Proceedings of the 55th annual session of the ASHP House of Delegates, June 1 and 3, 2003

Henri R. Manasse, Jr., Secretary

The 55th annual session of the ASHP House of Delegates was held at the San Diego, California, Convention Center, in conjunction with the 2003 Summer Meeting.

First meeting

The first meeting was convened at 2 p.m., Sunday, June 1, by Chair of the House of Delegates Roland A. Patry. Daniel M. Ashby, Vice Chair of the Board of Directors, gave the invocation.

Chair Patry introduced the persons seated at the head table: Steven L. Sheaffer, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Debra S. Devereaux, President of ASHP and Chair of the Board of Directors; Henri R. Manasse, Jr., Executive Vice President of ASHP and Secretary to the House of Delegates; and Joy Myers, Parliamentarian.

Chair Patry welcomed the delegates and described the purposes and functions of the House. He emphasized that the House has considerable responsibility for establishing policy related to ASHP professional pursuits and pharmacy practice in health systems. He reviewed the general procedures and processes of the House of Delegates.

The roll of official delegates was called. A quorum was present, including 188 voting delegates representing 50 states, the District of Columbia and Puerto Rico, delegates from the federal services, chairs of the sections of Home, Ambulatory, and Chronic Care Practitioners and Clinical Specialists and Scientists, chair of the Student Forum, ASHP officers, members of the Board of Directors, and ASHP past presidents.

Chair Patry reminded delegates that the report of the 54th annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 54th House of Delegates session were received without objection.

Board Chair Debra S. Devereaux presented the preliminary report on Resolutions.[a] The report, which had been distributed to delegates before the Summer Meeting, consisted of one Resolution from Karen R. Mulheron and Judy Gardner, titled "Pharmacy Drug Theft."

Chair Patry called on Barbara Poe for the report of the Committee on Nominations.[b] Nominees were presented as follows:

President-elect

Roland A. Patry, D.P.H., FASHP, Amarillo, TX, Professor of Pharmacy Practice and Associate Dean, Patient Care Services, Texas Tech School of Pharmacy.

T. Mark Woods, Pharm.D., FASHP, Kansas City, MO, Clinical Coordinator and Residency Program Director, Saint Luke's Hospital.

Board of Directors (2004-2007)

John A. Armistead, M.S., FASHP, Lexington, KY, Director of Pharmacy Services, University of Kentucky Hospital and Assistant Dean and Clinical Associate Professor, University of Kentucky College of Pharmacy.

David A. Kvancz, M.S., FASHP, Cleveland, OH, Director of Pharmacy, The Cleveland Clinic Foundation Hospital.

Agatha L. Nolen, M.S., FASHP, Nashville, TN, Director of Pharmacy, Centennial Medical Center.

Philip J. Schneider, Pharm.D., FASHP, Olathe, KS, Director of Pharmacy, Olathe Medical Center.

Chair, House of Delegates

Teri L. Bair., J.D., FASHP, Houston, TX, Counsel, Jones Walker, L.L.P.

Marjorie Shaw Phillips, M.S., FASHP, Augusta, GA, Pharmacist, Medical College of Georgia Hospitals & Clinics, and Adjunct Clinical Associate Professor, University of Georgia College of Pharmacy.

A "Meet the Candidates" session to be held on Monday, June 2, was announced.

President and Chair of the Board. President Devereaux referred to the combined report of the Chair of the Board and the Executive Vice President, which had been previously distributed to delegates and which included all of the actions taken by the Board of Directors since the last House session. She updated and elaborated upon various aspects of the report. (The combined written report presented to the House is included in these Proceedings.) There was no discussion, and the delegates voted to accept the report

of the President and Chair of the Board.

President Devereaux, on behalf of the Board of Directors, then moved adoption of the proposed policy recommendation titled "Sale and Manufacture of Dietary Supplements Containing Ephedrine Alkaloids," which originated with the Commission on Therapeutics. There was no discussion and the policy recommendation was adopted. It reads as follows:

Sale and Manufacture of Dietary Supplements Containing Ephedrine Alkaloids

To support a ban on the manufacture and sale of dietary supplements containing ephedrine alkaloids because (1) ephedrine alkaloids pose a significant risk of illness and injury, (2) changes in product labeling are not adequate to protect the public from these dangers, (3) the use of these products represents significant expenditures for a health-related remedy of unsubstantiated value, and (4) other safe and effective interventions are available for all common uses of these products.

President Devereaux, on behalf of the Board of Directors, moved adoption of the proposed policy recommendation titled "Continuity of Care" which originated with the Executive Committee of the Section of Home, Ambulatory, and Chronic Care Practitioners. There was no discussion and the policy recommendation was adopted. It reads as follows:

Continuity of Care

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of pharmaceutical care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development of strategies to address the gaps in continuity of pharmaceutical care.

Treasurer. Marianne F. Ivey presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer's report.

Executive Vice President. Henri R. Manasse, Jr., presented the report of the Executive Vice President. He reported the progress in implementing the recommendations of the Task Force on Organizational Structure, introducing the new Section of Inpatient Care Practitioners and the Practitioners and Residents Forum. He also reviewed how ASHP is reorganizing its internal structure to better integrate membership services with the sections and forums. He discussed how ASHP is continuing to carefully control the budget as the Society works to meet important objectives during the current economic environment. Additionally, Dr. Manasse reviewed how ASHP is reaching out and working with other key organizations, including the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, the Food and Drug Administration, the National Quality Foundation, and several nursing organizations.

Recommendations. Chair Patry called on members of the House of Delegates for Recommendations. (The name(s) and state(s) of the delegate(s) who introduced the item and the subject of the item precede each Recommendation.)

Michael Rubino, Dave Pudim, and Kathy Spooner (CT): Pharmaceutical Reimbursement

Recommendation: To encourage ASHP to develop a method of communicating to members changes in drug reimbursement regulations promulgated by the Center for Medicare and Medicaid Services (CMS) in a simple and concise manner, using a format similar to the drug shortage section on the ASHP Web page.

Background: Reimbursement of pharmaceuticals has gained prominence in the financial management of health systems over the past several years. Once thought of as a cost center, pharmacy departments and pharmacy administrators are focusing more on charge capture and revenue generation, primarily due to the expansion of ambulatory services. As this shift continues to occur, pharmacists must maintain knowledge of all aspects of reimbursement, particularly those affecting Medicare. Accessing current as well as updated information related to changes in CMS pricing has always been a challenge. As difficult as accessing the information is, more confusing is interpretation of information related to HCPC codes and APC status of drugs. Furthermore, hospital financial services do not consistently interpret reimbursement information to the benefit of pharmacy departments.

Suggested Outcome: Assistance on drug reimbursement from ASHP to members via ASHP Web page.

Patrick Parker (MS): Medication Copayment Cost-Shifting

Recommendation: ASHP investigate and make appropriate policy statements regarding the practice of insurance company copayment cost-shifting.

