

Report of the ASHP Task Force on Pharmacy's Changing Demographics

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In September 2005, American Society of Health-System Pharmacists (ASHP) President Jill Martin commissioned the ASHP Task Force on Pharmacy's Changing Demographics, a diverse group comprising pharmacy administrators, academics, clinical practitioners and educators, and members of other relevant disciplines, including a human resources manager, futurist, and sociologist (Appendix A). The charge to the Task Force, approved by the ASHP Board of Directors in September 2005, was to

1. Study trends in the demography of practicing pharmacists,
2. Identify the implications of these trends for hospital and health-system pharmacy, and
3. Recommend ways that hospital and health-system pharmacy practice can capitalize on the evolving demography of the profession to improve its contributions to patient care.

The Task Force met in person at ASHP headquarters in Bethesda, Maryland, on January 30 and 31 and April 17, 2006.

Reasons for examining demographic changes

The demand for pharmacy and other health care services in the United States will increase in the coming decades because of the aging of the population. The number of Americans over the age of 65 years was approximately 40 million in 2000, but it is expected to exceed 70 million by 2030.¹ Eighty-five percent of Americans 65 years of age or older have at least one chronic disease (e.g., heart disease, cancer, stroke, musculoskeletal disorders, Alzheimer's disease), many of which are managed using prescription drug therapy.

Demographic changes in the pharmacy work force warrant examination because an increase in the demand for pharmacy services has the potential to exacerbate the current shortage of pharmacists, resulting in an inability to meet societal needs.²⁻⁴ In 2004, 86% of licensed pharmacists were actively practicing pharmacy, 23% of whom indicated that they likely would leave their positions within the next year, according to the National Pharmacist Workforce Survey, a survey of the demographic and

work characteristics of the pharmacy work force.⁵⁻⁹

Impending retirements could worsen the pharmacist shortage and lead to the loss of valuable leadership.¹⁰ A 2004 survey of 517 pharmacy directors and 489 middle managers revealed that 80% of pharmacy directors and 77% of middle managers anticipated resigning their position within the next decade.

Between 2000 and 2004, the number of weekly hours worked by full-time pharmacy practitioners decreased, and the percentage of pharmacists working part-time (i.e., 30 or fewer hours per week) increased.⁵ Possible reasons for these changes include a desire for a greater work-life balance and a need to care for family members.

Gaining an appreciation of the demographic changes in the pharmacy work force may help identify ways to increase staff recruitment and retention and provide for succession in leadership. Because pharmacy is a patient-oriented profession, efforts to improve pharmacy staffing and leadership should translate into improved patient care.

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Gender gap

In fall 2004, 62% of applications to schools and colleges of pharmacy were submitted by women.¹¹ In the 2003–04 academic year, women received two thirds of the first professional pharmacy degrees (i.e., baccalaureate, doctor of pharmacy) conferred. In the same year, 39% of faculty members were women.¹² By the 2005–06 academic year, the percentage of female faculty members had increased slightly to 41%, but women remained underrepresented among faculty in pharmacy schools and colleges.¹³

The percentage of licensed female pharmacists increased markedly from 31% in 1990 to 43% in 2000.¹⁴ By 2004, this percentage had increased to 46%.⁵ The percentage of women in management positions increased from 37% in 2000 to 41% in 2004, but women remain underrepresented in these positions.⁵

In 2004, nearly twice as many licensed female pharmacists as licensed male pharmacists (24% versus 13%, respectively) worked part-time schedules.⁵ Women tended to work on a part-time basis at an earlier age than men, probably because of child care responsibilities. For example, the age group with the largest percentage of female pharmacists working part-time in 2004 (21%) was 31–35 years of age.⁵ By contrast, the age group with the largest percentage of male pharmacists working part-time in 2004 (21%) was 72 years of age or older. Women comprised 70% of nonretired licensed pharmacists who were not working.⁵

Among full-time pharmacists, women were more likely than men to practice in a hospital pharmacy setting, and men were more likely than women to work in a chain pharmacy setting.⁵ In 2004, hospital pharmacies employed the largest percentage of full-time female pharmacists (31%), and chain pharmacies employed the largest percentage of full-time male pharmacists (30%). The two practice

settings in which the largest percentages of part-time female pharmacists were employed were chain pharmacies (26%) and hospital pharmacies (25%).⁵ Chain pharmacies employed the largest percentage of part-time male pharmacists (34%).

