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ACCP WHITE PAPER

Rewards, recognition, and advancement for clinical pharmacists

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Abstract

Clinical pharmacy has continually evolved, with significant expansion in clinical pharmacists' qualifications and roles. However, this growth has not necessarily correlated with improved job satisfaction among clinical pharmacists. A survey of practicing clinical pharmacists performed by the American College of Clinical Pharmacy (ACCP) Clinical Practice Affairs Committee A identified low satisfaction with the time allocated for clinical activities, quality improvement, research and scholarship, and teaching and mentorship. There was also low satisfaction with the recognition provided, despite a high desire for recognition and strong agreement that recognition affects job satisfaction. Rewards for workplace successes and advancement pathways are also not commonly provided. This white paper provides an update to the previous ACCP publications from 1995 and 2010 on the current state of rewards, recognition, and advancement for clinical pharmacists. Suggestions for the pharmacy profession and administrators on how to improve job satisfaction and retention and reduce burnout were developed by the committee and are provided as best practice recommendations.

KEYWORDS
advancement, career ladder, clinical pharmacist, recognition

1 | INTRODUCTION

Clinical pharmacy has advanced over the past 60 years, with clinical pharmacists now having doctorate degrees, residency training, board certification, collaborative practice agreements, and even prescriptive authority.[1,2] However, although the role of clinical pharmacists has also expanded, high burnout rates and job dissatisfaction remain problematic.[3–8] To address this, the American College of Clinical

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Pharmacy (ACCP) published a white paper in 1995 and an update in 2010 to describe motivators and existing systems of rewards and advances for clinical pharmacists, as well as to identify perceived barriers and challenges.[9,10] The 2010 white paper reported that work-life balance, challenging/stimulating positions, and professional advancement opportunities were the most important factors for career success to clinical pharmacists.[9] However, many of the rewards and advances identified in the survey were not commonly provided, including financial incentives, job flexibility, and autonomy, support for additional education and training, career advancement criteria, advancement opportunities, career ladders, and professional development plans. In addition, perceptions of major motivators and the most important workplace factors for clinical pharmacists differed between managers and clinical pharmacists.

This white paper provides an update on the current state of rewards, recognition, and advancement for clinical pharmacists and develops best practice recommendations that will promote sustainability and growth in clinical pharmacy.

2 | CHANGES IN THE PHARMACY LANDSCAPE

2.1 | Pharmacist demographics

Since the 2010 white paper, substantially more graduating pharmacists have entered the workforce.[9,11,12] Residency training and board certification have also exponentially increased.[1,13–15] Previously, there was a national pharmacist shortage and a moderate to high demand for pharmacists in institutional practice settings.[9,16] However, the overall demand for pharmacists in 2019 was estimated to be lower than the number of pharmacists available.[17] Of note, the full impact of the coronavirus disease 2019 pandemic on altered demand for healthcare workers remains to be seen, though a discrepancy between previously published supply-and-demand reports and the postpandemic reality is likely. Table 1 details changes in pharmacist demographics over the past decade.

2.2 | Clinical pharmacy services

Clinical pharmacy as a profession has continued to evolve. ACCP's vision for the profession is that, as healthcare providers responsible for providing high-quality patient care, pharmacists will be accountable for medication optimization.[18] Indicators of progress toward this vision include increasing numbers of pharmacists seeking postgraduate residency training and increasing frequency of pharmacists providing direct patient care and participating in clinical activities.[18] Significant advances supporting the profession's evolution include passage of legislation supporting credentialing, provider status for pharmacists in some states, and expansion of clinical pharmacy services into more practice and specialty areas. An annual national survey of pharmacy practice in hospital settings in 2019 reported pharmacists were able to independently prescribe in 21% of hospitals, practice in ambulatory settings in 46% of health systems, and provide telepharmacy services in 28% of institutions.[2]

The clinical pharmacist's role has shifted from consultant to integrated, active interprofessional team member with an emphasis on collaboration with other healthcare clinicians. To support expanded clinical pharmacy practices, the ACCP Guideline for Clinical Pharmacist Competencies was updated in 2017 to ensure the competency of all clinical pharmacists in six essential domains to deliver comprehensive medication management in team-based, direct patient care environments.[19] The ACCP Template for Evaluating a Clinical Pharmacist, updated the same year, includes more emphasis on professional development through maintaining certifications, generating and sharing research, and providing education to other healthcare professionals.[20] Professional organizations clearly support an expanded clinical pharmacy practice role, and it is important that individual health systems also support their clinical pharmacy staff in achieving and sustaining a high level of practice.

2.3 | Pharmacists' job satisfaction and burnout

Job satisfaction, defined as feelings of enjoyment or fulfillment with one's work, has been associated with improved job performance and other positive organizational outcomes.[21] Pharmacists' job satisfaction is likely to improve with increased time spent on clinical activities,[22] an expanded scope of practice and skills development,[23] continuous professional development opportunities,[23,24] career ladders and advancement,[25,26] incorporation of staff engagement in developing consistent work schedules,[27] and self-perception of professional impact and value.[22,24] Job satisfaction is also inversely affected by burnout. The WHO defines burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed."[28] The WHO further characterizes burnout with three dimensions: (1) feelings of energy depletion or exhaustion, (2) increased mental distance from one's job or feelings of negativism or cynicism related to one's job, and (3) reduced professional efficacy. Unfortunately, clinical pharmacists currently experience high levels of burnout, ranging from 47% to 70% of the health-system pharmacists surveyed.[3,4,8,29–31] Factors associated with burnout include dissatisfaction with work-life balance,[31] high patient volume,[8] lower percentage of direct patient care time/too many nonclinical duties,[5,8] feelings that contributions are unappreciated,[5,31] emotional exhaustion,[3,4,30] feelings of depersonalization,[3,4,8,30] concern for having made a recent major medication error,[4] and lack of protected administration and teaching time.[5] Improvements in rewards, recognition, and advancement for clinical pharmacists can help address these challenges with the goal of improving job satisfaction, reducing burnout, and improving job retention.

3 | REWARDS AND RECOGNITION

Rewards are usually tangible or transactional in nature, where individuals perform tasks to receive compensation, gifts, or prizes. In many

TABLE 1 Changes in pharmacist demographics.[1,11–15]

Demographic	Reported 2008–2010	Reported 2019–2022
Pharmacy graduates (*n*)	10 988 (year: 2008–2009)	14 320 (year: 2019–2020)
PGY1 residents matched (*n*)	1801 (year: 2010)	4015 (year: 2021)
PGY2 residents matched/early committed (*n*)	369 (year: 2010)	1452 (year: 2021)
Types of PGY2 residencies focused on direct patient care or clinical practice[a]: positions offered (*n*)	Total: 15 types (year: 2010) • Ambulatory Care: 51 • Cardiology: 19 • Critical Care: 100 • Emergency Medicine: 8 • Geriatrics: 13 • Infectious Diseases: 35 • Internal Medicine: 21 • Oncology: 74 • Pain/Palliative Care: 4 • Pediatrics: 32 • Pharmacotherapy: 6 • Psychiatric: 22 • Solid Organ Transplant: 14 Availability stopped before 2022: • HIV: 3 • Nutrition Support: 1	Total: 15 types (year: 2021) • Ambulatory Care: 287 • Cardiology: 50 • Critical Care: 205 • Emergency Medicine: 88 • Geriatrics: 29 • Infectious Diseases: 136 • Internal Medicine: 60 • Oncology: 211 • Pain/Palliative Care: 35 • Pediatrics: 100 • Pharmacotherapy: 7 • Psychiatric: 100 • Solid Organ Transplant: 55 Availability added after 2010: • Clinical Pharmacogenomics: 10 • Neurology: 3
Board-certified pharmacists (*n*)	15 862 (year: 2012)	54 700 (year: 2022)
Types of board certifications	Total types: 6 (year: 2012) • Ambulatory Care: 1000 • Nuclear: 552 • Nutrition Support: 523 • Oncology: 1421 • Pharmacotherapy: 11608 • Psychiatric: 758	Total types: 13[b] (year: 2022) • Ambulatory Care: 5364 • Nuclear: 364 • Nutrition Support: 866 • Oncology: 3823 • Pharmacotherapy: 29435 • Psychiatric: 1460 Availability added after 2010: • Cardiology: 518 • Critical Care: 3570 • Geriatrics: 4714 • Infectious Diseases: 1448 • Pediatrics: 1568 • Solid Organ Transplant: 151 • Sterile Compounding: 1106

Abbreviations: PGY1, postgraduate year 1; PGY2, postgraduate year 2.

