

Randall D. Seifert, Pharm.D.
Narrator

Lauren E. Klaffke
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Randall Seifert was born in Oakland, CA, but spent most of his youth in Perham Minnesota. He attended North Dakota State University as part of the College of Pharmacy's five-year bachelor's degree program, which he complete in 1975. He then earned his Pharm.D. in 1978 and completed a postdoc in pharmacokinetics in 1979 at the University of Minnesota. Returning to Fargo, North Dakota after completion of his postdoc, Dr. Seifert worked for North Dakota State University, North Dakota State Hospital, and Dakota Heartland Hospital. In 1987, Dr. Seifert moved to California, where he worked as a clinical coordinator in Santa Barbara, then at Pharmacy Corporation of America, Health Net, and California Clinical Trials. He returned to Minnesota in 2005 and continues to serve as senior associate dean and professor in Pharmacy Practice and Pharmaceutical Sciences in the College of Pharmacy at the University of Minnesota, Duluth.

Interview Abstract

Dr. Randall Seifert begins his interview by describing his early life and education, including his pursuit of a Pharm.D. and a postdoc in pharmacokinetics at the University of Minnesota. He then discusses his work in North Dakota. He reflects on changing trends in pharmacy hospital practice, ways to build sustainable clinical practices, and problems pharmacists face in smaller communities. He then describes the various positions he held in Southern California, particularly his work for California Clinical Trials and Health Net. He then describes his return to the University of Minnesota in 2005, including his work on the implementation of medication therapy management benefits for the City of Duluth and it adoption by U-Plan at the University of Minnesota. He then discusses the following topics: relationships between the Twin Cities and Duluth campuses of the College of Pharmacy; current trends in pharmacy education; efforts to recruit Native American students; his work with Marilyn Speedie and her leadership as dean; Frank Cerra's leadership as vice president of the Academic Health Center; relations between medical and pharmacy students at UMN Duluth; collaborations between schools and colleges in the health sciences; and his work with the State Legislature. He concludes with his ideas for interprofessional communication in education.

Interview with Doctor Randall D. Seifert

Interviewed by Lauren Klaffke

**Interviewed for the Academic Health Center, University of Minnesota
Oral History Project**

**Interviewed in Weaver Densford Hall
on the University of Minnesota Campus**

Interviewed on August 5, 2013

Randall Seifert - RS
Lauren Klaffke - LK

LK: This is Lauren Klaffke. I'm interviewing Doctor Randall Seifert. It's August 5, 2013, and we are in Weaver-Densford Hall.

Thank you for meeting with me today.

RS: You're welcome.

LK: I wanted to start off talking a little bit about your background, where you born and raised, and your early education.

RS: Okay. I was born in Oakland, California, where my dad was stationed in the Navy. They, subsequently, moved to back to where their home community was, Perham, Minnesota, which is where I grew up and went to grade school and high school. Then, I went to North Dakota State University [NDSU] and to the pharmacy program at NDSU. At that time, the pharmacy program was what we would call a zero-five. So you entered into the school of pharmacy right away and it was a five-year bachelor's degree program.

That's where I met my wife, Kathy [Katherine]. After we graduated, we decided we would take two jobs in the same community. There were two options. One was Bloomington, Illinois, and the other one was Manchester, New Hampshire. So we sort of looked at each other and said, "Have you ever been to New Hampshire?" "No, I've never been to New Hampshire." So we went there. She worked in one Osco Drug Store and I worked in another Osco. Osco is a chain of pharmacies. I was there just a few weeks and realized that was not what I wanted to do for the rest of my life. In fact, I could not

see myself doing that for forty years, even though I really liked retail. I like retail business. Being a retail pharmacist in that setting just was not what I was interested in doing.

So I applied to two doctors of pharmacy programs: one at the University of Michigan and one at the University of Minnesota. I thought I'm going to try to find a Pharm.D. program that I can go to and if I don't get admitted, I'll consider going and getting a master's degree probably from the University of Massachusetts or someplace that had a master's program. That was my other consideration. I was not accepted to Michigan, which was very good because that program folded, I think.

LK: Oh, wow.

RS: I did a proxy interview with a fellow that was in a post doctorate at Boston [University], at BU and was a Minnesota grad. It must have gone pretty good, because I got a telegram that I had twenty-four hours to respond.

LK: Oh, wow, a telegram!

RS: It was an actual telegram from Western Union. That was 1976. I agreed and wound up starting my Pharm.D. program here at the University in 1976.

It was an interesting program. At the time, we had our own course work for the first year, but a lot of our course work was taken with the second-year medical students in their pathophysiology course. That was really a very rewarding experience.

Actually, when I came back several times just to visit friends, I was somewhat disappointed that we were not training pharmacists in the same classes as with medical students, because I thought that was a great interprofessional experience. So we sort of moved away from that into more silos and, now, we're trying to come back to that with Barbara Brandt's program. So it seems somewhat ironic that we actually didn't keep that.

As pharmacy students, we weren't given any fewer things to do. Several labs we didn't participate in, obviously, but we did in the small group sessions. I remember in particular one was an oncology case presentations that we had, I had to present a case just like everybody else. It was a wonderful experience. I think we really got to know the medical students and they got to know us. We shared information. I think that was a valuable experience.

LK: I talked to someone else—this was a dental student—who came here and was taking classes with the medical students. His one complaint was that the class was very large. Was that something you ran into?

RS: Yes. It was quite large. I don't know how many medical students were there at the time. We were only a small group; there were only seventeen of us.

LK: Oh, pharmacy...

RS: Pharmacy students, so it was small. Obviously, it would be more difficult to do now with a hundred and some of us and a couple hundred medical students. It probably isn't practical. But, at the time, it was really a valuable experience. I'm glad that we did it that way.

LK: You said you didn't like working in the pharmaceutical retail at Osco. Did you have an interest in going back for your Pharm.D. to do research or work in academia? What was the next stage of your career?

RS: I think what motivated me mostly was that I think I needed another option, a different career path. I think, at the time, I didn't think of things outside of pharmacy. I thought, gee, I just spent five years in pharmacy school. I needed to build on whatever that was. It's mostly that I didn't think about a master's in business administration or going back and getting a master's in public health or adding a different type of degree on to the bachelor's degree in pharmacy. I only saw a pathway to add a doctorate or a master's degree in pharmacy. I really loved pharmacy as a profession. I just didn't like the professionalism of retail in that large chain environment. It was very impersonal. It was mostly robotic in terms of the things that you did. While I think people appreciated your knowledge, it wasn't terribly rewarding.

LK: I've heard some discussions regarding that changing nature of pharmacy, the larger chains versus the neighborhood pharmacy store. It seems like there was a change in culture.