Although women have long been known to seek a balance between work and their personal lives and base their career choices on family responsibilities, men are increasingly seeking the same balance.^{15–17} An increased interest in career paths with controllable work schedules and lifestyle has been observed among both male and female medical students.¹⁷

Ethnic and racial diversity

In the 2000 U.S. census, the population was classified as 75.1% white, 12.5% Hispanic or Latino, 12.3% black or African American, 3.6% Asian, 0.1% native Hawaiian or other Pacific Islander, and 0.9% American Indian or Alaska Native.¹⁸ In the 2003–04 academic year, white Americans received 60% of Pharm.D. degrees conferred as the first professional degree by schools and colleges of pharmacy in the United States.¹¹ Asian Americans received 23% of the degrees, and underrepresented minorities received 12%, including 7.7% for blacks, 3.7% for Hispanics, and 0.4% for American Indians. Underrepresented minorities submitted 13% of applications to pharmacy schools and colleges for first professional pharmacy degree programs during the 2003–04 academic year.

In the 2005–06 academic year, relatively small percentages of full-time faculty at American schools and colleges of pharmacy were Asian, native Hawaiian, or other Pacific Islanders (11%); black or African American (5.5%); Hispanic or Latino (3.2%); and American Indian or Alaska Native (0.1%).¹³ These percentages reflect slight increases from the 2003–04 academic year, but these groups are underrepresented in faculties at pharmacy schools and colleges.¹²

In 2004, 88% of licensed pharmacists were white.⁵ Asian Americans and black Americans comprised another 7% and 2%, respectively. These figures reflect little change since 2000. Thus, minority ethnic and racial groups are underrepresented in the pharmacy profession.

Aging pharmacy work force

The age of the pharmacy work force is increasing. In 2000, 44% of practicing pharmacists were 40 years of age or younger, and 17% were over 55 years of age.⁵ However, in 2004, one third of practicing pharmacists were 40 years old or younger, and 25% were over 55 years of age.

Implications of demographic changes

The relative lack of ethnic and racial diversity in the pharmacy profession and among pharmacy students and faculty suggests a need to recruit into the profession and academia a more diverse group who will better represent the U.S. population. The goal of schools and colleges of pharmacy should be to recruit faculty and students who mirror the American population (i.e., the patient population served by pharmacy services). The cost of tuition and prospect of a large student loan debt after graduation may present a barrier to the recruitment of students.⁵

The ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence was established in 2003.¹⁹ Among the charges of the Committee were to study the current and future ethnic and racial composition of health-system pharmacy practitioners and foster ethnic and racial diversity within the ASHP membership. The provision of training and resources for members to use in discussing pharmacy as a career with young people from diverse racial and ethnic backgrounds was recommended by the Committee. Training and resources for use in discussing careers in health-system

pharmacy and ASHP membership with pharmacy students from diverse racial and ethnic backgrounds were also among the Committee's recommendations.

Recruiting and retaining staff.

Innovative staff recruitment and retention strategies are needed that take into consideration generational differences in characteristics, personal priorities, and factors that lead to job satisfaction. "Traditionals," born between 1930 and 1945, are now retirement age, although some continue to work on a part-time basis.⁵ As a group, the traditionals have considerable loyalty to employers, are career oriented and motivated by salary and professional recognition, and work a fairly conventional full-time schedule.

Baby boomers were born between 1946 and 1964. At this point in their careers, they are knowledgeable and experienced, characteristics that make them good mentors. They tend to be mature and responsible, with a strong sense of professional commitment. Baby boomers tend to be pragmatic about career aspirations and seek meaningful work.²⁰ As a group, baby boomers are less likely to change jobs than are younger persons. Members of this age group appreciate flexible work schedules that can accommodate family obligations (e.g., caring for elderly parents or children).

