staff members are able to shift their paradigm, the change will spread to others. He proposed four keys to building influence: credibility, reliability, belonging, and partnering.

A leader who speaks with candor and courage is perceived as credible. Delivering on promises demonstrates reliability. Creating a sense of belonging is what helps a group become a team. Leaders need to let people know that they are valued and their opinions are important. Partnering means having a sense of ownership. It relates to values-based motivation: letting values dictate what we risk. To win a seat or be heard by those at the table, leaders must risk expressing themselves with courage and candor.

EXECUTIVE PHARMACY LEADERSHIP: THE ROLE OF THE CHIEF PHARMACY OFFICER

Marianne F. Ivey
David A. Kvancz

Marianne Ivey and David Kvancz discussed pharmacy's need for representation at a high level in health systems and the creation of a chief pharmacy officer (CPO) position.

Why a Chief Pharmacy Officer in a Health Care Organization?

With the current emphasis on patient safety and Joint Commission on Accreditation of Healthcare Organizations® medication management standards, conditions are right for CPOs in health systems, said Ivey. She summarized the rationale for a CPO role as presented in a white paper published in the *American Journal of Health-System Pharmacy* (May 1, 2005).

A CPO should participate in regularly scheduled meetings at the health-system executive level, be involved in strategic initiatives (planning, high-level exchange, and operations issues), and have at least as much influence as a chief nursing officer (CNO). No more than one level in the reporting structure should separate the CPO and the chief executive officer (CEO); for example, the CPO might report to the chief operating officer (COO), who reports to the CEO.

Ivey reviewed characteristics and functions of health-system pharmacy, both in patient care and in furthering the organization's financial health, that make a strong case for a CPO role. Pharmacists make valuable contributions to medication safety, analysis of individual and population clinical data, and emergency preparedness. They are integral to health systems' risk assessment and quality improvement programs.

Pharmacists also make a major contribution to the organization's financial health. They understand the pharmaceutical supply chain, are experienced at negotiating and inventory management, and ensure the integrity of

patients' medications. Pharmacy departments typically account for a 30% share of the total supply expense in a hospital budget.

Pharmacies use formulary systems to drive market share and derive volume-based price reductions. Pharmacy directors are experienced at human resources and technology management. They are experts in reimbursement and revenue capture.

Pharmacy directors demonstrate organizational and leadership skills. They are experienced at collaboration and consensus building. They have expertise in managing their organizations' research and education missions and balancing teaching responsibilities with patient care and in maintaining regulatory compliance and professional standards.

Organizations should recognize these assets by making the pharmacy director a participant in decision-making at the enterprisewide level and by giving the director a commensurate title, such as CPO.

The Evolution of a Chief Pharmacy Officer Position: Why, Where, and How?

Kvancz described how he came to have the CPO title at the Cleveland Clinic Foundation (CCF). When he joined CCF nine years ago, pharmacy reported to the CNO, who reported to a vice president, who reported to the COO. The organization had a matrix structure with administrative and physician entities, and pharmacy had at least eight direct or indirect reports within the matrix. Division chairs "carried the weight" in the organization, and pharmacy was not a division, but a member of the division of operations, which included few clinical departments.

During Kvancz's first seven years, the pharmacy director's role became more strategic within CCF and its health system. The CEO, a physician, recognized that it was difficult for pharmacy issues to gain the attention of key decision-makers because of the matrix organization and a lack of formal status. Kvancz recommended that pharmacy become a division. The CEO suggested that pharmacy be represented on the medical executive committee (MEC) and report directly

to the COO. Instead of division chairman, the pharmacy department head would be called the CPO.

Kvancz and the CEO identified four areas in which to justify the organizational change: financial, scope of services, safety, and accreditation and regulatory issues. Drug expenses accounted for 30% of all operating supply costs. Drug charges were 90% of CCF gross revenue, and pharmacy was ninth in gross revenue among the 27 CCF divisions. Pharmacy's net income was 33% of the total operating net income, eighth in net income among the 27 divisions. Significant pharmacy resources were dedicated to corporate compliance (ensuring proper coding, billing, and reimbursement for drug charges) and to cost management.

For patients throughout the health system, pharmacy is responsible for appropriate drug therapy selection, utilization, risk reduction, intended therapeutic outcomes, and cost minimization. Pharmacy needed recognition by the administration that medication use is a high-risk area and high-level access to decision-makers is necessary. With ongoing redesign of the medication-use system, it was important for pharmacy to collaborate at high levels with physicians, nurses, and others. Although pharmacy was involved in quality, safety, and accreditation efforts, it was not at the table for discussion of the organization's quality initiatives with administrators and the medical and nursing staff.

As CPO, Kvancz participates with the CNO, COO, chief financial officer, and division chairs in weekly meetings of the MEC. His responsibilities include strategic planning, managing medication-use systems, human resource management, supply chain management, utilization management, financial management, education and research, and organizational representation and leadership. He believes that whether a CPO is appropriate depends on the organizational structure (e.g., are there similar position titles, such as CNO?) and pharmacy's scope of responsibilities. "This is not about the stature or elevation of the pharmacy director or department within the organization," Kvancz

emphasized. “It is about the ability of pharmacy leaders to proactively influence and direct the organization’s initiatives and resource allocation related to medication-use systems.”

MEDICATION THERAPY MANAGEMENT SERVICES: ADVANCING PATIENT CARE

Steven M. Riddle

To provide medication therapy management (MTM) services under the Medicare Part D prescription drug benefit, institutions will need to incorporate certain key components into their services and demonstrate patient outcomes. Steven Riddle described how existing services may align with MTM requirements, using the example of clinical pharmacy services at Harborview Medical Center (HMC) in Seattle.

MTM will be offered to Part D beneficiaries who have multiple chronic conditions, take multiple medications, and have projected annual drug expenses exceeding \$4000. Prescription drug plans (PDPs) that provide the Part D benefit will decide which patient populations to target for MTM, as well as which services to cover. To participate in MTM, pharmacies will contract with PDPs.

Two Perspectives

Some believe the establishment of MTM brings pharmacists one step closer to provider status. Health-system pharmacies can use the opportunity to offer MTM as financial leverage in requests for increases in clinical services. However, PDPs may have insufficient incentive to provide substantive services; they will benefit from MTM only if costs decrease markedly, and the number of eligible beneficiaries initially will be limited. Furthermore, PDPs may use nonpharmacists to provide MTM; this could supplant services by clinical pharmacists. Pharmacists must sell the value of their clinical services to PDPs as a way of reducing costs.

HMC Services

As the HMC pharmacy decentralized distribution into its clinics, physicians began requesting clinical services. Now, only clinical services are offered in some areas. The physicians have learned better drug therapy management from the pharmacists, and they refer complex problems—in patients who

would fit the MTM criteria—to the pharmacists. Collaborative drug therapy management (CDTM) contracts enable the HMC pharmacists to have a broad scope of practice; CDTM gives an organization leverage to start MTM, said Riddle.

Physicians' positive reaction to the HMC pharmacists' services "went a long way with our administrators and boards," said Riddle. The clinical services also increased patient and staff satisfaction. However, as demand for these services grew, distributive and clinical staffing had to be increased, and physicians' expectations for services outpaced some of the pharmacists' skills. Although the pharmacy tried to raise clinical skill levels, it now has distributive pharmacists and clinical pharmacists.

Other Models

Other organizations may take a different approach to providing clinical services. For example, carve-out models for specific care, such as anticoagulation clinics, make it easier to define a target group, initiate service, supply staff to provide the service, and track outcomes. However, this approach limits pharmacists' interventions and does not foster integration within the system and the support of physicians. Also, carve-out services are susceptible to changes in practice due to the availability of new drugs.

Preparing for MTM

In preparation for MTM, organizations should consider the following:

- The number of eligible patients, their demographics and conditions, and their drug costs and drug information needs;
- The existing staff's ability to provide clinical services;
- Whether services currently provided will be covered as MTM;
- What services are offered by competing organizations;
- Whether to reallocate staff to patient care services or add services (e.g., medication reconciliation);
- What services can be added or expanded under the organization's policies and the

state's practice act;

- What problems pharmacy can solve for patients and providers; and
- The needs and opportunities of the organization (e.g., what are its challenges in meeting quality improvement goals?).

Demonstrating Outcomes

Quality improvement organizations (QIOs) will drive PDPs to look at evidence-based use of medications. QIOs track whether patients are achieving clinical goals, such as for blood pressure, weight, and lipid levels—measures that pharmacists can monitor. Pharmacists should ask QIOs in their states which clinical interventions they will track and try to influence which outcomes the QIOs choose to monitor; the QIOs could then try to expand the scope of services PDPs will cover.

Since the success of MTM will be measured by outcomes data, it is important to obtain baseline data on patients before pharmacy interventions. Pharmacies can track process measures showing time spent in clinical activities and the outcomes in terms of clinical efficacy, safety, cost, and education of patients and resident physicians. Although it is difficult to isolate the cost and value of clinic pharmacists' interventions from the overall care of the patient, HMC has been able to demonstrate value on the basis of the number of outpatients seen and published evidence of the benefits of clinical services.

Reimbursement

MTM reimbursement is separate from reimbursement for dispensing or administration. To qualify for reimbursement, a service must be authorized in the contract with the PDP. A consulting firm has recommended MTM reimbursement of \$1 to \$2 per minute, but PDPs will determine the actual rate.

Many pharmacists use current procedural terminology (CPT) codes, based on time and severity, in billing for services incident to the services of physicians. New CPT codes established for MTM are based solely on time. They are in a category intended for experimental and emerging practices and

have no associated relative value units (RVUs) and thus no dollar figure to guide reimbursement. The Centers for Medicare and Medicaid Services (CMS) will collect data on how these codes are being used, and then will assign RVUs. Point of service code 01 will be used for MTM services in a pharmacy setting. Although PDPs will likely use the CPT codes established by CMS, they may use their own coding systems instead.

Some pharmacies, including HMC's, use facility billing (on CMS form UB92; based on time and intensity of service) rather than billing for professional services in conjunction with those of a physician. With the number of patient visits to HMC, pharmacists could bill for nearly \$1.3 million in facility charges. Combined with an estimated \$1.7 million in annual cost avoidance through clinical pharmacy services, this comes to \$3 million, more than twice the combined salaries of the clinical pharmacists.

Initial reimbursement for MTM is unlikely to offset the costs of services by clinical staff; pharmacies will need to use other opportunities to justify clinical services. For example, pharmacists further the MTM goal of ensuring the use of cost-effective therapies; the use of a preferred drug formulary at HMC saved \$500,000 in six months.