RS: Sure. When I grew up in Perham, Minnesota, I worked in a Ben Franklin and Pharmacy. I think originally I was thinking I would just go into music and history and I ought to teach. Then, I got a job in the pharmacy and I started working with the pharmacist, actually almost sort of as a clerk tech [technician] in the back, eventually. I just liked that small... It was a small community, so the pharmacists there knew everybody. Everybody knew him. Half the time, they came around the corner and stood next to the pharmacist as he was filling their prescriptions. We did a tremendous amount of veterinary medicine which I found very interesting and a lot of fun. That was my image of what a pharmacist should be and should do. Then, I think it was very shocking to see what it was like in a chain.

Without really thinking about should we go back and actually buy our own pharmacy, I don't think my wife really wanted to own a pharmacy. So those were sort of how you made those decisions and that's what happened.

LK: She was a pharmacist as well?

RS: Yes, she's a pharmacist as well.

LK: Did she come into the Pharm.D. program, too?

RS: No, she has a very different pathway. When we got here to Minnesota, she started working in a small pharmacy out in Stillwater. Then, one of our classmates from Minnesota, who was in the master's program here, told her about nuclear pharmacy. So she actually started working in the nuclear pharmacy here on campus, I think almost as a volunteer to start off with just so she could get some formal training. She would come really early in the morning. In nuclear pharmacy, they make their diagnostics early in the morning. Then, she would drive out to Stillwater and work in Stillwater.

LK: Oh, wow, long days.

RS: Long days, yes. Eventually, her career path was nuclear.

LK: Okay. That's really interesting.

When you came to the University, you were talking about taking classes with medical students. You had said when you were sort of the clerk tech at that other pharmacy, you were doing a lot of vet work. Did you do any crossover with Veterinary Medicine here?

RS: Not during my Pharm.D. training program. No.

LK: I saw that you went on to do a post doc at the University in pharmacokinetics.

RS: Yes.

LK: Was that part of your research as a Pharm.D. [student] or an interest you had?

RS: Yes. I think it was my mentors. I had fabulous mentors. Doctor Bob [Robert J. Cipolle, Harry [G.] McCoy, Darwin [E.] Zaske, Jim [James C. III] Cloyd were all phenomenal mentors at the time. I think my real desire was to do a fellowship, because I could do a research fellowship. I liked the things that they were doing. It was a lot of fun. I got involved in some of the studies early when I was doing my rotations. I thought it would be great to do, so that's why I stayed on and did a fellowship, because I could still hang out with those guys. I really kind of wanted to stay. There was an opening at [Saint Paul-] Ramsey [Hospital] in psychiatry. While I didn't really have that much psych background, I think Harry and Bob really tried to encourage me to consider taking that position that was opening up.

But, instead, I moved, because of my wife's career. The gentleman that ran the nuclear pharmacy on the campus here wanted her to set up a nuclear pharmacy in Fargo, North Dakota. The University no longer really wanted that nuclear pharmacy. They wanted it to go private. So they took it private. There was a nuclear pharmacy here in the community that was actually eventually a private business. Then, they set up a nuclear pharmacy branch in Fargo, North Dakota, so I wound up going back to Fargo with my

wife. That's how I eventually started working for the North Dakota State University in academics after my fellowship.

LK: Okay.

I also have a question about the Pharm.D. program itself. I know that in 1978, the University ended their bachelor of science in pharmacy. I didn't know if you had much awareness of sort of that changing professionalization in pharmacy.

RS: I did not so much. Actually, I think it was in 1996.

LK: Oh! In 1996?

RS: Yes. Well, all schools of pharmacy went to the all Pharm.D. program in 1996 and I think Minnesota did the same. So it was 1996.

I went back and did the two years of a doctorate program and stayed on and did the fellowship, because I really felt that I needed to differentiate myself in the marketplace. I didn't want to go and work at Walgreens. In order to do that, I had to advance myself somehow to differentiate myself in the marketplace.

I think that, at the time that most of us were getting Pharm.D. degrees, the vast majority of us probably found jobs in academics. There wasn't a lot of private jobs for Pharm.D.s, at the time. So we were sort of the first ones to set the tone and have to take the lead to build practices in that part of the profession. I think it was kind of an important time. Then I left academics, of course, in 1987, so it was it was kind of before the big debate: Should we all have an All Pharm.D. program or not? One of the experiences was moving to California in 1987 where all of the pharmacists had a Pharm.D. degree. The problem with it was that, yes, they all had doctorate degrees but they were doing the same thing that bachelor's pharmacists were doing, a lot of them, the vast majority of them were. So were we just giving everybody a doctorate degree and not changing the profession or were we giving people a doctorate degree in order for them to change the profession? I think we can still someday have that debate. But it's a lot better now.

Consequently, I wasn't really for it. I was doing, more or less, my own thing and I didn't really get into that debate academically. I just felt I was building on my own career. It was important to me as a professional pharmacist, but as an individual impact, it didn't really have an impact on me and where I was going and what I was doing. I think the thing that was most important for me was going back and getting my Pharm.D. and, then, doing that research fellowship. That was huge. That fellowship probably opened up more doors for me than I think anything that I've ever done in my career.

LK: Oh, wow.

RS: That one thing, that one year was so valuable.

LK: In terms of your mentors, did they largely have their degrees in basic sciences?

RS: No, they were all clinicians.

LK: Okay.

Going back to your fellowship... Was it contacts you made that opened up the doors or...?

RS: I think it was that additional experience. Going back to North Dakota State didn't necessarily open up any doors. It was interesting because it gave me enough knowledge, which I think is kind of an interesting story. When I went to Fargo, I actually didn't have a job at the time. There wasn't really anything at the college pharmacy, so I was just going out and seeing if I could find some consulting work. I went to nursing homes to see if they needed a consultant pharmacist. The problem is that they were getting that service for a very low cost from pharmacists in the community who were supplying the pills. So to add extra money for a consultant, they weren't going to do that in nursing homes.

But I ran into a fellow who also became a mentor of mine. His name was Russ [Russell] Gardner [Jr.]. Russ was the department head for psychiatry at the University of North Dakota School of Medicine. I don't exactly remember the details of how Russ and I got to know each other, but Russ asked me if I would go to The Neuropsychiatric Institute [TNI, Fargo] and give a seminar on the pharmacokinetics of anti-psychotic and anti-depressant drugs. I really didn't know very much about those drugs. So I sat down and did the literature review and put a slide presentation together and went and gave the grand rounds at TNI. It went pretty well. I don't think they were ready to hire a pharmacist there. Russ said, "I think they could use your help out at the North Dakota State Hospital. So I went out to the state hospital and gave a talk at the state hospital. They hired me as a consultant a day a week to go to the state hospital and review patients and so on. So that kind of started it.