Generation X'ers were born between 1965 and the late 1970s or 1980 (definitions vary). They value a balance between work and their personal lives, often placing greater emphasis on life outside the workplace than on their careers.²⁰ Spending time with family, friends, and pets and on hobbies, sports, or fitness activities takes priority for some members of this age group. Some Generation X'ers will readily switch jobs to find greater intellectual stimulation, more interesting work, better relationships with coworkers, or opportunities for learning.²¹ They seek alternative

work schedules (e.g., job sharing, telecommuting, flexible hours, sabbatical leaves).²⁰ As a group, Generation X tends to be technology savvy and family oriented, has little trust in government and other authority, and exhibits limited organizational loyalty.²² Power, prestige, recognition, and even salary may not motivate this age group.^{21,23}

Persons born in the early 1980s or more recently are referred to as Millennials (also known as Generation Y) because they will reach adulthood in this millennium. Millennials are optimistic, trusting, accepting of diversity and authority, community and group oriented, and loyal (i.e., they may be more willing to stay with an organization for longer periods than previous generations).²⁴ They are smart, technologically advanced, and skilled in multitasking.

Millennials are the fastest growing part of the work force because the oldest members of this group are finishing their educations and landing their first jobs. They have high expectations of managers, seek creative challenges on the job, and prefer continual feedback to annual job performance reviews.²⁵ Millennials value self-fulfillment and seek alternative work arrangements (e.g., telecommuting arrangements, flexible hours, part-time work, temporary leave for childbearing or other personal needs) to achieve a work-life balance. Many members of this group involve their parents in decisions. Financial concerns are common among Millennials, and their student loan burden is higher than that of other groups.⁵

Alternative schedules. Alternative work schedules (e.g., part-time work, flexible hours, job sharing) are needed to recruit and retain practitioners of all ages and meet institutional needs. In the National Pharmacist Workforce Survey, work schedule was the most important factor in deciding to stay or leave a job within the next year.⁵ Potential advantages

of alternative work schedules for the institution include flexibility in filling staffing needs, greater leverage in recruiting talent who might otherwise be unavailable, increased opportunity for part-time staff to advance in their careers, and cost savings from benefits not provided to part-time workers and uncompensated hours worked at home by part-time employees. Possible disadvantages of alternative work schedules for the institution include difficulty filling part-time positions with qualified staff and providing coverage for staffing needs, the extra effort required to provide training and staff development programs for part-time workers, a lack of familiarity of workers with institutional policies and procedures, a risk of error due to a lack of continuity in patient care, and resentment among full-time staff because of a perceived lack of commitment among part-time workers to meeting institutional goals.²⁶ Changes in institutional culture are needed to remove the stigma associated with part-time work, flexible hours, and planned time away from work, which may increase the number of women in leadership positions.

Lessons from the nursing profession. The nursing profession has encountered many of the challenges currently faced by the pharmacy profession. Nearly 25% of nurses worked on a part-time basis in 2004.²⁷ Registry or contingent nurses who work on a temporary basis provide quality care but often lack familiarity with institutional policies and procedures, placing a burden on full-time employees.

The nursing profession has had a severe work force shortage since the 1980s.²⁸ The nursing work force is aging (the average age in 2004 was 47 years), which will exacerbate the shortage.²⁷ Some workplaces have managed to recruit and retain nursing staff despite the shortage. A magnet model with 14 forces of magnetism that contribute to recruitment

and retention has been devised by members of the nursing profession (Table 1).²⁸ These 14 forces of magnetism are the essential elements of excellence in nursing and the provision of high-quality care. Benefits from implementation of the model include recognition within the community for nursing and the health care organization, attraction of highly qualified physicians and specialists, reinforcement of positive collaborative relationships, and increased staff satisfaction and productivity.²⁸ Implementation of the model can be time-consuming and costly, but it can provide financial benefits from reduced staff turnover because the costs of training new staff are high.²⁹ The pharmacy profession may want to consider adopting this magnet model to promote staff recruitment and retention.

Cultivating leadership. Innovative approaches are needed to engage young pharmacy practitioners

in management roles to prevent a crisis when the current managers retire. Nontraditional role models and job structures are needed for managers. The job structures should be flexible enough to accommodate part-time and other alternative work schedules.

A survey of 517 pharmacy directors and 290 current pharmacy practitioners found that more than half of the directors did not know of anyone who could replace them if they were to resign, and only 30% of current practitioners indicated that they would seek a leadership or managerial position during their career.¹⁰ Thus, efforts to cultivate leadership must be designed to overcome a lack of interest in management responsibilities among young practitioners.