Pharmacies should consider their current and potential clinical services in relation to the new codes for MTM. They should work with administrators and payment staffs to ensure that the codes are incorporated in the billing structure. Because of changes in the payer mix with the advent of Part D coverage, overall reimbursement should improve. However, the complexity of the system, formulary issues, and poor patient participation could negate this.

Conclusion

Pharmacists' MTM services should be marketed to patients and physicians. To realize the potential of MTM, pharmacists must convince payers, PDPs, and QIOs of the value of their clinical services.



Information on Medicare reform and MTMS is available through pharmacy organizations, CMS, and other groups. See the following Web sites:

- www.ashp.org/medicare/
- www.aphanet.org (Resources/Medicare section)
- www.pstac.org/aboutus/profsvc.html (information on MTMS and billing codes)
- www.ama-assn.org/ama/pub/category/3885.html (CPT codes)
- www.cms.hhs.gov/medlearn/provtoolkit.pdf
- www.cms.hhs.gov/medicarerereform/pharmacy/
- www.pharmacist.com/celist.cfm
- www.kff.org/medicare/rxdrugdebate.cfm
- www.ascp.com/MedicareRx/

THE NEW LEADER'S FIRST 100 DAYS: KEY STRATEGIES FOR SUCCESS

Mick Hunt, Jr.,
Daniel M. Ashby
Bruce E. Scott

The first 100 days in a new job or a position with greater responsibility set the stage for a leader's long-term success. Three past presidents of ASHP described strategies for rapid and effective transition to the new role.

The "gearing up" period between accepting the new job and reporting for the first day of work is a time to disengage from the previous position and learn as much as possible about the new organization. New leaders can identify gaps between the new job description and their skills, knowledge, and experience and brush up on those areas. They can plan introductions and think of questions that will help them learn about the organization from the staff.

Aligning Expectations

Upon reporting to work, the new leader immediately begins learning what others expect. Leaders need to understand people's expectations and align them with their own. They can meet individually with staff, asking what the organization does well, what it does not do well, and what one thing is most important to change. Everyone's problem will seem equally urgent, and the leader will need time to understand the issue and its priority. Staff can be asked to put in writing things they believe the leader should know.

New leaders are on stage: what they say and how, their interactions, and their decisions are being scrutinized. It is important to meet the team early. Employees want to know the new leader's background and expectations for the organization. The new leader does not need to have all the answers when he or she first meets with staff, but should mention plans for additional communication.

The "on-boarding" process of getting to know the team members can address emotions created by the new leader's arrival and create excitement about the organization's future. The leader may encounter resentment, for example, from a staff member who applied unsuccessfully for the leadership position. To neutralize this, the leader can exhibit empathy and ask what the other person would like him to know and to accomplish.

The new leader needs to recognize that he or she is in a temporary state of incompetence, not knowing the informal structure, how things are done, or who can be trusted. Leaders should resist the temptation to hit the ground running. Significant actions should be deferred for the first month or so, except when necessary for legal or safety reasons.

Leaders need to use this time to learn about the organization's culture, budget, and scope and quality of services, and to define the new reality for the team and "test drive" elements of their agenda. Aligning the expectations of the new team lays the groundwork for positive change.

Shaping the Team

Success as a leader depends on the success of the team. In considering how to form the best possible team for the organization, the new leader must first establish a relationship with the current team. Working together in meetings and on projects creates trust among the team and gives the leader insight into how team members interact. In assessing the team, the leader may look at past evaluations as a predictor of performance; however, a person's behavior may be different in the new environment with a new leader. Looking at team members' resumés can reveal areas of interest and competency that can be of value to the team. Leaders need to understand the strengths of the team and which member is most likely to succeed in addressing a given issue.

In addition to team members' performance and interpersonal skills, leaders can assess their competence, judgment, attitude, future potential, and fit with the team. They can begin categorizing members as "keep, move (a

strong performer is in the wrong position), replace, and observe.”

While nurturing relationships with the team, the leader must remember that his or her role is to make decisions and direct the team. It is best to resist making personnel changes in the first 100 days, but changes should be made when necessary. In such decisions, leaders should consider the policies and norms of the organization. They should avoid hiring people with competencies the same as their own. New team members’ values (e.g., integrity, accountability, passion) should match those of the leader, but their competencies should complement the leader’s. Creating the optimal team may take a year or more.

Crafting a Strategic Agenda

The team needs to know the new leader’s strategic agenda. This is a framework for action, different from a fully developed strategic plan. It should be a written document giving background about what was promised and conveyed to the leader in the interview process and the leader’s early observations and direction for the organization. The agenda should contain a limited number of actions that everyone can understand and remember. It should prioritize actions and define a time frame, but allow flexibility to add new priorities. To build the strategic agenda on the right foundation, the leader needs a grounded view of practice in the new organization, including which areas may not meet standards and what resources are needed.

Everyone in the department should understand his or her role in implementing the agenda; staff members should be assigned responsibility for specific objectives, with each person doing what he or she does best. A checklist for assessing progress toward the agenda items and a framework for communication and feedback should be established. For example, weekly leadership meetings could be held for discussing specific topics and sharing information; team members would be expected to prepare in advance and attend the meeting; and decisions would be made by consensus, not voting.

The strategic agenda focuses the department. It can foster innovation (new programs and services to address needs), build teamwork, and create a sense of urgency. In using the agenda to implement change, early wins are valuable for creating momentum. More substantial changes in structure, strategy, systems, programs, or skills are the next step, followed by fine tuning.

In moving the strategic agenda forward, leaders should look for opportunities to teach the ideas promoted by the agenda both within and outside the department. When given the relevant information, others are likely to support the agenda.

Communicating

New leaders should intentionally and systematically communicate their plans, their actions to further a plan or goal, their assessment of progress, and their strategic agenda. Listening is key to understanding different audiences and tailoring the message. The delivery of a message should be appropriate to the issue and the institution’s culture. Leaders should seek feedback on the message, delivery, and perception to be sure what was heard was what the leader intended.

Forming a Relationship with the Boss

A productive working relationship with the boss is key to a new leader’s success. The roles of the two are different, and talking about those roles and their mutual dependence is a good way to begin establishing the relationship. At their first meeting, the new leader can ask about the boss’s background, interests, and preferred management and communication style. It may be helpful to talk with others who have experience working with him or her.

New leaders should learn how the boss wants them to handle particular situations and how much authority they have (i.e., what they can sign off on). The boss can help a new leader understand the organizational culture and keep him or her informed about issues in other parts of the health system.

It is important to learn the boss’s working style. How often does boss want to be updated, and in what level of detail? What form of

communication—written, spoken, e-mail, voice mail—is preferred? Leaders can share new information (e.g., journal articles) with their boss and prepare periodic reports on the department for senior leadership.

By listening and looking for signals, new leaders can find out what issues are important to the boss and how they can help solve them. They can demonstrate leadership by making commitments. The new leader should respect the chain of command; the boss should know beforehand when the leader discusses pharmacy needs and issues with someone else in the organization.

Leaders should regularly validate with the boss that they are on the right track. They should try to understand what level of investment the boss has in their agenda, and look for ways to strengthen that. Establishing and maintaining credibility is crucial. The boss may not understand enough about pharmacy to evaluate the details of a request and will need to trust the pharmacy leader's judgment.

Building Coalitions

Coalitions enable leaders to gain support and influence with people who do not report to them. New pharmacy leaders should begin immediately to build coalitions with people who have respect, resources, decision-making authority, and the ability to influence others.

New leaders should discipline themselves to build relationships with people they anticipate needing to work with later. Going to someone for the first time when you need something is not the way to build coalitions.

Leaders should build coalitions between their group and others with whom they work closely (nurses, physicians, finance officers). They can ask the boss to identify 10 people to talk with in coalition building. They should identify opinion leaders (e.g., those who are listened to in meetings) and members of informal networks, as well as members of power coalitions.

The new leader should identify likely supporters and opponents of the pharmacy agenda, as well as neutral parties whose support is needed. Potential supporters

include peers in the organization and external parties such as colleges and state boards. Supporters should be cultivated and not be taken for granted. Arguments can be developed to gradually gain the support of opponents; for example, presenting the status quo as a problem needing a solution, or making a previously rejected idea more palatable by explaining how the situation is now different.

Transforming the Culture

An important part of leadership is establishing, supporting, and nurturing a culture in which the entire team can be successful. The culture of an organization can make or break the ability to accomplish goals. It may be the single most important determinant of a department's success.

Although difficult to define, the culture of a work environment lies in the way people go about their work, whether new ideas are welcome, and how decisions are made. Successful organizations develop a culture that matches their strategic direction.

A new leader needs to create conditions for cultural change and assess the organization's readiness. The leader brings to the organization new expectations, processes, and measures. In transforming culture, the leader leads by example and identifies and rewards others who model the new expectations. Leaders can hire people who model the culture they want to achieve.

Questions to ask in assessing readiness to change include the following:

- Is there administrative or organizational support?
- Do I have the capacity to lead the change? Is there another change leader or champion?
- Are processes and systems in place to support the change (i.e., to obtain data, set goals, and provide progress reports)?

The impact of culture should not be underestimated. Culture trumps strategy, and transforming a culture takes months or years.

Avoiding the Top 10 Traps

When leaders fail, it is often because they have not established a firm foundation in their early days on the job. Ten traps that can dilute and delay a new leader's effectiveness are as follows:

1. Setting unrealistic expectations: Trying to do too much too soon, overpromising and underdelivering.
2. Making untimely decisions: Although new leaders should not rush into long-term decisions, they should not wait to have 100% of the information before making a decision. They should solicit the input of the team and go with best decision possible at the time.
3. Thinking you have to do it all yourself. This risks alienating staff and suffering burnout. New leaders need to delegate so they can spend time listening and learning.
4. Failing to disengage from your past identity.
5. Insulating yourself. Failure to see problems firsthand will delay solutions. Decisions made in isolation alienate the team and reflect a lack of trust and respect for others.
6. Judging people too soon.
7. Failing to communicate adequately. Lack of communication leads to a lack of trust; rumors fill the communication gaps.
8. Failing to establish new networks.
9. Working on the wrong priorities. Your calendar should reflect your priorities.
10. "Dissing" your predecessor. Be respectful, and don't blame your predecessor for problems; your predecessor likely hired your staff and has their loyalty. In some cases your predecessor can act as a partner.

Day 100

At the end of the first 100 days, new leaders should have

- Assessed the team,
- Personally reviewed financials, including the assumptions behind the numbers,
- Established goals and priorities, although

there may not yet be a strategic plan,

- Prepared themselves to make decisions and commitments, and
- Positioned themselves to become integrators, prioritizers, synthesizers, direction setters, motivators, and executors.

In the first 100 days, the organization is watching and evaluating the new leader. This is an opportunity for the leader to show how he or she will lead. People will decide whether to follow.