Then, very shortly, almost at the same time, a position opened in a family medicine residency program at the University of North Dakota and it was a combined position with pharmacy. So I went back to the College of Pharmacy. I had this consulting job as well as my work at the College of Pharmacy. I was in their residency program where we had pharmacy students and medical residents together in the same clinic for about two years.

Then, they moved over to the Dakota [Heartland] Hospital instead and we established a pharmacokinetic consultation practice there. That would have been in about 1981. That was a really exciting time. That was great. That was a hospital that probably had 250 beds or so, a medical/surgical hospital. We had privileges, which is something that was not always heard of, privileges that allowed us to write orders and have them cosigned.

LK: Oh.

RS: So we wrote all the orders and we managed all the patients on aminoglycoside antibiotics, Vancomycin and Amphotericin, and, then, there were other consultations for cardiovascular and anticonvulsant drugs.

One of the areas that was really of interest to me... I had worked with Bob Cipolle and we had performed this study looking at heparin and how we could coagulate patients that were acutely ill on heparin a lot better. This is one of the studies I had worked with at Saint Paul-Ramsey when he was there. I took that information, the method that we had looked at, and went down to the dialysis unit. In the dialysis unit, at the time when I went there, they would put their dialysis patients on heparin. They gave them all the same dose. They ran them, virtually, at the same infusing rate for three and a half hours and, then, they shut the heparin off a half hour before the end of dialysis. It almost didn't matter if you were 250 pounds or you were 125 or if you were sixty or you were eighteen. It didn't matter. Yes, everybody was getting, virtually, the same dose. And the nurses would say, "We have to keep so and so around a little longer because he tends not to clot off right away." I thought, well, we should do the same kind of study that we did at Saint Paul-Ramsey on these dialysis patients. So we did. The nephrologists were all pretty supportive of it and, eventually, it turned out that we actually individualized each patient's heparin dose. Some patients got a small loading dose and, then, a very small infusion. Some got bigger ones. For some, we shut the heparin off at an hour. Some we shut it off later or even earlier. That's what we did. We dosed everybody and everybody got their own individualized heparin dose. So that was something new in terms of dialysis, especially for that hospital.

We, subsequently, published that information and Bob was one of the co-authors of course, along with me, and one of my students. [Heparin kinetics: variables related to disposition and dosage, *Clinical Pharmacology and Therapeutics*, 1981]

Those were the kinds of things that I learned at the University of Minnesota. I think the knowledge that you got at the University of Minnesota was with the people that were the faculty here at the University of Minnesota and, even more so, with those mentors. That's huge. To me, that was really a valuable thing from the University that I received here in my education.

LK: Is the, I guess, individualized dosages of heparin a more standard treatment now?

RS: You know, I've been gone so long from it that I don't really know.

[chuckles]

RS: I would assume they still have to coagulate. They still have Coumadin and they still have to coagulate during dialysis. I haven't been involved in that since probably 1987. So I'm really out it.

LK: Okay. It just seems like an interesting change in the way people were thinking about medicine, at the time.

RS: Yes, and I don't know if everybody adopted that necessarily from the article. Perhaps, they did in certain places, but we didn't really go out and present that at a lot of meetings. It was probably just shortly before I left.

LK: I also wanted to talk a little bit about the privileges you said you had at the hospital. I read between different specialties within medicine and different health practitioners that there's a lot of competition for who has the authority to do different procedures. So do you think that was just sort of a result of the environment you were working in and the personalities there?

RS: I think in terms of pharmacy, it was kind of novel. I do know that there were other pharmacists in other places that had privileges to write orders on each patient independently. But there weren't many of us. There's kind of an interesting debate in pharmacy now: should we change our practice act so that we can have prescribing privileges? I look at it and go, "I'm not so interested in having prescribing privileges as I am of having privileges within and being recognized within a group of professionals in an interprofessional way." In other words, if I were a clinician at Fairview [Medical Center Minneapolis], it would be far more important to me to have privileges that were set up by the medical staff within Fairview that allowed me to prescribe than it is for me to go out to the Legislature and change prescribing laws. I would rather have those as part of my credentials than to have that necessarily mandated. And that's the way that was. It was, basically, having privileges in a collaborative practice that they recognized you for your skills and the level of professionalism and knowledge that you provided. They knew it was at a higher level than theirs, so it was okay with them. They just trusted you. I think that was really important.

LK: Yes.

The other thing that I had a question about was conversations about getting a large enough workforce out into rural areas in Minnesota, and as the feeder school into North and South Dakota. I didn't know if you had any perspective on that because of your moving between Minnesota and North Dakota.

RS: I think that the program has been very important from a perspective of trying to attract rural—I'll call them kids—students into pharmacy. I think that has been real positive. I think we have been successful at doing that. Now, getting the students into the pharmacy program and getting them trained and educated is one thing. Getting them out and getting them back to a rural community where they have a sustainable practice is quite another.

LK: Right.

RS: So what we have to do is we have to work on ways to build sustainable practices for pharmacists. That may not necessarily be putting pills in a bottle, but it may be other pharmacist-related services that are collaborative with other healthcare professionals that

meet needs of the community, that may be somewhat public health related, but, also, how do we get them paid so that it becomes something that is sustainable and that they can make a respectable living at and have a nice life professionally as well as personally. That's more of a challenge and something that we have to transition pharmacists from. Right now, in many of those communities, the survival is based on dispensing a product, because that's what they get paid to do. We need to change that from being product oriented to being service oriented.

LK: Oh.

RS: We're really on the forefront here at this College of Pharmacy in building those sustainable clinical practices, if you want to call them clinical, and finding ways that we can document the value so that we can get pharmacists paid for that service.

LK: Is part of the problem with the older model based on providing a good because a lot of the community is smaller and it's difficult to make a living doing just that?

RS: It's the competition and the reimbursement. Reimbursement for dispensing prescriptions has really dropped over the years to where the margins on any individual prescription are very small. Some of it has to do with the fact more and more of the drugs are generic versus branded. Branded products tended to have on a percentage basis maybe a lower margin but the net branded product because it was more expensive was more dollars than a generic. That has squeezed profitability and value and made it more challenging to make a living in a smaller community pharmacy where there might not be so much volume. What happens then, Lauren, with that is you have to operate on volume. You have to dispense a lot of prescriptions. Well, there might not be a lot of people to dispense a lot of prescriptions to. That becomes a struggle in smaller communities.

The other challenge is that of mail order. If I get my prescriptions by mail, I don't get them from my local pharmacy. We know that in Main Street in small communities if you lose the pharmacy in the community that is very difficult within that community. A pharmacy tends to be a place that is an anchor where people come into town... or go to on a frequent basis. When they go there, they oftentimes pick up something somewhere else.

LK: Right.

RS: That's a challenge that we have. So we need to find ways to make those communities stable and see if we can grow some places where we can actually provide additional services. Maybe it doesn't have anything to do with prescriptions itself. It might have, actually, just to do with the medications that you're taking.