Background: Pharmacists for many years have dispensed standard, economically sound quantities of long-term medications for their patients. This practice has been

subverted by insurance companies in an effort to shift costs to patients.

The result is often the loss of the patient-pharmacist relationship and confusion on the part of patients.

Example:
Traditional 100 doses of a $1.00 per dose drug:

Doses	100
Rx Cost	$100
Disp Fee	$ 25
Total	$125
Patient Co-pay	$ 15
Insurance Pays	$110

Insurance cost shift: The company policy requires a monthly amount to be obtained and tells patients that they must pay a monthly copayment. They also offer an option for patients to obtain a 90-day supply and only pay two month's co-pay if they obtain the drug through a preferred mail order program. The patient is coerced into giving up their pharmacist relationship and the insurance company profits. There is no other need (patient related) to require the 30-day supply rules.

Dose	30	30	30	90
Rx Cost	$30	$30	$30	$90
Disp Fee	$25	$25	$25	$75
Total	$55	$55	$55	$165
Patient Co-pay	$15	$15	$15	$45
Insurance Pays	$40	$40	$40	$120

It appears that everyone actually pays more here, but in fact the patient is coerced to opt for a 90-day supply and the patient is given a "discount" of only two copays paying $30. Since there is now only one dispensing fee, the insurance company now pays $75. The insurance company has shifted $15 of the overall payment to the patient by placing an unnecessary and confusing requirement on the patient.

Doses	90
Rx Cost	$90
Disp Fee	$25
Total	$115
Patient Co-pay	$30
Insurance Pays	$75

Suggested Outcome: Help people understand that there is no need for monthly co-pays in these instances and uncover the confusion. Find ways to foster the patient-pharmacist relationship within ASHP efforts related to access to care.

Carl W. Grove (ME): Policy Recommendation - "Continuity of Care"

Recommendation: That ASHP develop practice standards to facilitate implementation of this process.

Background: A how-to pathway is needed so that there is a standard and consistent method for assuring continuity of care.

Suggested Outcome: A policy statement that describes the standard(s) of care that should be applied to this process.

Larry Clark (CT): Definition of Dietary Supplements and Complementary and Alternative Substances

Recommendation: That ASHP develop educational information regarding the definitions of and regulatory issues associated with dietary supplements, medical foods, over-the-counter medications, and complementary and alternative substances in an effort to clarify the membership's understanding of these terminologies. Further, that ASHP communicate this information through the *AJHP* or other communication resources of the Society.

Background: There is continual discussion regarding the definition and regulatory requirements related to these terms. This results in misunderstanding and misinterpretation in organizational policy and policy development. Such an article included in *AJHP* or other publication would help minimize this misunderstanding.

Suggested Outcome: Printing of an article to this effect in *AJHP* or other publication of the ASHP.

Council reports. (Note: The policy recommendations of the ASHP councils were published in the April 1, 2003, issue of *AJHP*. The complete council reports, including background on the policy recommendations and information on other council activities, were published on the ASHP Web site [ashp.org, under "Policy and Governance"] and were distributed to delegates.)

Chair Patry outlined the process used to generate council reports. He announced that each council's recommended policies would be introduced as a block. He further advised the House that any delegate could raise questions and discussion without having to "divide the question" and that a motion to divide the question is necessary only when a delegate desires to amend a specific proposal or to take an action on one proposal separate from the rest of the recommendations; requests to divide the question are granted unless another delegate objects.

(Note: Policy recommendations are presented here in the order in which they were published, not in the order in which they were discussed for purposes of amendment. Policy recommendations not amended were approved as a block.)

William H. Puckett, Board Liaison to the **Council on Administrative Affairs**, presented the council's policy recommendations A through C.

After a request to consider Policy A separately, it was moved and seconded to amend the second paragraph by deleting the word 'and', adding a comma following the word

'Administration'; deleting the words 'manufacturers and suppliers,' before the words 'contracting entities; adding the words 'pharmaceutical manufacturers place' before the word 'standardized'; deleting the word 'including' and adding the words 'which includes' before the word 'National'; deleting the words 'lot number, and expiration date, be placed' before the words 'on all'; adding the words 'unit of use, and injectable' before the words 'drug packaging'; and adding a third paragraph that reads 'To encourage, at a minimum, the addition of lot number and expiration date to machine-readable coding; further,'

Following discussion and a call for the question, the amendment was defeated. It was then moved and seconded to amend Policy A in the second paragraph by deleting the word 'and', adding a comma following the word 'Administration'; deleting the words 'manufacturers and suppliers,' before the words 'contracting entities; adding the words 'pharmaceutical manufacturers place' before the word 'standardized'; deleting the word 'including' and adding the words 'which includes' before the word 'National'; deleting the words 'be placed' before the words 'on all' and adding the words 'unit of use, and injectable drug' before the word 'packaging.' Following discussion, the amendments were approved. Policy Recommendation A was then adopted.[c] It reads as follows (italic type indicates material added; strikethrough indicates material deleted):

A. Machine-Readable Coding and Related Technology

To declare that the identity of all medications should be verifiable through machine-readable coding technology and to support the goal that all medications be electronically verified before they are administered to patients in health systems; further,

To urge the Food and Drug Administration, ~~and~~ other regulatory agencies, ~~pharmaceutical manufacturers and suppliers~~, contracting entities, and others to mandate that *pharmaceutical manufacturers place* standardized machine-readable coding, *which* ~~including~~ includes National Drug Code, lot number, and expiration date, ~~be placed~~ on all manufacturers' unit dose, *unit of use, and injectable drug* packaging; further,

To strongly encourage health systems to adopt machine-readable coding and point-of-care technology to (1) improve the accuracy of medication administration and documentation, (2) improve efficiencies within the medication-use process, and (3) improve patient safety; these systems should be planned, implemented, and managed with pharmacist involvement and should be in all areas of the health system where drugs are used.

B. Unit Dose Packaging Availability

To advocate that pharmaceutical manufacturers provide all medications used in health systems in unit dose packages; further,

To urge the Food and Drug Administration to support this goal in the interest of public health and patient safety.

It was requested to consider Policy Recommendation C separately to amend it by deleting the word 'dispensing' following the word 'technician'; deleting the words 'increase the time' and adding the word 'redirect' following the words 'in order to'; add the words 'resources to', delete the words 'have available for other' and add the words 'patient care' before the word 'activities' in the first paragraph and in the second paragraph deleting the words 'support health system pharmacists in advocating' and adding the word 'advocate' after the word 'To.' The amendment was approved. Policy Recommendation C, as amended, was then adopted.[c] There was also a suggestion to change the title of the policy. It reads as follows (italic type indicates material added; strikethrough indicates material deleted):

C. Technician-Checking-Technician Programs

To advocate technician-checking-technician ~~dispensing~~ programs (with appropriate quality control measures) in order to ~~increase the time~~ *redirect* pharmacists' *resources to* ~~have available for other~~ *patient care* activities; further,

To ~~support health-system pharmacists in advocating~~ *advocate* state board of pharmacy approval of these programs.

