AACP REPORTS

Report of the 2013-2014 AACP Standing Committee on Advocacy: Improving Advocacy through the Use of Implementation Science Concepts and Frameworks

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INTRODUCTION

According to the Bylaws of the American Association of Colleges of Pharmacy (AACP), the Advocacy Committee: *“will advise the Board of Directors on the formation of positions on matters of public policy and on strategies to advance those positions to the public and private sectors on behalf of academic pharmacy.”*

PRESIDENTIAL CHARGE

President Peggy Piascik charged the standing committee on Advocacy with the following charge: *“Working synergistically with the Research and Graduate Affairs Committee and building on President Bootman’s Advocacy Committee work, the Advocacy Committee, led by Hershey Bell, Lake Erie College of Osteopathic Medicine, will use 3 working groups to develop issues briefs in the areas of wellness and health promotion, community engagement, and the scholarship of engagement. The issue briefs will provide a statement of each topic’s benefit to the public and recommendations for action by local, state, and federal agencies.”*

Selection and Development of AACP public policy priorities: A sustainable approach for advocacy

Academic experts continue to rank high among policy makers, including congressional staff as sources of trustworthy information.¹ AACP efforts to educate policy makers about issues of importance to academic pharmacy are therefore enhanced when they are developed using the content expertise of our members. The 2013-2014 standing committee on Advocacy continued the process developed by the 2012-2013 committee: *“The creation of issue-specific workgroups is a strategy to improve AACP’s capacity to proactively engage in public policy development and implementation. The expertise of each workgroup*

assists AACP in the development of strategies to enhance communications to and from AACP members on priority issues. The list of priority issues was established through AACP leaders and staff input and in alignment with the AACP policy framework. The rationale for such action is to:

- ensure that AACP advocacy is aligned with organizational priorities;
- engage more AACP members in the identification and articulation of AACP public policy positions;
- increase AACP member awareness of AACP organizational activity related to public policy development and implementation; and
- provide AACP members and staff with evidence-based policy/issue briefs to support effective organizational, institutional, professional, and individual advocacy. “

Participation in the priority-issue workgroups was solicited from the AACP membership in a series of emails and to the attendees of the 2013 AACP annual meeting. AACP members with content expertise relevant to the priority issues were asked to submit their interest to AACP staff.

President Piascik asked the advocacy committee to consider three priority issues: community engagement; scholarship of community engagement; and wellness and health promotion. The following rationale for including these three issue areas was shared by President Piascik with the committee.

Community Engagement

“In the 1980’s, a community engagement movement began to emerge in higher education, asserting that a goal of the American university should be to restore its original purpose, that of preparing graduates for a life of involved and committed citizenship.”² The current atmosphere of

greater accountability in higher education includes calls for an engaged university. For health professions schools there are many opportunities in health care reform and funding available from agencies such as the Patient Centered Outcomes Research Institute (PCORI). Academic pharmacy schools and faculty are perfectly poised to participate meaningfully in this effort and have done so for many years. Community engaged service is a valuable contributor to addressing critical public health issues. "While an area of emphasis for many universities or schools of pharmacy, many pharmacists are also actively engaged in this work. This may be via initiatives emanating from their practice or through collaborations with community-based organizations with service missions with which they hold a personal affinity." The public and policymakers need to be educated to the value of pharmacists, in academic settings as well as community-based practice, in contributing to the health of our citizens via community engagement.

Scholarship of Community Engagement

Community-engaged scholarship is "teaching, discovery, integration, application and engagement that involves the faculty member in a mutually beneficial partnership with the community and has the following characteristics: clear goals, adequate preparation, appropriate methods, significant results, effective presentation, reflective critique, rigor and peer-review."³ In other words, it goes beyond merely providing service to the community, but also involves addressing public health issues in a scholarly manner. This also requires sharing the results obtained via publishing and presenting the results. The ability to engage with the community in this manner is unique to higher education. The public and policymakers need to be educated to the value of academic pharmacy's community-engaged scholarship and the need for continued/expanded funding to these efforts that may improve the health of citizens.

Wellness and Health Promotion

According to Giberson et al., "chronic diseases are the leading causes of death and disability in the United States. Chronic diseases currently affect 45 percent of the population (133 million Americans), account for 81 percent of all hospital admissions, 91 percent of all prescriptions filled, 76 percent of physician visits, and continues to grow at dramatic rates. These numbers are daunting. Quality medical care for people with chronic conditions requires a new orientation toward prevention of multiple chronic disease conditions, and provision of ongoing care and care management to maintain their health status and

functioning."⁴ Community pharmacists are well positioned to provide preventive care including health screenings, immunizations, and lifestyle modifications. Contemporary curricula prepare pharmacists to work effectively with patients in wellness and health promotion efforts. Given the focus on these topics in health care reform, the public and policymakers need to be educated to the value of pharmacists in providing these services in a convenient, cost-effective manner.

Chair Bell identified and contacted a leader for each of the three workgroups. As was expected of the 2012-2013 workgroup leads this year's leaders were asked to ensure their capacity to:

- Serve as an issue expert for the workgroup;
- Directly communicate with the Advocacy Committee Chair and staff liaison to ensure the workgroup stays on and completes tasks according to timelines and deadlines;
- Participate in monthly conference calls with other workgroup leads to present workgroup progress, identify challenges and present recommended solutions;
- Provide input and accept responsibility for the workgroup's work;
- Establish a schedule for the workgroups consideration, production and completion of its work; and
- Contribute to the success of the workgroup including the completion of required documents prior to the final deadline.

Individual workgroup members were contacted to verify the interest they had expressed earlier and commit to:

- Serving as an issue expert for the workgroup;
- Directly communicating with the workgroup leader to ensure the workgroup stays on and completes tasks according to timelines and deadlines;
- Providing input and accepting responsibility for the workgroup's work;
- Providing input into the establishment of the schedule for the workgroups consideration, production and completion of its work; and
- Contributing to the success of the workgroup including the completion of required documents prior to the final deadline.

Members of the advocacy committee served as leads for one of the three workgroups. Chair Bell, the AACP staff liaison and the workgroup leads met face-to-face in October, 2013 during the meeting of AACP standing committees. The committee discussed the technical aspects of the report and workgroup deliverables as well as the basic constructs of implementation science that would ground and influence their work.

"The application of interventions that improve health, including clinical interventions, can take 17 years after discovery." -

*Translating Scientific Discoveries into Public Health Action: How Can Schools of Public Health Move Us Forward?*⁵

The Advocacy Committee also met with the members of the Research and Graduate Education Committee to discuss common aspects of each committee's work.

After an organizing webinar that provided general directions for all the workgroups, each of the workgroups met via conference call, usually on a monthly basis. Workgroup leads met via conference calls, usually monthly, to discuss their workgroup progress with the Chair. All workgroup members were invited to participate in a webinar in which the Advocacy Committee members (Chair and workgroup leads) described the workgroup expectations, deliverables, process and timeline.

Considering the need to continually improve AACP advocacy tools and resources and their utility to AACP members, stakeholder and policymakers, Chair Bell focused the committee and workgroups on the following anticipated outcomes of their work:

- Describe the current strengths of the academy in regard to development and use of effective, evidence-based interventions;
- Describe alignment of those strengths with public policy initiatives;
- Describe areas of needed improvement in regard to the utility of and evidence associated with specific interventions- thus establishing a research agenda to improve areas where we are not as strong; and
- Support AACP staff development of advocacy materials that can support members in their advocacy efforts as necessary.

Implementation science concepts as a unifying framework for member engagement to support AACP advocacy activities

The United States spends billions of dollars annually in the pursuit of new knowledge across a wide range of disciplines. The National Institutes of Health, the premier agency for biomedical research, funds nearly \$30 billion of competitive research grants annually. The National Science Foundation funds nearly \$7 billion of research annually that includes competitive grants for social, behavioral and economic science research. The evidence generated from this research informs the development of evidence-based and science-based services and programs such as guidelines from the US Preventive Services

"Over the last 20 years, there has been a growing emphasis on developing and identifying evidence-based programs and practices for children and families and within the last decade an increasing number of federally funded initiatives have been dedicated to replicating and scaling evidence-based programs with the hope of achieving socially meaningful impact. However, only recently have efforts to promote high-fidelity implementation been given the attention needed to ensure evidence-based practices are used as intended and generate the outcomes they were designed to produce. In this article, we propose that the wide-scale implementation of evidence-based practices requires: (1) careful assessment and selection of the "what"; (2) a stage-based approach that provides adequate time and resources for planning and installation activities; (3) the co-creation of a visible infrastructure by a triad of key stakeholders including funders and policymakers, program developers, and implementing sites; and (4) the use of data to guide decision-making and foster curiosity into continuous improvement among grantees. Each of these strategies is explored in greater detail through the lens of the Teen Pregnancy Prevention (TPP) Program, a \$100 million initiative overseen by the Office of Adolescent Health (OAH) in the U.S. Department of Health and Human Services." - What Does It Take? How Federal Initiatives Can Support the Implementation of Evidence-Based Programs to Improve Outcomes for Adolescents.⁶

Task Force, the Community Preventive Services Task Force and clinical and community-based prevention programs developed at the Centers for Disease Control and Prevention.

In an era of constrained resources at the federal and state level, it becomes challenging to seek additional funding to support new knowledge development when current knowledge is used ineffectively or inefficiently. Policy makers challenge advocates by asking: 'How do we maximize the use of current knowledge so that our needs for new knowledge can be better defined and targeted?' Another challenge is: 'How can we improve the diffusion of current knowledge in the form of evidence-based interventions across communities, populations and individuals?' An approach to addressing these challenges is through a process improvement framework known as implementation science.