LK: Is this realization about the importance of the pharmacy to the community more of a recent phenomenon?

RS: I think it's been studied now. A lot of the work was done here probably in the early 2000s.

LK: Okay.

I'm going to come back to that when we get to the later career.

I wanted to ask you about... Maybe this happened when you moved to California. But from what I found about your career, you kind of switched from... You continue doing consulting work, but I saw that you had a lot of experience in managed care and medical group management.

RS: Yes.

LK: It seems like there was a career change.

RS: I think the philosophy is bloom where you are planted. So in 1987, my wife was asked to move to their corporate offices in the Los Angeles area for a company called Syncor International which was a large chain of nuclear pharmacies. I said, "Okay, I'll go with you." So I moved out. I started as a clinical coordinator at a cottage hospital in Santa Barbara, California, which was okay but it just was not really what I had in mind.

Eventually, I left and I worked as a consulting pharmacist for a nursing home company called Pharmacy Corporation of America.

Then, I had an opportunity to go to work for a friend of mine who had graduated from this program at Minnesota a year before I did, Robert [P.] Navarro, so I went to Health Net. That was my first exposure to managed care. I worked there for, I don't know, eight or nine months. [chuckles]

One of the district managers from Pharmacy Corporation of America came and convinced me that I should come back and manage a long-term care pharmacy in Camarillo, California. The salary and incentive was just too much to say no to. So that's what I did. It was one of those things where you should do more research and take more care of your fiduciary responsibilities to yourself. Anyway, I thought the pharmacy was not losing as much money as it actually was losing when I got there. So we tried to build the business. We were able to start a couple of new nursing homes, but it wasn't long after that I was asked could we make this pharmacy at least break even or we were going to have to close it. There was just no way this was going to be profitable within the short term, so they closed that pharmacy.

I wound up going to work at a company called California Clinical Trials. That was in Beverly Hills. What a great experience. It was owned by a psychiatrist neurologist who was from the Los Angeles area but had worked at the National Institute of Mental Health. There were two Pharm.D.s, myself and another Pharm.D.. We did a lot of the research design work. We worked with pharmaceutical companies. We did pivotal clinical trials,

large trials for the FDA [Food and Drug Administration]. We did a lot of work on Alzheimer's, and depression, and obsessive-compulsive disorder, and hypertension, and some other cardiovascular studies, but a lot of Alzheimer's work, the first-time-in-man studies, really interesting stuff.

[chuckles] I took responsibility for part of the operations which included how do we advertise to get people to call in to our call line so that we can get them enrolled in the studies. So I learned all kinds of things about how do you advertise for patients who have depression? When do you advertise for that? You don't advertise for them in the middle of the morning, because they're sleeping. When do you advertise of Alzheimer's patients? Well, you advertise for them on work radio when their sons and daughters are on their way to work.

LK: Ohhh.

RS: Things like that...very interesting, even television commercials. That was just really fascinating from a marketing perspective. The studies were very interesting...lots of contacts and lots of work with the pharmaceutical industry and entertaining people from the industry, taking them to restaurants where they could see stars and all that kind of stuff.

LK: Okay. [chuckles]

RS: It was a very exciting time.

LK: Was that part of trying to get them to go through your company?

RS: Yes. We'd do lots of entertainment for large studies. I think my last advertising budget at the time—this would be back in 1992, 1993—was \$1.2 million...

LK: Wow.

RS: ...which I spent on radio and TV ads. Gosh, I bet we had twenty or so people taking calls, a call center, huge. Great fun.

LK: It seems like a lot of your career has evolved to really focus on business.

RS: It has. Yes. You think back on your career and you go who were all of those really wonderful mentors that you had.

We had a mentor who was a very successful businessman, started up U.S. Bioscience and sold it. Then, he was a consultant who actually worked with Dow Chemical to do the merger between Merrell-Dow, a large pharmacy. He was our business consultant. We would have dinner with him probably once a month in the evening. He would go over our numbers. I learned so much from him in terms of business. A lot of it was common sense. A lot of it was look at it in a different way.

LK: Who was this?

RS: His name was Sam Berkman. Sam was phenomenal.

LK: How long did you work for...?

RS: I was there three years. I thought if I stay here, this is a privately held company and I can stay here, yes, but I don't know if there was any desire to go public. I think the fellow that owned it was going to sell it to someone. I could probably stay on with the new company, but was there a time when I should just move on?

So I did. I moved on to take a job as a clinical pharmacist with Health Net. Health Net was a large health maintenance organization, managed care.

LK: Had you been at Health Net previously?

RS: Yes, for that short period of time between being a consulting pharmacist for Pharmacy Corporation and, then, going out and managing one of their pharmacies. There was about an eight or ninth month period that I was at Health Net. Yes.

So my job at Health Net this time...

LK: [chuckles]

RS: ...was to go out and help two medical groups, to work with two medical groups. One was the Santa Barbara Medical Foundation Clinic and the other one was Mission Medical [Associates] in San Luis Obispo. These were two high utilizing, high pharmacy cost medical groups. The idea was that they appointed a pharmacist to go there and help those physicians manage their pharmacy costs. At that time, physician groups took risks for their pharmacy budgets. Let's say the pharmacy budget was ten dollars per member per a month. That's what they got allocated for cost but if they came in at nine dollars per member per month at the end of the year, they split fifty cents. They would split it with the health plan, so they got a bonus. But if they went the other direction, they actually had to take money out of their group to pay the health plan back for part of the loss. So they had this risk. The idea was to help them manage this risk. I went out, and I set up a pharmacy and therapeutics committee working with physicians to help physicians manage themselves, not me going out and telling them whatever it was they were supposed to do.

I think my experiences back in Dakota Hospital and working with physicians when I was in my fellowship and even, to a certain extent, the work at California Clinical Trials all kind of built on my ability to communicate and have a collegial relationship with physicians. I've always been lucky enough to have that nice relationship, and I still do today. I still have one physician group that once a month I do some work in their pharmacy and therapeutics committee to keep me current.

LK: Yes.

RS: I would go to Santa Barbara and San Luis Obispo. That was not really tough duty, by the way. That was pretty decent duty.

LK: [chuckles]

RS: So I started off as an employee with Health Net going to those groups.

Then, one day, I was approached by the CEO [chief executive officer] of Santa Barbara Medical Foundation and Clinic, and he asked me if I would like to come and work for the physician group. So I did. Then, I became part of the physician group. That's when I became vice president for pharmacy. Then, they gave me disease management and research, as well. So I set up a little research program. We tried to start some disease management programs, as well. I look back on that as being really a lot of fun, but, also, probably spreading myself too thin and not focusing enough. Then, I took on some operation management.

LK: Right.