REIMBURSEMENT 101: UNDERSTANDING AND IMPROVING THE PROCESS

Anne T. Jarrett
RoseMarie Babbitt
Rita R. Shane

In this three-part session, Anne Jarrett reviewed “game pieces” that must be in place to ensure appropriate reimbursement for pharmaceuticals. RoseMarie Babbitt gave an update on the Medicare Part D prescription drug benefit and medication therapy management (MTM) opportunities. Rita Shane discussed the growth in expensive i.v. drug therapies for chronic diseases and described a process for ensuring that institutions are reimbursed for potential revenue. A common thread in these talks was that pharmacy leaders should work more closely with their health systems’ financial departments.

Reimbursement: The Game

To win the reimbursement game, said Jarrett, pharmacies must have the right card—the correct information or process—for variables such as patient location, payer, drug, and various codes, and must keep up with changes in the rules.

Pharmacies should bill for the few drugs given in inpatient settings, such as blood factor products, that are reimbursed separately from the hospital’s reimbursement by diagnosis-related group (DRG). For Medicare inpatient claims, form UB-92 is used. All information on the hospital’s chargemaster must be correct: the transaction code (general ledger code), description (drug name and strength), insurance coverage (i.e., for non-self-administered or self-administered drug), charge indicator (variable, fixed, or no charge), billing codes (health care common procedure coding system [HCPCS] code, conversion factor), and revenue code. Pharmacies can help contain inpatient drug costs by determining which drugs are being used in the most expensive DRGs and whether their use

is appropriate. They can investigate whether the hospital has negotiated carve-outs with insurance companies; look at outlier costs, acquisition costs, replacement programs, and purchasing contracts; and benchmark with other hospitals.

Medicare’s reimbursement mechanism for hospital outpatient treatment is cost-based ambulatory payment classifications (APCs). Here again, the appropriate form (UB 92, CMS 1500, or other) and correct codes must be used. Outpatient drug claims can have both an APC and a HCPCS number. A status indicator tells whether the drug is paid separately or packaged into the APC. HCPCS codes are used for reporting professional services, procedures, and supplies; the list of codes (Addendum B at www.cms.hhs.gov/providers/hopps) is updated quarterly. Claims must use the correct billing unit and conversion factor. Revenue codes are used to track the cost center; pharmacy codes begin with 25 and 63. Also required are diagnosis and procedure (ICD-9) codes. Claims will not be reimbursed unless the ICD-9 code matches an approved indication for the drug, and expensive drugs often are used for unapproved indications. Which codes support medical necessity for use of a particular drug may be determined at the national or the local level.

Medicare claims for pharmaceuticals used in physician-owned outpatient clinics are submitted on CMS form 1500. The fee schedule can be found at www.cms.hhs.gov/providers/drugs/asp.asp.

Pharmacies must have complete and correct data to win reimbursement, and they should not assume that non-Medicare claims will be paid, said Jarrett. Maximizing reimbursement requires persistence in obtaining information from other departments: billing, reimbursement accounting, contracting, information systems, patient financial services, and medical coding. Jarrett led the participants through examples of specific claims to show reasons why a claim might not be fully reimbursed.



Additional resources on reimbursement:

- www.ashp.org/reimburse
- www.cms.hhs.gov/medlearn/matters
- www.coverageandpayment/mediregs.com, available through www.coverageandpayment.com (This is a subscriber service, but pharmacists can learn from the 30-day free trial subscription, Jarrett said.)

Medicare Prescription Drug Coverage

Babbitt summarized the history and provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA), which established Part D drug coverage and payment for MTM services.

For Part D coverage, beneficiaries must enroll in a Medicare prescription drug plan (PDP) operating in their geographic area. For most Medicare beneficiaries, enrollment in Part D is voluntary, but the penalty can be substantial for signing up after the initial enrollment period, which ends May 15, 2006. Medicare Part A or B beneficiaries who have employee or retiree drug coverage at least equivalent to the Part D benefit should retain the letter from their company stating this, in order to prevent a penalty if they apply later for Part D.

Beneficiaries can apply through the Social Security Administration (SSA) for extra help with the Part D premium and copayments; eligibility for assistance is based on income and resources. Persons who are eligible for full Medicare and Medicaid benefits (dual eligibles), Supplemental Security Income (SSI) recipients, and other Medicare Savings Program groups are “deemed” eligible; they are automatically enrolled in a PDP but can change without penalty to another PDP for

better coverage of their specific medications. Medicaid no longer covers prescription drugs. Persons who have annual income below 150% of the federal poverty level or \$20,000 but are not in groups deemed eligible should apply through SSA for the low-income subsidy (LIS). Babbitt encouraged pharmacists to help patients enroll in low-cost PDPs and apply for the LIS—and to understand that these are two separate processes. Upon request, SSA staff will visit hospitals and explain the program to staff, providers, and patients, she said.

Part D coverage excludes some types of drugs, such as those for weight loss or weight gain. Babbitt predicted that Medicare may cover drugs for weight gain in oncology and HIV patients, as well as drugs in other excluded categories when used for certain indications (e.g., benzodiazepines for psychiatric diagnoses, barbiturates for epilepsy).

Babbitt believes pharmacists should become involved in MTM and inform patients and physicians about the program. Every person who provides MTM must register by May 2007 for a national provider number; this can be done at www.cms.hhs.gov. Health-system pharmacies should partner with patient financial services departments to identify beneficiaries eligible for MTM.

To provide MTM services, pharmacies contract with PDPs. The Centers for Medicare and Medicaid Services (CMS) developed the program in cooperation with pharmacists and physicians; MTM services are to be provided by a pharmacist or other qualified provider. The current procedural terminology (CPT) codes to be used in billing for MTM are temporary. In five years, the program will be reviewed for appropriate code use. “We’ll be closely watched to see how we handle this,” said Babbitt. “We don’t want to charge inappropriately and have the program taken away from us.” She said that 340B contracts may include MTM, but that disproportionate-share hospitals must be sure they are not “double dipping” if they sign contracts with PDPs. She also suggested that pharmacies with an established means of reimbursement for professional services may want to stay

with that rather than contracting for MTM through a PDP.

Contracts for MTM should distinguish between ambulatory care and inpatient settings and separate product from service; a health-system pharmacy could contract for services only. Compensation should reflect the time and resources spent; having data on how an institution's pharmacists spend their time is a plus. "Be careful on contracts with PDPs," said Babbitt, because "they told CMS they could provide the service for x patients for \$x." Also, plan formularies vary; PDPs are supposed to have at least two drugs in each category. Dispensing fees for pharmacists, when applicable, are determined by the PDP; in contracting, pharmacies should consider whether they will still make money on high-cost drugs.

Babbitt also noted that physicians have been shifting patients on expensive therapies to hospital outpatient clinics since the Medicare Part B change to reimbursement on the basis of average sales price (ASP) of a drug. With reimbursement at 106% of ASP, pharmacies may need to negotiate better contracts for drug products in order to make a profit.

At the end of Babbitt's presentation, participants discussed what a health system with a pharmacist-managed anticoagulation clinic might do to prepare for MTM:

Revenue Cycle Management

Shane described clinical, financial, and operational considerations in managing high-cost specialty medications; the process of revenue cycle management; and implications of the growth of specialty pharmacies.

Most biopharmaceuticals and other expensive drugs in the pipeline are injectables. The average annual cost per patient of injectables administered in outpatient clinics for cancer and other diseases exceeds \$70,000; for some drugs, it tops \$200,000. Specialty pharmacies have a growing share of the outpatient infusion business: 21% in 2003, compared with 26% for hospitals and 42% for physician offices.

Three fourths of 83 managed care organizations surveyed in 2003 used or planned to use specialty pharmacies (many acquired by pharmacy benefit managers) for injectables. Managed care organizations want these specialty vendors to help them integrate pharmacy and medical data to determine the impact on the plan's costs. Services provided by specialty pharmacies include utilization management (patient screening and monitoring); formulary and rebate management; compliance, patient education, and adverse drug reaction monitoring; reimbursement services; and contracting with manufacturers to reduce costs. Although most health systems prefer to purchase and prepare their own injectable drugs, some may need to outsource this to a specialty pharmacy and have the drugs infused offsite or in a home care setting.

Payers may require that patients obtain injectables from a specialty pharmacy. When patients bring these drugs to health systems, product integrity and related liability are of concern. Pharmacists need to alert their institutions' contracting and financial officers to these concerns. Furthermore, if injectables come from specialty pharmacies, the health system is reimbursed only for administration of the product, not for preparation.

With reimbursement based on ASP and the shift of patients from physicians' offices to outpatient clinics, outpatient infusion therapy may cease to be a profit center for health systems. The complexity of Medicare Part D coverage, particularly regarding whether some therapies fall under Part D or Part B, is another challenge. Pharmacists should educate physicians about the negative financial impact of some therapies on pharmacy and differences in reimbursement by site of care.

Pharmacists must plan for outpatient use of expensive new drugs in long-term therapy by projecting how many patients, covered by which payers, will be receiving such drugs; educating prescribers about reimbursement; and engaging other health-system departments in financial planning for new therapies. For example, at Cedars-Sinai, the

business planning department is considering whether an infusion center serving patients across all service lines is feasible. Contracting officers are informed of breakthrough therapies and their potential impact. The admissions and patient accounting departments are developing processes for outpatient injectable therapy.

“Connecting the dots” in the revenue cycle to ensure actual reimbursement for potential revenue requires ongoing discussion with many players. At Cedars-Sinai, pharmacy’s roles in managing the revenue cycle for outpatient medications include the development of usage guidelines; clinical review of orders for appropriateness; intervention concerning the indication, dose, or frequency of a drug; updating medication codes; providing feedback to physicians on medication use evaluation; and analysis of reimbursement (Appendix 1; page 36).

Breakout Session 3

APPLICATION OF NEW TECHNOLOGY TO IMPROVE PATIENT SAFETY

Leslie R. Mackowiak

William W. Churchill

Before implementing technologies such as computerized prescriber order entry (CPOE), bar code scanning, and the electronic medication administration record (eMAR), institutions should evaluate them from clinical, operational, technological, and financial perspectives. Leslie Mackowiak discussed CPOE and pharmacy system integration, and William Churchill discussed bar-code technology and intelligent infusion devices.

CPOE and System Integration

A key element of success in implementing a computerized prescriber order entry (CPOE) system—intensive pharmacy support—can too easily be overlooked, said Mackowiak. Similarly, hospitals may rely too heavily on the information technology (IT) staff during integration of the pharmacy system with CPOE, when full involvement of the entire pharmacy staff is crucial. Mackowiak heads a group of 10 members of the Duke University Health System IT staff dedicated to CPOE. Implementation of CPOE for Duke’s adult population was completed in June 2005, and integration with the pharmacy system is in process.