Federal interest in implementation science

Improving the application of evidence-based interventions (EBI) is becoming a priority of federal agencies. In a brief published by the US Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation the need for improving not only the use of EBIs, but more fully articulating the program components that are critical for that intervention reaching the intended outcome are highlighted.⁸ Similar interest in improving the efficient and effective use of new knowledge is reflected in the activities of specific federal agencies within HHS such as the National Institutes of Health and the Centers for Disease Control and Prevention.^{9,10,11}

"Effective program implementation must be multidisciplinary," said Fogarty Director Dr. Roger I. Glass. "We need to think with an open mind how to make these programs work. We've seen lots of money for activities, but our programs are not as effective as they could be. In every realm of interventions, we have lots of knowledge that isn't applied." - Global Health Matters Newsletter. ⁷

"Rather than being based on hunches and best guesses, intervention programs are increasingly expected to be evidence-based. However, when evidence-based programs are replicated or scaled up, it is critical not only to know whether a program works, but which program elements are essential in making the program successful. To date, though, few programs have had hard data about which program features are critical—core components-- and which features can be adapted without jeopardizing outcomes." - ASPE Research Brief, February 2013⁸

Determining institutional ability to implement interventions

Defining Context

Interventions alone are not sufficient to increase their effective and efficient use. The intervention must match the needs and expectations of the organization. Therefore an institution must define the context in which the intervention matches those needs and expectations. The compelling reason or context must be well articulated by the organization as it provides the vision and starting point for successful implementation. For each of the three priority issues, President Piascik presented a compelling reason - defined the context- for the installation of those issues within academic pharmacy.

Even when the context is well described and valid, other elements may come into play that must be identified and resolved so successful implementation can proceed. One framework for identifying these elements is the Hexagon Tool. This tool consists of six elements- capacity, need, fit, resources, evidence, readiness- that an organization can use to evaluate whether the selected intervention can successfully be implemented by the organization. Should the organization be unable to meet any of the six elements it might be appropriate to consider 1) how the organization can leverage resources to meet the element or 2) whether there are other interventions that the organization can successfully implement.¹²

Defining Core Intervention Components

A critical element of the effective implementation of evidence-based interventions is the complete description of all the elements essential for reaching the expected outcome. These essential elements are referred to as core components or core elements. While there may be components that are amenable to adaptation to local situations it is likely that the identified core components of an intervention must be present and must be sequenced in a consistent manner to reach the expected outcome.

Critical gaps exist in communicating the essential elements or core components necessary for successful intervention implementation. One gap is the lack of clear articulation of the critical- components that must be in place and how these components must be sequenced so that the intervention's expected outcome is achieved.

Currently, published articles and reports provide evidence of impact (expected outcome) but little knowledge about *how* that outcome was achieved and which activities were most important in that achievement. There is evidence that something works, but not enough evidence about what makes it work.

Describing core components for each of the three priority areas

Community Engagement

Table 1 depicts the core components deemed necessary in any successful community engagement program. The components were derived by the workgroup from the following sources:

1. Criteria from the Carnegie Foundation for the Advancement of Teaching designation for community engagement^{19,20}
2. Principles of partnerships adopted by Community-Campus Partnerships for Health (CCPH)²¹
3. Interviews conducted by members of the 2013-2014 AACP Advocacy Workgroup on Community Engagement with seven colleges/schools of pharmacy
4. Review of application packets submitted by winners of the American Association of Colleges of Pharmacy Lawrence C. Weaver Transformative Community Service Award

The key component to any successful community engagement program is a sustained ***culture of community-engaged service*** throughout an institution and/or organization (Table 1). Indicators of commitment to service include: 1) alignment of service activities with the mission statement of an institution and profession-specific program; 2) visible support by the upper levels of administration including the president, provost and deans; and 3) recognition and celebration of commitment and dedication to serving the community. A pervasive culture of service requires three core components for sustainability: 1) mechanisms that facilitate engagement; 2) sufficient level of personnel support; and 3) strong partnerships between communities and the university and/or pharmacy program. Specific criteria for each of these three core

Examples of interventions that describe the sequencing of core components:

AHRQ Team STEPPS 2.0¹³
AHRQ Quality Indicators™ Toolkit for Hospitals¹⁴
AHRQ Re-engineered Discharge Toolkit¹⁵

components are listed in Table 1. Success of a community engagement program requires appropriate assessment of service activities, including level of engagement and impact on communities, teaching, learning, and scholarship.²² Existing programs require periodic assessment to ensure relevancy of activities in relation to community need and quality improvement.²³

Scholarship of Community Engagement

As outlined by AACP President Peggy Piascik when establishing the workgroup on the Scholarship of community Engagement and as outlined on the Community Campus Partnership for Health website, the characteristics of community engaged scholarship (CES) are: clear goals, adequate preparation, appropriate methods, significant results, effective presentation, reflective critique, rigor and peer review.

After a thorough review of the literature and best practices, the workgroup agreed these characteristics align well with the six standards of scholarly work outlined by Charles Glassick, et al.²⁴ The workgroup proposes that the six standards of scholarly work- clear goals, adequate preparation, appropriate methods, significant results, effective presentation, reflective critique- as the core components of CES.

Clear Goals –establish the need for the research by engaging the community. The scholar should assist in the identification of the gaps in the community that would drive this research? A community health needs assessment, focus groups or community advisory boards may help in identifying goals.

Adequate preparation –Building partnerships with the community may take a significant amount of time to build trust, which is critical to carrying out the research.

Appropriate methods – Community members are key to the design of methods specific for the community which may include cultural or social determinants that may impact the expected outcomes. The scholar should work to power the study for significance.

Significant results – Will the results impact the health of the community or provide a change in behavior? The results may be used to change policy on a local, regional or national level.

Effective presentation – The results of the research must be shared with the community to maintain trust and

"Notwithstanding the lack of current MTMP standards and performance measures, we believe that MTMP must evolve and become a cornerstone of the Medicare Prescription Drug Benefit." - Federal Register¹⁶

communication. The results must also be published in a peer-reviewed journal which may include a research journal less familiar to faculty in an academic pharmacy institution.

Reflective critique – Limitations of the research must be identified and shared with the community. The scholar should state whether the results inform the need for additional research.

Wellness and Prevention

Public health programs succeed and survive if organizations and coalitions address 6 key areas ("Frieden's six elements")²⁵ :

1. Innovation to develop the evidence base for action: Pharmacists-delivered medication therapy management (MTM) in collaboration with other primary care providers combined with innovations related to enhancing efficiencies in the healthcare system (e.g., information technology and reimbursement) as well as the public health system (e.g., health and wellness education) can improve and revolutionize both individual and population health especially in chronic diseases.

2. A technical package of a limited number of high-priority, evidence-based interventions that together will have a major impact:

Positive clinical evidence of medication therapy management (MTM) with respect to Patient-Centered Medical Home (PCMH) and Employer-based Pharmacist/Ambulist (EBPA) have been demonstrated and supports pharmacists in various interprofessional and collaborative team-based care roles.^{26,27} Significant improvements in therapeutic and safety outcomes, such as hemoglobin A1c, LDL cholesterol, blood pressure, and adverse drug events, further supports the effectiveness of pharmacist in team-based patient care.²⁸ Thus, the technical package involves specific activities related to MTM delivered thorough PCMH and EBPA.

3. Effective performance management, especially through rigorous, real-time monitoring, evaluation, and program improvement:

Valid and reliable metric in economic analysis and pharmacoeconomics (e.g., return on investment, cost-effectiveness analysis and cost-benefit analysis) will be implemented to monitor, evaluate, and continuously improve activities related to MTM, PCMH and EBPA. In addition, operations management technique, such as Lean

"...publication to date has usually been restricted to the final reporting of studies with little or no opportunity to describe the important contextual, developmental and supporting work that would allow for a better interpretation of results and enhance the likelihood of successful replication of an intervention." - *Welcome to Implementation Science*.¹⁷

Six Sigma and total quality improvement (TQM) tools, will be employed.

4. Partnerships and coalitions with public- and private-sector organizations:

Partnerships and coalition-building with the private sector as well all levels of the public sector (local, state, and federal) will drive the importance of pharmacist-delivered MTM, enhance pharmacists role in collaborative team-based care, as well as demonstrate the public health importance of pharmacists in many health and wellness activities.²⁹ Specific partnerships to establish include the American Public Health Association and Healthy-People 2020.

5. Communication of accurate and timely information to the health care community, decision makers, and the public to effect behavior change and engage civil society:

The socio-ecological model along with other media and advocacy tools will help frame the communication of information.³⁰

1. Public policy: Public opinion process and policy changes can change the incentives for certain behaviors.
2. Community: Social marketing and community organizing can change community norms on behavior.
3. Organizations: Behavior can be influenced through organizational change and social marketing strategies.
4. Interpersonal: Family, friends, and peers provide role models, social identity, and support.
5. Individual: Knowledge is necessary but not sufficient to produce most behavioral changes.
6. Political commitment to obtain resources and support for effective action. AACP and key stakeholders will develop the political commitment to obtain resources and support for effective action.

Identification of advocacy action points

Successful intervention development and implementing that intervention with fidelity generally proceed

"The conclusions of the authors were mostly positive – MTM services improved outcomes. Common limitations addressed by researchers were: limited generalizability; small sample size; non-randomized study method, difficulty in identifying what part of the program had the most benefit (e.g. education versus counseling), and missing data." - *A Review of Outcomes Associated with Medication Therapy Management (MTM) Programs*.¹⁸

in regular order. A need is identified for the development of an intervention that addresses a particular issue of public interest and for which a socially acceptable outcome is desired. Evidence is gathered that a particular approach or intervention leads to that desired outcome. The intervention is tested to determine the sequencing of actions that lead to that outcome. If successful, the intervention becomes part of a guideline or program component focused on the target of the intervention.