RS: I was actually a clinic manager for the clinic. It had allergy. It had pulmonary. It had surgery. It had GI [gastrointestinal]. It had internal medicine. It had some family medicine. It had psychiatry. It had endocrinology. It had orthopedics. So it was very large, so then it became all personnel management. While that was interesting, that was not what I was trained for. When you're spending all your time doing that, you sort of take your eye off the ball on the other things.

What began to happen is that a lot of the plans began to allow the physician groups to not take risk for pharmacy. In other words, the plans began to take risk for it all instead of the physician groups. Consequently, there was less and less of a need for pharmacists. At the time that I first started, there were maybe ten or twelve of us in Southern California and several in Northern California, pharmacists that worked with physician groups helping physicians manage risk. The problem with that is it's sort of a zero sum game. I can only get you down to a certain level and, then, what do I do from there? It was kind of one of those jobs that had an ending.

LK: Yes.

RS: During all of that time, I had managed to build up a pretty good relationship with a lot of people in the pharmaceutical industry. So when the time came to leave the Santa Barbara Medical Foundation Clinic, I stepped out. I had a really good friend who worked for Astra Pharmaceuticals, at the time. One night, he and I were having a cocktail and he said, "I'll put you on a retainer if you want to go set up your own consulting company."

LK: Oh, wow.

RS: That was for \$100,000. I had one other physician group that I kept. So I just thought I can leave, so I'll just do this.

LK: Okay.

RS: That's kind of where I think entrepreneurship came from. It was, like, okay. What do I have to lose? I might as well just go do this. I started with Astra and, then, I added Parke-Davis [Pharmaceuticals] shortly after, in a couple months. Then, I added Pfizer [Pharmaceuticals]. I don't know how many pharmaceutical companies I worked with. It was all about how do they position their products within physician groups where there is some risk involved?

LK: When you say risk, are you talking about financial risk?

RS: Financial risk, yes.

LK: Okay, okay.

RS: The industry was very interested in how to best position their products. How would they differentiate their product within a physician group when physicians felt that they had risk involved in managing that risk? That was a time in the 1990s when there were lots and lots of new products coming out.

LK: Right.

RS: So it was a very good time; although, I wish I had gotten in a couple years earlier. That was really great. I had lots of clients. I was mostly on a retainer with them.

In about 2003 or so, the Office of Inspector General guidelines changed dramatically and the pharmaceutical guidelines changed dramatically. There were probably two things in the market that really changed things for that business. A lot of products coming out was one and the changes in the Office of Inspector General guidelines and how pharmaceutical companies related to physicians made it much more difficult to get and keep pharmaceutical clients.

LK: Hmmm.

RS: In about 2004, another friend of mine, Steve [Stephen G.] Hoag, who was the senior associate dean at [the University of Minnesota-] Duluth [UM-D], called me up and said, "Maybe you'd like to think about coming back to academics. I could use a senior person to mentor faculty. Would you be interested?" I said, "Well, I don't know." We talked for nearly a year and I finally said, "You know, this business of mine..." I could see that we were really going to... It was fine. I was the only employee ever. I just didn't really want to try and find something else to do in that business. My wife's company was sold to Cardinal Health, which is a large wholesaler, at about the same time. She had a very

good, lucrative exit package. So here she is with hers. Here I am with mine, and here's this offer on the table from the University of Minnesota to come back. I thought why not?

What did we do? I come back the middle of January 2005.

LK: [laughter] From California.

RS: I think it was a blizzard, about thirty below. I thought what have I done?

LK: It's a hard move in the middle of January.

RS: Oh, yes.

LK: If you don't mind, I'd like to ask you a couple more questions about your consulting work.

RS: Sure.

LK: Are you acting to mediate prices between the pharmaceutical companies and doctors?

RS: No, no, no, no, no. I really didn't do anything with pricing. The pharmaceutical companies would set their own prices. What I would do is work with the physicians to figure out which ones would offer them the best value, based on that. But the physicians didn't pay me. The pharmaceutical companies paid me to do that for the physicians.

LK: Okay.

RS: It was a very odd business model, believe me. If you had sat down and put that on paper and said, "That's a business I'm going to develop," I don't think you ever would have done it. I think it just sort of happened that way.

LK: It's interesting that you had so many different pharmaceutical companies on retainer. It seems like they would have competing products and you would have to...

RS: I tried really hard not to pick companies where I was going to have conflicts. Yes. So what I did is I focused on very specific areas. With my work with Parke-Davis, I focused on hypertension and lipid management.

LK: Ohhh.

RS: That worked out okay with Pfizer because they shared the same product with Parke-Davis. They co-marketed it. Then, they had some anti-depressant products, so I could work with Pfizer. Then, Astra had a nasal steroid, so I could work with them on allergy and asthma. Every company kind of had their niche. What I tried to do is find

companies that I knew I could work with where I didn't have any ethical issues with their product and that I would not have any conflict of interest with the physicians. I'm not going to go out and sell physicians a bunch of stuff that I don't believe in...

LK: Right, right.

RS: ...and is not in their best interest. It really was, if you think about it, almost sort of like being a matchmaker.

LK: Yes.

RS: Then, it was putting together things that were educational programs. I had this little formulary booklet that I individualized for the different physician groups. We used that. Then, we had some guidelines in that booklet, as well.

LK: I think that physician education angle is very interesting. I had read a little bit in the history about concerns, in the 1970s maybe, regarding doctors having continuing knowledge of drugs that were developing and just how quickly pharmaceuticals change and pharmaceutical companies stepping in to do that kind of education. It's just interesting. I hadn't realized there was this maybe third player that would have been you, that would have been the intermediary between those two groups.

RS: Yes. We'd run other things like focus groups on new products being developed. Eventually, I wrote dossiers, a large summary of studies and background for health plans or groups to use in their pharmacy and therapeutics committees. It evolved into some other kinds of work with the industry, as well. It wasn't all just with physicians, but that was the lion's share. That was the reason I had the other business, because I had all these contacts with physicians. That relationship that I had with physicians and physician groups was probably what convinced the industry that they should hire me as their consultant, because I had these great relationships.

LK: Right.

Did you do any patient work at all?

RS: No. That's why they wouldn't allow me to do patient care, you know. I can only practice on myself and my family, probably, [motions no].

LK: Oh, okay. [laughter]

When you decided to come to Duluth, what kind of goals were set out for you and what did you envision you needed to do here? That definitely connects back to what we talking about earlier with the viable businesses for pharmacists. Was that something that you came in knowing that you wanted to work on?

RS: Ummm... That's a really good question, Lauren. I think I came in because I wanted something to do that I thought was important towards the end of my career. How old was I? In 2005, I would have been fifty-three, I suppose, something like that, not real old. I just thought this is not a bad place to end your career. I don't know if I really had any goals when I got there. It was really to help Steve out.

