

Let me start by saying that I am deeply humbled and honored to have been chosen to receive the Dorothy Dillon Award. I did not have the opportunity to know Dorothy but word on the street is that she was one heck of a pharmacist. She was one of the founding members of NMSHP, though at that time it was called the New Mexico chapter of the American Association of Hospital Pharmacists. I found a description of Dorothy in an old NMSHP Pager and it said “She dealt with the same problems we have today and faced them head on, using the skills that served her so well throughout her career: vision, leadership, innovation, compassion, commitment, a willingness to take risks, being a teacher/mentor, and the ability to extend a gentle guiding hand to others.” I must admit that I feel a bit like Wayne and Garth in saying “I’m not worthy, I’m not worthy!” However, it fills me with great pride to be recognized by past award winners, John Hutchinson, Christy Vigil, and Tamara Daniel whom I have the utmost respect for as they truly embody the qualities that this award represents.

I would like to begin by telling you just a bit about myself and how I ended up at the University of New Mexico (UNM). I received my Bachelors of Science (B.S.) in Biology from UNM in 1988 and another B.S. degree in Pharmacy from UNM in 1991. I then moved to Texas to embark on my career as a hospital pharmacist at Scott and White Hospital in Temple. I picked Texas because I knew I wanted to get my PharmD degree and I was counseled by the clinical faculty at UNM that the University of Texas was one of the best programs in the country, but first I wanted to obtain some practice experience. At Scott and White, I was placed in a patient care pharmacist position and loved my job. However, after two years I realized that it was time to go back to get the PharmD. So I applied and was accepted into the University of Texas (UT) Doctor of Pharmacy program. During the first day of the program we were asked to introduce ourselves and to state where we saw ourselves practicing following the program. One by one my classmates indicated that they wanted to practice in academia. Then when it was my turn, I stated that I wanted to practice ambulatory care in the “real world” and not in an academic setting. After I finished my degree, I completed a two-year residency in Pharmacotherapy and Primary Care at the University of Texas Health Sciences Center and the South Texas Veteran’s Administration Hospital. It was during my residency (1995 – 1997) when I heard the news that New Mexico had passed a new law allowing specially trained pharmacists, called pharmacist clinicians to prescribe under a protocol. I knew right then and there that I wanted to get back to NM so that I could become a pharmacist clinician (PhC). At that time, I saw prescriptive authority as the rate-limiting step to providing pharmaceutical care in the ambulatory setting.

When my wife and I were both finished with our graduate training, the time had come to return to NM. So naturally, I took a position in of all places...academia...at the University of New Mexico COP. I should have listened to Casey Stengel who once said: “Never make predictions, especially about the future.” My initial position at the College was to help facilitate the development of clinical pharmacy practice in the community pharmacy setting. I took the position, because, while I was not directly working in the “real world”, I saw it as an opportunity to help develop “real world” clinical sites. It was in this role that I met many wonderful, bright, and motivated pharmacists. Together we began providing medication therapy management to patients before we knew it was

called medication therapy management (MTM). It was quite rewarding as the patients were extremely pleased with the education that we were providing them and some were even willing to pay. Unfortunately, I soon realized that the major hurdle to developing clinical pharmacy practice in the “real world” was reimbursement. And without consistent payment it was difficult for the community pharmacists to justify their time providing MTM. After meeting with several insurance plans, it was obvious that without federal recognition as a healthcare provider for Medicare, Part B, the plans would be unlikely to recognize pharmacists as providers. Ever since, federal provider status under Medicare, Part B has become my windmill to joust.

Physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, psychologists, and social workers are all considered healthcare providers by the Social Security Act and yet we (pharmacists) are not.<sup>1</sup> I believe that lack of Federal recognition as a healthcare provider is the single most important issue facing our profession today. Why do I believe this? We have advanced far as a clinical profession since adopting in the early 90’s the delivery of pharmaceutical care, as coined by Hepler and Strand, as the mission of pharmacy.<sup>2</sup> The Doctor of Pharmacy degree is now the entry level degree and is offered by 115 accredited colleges and schools of pharmacy.<sup>3</sup> There are now over 1,900 PGY1 residency positions available and while this represents an increase, unfortunately (or perhaps fortunately) demand is exceeding supply as over 1,000 resident applicants went unmatched this last year.<sup>4</sup> Simultaneously, technology and innovation in distribution, such as central fill, e-prescribing, and greater utilization of administrative personnel to deal with adjudication and formulary issues will decrease the need for pharmacists in primarily distributive positions. This all means that our profession is ready to break away from our ties to product (drugs) and allow pharmacists to do what they are trained to do, which is to provide direct patient care services such as MTM and medication reconciliation. The Pharmacy Manpower Project has estimated that by 2020 the number of pharmacists required for order fulfillment will decrease by some 35,000; however, the number of pharmacists needed to provide primary care pharmacy services will increase by 135,000.<sup>5</sup> We have increased the capacity at the college and school of pharmacy level to meet this increased demand; however, we have not yet provided the mechanism for pharmacists to be able to step away from distribution and step toward delivery of direct patient pharmaceutical care. Only provider status under Medicare B and likely other payment mechanisms such as for MTM will facilitate this movement.

Some of you may know the MAD magazine cover boy, Alfred E. Newman whose face has graced the majority of covers since the 1950’s. Well Alfred E. Newman is not just another pretty face, he is also a part-time philosopher and he once said, “***Most people are too lazy to open the door when opportunity knocks.***” Let me repeat that, “***Most people are too lazy to open the door when opportunity knocks.***” Well guess what folks? With the passage of the historic Patient Protection and Affordable Care Act (PPACA) this past March, opportunity is a knock’in.<sup>6</sup> A quick word search of the 906 page document reveals that the word ‘pharmacist’ appears 19 times while nurse practitioners (NPs), and physician assistants (PAs) are mentioned 35 and 43 times, respectively. While I am disappointed that we were not thought of as often as NPs and

PAs, consider that the other non-physician providers under Medicare B (social workers and psychologists) are mentioned 14 times collectively. I have heard from others that it's not the size that matters anyway, it's the quality. And there are some exciting opportunities in the PPACA for pharmacists and specifically health-system pharmacists that I hope you are willing to open the door for and they are as follows<sup>7</sup>:

**1. MTM Grant Programs.** The new law establishes a stand-alone grant program to ensure pharmacist-provided MTM services. The grant program will provide for testing of practice and care delivery models, such as patient-centered self-management programs, that improve patient outcomes through team-based collaborations between prescribers and pharmacists. Providing MTM for inpatients, clinic patients, home care, and long term care facility patients with complex or high-risk medication regimens is consistent with ASHP 2015 goals and should be something that we are all striving for. To facilitate pharmacists and 3<sup>rd</sup> party payers' participation in MTM programs, our organizations need to develop standardized MTM training programs and a recognized credentialing process. These programs should be multi-tier to provide for the various levels of MTM, from drug regimen review to PhC provided disease-state management (DSM). Not all pharmacists want to or are trained to provide DSM, but all pharmacists should be able to provide some level of MTM. I envision a day when pharmacists refer patients to other pharmacists for various levels of specialized MTM services.

**2. Integrated Care Models.** The law also includes provisions to ensure that providers with expertise in pharmacotherapy, including pharmacists, are fully engaged in integrated, collaborative, team-based approaches to delivering care, including medical homes, accountable care organizations, community health teams, and home-based chronic care programs. These models are perfect opportunities for pharmacists to provide care in. If you become aware of any of these models, such as the medical home, being developed at your health-system, make sure that pharmacists have a room or at least a cot.