Likewise, implementation of the intervention is a similarly sequenced process. Individuals and organizations explore the potential use of an intervention within a context they collectively describe. The intervention is installed and support structures, including ongoing evaluation, are put into place. A period of initial implementation is initiated with providers and recipients prepared to deliver and receive the intervention. Organizational structure may change as rapid-cycle quality improvement approaches provide an ongoing stream of information.

As implementation of the intervention is evaluated for fidelity in its delivery and whether the expected outcome is reached, data drives the increased use of the intervention across the organization. Each stage of intervention development and intervention implementation provides for the identification of advocacy action points. Identifying both successes and challenges to intervention development and implementation allows advocates to describe the need for a particular activity that must be supported or overcome for the intervention to be effectively implemented. Advocacy tools and resources are more efficiently developed and more effective since they are based on the success or challenges associated with the implementation of specific interventions. These resources can be shared with policy makers formally through issue briefs and white papers or informally during personal discussions. The following examples

provide a context for identifying the advocacy action points of intervention development and their successful implementation:

STAGES OF INTERVENTION DEVELOPMENT

Use of an *existing* evidence-based intervention developed by a *federal agency*:

- **Advocacy opportunity**- support the agency's continued development of interventions

Example-Use of team-based care to improve blood pressure control guidelines recommended by Community Preventive Services Task Force <http://www.thecommunityguide.org/cvd/teambasedcare.html>

Interventions *being developed* by a *federal agency* that benefit from academic input:

- **Advocacy opportunity**- support academic institutions knowledge and skills to improve federal intervention development

Example- Pharmacy faculty review high blood pressure protocols to determine best fit with Million Hearts criteria http://millionhearts.hhs.gov/Docs/MH_Protocol_Implementation.pdf

Interventions *being developed* by *academia* based on recommendations of federal agency reports, research agendas (fill gaps, better data, increase population impact, support interdisciplinary research platforms, etc.):

- **Advocacy opportunity**- support continued engagement of academia through grants provided through federal agency

Example- Pharmacy faculty participation in a broad array of federal grant supported activities that improve health, education, etc. (See in particular Faculty News in any edition of *Academic Pharmacy Now* <http://www.aacp.org/news/academicpharmnow/Pages/default.aspx>)

STAGES OF INTERVENTION IMPLEMENTATION

Exploring implementation of evidence-based intervention into institution/practice:

- **Advocacy opportunity**- support academic translation of federally developed/supported interventions into practice

Example- Integration of community partners into research agenda development of faculty participating in NIH supported Clinical and Translational Science Awards programs <http://www.ncats.nih.gov/research/cts/cts.html>

Installing the intervention into an institution/practice:

- **Advocacy opportunity**- support institutional and faculty development for consistent use of intervention

Example- Integration of Team-STEPPS as an inter-professional education strategy <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/index.html>

Initial implementation of intervention into institution/practice:

- **Advocacy opportunity**- continued support for institutional and faculty development for consistent use of intervention

Example- Curriculum mapping based on 2013 CAPE Outcomes to improve education quality <http://www.aacp.org/resources/education/cape/Open%20Access%20Documents/CAPEoutcomes2013.pdf>

Intervention is fully implemented into the institution/practice:

- **Advocacy opportunity**- commitment to continuous quality improvement based on use of effective evidence-based intervention needs recognition and support to maintain sustainability

Example- Use of rapid-cycle quality improvement strategy [Plan, Do, Study, Act] to improve patient safety in community health centers through the integration of a team-based approach to comprehensive pharmacy services. <http://www.hrsa.gov/communitiesofpractice/ata glance/patientsafety.pdf>

Tools such as the Hexagon Tool, allow organizations to determine what challenges, if any, might limit the organizations ability to successfully implement an intervention. The Hexagon Tool also provides organizations such as AACP to identify advocacy action points. The 2014 Advocacy Committee sought to identify advocacy action points regarding organizational ability to implement all three of the priority issues: community engagement; scholarship of community engagement; and wellness and prevention. A survey developed by the committee and administered through Survey Monkey was sent to the CEO Deans, Advocacy Committee and workgroup members and the Research and Graduate Affairs Committee to help in the identification of advocacy action points related to the six elements of the Hexagon Tool: capacity; relevance; need; fit; resources; and evidence.

WORKGROUP OUTCOMES

For each of the three priority issues identified by President Piascik, the respective workgroup was asked to respond to the following:

- Academic pharmacy's interest in the issue.
- Curricular as well as clinical interventions/activities associated with the issue.
- Academic alignment of one or two of these interventions with the core components defined by the workgroup.
- Institutional ability to effectively implement the intervention using the six elements presented in the Hexagon Tool
- Challenges to effective implementation and to provide a description of advocacy action points through issue briefs generated by AACP staff.

As mentioned earlier in this report, three workgroups, in order to address the three issues identified by President Piascik, selected one available implementation framework to identify and evaluate the barriers academic pharmacy faces in the successful implementation of interventions related to community engagement, the scholarship of community engagement and wellness and prevention.³¹ Each workgroup took a slightly different mixed methods approach that included surveys, structured interviews, literature reviews and personal experience to inform their identification of barriers to successful implementation of interventions. Identification of these barriers will provide the basis needed to engage public policy makers in discussions focused on effective implementation.

Community Engagement

Table 2 is a summary of findings from key informant interviews and review of applications to the Lawrence C.

Weaver Transformative Community Engagement Award (AACP), Student Community Engaged Service Award (AACP), and profiles of recent recipients of the American Pharmacist Association (APhA) Pinnacle Awards. Recognizing the limitations of their methodology the workgroup suggests that a sustained culture of community-engaged service is a primary driver of successful community engagement programs. Facilitating mechanisms found consistently across successful programs include organizational support of a central infrastructure, curricular engagement and active student organizations. Sufficient human resources that encompass faculty, students, residents, preceptors and other volunteers are essential to any successful program. Most programs also reported the importance of inter-professional collaborations as another key success factor. Institutions with dedicated staff support identify this human resource as extremely helpful in coordinating programmatic activities.

Table 2. Summary of Interviews and Review of Award Winners' Applications

Component	UMKC	UConn	USC	CU	UMinn	CalNST	UK	UMiss	UW
CULTURE									
Align with mission	+	+	+	+	+	+	/	+	+
Visible support	+	+	+	+	+	+	/	+	+
Recognize/celebrate	+	+	*	+	+	*	+	*	*
FACILIATING MECHANISMS									
Infrastructure	+	+	+	+	/	*	-	/	+
Curricular engagement	+	+	+	+	+	+	/	+	+
Student organizations	+	+	+	+	+	+	+	*	+
Skills development	/	*	/	/	/	/	-	*	*
Financial resource/ fundraising	+	/	/	/	/	-	-	+	/
P & T policies	*	-	*	+	+	*	-	*	*
HUMAN RESOURCES									
Faculty	+	+	+	+	+	+	/	+	+
Students	+	+	+	+	+	+	+	+	+
Staff	*	*	*	+	-	*	/	/	*
Volunteer preceptors	*	*	*	+	+	*	*	+	+
Pharmacy resident support	+	*	+	+	+	*	*	+	+
IP collaborations	+	+	*	+	+	+	*	+	+
STRONG PARTNERSHIPS									
Community-identified need	+	+	+	+	+	+	/	+	+
Community voice	/	+	+	+	+	+	/	+	+
University participation	/	+	+	+	+	+	-	+	+
Reciprocity	+	+	+	+	+	+	/	+	+
Commitment	+	+	+	+	+	+	-	+	+
Sustainability	+	+	+	+	+	*	-	+	+
IMPACT									
Measure level of engagement	+	*	+	+	+	*	-	+	+
Assessment impact	/	*	+	/	/	*	-	+	+
Process improvement	*	*	*	*	*	*	*	+	*

Legend: met criteria (+); not in place/did not meet criteria (-); met criteria for some activities (/); not assessed at interview or addressed in award application packet (*)

Successful programs build on the strengths and diversity of their community partners so that engagement activities are in response to community needs and concerns, and community partners have a voice in the development of activities. Commitment of faculty and their institutions is demonstrated when faculty actively participate in community meetings/coalitions and work collaboratively to find ways of sustaining activities and partnerships. Measuring the impact of activities at varying levels can lead to sustainability and continued relevancy of any community engagement program.

Through their interviews and application reviews the workgroup identified a number of barriers to successful community engagement. Lack of recognition for service activities in promotion and tenure policies is noted as a barrier to sustained engagement efforts despite faculty desire to serve. Lack of opportunities for skills-development may actually be a barrier, but the inconsistent finding may be due to the fact that no specific question was asked during the interviews about whether skills-training is provided for students, faculty, preceptors and other volunteers. From the survey the workgroup identified the lack of consistent financial support, including fundraising, as a major barrier to successful community engagement. The input leads the members of the workgroup to infer that greater support and guidance on measuring and evaluating the impact of community engagement among colleges and schools of pharmacy is needed to improve the likelihood of program sustainability and to collectively record the impact of academic pharmacy involvement in service.

The Hexagon Tool was applied in analyzing the current state of readiness for community engagement among colleges/schools of pharmacy in the United States. Findings from the workgroup support results from the national survey. A majority of colleges/schools of pharmacy agree on the following:

- **NEED:** There is a need for my college or school of pharmacy to implement initiatives in community engagement. [93% agree/strongly agree]
 - **FIT:** There is alignment between the values/priorities of my college or school of pharmacy and the values/priorities of my community to implement initiatives in community engagement. [91% agree/strong agree]
 - **EVIDENCE:** There is sufficient evidence to support the commitment of my college and school of pharmacy to the implementation of an initiative in community engagement. [92% agree/strongly agree]
- Discrepancies were noted for the following categories:
- **RESOURCES:** My college or school of pharmacy has sufficient resources to support implementation of an initiative in community engagement.