Establishing mentor relationships. Mentors are needed to foster new pharmacy leaders. Of 290 pharmacy practitioners surveyed, 70% did not have a mentor.¹⁰ Mentoring programs can be established to increase gender equity in pharmacy management and among pharmacy faculty and to cultivate new leadership.³⁰ Novel approaches to mentoring (e.g., electronic mentoring) may be needed to accommodate the needs of mentors and mentees.³¹

Facilitating work force reentry. Fourteen percent of licensed pharmacists were not actively practicing in 2004.⁵ Some trained pharmacists may have stopped maintaining their licenses and gone uncoun-
 ted.

Possible reasons for career inactivity among health care professionals include responsibility for caring for family members (e.g., children, elderly parents), personal illness (e.g., cancer, depression, substance abuse), career dissatisfaction (e.g., stress, burnout, hitting the “glass ceiling”), and involvement in alternative careers (e.g., volunteer work).³² The National Task Force on Reentry into Clinical Medicine for Health Professionals defined career reentry as returning to professional activity

after a prolonged time lag after one has been trained or certified. Reentry poses a challenge for both men and women. Barriers to career reentry include a high level of anxiety, low self-esteem, lack of professional and institutional support, and a lack of mentors.³²

Career reentry programs for pharmacists should address personal and educational needs. A variety of hospital- and university-based refresher courses for nurses have been used to facilitate reentry into the work force.³³⁻³⁵ The courses are usually paid for by the participant or institution, and a lack of funding for reentry programs has been an issue for some health care professionals.³² Joint efforts of public and private organizations may be needed.

In the business setting, temporary leaves from the work force for child-bearing or other personal pursuits have been facilitated by “off ramp” and “on ramp” programs.³⁶ Such programs allow top performers to pursue nonlinear career paths by taking a leave of absence during which mentoring, training, career planning, and the opportunity to network and work at home on projects are provided.³⁷ The “on ramp” portions of these programs address barriers to reentry by offering flexible schedules and opportunities to update skills. These programs can help stem the loss of valuable talent from the work force and could be adapted for the pharmacy work force as a way to retain valuable staff and foster leadership development.

Managing diversity. Improving the management of workplace diversity can improve organizational effectiveness.³⁸ Three key dimensions to workplace diversity have been identified: (1) human diversity (e.g., race, ethnicity, age, gender, marital status, sexual orientation, physical abilities), (2) cultural diversity (e.g., personal beliefs and values, family structure, influence of culture, community, environmental experienc-

Table 1.
Fourteen Forces of Magnetism^{28,29,a}

Quality of nursing leadership
Organizational structure
Management style
Personnel policies and programs
Professional models of care
Quality of care
Quality improvement
Consultation and resources
Autonomy
Community and the hospital
Nurses as teachers
Image of nursing
Interdisciplinary (e.g., nurse–physician) relationships
Professional development (i.e., orientation, inhouse education, continuing education, formal education, and career development)

^aThese forces of magnetism are the essential elements of excellence in nursing and the provision of high-quality care that promote staff recruitment and retention. Implementation of a magnet model with these forces of magnetism can be time-consuming and costly but can provide financial benefits from reduced staff turnover.

es), and (3) systems diversity (e.g., teamwork, partnerships, employee autonomy and empowerment, staff development, innovations).³⁹

Several paradigms or models have been put forth for managing diversity in a business setting. In the assimilation paradigm, employers hire diverse employees and seek to treat them equally and fairly, providing equal opportunities.³⁸ Differences are typically ignored or subverted, and new ideas based on cultural experiences may not be shared.

The differentiation paradigm values and capitalizes on ethnic diversity to develop previously unexplored markets with which employees are familiar.³⁸ However, employees may feel trapped in specialized positions.

The integration paradigm builds and expands on the models of assimilation and differentiation by looking beyond equal opportunity to the organization's utilization of an individual's expertise, unique contributions, and broad experiences influenced by culture.³⁸ The integration paradigm values differences and expects and accommodates the natural tension created by varied and diverse input to face challenges and solve problems. The organization wins because new solutions are discovered based on workers' cultural backgrounds and life experiences, and people feel valued for contributing based on these unique differences. Organizations embracing this paradigm must create a culture that unleashes the talents of all workers and encourages and invites all to contribute.

Impetus for change

The ongoing pharmacist shortage and recent demographic changes in the pharmacy work force serve as impetus for change. The current workplace differs substantially from the workplace of the not-too-distant past, and many management approaches that were successful in the past are no longer appropriate. Failure to address recent changes in

demographics could lead to professional dissatisfaction and compromise the ability of the profession to meet societal needs for pharmacy services. The prospect of a growing gap between the supply of and demand for pharmacy practitioners at a time when the demand for pharmacy services is increasing and many senior pharmacy managers prepare to retire without a plan for succession is cause for concern that warrants prompt action by members of the pharmacy profession. Efforts to embrace and capitalize on changes in pharmacy demographics will help position the profession to optimize professional satisfaction and meet societal needs.