Although CPOE has been well accepted by Duke physicians, Mackowiak said that in the 5% of U.S. hospitals that have CPOE, it is rare for all physicians to use the system. CPOE means imposing standardization on physicians, who are accustomed to individualized, nonstandard practice.

Going into CPOE implementation, hospitals cannot appreciate its complexity and its effect on the entire organization. Mackowiak said one of the hardest things in setting up a CPOE system is teasing out the decision-making process. For example, the choice of pain medication depends on what? How did you come to that conclusion?

CPOE will not increase medication safety immediately, because it is such a huge disruption to the institution. Hospitals are likely to experience a peak of inflated expectations for CPOE implementation, followed by a trough of disillusionment when it does not solve all medication-use problems.

Pharmacists, because they best understand the medication-use process, can help move from there to “the slope of enlightenment.”

Commitment at the executive level of the medical staff is key to the success of CPOE. At Duke, the medical staff chair expected physician participation in CPOE development and training, and he led by example.

Need for Pharmacy Support

Broad pharmacy support for CPOE and a major pharmacy role on the CPOE team are crucial. Although the CPOE team typically includes a pharmacist integration analyst (an IT person), pharmacy must have more than a technical understanding of the change. CPOE is a clinical project that requires attention from clinical staff. Further, it needs operational guidance from pharmacy administrators to ensure that all pharmacy staff members understand what will happen when information comes to them in a different format.

Even when not integrated with the pharmacy system, the CPOE system affects pharmacy workflow. The nomenclature in CPOE systems (e.g., pick lists) is chosen by and for physicians and can differ from pharmacy’s terminology. Pharmacists can educate physicians on the IT team about the pharmacy process, how the medication administration record is created, and the role of the pharmacy and therapeutics (P&T) committee. Also, the IT team needs pharmacy’s help in understanding what the organization’s medication safety issues are and how the system will affect safety.

Pharmacy leaders need to think through every step of the medication process and what will change because of CPOE, and they need to walk the staff through the new process. For example, on paper physicians write “...now”; with CPOE the computer translates “now” to an exact time and date, which initially caused

consternation in the Duke pharmacy. Pharmacists must learn to think about what the physician intended, as they would with a paper order, and make a phone call if the intent is unclear.

CPOE initially can jeopardize safety because it changes interactions among the physician, nurse, and pharmacist. Good communication must be reestablished in the new system to restore the safety net. The clinical information and use of default dosages in CPOE can make prescribing safer. However, physicians can accept default dosages without thinking about individual patient factors such as age, creatinine clearance, and liver function. Pharmacists need to know the limitations of the system and when to intervene.

Duke wanted its system to have few “roadblocks” that would frustrate physicians and lead to workarounds. Finding the right balance to make prescribing both easy and safe was a challenge. Since both learners and expert prescribers use the system, the amount of available information is geared toward learners, but prescribers can order quickly if they do not need all the information. The system requires an attending physician’s approval of orders for certain drugs, such as Xigris. It uses “soft stops” or “speed bumps” to question orders and encourage change, such as from ciprofloxacin injection to the oral form.

When organizations start work on CPOE, pharmacists must become involved at the outset. Mackowiak noted the need for published evidence that a pharmacy role in CPOE development and implementation is vital.

CPOE System Integration

Integration of the pharmacy system with CPOE is a bigger change for pharmacists than CPOE implementation. High-level decisions about system integration should not be made without pharmacy input. Decisions by physicians, nurses, and pharmacists affect all of these practitioners. Pharmacy leaders need to understand what parts of existing practices should be kept and what can be changed; then they must prepare their staffs for the changes.

The entire pharmacy staff must be involved in preparing for the change on technical, operational, and clinical levels. The goals must be defined before integration: Is medication safety the institutional goal, and is it pharmacy's goal? Is operational efficiency the goal? Does the administration expect that integrated systems will reduce the need for pharmacy staff? Cost containment and return on investment are not realistic short-term goals.

Changing systems bring subtle shifts in power. Traditionally, physicians wrote orders and pharmacists and nurses decided the details. In contrast, computerized ordering systems give details, and pharmacists and nurses must learn to work with this information presented in a new way.

Some challenges in the transition to integrated electronic processes include accommodating the different vocabularies of prescribers and pharmacists and defining order priorities. For example, the term "first today" was chosen at Duke to help clarify "now" orders. With a bidirectional interface, drug nomenclature may need to change; the Duke pharmacy preferred "Sodium chloride 0.9%" but accepted the physicians' "NaCl."

Factors to consider in deciding whether and how to integrate the pharmacy system with CPOE include existing systems and vendor relationships, the availability of personnel and capital resources, and health system priorities and politics. Mackowiak was sure that Duke's pharmacy system would not work if interfaced with the CPOE system, but the chief information officer would not approve changing pharmacy system vendors to use the CPOE system vendor. Mackowiak prevailed only by taking her case to the head of the medical staff.

Pharmacy should find out exactly what vendors are promising. Vendors may say they offer bidirectional interface, but often the term is misused and pharmacy must manage communication between the systems. Ask vendors to describe what they mean, said Mackowiak, and if necessary enlist expert help to understand the following:

- What is vendor's plan for a closed loop and integration?
- What is the institution's strategy for medication safety?
- What will happen with the nursing system or eMAR?

The greatest challenge integration presented at Duke was pharmacy notification of orders. Instead of hourly manual pickup of orders from the nursing units and the ability to manage the order queue, individual orders stream in electronically. It is unclear when the "last run" is completed and the evening shift's work is finished. Since they no longer see the entire order sheet, pharmacists wonder what lab tests have been ordered. Pharmacy leaders need to help staff determine when checking an order truly requires lab information and how results can be accessed. And if pharmacists are accustomed to making a check mark after reading each order to ensure that nothing is missed, how can they accomplish this electronically?

Pharmacists' role in decision support is different with integrated systems. Pharmacists can see the alerts provided in CPOE and how they were acted upon, but the pharmacist can still phone the physician and say, I know you saw this alert and overrode it, but would you want to reconsider on the basis of...?

Organizations must work with vendors on how to present orders on screen appropriately for both physicians and pharmacy. For example, "Dopamine infusion 2 mcg/kg/min" for the physician becomes "D5W 250mL containing dopamine 200 mg titrate q24h" for the pharmacist. Particularly for discontinuing or modifying orders or tapering doses, this presents difficult IT challenges and takes time. One of the greatest challenges at Duke was demand doses and lockout intervals with patient-controlled analgesia (PCA). Another issue was notifying physicians to renew orders after automated mandatory stop orders.

Many work processes change in an integrated system with bidirectional interface. Technicians no longer need to enter orders in the pharmacy system. Pharmacists may be

able to check orders from home. Nurses need new ways of knowing that an order has been verified.

Conclusion

Our expectations for these systems should be reasonable, said Mackowiak, and we should remember that a CPOE system is not a modified pharmacy system and physicians do not think like pharmacists.

Bar Code Technology and Intelligent Infusion Devices

Churchill's institution, Brigham and Women's Hospital (BWH), approved funds for the design and development of a new pharmacy information system that would drive the hospital's bar code eMAR initiative. The plan included bar code scanning in all phases of drug preparation and distribution within the pharmacy, an onsite packaging center, design and development of a Web-based eMAR bidirectionally interfaced with the pharmacy system and supporting bar code scanning at the bedside, and linkage of the pharmacy system and eMAR with an intelligent infusion pump platform.



Factors to Consider in Bar Code Implementation

- Food and Drug Administration (FDA) requirements. Requirements for bar code labeling of drugs and biologics take effect in April 2006; hospitals are unlikely to have all drugs bar coded by then. Whether FDA will enforce the requirement is unknown; enforcement will affect what hospitals do in terms of repackaging.
- Bar code format. How and where will bar codes be used? Two-dimensional formats have greater capability. Since there is no industry standard for bar coding, equipment should be able to decode multiple formats.
- Choice of scanner. This is determined by the bar-code format selected. Hospitals

should invest in high-quality bar code printers and scanners or imagers.

- Availability of unit-of-use bar coded products. Availability of unit dose products is unlikely to increase.
- Inhouse repackaging versus outsourcing. Repackaging is an industrial process and not a core competency for pharmacy; there is a high risk for error. Technicians should double-check data entry before starting the repackaging process. The process should include visual verification by a pharmacist and electronic verification of the repackaged product. A repackaging center needs to be able to handle all dosage forms, and it must have a redundant backup system.
- Maintenance of the drug dictionary. Bar coding systems require continuous maintenance of the drug database. For example, when a wholesaler supplies a different generic version, the scan will not work if the national drug code (NDC) number of the original generic version is in the system. BWH translates NDCs to generic sequence numbers.
- Scanning technique. Staff must be taught to scan properly.
- Potential workarounds involving patient wristbands and employee identification badges. Nurses can scan extra wristbands that are not on the patient; pharmacy staff can photocopy bar codes and scan the copy. Pharmacy leaders should require a commitment to work within the process. Employee identification badges should require daily activation, and no temporary badges should be issued.
- System platform choices (radiofrequency-based or hard-docked).
- Role of radiofrequency identification (RFID) versus bar codes. An RFID tag can be thought of as a passive bar code; a physical scan of an item with an RFID tag is not necessary. RFID can be used for automated programming of i.v. pumps and to track patients, staff, and equipment. RFID tagging is more costly than bar coding.
- Obstacles to implementation. Consider how people will work with or work around the system.

Bar Coding at BWH

BWH uses a bar-code based process to restock automated dispensing machines; it is less labor intensive, maintains perpetual inventory, and automatically reorders. Bar codes containing patient identification, drug name and concentration, expiration date, and starting flow rate can be used for automated programming of i.v. pumps; the nurse scans the code to program the pump. This potential use should be considered in the selection of a bar code format.

BWH developed its own integrated pharmacy platform to support the eMAR and bar coding process. It has a bidirectional interface between nursing and pharmacy. If a medication is put on hold or the time is changed, this appears in both the nursing and pharmacy systems. The system prioritizes orders for pharmacy review, and the nurse can track this. Developing such a system is worth the investment of time; it is an opportunity to automate the slow, labor-intensive drug distribution process. Developing their own system enabled the BWH staff to include features vendors do not offer. Pharmacists need to demand better functionality from vendors.

Pharmacy dispensing errors decreased 85% after implementation of the eMAR and bar coding system. BWH data indicate that eMAR and bar coding will pay for itself within a year of implementation, or within three years of the start of design and development.