Resources may include curricula, technology, faculty and administrative support, faculty development, etc. [65% agree/strongly agree vs. 35% disagree/strongly disagree]

- **READINESS:** My college or school of pharmacy has identified the core components necessary to implement initiatives in community engagement. [69% agree/strongly agree vs. 31% disagree/strongly disagree]
- **CAPACITY:** There is sufficient qualified faculty/staff within my college or school of pharmacy to implement and sustain initiatives in community engagement. [58% agree/strongly agree vs. 42% disagree/strongly disagree]

Scholarship of Community Engagement

Community-engaged scholarship (CES) is the collaboration of academicians and community partners who use their skills and expertise to solve societal problems in order to generate, disseminate and apply new knowledge. What makes community engagement “scholarly” is that it combines the principles of community engagement and accepted standards of scholarship to impact future outcomes. The research is subject to peer review and should be replicable based on similar circumstances.

Using the Hexagon Tool as a tool to assess the ability of the colleges and schools of pharmacy to implement CES, a survey was prepared to collect data based on the six elements of the Hexagon Tool. The survey was sent to the CEO Deans of Colleges and Schools of pharmacy as well as members of the Advocacy Committee and respective workgroups- community engagement, scholarship of community engagement, and wellness and prevention. Questions 13-23 pertained to the scholarship of community engagement.

- There were 80 responses to the questions (34 from public institutions and 46 from private institutions). Ninety seven percent of public institutions and 96% of private institutions agreed that all academic pharmacy institutions have a responsibility to improve health at the community’s interface with the practice of pharmacy through scholarship.
- Ninety-four percent of respondents from public and 95% of respondents from private schools indicated that there is a need for their college or school to implement initiatives to promote CES.
- Seventy-six percent of respondents from public institutions and 84% of respondents from private schools indicated that there is an alignment between the values/priorities of their college and the values/priorities of the community to implement initiatives to promote CES.

- With respect to resources, 44% of respondents from public institutions and 35% of respondents from private schools say they lack sufficient resources to support the implementation of initiatives to promote CES.
- Although over 90% of all respondents replied that there is a need to implement initiatives to promote CES, 20% of respondents from public and 22% of respondents from private schools said there is not sufficient evidence to support commitment of their colleges to the implementation these initiatives.
- Twenty-one percent of respondents from public and 45% of respondents from private schools said that the school has identified the core components necessary to implement initiatives to promote CES.
- Thirty-five percent of respondents from public and 45% of respondents from private institutions say they lack sufficient qualified faculty/staff to implement and sustain initiatives in promoting CES.

When asked about the strategies necessary to build a program of CES, respondents from the public institutions indicated the acquisition of extramural funding resources (41%) as the number one need with the development of one or more faculty positions focused on CES as second at 26%. Respondents from private institutions indicated the development of new partnerships with external organizations interested in collaborating on projects of CES as the number one strategy at 26%. However, extramural funding resources were the second strategy at 23% along with more faculty positions focused on CES (23%). The development of the necessary skills required to participate in CES was third at 12%. Overwhelmingly, the greatest barrier to CES identified by respondents of both public and private institutions was a scarcity of resources followed by the lack of capability.

Gelman, Jordan and Seifer in their action agenda identified why the scholarship of community engagement is important to higher education and the current challenges related to this type of scholarship.³² There is an increasing expectation that universities must play a key role in addressing the problems of our communities. The scholarship of community engagement helps meet that expectation as it prepares students and faculty for democratic citizenship through their involvement with community-informed decision making. The scholarship of community engagement provides the knowledge base practitioners, policymakers, community leaders and the public can use to shape legislation, rules and regulations. It is the impression of the workgroup that the scholarship of community engagement will continue to become more valuable to our communities given the continued complexity

of challenges in our communities in a time of declining fiscal resources.

Academic pharmacy is and must be a key player in the scholarship of community engagement given the focus of our practice in community and institutional-based pharmacy. The profession has evolved from its traditional dispensing role to an enhanced scope of practice involving specialty pharmacies, innovative new drug delivery systems, immunizations, medication therapy management and collaborative drug therapy management. With each of these areas, there are new questions being raised related to interprofessional patient-centered care involving pharmacists practicing in our communities. Many of the answers to these questions will involve collaboration between faculty and students and community stakeholders.

Based on the survey results, the academy must advocate for the resources (fiscal as well as human) necessary to implement CES. Institutional leaders must recognize that research that involves the community can be “scholarly” and meet the criteria necessary for peer review in the tenure process. Finally members of the Academy must recognize that there is sufficient evidence to support the need for CES and the impact that it may have on the overall health of the community or policies that impact their health.

Wellness and Prevention

The pharmacist’s role is expanding beyond the traditional product-oriented functions of dispensing and distributing medicines and health supplies. The pharmacist’s services of today include more patient-oriented, administrative and public health functions. There are many functions in public health that can benefit from pharmacists’ unique expertise that may include pharmacotherapy, access to care, and prevention services. Apart from dispensing medicine, pharmacists are an accessible resource for health and medication information. The pharmacist’s centralized placement in the community and their clinical expertise are invaluable. The reexamination and integration of public health practice into pharmacological training and pharmaceutical care is essential. The encouragement of cross-training will also maximize resources and aid in addressing the work force needs within the fields of pharmacy and public health.³³

The movement towards wellness and prevention is an overarching intent of the Patient Protection and Affordable Care Act (PPACA) and provides an opportunity for both academic and professional pharmacy to shine. Coupling this intent with Medicare payment for these services establishes opportunities for pharmacist-delivered wellness and prevention services. Academic pharmacy should care about this issue because all pharmacists must

possess the ability to effectively educate communities and patients to ensure optimal patient and public health outcomes.

Pharmacists are arguably the most accessible of all healthcare professionals and have the potential to significantly impact the health of individuals and populations in more ways than dispensing medications or providing information concerning medications. Regardless of the setting, pharmacists possess the opportunity to counsel patients concerning their disease management, polypharmacy, medication adherence, and important lifestyle modifications. The Centers for Disease Control and Prevention (CDC) reports the following impacts on our health: 50% lifestyles, 20% immediate environment, 20% genetics, and 10% health care delivery or access. Pharmacists can impact the 50% lifestyle factor through education, proper use of medications for prevention, immunizations, smoking cessation, etc.

The workgroup selected medication management therapy as an intervention to evaluate the utility of the six elements of the Hexagon Tool as an effective tool for identifying advocacy action points. Medication therapy management (MTM) that incorporates the characteristics listed above that impact health and has been proven to improve chronic disease management and patient outcomes. It is thus imperative that didactic and laboratory training in pharmacy school and post-graduate education develops and implements a curriculum optimizing MTM

knowledge and skills. With patient-centered medical homes (PCMH) becoming the next frontiers of care to manage chronic diseases, educational and practice policy need to be developed that includes pharmacist as key member of the interprofessional and collaborative team-based care. The need for and effectiveness of pharmacists in interprofessional and collaborative team-based care roles have been envisioned and supported in the literature.^{26,27,28,29,34} Pharmacists belonging to PCMH teams will also be called upon to track and manage care, provide self-care education to patients, and track patient progress in managing their health. These activities are not only critical to promoting health and wellness but also for pharmacists to enhance the visibility, value, and importance of pharmacy and pharmacist in individual and population-level outcomes through education, research and service.

The academy's ability to effectively implement interventions should be guided by the recommendations that are based on the framework/model (Figure 1) and selecting key interventions (See Table 1 in complete workgroup report, Appendix B) that can be implemented now but have long-term effects. Thus, curricular/educational-level interventions, which are low-hanging fruit, may be easier to implement while having great potential to revolutionize pharmacy practice. The higher-hanging fruit may have greater potential and impact overall in advancing pharmacy but a combination of prudent, elite, and

Figure 1. Framework for defining and developing interventions: A model for pharmacy to enhance individual and population health and wellness promotion.

innovative strategies by key pharmacy stakeholders is essential. From the survey the workgroup drew the following conclusions related to wellness and prevention:

- A majority of respondents agree or strongly agree that their school needs to implement initiatives in Wellness and Health Promotion activities.
- A majority of respondents agree or strongly agree that their school values and priorities are in line with the values and priorities of their community to implement initiatives in Wellness and Health Promotion activities.
- About half of respondents agree or strongly agree that their school has sufficient resources to support implementation initiatives in Wellness and Health Promotion activities. The other half disagrees or strongly disagrees.
- A majority of respondents agree or strongly agree that there is sufficient evidence to support the commitment of their college or school to implement initiatives in Wellness and Health Promotion activities.
- A majority of respondents agree or strongly agree that their school has identified the core components necessary to implement initiatives in Wellness and Health Promotion activities.
- About half of respondents agree or strongly agree that there is sufficient qualified faculty and staff to implement and sustain initiatives in Wellness and Health Promotion activities. The other half disagrees or strongly disagrees.

The results of the survey provide some of the evidence necessary to identify advocacy action points to promote health and wellness activities provided by pharmacists. These advocacy action points may be able to enhance the visibility, value, and importance of pharmacy and pharmacist in individual and population-level outcomes through education, research and service.

CONCLUSION

President Peggy Piascik outlined three charges for the Advocacy Committee – community engagement, the scholarship of community engagement and wellness and health promotion – as areas of critical concern for the academy. Thought leaders were identified from the membership of the academy who used a multi-faceted approach to answer key questions surrounding an advocacy agenda for each charge. The answers were informed by a review of the literature, a review of recognized, successful interventions and by anecdote. Core components of effective interventions in each charge area were identified and articulated.