Task Force recommendations

To address the demographic changes in the pharmacy profession and improve contributions to patient care, the Task Force developed seven recommendations for ASHP, three recommendations for pharmacy practice managers, and four recommendations for pharmacy practitioners. The recommendations are listed in Appendix B and discussed individually below.

Recommendations for ASHP

1. ASHP should develop a comprehensive plan to assist pharmacy practice managers in developing service-delivery models that take into account the current and projected demographics of the pharmacist and pharmacy technician populations.

A departmental self-assessment tool on practices accommodating the changing work-force demographics could be developed and used to create the comprehensive plan. Pharmacy leaders should be educated about generational differences in characteristics, personal priorities, and factors that lead to job satisfaction and on the need for alternative work schedules and career paths. Models

Open Hearing Feedback

The Task Force conducted an Open Hearing at the 41st ASHP Midyear Clinical Meeting on Wednesday, December 6, 2006, in Anaheim, California. The preliminary report and recommendations of the Task Force were discussed by a group of approximately 30 people. Twelve people made verbal comments to the Task Force during the session.

Task Force Chair Jennifer Edwards polled the audience regarding their agreement with the report and recommendations at the conclusion of the Open Hearing. The participants believed the Task Force report was on track and the recommendations were appropriate given the report.

There were several common themes among the comments made during the Open Hearing. They included the following:

- Flexibility at all levels within the pharmacy enterprise regarding staffing issues is critical to success. Find ways to be flexible. Long-term benefits outweigh short-term headaches. "Keep excellent people by finding ways to be flexible." Examples include removing stigmas associated with flexible schedules by creating a friendly environment, offering nontraditional coverage of hours, giving ownership of coverage back to staff, working remote, and job sharing.
- Get top management on board regarding flexible staffing models. Educate corporate leaders about the benefits of new flexible staffing models and the risks of not making changes to traditional models.
- Mentor pharmacists to be leaders. "There are no passes on a leadership role." Examples include developing formal mentoring programs and breaking management-leadership roles into small pieces with pharmacists beginning to take on these responsibilities with guidance.

of practice excellence that capitalize on the profession's changing demographics could be published, including best-practices staffing models. A pharmacy resource center could also be designed to reside on the ASHP website for use by all health-system pharmacists.

2. ASHP should develop a strategy to assist practitioners who are pursuing alternative career patterns (e.g., returning to practice after an extended absence, pursuing part-time practice) in maintaining their professional competence.

ASHP should develop new ways to deliver lifelong education that is focused and effective in communicating the knowledge required to maintain professional competence. Innovative technologies may play a role in these new delivery methods.

3. ASHP should foster the development of innovative on-the-job management training programs and residency training programs in pharmacy practice management and leadership that are geared toward pharmacists who have been in practice for a number of years.

Management training programs and residencies should be developed for experienced pharmacists to provide for future leadership. Stipends at or near pharmacist wages would minimize financial barriers to pursuing these programs and increase the number of pharmacists receiving such training.

4. ASHP should collaborate with other organizations in conducting highly accessible regional educational programs on pharmacy practice management and leadership.

Workshops conducted on a state or regional level have the potential to affect large numbers of practitioners, including those who are unable to attend programs presented at national

meetings. ASHP should collaborate with affiliated state societies or various organizations (e.g., the Health Occupations Students of America, an organization that recognizes the importance of leadership skills in health occupations⁴⁰) in conducting educational programs.

5. ASHP should collaborate with affiliated state societies in creating a formal mentorship program that allows new practitioners to be guided in their career development by seasoned practitioners.

A formal mentor program should be created using experienced ASHP members as mentors. Mentor-of-the-year awards and published stories of mutually beneficial mentor-mentee relationships could be used to provide visibility and inspiration.

6. ASHP should collaborate with the American Association of Colleges of Pharmacy (AACP) to develop a strategy for recruiting individuals into the profession who have the personal characteristics needed to help the profession achieve its vision for the future, including individuals who have an aptitude for practice management and leadership.