[a]PGY2 programs excluded (i.e., not primarily focused on direct patient care or clinical practice): PGY2 Corporate Pharmacy and Leadership, PGY2 Drug Information, PGY2 Health-System Pharmacy Administration and Leadership, PGY2 Investigational Drugs, PGY2 Managed Care Pharmacy Systems, PGY2 Medication Safety Use and Policy, PGY2 Nuclear Pharmacy, PGY2 Pharmacy Administration, PGY2 Pharmacy Informatics, PGY2 Population Health and Data Analytics, PGY2 Specialty Pharmacy Administration and Leadership.

[b]The Board of Pharmacy Specialties anticipates further expansion in 2023 with the addition of board certification in Emergency Medicine Pharmacy.

instances, these rewards are fixed and rarely personalized, placing a greater emphasis on outcomes than on employee behaviors.[32] Alternatively, recognition exists as a more organic and intangible form of motivation. It allows space for personal acknowledgment, which can support an emotional tie or sense of pride in the individual receiving recognition.[32] This approach is less structured, allowing recognition to occur more often and unexpectedly to demonstrate appreciation of positive behavior.

These motivators can instill pharmacists with feelings of appreciation and support for their efforts as valued members of the healthcare team.[33] Rewards and recognition encourage long-term retention, allowing further advancement of the profession.[34] Clinical pharmacist turnover is harmful because it reduces productivity associated with perpetually training new staff and causes an overall decrease in morale among the remaining clinical pharmacists.[35] In addition, significant costs are associated with replacing staff, with recent estimates across all occupations in the healthcare industry of $60 000 to turn over one healthcare position.[36] To address this, the American Society of Health-System Pharmacists (ASHP) recommends individual health systems develop retention plans that include professional promotion, reward, and recognition opportunities as well as increased salary and benefits.[35] Administrators should consider the following when designing these plans: (1) identification of rewards deemed valuable and achievable by team members that also support the department's mission and vision, (2) establishment of clear criteria for reward and advancement, (3) creation of a clear process to identify exceptional

performance, (4) determination of timing of rewards, and (5) creation of a method to ensure awareness of the program.[37]

3.1 | Review of the literature for rewards and recognition

Financial (e.g., raises, bonuses, benefits) and nonfinancial (e.g., autonomy, flexibility, recognition) rewards have been described.[38,39] The development and implementation of pharmacist career ladder programs that involve title changes and monetary compensation have resulted in improvements in engagement and satisfaction, documentation of interventions, reporting of medication use events, staff participation in process and policy improvements, peer-reviewed publications, and board certifications among staff.[25,34] However, beyond career ladder advancement programs, there is a paucity of pharmacy literature on other reward and recognition programs.

In a survey of institutions regarding best practices for recognition and rewards for pharmacy staff, the most commonly reported types of programs were criteria-based awards, thank-you notes from department leadership, and public recognition.[37] Several criteria-based awards were described, including a "good catch" medication safety award, preceptor of the year award, clinical service award, scholarship award, and employee of the month award. These awards were typically a certificate, trophy, or monetary incentive. Modes of public recognition included verbal (e.g., in-person feedback and in meetings) and written (e.g., emails, newsletters, bulletin boards). Additional rewards described included opportunities for professional growth and development, such as support for additional education and opportunities for research and leadership roles.[39]

Several publications from other professions have advocated for transition from career ladders to personalized professional recognition programs.[40,41] These models place value on expertise and experience. For example, some nursing programs have incorporated staff nurse feedback to develop unit-specific concepts of the "ideal nurse" and then used these to identify high-performing nurses.[40,41] Physician assistants and nurse practitioners have evaluated predictors of job retention and satisfaction, which include increased salary and autonomy.[42] A survey assessing rewards offered to nurse practitioner preceptors from an affiliated university found the number of reward options varied widely, as did their relative monetary value.[43] Rewards included continuing education vouchers, discounted conference registration, access to the campus library, discounts to cultural and sporting events, participation in research and publications, title of adjunct clinical instructor, and invitations to serve on advisory boards.

3.2 | Role of social media

An evolving tool to recognize clinical pharmacists is the use of social media platforms. Professional organizations and pharmacy schools use social media to highlight the accomplishments of their members and faculty, including recent publications, professional awards, and advanced credentials. Healthcare institutions use this platform to showcase accomplishments and advances in the delivery of care. Integrating the accomplishments of clinical pharmacists into institutional social media platforms can be a powerful tool to recognize pharmacists both within and outside their healthcare institution and create pathways toward professional advancement.

Because social media recognition is still in the early stages in health care, many considerations regarding effective recognition exist. Specifically, determining which achievements or activities are recognized and who decides their dissemination are paramount to ensure equity throughout the department or health system. Disparities in recognition may inadvertently be detrimental to the department. Pharmacists may feel discouraged from continually performing at a high level if they perceive that their efforts are valued less than those of others. In addition, understanding how recognition from a pharmacy-specific social media account interacts with the larger health system's account may play a role in the individual pharmacist's satisfaction, with the potential for greater satisfaction when recognition is more widespread.

4 | ADVANCEMENT

The framework outlining professional advancement opportunities for clinical pharmacists remains ambiguous except for faculty promotion criteria. One contemporary professional pathway in becoming a clinical pharmacist includes successful completion of postgraduate residency training.[26] Although the process of developing clinical pharmacists has been well established, further formal professional development and training strategies intended for clinical pharmacists' career advancement are lacking.[9] Data for providing a narrative summary of advancement opportunities in health-system pharmacy careers are minimal. Unfortunately, most health systems have neither developed robust professional growth strategies nor created promotion pathways for clinical pharmacists, despite the overwhelming desire for career planning.[25,26]