Using the Hexagon Tool and its focus on six key areas of attention – need, fit, evidence, resources, readiness, and

capacity – each working group identified strengths of the academy for each charge as well as barriers that need to be confronted in order that successful approaches can be implemented. These barriers served to inform an advocacy agenda that can be used by the American Association of Colleges of Pharmacy to assist its member organizations in community engagement, the scholarship of community engagement and wellness and prevention.

REFERENCES

1. Credibility on Capitol Hill. The George Washington University. <http://gwtoday.gwu.edu/credibility-capitol-hill>. Accessed March 14, 2014.
2. Sorenson TD, Davis RL, Balidemaj F. Sharing community engagement in Pharmacy – An invitation. *Inov Pharm*. 2011; 2(1).
3. Community-Campus Partnerships for Health. <http://ccph.membersclick.net>. Accessed January 22, 2014.
4. Giberson S, Yoder S, Lee, MP. Improving patient and health system outcomes through advanced pharmacy practice. A Report to the U.S. Surgeon General. U.S. Public Health Service. 2011.
5. Brownson RC, Kreuter MW, Arrington BA, True WR. Translating scientific discoveries into public health action: How can schools of public health move us forward. *Public Health Rep*. 2006; 121(1): 97-103.]
6. Metz A, Albers B. What does it take? How federal initiatives can support the implementation of evidence-based programs to improve outcomes for adolescents. *J Adolesc Health*. 2014; 53: S92-S96.
7. Gray J. Global health experts seek to transform programs through implantation science. National Institute of Health. 2010; 9(2).
8. Blase K, Fixsen D. Core Intervention Components: Identifying and Operationalizing What Makes Programs Work. ASPE Research Brief. 2013. http://aspe.hhs.gov/hsp/13/KeyIssuesforChildrenYouth/CoreIntervention/rb_CoreIntervention.pdf. Accessed April 14, 2014.
9. Implementation Science Information and Resources. National Institute of Health. <http://www.fic.nih.gov/researchtopics/pages/implemtationscience.aspx>. Accessed April 17, 2014.]
- [Implementation Science.
10. National Cancer Institute. <http://www.cancercontrol.cancer.gov/IS/>. Accessed April 17, 2014.
11. Implementation Science + the Infection Preventionist = Safe Healthcare. Centers for Disease Control and Prevention. <http://blogs.cdc.gov/safehealthcare/2011/02/10/implementation-science-the-infection-preventionist-safe-healthcare/>. Accessed April 18, 2014.
12. The Hexagon Tool – Exploring Context. The Active Implementation Hub. <http://implementation.fpg.unc.edu/resources/hexagon-tool-exploring-context>. Accessed March 24, 2014.
13. TeamSTEPPS 2.0. AHRQ. <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/index.html>. Accessed April 17, 2014.
14. AHRQ Quality Indicators Toolkit for Hospitals. AHRQ. <http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html>. Accessed April 16, 2014.
15. Reengineered Discharge Toolkit. AHRQ. <http://innovations.ahrq.gov/content.aspx?id=3902>. Accessed April 16, 2014.
16. Federal Register, Department of Health and Human Services, Centers of Medicare and Medicaid Services, Final Rule. 2005; 70(18). <http://www.gpo.gov/fdsys/pkg/FR-2005-01-28/pdf/05-1321.pdf>. Accessed April 15, 2014.
17. Eccles MP, Mittman BS. Welcome to implementation science. *Implement Sci*. 2006;1(1).

18. Rascati KL, Oladaop AO, Suh K, et al. A review of outcomes associated with Medication Therapy management (MTM) programs. Pharmacy Quality Alliance. 2010. http://www.pqaalliance.org/images/uploads/files/MTM-Outcome_6_14_12.pdf. Accessed March 13, 2014.
19. Classification Description. http://classifications.carnegiefoundation.org/descriptions/community_engagement.php?utm_source=Carnegie+Foundation+Mailing+List&utm_campaign=3b5562162a-CE_Classification_announcement_2013&utm_medium=email. Accessed April 30, 2014.
20. Driscoll A. Carnegie's community-engagement classification: intentions and insights. *Change*. 2008; 40: 38-41.
21. Position Statement on Authentic Partnerships. Community-Campus Partnerships for Health. <https://ccph.memberclicks.net/principles-of-partnership>. Accessed May 1, 2014.
22. Medina MS, Plaza CM, Stowe CD, et al. Center for the advancement of pharmacy education 2013 educational outcomes. *Am J Pharm Educ*. 2013; 77(8): 162.
23. Smith RE, Kerr RA, Nahata MC, Roche VF, Wells BG, Maine LL. Engaging communities: academic pharmacy addressing unmet public health needs. Report of the 2004-05 Argus Commission.
24. Glassick CE, Huber MT, Maeroff GI. *Scholarship Assessed. Evaluation of the Professoriate*. Jossey-Bass, Inc. San Francisco, CA. 1997
25. Frieden TR. Six components necessary for effective public health program implementation. *Am J Public Health*. 2014; 104(1): 17-22.
26. Lenz TL. Employee health: a prime opportunity for pharmacists. *Am J Pharm Educ*. 2013; 77(2).
27. Chisholm-Burns M, Lee JK, Spivey CA. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. *Med Care*. 2010; 48(10): 923-933.
28. Smith M, Bates DW, Bodenheimer T, Cleary PD. Why pharmacists belong in the medical home. *Health Aff*. 2010; 29(5): 906-913.
29. Hunt, J. S., Siemenczuk, J., Pape, G., Rozenfeld, Y., MacKay, J., LeBlanc, B. H., & Touchette, D. (2008). A randomized controlled trial of team-based care: impact of physician-pharmacist collaboration on uncontrolled hypertension. *Journal of general internal medicine*, 23(12), 1966-1972.
30. Glanz K, Rimer BK, Viswanath K. Health Behavior and health Education: Theory, Research, and Practice. John Wiley & Sons; 2008.
31. The Hexagon Tool- Exploring Context. Available at <http://implementation.fpg.unc.edu/resources/hexagon-tool-exploring-context>. Accessed on March 24, 2014.
32. Gelmon SB, Jordan C, Seifer SD. Community-Engaged Scholarship in the Academy: An Action Agenda. *Change*. July-August, 2013.
33. APHA. (2006, November 8, 2006). Policy Statement Database: The Role of Pharmacist in Public Health. Retrieved April 26, 2014, from <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1338>
34. Abrons JP, Smith M. Patient-centered medical homes: primer for pharmacists. *J Am Pharm Assoc*. 2003; 51(3): e38-e48.

Appendix A

List of workgroup members including institutional affiliation

*Members of the AACP 2013-2014 Standing Committee on Advocacy served as leaders of their respective workgroups

Community Engagement:

Suzanne Clark, Assistant Professor, University of Wyoming
Shane Deselle, Dean, California North State University
Anandi Law, Professor, Western University
Linda Ohri, Associate Professor, Creighton University
Veronica Young, Clinical Associate Professor, University of Texas at Austin*

Scholarship of Community Engagement:

Gayle Brazeau, Dean, University of New England
Jeff Goad, Associate Professor, University of Southern California
Kathleen Kennedy, Dean, Xavier University of Louisiana*
Sharon Park, Assistant Professor, Notre Dame University of Maryland
Ann Ryan-Haddad, Associate Professor, Creighton University

Wellness and Prevention:

Christian Albano, Associate Professor, Concordia University*
Marialice Bennett, Emeritus Faculty, Ohio State University
Kimberly Braxton Lloyd, Assistant Dean, Auburn University
Radhika Devraj, Associate Professor, Southern Illinois University Edwardsville
Abby Kahaleh, Associate Professor, Roosevelt University
Clark Kebodeaux, Assistant Professor, St. Louis College of Pharmacy
Sean King, Associate Professor, Union University
Tom Lenz, Associate Professor, Creighton University
Hoai-An Truong, Associate Professor, University of Maryland Eastern Shore

Appendix B

Complete reports/input of the priority issue workgroups

The complete, unedited version of the workgroup reports is presented in this appendix. The members of the committee determined that including the unedited submissions was important to acknowledge the breadth of work undertaken by the workgroups as well as to ensure that important elements of their work would not be lost due to editing of the final report.

2013 – 2014 AACP Advocacy Committee

Workgroup on Community Engagement

Final Report

Submitted by: Veronica Young

Date: May 6, 2014

Workgroup members:

Suzanne Clark (University of Wyoming)
Shane Desselle (California Northstate University)
Anandi Law (Western University)
Linda Ohri (Creighton University)
Veronica Young, Workgroup Lead (The University of Texas at Austin)

Why is community engagement important?

Community engagement instills in pharmacy and other health professions students civic responsibility and social accountability, two principles integral to the preparation of providers to deliver quality and culturally-sensitive patient-centered and population-oriented care. According to the Carnegie Foundation for the Advancement of Teaching, “the purpose of community engagement is the partnership of college and university knowledge and resources with those of the public and private sectors to enrich scholarship, research, and creative activity; enhance curriculum, teaching and learning; prepare educated, engaged citizens; strengthen democratic values and civic responsibility; address critical societal issues; and contribute to the public good.”

What are the core components of a successful community engagement program?