Intelligent Infusion Device Technology

An intelligent infusion device contains a clinical guidance system (drug library) that alerts the user to potential or actual administration errors. Intelligent infusion technology offers a relatively quick and inexpensive way to improve medication safety, since most high-risk drugs are given by the i.v. route, pump programming errors are common, and feedback mechanism to alert users to an error are not well designed. Bar code scanning and drug dose checking are not widely available on pumps, and current pumps may not have RF or infrared communication capability. Most infusion devices have little connection to other

systems. Information for setting up and programming the devices comes from multiple sources (e.g., the medical record, the pharmacy order entry process), increasing the risk for error. Required double-checks of pump programming may not occur when nurses' workload is heavy.

An ideal medication administration system would use CPOE, eMAR with bar coding, and intelligent infusion device technology, including pumps that enable the nurse to automatically verify the medication, dose, and concentration by sending information from the pump to the eMAR. However, most hospitals must begin with one of these technologies. Although the financial return on investment is lower than for eMAR with bar coding, intelligent infusion device technology can be implemented in a shorter time at a lower cost than CPOE or eMAR with bar coding; development and implementation at a 700-bed hospital can be accomplished in six months for less than \$2 million.

Goals in automating i.v. drug delivery systems are

- Bidirectional communication with pharmacy, order entry, and eMAR systems.
- Automated pump programming with bar code scanning or RF or infrared interface.
- A feedback loop to pharmacy to coordinate timely delivery of i.v. drugs; pharmacy would be able to see the locations of all i.v. pumps in the hospital and the drug, flow rate, and amount of solution remaining for all patients.
- Processing and reporting information in real time through wireless connectivity.
- Tracking and reporting changes in rate and dosage.
- Minimizing wrong drug, wrong rate, and wrong patient errors, and tracking and reporting near misses and error intercepts.
- Automatic identification of care providers.
- An intuitive and user-friendly process, and prevention of workarounds.
- Standardizing processes and improving process controls to eliminate variability (e.g., among nursing units).

- Improving communication and coordination of care among care providers; pharmacy and nursing would have the same information from the pump system.

Hospitals considering intelligent infusion devices should encourage vendors to provide the following functionality:

- Wireless means of sending new information to drug libraries and downloading data for quality improvement purposes.
- Multiple delivery platforms (e.g., continuous infusion, PCA).
- Patient monitoring (e.g., linking the infusion system with vital signs).
- Drug libraries, with hard and soft alerts to clinicians and multiple platforms (e.g., general medicine, intensive care, pediatrics).

Current intelligent infusion systems have a server sending information to the pumps, with a handheld device for programming the pump and bidirectional data flow between the pump and the CPOE system, the pharmacy information system, and the eMAR. The ideal system would function in a wireless environment that integrates advanced rules and alerts, patient identification, and smart pumps with drug libraries. It would support predictive maintenance, remote updates, and device management. The most advanced pumps contain an internal or attachable bar-code scanner or RFID tag for automated drug identification and can automatically identify the clinician user and the patient.

Before an organization purchases intelligent pumps, a multidisciplinary team should thoroughly evaluate how various vendors' products meet the needs of the users. During usability testing (demonstration of vendors' products), nurses should operate the pumps, and their comments should be recorded and evaluated.

Conclusion

The appropriate use of intelligent infusion devices and bar coding or, ideally, RFID, can reduce errors and standardize best practices.

These systems must be carefully designed to avoid introducing new errors. The available technology needs refinement. Use of the drug library is not mandatory. Users can bypass the library and ignore alerts, and alerts are not provided if errors are within an accepted range. Programming is still a manual process. Maintaining the drug library requires dedicated resources (at BWH, one-half pharmacist full-time equivalent (FTE) and one nurse educator FTE).

Exercise

At the end of the presentation, each table was assigned the following exercise: If you were the director at a hospital that had none of these technologies, which one would you choose to implement first, and why? Participants were to answer from the perspective of nurses, physicians, biomedical engineers, information system specialists, or other team members, as well as pharmacy. A majority chose to start with intelligent pumps, which they thought would be the most cost-effective. Although BWH has had CPOE for many years, Churchill said that if starting over he would choose eMAR with bar coding because it provides the greatest safety advantage.

Breakout Session 4

EFFECTIVE COMMUNICATION SKILLS: TECHNIQUES FOR PHARMACY LEADERS

Stephanie Barnard

Stephanie Barnard presented communication techniques for building relationships, encouraging behavior change, providing motivational feedback, and dealing with complaints. She offered tips for effective telephone, voice mail, e-mail, and written communication. She encouraged new pharmacy leaders to practice public speaking and offered tips for conducting and speaking in meetings.

Building Professional Relationships

Begin building professional relationships by greeting each person you see in the workplace, Barnard advised. Go in person to meet new people (e.g., physicians) in your facility. Establishing rapport paves the way for collaboration. People do business with people they like and trust. When presenting information to physicians, it may help to think of yourself as an educator or consultant.

Barnard offered a “wrap and roll” solution for use when a pleasant hello leads to an unwanted long conversation: Summarize or comment on what the other person said, then make a transition to the next topic (e.g., “Let’s talk about what we need to get done today”).

Leaders can set a positive tone in the workplace by choosing positive words, being specific when giving or requesting information, and remembering that tone of voice is important for ensuring that a message is understood as intended. Managers should always say something positive to people they have called to their offices; this might simply be “Thank you for coming to talk to me.” When giving negative feedback, the manager should use the word “and”—never “but”—to connect the criticism to an initial positive statement. For example, “I understand that you’ve said... [pause to give the other time to think], and I think...”

Listening to understand requires remaining silent until the other person finishes. Making eye contact while listening shows interest in what the speaker is trying to communicate. Smiling and nodding to acknowledge the speaker and echoing what is being said signal interest and understanding.

Eye contact by the speaker signals trustworthiness. It is particularly important at the beginning of a conversation, while making the most important point, and while summarizing at the end. During presentations, the speaker should look at each person in the group at least once or, in a large group, at one person in each quadrant of the audience.

Persuading Others to Change Behavior

Skilled interpersonal communication is needed for persuading others to change their behavior. We may not see ourselves as salespersons, but we are always selling ideas, said Barnard. The following steps are useful in a conversation about behavior change:

1. Ask questions to establish rapport.
2. Establish a need (or a want) that you can fulfill.
3. Focus on the benefits of the change (“what this means to you”).
4. Close with a call to action, preferably an “if/then” statement (e.g., “If I take care of this, then will you take care of that.”)

Constructive Criticism

Constructive feedback from leaders and mentors can motivate colleagues and staff to improve performance. Barnard suggested easing criticism with assertive phrases and “I” statements. For example, “I see that...” can introduce a statement about a problematic behavior. Avoid “I hear that...,” she cautioned, because it implies that the listener is being talked about. Time and place are important. It is usually best to give negative feedback at the end of a shift. To have more power in such a meeting, hold it in your office. For control of when the meeting ends, have it in the other person’s office and stand when you are ready to leave.

For conversations that turn problems into opportunities

1. State your feelings openly. Begin with an I statement: "I am concerned about..." State your agenda: "I have two things to ask you."
2. Listen with empathy. Ask questions to elicit that person's side of the story: "I'm concerned about...Tell me what happened." Then listen quietly.
3. Describe rather than evaluate behaviors.
4. Identify and focus on areas of agreement.
5. Treat others as if their opinions are equal.

Conflict Resolution

Managers can respond to complaints as follows:

1. Thank the complainer, saying you are glad to learn about problems before they escalate.
2. Apologize for the problem. (Even if you did not cause it, you represent the organization.)
3. Promise to deal with the problem right away.
4. Collect all the information you need.
5. Correct the mistake as quickly as possible.
6. Follow up to make sure the person who complained is satisfied with your actions.

Managers can best approach a person who is upset as follows:

1. Remain silent so the person can speak.
2. Echo what has been said; use I statements.
3. Make an intention statement. This clarifies your position (e.g., "I'm sorry this happened; it's not our intent for this to happen") and helps defuse the person's anger.
4. Offer a solution while giving the upset person a choice, if possible: "How can we rectify this? Would you prefer that we do A or B to fix the problem?" This moves the focus from the problem to the solution, and it gives the person some control. When other people are involved in the issue, talk to them, expressing concern and asking how the problem might be fixed.

Effectiveness and Communication Mode

Concerning various communication modes, Barnard advised getting to the point immediately in telephone and voice mail messages. Plan calls; divide them into introduction, body, and conclusion. Repeat your name and necessary phone numbers at the end. Replace "You know," "Um," and other fillers with a pause. Smile when speaking over the phone. Speak slowly and clearly.

Begin written documents with "thank you," and use "please" in making requests. Outline before you begin, use active voice, and remember that less is more. To provide visual breaks, use bullets, headings, indents, and spaces between paragraphs.

E-mail messages should be limited to one screen and no more than three topics. Draft the message in a word processing program first, then import it into e-mail or attach it. Be specific in the subject line. Keep the writing professional. Avoid discussing confidential patient information, and send copies to others only when they need or request them. Hesitating before sending e-mail, like counting before speaking, helps prevent nonconstructive communication.

Breakout Session 5

DEVELOPING TOMORROW'S LEADERS

Scott M. Mark
Scott Knoer
Alison Apple

Health-system pharmacy has not done enough to prepare a leadership “bench” to replace retiring leaders and fill vacant positions at the director and assistant director level. In this session, Scott Mark discussed succession planning; Scott Knoer looked at the need for leadership development in terms of ASHP’s 2015 Initiative and advice from business gurus and current pharmacy leaders; and Alison Apple discussed ways to identify potential leaders early in their careers and encourage their development.

Leadership Succession Planning

Succession planning involves determining what skills an organization will need for its future work, identifying potential leaders among current staff, and providing experiences to develop their leadership competencies. It should be an ongoing activity.

The right leader can maximize a groups’ performance. When corporations seek internal and external candidates for top executive positions, a potential leader’s fit with the organization is key. Organizations that use succession planning to keep the leadership style consistent do not experience dips in performance or high employee turnover when the leadership changes.

Some corporations keep an inventory of potential candidates for positions on the organizational chart and how soon they will be ready to move into new roles. Candidates from all parts of the chart are considered, if they have the ability to influence people or the political skills to interface with other departments.

Input from employees’ superiors and their peers, as well as those below them in the organization, is useful in identifying staff members with potential to rise to the next level of leadership. This type of feedback helps

identify both strengths and weaknesses of a potential leader.

Succession planning in pharmacy needs to recognize differences in skill sets among levels of management; for example, the skills needed for operations management are different from those needed by the director. Excellent performance at the current level is not the same as readiness for the next level. Readiness to move into leadership can be gauged by a candidate’s “soft” skills, such as interpersonal skills and decision making.

Leadership candidates should have an individual development plan that states goals, actions for meeting those goals, and a timeline (Appendix 2; page 37). When skills need to be developed, on-the-job training works best. Placing a high performer in a “stretch” job accelerates development.

