



2009 Issue Summaries

Developed by the Pharmacy Student Forum Policy & Legislative Affairs Advisory Group

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Council on Education and Workforce Development

Summary prepared by Ashley Garcia, University of Colorado, Rebecca Lalani, University of Michigan

A. Pharmacy Student Experiences in Medically Underserved Areas

The responsibility of all accredited Colleges of Pharmacy is to educate and prepare informed, dynamic and well-rounded individuals determined to benefit patients from all backgrounds. Integral to this is service in traditionally underprivileged areas such as rural or urban towns, not only for practical but also ethical considerations. The Board has agreed that mandatory service or rotations would help prepare students by exposing them to patients from an array of financial, cultural and ethnic backgrounds.

Benefits:

- Exposure to variety of backgrounds prepares students for all potential practice settings
- Fosters understanding, cultural sensitivity and spurs motivation to effect change
- Provides underserved area with additional resources that otherwise would not be afforded
- Social awareness and compassion comes with the experience

Concerns:

- Quality of rotation education can be compromised with the limited resources in the area (What will I learn?)
- Preceptors are not readily available/Poor quality mentors (Will I just be another tech?)
- Housing, transportation and safety are of great consideration (Where will I stay? Will it be safe?)
- Better models available to expose students to the same areas (Student groups, Sponsored volunteer days)
- Can/should students be forced to work in the area rather than encourage volunteerism? (What about the rotation space I lose to do something else?)

Conclusions:

The council decided to encourage Colleges of Pharmacy to continue fostering voluntary student involvement in underserved areas while developing infrastructure that could support a required rotation sometime in the future.

B. Medication Safety Related Education in US Colleges of Pharmacy

Although medication education and the pharmacist's responsibility for patient safety are taught in Colleges of Pharmacy, the pertinent topics are interwoven with various other topics/classes and thus, minimized. In order to emphasize the importance of medication safety, a specific and separate course should be added to the curricula to encourage student cognizance, recommendation and application in the practice setting.

Benefits:

- Heightened awareness of common medication/patient safety issues
- Better preparation of rotation students entering P4 year
- Increased patient safety

Concerns:

- An increased workload for already burdened curricula (Another class? Another final to take?)
- Excessive emphasis on one point (It's definitely important but an entire course?)
- One specific course might take safety out of context (What situations cause the greatest frequency of errors?)
- Preceptor response to student recommendations could be negative (Isn't it a bad idea to anger my preceptor/boss?)

Conclusions:

Although ASHP has a policy on integrative care, the focus is not on patient safety specifically. The board has recommended the development of classroom materials in conjunction with a similar program being developed by ACPE that is dedicated to safety instruction. Although Council members do note the importance of this recommendation, further development and basic planning is needed before the idea can come to fruition.

C. Pharmacy Expertise in the Preparation and Handling of Injectable Medications

ASHP would like to incorporate more sterile compounding techniques into lectures and experiential curriculum for pharmacy students. Injectables and biologics are going to be mainstays of therapy for many years to come, and proper handling and compounding techniques need to be taught in pharmacy school. They would also like to develop postgraduate curriculum based sterile compounding training programs.

Education on sterile compounding varies greatly. Some students learn to compound intravenous admixtures proficiently by spending time working in a hospital pharmacy. Others graduate without ever handling or touching an intravenous solution.

Sterile product experts should receive more extensive training beyond simple aseptic technique. It is suggested that ASHP seek ways to develop a model that combines classroom instruction with hands-on experience.

Benefits:

- Education is important (many students do not receive training on aseptic technique and IV preparations in school)
- ASHP members will be in the health system and required to work in sterile situations
- Students should be taught sterile technique school, and later have CE that will train us to prepare sterile entities.

Concerns:

- Cost is always an issue. What will it cost to implement this into an already full curriculum? Do you hire new faculty for this position? This area of pharmacy will be around for years and patient safety is number one.

D. Continuing Professional Development

ASHP endorses and promotes the concept of continuing professional development that involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation.

ASHP wants to continue the development of a variety of mechanisms and tools that pharmacists can use to assess their professional development needs; encouraging individual pharmacists to maintain their own professional competence; and encourage pharmacy managers to promote professional development.

ASHP wishes to collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods for implementing professional development and endorse the efforts of colleges of pharmacy and

ASHP accredited pharmacy residency programs to teach the principles, concepts, and skills of professional development.

Benefits:

- Continuing education is something that is required for licensure and should be on every pharmacist's to-do list.
- Education is so important, especially with many new medications coming to market. Keeping up-to-date is so important for the profession as well as our patients.
- Working with other organizations and boards of pharmacy will bring east and west coasts closer together with information from both ends of the nation. Collaboration is much better than working alone.

Concerns:

- Continuing education is expensive and takes a lot of time to prepare.

E. Pharmacy Residency Training

ASHP will continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available. ASHP also wishes to expand efforts to make pharmacy students aware early in their education of the career choices available and the importance health-system employers attach to the completion of a residency.

Benefits:

- With initiative 2015, pharmacists with any patient contact are going to need to be residency trained.
- The hands on experience from a residency will make better pharmacy practitioners.

Concerns:

- There are not nearly enough residencies for every student that graduates from a school of pharmacy.
- Residencies are expensive and take a lot of time from not only the preceptors in the institution.

Council of Pharmacy Management

Summary prepared by Brooke Ade, Hampton University, and Travis Garrett, Texas Tech University

A. Pharmacist Leadership of the Pharmacy Department

The Council wants to amend ASHP 0606, which affirms responsibility to a pharmacy leader such as administrative, clinical and operational tasks, and establishes an organizational structure to health systems. The amendments include affirming the role of the pharmacy leader over all pharmacy personnel and the role of non-pharmacists within the pharmacy department

There is an increased complexity in managing medication use and the expanding roles for non-pharmacists. The factors that fuel this expansion include a shortage of pharmacists, pharmacist's salaries, and growing complexity of pharmacy operation. Roles of non-pharmacists include supervision of technologies and management of technology, business, and financial matters.