Table 1 depicts the core components deemed necessary in any successful community engagement program. The components are derived by our workgroup from the following sources:

1. Criteria from the Carnegie Foundation for the Advancement of Teaching designation for community engagement
2. Principles of partnerships adopted by Community-Campus Partnerships for Health (CCPH)
3. Interviews conducted by members of the 2013-2014 AACP Advocacy Workgroup on Community Engagement with seven colleges/schools of pharmacy
4. Review of application packets submitted by winners of the American Association of Colleges of Pharmacy Lawrence C. Weaver Transformative Community Service Award

Methodology for Interviews and Award Application Reviews

1. The aim of the interviews is to learn more about community engagement programs at selected colleges/schools of pharmacy.
2. A semi-structured interview questionnaire was developed by members of the Community Engagement Workgroup to ensure uniformity.
3. Institutions were identified from past award winners of community engagement awards from AACP and APhA, as well as from workgroup member recommendations.
4. The following colleges/schools of pharmacy were interviewed:
 - a. University of Missouri, Kansas City
 - b. University of Connecticut
 - c. University of Southern California
 - d. Creighton University
 - e. University of Minnesota
 - f. California Northstate University
 - g. University of Kentucky
5. Application materials from past winners of the two AACP community engaged service awards were reviewed. In addition to programs selected for interviews, applications from University of Mississippi and University of Washington were reviewed.
6. Limitations from interviews and application packets were identified.
 - a. Newer pharmacy programs may not have a sustained record of community engagement at the time of the interview.
 - b. Application materials may not contain all information needed in our retrospective application of core components.
 - c. Because the core components are developed based on our findings, detailed information for some programs interviewed may be absent since we are retrospectively applying the new criteria.
 - d. Constraints of time to re-interview programs to obtain additional data.

Core Components

The key component to any successful community engagement program is a sustained **culture of community-engaged service** throughout an institution and/or organization (Table 1). Indicators of commitment to service include: 1) alignment of service activities with the mission statement of an institution and profession-specific program; 2) visible support by the upper levels of administration including the president, provost and deans; and 3) recognition and celebration of commitment and dedication to serving the community. A pervasive culture of service requires three core components for sustainability: 1) mechanisms that facilitate engagement; 2) sufficient level of personnel support; and 3) strong partnerships between communities and the university and/or pharmacy program. Specific criteria for each of these three core components are listed in Table 1. Success of a community engagement program requires appropriate assessment of service activities, including level of engagement and impact on communities, teaching, learning, and scholarship. Existing programs require periodic assessment to ensure relevancy of activities in relation to community need and quality improvement.

Table 2 is a summary of findings from interviews and review of application materials. Given the limitations of our methodology, successful community engagement programs require first and foremost a culture of community-engaged service. Facilitating mechanisms found consistently across successful programs include support of a central infrastructure, curricular engagement and active student organizations. Sufficient human resources from faculty, students, residents, preceptors and other volunteers are essential to any successful program. Most programs also reported the importance of interprofessional collaborations. Among the few institutions that had staff support, they believe this is extremely helpful in coordinating programmatic activities. Strong partnership with various community partners is obviously essential in any successful program. This involves ensuring that engagement activities are in response to community needs and concerns, and community partners have a voice in the development of activities. University personnel should be involved in community meetings/coalitions to demonstrate commitment. Building programs that can be sustained will help improve success of the relationship. Finally, measuring impact of activities at varying levels is integral to the sustainability and continued relevancy of any community engagement program.

A number of barriers were identified, again, keeping in mind limitations of our methods. Inconsistent finding is observed for skills development which is most likely due to the fact that we did not specifically ask whether skills training are provided for students, faculty, preceptors and other volunteers. Lack of recognition for service activities in promotion and tenure policies is noted as

a barrier to sustained engagement efforts despite faculty desire to serve. As demonstrated from the online survey administered by the Advocacy Committee, the lack of consistent financial support, including fundraising, is a major barrier to successful engagement. Support and guidance on measuring the impact of pharmacy community engagement is needed to improve the likelihood of program sustainability and to collectively record the impact of pharmacy involvement in service.

Online Survey Results on Community Engagement from the 2013-2014 Advocacy Committee

The hexagon tool was applied in analyzing the current state of readiness for community engagement among colleges/schools of pharmacy in the United States. Findings from our workgroup support results from the national survey. Majority of colleges/schools of pharmacy agree on the following:

- **NEED:** There is a need for my college or school of pharmacy to implement initiatives in community engagement. [93% agree/strongly agree]
- **FIT:** There is alignment between the values/priorities of my college or school of pharmacy and the values/priorities of my community to implement initiatives in community engagement. [91% agree/strongly agree]
- **EVIDENCE:** There is sufficient evidence to support the commitment of my college and school of pharmacy to the implementation of an initiative in community engagement. [92% agree/strongly agree]

Discrepancies were noted for the following categories:

- **RESOURCES:** My college or school of pharmacy has sufficient resources to support implementation of an initiative in community engagement. Resources may include curricula, technology, faculty and administrative support, faculty development, etc. [65% agree/strongly agree vs. 35% disagree/strongly disagree]
- **READINESS:** My college or school of pharmacy has identified the core components necessary to implement initiatives in community engagement. [69% agree/strongly agree vs. 31% disagree/strongly disagree]
- **CAPACITY:** There is sufficient qualified faculty/staff within my college or school of pharmacy to implement and sustain initiatives in community engagement. [58% agree/strongly agree vs. 42% disagree/strongly disagree]

Summary and Points of Consideration

1. Encourage visible support from upper administration to include funding support and recognition of service by students, faculty, preceptors, and other volunteers involved in community engagement.
2. Develop and fund a central infrastructure, including personnel, within respective colleges/schools of pharmacy to support community engagement activities through teaching, service and research.
3. Develop internal policies that encourage faculty, residents and preceptors to engage in service.
4. Establish promotion and tenure policies that support community engagement activities.
5. Provide guidance and skills-building learning opportunities for colleges/schools of pharmacy and their faculty to:
 - a. build strong relationships with community partners
 - b. develop and implement community engagement programs that can be sustained
 - c. assess the impact of community engagement activities
 - d. seek funding opportunities
 - e. identify the core components necessary to a successful community engagement program
6. Identify opportunities for funding of community engagement activities at all levels (e.g, service, service learning, research).
7. Build interprofessional community engagement activities that foster collaboration, increase personnel and financial support, and improve health outcomes.

References:

1. Classification Description. Available at: http://classifications.carnegiefoundation.org/descriptions/community_engagement.php?utm_source=Carnegie+Foundation+Mailing+List&utm_campaign=3b5562162a-CE_Classification_announcement_2013&utm_medium=email. Accessed: April 30, 2014.
2. Driscoll A. Carnegie's community-engagement classification: intentions and insights. *Change*. 2008;40:38-41.
3. Principles of Partnerships. Available at: <https://ccph.memberclicks.net/principles-of-partnership>. Accessed: May 1, 2014.
4. Medina MS, Plaza CM, Stowe CD, et al. Center for the advancement of pharmacy education 2013 educational outcomes. *Am J Pharm Educ*. 2013;77(8): article 162.
5. Smith RE, Kerr RA, Nahata MC, et al. Engaging communities: academic pharmacy addressing unmet public health needs. Report of the 2004-05 Argus Commisision. Available at: http://www.aacp.org/governance/committees/argus/documents/2004-05_argusfinalreport.pdf. Accessed March 4, 2014.

Scholarship of Community Engagement

Community-engaged scholarship (CES) is the collaboration of academicians and community partners who use their skills and expertise to solve societal problems in order to generate, disseminate and apply new knowledge. What makes community engagement

“scholarly” is that it combines the principles of community engagement and accepted standards of scholarship to impact future outcomes. The research is subject to peer review and should be replicable based on similar circumstances.

Survey Results

Using the Hexagon Tool as a planning tool to assess the ability of the Colleges and Schools of pharmacy in the Academy to implement CES, a survey was prepared to collect some preliminary data on need, fit, resources, evidence, readiness and capacity in the respective institutions.

The survey was sent to the CEO Deans of Colleges and Schools of pharmacy as well as members of the Advocacy Committee and respective subcommittees on health and wellness, community engagement and the scholarship of community engagement. Questions 13-23 pertained to the Scholarship of Community engagement.

There were 80 responses to the questions (34 from public institutions and 46 from private institutions). Ninety seven percent of public institutions and 96% of private institutions agreed that all academic pharmacy institutions have a responsibility to improve health at the community’s interface with the practice of pharmacy through scholarship.

Ninety-four percent of public and 95% of private schools responded that there is a need for their college or school to implement initiatives to promote CES.

While 76% of public institutions and 84% of private schools responded that there is an alignment between the values/priorities of their college and the values/priorities of the community to implement initiatives to promote CES, 23% of public institutions disagreed.

With respect to resources, 44% of the public institutions and 35% of private schools say they lack sufficient resources to support the implementation of initiatives to promote CES.

Although over 90% of all schools replied that there is a need to implement initiatives to promote CES, 20% of public and 22% of private schools said there is not sufficient evidence to support commitment of their colleges to the implementation these initiatives.

Twenty-one percent of public and 45% of private schools said that the school has identified the core components necessary to implement initiatives to promote CES.

Thirty-five percent of public and 45% of private institutions say they lack sufficient qualified faculty/staff to implement and sustain initiatives in promoting CES.

When asked about the strategies necessary to build a program of CES, the public institutions indicated the acquisition of extramural funding resources (41%) as the number one need with the development of one or more faculty positions focused on CES as second at 26%. Private institutions indicated the development of new partnerships with external organizations interested in collaborating on projects of CES as the number one strategy at 26%. However, extramural funding resources were the second strategy at 23% along with more faculty positions focused on CES (23%). The development of the necessary skills required to participate in CES was third at 12%.

Overwhelmingly, the greatest barrier to CES identified in both public and private institutions was a scarcity of resources followed by the lack of capability.

As outlined by AACP President Peggy Piascik when establishing the workgroup on the Scholarship of community Engagement and as outlined on the Community Campus Partnership for Health website, the characteristics of community engaged scholarship are: clear goals, adequate preparation, appropriate methods, significant results, effective presentation, reflective critique, rigor and peer review.