Bonnie L. Senst, Board Liaison to the **Council on Educational Affairs**, presented the Council's Policy Recommendations A through F.

A. Skills Needed to Provide Interdisciplinary and Interprofessional Patient Care

To encourage colleges of pharmacy and other health professions schools to focus on the need to teach students the skills necessary for working with other health care professionals to provide patient care; further,

To encourage the American Council on Pharmaceutical Education to include standards for teaching the provision of interprofessional patient care throughout the curriculum; further,

To encourage and support pharmacists' collaboration with other health professionals in the development of purposeful, deliberative interprofessional practice models.

(Note: Interdisciplinary refers to communication between disciplines within a profession; interprofessional refers to communication across the health care professions.)

After a request to consider Policy B separately, it was moved and seconded to amend by adding the words 'and health care worker' before the words 'safety and train students.' There was no discussion and the amendment was approved. Policy Recommendation B, as amended was adopted.[c] It reads as follows (italic type indicates material added):

B. Interdisciplinary and Interprofessional Instruction on Performance Improvement and Patient Safety

To urge colleges of pharmacy and other health professions schools to include instruction, in an interdisciplinary and interprofessional fashion, on the principles of performance improvement and patient *and health care worker* safety and train students in how to apply these principles in practice.

(Note: Interdisciplinary refers to communication between disciplines within a profession; interprofessional refers to communication across the health care professions.)

(This policy supersedes ASHP Policy 0208.)

C. Patient-Centered Care

To encourage that the principles of patient-centered care be integrated throughout the college of pharmacy curriculum.

After a request to consider Policy Recommendation D separately, it was moved and seconded to delete the words 'an enhanced level of' before the words 'cultural competence' and adding the words, 'for the purpose of achieving optimal therapeutic outcomes in diverse populations' at the end of the sentence and adding the following paragraphs: "To develop tools and strategies for improving care delivery to diverse patient populations in an era of health disparities. To promote knowledge of culturally responsive models of patient care; further," The amendments were approved. It was then moved and seconded to add an additional paragraph which reads:

'To encourage colleges of pharmacy to train students in skills needed to recognize, define, and address cultural issues in providing patient care.' This amendment was approved. Policy Recommendation D, as amended, was adopted.[c] It reads as follows (italic type indicates material added; strikethrough indicates material deleted):

D. Cultural Competence

To foster ~~an enhanced level of~~ cultural competence among pharmacy students, residents, and practitioners and within health systems *for the purpose of achieving optimal therapeutic outcomes in diverse patient populations.*

To develop tools and strategies for improving care delivery to diverse patient populations in an era of health disparities.

To promote knowledge of culturally responsive models of patient care; further,

To encourage colleges of pharmacy to train students in skills needed to recognize, define, and address cultural issues in providing patient care.

E. Practice Sites for Colleges of Pharmacy

To encourage practitioner input in pharmacy education; further,

To encourage that institutional and health-system environments be used as sites for experiential training of pharmacy students; further,

To encourage colleges of pharmacy and health systems to define and develop appropriate organizational relationships that permit a balance of patient care and service, as well as educational and research objectives, in a mutually beneficial manner; further,

To include the administrative interests of both the health system and the college of pharmacy in defining these organizational relationships to ensure compatibility of institutional (i.e., health system or university) and departmental (i.e., pharmacy department and department in the college) objectives; further,

To encourage pharmacists and pharmacy leaders to recognize that part of their professional responsibility is the development of new pharmacy practitioners.

(This policy supersedes ASHP policy 9810.)

F. Biological Drugs

To encourage pharmacists to take a leadership role in their health systems for all aspects of the proper use of biologic therapies, including preparation, storage, control, distribution, administration procedures, safe handling, and therapeutic applications; further,

To facilitate education of pharmacists about the proper use of biologic therapies.

(This policy supersedes ASHP policy 0017.)

Cynthia Brennan, Board Liaison to the **Council on Legal and Public Affairs**, presented the Council's Policy Recommendations A through I. Following a request to consider Policy Recommendation A separately, it was moved and seconded to add the word 'eligible' before the word Medicare' in the first sentence and to add the following at the end of that sentence '(fully funded means the federal government will make adequate funds available to fully cover the Medicare program's share of prescription drug program costs; eligible means that the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program).' There was no discussion and the amendment was approved. Policy Recommendation A, as amended, was adopted.[c] It reads as follows (italic type indicates material added):

A. Medicare Prescription Drug Benefit

To strongly advocate a fully funded prescription drug program for *eligible* Medicare beneficiaries that maintains the continuity of patient care and ensures the best use of medications *(fully funded means the federal government will make adequate funds available to fully cover the Medicare program's share of prescription drug program costs; eligible means that the federal government may establish criteria by which Medicare beneficiaries qualify for the prescription drug program)*; further,

To recommend that the program should at a minimum contain the following: (1) appropriate product reimbursement, (2) appropriate coverage and payment for patient care services provided by pharmacists, and (3) open access that allows any willing provider to participate.

B. Role of Licensing, Credentialing, and Privileging in Collaborative Drug Therapy Management

To recognize licensure of pharmacists as the only state-imposed legal requirement necessary for pharmacists engaged in providing collaborative drug therapy management services; further,

To support the current practice of pharmacists and prescribers negotiating and establishing collaborative drug therapy management agreements in which the pharmacist receives delegated authority; further,

To support the use of privileging processes in those practice environments where explicit privileging is required to receive delegated authority; any additional training or credentials required of pharmacists engaging in these practices should be determined by the local practice site; further,

To stipulate that privileging should be conducted by an oversight body of the practice site.

(Note: Privileging is the process by which an oversight body of a health care organization or other appropriate provider body, having reviewed an individual health care provider's credentials and performance and found them satisfactory, authorizes that individual to perform a specific scope of patient care services within that setting.)

(This policy supersedes ASHP policy 0219.)

C. Drug Product Shortages

To strongly encourage the Food and Drug Administration to consider, in its definition of "medically necessary" drug products, the impact of medication-use factors, taking into account that if an unfamiliar product is introduced in a clinical setting because the customary product is unavailable, there is increased risk to patient safety; further,

To support government-sponsored incentives for manufacturers to maintain an adequate supply of medically necessary pharmaceutical products; further,

To advocate laws and regulations that would (1) require pharmaceutical manufacturers to notify the appropriate government body at least 12 months in advance of voluntarily discontinuing a medically necessary product, (2) provide effective sanctions for manufacturers that do not comply with this mandate, and (3) require prompt public disclosure of a notification to voluntarily discontinue a medically necessary product; further,

To encourage the appropriate government body to seek the cooperation of manufacturers in maintaining the supply of a medically necessary product after being informed of a voluntary decision to discontinue that product.

(This policy supersedes ASHP policy 0221.)

D. Re-importation of Pharmaceuticals

To oppose re-importation of pharmaceuticals except in cases where the Food and Drug Administration determines it would be necessary for the health and welfare of United States citizens.