LK: Okay.

RS: When I got there, there was a lot of young faculty. I think Steve and I were probably the old guys. I just did a lot of things, at that time. I don't think I really knew very well how to be an academic mentor for faculty.

But I got to Duluth and I don't really know how it started, but I started doing some work with what is now Essentia [Health], but at that time was Duluth Clinic and Saint Mary's Hospital, on their pharmacy program. Mostly it was how could they save some money on their own employees. I had some knowledge of things that I had done in California that I knew would work for them here. Like if you have your employees get their prescriptions from the Duluth Clinic, you can actually buy products off of the hospital contract for them specifically, because you're at risk for that. Normally, you can't do that. It would be breaking the Hatch Act.

LK: Oh, okay. Yes.

RS: That saved them hundreds and thousands of dollars by doing that. [chuckles] Mandating that their employees get their prescriptions from a Duluth Clinic pharmacy, they could actually buy some of their products at pennies on the dollar in comparison. So we did that.

Then, I saw this ad for what's called the Ten City Challenge with the diabetes program that APhA [American Pharmacists Association] was putting on. I thought I wonder if we could do that in Duluth. I got the pharmacists from Saint Mary's and from Duluth Clinic and from Saint Luke's together with their HR [human resource] managers. I invited the HR manager from the City of Duluth, Gary Meier, which will turn into a story.

LK: Okay.

RS: I think the HR manager from Minnesota Power came. I used some of my startup funds to provide a luncheon and invited Dan [Daniel G.] Garrett from APhA to give a talk on the Ten City Challenge. It went really quite well. There was some interest amongst the parties. I thought if I can get this to Duluth that would be really a feather and be really great. Anyway, we needed 5,000 lives in order to put that together. Well, I got Saint Luke's which was only about 2,200 and the city was kind of close but then Gary said, "No." He just couldn't put it together. So it sort of waned.

It wasn't long after that that Gary gave me a call from the City of Duluth and said, "I want to know if you would be willing to sit on a committee to work on importation of drugs from Canada.

LK: Oh.

RS: "Gary, first of all," I said, "my colleagues would be *very* unhappy with me. I'm on the College of Pharmacy. That's not a good thing to do."

LK: Right.

RS: "Two, I think there are a lot of other ways that you can do this without importing drugs from Canada. If you are willing to sit down, I will work on a committee with you if it looks at your entire pharmacy benefits." We did put this group together and I brought my students along with me. It was a really terrific experience.

LK: Oh, yes.

RS: So we sat down. We, eventually, hashed out... I don't know how long it took. It was a long time. It was well over a year. We started having meetings with the insurance committee and there was somebody on the insurance committee who was chair. His name is Erik Simonson. Erik is now a state representative from Duluth. What we did is we revised their pharmacy benefit, which was at about \$4 million then, so that it would either go down some or would at least not grow. In fact, it's still probably around \$4 million and that was back in 2008, 2009. They are very pleased. To do that, I asked them if they would add the medication therapy management [MTM] benefit to that. I think it might have been the first public organization within Minnesota to offer their employees medication therapy management as a separate benefit in the pharmacy benefit. They did put that in.

Erik and I worked together with two or three other individuals within the city to do a request for proposal and, then, an evaluation of different pharmacy benefit managers [PBM]. In the end, we selected ClearScript, which is Fairview's [Health Services] PBM. Then, they manage the medication therapy management benefit. To my knowledge that was the first real MTM benefit in the state, at least in a public organization like that.

LK: Has that been adopted elsewhere?

RS: Yes. Then, it was adopted by... I don't remember the entire sequence, but we had this group called the Northwest Chronic Illness Reduction Initiative. It was kind of a group of HR managers and myself. We talked about diabetes management. That way, I got to know a couple of other people. One was the chief financial officer, Jean DeVito, over at Superior [Wisconsin] and a fellow by the name of Jim Gottshald, who was the HR benefit manager at Saint Louis County [Minnesota]. They began talking. So I went over to Saint Louis County and talked to them, and I went to the City of Duluth and I talked to

the city council and those people about the same program that we had at the City of Duluth. I went to Douglas County, actually, over in Wisconsin, as well.

About the same time—I don't remember the entire sequence—I thought why are we doing this here? I called up Greg [Gregory R.] Fox, who was the vice chancellor for finance at UM-D, and Judith [S.] Karon, who was very instrumental. She was the director of HR at UM-D and recently retired. Judith was very supportive, because she had been going to these meetings that we'd been having. So we got together with Greg and we did this presentation on medication therapy management. At the end, Greg said, "I don't understand why we're not doing that for our own employees." So, then, he agreed to be our advocate and our champion, and he took it to the advisory work group that Doctor Cerra...

LK: Frank?

RS: Yes...that was a group he oversaw and went with Steve [Stephen W.] Schondelmeyer and myself and Greg was there and there were other members of that committee. We presented a few slides. Then, they decided that, yes, they would advise U-Plan that, perhaps, they should do this. Then, it went to the Benefits Advisory Group, another group. Then, they agreed on it. Finally, U-Plan implemented this. It was going to only be implemented as a pilot effort. Oh, gosh, when did we start this? In 2008, we decided that we would have a little clinic on the campus of the University of Minnesota-Duluth over by the Kirby [Student] Center. We got this all set up and we had the practitioners all lined, the pharmacists, and we'd see our own employees right on campus. The idea was for that to go for about a year and a half or so and, then, we would analyze how it was going. But for some reason, it must have been reasonably good because by the time we got to March of 2009, they decided to launch it system-wide.

LK: Oh, wow.

RS: So Morris, Crookston, Duluth, this campus, and Rochester, wherever there are University of Minnesota employees could access the U-Plan MTM benefit.

LK: Yes.

RS: There were some failures, too. Let's see, we worked really hard to get 3M to adopt something like this. I went at least twice to 3M and that just never really got any legs. There were some other ones, but, generally speaking, we had U-Plan. We had Saint Louis County. We had the City of Duluth. We had the City of Superior. We had Douglas County. There are lots of other places now that are providing it. Health Partners provides it. General Mills provides it. It's very exciting to be in Minnesota.

LK: Yes! You said that you had involved your students in some of these talks.

RS: Yes.

LK: Have they been involved in a lot of this kind of thing?

RS: They were involved. I had five students who really worked a lot on this. Phil Brummond, who graduated in 2007. Then, Phil went on to get a master's degree and recently was assistant director of pharmacy at the University of Michigan hospitals, and, now, has become the director of pharmacy at Froedtert in Milwaukee, a large hospital system in Milwaukee, so a very successful young man.

LK: Yes.