After a thorough review of the literature and best practices, the working group on CES agrees with these characteristics and sets the core elements of CES as the same as the six standards of scholarly work outlined by Charles Glassick, et al which are: 1) clear goals, 2) adequate preparation, 3) appropriate methods, 4) significant results, 5) effective presentation, and 6) reflective critique.

Core Elements

Clear Goals – In CES it is important to establish the need for the research by engaging the community; what are the gaps in the community that would drive this research. A community health needs assessment, focus groups or community advisory boards may help in identifying goals.

Adequate preparation – This component requires building partnerships with the community and may take a significant amount of time to build trust, which is critical to carrying out the research.

Appropriate methods – The community members are key to the design of methods specific for the community. This may include cultural or social determinants that may impact the expected outcomes. Is the study powered for significance?

Significant results – Will the results impact the health of the community or provide a change in behavior. The results may be used to change policy on a local, regional or national level.

Effective presentation – The results of the research must be presented to the community to maintain trust and communication in a bidirectional manner. The results must also be published in a peer-reviewed journal, although this may be a non-traditional journal for research in an academic pharmacy institution.

Reflective critique – It is important to recognize the limitations of the research and to determine whether the results inform the need for other research.

Importance of Advocacy

Gelman, Jordan and Seifer in their action agenda identified why the scholarship of community engagement is important to our higher education and the current challenges related to this type of scholarship. Besides the increasing expectations that universities must play a key role in addressing the problems of our communities, the scholarship of community engagement is also important because it educates students and faculty members for democratic citizenship in how they can be involved with informed decision making by leveraging the collective intellect of all the participants, including community partners, in these scholarly efforts. The scholarship of community engagement is also critical because it forms the knowledge base utilized by practitioners, policymakers, community leaders and the public as we shape legislation, rules and regulations. The scholarship of community engagement will continue to become more valuable to our communities given the continued complexities of challenges in our communities across all stakeholders in a time of declining fiscal resources. Academic pharmacy is and must be a key player in the scholarship of community engagement given the focus of our practice in community and institutional based pharmacy that has evolved from the tradition dispensing role to the enhanced scope of practice involving specialty pharmacies, innovative new drug delivery systems, immunizations, medication therapy management and collaborative therapy management. With each of these areas, there are new questions being raised related to interprofessional patient centered care that involves pharmacists who are practicing in our communities and these will involve collaboration between members of the academy (faculty and students) and community stakeholders.

Based on the survey results, the academy must advocate for the resources (fiscal as well as personnel) necessary to implement CES. Administrators (deans and chairs) must recognize that research that involves the community can be “scholarly” and meet the criteria necessary for peer review in the tenure process. Finally members of the Academy must recognize that there is sufficient evidence to support the need for CES and the impact that it may have on the overall health of the community or policies that impact their health.

References

1. Community Campus Partnership for Health website
2. Six Standards of Scholarly Work by Glassick, Huber, Maeroff
3. S.B. Gelman, C. Jordan, S.D. Seifer, Community-Engaged Scholarship in the Academy An Action Agenda, Change July-August 2013

WORKGROUP REPORT

AACP Advocacy Committee on Wellness and Health Promotion

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Describe academic pharmacy’s interest in the wellness and health promotion. (Why do we care?)

The pharmacist’s role is expanding beyond the traditional product-oriented functions of dispensing and distributing medicines and health supplies. The pharmacist’s services of today include more patient-oriented, administrative and public health functions. There are many functions in public health that can benefit from pharmacists’ unique expertise that may include pharmacotherapy,

access to care, and prevention services. Apart from dispensing medicine, pharmacists have proven to be an accessible resource for health and medication information. The pharmacist's centralized placement in the community and clinical expertise are invaluable. The reexamination and integration of public health practice into pharmacological training and pharmaceutical care is essential. The encouragement of cross-training will also maximize resources and aid in addressing the work force needs within the fields of pharmacy and public health. (<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1338>)

The movement towards primary prevention, population and public health provisions is mandated in the Patient Protection and Affordable Care Act (PPACA) and is an opportunity for pharmacy and pharmacists to progress and shine as an academy and profession, respectively. The emphasis of prevention and wellness services in the PPACA along with Medicare's reimbursement for these services establishes opportunities and the importance of health and wellness activities related to MTM and other pharmacy-based population health services (e.g., immunization and tobacco cessation). Academic pharmacy should care about this issue because all pharmacists must possess the abilities to effectively educate communities and patients to ensure optimal patient and public health outcomes. Moreover, academic pharmacy must assure that graduates are prepared to meet the challenges associated with combating chronic diseases in various healthcare delivery and public health settings.

Pharmacists are arguably the most accessible of all healthcare professionals and have the potential to significantly impact the health of individuals and populations in more ways than dispensing medications or providing information concerning medications. Regardless of the setting, pharmacists possess the opportunity to counsel patients concerning their disease management, polypharmacy, medication adherence, and important lifestyle modifications. The Centers for Disease Control and Prevention (CDC) reports the following impacts on our health: 50% lifestyles, 20% immediate environment, 20% genetics, and 10% health care delivery or access. We can impact the 50% lifestyle factor through education, proper use of medications for prevention, immunizations, smoking cessation, etc.

Medication therapy management (MTM) is one such pharmaceutical provision that incorporates these activities and has been proven to improve chronic disease management and patient outcomes. It is thus imperative that didactic and laboratory training in pharmacy school and post-graduate education develops and implements a curriculum optimizing MTM knowledge and skills. With patient-centered medical homes (PCMH) becoming the next frontiers of care to manage chronic diseases, educational and practice policy need to be developed that includes pharmacist as key member of the interprofessional and collaborative team-based care. The need for and effectiveness of pharmacists in interprofessional and collaborative team-based care roles have been envisioned and supported in the literature (Abrons & Smith, 2011; Hunt et al., 2008; Lenz, 2013; M. Smith, Bates, Bodenheimer, & Cleary, 2010). Pharmacists belonging to PCMH teams will also be called upon to track and manage care, provide self-care education to patients, and track patient progress in managing their health. These activities are not only critical to promoting health and wellness but also for

Figure 1. Framework for defining and developing interventions: A model for pharmacy to enhance individual and population health and wellness promotion.

Table 1. Core Components for Successful Community Engagement Program

Culture of Community Engaged Service		
<ul style="list-style-type: none"> ● Align with institution's and program's mission statement ● Visible support from dean and other administrators ● Recognize and celebrate community engaged activities 		
Facilitating Mechanisms	Sufficient Human Resources	Strong Partnerships
Central infrastructure	Faculty champions (critical core)	Community-identified needs
Curricular engagement	Student champions	Community voice
Student professional organizations	Staff support	University participation in community planning/coalitions
Skills-building opportunities (for students/faculty/volunteers)	Pharmacy preceptors and other faculty volunteers	Reciprocity/mutual benefit and respect
Financial resources and fundraising	Pharmacy resident support	Commitment to partnership
Promotion and tenure policies	Interprofessional collaborations	Sustainability of efforts or programs
Impact of Community Engaged Service		
<ul style="list-style-type: none"> ● Measure level of engagement ● Assess impact on communities, teaching, learning and scholarship ● Utilize data for program and quality improvement 		

pharmacists to enhance the visibility, value, and importance of pharmacy and pharmacist in individual and population-level outcomes through education, research and service.

List curricular as well as clinical interventions/activities.

A framework was developed to guide the AACP Advocacy Committee on Wellness and Health Promotion (and disease prevention) activities to enhance the visibility, value, and importance of pharmacy and pharmacist in individual and population-level outcomes through education, research and service. The framework below (Figure 1) is a developing and dynamic framework that displays a process for guiding the workgroup as well as determining and defining interventions that will enhance AACP and key stakeholder's goals and outcomes in Wellness and Health Promotion (and disease prevention) in pharmacy. Table 1 shows a listing of the description and types of intervention. The list is not exhaustive but can be prescriptive on some key recommendations, such as MTM.

The workgroup has categorized the interventions into primary and secondary drivers:

- **Primary drivers** consist of curricular- and educational-level activities in pharmacy school (which can be didactic, laboratory, IPPE, and APPE activities) and post-graduate (which can be related to residency, fellowship and specialty pharmacy certifications).
- **Secondary drivers** consist of activities related to patient-level (which can be clinical and medical practice in preventive medicine, ambulatory care, etc.); community-level (which can be public and population health activities such as health promotions and screening/immunizations to other public health competencies such as community-based participatory research); and association/national-level activities (e.g., incorporating association- or nationally-guidelines, such as HealthyPeople 2020 and American Heart Association).

Readiness to implement: While the Hexagon Tool and Frieden's Six Elements are ways to systematically assess implementation and capacity, it was useful to generalize readiness using a pragmatic strategy – "low-hanging vs. high-hanging fruits." Interestingly, we feel that the primary and secondary drivers can be viewed as low- and high-hanging fruits, respectively. By definition, we believe that the low-hanging fruits are easier to implement because these activities are contained within the institution of pharmacy and thus less bureaucracy. On the other hand, the high-hanging fruits, the secondary drivers, could be more difficult to implement because these activities cut across various institutions of the healthcare systems, such as consumers/patients, insurance, providers, and government (local, state, and federal), thus making it more bureaucratic. There can be exceptions however. Categorized as Association/National-level and Community-level activity (Table 1) – *Stronger marketing of awards such as the Lawrence C. Weaver Transformative Community Service Award and the Student Community Engaged Service Awards, etc. may encourage greater engagement in health promotion and wellness issues* – this intervention is a low hanging fruit because it is contained within the pharmacy institution. It would seem relatively easy for AACP to promote such awards. (Note: although the process appears linear starting with the primary driver followed by the secondary drivers; we recognize that both primary and secondary drivers/interventions can occur concurrently.)

