capital for investments in electronic health records, other technologies, and equipment replacements. Potential breakthroughs in genomics may result in the need for investments in new modes of diagnosis and treatment. There will be renewed interest in finding opportunities for meaningful hospital roles in wellness and population health. However, hospitals must not allow planning for the future to become a distraction to their immediate patient care priorities.

Quality, safety, and service. In the case of Baylor Health Care System, the specific issues to be addressed are how to (1) balance value-oriented services with the organizational requirement to grow, (2) become more clinically and strategically integrated across patient care populations, (3) strike a balance between patient satisfaction and service orientation, (4) become a more-accountable health organization, (5) use information technology more effectively to foster continuity of care, including beyond the hospital walls (total care integration), and (6) be an attractive place for physicians, nurses, and pharmacists to practice.

Pharmacist leadership. Hospitals will continue to need pharmacy leaders who focus on integrating the pharmacy enterprise with their institution’s overall mission. Pharmacists will have other professional opportunities, including leading chronic care teams, wellness accountability counseling groups, and genomics and targeted science research and development.

Health-system pharmacy’s imperative for practice model change

Redefining care models for pharmacists will not happen if we continue to simply do more of what we have been doing and deploying our scarce resources in the same way. It is time to be bold and forceful in our actions.

Given our franchise, we have an ethical and moral responsibility to maintain our knowledge and apply it on behalf of patients. And we must care for the franchise lest it be taken from us.

The third driver is the “doctrine of being your brothers’ and sisters’ keeper.” Pharmacists are expected to help protect patients from potential and preventable adverse drug events. Logically, this includes warning patients about potential adverse events. The legal term applicable to such professional behavior is “learned intermediary.” In litigation about whether pharmacists have a duty to warn patients about potential adverse effects, the courts have generally held that only physicians are accountable as learned intermediaries. However, it seems reasonable to anticipate that pharmacists in hospitals and health systems who care directly for patients will be found by future courts to be functioning as learned intermediaries.

The fourth driver is our professional covenant. We are subject to the ethical imperative passed down by Hippocrates: not just to do no harm, but to continuously strive to do only good. This is not always easy to do, as our profession is constantly tested by forces that focus on profit, speed, and corporate growth.

Collaboration. As we create new practice models, we must consider...
Implementing practice model change:
Opportunities and challenges in a changing environment

BILLY WOODWARD

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Over the past 50 years, hospital and health-system pharmacy has been on an evolutionary spiral, moving continuously toward greater accountability for patient safety and optimum outcomes from the use of medicines. These advances occurred through the application of three facets of leadership—the same elements that the Institute for Healthcare Improvement (IHI) has identified as keys to improving health care:

- Will—necessary change supported by professional leadership with courage and commitment,
- Ideas—shared vision for improvement, combining new thinking with creativity, innovation, and enthusiasm, and
- Execution—combining process change with logical use of technology, along with organizational skills to make change happen. (This is usually the most challenging aspect of fostering change.)

Pharmacy’s scorecard. We have made progress in some areas of practice and have struggled in others. Here is how I would score our performance:

- Patient-specific drug distribution: A
- Unit dose drug distribution: A–
- Drug-use control: B
- Drug information services: A–
- I.V. admixture services: A–
- Clinical practice: globally, C; selected areas and patients, A+
- Pharmaceutical care: implementation, C–; rhetoric, A+
- Medication safety: related to product handling, B–; related to clinical care, C–

Lessons from IHI. IHI teaches that neither single nor multiple proj-