Career advancement may be defined as the ascending progression within an organizational hierarchy. Historically, career advancement for clinical pharmacists was often limited to transitions into a management role such as a pharmacy coordinator, manager, or director.[9,25] These administrative roles require significant leadership knowledge and skills. Unfortunately, most institutions lack the necessary professional training and defined minimum required criteria to successfully transition clinical pharmacists into formal leadership roles.[26] In addition, most clinical pharmacists do not view this as an attractive professional advancement opportunity.[9,26] Professional growth is highly individualized according to the clinical pharmacist's interests and goals. The practice setting (community or academic) and/or location (rural or urban) further contributes to the need for individualization. Many clinical pharmacists envision career advancement as assuming expanded clinical roles or direct patient care responsibilities with increased autonomy. This may include expanding to more health system-wide clinical responsibilities related to a specialty practice area that spans several practice sites (e.g., coordinating

cohesive emergency medicine pharmacy services for all emergency departments and urgent cares within a system) or focusing on medication use optimization for all clinical services throughout the institution or organization (e.g., antimicrobial stewardship, pain management, and opioid stewardship). Another example is broadening the scope of practice with prescriptive authority capabilities. Some states have codified an advanced practice pharmacist designation authorizing prescriptive authority on the basis of patient-specific or population-specific criteria through collaborative practice agreements. Although many clinical pharmacists practice with some degree of prescriptive authority, these authorities are often limited to specific medications or finite clinical scenarios (e.g., dose adjustments based on renal function), and significant legal and logistical barriers remain to widespread, comprehensive implementation.[44,45]

There is significant variability among clinical practice settings and lag between current roles and future opportunities for clinical pharmacists.[9,46,47] Structural barriers, such as the absence of well-defined career ladder distinctions and those with the appropriate reward for a sustained level of practice at higher rungs, may limit opportunities beyond an individual's current position or activities. Career planning and potential for career growth are important, with 84% of clinical pharmacists surveyed in 2010 expressing interest in career planning.[9] However, structured career planning in the form of career ladders, defined as clear processes for employees to progress in their job responsibilities within their current position, was in place for only 16% of practicing pharmacists and 21% of administrators. Of those who had career ladders, 88% of practicing pharmacists and 90% of administrators were satisfied with their existence.

A survey of public service pharmacists in Malaysia assessing perceived challenges to career advancement found that around one-half of respondents agreed that there was an absence of a performance-based salary and promotion scheme.[48] Lack of formally accredited pharmacy subspecialties, inadequate job-related training, and the absence of a performance-based advancement system were identified as major challenges to career advancement. Similarly, in the United States, the lack of system-level clinical opportunities compared with management advancement has led clinical pharmacists to leave their positions to pursue roles outside inpatient pharmacy.[9] When compared with their physician colleagues, pharmacists often do not receive a stipend or have clinical buy-down models for taking on additional responsibilities (e.g., committee chair, residency program director) or advancing in the clinical career ladder, exacerbating burnout and attrition of talented clinical pharmacists.[49]

Despite the perceived value of having clear career advancement pathways, minimal data describe their development and implementation in practice. Institutional benefits include improving employee retention and recruitment, eliminating wage inequities, motivating staff, and improving job satisfaction.[25,34,50–54] Although these reports can assist with the development of a framework, the sustainability of clinical pharmacists to function at a particular level with only monetary compensation and without other forms of reward or incentive (e.g., off-service time, reduced weekends/holidays, increased autonomy, work flexibility, continuing education days) is of concern.

5 | BARRIERS

The 2010 white paper identified that the lack of structured and robust reward and recognition programs may be the result of limited comprehension from departmental and institutional leadership on clinical pharmacist roles and responsibilities.[9] Pharmacy practice models vary greatly, and time allocation for patient care, distributive functions, research, and teaching differs significantly across institutions.[49] Additional barriers may stem from the variety of activities clinical pharmacists engage in and the difficulty with applying consistent, measurable evaluation tools across different practices.[20,46] Some tools exist to aid in measuring, evaluating, and documenting a clinical pharmacist's performance normalized across varied practice settings, such as the ACCP template developed to assess the key domains of direct patient care, pharmacotherapy knowledge, systems-based care and population health, communication, professionalism, and continuing professional development.[20] However, despite the availability of these tools, larger health systems or corporations may use standardized evaluation templates for all employees, which may not be in line with pharmacy-specific or institution-specific goals, thus affecting the pharmacy department's ability to provide a meaningful annual performance appraisal. In addition, there are few data on the implementation of performative evaluation tools that specifically reflect pharmacist performance. Although evaluations are a component of assessing the quality of a clinical pharmacist's work and providing evidence of competence, their role in career advancement is unclear.

As mentioned earlier, the primary path for clinical pharmacy advancement in the early career setting is residency training. ACCP has called for mandatory pharmacy residency training for entry into pharmacy practice.[18,47] However, financial resources may be inadequate to establish enough new residency sites to meet the growing number of pharmacy school graduates, and renewing current residencies may be difficult with limited funding.[47] The large salary disparity between residents and staff pharmacists, together with the demanding workload, may discourage individuals from applying for residency. Precepting residents without protected time or financial incentives further affects the sustainability of residency training and may contribute to the attrition of experienced and established clinical pharmacists. This is exacerbated by the required scholarly activities for pharmacy residents that exceed the requirements for medical residents,[49] given that these activities further add to preceptor burden.

Those who obtain advanced pharmacist designations still face challenges in billing for services provided and may be reimbursed for only a fraction of the median pharmacist's salary. Financially, inpatient pharmacy departments also face the difficulty of being a high-cost center because of medications dispensed and often struggle with position justification when approval is contingent on revenue generation alone.[49] Moreover, this lack of revenue generation may result in an attempt to justify the worth of clinical pharmacists with unsustainable goals related to patient care, teaching, and research, further contributing to burnout.[49] Additional financial constraints amplify these issues when compensation, raises, market adjustments, and allocation of funds are often determined outside the pharmacy department by

individuals with limited understanding of a clinical pharmacist's roles. Pharmacists who receive only market adjustment raises over long periods are also discouraged from taking on new responsibilities or precepting/mentoring without a functional reward program in place. Such obstacles may drive clinical pharmacists to other career paths.

6 | SURVEY OF CLINICAL PHARMACIST REWARD, RECOGNITION, AND ADVANCEMENT PROGRAMS

6.1 | Methods

To better describe the current state of rewards, recognition, and advancement for clinical pharmacists, a web-based survey was developed and distributed in March 2022. The survey sought participation from clinical pharmacists who were either employed by a hospital, health system, other healthcare facility, or community pharmacy or had a clinical practice in one of these areas as faculty at a college/school of pharmacy. The survey included questions regarding participant demographics, personal preferences for rewards and recognition, and the current state of reward, recognition, and advancement pathways at their institution. The survey was developed by the 2021–2022 ACCP Clinical Practice Affairs Committee A and distributed to ACCP members with full, active membership status ($n = 11\,140$).

6.2 | Results

A total of 571 pharmacists completed the survey, corresponding to a response rate of 5.1%. Most clinical pharmacist respondents were 35–49 years of age and had been in practice 5–15 years. Almost all had completed some postgraduate training or certification (99%), with 74% and 49% having completed PGY1 and PGY2 pharmacy residencies, respectively. Most (87%) had board certification, and 29% were primary faculty at a college/school of pharmacy. These demographics are similar to those of all full members of ACCP. Table 2 summarizes survey participant demographics.

Survey participants were asked how they preferred to be recognized and how their institution currently provided recognition. Most participants preferred peer/public recognition (57%) followed by private recognition (28%), whereas 12% reported recognition was not important. Despite this, 36% reported recognition was rarely provided at their institution (Figure 1).

Lists of various statements regarding recognition, allocation of time, and rewards were given to survey respondents, who were asked to rank their agreement with those statements on a 5-point Likert scale from "strongly agree" to "strongly disagree." Less than one-third of participants agreed (i.e., "strongly agree" or "agree") that their institution recognized all pharmacists equitably throughout the department, and less than one-fourth agreed the pharmacy department was recognized equitably to other professions at their organization (Table 3). Although only 32% were satisfied with their current recognition as an employee, 71% said recognition of workplace successes was important for their job satisfaction.