Possible collaborative activities of ASHP and AACP include

- Conducting research to identify characteristics of the Millennials and developing plans based on that research to attract the best future practitioners into the profession,
- Ensuring that student recruitment efforts are aimed at appropriate targets and have a clear message that is delivered successfully,
- Developing education and training programs in which management is portrayed as an essential pharmacist responsibility (e.g., drug product selection, staff scheduling, participation on committees, policy and procedure development),

- Identifying reasons why many current students are not interested in managerial roles and what impact this trend will have on the existing leadership crisis, and
- Developing minority recruitment programs for high school students using role models from the membership of pharmacy associations.

7. ASHP should establish an ongoing process to periodically assess and revise the Task Force recommendations for appropriateness and timeliness.

ASHP should develop a method to regularly review the progress being made on the recommendations of the Task Force to the Society. The appropriateness and timeliness of recommendations should be evaluated and revised as needed as the profession progresses.

Recommendations for pharmacy practice managers

1. Pharmacy practice managers should examine their staffing and departmental career-development practices in light of what is known about the changing demographics of the pharmacist and pharmacy technician populations and implement, as indicated, contemporary techniques that have proven to be effective in enhancing staff satisfaction and productivity.

Practice leaders should incorporate staffing models and schedules that are structured around the diverse work force. These could include

- Phasing out purely distributive roles and replacing them with more integrated roles,
- Developing part-time opportunities as a core staffing resource,
- Creating a career structure that allows for easy reentry into the profession (e.g., "off ramp" and "on ramp" programs),
- Ensuring professional competency of all staff, including part-time staff,

- Obtaining regular feedback on work schedule and activity preferences and work–personal life balance,
- Engaging staff in work schedule development that meets both organizational and staff needs,
- Promoting intergenerational cooperation through job sharing,
- Developing attractive incentives for undesirable work shifts, and
- Leveraging technology to increase work schedule flexibility (e.g., telecommuting arrangements) and access to information.

Practice leaders should develop recruitment strategies that leverage the changing pharmacy work force, such as

- Providing financial assistance to lighten students' school loan burden (e.g., loan repayment programs) and ongoing training in personal financial management,
- Developing innovative programs to recruit community pharmacists to transition to health-system positions,
- Exploring development of competitive recruitment packages, and
- Developing roles and work schedules that accommodate the retirement-age work force.

2. Pharmacy practice managers should develop a strategy for fostering the development of department managers that takes into account what is known about the changing demographics of the pharmacist population.

Practice leaders should seek opportunities to develop leadership skills in all pharmacy staff members by

- Combining clinical and management functions into the responsibilities of specific positions,
- Recognizing and rewarding staff, with the goal of fostering an interest in leadership,
- Educating students and staff about the importance of their leadership role in daily practice,

- Creating a structured mentoring program for all new practitioners,
- Organizing a formal succession plan, and
- Integrating diversity into the workplace and ensuring cultural competency to benefit both patients and employees.

Pharmacy practice managers should cultivate leadership qualities in their staff, and every pharmacy practitioner should exhibit leadership characteristics (e.g., professionalism, a sense of responsibility, vision and understanding of organizational goals), regardless of supervisory responsibilities.

3. Pharmacy practice managers should ensure that their departmental work force is diverse and culturally competent, taking into account the population of patients it serves to enhance innovation, encourage teamwork, and improve productivity.

Establishing a diverse work force, with contributions from multiple cultures and generations, may facilitate innovation and enhance organizational effectiveness.³⁸ Efforts to promote cultural competence (i.e., knowledge, skills, attitudes, and ability to provide optimal health care services to patients from a wide range of cultural and ethnic backgrounds¹⁹) and encourage teamwork may improve productivity and patient care.

Recommendations for pharmacy practitioners

1. All pharmacy practitioners should pursue a lifelong process of maintaining competency with respect to generational and cultural issues that have a bearing on patient outcomes and practitioner team effectiveness.

Health-system practitioners should assess their competency in managing issues related to workplace diversity and take steps to maintain competency. For example, practi-

tioners should participate in diversity programs in the workplace to ascertain and improve their awareness of and sensitivity to cultural and generational differences and their ability to resolve conflict related to differences.

2. All pharmacy practitioners should develop the communication skills necessary to work effectively with patients and a work force that are diverse generationally and culturally.