Leadership candidates should be given visibility to the overall organization. They may find good mentors outside the pharmacy. Mark advised involving top management in pharmacy leadership development plans. Your superiors need to understand why a developing leader may be representing you at meetings, he said.

Staff members vying for a higher position will want to know why another candidate was hired. They should be informed about the choice in a way that keeps them “on board.” The selection criteria should be predefined and defensible.

Leadership development requires a willingness of current leaders to share their knowledge. Older leaders may be reluctant to help prepare successors, fearing they will no longer be needed if they share their unique knowledge. The exit style of older leaders leaving the department has an impact on succession planning and the organization’s subsequent performance. The organization benefits when outgoing leaders make themselves available to their successors but do not interfere in the new leaders’ decision-making.

Leadership...Traits, Qualities, and Competencies

Reviewing goals and objectives of ASHP's 2015 Initiative, Knoer said strong leadership will be needed to reach those goals. Competencies identified by health-system pharmacy leaders (December 1, 2004, *AJHP*) can be incorporated into a department's leadership development plan.

Knoer presented "pearls" based on current business articles:

- How a person deals with adversity is an indicator of his or her capacity to be a good leader. Difficult circumstances present opportunities for learning leadership.
- The needs of the hospital, the department, and society at large determine what characteristics are important in a pharmacy leader. A leader can exercise different styles at different times. For example, participative leadership helps engage and motivate people outside the department, but autocratic leadership may work best when a troubled department is preparing for accreditation review.
- Effective leaders practice "tough empathy"; for example, a decision that is cost-effective for the overall organization will not please everyone. They capitalize on their unique abilities; for pharmacists, this might be expertise at conducting research and presenting data effectively. They are willing to reveal weaknesses; this establishes trust and a collaborative atmosphere.

Noting health-system pharmacy's strong tradition of mentoring, Knoer described how he has benefited from older leaders' willingness to share their knowledge and experience. Just ask, he said, and an ASHP presidential officer or Whitney Award recipient will talk with you by phone or speak at your meeting. Each pharmacy resident at Knoer's institution interviews a Whitney Award recipient and prepares a presentation on that leader.

To increase your team's interest in leadership, said Knoer, talk about it and demonstrate it, and encourage participation in professional organizations. Knoer passed on tips for new

leaders presented at a national meeting. Your job is to make your boss and your organization look good. Never say no to a request from your boss. Give credit for the organization's success to your staff and managers. Always follow through on commitments; this helps build the relationships you need for managing through other people.

Knoer is part of an advisory group on leadership development within the ASHP Section of Pharmacy Practice Managers. The group encourages current leaders to be models for managers who may step up to leadership, and to include leadership goals in the managers' performance plans. Leadership training ideas from the advisory group are posted on the ASHP Web site, and its suggestions for involving students in leadership and management will be published in *AJHP*.

Developing Pharmacy Leaders through Student and Resident Experiences

Apple, who directs a two-year combined master's degree residency program in Memphis, Tennessee, cited challenges in developing future leaders: capturing student interest early, identifying potential leaders among students, developing core leadership skills during first-year residency, and making more practice management residencies available.

Students

In their first professional year, pharmacy students should be introduced to opportunities in health-system leadership. In their early work experience, students can be engaged in projects with department leaders and managers. In the classroom, they can be introduced to health-system pharmacists working in different roles. Apple's students have an introductory management course in their second professional year; new clinical practitioners talk to the class about their need for management skills on the job, and the course content is aligned with the students' therapeutics courses.

During the hospital pharmacy rotation, each student has lunch with a series of health-system leaders, who talk about how they

arrived at their current position and what it means to them. Students in one program spend a week with a member of the pharmacy management team. Each pharmacy administration clerkship student completes a major project and presents it to the class, as well as writing a review of a leadership book.

Residents

The 14 specialty residency training programs in pharmacy practice management offered in the United States (8 one-year and 6 two-year) graduated a total of 25 pharmacists in 2005—far too few to fill the leadership bench. Apple believes that core leadership skills can be developed during first-year residency, and that more one- and two-year programs are needed in all parts of the country.

She reviewed advantages and disadvantages of 12- and 24-month programs. The shorter programs are not offered in collaboration with universities and do not grant degrees; all of the resident's time is spent at the hospital. The shorter programs may interest practitioners who have completed a pharmacy practice residency in the past. In two-year programs, time conflicts between academic and practice experiences can occur, and tuition costs can be an issue. However, combined programs have a proven track record for leadership development, and many employers look for candidates with a master's degree. The collaborating university determines what master's degree is granted; a thesis may be required or optional.

Apple's residency program leads to an M.S. in Health Sciences Administration from the University of Tennessee. The courses are spread over both years. The hospital defines special projects for the second year. Tuition comes from hospital funds, and the university helps fund one of the residency positions. The residents spend time on clinical services in the summer months when they can be at the hospital full-time. In the second year, residents have rotations at other hospitals.

Our Current versus Future Competencies

Mark led an exercise in which attendees looked at 18 competencies for midlevel managers and associated skill sets, as

identified by The Advisory Board Company. First, the attendees divided their own skills in these areas into equal high, medium, and low groups.

One competency on which pharmacists tend not to rate their skills as high is giving others feedback about areas of performance that need improvement. It is our responsibility to do this, said Mark, and the lack of honest feedback is a major barrier to succession planning.

Another weak area is developing and retaining talent. We don't give stretch assignments, said Mark, and we look at current, not potential performance.

Pharmacists rate themselves high on strengthening and building relationships. But, said Mark, this may denote a weakness; pharmacists tend to deal with conflict either by avoiding it or by compromising.

By identifying weaknesses, this exercise effectively creates an individual development plan. Mark cautioned, however, that areas ranked as medium may be more important to work on in terms of competencies for the future.

Next, the participants chose which competencies will be most important 10 years into the future. Many chose identifying, recruiting, developing, and retaining talent. Another competency recognized as important for the future was managing vision and purpose, with the skill "articulates a clear and compelling direction for a program or project that is in line with the organization line." Comparing important competencies for the future with current strengths is the basis of succession planning. Plans for developing leadership skills can be part of a departmental performance plan.

If leaders in our institutions were asked these same questions about pharmacy, their answers would be different from ours and would show us the directions in which we need to move, Mark concluded.

Breakout Session 6

MOTIVATING STAFF TO IMPROVE THE MEDICATION SAFETY PROCESS

Virginia W. Barnes

Creating a motivational environment requires addressing human needs for value, control, and self-esteem, said Virginia Barnes. Elements of a motivational environment include involvement and participative leadership; a comfortable, informal climate; open communication; a sense of belonging (wholeness); value for uniqueness and diversity; creativity and risk taking; a process for operating and handling conflict; and high-quality decisions. Pharmacy leaders can create an environment that fosters internal motivation to improve the medication-use process.

Understanding Behavioral Styles

Understanding people's differing behavioral styles and choosing a communication technique appropriate to the particular performance issue can help leaders motivate staff to produce high-quality results. Barnes has developed a questionnaire that categorizes people as socializers, directors, relaters, and thinkers on the basis of their need to be in control and their preference for being around others or alone.

Both socializers and directors have a high need to be in charge, but the socializer accomplishes this through other people while the director acts unilaterally (Appendix 3; page 38). Socializers' most important need is recognition from others. They are persuasive, competitive, confident, inspiring, open, direct, and outgoing. They like risk and change. To people with other behavioral styles, socializers may seem pushy, intimidating, overbearing, restless, impatient, manipulative, abrasive, reactive, or dominating.

Directors' greatest need is on-time results. Directors are practical, orderly, self-determined, organized, traditional, goal-oriented, dependable, economical, and ambitious. To nondirectors, they may seem

dogmatic, stubborn, rigid, unapproachable, distant, critical, or insensitive.

Relaters like being with people but do not want to be in charge. Their greatest need is to be liked, appreciated, and valued. They are team oriented, caring, devoted, enthusiastic, helpful, trusting, sensitive, friendly, and gregarious. They are good listeners and peacemakers. People with different styles may see them as too other oriented, indecisive, impractical, vulnerable, hesitant, and subjective.

The thinker's greatest need is to have the facts correct. Thinkers are exacting, thorough, factual, reserved, meticulous, practical, and calm. They have high standards and avoid risks. Others may find them slow to get things done, perfectionistic, withdrawn, dull, sullen, shy, or passive.

Understanding these different types gives insight into how coworkers perceive the way they do their jobs and what is important to them. Many workplace conflicts are related to how the different types interact. When interacting with colleagues who have different behavioral styles, pharmacy leaders can alter their own communication style so their coworkers will better understand what is wanted—and will be more likely to do it because they feel more valued, more in control, and better about themselves.

Attitude

Staff members' attitude affects an organization's level of performance. Attitude is a choice, said Barnes; the "attitude formula" is decision plus behavior equals feelings (emotional response). In other words, feelings are the byproduct of a choice, such as a decision to act as if our expectations for the day at work are positive, not negative. Barnes believes that negative attitude comes from a lack of strong positive behaviors, and that we can change behavior to start changing attitudes. Pharmacy leaders can contribute to an environment in which people improve their behavior and thus their attitude—and thus the results.

Coach, Teacher, Counselor


How a leader or mentor can best motivate people depends on the desired behavioral outcome. If the desired outcome is a higher level of performance for a staff member who is already performing well, coaching or cheerleading can be used to acknowledge the good work and challenge the employee to move to the next level. The leader can explore the employee's individual goals, asking questions to learn more about his or her attitude, values, and ego involvement. The leader should focus on the benefits, not the features, of the desired outcome, keeping in mind the person's behavioral type (e.g., use statistics for a thinker; remind a socializer about the recognition the behavior will bring).

If the desired outcome is to improve substandard performance, the leader must act as a teacher or counselor. Barnes listed five reasons people do not cooperate:

1. They do not know the rules.
2. They know the rules but do not like them.
3. They do not trust the players (possibly including the leaders) to do the job.
4. They do not care about the game (e.g., they have done it for long enough).
5. They do not see the reward.

When employees are uncooperative because they do not know the rules, the leader needs to teach by example, work together with the employee, and provide guidance as the employee begins to perform independently. Instruction should come in small chunks, geared to the employee's preferred learning style (e.g., visual, auditory, kinesthetic). Barnes suggested a three-part template for giving instructions in a seven-minute period. First, introduce the topic; this part should include the benefit of the proposed outcome and a transition to the second part. Second, provide detail: facts, illustrations, stories, or other types of information to communicate the benefit in a way that appeals to the individual's behavioral style. Third, repeat the benefit and include a call to action (e.g., "This is what to do from now on, because...").