TABLE 2 Survey participant demographics.

Demographic, *n* (%)	Clinical pharmacists ($n = 571$)
Age (yr):	
<35	183 (32.1)
35–49	267 (46.8)
50–64	97 (17.0)
65+	24 (4.2)
Years in Practice Since Graduation from Pharmacy School	
<5	57 (10.0)
5–9	135 (23.6)
10–14	131 (22.9)
15–19	72 (12.6)
20+	176 (30.8)
Postgraduate Training/Certifications	
PGY1 Pharmacy Residency	425 (74.4)
PGY2 Pharmacy Residency	281 (49.2)
Pharmacy Fellowship	55 (9.6)
Other Graduate Degree	64 (11.2)
Board Certification (Board of Pharmacy Specialties)	495 (86.7)
Other Certificate Program[a,b]	215 (37.7)
Other[b]	23 (4.0)
None	6 (1.1)
Primary Faculty at a College/School of Pharmacy	167 (29.3)
Allocation of time in current position:	
100% clinical practice	310 (54.4)
Mainly clinical (>60%), some distributive/operational (<40%)	162 (28.4)
Almost even split between clinical and distributive/operational	53 (9.3)
Mainly distributive/operational (>60%), some clinical (<40%)	36 (6.3)
100% distributive/operational	9 (1.6)
Clinical practice location	
Academic medical center or Veterans Affairs hospital	253 (44.3)
Community teaching hospital	127 (22.2)
Community nonteaching hospital	67 (11.7)
Ambulatory clinic	87 (15.2)
Long-term care	5 (0.9)
Telemedicine/telehealth	5 (0.9)
Community/retail pharmacy	4 (0.7)
Specialty pharmacy	3 (0.5)
Home health care	2 (0.4)
Other	18 (3.2)

[a]Does not include Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or Pediatric Advanced Life Support (PALS).
[b]Other training/certifications include completion of various leadership programs, teaching programs, postdoctoral medical fellowship, Certification Board for Diabetes Care and Education, Certified Professional in Patient Safety, Certified Menopause Educator, Certified Dementia Practitioner, and pharmacist clinician licensure.

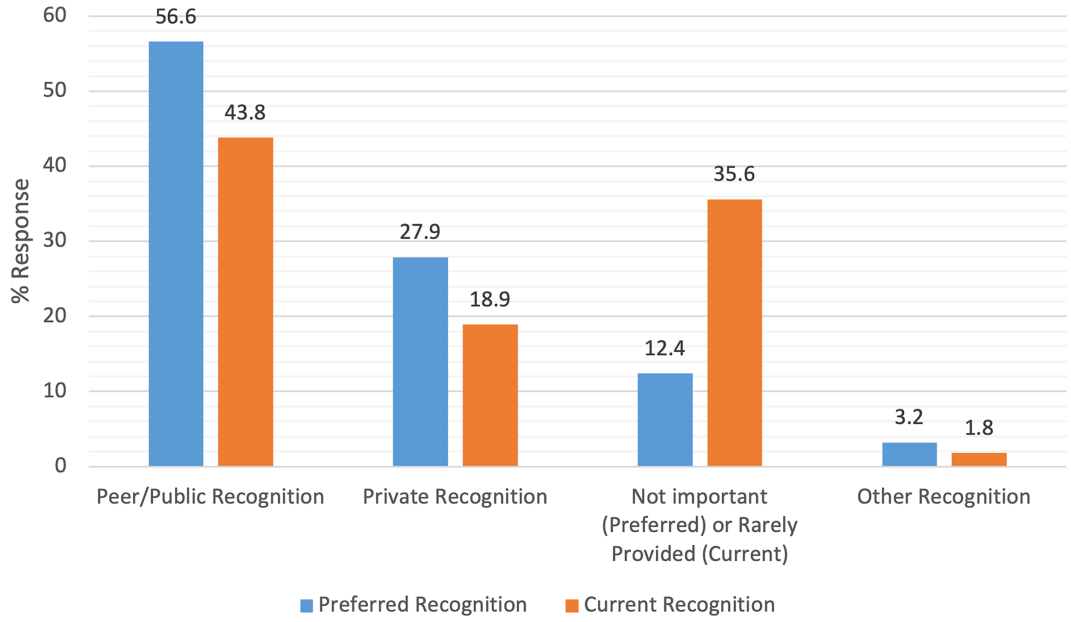

FIGURE 1 Preferred vs. current recognition of clinical pharmacists ($n = 571$). Survey respondents were asked to select which of the following types of recognition categories they most preferred: peer/public announcement (e.g., department-wide email or announcement in a department-wide meeting), private recognition (e.g., one-on-one meeting with manager or personal email), recognition not important to them, or other. They were then also asked to indicate which of these categories was currently done at their institution: more commonly as peer/public announcement, more commonly as private recognition, rarely provides employee recognition, or other. Results indicate that peer/public recognition is both the most preferred and the most commonly provided at institutions. However, recognition is perceived to rarely be provided to 35.6% of survey respondents despite only 12.4% indicating that recognition was not important to them.

Clinical pharmacists were asked to rank five major categories of rewards for workplace successes in order of importance. Financial incentives were the most preferred option in over one-half of survey participants, followed by personal/professional commitment changes. The remaining reward categories were professional advancement rewards, workplace improvements, and employee appreciation. Figure 2 lists complete results and category descriptions.

Clinical pharmacists were asked which rewards were currently available at their institution. The most common rewards available were education days for attending conferences/meetings (55%), reimbursement for new credentials/certifications (52%), department discretionary funds for approved activities/travel (49%), verbal/written employee recognition (48%), and dedicated office space (45%) (Table 4). The least commonly offered rewards were additional staffing support (8%), routine project or off-service time and/or clinical buy-down of time (9%), and improved scheduling of shifts to accommodate employee preferences (9%). Advancement pathways offered were uncommon: management career ladders (3%), opportunity for management mentorship (6%), clinical career ladders with the highest rung as management (7%), career development plans (11%), clinical career ladders (12%), and ability to train in new areas of practice (12%). Provision of time (29% vs. 55%) and funds (30% vs. 49%) for education and training was notably increased in the current survey results compared with the 2010 survey results.[9] In addition, availability of bonuses (13% vs. 20%) and work flexibility (18% vs. 36%) were increased compared with 2010.[9] However, raises outside adjustment raises or those for promotion (33% vs. 23%) and favorable/improved work scheduling (24% vs. 9%) were decreased compared with 2010.[9] The 2010 survey results showed that the reward of increased work time for clinical practice activities and increased work time for research activities was available to 28% and 11% of survey respondents, respectively; however, routine project or off-service time and/or clinical buy-down of time was available to only 9% of participants at their institution in the current survey.[9] The impression of clinical pharmacists regarding employer commitment to work-life balance remained low at 17% and 18% in the 2010 and current surveys, respectively.[9]

Tables 3 and 4 compare primary faculty and nonfaculty. Faculty had greater satisfaction with their current recognition, clinical and/or patient-care workload, time for research and scholarly activities, and time for teaching/mentoring activities. They also had greater satisfaction with personal/professional commitment changes offered as rewards in their current position as well as professional advancement rewards. Faculty reported the following rewards more than nonfaculty: department discretionary funds for approved activities/travel, dedicated office space, work flexibility, remote work, technology upgrades, social media recognition of the employee, and career development planning. In contrast, nonfaculty rewards, including gifts or gift cards, a clinical career ladder, improved scheduling of shifts to accommodate employee preferences, and additional staffing support, were reported more often by nonfaculty than faculty; however, these were only offered to a minority of clinical pharmacists.