Describe the academy's alignment of one or two of these interventions with Frieden's six elements for effective public health program implementation. (How well are we using evidence-based approaches to wellness and health promotion in our academic and/or clinical work?)

Public health programs succeed and survive if organizations and coalitions address 6 key areas ("Frieden's six elements") (Frieden, 2014) :

(1) Innovation to develop the evidence base for action:

Pharmacists-delivered medication therapy management (MTM) in collaboration with other primary care providers combined with innovations related to enhancing efficiencies in the healthcare system (e.g., information technology and reimbursement) as well as the public health system (e.g., health and wellness education) can improve and revolutionize both individual and population health especially in chronic diseases.

(2) A technical package of a limited number of high-priority, evidence-based interventions that together will have a major impact:

Positive clinical evidence of medication therapy management (MTM) with respect to Patient-Centered Medical Home (PCMH) and Employer-based Pharmacist/Ambulist (EBPA) have been demonstrated and supports pharmacists in various interprofessional and collaborative team-based care roles (Hunt et al., 2008; Lenz, 2013; M. Smith et al., 2010). Significant improvements in therapeutic and safety outcomes, such as hemoglobin A1c, LDL cholesterol, blood pressure, and adverse drug events, further supports the effectiveness of pharmacist in team-based patient care (Chisholm-Burns et al., 2010). Thus, the technical package involves specific activities related to MTM delivered thorough PCMH and EBPA.

(3) Effective performance management, especially through rigorous, real-time monitoring, evaluation, and program improvement:

Valid and reliable metric in economic analysis and pharmacoeconomics (e.g., return on investment, cost-effectiveness analysis and cost-benefit analysis) will be implemented to monitor, evaluate, and continuously improve activities related to MTM, PCMH and EBPA. In addition, operations management technique, such as Lean Six Sigma and total quality improvement (TQM) tools, will be employed.

(4) Partnerships and coalitions with public- and private-sector organizations:

Partnerships and coalition-building with the private sector as well all levels of the public sector (local, state, and federal) will drive the importance of pharmacist-delivered MTM, enhance pharmacists role in collaborative team-based care, as well as demonstrate the public health importance of pharmacists in many health and wellness activities. Specific partnerships to establish include the American Public Health Association and HealthyPeople 2020.

(5) Communication of accurate and timely information to the health care community, decision makers, and the public to effect behavior change and engage civil society:

The socio-ecological model along with other media and advocacy tools will help frame the communication of information (Glanz, Rimer, & Viswanath, 2008).

- **Public policy:** Public opinion process and policy changes can change the incentives for certain behaviors.
- **Community:** Social marketing and community organizing can change community norms on behavior.

- **Organizations:** Behavior can be influenced through organizational change and social marketing strategies.
- **Interpersonal:** Family, friends, and peers provide role models, social identity, and support.
- **Individual:** Knowledge is necessary but not sufficient to produce most behavioral changes.

(6) Political commitment to obtain resources and support for effective action.

AACP and key stakeholders will develop the political commitment to obtain resources and support for effective action.

Describe the academy's ability to effectively implement the intervention using the six elements presented in the Hexagon Tool. (What keeps us from effectively using evidence-based approaches to wellness and health promotion?)

The academy's ability to effectively implement interventions should be based partly on the recommendations that are based on the framework/model (figure 1) and selecting key interventions (Table 1) that can be implemented now but have long-term effects. Thus, curricular/educational-level interventions, which are low-hanging fruits, maybe easier to implement while having great potential to revolutionize pharmacy practice. The higher-hanging fruits may have greater potential and impact overall in advancing pharmacy but a combination of prudent, elite, and innovative strategies by key pharmacy stakeholders is essential. Effective implementation will also be impacted and determined by the current leaders in academic pharmacy. Thus, a survey of CEO/Deans was completed to assess this critical group of leaders:

Question 1 (Need): There is a need for my college or school of pharmacy to implement initiatives in Wellness and Health Promotion activities (e.g., a new orientation toward prevention of multiple chronic disease conditions including but not limited to medical homes, health screenings, immunizations, and lifestyle modifications).

- Results: A majority of CEO/Deans agree and strongly agree that their school needs to implement initiatives in Wellness and Health Promotion activities.

Question 2 (Fit): There is alignment between the values/priorities of my college or school of pharmacy and the values/priorities of my community to implement initiatives in Wellness and Health Promotion activities.

- Results: A majority of CEO/Deans agree and strongly agree that their school values and priorities are in line with the values and priorities of their community to implement initiatives in Wellness and Health Promotion activities.

Question 3 (Resources): My college or school of pharmacy has sufficient resources to support implementation of an initiative in Wellness and Health Promotion activities (Resources may include curricula, technology, faculty and administrative support, faculty development, etc).

- Results: About half of CEO/Deans agree and strongly agree that their school has sufficient resources to support implementation initiatives in Wellness and Health Promotion activities. The other half disagrees or strongly disagrees.

Question 4 (Evidence): There is sufficient evidence to support the commitment of my college and school of pharmacy to the implementation of an initiative in Wellness and Health Promotion activities.

- Results: A majority of CEO/Deans agree and strongly agree that there is sufficient evidence to support the commitment of their college or school to implement initiatives in Wellness and Health Promotion activities.

Question 5 (Readiness): My college or school of pharmacy has identified the core components necessary to implement initiatives in Wellness and Health Promotion activities.

- Results: A majority of CEO/Deans agree and strongly agree that their school has identified the core components necessary to implement initiatives in Wellness and Health Promotion activities.

Question 6 (Capacity): There is sufficient qualified faculty/staff within my college or school of pharmacy to implement and sustain initiatives in Wellness and Health Promotion activities.

- Results: About half of CEO/Deans agree and strongly agree that there is sufficient qualified faculty and staff to implement and sustain initiatives in Wellness and Health Promotion activities. The other half disagrees or strongly disagrees.

These results justify this report and indicate the necessary strategic planning needed by key pharmacy stakeholders to promote health and wellness activities by pharmacists but also for pharmacists to enhance the visibility, value, and importance of pharmacy and pharmacist in individual and population-level outcomes through education, research and service. Challenges to effective implementation provide description of advocacy action points through issue briefs generated by AACP staff. (This incorporates aspects of the survey and Questions 7 and 8 and sets advocacy as both internal. . .how do we help the academy. . .and external. . .how do we build support to overcome challenges?)

Completed by AACP Advocacy Committee

References

AACP. (2008). Successful Practices in COD/COF Task Force on the Healthy Student Program: American Association of Colleges of Pharmacy (AACP).

Abrons, J. P., & Smith, M. (2011). Patient-centered medical homes: primer for pharmacists. *J Am Pharm Assoc*, 51(3), e38-e48.

- APHA. (2006, November 8, 2006). Policy Statement Database: The Role of Pharmacist in Public Health. Retrieved April 26, 2014, from <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1338>
- Chisholm-Burns, M., Lee, J. K., Spivey, C., Slack, M., Herrier, R., Hall-Lipsy, E., . . . Martin, J. (2010). US Pharmacists' Effects as Team Members on Patient Care: Systematic Review and Meta-Analyses. *Medical care*, 48, 923-933.
- Dedhia, P., Kravet, S., Bulger, J., Hinson, T., Sridharan, A., Kolodner, K., . . . Howell, E. (2009). A quality improvement intervention to facilitate the transition of older adults from three hospitals back to their homes. *Journal of the American Geriatrics Society*, 57(9), 1540-1546.
- Frieden, T. R. (2014). Six components necessary for effective public health program implementation. *American journal of public health*, 104(1), 17-22.
- Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behavior and health education: theory, research, and practice*: John Wiley & Sons.
- Hunt, J. S., Siemienczuk, J., Pape, G., Rozenfeld, Y., MacKay, J., LeBlanc, B. H., & Touchette, D. (2008). A randomized controlled trial of team-based care: impact of physician-pharmacist collaboration on uncontrolled hypertension. *Journal of general internal medicine*, 23(12), 1966-1972.
- Lenz, T. L. (2013). Employee Health: A Prime Opportunity for Pharmacists. *American Journal of Pharmaceutical Education*, 77(2).
- Offiong, C. Y., Oji, V. U., Bunyan, W., Lewis, J. A., Moore, C., & Olusanya, O. A. (2011). The role of colleges and schools of pharmacy in the advent of healthy people 2020. *American Journal of Pharmaceutical Education*, 75(3).
- Setter, S. M., Corbett, C. F., Neumiller, J. J., Gates, B. J., Sclar, D. A., & Sonnett, T. E. (2009). Effectiveness of a pharmacist-nurse intervention on resolving medication discrepancies for patients transitioning from hospital to home health care. *American Journal of Health-System Pharmacy*, 66(22), 2027-2031.
- Smith, M., Bates, D. W., Bodenheimer, T., & Cleary, P. D. (2010). Why pharmacists belong in the medical home. *Health Affairs*, 29(5), 906-913.
- Smith, R. E., & Olin, B. R. (2010). Wellness: pharmacy education's role and responsibility. *American Journal of Pharmaceutical Education*, 74(4).
- Truong, H.-A., Taylor, C. R., & DiPietro, N. A. (2012). The Assessment, Development, Assurance Pharmacist's Tool (ADAPT) for Ensuring Quality Implementation of Health Promotion Programs. *American Journal of Pharmaceutical Education*, 76(1).
- Wongwiwatthanakut, S., Zeszotarski, P., Thai, A., Fuller, R., Owusu, Y., Tan, C., . . . Holuby, S. (2013). A Training Program for Pharmacy Students on Providing Diabetes Care. *American Journal of Pharmaceutical Education*, 77(7).