Following a request to separate Policy Recommendation E, it was moved and seconded to amend it by adding the following second paragraph: 'To encourage the Food and Drug Administration to develop and implement regulations to: 1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers and manufacturers) from purchasing legend drugs from unlicensed entities, 2) to accurately document at any given point in the distribution chain the original source

of drugs and chain of custody from the manufacturer to the pharmacy, further;'. There was no discussion and the amendment was approved. Policy Recommendation E, as amended, was adopted.[c] It reads as follows (italic type indicates material added):

E. Integrity of Drug Products in the U.S. Supply Chain

To encourage the Food and Drug Administration (FDA) to take the steps necessary to ensure that (1) all drug products entering the country are thoroughly inspected and tested to establish that they have not been adulterated or misbranded and (2) patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, or non-FDA-approved drug products; further,

To encourage the Food and Drug Administration to develop and implement regulations to: 1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers and manufacturers) from purchasing legend drugs from unlicensed entities, 2) to accurately document at any given point in the distribution chain the original source of drugs and chain of custody from the manufacturer to the pharmacy; further,

To urge Congress to provide adequate funding or authority to impose user fees to accomplish these objectives.

(This policy supersedes ASHP policy 8609.)

There was a request to consider Policy Recommendation F separately. It was then moved and seconded to amend it by adding the words 'by the Pharmacy Technician Certification Board' following the word 'certification' in the second paragraph. Following discussion, the amendment was approved. Policy Recommendation F, as amended, was adopted.[c] It reads as follows (italic type indicates material added):

F. Regulation of Pharmacy Technicians

To advocate and support registration of pharmacy technicians by state boards of pharmacy (registration is the process of making a list or being enrolled in an existing list; registration should be used to help safeguard the public through interstate and intrastate tracking of the technician work force and preventing individuals with documented problems from serving as pharmacy technicians); further,

To advocate that state governments mandate certification *by the Pharmacy Technician Certification Board (PTCB)* of all pharmacy technicians (certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association); further,

To advocate the adoption of uniform standards for the education and training of all pharmacy technicians to ensure competency and the protection of public health and safety; further,

To advocate that licensed pharmacists should be held accountable for the quality of pharmacy services provided and the actions of pharmacy technicians under their charge.

(This policy supersedes ASHP policy 0224.)

G. Licensure for Pharmacy Graduates of Foreign Schools

To support state licensure eligibility of a pharmacist who has graduated from a pharmacy program accredited by the American Council on Pharmaceutical Education (ACPE) or accredited by an ACPE-recognized accreditation program.

H. Regulation of Dietary Supplements

To advocate a change in the Dietary Supplement Health Education Act such that dietary supplements shall at a minimum meet the same legal requirements as nonprescription drug products; further,

To support the routine reporting and monitoring of product defects and adverse effects associated with dietary supplements through the FDA MedWatch and United States Pharmacopeia reporting programs.

(This policy supersedes ASHP policy 9818.)

I. Public Funding for Pharmacy Residency Training

To support legislation and regulation that ensures public funding for accredited pharmacy residency programs consistent with the needs of the public and the profession; further,

To oppose legislation or regulation involving reimbursement levels for graduate medical education that adversely affects pharmacy residencies at a rate disproportionate to other residency programs.

(This policy supersedes ASHP policy 9811.)

Jill E. Martin, Board Liaison to the **Council on Organizational Affairs**, presented the Council's Policy Recommendation A.

There was no discussion and Policy Recommendation A was adopted. It reads:

A. ASHP Planning Process and ASHP Long-Term Goals

To discontinue ASHP policy 8311, ASHP Planning Process and ASHP Long-Term Goals, which reads:

> To encourage ASHP's long-range planning process and to inform the membership annually of the activities, conclusions, and outcomes of this process.

Brian L. Erstad, Board Liaison to the **Council on Professional Affairs**, presented the Council's Policy Recommendations A through F.

A. Complementary or Alternative Substances

To recognize that patients may choose to use dietary supplements and complementary or alternative substances; further,

To recognize that when providing patient care, pharmacists need to be aware of all substances a patient is using, including dietary supplements and complementary or alternative substances; further,

To support the principle that pharmacists should be informed about dietary supplements and complementary or alternative substances and capable of providing sound advice to patients about their use; further,

To support the principle that pharmacists' recommendations about the use of dietary supplements and complementary or alternative substances should be based on sound scientific evidence of safety and efficacy; further,

To support the principle that sound research on the safety and efficacy of dietary supplements and complementary or alternative substances is required for pharmacists to perform this function, and to advocate that the Food and Drug Administration take an active role in encouraging such research.

(This policy supersedes ASHP policy 9817.)

B. Expression of Therapeutic Purpose of Prescribing

To advocate that the prescriber provide or pharmacists have immediate access to the intended therapeutic purpose of prescribed medications in order to ensure safe and effective medication use.

(This policy supersedes ASHP policy 9708.)

C. Pain Management

To advocate fully informed patient and caregiver participation in pain management decisions as an integral aspect of patient care; further,

To advocate that pharmacists actively participate in the development and implementation of health-system pain management policies and protocols; further,

To support the participation of pharmacists in pain management, which is a multidisciplinary, collaborative process for selecting appropriate drug therapies, educating patients, monitoring patients, and continually assessing outcomes of therapy; further,

To encourage the education of pharmacists, pharmacy students, and other health care providers regarding the principles of pain management.

(This policy supersedes ASHP policy 9815.)

Following a request to separate Policy Recommendation D, it was moved and seconded to delete the word 'pharmaceutical' in the first paragraph and to delete the word 'pharmaceutical' and replace it with 'patient' in the second paragraph. There was no discussion and the amendment was approved. Policy Recommendation, as amended, was adopted.[c] It reads as follows (italic type indicates material added; ~~strikethrough~~ indicates material deleted):

D. Pharmacist Support for Dying Patients

To support the position that care for dying patients is part of the continuum of ~~pharmaceutical~~ care that pharmacists should provide to patients; further,

To support the position that pharmacists have a professional obligation to work in a collaborative and compassionate manner with patients, family members, caregivers, and other professionals to help fulfill the ~~pharmaceutical~~ *patient* care needs, especially the quality-of-life needs, of dying patients of all ages; further,

To support research on the needs of dying patients; further,

To provide education to pharmacists on caring for dying patients, including education on clinical, managerial, professional, and legal issues; further,

To urge the inclusion of such topics in the curricula of colleges of pharmacy.

(This policy supersedes ASHP policies 9814 and 9816.)

E. ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness

To approve the ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness

(Note: Supersedes the ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness approved by the ASHP House of Delegates June 2, 2002.)

F. ASHP Statement on the Pharmacist's Role in the Care of Patients with HIV Infection

To approve the ASHP Statement on the Pharmacist's Role in the Care of Patients with HIV Infection.

G. ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

To approve the ASHP Statement on the Pharmacists's Role in Substance Abuse Prevention, Education and Assistance

(Note: Supersedes the ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance approved by the ASHP House of Delegates June 3, 1998.)