Clinical pharmacists were also allowed to write in any rewards or recognitions they currently received or would prefer to receive that

TABLE 3 Recognition and rewards results and comparisons between nonfaculty and faculty.

Statement regarding recognition and rewards, *n* (%)	All who agree or strongly agree (*n* = 570)	Nonfaculty who agree or strongly agree (*n* = 403)	Faculty who agree or strongly agree (*n* = 167)	*p*-Value[a]
Recognition				
My institution currently recognizes all pharmacists equitably throughout the department	176 (30.9)	118 (29.3)	58 (34.7)	0.20
My institution currently recognizes the pharmacy department equitably to other professions throughout the organization	138 (24.2)	84 (20.8)	54 (32.3)	**0.004**
I am satisfied with my current recognition as an employee	183 (32.1)	117 (29.0)	66 (39.5)	**0.02**
Recognition of my workplace success, whether in private or in public, is important for my job satisfaction	405 (71.2)	291 (72.2)	114 (68.7)	0.40
Time				
I am satisfied with the time my current position allows me to spend on clinical and/or patient care activities	391 (68.6)	268 (66.5)	123 (73.7)	0.09
I am satisfied with the current clinical and/or patient care workload (e.g., patient-to-pharmacist ratio) of my current position	314 (55.1)	200 (49.6)	114 (68.3)	**<0.001**
I am satisfied with the time my current position allows me to spend on quality improvement activities (e.g., guideline/policy development, medication use evaluations)	230 (40.4)	156 (38.7)	74 (44.3)	0.22
I am satisfied with the time my current position allows me to spend on research and scholarly activities	181 (31.8)	114 (28.4)	67 (40.1)	**0.006**
I am satisfied with the time my current position allows me to spend on teaching/mentoring activities	311 (54.6)	188 (46.7)	123 (73.7)	**<0.001**
Rewards				
I am satisfied with the "Financial Incentives" offered in my current position (e.g., raises, bonuses, department discretionary funds for approved activities/travel, reimbursement for new credentials/certifications, reimbursement for maintenance of credentials/certifications)	131 (23.0)	94 (23.3)	37 (22.2)	0.76
I am satisfied with the "Personal/Professional Commitment Changes" offered in my current position (e.g., improved scheduling of shifts to accommodate employee preferences, increased autonomy, work flexibility, project/off-service time, employer commitment to improve work-life balance, additional staffing support [more staff, shift overlap])	215 (37.7)	132 (32.8)	83 (49.7)	**<0.001**
I am satisfied with the "Professional Advancement" offered in my current position (e.g., ability to train in new areas of practice, time off for attending national conferences and meetings, career development plan, opportunity for career ladder advancement [clinical or management], opportunity for management mentorship, if interested)	211 (37.0)	115 (28.5)	96 (57.5)	**<0.001**
I am satisfied with the "Workplace Improvements" offered in my current position (e.g., additional office space, technology upgrades, remote work)	181 (31.8)	119 (29.5)	62 (37.1)	0.07
I am satisfied with the "Employee Appreciation" offered at my current institution (e.g., verbal/written recognition of the employee, catered food during work, sponsored employee social events, gifts or gift cards)	147 (25.8)	102 (25.3)	45 (26.9)	0.66

[a]Analyzed with the chi-square or Fisher exact test, as appropriate, comparing nonfaculty with faculty.
Bold indicates statistically significant value ($p < 0.05$).

were not mentioned in the survey. For current recognition and rewards, write-ins included awards/certificates ($n = 10$) and preferred parking ($n = 1$). For preferred recognition and rewards, write-ins included recognition specifically from interdisciplinary colleagues or upper hospital administration ($n = 5$), recognition systems that avoid self-recognition strategies only ($n = 2$), highlighting of clinical metrics ($n = 2$), financial compensation for precepting students ($n = 1$), free continuing education ($n = 1$), mentorship for fellowship status in a professional organization ($n = 1$), awards/certificates ($n = 1$), preferred parking ($n = 1$), and a pin or insignia to wear identifying certain accomplishments ($n = 1$).

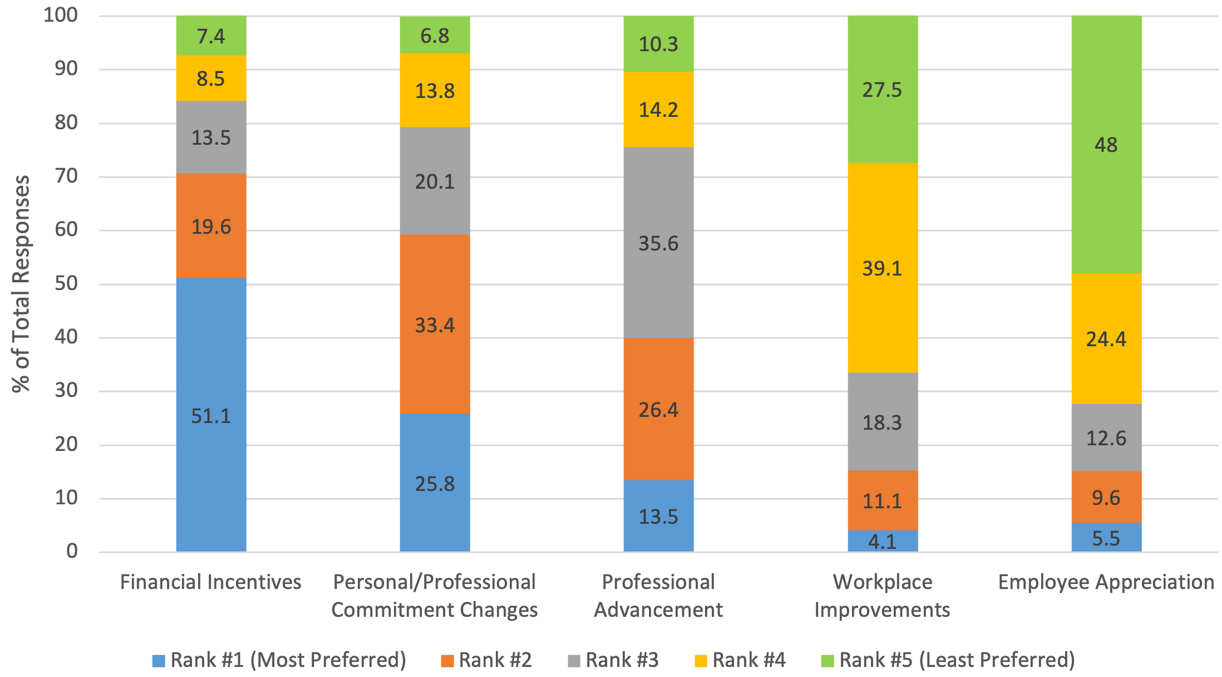

FIGURE 2 Preferred workplace rewards ($n = 542$). Each reward category within the survey was defined as (1) Financial Incentives (e.g., raises, bonuses, department discretionary funds for approved activities/travel, reimbursement for new credentials/certifications, reimbursement for maintenance of credentials/certifications); (2) Personal/Professional Commitment Changes (e.g., improved scheduling of shifts to accommodate employee preferences, increased autonomy, work flexibility, project/off-service time, employer commitment to improve work-life balance, additional staffing support [more staff, shift overlap]); (3) Professional Advancement (e.g., ability to train in new areas of practice, time off for attending national conferences and meetings, career development plan, opportunity for career ladder advancement [clinical or management], opportunity for management mentorship, if interested); (4) Workplace Improvements (e.g., additional office space, technology upgrades, remote work); (5) Employee Appreciation (e.g., verbal/written employee recognition, catered food during work, sponsored employee social events, gifts or gift cards).