When employees know the rules but performance is substandard, the mentor uses counseling and correcting. People who refuse to follow approved procedures may be retaliating because they do not feel valued. The leader must engage them in dialogue, listen actively, and clearly specify the desired result and time frame. The leader can use the following model: Describe the performance that is occurring, express needs, seek opinion and needs, and come to a cooperative agreement. For example, "When [this happens]....I prefer...because....What do you think about what I just said, and what do you need in order to be able to do what I'm asking?...This is what I've asked for, and this is what you've agreed to do, so when do you want to get back together to evaluate how it's going, how you feel about it, and what I think about your progress?"



Choosing a Motivational Approach

In groups, the participants chose a motivational approach and applied it to a workplace issue, as in the following examples:

Teaching/instructing: Why garbing for compliance with USP Chapter<797> is important

1. Introduce three reasons why this topic is important:
 - Patient safety
 - Product integrity
 - Regulatory compliance
2. Give more specifics, attempting to appeal to different behavioral styles:
 - Patient safety is improved through reducing particulates in the air and decreasing infection.
 - Compliance with the standard improves product sterility; this has been verified through monitoring.

- Data on product sterility and infection rates show....
 - The pharmacy can be proud of the quality of its products. We are doing a good job, and we can be the first pharmacy to be 100% compliant with the garb requirements.
3. Call to action:
- Proper garbing is demonstrated.
 - Boots, gloves, and hairnets are passed around for people to try.
 - The group agrees to start using the proper garb.

Counseling/correcting: Staff members dislike and do not talk to each other, causing inadequate communication at shift change

Describe the behavior: A patient with febrile neutropenia needed a drug that had to be obtained from another site. Calls were made to get the drug, but this was at shift change. The pharmacist who was leaving did not communicate to the oncoming pharmacist what needed to be done, and the patient did not receive the dose for six hours. That generated an incident report.

Express the need: To ensure appropriate patient care, we need to come up with a way for pharmacists to communicate at shift change any outstanding issues.

Seek opinion: What would you like to do to ensure that this communication occurs?

Cooperative agreement: Two people will devise a form to be implemented in the next week. We will try it for two weeks and then get together to assess whether it is effective and whether it needs to be revised because of unanticipated problems.

BRIDGING THE PHARMACIST GENERATIONAL AND GENDER GAP

Sara J. White

The makeup of the pharmacy work force is changing, and current leaders have been concerned that not enough pharmacists are preparing themselves to step into leadership positions. Working as an ASHP Research and Education Foundation Scholar in Residence, Sara White surveyed pharmacy directors, middle managers, and practitioners about their job satisfaction and future plans. Directors, managers, practitioners, and pharmacy students were asked about their attitudes toward the balance between family and work. Employers recruiting for management positions were asked about the perceived ease of filling such positions.

More than four fifths of the directors responding to the survey were men, compared with 65% of middle managers, 35% of current practitioners, and only 15% of pharmacy students. When asked how they wanted to divide their time between career and personal life, managers, practitioners, and students all indicated they desired a balance. More than half of the middle managers and practitioners had children and working spouses.

Women, in particular, may want to work less than full time, and pharmacy leaders should recognize that this desire does not indicate a lack of commitment to the profession, said White. Pharmacists in other generational cohorts cannot be expected to have the same view of the world as do current leaders, or to make the same decisions. Managers must find ways to keep younger workers engaged.

White suggested that managers and staff together discuss why they chose pharmacy, what they expect in their careers, and how they define success. This “meeting of the minds” helps managers begin to understand the needs and preferences of their staff. Equally important, the staff must understand what the manager needs to keep the departments running.

Managers should invest in their staff members' development, even as they recognize that younger workers are unlikely to spend their entire career in one organization. For example, leaders can help staff learn to manage time, deal with workplace politics, and prepare a presentation or write an article for publication. Timely feedback on performance is important. Staff can benefit from increased responsibility. Some departments are dividing middle management roles among several people. Leaders can provide opportunities to grow through teaching and preceptorship responsibilities.

Pharmacy department leaders should consider whether work can be reorganized to make it interesting and challenging for all staff members. Pharmacists want to use their knowledge and stretch their abilities; frank discussions with staff will reveal their particular interests.

To maintain a family-friendly work environment, leaders should give their pharmacists and managers as much flexibility as possible, through part-time work, job sharing, or extended shifts to allow more days off. Part-time workers should be expected to read their mail and keep up with events in the department. Job sharers should schedule themselves so that the position is covered at all times. Pharmacists may be willing to take positions outside their main areas of interest if those positions offer the schedule they desire. White encouraged leaders to be open to new staffing arrangements that allow a balance between career and personal life.

PART-TIME PHARMACISTS/FULL- TIME PROFESSIONALS: THE CHANGING WORK FORCE

Craig Kirkwood
Kelly Rogers
James A. Eskew

Craig Kirkwood described experience with part-time clinical pharmacist positions, Kelly Rogers reported on her part-time management position, and James Eskew discussed pros and cons of employing part-time staff.

Part-time Clinical Pharmacists

Nearly 10 years ago, Virginia Commonwealth University Health System (VCUHS)/Medical College of Virginia Hospitals filled three full-time equivalent (FTE) clinical positions with six part-time pharmacists, all women. Kirkwood described the development of this arrangement and its benefits and challenges.

The new positions began when two full-time clinical pharmacists approached the director about part-time work; another two followed, then a fifth, and finally a sixth, to make three FTEs. One pharmacist wanted to turn her hobby, photography, into a profession; the others wanted part-time work for family reasons.

The first pair, who filled one FTE drug information (DI) position, consisted of the director of DI and a clinical specialist in DI who had moved to a part-time dispensing position when no part-time clinical slot had existed. The other four were clinical specialists in the acute pain service, surgery service, internal medicine, and transplantation. The pain and internal medicine specialists filled one FTE on the antibiotic monitoring team. The surgery and transplantation pharmacists filled one surgical services FTE. Each of the six pharmacists worked 40 hours in a two-week period, one day on and one day off, in exempt, half-time positions, with half the full-time benefits, operational responsibilities, and holiday coverage requirements.

The pharmacy leaders realized that having two people fill one FTE would mean extra work for their supervisors (e.g., twice as many competency assessments and performance evaluations) and for the human resources department. Efficiency would be diminished by handoffs to the other person in the job, as might safety, since errors are common at handoffs.

All six of the pharmacists were familiar with the institution and competent in both clinical and operational roles. All desired to succeed in part-time positions and were willing to do what was necessary to make the arrangement work. Strengthening the case for approval of the part-time positions were departmental vacancies and a national pharmacist shortage.

Although scheduling could have meant extra work for the pharmacy managers, the part-time pairs made their own schedules. The potential need for family leave was greater with six people filling three FTEs than it would have been with three full-time people. It was difficult for the staff to understand that since each pair represented one FTE, other people would need to cover days off.

Nine years into the arrangement, the part-time DI positions were recombined into one FTE. The other two paired positions still exist. Mismatch of personalities in a pair was an unanticipated problem, as was jealousy among the full-time pharmacists. The department was initially concerned about handoffs between the two partners and with their manager, but more attention should have been given to handoffs with other people; it was unclear to others which partner to approach and inefficient to deal with both. Although the part-time schedule imposed some limitations on extra duties, such as committee meetings, it enabled the pharmacists to take on extra shifts in operations.

Pairing or partnering to fill clinical positions is feasible, but the risks and benefits should be thoroughly explored before such an arrangement is initiated. Part-time pharmacists' desire to succeed may be strong, but it can change over time and be

uneven between participants (i.e., the interest of one partner may fade). Continuance of such positions cannot be guaranteed if one of the half-time slots becomes vacant or a position is abolished.

The Successful Part-time Manager

Rogers described her path to part-time management at Clarian Home Care and reviewed critical skills for success in such a position.

Informal leaders exist in every work group, but they may not consider management because they think it implies too great a commitment. Pharmacy departments need to invest in the talent of these potential leaders, whether in full-time or part-time positions. Part-time employees may change to or return to full-time status in the future. Offering employees flexibility can foster loyalty and commitment.

After the birth of her son, Rogers re-entered the work force as a supplemental employee in the health system's home care operation. She assumed some management duties in the wake of a health-system merger and turnover in home care pharmacists. When offered the manager slot, she eventually accepted the role in an 0.8 full-time-equivalent (FTE) position. The Clarian Home Care pharmacy has 29 employees (23 FTEs). With only one supervisor, a technician, reporting to her, Rogers believes 0.8 FTE (64 hours per pay period) is the minimum required for the manager position.

Potential part-time managers should prepare for resistance or skepticism, said Rogers. If the pharmacy director and human resources department agree to hire a part-time manager, the manager can suggest a trial period of 6 to 12 months—which should not fall during the department's busiest times. Rogers said she has been energized by her management role, but she acknowledged that part-time management may not work for every person and setting.

Part-time managers need to be flexible but assertive about keeping control of their schedules. They can give more hours in times of need and negotiate for flexibility in return. They should be willing to work in nontraditional

ways and places (at home, in the car, during children's sports events) and to utilize technology. Key skills are setting priorities, managing time, organizing, handling stress, multitasking, and, most important, delegating. Part-time managers can expect jealousy and sabotage from full-time managers, and some loss of clinical expertise. They should meet regularly (every few weeks or months) with their managers, ask for feedback, and be ready to accept constructive criticism.

Part-time managers must learn to accept role conflict. Think of a pie cut into four pieces labeled self, family, work, and other, said Rogers. Understand that work-life balance is fluid, and the pieces vary in size over time. Make an appointment with yourself to review your pie at least monthly. If the work piece becomes too large, delegate; ask yourself if the situation is temporary; ask your manager for help with specific issues, have possible solutions, and remain open to suggestions. If the family or self piece becomes too large, look to others (outside the workplace) for help: friends, family, hired help.

Managing the Changing Work Force

Eskew is pharmacy director for Clarian Health Partners, a 1400-bed multihospital system. Its three 24-hour inpatient pharmacies are staffed by 98 pharmacist full-time equivalents (FTEs):

- 71 full-time pharmacists (80 hours per two-week pay period)
- 41 part-time pharmacists (40–72 hours per pay period; partial benefits), and
- 26 supplemental pharmacists (less than 40 hours; no benefits).

Eskew discussed the advantages and the challenges of employing a large number of part-time health-system pharmacy staff.

The advantages include a larger labor pool, greater flexibility in staffing, improved staff morale, and lower risk of burnout and turnover. The large number of pharmacists can be mobilized to help with special projects, such as computer system conversion. The Clarian staff is more diverse because of the part-time pharmacists, including pharmacists who also work at chain pharmacies and the nearby Eli Lilly and Company.

A disadvantage is having a greater number of staff members to manage; a manager responsible for 40 FTEs might be managing 60 people. Similarly, a greater number of people must be trained on new systems and processes. The number of employee evaluations and other documents to be processed is greater. There are arguments on both sides, said Eskew, as to whether part-time staff is less productive and less committed.