Chair Patry reminded delegates of the process for submitting New Business items. Announcements were made. The meeting adjourned at 4:25 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 3, at 4:30 p.m. A quorum was present.

Resolutions. President Devereaux presented the Resolution from Karen R. Mulheron and Judy Gardner on "Pharmacy Drug Theft." Following discussion, the Resolution was adopted. It reads as follows:

Pharmacy Drug Theft

Motion: To support the development of policies and guidelines for health-system pharmacists designed to deter drug product theft and thereby enhance both the integrity of the drug distribution chain and the safety of the workplace; further,

To encourage the development of systems that limit the diversion and abuse potential of medications including high-cost drugs and controlled substances and thereby reduce the likelihood that these products will be targets of theft.

Background: A review of existing ASHP policy on drug theft reveals language focusing on the criminal aspects of diversion, chemical dependency, and substance abuse. The purpose of this Resolution is to provide an additional dimension to the issue of drug theft. This Resolution addresses drug theft from the perspective of workplace safety for pharmacy staff and for the security of high-cost inventory. To this end, this Resolution provides a unique aspect to the difficult and multidimensional problem of drug theft, and should be endorsed by the House of Delegates.

The location and availability of controlled substances and high-cost drugs in the pharmacy make our workplace a high-profile target for theft. Drugs with substantial "street" value or significant dependency and abuse potential are targets of attempted theft endangering the safety and the lives of the pharmacy staff. Drug thieves are typically seeking either the promise of quick, high profits or the relief of chemical dependency, and they are willing to attempt desperate acts to achieve these goals. This places the pharmacy staff in the concomitant role of potential victim of violent crime, acting law enforcement agent, and health care provider. One example of a target drug is the narcotic OxyContin. The U.S. Justice Department reports that the development and distribution of the product OxyContin sparked a virtual explosion in the rate of drug theft, armed robbery, and fraud (U.S. Department of Justice Information Bulletin: OxyContin Diversion and Abuse, January 2001). In recent communication with Asa Hutchinson, Administrator of the DEA, and Edith Rosato, Vice President of Strategic Development, National Association of Chain Drug Stores (NACDS), we learned that a collaborative group of pharmacy professionals, regulatory agency personnel, Purdue Pharma representatives and law enforcement officials are actively pursuing a "proprietary response" to the OxyContin diversion problem. Adequate funding from private and federal sources is driving forward solutions to address the illicit OxyContin problem. However, the exponential nature of the growth in OxyContin thefts illustrates the power and depth of the national drug theft problem. Further, drug targets for theft are not limited to controlled substances. High-cost drugs or drugs with high resale value also top the list of targets for drug thieves. Identified targets of hospital drug theft have included epoetin alpha for its high acquisition cost and cefazolin for its street value. Additionally, the ever-changing drug shortage problem may lead to drugs being sought for their black market value that would currently seem unlikely targets. The hospital and institutional environment is not insulated from these dangers. Within the past year, an increasing number of attempted thefts have occurred in these settings. Thieves are becoming more brazen with their attempts, and in a number of instances have demonstrated their ability to learn details of hospital pharmacy/drug operations. Technologic advances in pharmacy automation directed at improving patient safety have led to a resultant increase in the variety and number of persons admitted to the pharmacy, and an increase in the number of persons with "inside knowledge" of sensitive operational information. A clear position paper expressing

consensus support of the ASHP membership for a comprehensive model response to this problem would offer a foundation from which policy and legislative action could develop. The ever-changing nature of drug development and changing market values for current medications speaks to the need for ASHP to craft an assertive affirmative action plan to drive forward the legislative process to proactively support or create legal action against persons convicted of robbery with the intent of drug trafficking and to encourage innovation in drug distribution methods that promote pharmacy staff safety. The high profit and marketability of pharmaceutical-grade controlled substances will continue to seduce thieves into desperate acts with the hope of scoring huge rewards. As government and professional organizations work at solutions to current high-profile targets, it is imperative that as a profession we take a proactive stance for optimal safety in the workplace, for aggressive legislative action against drug thieves, and for support of the development of novel methods to limit the diversion and abuse potential of high cost drugs and controlled substances. Our professional responsibilities should not include endangering our lives to act as law enforcement officials.

Conclusion: The profession of pharmacy is a highly skilled discipline of professionals dedicated to the wellness and improvement of health in the community. As a 30,000-member national professional association, the American Society of Health-System Pharmacists represents a significant force to affect federal and state legislative and political change. We hail the ASHP policy calling for the profession to "assume leadership, responsibility, and accountability" on this issue. ASHP aspires to serve as health-system pharmacists' "collective voice on issues related to medication use and public health." In support of this goal, the issue of drug theft offers an opportunity to assertively voice our concerns to our state and federal representatives to spark positive legislative change to optimize the safety of our work environment and the freedom to focus on our profession's dedication to patient care, wellness, and healing.

Chair Patry announced the appointment of tellers to canvass the ballots for the election of Chair of the House of Delegates. Those appointed were David Blanchard (NY), Jennifer Edwards (WA), and Risa Exum (FL).

Recommendations. Chair Patry called on members of the House of Delegates for Recommendations. (The name(s) and state(s) of the delegate(s) who introduced the item and the subject of the item precede each Recommendation.)

Carl W. Grove (ME): Legal and Public Affairs Accountability

Recommendation: That ASHP develop a broad-based policy that advocates support of all laws and regulations pertaining to licensure and the responsibilities thereof. This includes accountability for those responsibilities.

Background: As regards the regulation of pharmacy technicians (tech-check-tech) ASHP policy states we should be held accountable for pharmacy services provided and the actions of technicians. We already are held accountable for these things and if we are to make a statement about accountability, it should pertain to responsibilities of the pharmacist and we need not have a separate statement pertaining to the regulation of pharmacy technicians (or other processes).

Suggested Outcome: A global policy statement that would apply to all of our functions/processes.

Carl W. Grove (ME): Definition of Terminology

Recommendation: That ASHP develop or adopt a standardized formal list of definitions for items that relate to our practice area. Specifically: biological drugs, adverse drug reaction, medication errors, dietary supplements, herbals.

Background: ASHP has policy on "biological drugs," but there is currently different interpretation of this term in the marketplace (variability among pharmacists, providers, payors), and having a standard definition would clear up ambiguity. I feel that ASHP, a world leader, should develop definitions when necessary, adopt/support authoritative that already exist (e.g., as promulgate by WHO, CDC, NCPIE, etc) and, when necessary, take a stance on one standard definition for each item.

Suggested Outcome: The list should be published as a single document.

Stanley Chamallas (NH): Application of the Term "Health System"

Recommendation: That ASHP review the use of the term "health system" throughout each of the Society's documents to ensure that these documents fully represent the practice setting for which they are intended; further, encourage ASHP to review the use of the term "health system" as it relates to providing patient-focused care.