**3. Transitional Care Activities.** The law recognizes the gaps in care coordination and communication that often occur when patients are transferred from one care setting to another. We all know that inappropriate medication use is a leading cause of hospital readmissions. Inclusion of pharmacists in transitional care activities should lead to the prevention of these events. Transitional care activities include medication reconciliation, creation and provision of personal medication records, and discharge planning that may include MTM services. I believe that health-system pharmacists need to take ownership of the medication reconciliation process as our training uniquely suits us for this role. It is exciting to see NM pharmacists such as John Hutchinson (with Holy Cross Hospital) and Jake Mossman (with Taos Community Pharmacy) creating an innovative medication reconciliation model that facilitates the transition back and forth between the hospital and outpatient setting. Advances in health information technology are going to be critical for the improvements needed in transition of care. HIT provides another opportunity for pharmacists who are typically already IT savvy.

**4. Workforce.** The law establishes a National Health Care Workforce Commission that will study health care workforce supply issues and make recommendations to Congress.

Just last week, the Government Accountability Office (GAO) announced the appointment of 15 members to the new National Health Care Workforce Commission. And among the appointees is a pharmacy faculty member Dr. Brian J. Isetts at the University of Minnesota College of Pharmacy. What can you do? An increase in advanced practice opportunities is going to require an adequately trained and prepared pharmacist workforce. So you can help by serving as a faculty preceptor. You provide pharmacy students with a unique practice setting in which they can learn. They will learn from you and in many instances you can learn from them. Additionally, you can help to increase the number of residency positions available. If your hospital already has an accredited pharmacy practice residency, see about adding an additional 1 or 2 residents. If your hospital does not have a residency, talk to the hospitals that do and utilize all the residency accreditation materials available on the ASHP website.<sup>8</sup> A pharmacy resident can be utilized to help expand or even initiate MTM, transitions of care, and integrated care services.

So that is an overview of opportunities that are knocking with the PPACA.

**Now what about the big kahuna, Medicare B?** Well, once again opportunity is knocking. Last spring, Representative Martin Heinrich introduced H.R. 5389, the **“Medicare Clinical Pharmacist Practitioner Services Coverage Act of 2010”**. This bill would recognize pharmacist clinicians and clinical pharmacist practitioners as providers under Medicare, Part B. The passage of the PPACA, among other things, increases the number of insured Americans by 32 million. While a potentially good thing, the greater number of insured will increase the demand on the already limited primary provider system. The Association of American Medical Colleges Center for Workforce Studies recently released new estimates that report between now and 2015, which is the year after health care reforms are scheduled to take effect, the shortage of doctors across all specialties will quadruple to a shortage of 63,000 physicians, with a worsening of shortages through the year 2025.<sup>9</sup> Once again, I hear opportunity knocking!

If H.R. 5389 is passed into law, primary care pharmacists would be able to help ease the shortage by offloading patients with chronic disease states allowing primary care providers to see more acute cases while expanding their patient panel. ASHP has written a letter of support for this legislation but we need all of our organizations to openly voice support. So what can you do? If you are a member of ACCP, APhA, ASCP, AACP, AMCP, NACDS, or NCPA, contact that organizations Legislative Affairs Director and urge that organizations support. If you know someone in a position of leadership in one of these organizations, call on them and urge their support. Remind them that there are 46 states with collaborative drug practice acts and if this legislation is passed that the other 43 states could modify their practice acts so that they would qualify under the legislation. And please support legislators that have been supportive of improving health care and advancing pharmacy practice.

I have taken up way too much time. So I would like to conclude by thanking several special people. First and foremost, I would like to thank my wife, Veronica, and my children Luke and Sophia. They have been so very patient and understanding when I

am working late, or am away from home for meetings or attending health fairs. They are truly my inspiration and I love them with all of my heart. Second, I want to thank my fellow provider status jousters, Dr. Melanie Dodd, Dr. Ernie Dole, and Mr. Dale Tinker. We serve as a support group so that with each lost provider status battle we can pick each other up and ready ourselves to win the war. I would like to leave you with these words from the famous knight, Sir Paul McCartney, who sang: "Someone's knocking at the door, somebody's ringing the bell, do me a favor, open the door and let 'em in."

Thank you for your time.

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