7 | DISCUSSION

Results of the current survey show a discrepancy between the desired recognition of clinical pharmacists and what is currently offered. The fact that 36% of institutions rarely provide recognition and only 32% of clinical pharmacists are satisfied with their current recognition should be a call to action by administrators and the pharmacy profession as a whole. As stated earlier, recognition is an important factor in job satisfaction and aids in job retention. In addition, these survey results support that most clinical pharmacists currently do not receive adequate rewards for their workplace successes, with notable discrepancies between faculty and nonfaculty clinical pharmacists. Furthermore, to achieve workplace successes to warrant reward, pharmacists must be given adequate time in their position for accomplishments. However, many clinical pharmacists are dissatisfied with the time they are allotted for clinical activities, quality improvement, research and scholarship, and teaching and mentorship, again with notable discrepancies between faculty and nonfaculty. If the goal of administrators and the profession is for clinical pharmacists to provide quality patient care with expanded roles, improve health system-wide processes, and contribute to the growth of the clinical pharmacy through clinical practice, research, and scholarship, there must be commitment to provide adequate time and reward for these activities. Advancement pathways with respect to career ladders or career development plans also remain uncommon, and implementation that supports a high level of practice with appropriate reward to ensure sustainability has not been described. After a review of the available literature and the results of this survey, it is clear that there is a significant need for professional organizations and health systems to place a priority on improving rewards, recognition, and advancement for clinical pharmacists. If not addressed, the potential exists for even further increased rates of job dissatisfaction, burnout, and attrition in the field of clinical pharmacy, which is ultimately detrimental for optimal and safe pharmacotherapy-related patient care.

8 | RECOMMENDATIONS FOR REWARDS, RECOGNITION, AND ADVANCEMENT FOR CLINICAL PHARMACISTS

The following statements describe best practice recommendations for rewards, recognition, and advancement for clinical pharmacists as developed by the ACCP Clinical Practice Affairs Committee A:

1. General recommendations to address barriers to rewards, recognition, and advancement:

a. Overcoming barriers to rewards, recognition, and career advancement will require commitment and action from multiple stakeholders.

TABLE 4 Rewards currently available to clinical pharmacists.

Reward, *n* (%)	All clinical pharmacists (*n* = 571)	Nonfaculty clinical pharmacists (*n* = 404)	Faculty clinical pharmacists (*n* = 167)	*p*-Value[a]
Financial incentives				
Raises (outside adjustment raises or those for promotion)	130 (22.8)	95 (23.5)	35 (21.0)	0.51
Bonuses	114 (20.0)	89 (22.0)	25 (15.0)	0.06
Department discretionary funds for approved activities/ travel	282 (49.4)	178 (44.1)	104 (62.3)	**<0.001**
Reimbursement for new credentials/certifications	298 (52.2)	207 (51.2)	92 (54.5)	0.48
Reimbursement for maintenance of credentials/ certifications	191 (33.5)	127 (31.4)	64 (38.3)	0.11
Personal/professional commitment changes				
Improved scheduling of shifts to accommodate employee preferences	50 (8.8)	42 (10.4)	8 (4.8)	**0.03**
Increased autonomy	174 (30.5)	120 (29.7)	54 (32.3)	0.53
Work flexibility	206 (36.1)	125 (30.9)	81 (48.5)	**<0.001**
Routine project/off-service time/clinical buy-down	49 (8.6)	35 (8.7)	14 (8.4)	0.91
Employer commitment to improve work-life balance	99 (17.3)	70 (17.3)	29 (17.4)	0.99
Additional staffing support (more staff, shift overlap) as needed	44 (7.7)	37 (9.2)	7 (4.2)	**0.04**
Professional advancement				
Expanded clinical role or other additional opportunities for new credentials/certifications	69 (12.1)	55 (13.6)	14 (8.4)	0.08
Ability to train in new areas of practice	71 (12.4)	52 (12.9)	19 (11.4)	0.62
Education days for attending national conferences and meetings	312 (54.6)	213 (52.7)	99 (59.3)	0.15
Career development plan	63 (11.0)	36 (8.9)	27 (16.2)	**0.01**
Career ladder (clinical)	67 (11.7)	55 (13.6)	12 (7.2)	**0.03**
Career ladder (management)	16 (2.8)	10 (2.5)	6 (3.6)	0.46
Career ladder (clinical, but highest rung is management)	41 (7.2)	33 (8.2)	8 (4.8)	0.16
Opportunity for management mentorship	33 (5.8)	25 (6.2)	8 (4.8)	0.52
Workplace improvements				
Dedicated office space	254 (44.5)	155 (38.4)	99 (59.3)	**<0.001**
Technology upgrades	92 (16.1)	53 (13.1)	39 (23.4)	**0.002**
Remote work	190 (33.3)	120 (29.7)	70 (41.9)	**0.005**
Employee appreciation				
Verbal/written recognition	271 (47.5)	190 (47.0)	81 (48.5)	0.75
Social media recognition	76 (13.3)	32 (7.9)	44 (26.4)	**<0.001**
Catered food during work	102 (17.9)	79 (19.6)	33 (13.8)	0.10
Sponsored social events	59 (10.3)	39 (9.7)	20 (12.0)	0.41
Gifts or gift cards	91 (15.9)	78 (19.3)	13 (7.8)	**0.001**

[a]Analyzed with the chi-square or Fisher exact test, as appropriate, comparing nonfaculty with faculty.
Bold indicates statistically significant value ($p < 0.05$).

i. Professional pharmacy organizations should support clinical pharmacist recognition and reimbursement at state and national levels through advocacy and legislative efforts.
ii. Professional pharmacy organizations should support global initiatives to improve clinical pharmacists' rewards, recognition, and advancement at the health system level.
iii. Health system and pharmacy administrators should make a commitment to evaluate their current reward, recognition, and advancement programs and address areas needing improvement.

b. Professional organizations and health systems should work toward improving patient-to-pharmacist ratios and models with protected

time for clinical activities, quality improvement, research and scholarship, and teaching and mentorship.
    i. Professional organizations should engage in initiatives to evaluate appropriate patient-to-pharmacist ratios and develop recommendations for best practices.
    ii. Assessment of pharmacist activities to determine high versus low value add to patient outcomes should be performed.
    iii. Clinical pharmacy activities not associated with an increased value or improved patient outcomes should be minimized.
    iv. Collection and reporting of quality measures from high-value clinical pharmacy services should be used to demonstrate positive impacts on patient outcomes.[46]
    v. Operational services (e.g., order processing/verification) should be consolidated and optimized as able to allow for the expansion of clinical pharmacy services.
    vi. Use of electronic medical record algorithms and artificial intelligence should be encouraged to streamline operational services and enhance efficiency in clinical activities.
c. Payment models should allow reimbursement commensurate with clinical pharmacists' impact on patient outcomes, either through arrangements between private payers and pharmacists or enactment of advanced designations in more states.[44]
d. Standards for residency training should be reviewed and streamlined with consideration of residency program director and preceptor sustainability in these roles. This may also support the expansion of residency programs.[49]
e. Economic hurdles that prevent individuals from pursuing a pharmacy residency or other postgraduate training should be minimized.