Background: The Executive Committee of the Section of Home, Ambulatory and Chronic Care Practitioners discussed the current situation of unclear nomenclature in the use of the term "health system" within ASHP. We offer this recommendation in an effort to bring clarity to the use of the term. The recently approved policy statement on continuity of care is intended to

increase the focus on the systematic process of care rather than organizational or institutional boundaries. As practice standards are developed relative to "continuity of care", it will be important to be clear about the use of the term "health system" to focus on care of the patient across the continuum rather than focus on the venue of care. We recognize that the medication use process transcends organizational and facility boundaries. We recognize that different practice settings within a health system require unique and specialized procedures, guidelines, and statements. We recognize that pharmacists are an integral part of the health system and responsible for the medication use process in the ambulatory, community, home care, hospital, and other practice environments. We recognize that the provision of patient focused-care should occur as the patient transverses the various settings of health care, which collectively make up the "health system" in much broader terms. We recognize that changes and clarity in the use of the term "health system" will involve a comprehensive evaluation by ASHP and encourage that this be done in the context of patient-focused and care rather than in the context of membership categories and practice settings.

Suggested Outcomes: Clarity in the use of the term "health system" as it relates to every practice standard, guideline, or other ASHP document. Increased specificity regarding the appropriate application of policy statements and other resources (e.g., application to inpatient care, ambulatory care, home care, etc.) when specificity is warranted. Due consideration of all practice settings within the "health system" during all future policy and resource review, revision, and development.

Diane Ginsburg (TX), Teresa Hudson (AR), and Charles Jastram (LA): Section of Pharmacy Educators

Recommendation: That the Council on Organizational Affairs evaluate the formation of a section of pharmacy educators.

Background: The Task Force on Organizational Structure discussed the issue of pharmacists who provide education to students, residents, and others. The practices of these pharmacists emphasize education but not necessarily research or direct patient care. Members of the Section of Clinical Specialists and Scientists may include education in their practices; however, the emphasis on this section is primarily on practice and research. The current structure does not provide a common venue for educators to network, share ideas or provide leadership to ASHP with respect to educational issues. At least 5% of ASHP members have identified an academic environment of college of pharmacy as their practice setting. Therefore, we believe ASHP should consider developing a section for these members.

Suggested Outcome: The Council on Organizational Affairs include this issue on its agenda for its September 2003 meeting and provide feedback to the House of Delegates as to the feasibility and desirability of forming a section of pharmacy educators.

Lourdes M. Cuellar (TX): Location of Summer Meeting

Recommendation: That the ASHP Board of Directors consider San Antonio, Texas, as a location for an upcoming Midyear or Summer Meeting.

Background: San Antonio was on the rotation for 2004 but the meeting was relocated to Las Vegas.

Suggested Outcome: San Antonio will be added to the meeting rotation.

Diane L. Fox (TX), Doug Lang (MO), Pat Parker, (KS): Dispensing Medications for Patient Administration without Accepting Responsibility for Proper Preparation, Administration and Monitoring

Recommendation: The Board of Directors refer the issues raised by this practice to the appropriate councils to review and address the impact on patient safety and legal considerations.

Background: There is a cost-cutting trend of organizations to dispense injectable drugs requiring admixture pursuant to patient-specific prescriptions directly to the patient in a "not-ready-to administer" form (e.g., IVIG, Remicade, Prolastin). The patient receives the product in the manufacturer's packaging, often without diluents and other supplies necessary to prepare and administer the medications. This practice results in patients receiving medications that they have not been educated to store, prepare, and administer safely. When the patient requests assistance from their local pharmacy, physician's office, or clinic, they are often unable to obtain the qualified assistance they require. Under current law, pharmacies are not allowed to prepare a medication that has previously been dispensed pursuant to a prescription. In addition, physicians, clinics, hospitals, and pharmacists will not accept the liability for preparation and administration of products for which they cannot assure the integrity. This practice raises significant patient safety concerns.

Suggested Outcome: To advocate for regulatory changes that will prohibit this practice and maintain the continuity of patient care within the patient's health system, thereby, enhancing patient safety by including

all members of the health-care team and providing a safe environment for the patient.

David Zilz (Past President): *Priorities of National Alliance for Health Information Technology*

Recommendation: To strongly encourage ASHP to advocate that the National Alliance for Health Information Technology make the development of universal standards for computerized prescriber order entry an *immediate priority* in an effort to improve system functionality and safety, and prevent duplicative customization. Furthermore, to encourage the National Alliance to capitalize on the expertise of health system pharmacists and their many years of experience with automation and pharmacy systems development.

Background: The National Alliance for Health Information Technology is a multi-organizational alliance formed by the American Hospital Association to advocate for the development and adoption of universal standards for health information systems. ASHP joined the National Alliance in 2002 as a founding member, along with other organizations representing pharmaceutical industry, technology vendors, standards setting and accrediting bodies, wholesalers, health care practitioner organizations, and others. The National Alliance is viewed by many as the best avenue to force change toward national standards for *all* health information systems, including computerized prescriber order entry, machine-readable coding, electronic medical records, and other patient-safety-enhancing technologies.

Larry Anderson, Steve Spravzoff, and Jon Glover (AR): Pharmacy Leadership within Health Systems

Recommendation: That ASHP promote and advocate the value of including the director of pharmacy services in the health-system organization hierarchy. Further, that the idea of a chief pharmacy officer be explored and promoted at the level of chief information officer (CIO), chief operations officer (COO), and chief nursing officer (CNO). That ASHP assertively take steps to promote and communicate the value and role of health system pharmacists to health system leadership.

Diane Ginsburg and Teri Bair (TX): Repackaging Guidelines and Regulations for Use within Health Systems

Recommendation: Request that ASHP work with the Food and Drug Administration and the National Association of Boards of Pharmacy to update and clarify repackaging guidelines, regulations, and laws to permit a health system to repackage drugs for its own use within its related facilities.

Background: The FDA's main concern with repackaging is to ensure that drug products are not adulterated or misbranded during the repackaging process. The primary concern the FDA has centers around having assurances that the drug product is labeled correctly. The FDA believes that this is accomplished through obtaining a federal establishment registration from the FDA for the repackaging facility and then following CGMP procedures in the repackaging process.

Currently, health systems cannot repackage drugs for use within their related facilities. To do this, they would need to be registered as a repackager with the FDA. The only exemption to this requirement is the repackaging of drug products by licensed pharmacists within the regular practice of pharmacy. This exemption allows hospital pharmacists to repackage products into unit dose or for retail pharmacies to repackage products for purposes of filling prescriptions within their own physical location. In differentiating whether an establishment is acting as a pharmacy or as a repackager/relabeler, the FDA's Regulatory Procedures Manual states: "The repackaging of drug products by pharmacists, or any other entity, for resale or distribution to hospitals, other pharmacies, nursing homes, clinics, health care facilities, etc., are beyond the practice of pharmacy and these repackaging/relabeling facilities are thus required to register and list all such drug products with the FDA." Thus, while a pharmacy may repackage for use within its own institution without being registered with the FDA or meeting CGMP requirements, a pharmacy cannot repackage drug products for resale or distribution to other facilities within its own system. Perhaps FDA may be convinced to change this policy for health systems, given the number of integrated delivery systems and the emergence of robotic technology, but to our current knowledge, FDA's current position is that such practice would constitute FDA-regulated repackaging.