Health-system practitioners should implement strategies to improve communication skills and effectiveness in working with a diverse work force and patient population. Patient-counseling skills are an example of these communication skills. Patient counseling should take into consideration cultural differences among patients.

Managers should hone their communication skills to optimize their effectiveness in solving problems in the workplace. For example, a manager who repeatedly encounters conflict with subordinates about work schedules might participate in role-playing exercises to improve his or her communication skills to overcome problems related to generational differences.

3. All pharmacy practitioners should be assertive in negotiating, designing, and applying flexible work schedules that meet the needs of their institution, as well as their professional and personal needs for work–personal life balance.

Health-system practitioners should feel empowered to propose flexible scheduling solutions to managers and coworkers to achieve work–personal life balance and meet the needs of the institution. For example, a job-sharing arrangement involving two managers who are new parents and wish to spend extra time with their newborns might be proposed to achieve these goals.

4. All pharmacy practitioners should be alert for new opportunities to develop innovative practice roles that meet the needs of their institution and provide personal professional fulfillment.

Pharmacy practitioners should identify unmet institutional needs that might represent opportunities for alternative practice roles that are professionally rewarding. For example, a clinical specialist might identify problems with inadequate managerial oversight of clinical services and assume some of these responsibilities, resulting in a hybrid clinical–managerial position that improves patient care. It might be feasible for the clinical specialist to perform some managerial functions at home to accommodate personal needs.

Summary

Recent changes in the demographics of the pharmacy work force could profoundly affect the profession's ability to meet societal needs by worsening the imbalance between the supply of and demand for pharmacy practitioners and the pharmacist shortage. The impending loss of senior pharmacy managers due to retirement may exacerbate the problem. Gaining an understanding of the demographic changes helped the ASHP Task Force on Pharmacy's Changing Demographics identify ways to improve pharmacy staff recruitment and retention, provide for succession in leadership, and improve patient care.

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Appendix B—recommendations of the ASHP Task Force on Pharmacy's Changing Demographics

Recommendations for ASHP

1. ASHP should develop a comprehensive plan to assist pharmacy practice managers in developing service-delivery models that take into account the current and projected demographics of the pharmacist and pharmacy technician populations.
2. ASHP should develop a strategy to assist practitioners who are pursuing alternative career patterns (e.g., returning to practice after an extended absence, pursuing part-time practice) in maintaining their professional competence.
3. ASHP should foster the development of innovative on-the-job management training programs and residency training programs in pharmacy practice management and leadership that are geared toward pharmacists who have been in practice for a number of years.
4. ASHP should collaborate with other organizations in conducting highly accessible regional educational programs on pharmacy practice management and leadership.

5. ASHP should collaborate with affiliated state societies in creating a formal mentorship program that allows new practitioners to be guided in their career development by seasoned practitioners.
6. ASHP should collaborate with the American Association of Colleges of Pharmacy to develop a strategy for recruiting individuals into the profession who have the personal characteristics needed to help the profession achieve its vision for the future, including individuals who have an aptitude for practice management and leadership.
7. ASHP should establish an ongoing process to periodically assess and revise the Task Force recommendations for appropriateness and timeliness.

Recommendations for pharmacy practice managers

1. Pharmacy practice managers should examine their staffing and departmental career-development practices in light of what is known about the changing demographics of the pharmacist and pharmacy technician populations and implement, as indicated, contemporary techniques that have proven to be effective in enhancing staff satisfaction and productivity.
2. Pharmacy practice managers should develop a strategy for fostering the development of department managers that takes into account what is known about the changing demographics of the pharmacist population.
3. Pharmacy practice managers should ensure that their departmental work force is diverse and culturally competent, taking into account the population of patients it serves to enhance innovation, encourage teamwork, and improve productivity.

Recommendations for pharmacy practitioners

1. All pharmacy practitioners should pursue a lifelong process of maintaining competency with respect to generational and cultural issues that have a bearing on patient outcomes and practitioner team effectiveness.
2. All pharmacy practitioners should develop the communication skills necessary to work effectively with patients and a work force that are diverse generationally and culturally.
3. All pharmacy practitioners should be assertive in negotiating, designing, and applying flexible work schedules that meet the needs of their institution, as well as their professional and personal needs for work-personal life balance.
4. All pharmacy practitioners should be alert for new opportunities to develop innovative practice roles that meet the needs of their institution and provide personal professional fulfillment.