2. Recommendations for rewards and recognition:
    a. Health systems should offer and prioritize financial incentives to encourage clinical pharmacists to maintain their advanced credentials and reward those who make the greatest contributions (e.g., raises, bonuses, funds for educational activities/certifications). These factors can maintain clinical pharmacists' motivation and challenge them to pursue even greater achievements in clinical practice.
    b. Personal/professional commitment changes (e.g., improved scheduling of shifts and increased autonomy, project/off-service time, work flexibility) and professional advancement rewards (e.g., training in new areas, time for conferences and meetings, career development plans) should be improved for all pharmacists.
        i. Nonfaculty clinical pharmacists demonstrate significantly lower satisfaction than their faculty colleagues in these areas, which specifically should be addressed.
        ii. Considerations for temporary or permanent work flexibility that allows for a consolidated workweek, flexible hours, remote options, reduced hours, part-time, or job-sharing may further improve retention of qualified clinical pharmacists.
    c. Health systems and colleges/schools of pharmacy should implement a model for teaching and mentoring pharmacy trainees that includes stipends, work flexibility, and protected time for educational activities.
    d. Academic institutions should recognize clinical pharmacists as faculty members in academic medical centers to encourage and create sustainability in residency training models, teaching, research, and scholarly activity.
    e. Although private recognition is important, health systems should increase public/peer recognition of their employees, given that this was identified as the most preferred strategy. In addition, pharmacy administrators must develop processes to improve the equity of recognition provided to pharmacists in their department.
    f. Pharmacy administrators should create strategies that recognize the pharmacy department equitably to other professions at their organization.
3. Recommendations for advancement pathways:
    a. The ASHP Practice Advancement Initiative 2030 states: "All pharmacists should have an individualized continuing professional development plan."[55] We affirm this recommendation. Pharmacy organizations should collaborate to develop clear, standardized career ladder templates for health systems to use.
    b. Implementation of career ladders or personalized professional recognition programs within health systems must incorporate adequate rewards associated with advancement so that a high level of service can be maintained. The reward necessary to achieve and sustain this goes beyond a monetary reward alone.
    c. Health systems should develop an advancement pathway with increasing prescriptive authority responsibilities, medication management, and/or patient case complexity commensurate with clinical experience. These pathways should have clear definitions and descriptions of what is necessary for continued career growth, including board certification.
    d. Separate career ladders should exist for clinical and managerial advancement with a delineation in goals and expectations between them. Health systems should support training and mentorship for advancement.
    e. Health system–wide clinical pharmacist positions should be developed to coordinate and disseminate clinical pharmacy services consistently and equitably throughout specialty clinical areas at different practice sites within larger organizations. This will provide advanced opportunities as an alternative to management roles.
    f. Academic-based and practice-based pharmacy clinicians should be encouraged to cross-train and collaborate in areas of teaching, research, scholarship, leadership, and service to support professional growth, given that career goals may change from provision of direct patient care activities.
    g. The profession should standardize the terminology used to describe clinical pharmacy roles (e.g., clinical pharmacy specialist, clinical pharmacist, clinical staff pharmacist) to better align career advancement strategies between health systems.
        i. Clear communication and team-building strategies should be used by health systems when defining these roles to overcome any potential dissatisfaction from team members who may have title or responsibility changes as a result of terminology standardization.

9 | CONCLUSION

Clinical pharmacy is continually advancing, including significant increases in qualifications and expanded roles. Ensuring appropriate reward, recognition, and advancement pathways for clinical pharmacists can improve job satisfaction and retention and reduce burnout. Our current evaluation of clinical pharmacists demonstrates low satisfaction with the recognition currently provided, despite a high desire for it and strong agreement that recognition affects job satisfaction. In addition, clinical pharmacists currently have high rates of dissatisfaction with the time allocated for clinical activities, quality improvement, research and scholarship, and teaching and mentorship. Many of the rewards for workplace successes are infrequently provided, with significant variations between faculty and nonfaculty clinical pharmacists. Advancement pathways continue to be uncommon as well. The pharmacy profession and administrators are encouraged to improve the state of rewards, recognition, and advancement of clinical pharmacists at their health systems through applying the best practice recommendations provided.

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REFERENCES

1. Carter BL. Evolution of clinical pharmacy in the USA and future directions for patient care. *Drugs Aging*. 2016;33:169–77.
2. Pederson CA, Schneider PJ, Ganio MC, Scheckelhoff DJ. ASHP national survey of pharmacy practice in hospital settings: prescribing and transcribing-2019. *Am J Health Syst Pharm*. 2020;77:1026–50.
3. Durham ME, Bush PW, Ball AM. Evidence of burnout in health-system pharmacists. *Am J Health Syst Pharm*. 2018;75(23 suppl 4):S93–S100.
4. Golbach AP, McCullough KB, Soefje SA, Mara KC, Shanafelt TD, Merten JA. Evaluation of burnout in a national sample of hematology-oncology pharmacists. *JCO Oncol Pract*. 2022;18:e1278–88.
5. Jones GM, Roe NA, Louden L, Tubbs CR. Factors associated with burnout among us hospital clinical pharmacy practitioners: results of a nationwide pilot survey. *Hosp Pharm*. 2017;52:741–51.
6. McQuade B, Reed B, DiDomenico R, et al. Feeling the burn? A systematic review of burnout in pharmacists. *J Am Coll Clin Pharm*. 2020;3:663–75.
7. Prasad-Reddy L, Kaakeh R, McCarthy BC Jr. Burnout among health system pharmacists: presentation, consequences, and recommendations. *Hosp Pharm*. 2021;56:374–7.
8. Rozycki E, Bilhimer M, Bridgeman P, Slocum GW, Cocchio C, Weant K, et al. Evaluation of burnout among emergency medicine pharmacists. *J Am Coll Clin Pharm*. 2020;3:1423–33.
9. Goodwin SD, Kane-Gill SL, Ng TM, et al. Rewards and advancements for clinical pharmacists. *Pharmacotherapy*. 2010;30:114.
10. American College of Clinical Pharmacy (ACCP). Rewards and advancements for clinical pharmacy practitioners. *Pharmacotherapy*. 1995;15:99–105.
11. American Association of Colleges of Pharmacy (AACP). Academic pharmacy's vital statistics. 2022. Available from: https://www.aacp.org/article/academic-pharmacys-vital-statistics.
12. Taylor DA, Patton JM. The pharmacy student population: applications received 2008-09, degrees conferred 2008-09, fall 2009 enrollments. *Am J Pharm Educ*. 2010;74:S2.
13. American Society of Health-System Pharmacists resident matching program: summary of program and positions offered and filled 2021 match – combined phase I and phase II. National Matching Services. Available from: https://natmatch.com/ashprmp/stats/2021summpos.pdf.
14. American Society of Health-System Pharmacists (ASHP). Residency townhall: update from the commission on credentialing. 2021. Available from: https://www.ashp.org/-/media/assets/professional-development/residencies/docs/coc-presentation-update.pdf.
15. Board of Pharmacy Specialties (BPS). Certified stats by location. Available from: https://portalbps.cyzap.net/dzapps/dbzap.bin/apps/assess/webmembers/managetool?webid=BPS&pToolCode=certrecord&pRecCmd=StatsByLocation&pPrint=Yes&pLandScape=Yes.
16. Johnson TJ, Teeters JL. Pharmacy residency and the medical training model: is pharmacy at a tipping point? *Am J Health Syst Pharm*. 2011;68:1542–9.
17. American Association of Colleges of Pharmacy (AACP). National pharmacist workforce study report 2019. 2020. Jan 10. Available from: https://www.aacp.org/sites/default/files/2020-03/2019_NPWS_Final_Report.pdf.
18. American College of Clinical Pharmacy (ACCP). 2020 strategic plan of the American College of Clinical Pharmacy. Available from: https://www.accp.com/docs/positions/Additional_Resources/2020_Strategic_Plan_of_the_ACCP_Final.pdf?utm_source=accp&utm_medium=email&utm_campaign=ACCP%20Test.
19. Saseen JJ, Ripley RL, Bondi D, et al. ACCP clinical pharmacist competencies. *Pharmacotherapy*. 2017;37:630–6.
20. Lee M, Badowski ME, Acquisto NM, Covey DF, Fox BD, Gaffney SM, et al. ACCP template for evaluating a clinical pharmacist. *Pharmacotherapy*. 2017;37:e21–9.
21. Piercy CW, Gist-Mackey AN. Status shields and pharmacy work: differences among workers by role and context. *Soc Sci Med*. 2021;293:114671.
22. Losier M, Doucette D, Fernandes O, Mulrooney S, Toombs K, Naylor H. Assessment of Canadian hospital pharmacists' job satisfaction and impact of clinical pharmacy key performance indicators. *Can J Hosp Pharm*. 2021;74:370–7.
23. Terry D, Phan H, Peck B, Hills D, Kirschbaum M, Bishop J, et al. Factors contributing to the recruitment and retention of rural pharmacist workforce: a systematic review. *BMC Health Serv Res*. 2021;21:1052.
24. Mattsson S, Gustafsson M. Job satisfaction among Swedish pharmacists. *Pharmacy (Basel)*. 2020;8:127.
25. Heavner MS, Tichy EM, Yazdi M. Implementation of a pharmacist career ladder program. *Am J Health Syst Pharm*. 2016;73:1524–30.