Suggested Outcome: That this issue be referred to the Council on Legal and Public Affairs for review and determination of a recommended strategy to address this problem.

Doug Lang, Thomas Hall, and Ranee Neely, (MO); Caryn Bing (IL); Stan Chamallas (Section of Home, Ambulatory and Chronic Care Practitioners), Eric T. Hola (NJ); Leo Nickasch (WI); and Dennis Williams (NC): Compounding

Recommendation: ASHP assess its current policy statements and member services related to the compounding of all types of medications and their role in patient safety and public welfare. ASHP should provide guidance to its members and health care professional organizations regarding the need to adhere to established national compounding standards to assure quality patient outcomes.

Background: Currently, numerous occurrences have been reported both in the health care literature and public media of incidents of public harm and mortality in the use of compounded medications. The environment of drug product shortages has served as an impetus for pharmacy practitioners and others to attempt the production of these agents to meet patient care needs. Additionally, organizations are producing compounded products for readily available commercial products under the definition of compounding but in reality are engaging in manufacturing. These organizations are then bypassing traditional distribution channels and marketing directly to non-pharmacy health care personnel regarding the availability of these non-FDA-approved manufactured pharmaceuticals. These providers have then attempted to exert pressure on pharmacy practitioners to utilize these products in the provision of patient care services.

Recently, several state boards of pharmacy have passed and finalized revisions of state statutes or regulations in the areas of sterile product preparation and extemporaneous compounding. More states will begin to assess the status of their regulations in this arena to ensure public safety.

Suggested Outcome: Below is a listing of potential outcomes in no particular order of importance, but should not be limited to the following:

1) Potential revision of the current ASHP Guidelines on Sterile Product Preparation in light of the new release of USP standards in sterile product preparation;

2) Evaluation of the development of guidelines for extemporaneous compounding;

3) Encourage the development of model curricula for colleges of pharmacies in the training of new practitioners in the areas of sterile product preparation and extemporaneous compounding;

4) Develop and implement an ongoing educational programming for pharmacists and technicians in the arena of sterile product preparation and extemporaneous compounding;

5) Perform a needs assessment in the development and offering of a national certification program in sterile product preparation and extemporaneous compounding;

6) Communication with national organizations (JCCP, NABP, USP) in the formulation of model regulations for states in sterile product preparations and extemporaneous compounding;

7) Educational programming and policy statements addressing the ethics of compounding "readily available" commercial products;

8) Foster research and development of compounded product dosage forms in meeting the needs of unique patient populations;

9) Communicate with and educate other national health care provider organizations concerning the difference between compounded medications versus FDA-approved commercially manufactured medications;

10) Review and develop policy statement 0225 "Compounding versus Manufacturing" to address current issues in the compounding of medications, potentially to include support of the FDA compliance policy guide and strengthen enforcement by state boards of pharmacy;

11) Explore the development of a guidance document for health-system pharmacists in the use of contracted compounding services; and

12) Clarify with the FDA and educate health-system pharmacists on when an Investigational New Drug application is required in compounding FDA approved medications.

Jody H. Allen (VA): ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

Recommendation: To consider revising the recently approved referenced Statement to include discussion of reference to local drug courts as a venue for pharmacists to be knowledgeable about and to work with local, state, and federal authorities to assist, educate, and prevent drug abuse in their communities.

Background: One of the most revolutionary and widespread changes in the criminal justice system in the past 50 years has been the development of drug courts as alternative courses for nonviolent individuals charged with drug possession for personal use. There are more than 500 drug courts established; they exist in every state in the country.

The beneficial outcomes from the drug courts as an alternative for the traditional criminal justice system are well documented nationally. The recidivism rate is decreased from 70%-80% in the traditional system to 10%-25% in the drug court system, and the cost of incarceration versus the cost of maintaining an individual is significantly reduced. Most importantly, the individual participant becomes drug-free and a contributing member of society without a criminal record.

Therefore, pharmacists should be knowledgeable about the drug courts in their communities and realize the importance of these systems as a venue when criminal charges have been filed against individuals. Pharmacists should provide resources

to and support drug courts in their communities through public awareness, fund-raising, and education to the members of the drug court team, as appropriate.

Suggested Outcome: Revise the recently approved Statement to incorporate reference to local drug courts as a venue for pharmacists to be knowledgeable about and to encourage pharmacists to work with local, state, and federal authorities to assist, educate, serve on foundations, and prevent drug abuse in their communities.

Additionally, several publications and books have been written on the topic of drug courts and should be added to the "Other References" section of the Statement.

Renee Neely and Jane Tennis (MO): Methadone Clinics

Recommendation: ASHP to investigate the role of the pharmacist in methadone clinics with emphasis on client care and compliance; work with boards of nursing and departments of mental health as to the collaborative relationships that the pharmacist can offer to the free-standing and state-run clinics.

Background: Recently, one of us (Tennis) had the opportunity to participate as the pharmacist in a free-standing methadone clinic. In this role, she is expected to receive and verify the methadone inventory on a once-weekly basis. It is also her understanding that in many state managed methadone clinics there is not a pharmacist on duty.

In this clinic, the methadone is received in unit dose packaging. The clients will return on a daily basis for their dose; however, for Sundays and holidays, clients are given those doses to take home on the previous day. Once clients are compliant and able to manage therapy based on the treatment protocol, many clients are able to take upwards to seven days' therapy home.

Concerns:

1. The methadone is distributed by LPNs. We are still trying to understand the role of LPNs in this capacity per state regulations.

2. Since this particular clinic management requires a pharmacist to verify and accept inventory, these LPNs do not understand the rules and regulations for C-II controlled "substances. Any recommendations are presumed to "we do not need to do it that way", "other state run clinics do not require a pharmacist," etc.

3. Recently when the DEA visited the site, the pharmacist was not made aware of the visit until 2-weeks later and it was casually mentioned.

4. The pharmacist is not consulted, and in fact discouraged, to offer any pharmaceutical care activities or correct inappropriate advice to the clients. If would appear that some of the role of the LPN stretches into the RN rules and regulations.

5. The LPNs and counselors work under the direction of physician protocol; however, the physician is present only for three hours two days per week.

Suggested Outcome:

1. Determine the role of the pharmacist in these and other similar clinics. 2. To encourage all clinics to involve a pharmacist in a consulting activities and not solely focus upon the receipt and verification of methadone inventory. 3. To work with the nursing boards to verify the LPN's role and to encourage a collaborative relationship.

Ranee M. Neely and Doug Lang (MO): ASHP Financials Reports

Recommendation: A more detailed report of the financial status of the organization be presented for delegate review. This report should include, but is not limited to, actual versus expected financial performance for the current fiscal period, showing specific profit and loss areas as well as including the projected budget for the next fiscal period. This would allow the delegates a chance to look into the future and more accurately assess the current state of financial affairs of their organization.