RS: Another student was Adam Pavek, who does the formulary management at DHS [Department of Human Services] here for the Medicaid program in the State of Minnesota, Tim [Timothy] Cernohous, who is now one of the more senior managers at Essentia Health System Pharmacy, Dan [Daniel M.] Tomaszewski, who is one of our own graduate students now and going to be finishing up his Ph.D. Who am I missing? [pause] Those are the main ones.

LK: Those four, right?

RS: Those four. Yes.

LK: That's a really awesome educational experience.

RS: Oh, those guys... I wish somebody would have taken me by the hand and done that for me.

LK: Yes.

RS: I learned it all on my own just by working in the area.

LK: Right.

RS: There wasn't anybody to teach me this and be able to look at those relationships and how do you do this.

LK: See it go into action.

RS: Yes.

LK: That's really cool.

RS: It was cool.

LK: One of my questions was about relations between the University of Minnesota-Duluth and then the [University of Minnesota] Twin Cities. It sounds like there's a good

working relationship from what you did on MTM. Did you have any other comments on that relationship?

RS: I think there were some people within the Twin Cities College of Pharmacy who were not so happy about having a campus in Duluth.

LK: Was it about competition?

RS: Well, I think it was, maybe, about resources and was there really a need. We'd hire faculty in Duluth. How come we couldn't hire the same faculty in the Twin Cities and grow the class to 160 or 170 rather than having 60 students in Duluth? It's probably a valid argument. Does it service the rest of the state or, better yet, did it prevent a competitor from coming in? There are so many states now... For example, when I was in California and up until 2005, there were only three colleges of pharmacy. There was the University of the Pacific. There was UC-San Francisco, [University of California-San Francisco], and there was the University of Southern California. Now there are thirteen.

LK: Wow!

RS: So could that have happened in Minnesota? Sure. Why wouldn't Concordia [College] in Moorhead or [Saint Mary's University] Rochester or [University of] Saint Thomas or [College of] Saint Scholastica [Duluth] or any of the private schools think about putting in a pharmacy program? They could have done it. Will they do it now? Probably not, because we have two campuses, and I think we cover the state pretty well and we're committed in Duluth as well as here in the Twin Cities...but in Duluth our focus is rural. It's underserved populations. That's what we're looking for. We complement each other in terms of the Twin Cities and Duluth. I think it's a great partnership.

It took some really stellar, phenomenal leadership in Marilyn Speedie to put this together. She and I work all the time on our "One College, Two Campuses" philosophy. We have to do it everyday.

LK: [chuckles]

RS: Maybe some day, another ten years from now, nobody will think any differently. Is the relationship perfect? No, it's not perfect. Is it good? It's very good. Other schools look to us for our pattern. How did you make that work?

LK: I have to ask about the thirteen, did you say, colleges, now, of pharmacies in California.

RS: Yes.

LK: Is that just private schools opening up? Are they serving a need or people just want to be pharmacists?

RS: There was a shortage of pharmacists for a long time. They probably saw it as a moneymaker. So they opened up...a lot of those are private schools of pharmacy.

LK: That's a really interesting phenomenon that's going on right now. I've been interviewing people in the Dental School, as well. I've heard the same thing there. They're for profit dental schools.

RS: They might be for profit or they might be a not-for-profit but a private school, like a religious school or something. Yes.

LK: That's really interesting.

RS: It happened all over. In Milwaukee, there's Concordia [University]. There was no college of pharmacy there. Does it have an impact? It has a huge impact on [the University of Wisconsin,] Madison, because now there's another competitor. So you're competing for same pool.

How many pharmacy jobs are there in Minnesota? It's not unlimited. We're creating new opportunities for pharmacists all the time. We're probably really pretty good at it here. But I can't say that we would need another fifty, sixty graduates on an annual basis. I don't know where they would go.

LK: Right. It seems like trying to understand healthcare manpower and shortages and surpluses... It's been such a bizarre trend.

RS: It is a bizarre trend.

LK: What I've read in the 1970s is that a lot of the schools within the Academic Health Center are increasing their numbers, increasing their numbers. Then there is retrenchment, retrenchment.

RS: I think it's going to be interesting for all of the professions. I don't know so much about dentistry but certainly in pharmacy and nursing... Pharmacy is more and more from a gender perspective beginning to look like nursing.

LK: Really?

RS: Yes. We're sixty some percent female in our classes. I think our profession has just tipped over to fifty percent women. Well, for women, a lot of them come in and come out, go in and maybe go out, and maybe come back in or work part time. If you're an academic institution, how do you plan for providing pharmacists? We want women. Obviously, they're great pharmacists. That's not an issue from a gender perspective. I think the same thing is happening in medicine...

LK: Hmm.

RS: ...and certainly in nursing. I don't know how you plan for that strategically. Maybe you just adapt to the market.

LK: Yes.

RS: I'm thinking dentistry probably has seen the same.

LK: Yes.

RS: I think it's cool. It will be interesting to see how that works from a career perspective.

LK: Do you have any insight on that kind of recruiting? Being that you went to school during the 1970s, there was talk about an emphasis on trying to admit more women. Now, there's this majority in a lot of the healthcare professions. Do you have any commentary on that?

RS: No.

LK: Okay.

RS: I really don't. I think it's just fine.

LK: One comment you made about Duluth was that you're trying to serve undeserved populations. I didn't know if there was any emphasis at Duluth in recruiting, say, Native Americans or other minorities, serving those underserved populations?

RS: Yes. Up until, what, maybe two and a half, three years ago now, there were no Native American, American Indian faculty within the College of Pharmacy. We were able to attract Michelle Johnson-Jennings to the College, as well as now her husband, Derek [R. Jennings], will be joining us.

I think what really helped was Marilyn and I worked together to put some money together to start up what we called the Research for Indigenous Community Help, RICH. It's a cooperative venture between us and the Medical School in Duluth. We do all the funding, but one of their faculty is a co-director, Melissa [L.] Walls. That's all American Indian. Their job was to build this relationship with tribal communities and, also, for us to be able to recruit American Indian students in the pharmacy. Yes, that's a big focus. It's a huge focus at RICH.

It's one of our two centers in Duluth that I think really sets those apart from a college of pharmacy perspective. One is the RICH Center and the other one is our Brain Barriers Research Center.

LK: What is that?

RS: That looks at how do get drugs either across or not across the brain barrier?

LK: Hmm.

RS: Into the brain...

LK: Okay. [laughter] I was wondering if it was literally the brain barrier.

RS: Yes, it is.

LK: Is that something you were involved in establishing?

RS: Yes. Marilyn was largely the leader on that. We worked together on that. Yes.

LK: You've done a lot of work with Marilyn Speedie then?

RS: Oh, yes. She's another mentor. You can't be too old to have a mentor, you know.

LK: [chuckles] Do you have any comments on her leadership style?

RS: Yes. First of all, I think she is likely the best of all of the bosses I've had, either number one or number two, for sure...

LK: Oh, wow.