26. Isaacs D, Bishop MA, Burke ES, Clements JN, Fava JP, Kaakeh R, et al. Career advancement in health-system pharmacy: clinical pharmacists as future leaders. *Am J Health Syst Pharm*. 2021;78:1134–6.
27. Wright J, Arndt R, Christensen J, Kooda K, Cunningham J. Engagement of hospital pharmacists and technicians to optimize staffing schedules. *J Pharm Policy Pract*. 2021;14:70.
28. World Health Organization (WHO). Burn-out an "occupational phenomenon": international classification of diseases. 2019. Available from: https://www.who.int/mental_health/evidence/burn-out/en/.
29. Jones AM, Clark JS, Mohammad RA. Burnout and secondary traumatic stress in health-system pharmacists during the COVID-19 pandemic. *Am J Health Syst Pharm*. 2021;78:818–24.
30. Kraud A, Gardner N, Jarosi N. Assessment of burnout within a health-system pharmacy department. *Am J Health Syst Pharm*. 2020;77:781–9.
31. Weichel C, Lee JS, Lee JY. Burnout among hospital pharmacists: prevalence, self-awareness, and preventive programs in pharmacy school curricula. *Can J Hosp Pharm*. 2021;74:309–16.
32. Sprigg HR. The difference between reward and recognition. 2021 Dec. Available from: https://sprigghr.com/blog/management-tips/the-difference-between-reward-and-recognition/.
33. Jacobi J. Clinical pharmacists: practitioners who are essential members of your clinical care team. *Rev Méd Clín Las Condes*. 2016;27:571–7.
34. Hager D, Chmielewski E, Porter AL, Brzozowski S, Rough SS, Trapskin PJ. Interprofessional development and implementation of a pharmacist professional advancement and recognition program. *Am J Health Syst Pharm*. 2017;74:1895–902.
35. American Society of Health-System Pharmacists (ASHP). ASHP guidelines on the recruitment, selection, and retention of pharmacy personnel. *Am J Health Syst Pharm*. 2003;60:587–93.
36. Healthcare Finance. Cure for healthcare's high employee turnover is engagement, expert says. 2017. Jul 18. Available from: https://www.healthcarefinancenews.com/news/cure-healthcares-high-employee-turnover-engagement-expert-says.
37. Phillips H, Bogdanich I, Carter K, Holler J, Smith T, Ticehurst EH, et al. Commentary: exploring novel approaches to staff rewards and recognition. *Hosp Pharm*. 2017;52:729–31.
38. International Council of Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy. Guidelines: Incentives for Health Professionals. 2008. Available from: www.who.int/entity/workforcealliance/knowledge/publications/alliance/Incentives_Guidelines%20ENG%20low.pdf?ua=1.
39. Haase KK. Addressing burnout in clinical pharmacy: what can we learn from other health care disciplines? *J Am Coll Clin Pharm*. 2019;3:645–54.
40. Glen MJ, Smith JH. From clinical ladders to a professional recognition program. *Nurs Manage*. 1995;26:41–2.
41. Keyes MA. Recognition and reward: a unit-based program. *Nurs Manage*. 1994;25:52–4.
42. Hagan J, Curtis DL. Predictors of nurse practitioner retention. *J Am Assoc Nurse Pract*. 2018;30:280–4.
43. Campbell SH, Hawkins JW. Preceptor rewards: how to say thank you for mentoring the next generation of nurse practitioners. *J Am Acad Nurse Pract*. 2007;19:24–9.
44. Frost TP, Adams AJ. Are advanced practice pharmacist designations really advanced? *Res Social Adm Pharm*. 2018;14:501–4.
45. Adams AJ, Weaver KK. Pharmacists' patient care process: state "scope of practice" priorities for action. *Ann Pharmacother*. 2021;55:549–55.
46. Acquisto NM, Beavers CJ, Bolesta S, Buckley MS, Dobbins KF, Finch CK, et al. Development and application of quality measures of clinical pharmacist services provided in inpatient/acute care settings. *J Am Coll Clin Pharm*. 2021;4:1601–17.
47. Bright DR, Adams AJ, Black CD, Powers MF. The mandatory residency dilemma: parallels to historical transitions in pharmacy education. *Ann Pharmacother*. 2010;44:1793–9.
48. Chang CT, Hassali MA, Hss AS, Lee JCY, Chan HK. Perceived motivators, training supports and challenges to career advancement among pharmacists in the Malaysian public healthcare system. *Int J Pharm Pract*. 2019;27:555–64.
49. Rech MA, Jones GM, Naseman RW, Beavers C. Premature attrition of clinical pharmacists: call to attention, action, and potential solutions. *J Am Coll Clin Pharm*. 2022;5:689–96.
50. Barbaccia JG, Mowrey D. Clinical career ladders: the Washington hospital center. *Am J Hosp Pharm*. 1989;46:2276–9.
51. Crouch JB, Douglas JB, Wheeler DS. Clinical career ladders: the Moses H. cone memorial hospital. *Am J Hosp Pharm*. 1989;46:2272–5.
52. Wills TM, Garing TL. Clinical career ladders: St. Vincent hospital and health care center. *Am J Hosp Pharm*. 1989;46:2279–82.
53. Smith JE, Sheaffer SL, Frey BM. Clinical career ladders: Thomas Jefferson University Hospital. *Am J Hosp Pharm*. 1989;46:2263–7.
54. Meyer JD, Chrymko MM, Kelly WN. Clinical career ladders: Hamot medical center. *Am J Hosp Pharm*. 1989;46:2268–71.
55. ASHP practice advancement initiative 2030: new recommendations for advancing pharmacy practice in health systems. *Am J Health Syst Pharm*. 2020;77:113–21.

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