Background: The current budget reports are abbreviated versions of the actual budget. As members of the organization we should be privy to the entire budget. This would give a better appreciation of the near $4 million dollar loss over the past fiscal year.

If the projected budget is included, a member would be able to tell how close we are to projecting our future. Are we on target for the current year and are goals realistic for next year? This will give delegates a better understanding of the viability of our organization.

We realize that it is difficult to maintain financial stability in the current fiscal world. As members we place an implicit trust in the board of directors to keep tabs on the budget. This should not be a burden they bear alone. We should be given a full report of the budget at the summer meeting. Realizing that end of year reports are now presented a year later due to the fiscal year end having been changed to May 31, an interim report will have to be presented at the summer meeting.

With many new faces in the House of Delegates it is difficult to question an abbreviated report when you do not have any history to compare it with.

We are unable to ask educated questions when we do not know exactly what is being presented.

Suggested Outcome: A full financial report including current actual and projected budget as well as, the projected budget for the next fiscal period. A 15-minute slide show presentation at each Regional Delegate Conference with specific information versus projected information for discussion. Talking points could be prepared in advance for the Board member or the ASHP staff member attending the meeting.

Harold N. Godwin (Past President): Board of Directors Report on Duly Considered Amendments

Recommendation: Under the report of Duly Considered by the Board of Directors, I would recommend that the rationales be provided on those items which are not accepted during the "Duly Considered" process.

David B. Moore (MD): ASHP Policy on Medicare Prescription Drug Benefit

Recommendation: The Council of Legal and Public Affairs consider revising the last phrase of the policy "open access that allows any willing provider to participate" to eliminate or replace the term "any willing provider."

Background: Inclusion of the phrase "any willing provider" implies ASHP support for "any willing provider" legislation that may be proposed on the state level.

Board of Directors duly considered matters. The Board reported on eight professional policies that were amended at the first House meeting. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 3, 2003, to "duly consider" the amended policies. The Board presented its recommendations as follows.

- Regarding the first item from the Council on Administrative Affairs, titled "Machine-Readable Coding and Related Technology," the Board agreed that the amended language was acceptable.

- Regarding the second item, from the Council on Administrative Affairs titled "Technician-Checking-Technician Programs," the Board agreed that the amendments were acceptable; however, the language was edited slightly for purposes of clarification. (The editing is reflected in the language shown in the report of the first meeting of the House).

- Regarding the third item, from the Council on Educational Affairs, titled "Interdisciplinary and Interprofessional Instruction on Performance Improvement and Patient Safety," the Board agreed that the amending language was not acceptable.

- Regarding the fourth item, from the Council on Educational Affairs, titled "Cultural Competence," the Board agreed that the amended first clause was acceptable; the remainder of the language will be referred to the Ad Hoc Committee on Ethnic Diversity and Cultural Competence. Policy Recommendation C as adopted reads as follows:

D. Cultural Competence

To foster cultural competence among pharmacy students, residents, and practitioners and within health systems for the purpose of achieving optimal therapeutic outcomes in diverse patient populations.

- Regarding the fifth item, from the Council on Legal and Public Affairs, titled "Medicare Prescription Drug Benefit," the Board agreed that the amendments were acceptable.

- Regarding the sixth item, from the Council on Legal and Public Affairs, titled "Integrity of Drug Products in the U.S. Supply Chain," the Board agreed that the amendment was acceptable.

- Regarding the seventh item, from the Council on Legal and Public Affairs, titled "Regulation of Pharmacy Technicians, the Board agreed that the amendment was acceptable.

- Regarding the eighth item from the Council on Professional Affairs, titled "Pharmacists Support for Dying Patients," the Board agreed that the amendments were acceptable.

A point of information was raised by several delegates regarding the final outcome of Policy Recommendation B from the Council on Educational Affairs titled "Interdisciplinary and Interprofessional Instruction on Performance Improvement and Patient Safety." Since the Board of Directors did not accept the amended policy, the existing policy (ASHP Policy 0208) would remain in effect. Chair Patry then requested a suspension of the rules. There was no objection by Delegates. It was then moved, seconded, and approved that the original policy proposal be reconsidered. Following discussion, Policy Recommendation B in its original form was adopted. It reads as follows:

B. Interdisciplinary and Interprofessional Instruction on Performance Improvement and Patient Safety

To urge colleges of pharmacy and other health professions schools to include instruction, in an interdisciplinary and interprofessional fashion, on the

principles of performance improvement and patient safety and train students in how to apply these principles in practice.

(Note: Interdisciplinary refers to communication between disciplines *within* a profession; interprofessional refers to communication *across* the health care professions.)

(This policy supersedes ASHP Policy 0208.)

New Business. Chair Patry announced that there were no New Business items to consider

Election of House Chair. Chair Patry conducted the election for Chair of the House of Delegates. He called delegates to present completed official ballots to tellers, who certified the eligibility of delegates to vote. After the balloting, the tellers counted the ballots. Chair Patry received the tellers' certified report and announced that Marjorie Shaw Phillips was the newly elected Chair of the House of Delegates.

Recognition. Chair Patry recognized members of the Board who were continuing in office. He also introduced members of the Board who were completing their terms of office.

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Patry presented President Devereaux with an inscribed gavel commemorating her term of office. President Devereauxrecognized the service of Chair Patry as Chair of the House of Delegates and a member of the Board of Directors for the past three years.

Chair Patry recognized Steven Sheaffer's years of service as a member of the Board, in various presidential capacities, as Chair of the Board, and as Vice Chair of the House of Delegates.

Chair Patry then installed the chairs of ASHP's sections and forum: Marianne Billeter, Section of Clinical Specialists and Scientists, Barbara Prosser, Section of Home, Ambulatory, and Chronic Care Pharmacists, and Leslie Roth, Student Forum. Dr. Patry then recognized the remaining members of the executive committees of sections and the Student Forum and introduced the members of the Interim Executive Committee of the Section of Pharmacy Practice Managers.

Installation. Chair Patry installed Daniel M. Ashby as President of ASHP, Kevin J. Colgan and Janet A. Silvester as members of the Board of Directors, and Marjorie Shaw Phillips as Chair of the House of Delegates. He introduced the families of newly installed Board Members.

Parliamentarian. Chair Patry thanked Joy Myers for service to ASHP as parliamentarian.

Adjournment. The 55th annual session of the House of Delegates adjourned at 5:50 p.m.

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[a] In accordance with the ASHP Bylaws, the Board of Directors acts as a referral committee on Resolutions.

[b] The Committee on Nominations included Barbara A. Poe, Chair, Max L. (Mick) Hunt, Vice Chair; and Mark J. Isopi, Charles W. Jastram, Jr., Bonnie L. Pitt, Steven R. Spravzoff and Michele Weizer-Simon.

[c] See the report of the second meeting of this session, "Board of Directors duly considered matters," for final action on this issue. When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to reconsider the matter before it becomes final policy. The Board reports the results of its due consideration of amended proposals during the second meeting of the House.