For this large pharmacy staff, e-mail is used for all communications, including pharmacy and therapeutics committee updates, back order reports, and medication safety committee updates. Web-based education is used for staff development. A computer program is used to process performance evaluations, with face-to-face meetings at the conclusion.

Eskew recommended that pharmacy leaders read *The World Is Flat: A Brief History of the Twenty-First Century*, by Thomas L. Friedman. The author discusses how world events and the Internet have changed the way business is conducted and the way labor is used. The offshoring (international outsourcing) of service jobs is a change that pharmacy leaders should be aware of. Many small hospitals, Eskew noted, are sending radiology images to India and other countries to be read. The book also discusses "homesourcing," a term coined by the founder of JetBlue Airways. All 400 of the airline's reservation clerks work at home. In pharmacy, said Eskew, "We could see people at home processing physician orders with electronic charts, with computerized physician order entry, with document order imaging systems such as Pyxis Connect."

WHOSE LIFE ARE YOU LEADING, ANYWAY?

Jeffrey B. McMullen

Jeffrey McMullen shared strategies for overcoming fear of change and barriers to creative thinking by unleashing the power of humor. Each of us has the ability to become a more efficient, creative, proactive leader of our lives, *if we choose to*, he said. We can choose to celebrate rather than deliberate life. It can be difficult to implement that choice in our personal and professional lives, because we live in a negative environment, bombarded by issues that desensitize us and distract us from our personal mission, our passions, and our achievements.

Winners versus Whiners

Studying human potential, said McMullen, involves looking at differences between winners and whiners. Winners share four characteristics:

1. Courage to dream big dreams and expect good things to happen in their lives. They start each day expecting to make positive differences in their own lives and the lives of others. “What is your internal dialogue in the first five minutes of the day?” asked McMullen. “Is it encouraging? Nurturing? Exciting? Full of self doubt?”
2. Conviction to act. Winners understand that it is what they get done that makes a difference, not how busy they are. Busyness should not be confused with productivity.
3. Humility. Winners are not afraid to share the rewards of their efforts with others. They understand that we accomplish little by ourselves—that our individual successes are based on our collective efforts.
4. Creative vision of opportunity. Winners and whiners have the same opportunities, but the winner is excited by the opportunity and asks how it can be used, perhaps through a relationship with another person.

Creative Vision

Creative vision allows us to be effective leaders in all parts of our lives. Through

creative thinking, we can reframe our workplaces.

Creativity begins with acknowledging a need or problem and researching solutions, followed by incubating the information until it comes together logically to produce an “Aha!” moment. Such moments often occur when we are not focusing on the problem, said McMullen. The timing may be inopportune, but the creative idea should always be recorded while fresh.

Creative vision involves balancing one’s “self-life” (introspective life), social life, and professional or corporate life. In the self-life, the greatest block to the creative process is negative self-talk, such as “I can’t do that,” “I wish I could,” “I am safe if I don’t say anything (because if I say it then I’ll have to do it),” “As soon as...” (projecting happiness into the future rather than celebrating the now), and “Yes, but...”

Rules (e.g., “If you don’t conform, you won’t fit in”) are the greatest hindrance to creativity in our social lives. In corporate life, the greatest block is giving voice to negative thoughts: “We tried that last year,” “It’s not how we do it here,” “If it’s not broken, don’t fix it.” (The creative version, said McMullen, would be “If it’s not broken, break it—there’s probably a better way of doing it.”)

McMullen proposed the following ways to build, rather than block, creativity:

- Start the day with absolute faith in your ability.
- Do not judge.
- Ask questions.
- Learn by observing people’s actions, as well as by listening.

Putting Creativity to Work

How we see the world is key to our success and creativity. Ask yourself these questions, said McMullen:

1. Are you humorously impaired? Have your forgotten how to laugh *with* the world?
2. Have you noticed that people are less tolerant of each other?

3. Do you take time to laugh and celebrate each day, or just try to get to the end of it?

Humor has many benefits. A laugh lowers blood pressure, increases energy, and reduces stress. Humor enables us to handle crisis situations, makes us nicer people to be around, and helps create positive self talk.

To make our self talk positive, we should learn to

- Accept the word No. “It just means that the idea wasn’t right for the application,” said McMullen. “Don’t take it personally. It has nothing to do with the quality of the relationship or the type of person you are.”
- Accept compliments. If we say “It’s nothing,” other people come to believe that.
- Install a negative vocabulary filter. We will always have negative thoughts, but we can choose not to state them.

In the social realm, we can acknowledge that rules are meant for our protection, not our restriction. “Find out why the rules are in place,” said McMullen. “You can agree, disagree, or investigate more—but don’t just whine.”

In our corporate lives, we can create positive conversations, think before we respond, establish a “no complaint day,” and place positive visual reminders (e.g., positive quotations rather than cynical cartoons) in the work space. “*You* are the work environment,” said McMullen. “When I talk about humor in the workplace, I’m talking about the framework in which we resolve issues.”

McMullen suggested small steps toward overcoming fear of change, such as trying a new food, taking a new route to work, and meeting someone new every day.

He proposed “golden rules” to motivating others. (Think “I can have whatever I want if I help enough other people get what they want.”)

- Stop gossip.
- Stop complaining to others.

- Write weekly thank you notes to people who have made a positive difference in your day.
- Do something for someone with no intent of anything in return.
- Raise the bar on how you treat others. The respect, focus, and kindness we show will be reciprocated.

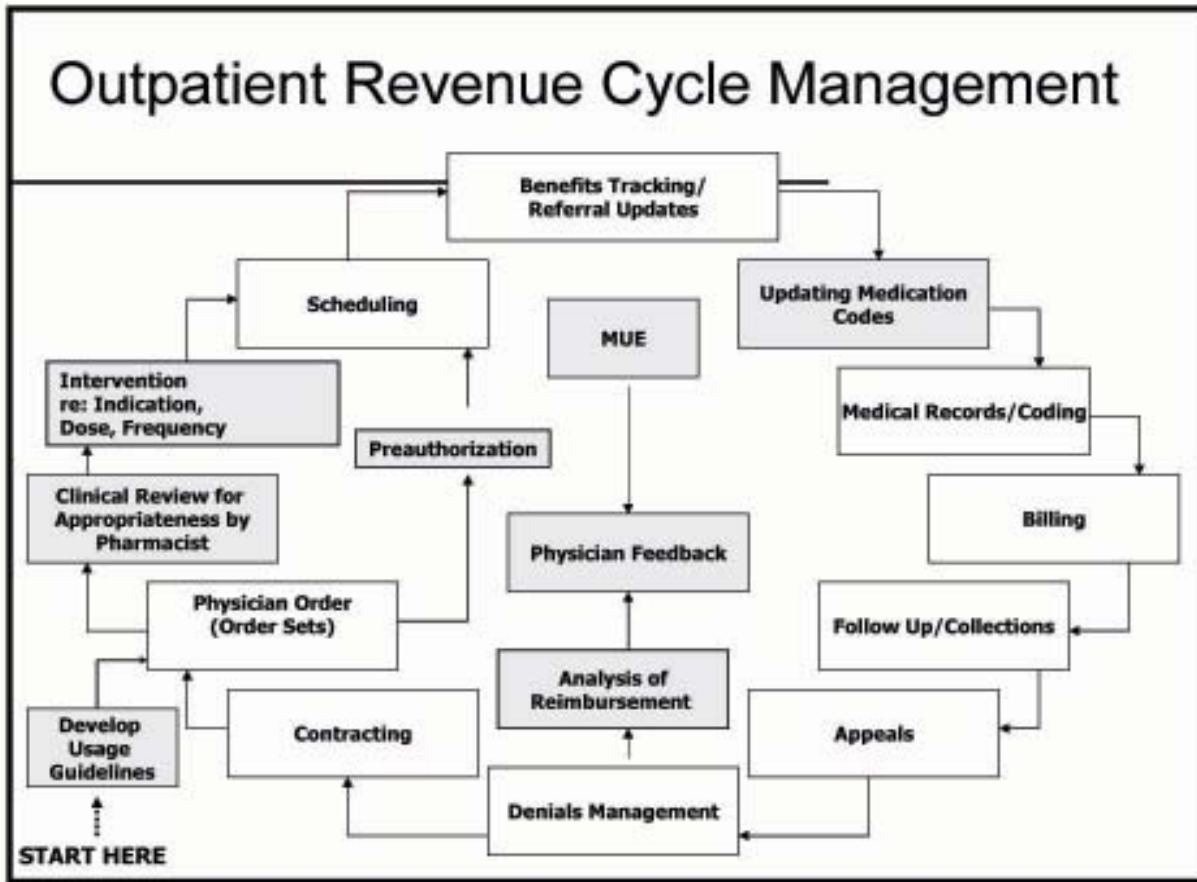
Taking the Risk

Implementing creative vision means taking risks. McMullen told how he once risked losing his job as Ronald McDonald by granting a dying child’s wish for Ronald to hold him. “I asked myself, ‘If I lose my job for doing the right thing at the right time, is my life over?... If I’m not willing to put my best foot forward, how hypocritical is it for me to ask anyone else to?’” When leaders have the courage, conviction, and humility to do the right thing at the right time, he said, they begin building an environment of creative vision, and others will follow.

APPENDIX 1:

REFERENCE ON PAGE 17 FROM THE ARTICLE:

REIMBURSEMENT 101: UNDERSTANDING AND IMPROVING THE PROCESS



APPENDIX 2:

REFERENCE ON PAGE 25 FROM THE ARTICLE:

DEVELOPING TOMORROW'S LEADERS

Individual Development Plan (IDP)

EXECUTIVE DEVELOPMENT PLAN

NAME: _____ TITLE: _____

Overall Performance Summary:

(Indicate recent performance including major accomplishments or performance issues.)

Key Strengths:

(List 2 - 3. Indicate key technical or professional competencies, skills, or knowledge the person has.)

Development Needs:

(List 2 or 3. Indicate key experiences, skills, or knowledge the person lacks in order to move to the next level.)

Development Actions:

1. On The Job: (What new responsibilities do you plan to assign to help this person develop this year?)

2. Special Assignment: (What task force, projects, or special assignments will be given this year to aid development?)

3. Training: (What specific training or seminars are recommended this year for his/her development?)

Potential For Promotion:

(Indicate this persons readiness to be promoted to the next organizational level.)

- Ready now for the next level.
- Ready in the next 24 months.
- Ready in 2 to 3 years.

Recommended Next Position: *(List the next assignment that would most benefit the individual in his/her development.)*

APPENDIX 3:

REFERENCE ON PAGE 28 FROM THE ARTICLE:

MOTIVATING STAFF TO IMPROVE THE MEDICATION SAFETY PROCESS