RS: ...in terms of the kind of person that she is. I think she's very much a visionary and very strategic, as well, which I like, because it matches well with me. She and I, if you took strength finders for her and you took strength finders for me, I think we'd match three out of the five together. So we're very compatible from the perspective of thinking alike. I think her leadership has done... I look at this College of Pharmacy and I didn't know a lot about what was going on in the mid 1990s, but I heard bits and pieces as an alumnus. It wasn't a very pretty picture. She came in in 1996. For her to have stayed at a college of pharmacy as a dean of this size for as long as she has with continued success is really something.

LK: Yes.

RS: It's a heck of a great legacy for her. Anyway, I have nothing but good to say, even though it's on tape.

LK: [laughter]

RS: I would say it anyway. It's even better that it's on tape. Now, somebody might listen to it.

LK: Earlier, you had mentioned working with Frank Cerra. I wonder if you had any commentary on things you worked on with him or on his leadership style.

RS: I liked Frank, because he did take this medication management and believe in it. I think he believed the value of what pharmacists bring to the table. What's really good about Frank is he encourages us in somewhat a... I don't know, scornfully isn't really the right word. He said, "It's really time for you to get going." "If you don't do this now, you're never going to get it." He's absolutely right. Besides, he's a surgeon, so, you know...

LK: [chuckles]

RS: ...he's a get-it-done guy.

LK: Right.

You were talking a little bit about when you were in the Pharm.D. program here at Minnesota taking classes with medical students. Is there that kind of relationship at Duluth between pharmacy and medical students?

RS: There is actually some pretty good give and take between the students. They have projects going together, interprofessional. There is the FIPSE program, but there are other things outside of that. I have a group of pharmacy and medical students, and they hold clinic and work together. They are also starting a program through a program called Champs [Champ Day - Connecting Hopes with Action to Mobilize People], I think it's called, where they're going to do an interprofessional medication therapy management program. There will be medical students and pharmacy students working together at Lake Superior Community Health Center. It's not completely a free clinic, but it serves underserved populations. So they're working together on that. That has brought faculty together, as well, working. So, yes, I think if you let the students pollinate with each other, they'll like it and they'll do great together. I'm pretty pleased with what we're doing in Duluth so far. We could do more, yes. Absolutely.

We just reestablished a nice relationship, I think, with the Saint Scholastica nursing program. I think if dentistry is able to put a small program in Duluth that will be great. That will be huge for us. I hope that happens.

LK: Are there talks about that?

RS: Yes.

LK: Oh, I didn't realize that.

You had mentioned as part of creating the viable business models that you were doing some public health work, as well.

RS: Yes, we're studying... We're trying to see whether or not there are things that pharmacists can do from a public health perspective that actually would be viable from a business perspective. There are some now. Pharmacists give immunizations.

LK: Ohhh.

RS: We can do immunizations. But are there other things within the community, needs that are not being fulfilled that pharmacists could fill? I don't know what all of those are, but we're hiring a faculty to help us figure it out.

LK: Okay. Is it like a public health faculty or a pharmacist?

RS: It's going to be a Pharm.D.. We haven't advertized for it yet, but I have somebody in mind for it. This person has a *huge* interest in public health, as well.

LK: Do you do any work with the School of Public Health here?

RS: Yes. We do a lot. We have a Pharm.D. MPH [Master of Public Health] program that's starting this fall, so a combined degree program. We work a lot with Labovitz [School of Business and Economics, Duluth] and they have Jennifer Schultz and Doctor [Jill] Klinger. I can't remember her first name.

LK: I can look it up.

RS: We work with them on their epidemiology. I think they would like to get a bachelor's program in public health at least started at UMD.

LK: Hmmm.

RS: So we're working really closely with them. We provide them some coursework, because they can't really provide through to the business school. So we're providing it though the College of Pharmacy.

LK: That's interesting.

RS: Yes, it's interesting. Actually, we have a really nice relationship with Public Health.

LK: It sounds like you maybe did a little bit through the MTM project, but have you done much work with the State Legislature?

RS: Yes. It's just sort of starting. It's mostly because of my friendship with Erik Simonson, but, also, we've gotten to know Senator Roger [J.] Reinert quite well. I did know Representative [Thomas] Huntley, a little bit in the past and we've been to

meetings together. Erik and I have worked together. We've worked so much together on that pharmacy benefit for the city so we developed a really nice relationship. What are we working on? We are mostly trying to focus with those two on developing some sort of gathered data on the impact of synthetic abuse within Duluth and elsewhere and to help Erik. Erik is the chair for the special subcommittee on synthetic use and abuse. So he needs to report to the Legislature in February. So we're helping him with data. We hope to maybe be able to do some surveys of users. So we've assigned a team which includes one of our American Indian graduate students. Michelle Johnson-Jennings is on that team. Mark [E.] Schniederhan, who is a faculty, is our site specialist. Then, we have a couple of students. One is doing an honor's project in this area. It's very fun. We have developed such a really good relationship with those two legislators.

LK: That covers all of my questions. I don't know if you have any final thoughts or anything that I didn't ask you.

RS: Gosh, I hope I didn't ramble too much.

LK: Not at all.

RS: It's interesting. I didn't know hardly anything about the Academic Health Center until I came here.

LK: Really?

RS: Yes, the second time.

LK: Okay.

RS: I don't even know if there was an Academic Health Center when I was here in the 1970s. Was there?

LK: Yes. It just started right around when you came.

RS: About that time?

LK: Yes.

RS: You're focused on just putting your head down and getting through your program and not worrying too much about the rest of it. I think it's really a good entity to have. It makes your health professions a lot stronger because we speak more with one voice, hopefully. I know it's not always that easy.

LK: Right. [chuckles] Just hearing the fact that you took classes with medical students, like that's what they were trying to do. I think it's interesting to get the student's perspective and, also, having someone who has come back. It's interesting.

RS: I think one of the interprofessional things that I'm sort of keeping my fingers crossed that might happen is... We have the two new active learning classrooms that we've put together. We have the one up in Duluth. I asked Kate Dean who manages the Medical Education Program for Essentia Health to visit. I invited her over to campus to show them the active learning classroom. Then, I suggested to her, "Wouldn't it be nice if we put together an actual, real group of practitioners like a couple of family medicine docs, nurses, and some pharmacists together, and we used this technology within this room to build some interprofessional communication and training programs for actual practitioners?" Could we adapt this technology that we're going to use for our own students to build teams to use on real life practitioners?

LK: That would be awesome...

RS: They were some pretty interesting events, so we'll see where that goes. We have Amy [L.] Pittenger working on that. Amy is a star. We hope that will take off.

LK: Okay. Well, great.

RS: That's about it, I think.

LK: Thank you.

RS: This has been a lot of fun. I got to chat. Good.

[End of the Interview]

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