The roles to be filled by the pharmacist utilize technology and well-trained technicians to allow pharmacists to become more fully engaged in patient care. Additionally, proper education and training as a pharmacist is critical for roles in management.

Benefits:

- Improves patient care
- More focused pharmacists
- Organized practice site
- Improved employee training

Concerns:

- Conflicts of interest between pharmacists and non-pharmacists

B. Medication Errors Related to Intimidating and Disruptive Behaviors

Two factors that can lead to medication errors include workplace intimidation and disruptive behaviors. They can contribute to poor patient satisfaction, increase cost, and result in staff turnover. Examples of disruptive behavior can range from passive behaviors such as refusal to answer questions or return pages and use of condescending languages to overt actions such as verbal outbursts or physical threats.

The Joint Commission, TJC, has a new leadership standard (LD.03.01.01) with two elements of performance (EP) that became effective January 1, 2009:

- EP4: organizations should establish a code of conduct defining acceptable, disruptive, or inappropriate behavior
- EP5: leaders need to create and implement a process for managing disruptive or inappropriate behaviors.

Benefits:

- Decrease medication errors
- Improve patient care
- Improve interdisciplinary relationships
- Holds all involved parties equally responsible for their actions
- Implements standards of conduct
- Improves skills of personnel to deal with possible situations

Concerns:

- Resistance to training programs
- Resistance by personnel

Conclusions:

TJC suggests educating all team members on appropriate professional behavior. The pharmacy has not given much attention to this issue, but the Council and Board agree it is important to encourage all professional to be targeted. Additionally, they believe training programs to deal with disruptive behaviors should be implemented in organizations and in colleges of pharmacy and residency training programs.

C. Standardized Clinical Drug Nomenclature

This policy recommendation is amending a policy that was previously adopted, policy 0801, addressing nomenclature of drugs for use in clinical decision support systems and CPOE, computer physician order entry. These clinical decision support systems use a database of medical information and combine it with patient specific factors and formulate medical advice for patient therapy. In order to promote patient safety and to allow for an automatic DUR, there needs to be a standardized system for drug nomenclature. At present, the NDC number is controlled in part by the FDA and in part by the manufacturer so there is no standardization in these numbers. The goal in the use of the CDSS in ambulatory practice is to combine the NDC number or something similar to a clinical drug nomenclature system such as RxNorm. RxNorm's nomenclature is based off the active ingredients, strength, and form of the medication. There are currently incompatibilities with the two that the National Committee on Vital and Health Statistics has recommended be worked out in order for its use in CPOE and CDSS.

Benefits:

- Improved patient care
- More informed prescribing

Conclusions:

The amendments to this bill are geared to expand the current systems to include the inactive ingredients. The amendment also recommends the addition of non-prescription medications and dietary supplements to the databases. The council believes that without these additions of the inactive ingredients and over-the-counter medications, these databases will be limited in their use with the clinical decision support systems.

D. Pharmacist's Role in Health Care Information Systems

This policy is an amendment to policy 0203. It has been updated to clarify "electronic patient information systems" to include computerized physician order entry (CPOE), electronic health records (EHR), pharmacy information systems, and e-prescribing and to include that pharmacists should be involved in the design of such products. The policy is amended also to say that ASHP advocates for incentives for health systems to adopt these patient technologies. While the current policy did include CPOE, the council believed that further definition was needed. E-prescribing is similar to CPOE, but it is usually less complicated and may be separate from the EHR. The council believes that the widespread use of e-prescribing can have a big impact on patient safety and can help reach the patient safety goals of The Joint Commission although many pharmacies are not yet equipped to fully utilize it. The council also noted and suggested that the Council on Public Policy address the need for the DEA to regulate the e-prescribing of controlled substances.

This policy would also advocate for the addition of incentives for health systems to incorporate patient technologies. In January of 2009, a program was started that offers incentives for professionals who are considered "successful electronic prescribers." These prescribers include those who "either report applicable electronic prescribing measures established under the Physician Quality Reporting Initiative or electronically submit prescriptions under Medicare Part D at a level determined by the Centers for Medicare & Medicaid Services."

Conclusions:

The Council believes these incentives should also include health systems that include these technologies in their ambulatory care areas.

Council on Pharmacy Practice

Summary prepared by Lorraine Sam, University of Southern California, and Daniel Crona, University of Colorado

A. Pharmacist's Role in Providing Care for an Aging Population

This policy is aimed at encouraging the expansion of geriatric health services in the pharmacy field. A report from the Institute of Medicine recommends three goals:

- To enhance geriatric competency in the workforce
- Recruit and retain geriatric specialists and caregivers
- Redesign models of care by expanding provider and patient roles to be more flexible

The pharmacist would be integral to patient counseling, monitoring drug-related problems, and supporting medication adherence. ASHP **does not** have guidance specifically addressing pharmacy services in the geriatric population, and the Council recommends placing higher priority on the ASHP Guidelines on Geriatric Pharmaceutical Services currently being developed.

Benefits:

- Expanded education for students and pharmacists that want to work with geriatrics in long-term care
- Potential growth area for pharmacy and clinical pharmacy jobs
- Potential area for an increase in pharmacy-practice residencies

Concerns:

- Potentially, there should be language included in the policy to address incorporating geriatric training and education into college of pharmacy curricula
- Should language be included to recognize pharmacists as providers, and language to address reimbursement for services?

Conclusions:

Ultimately this proposed policy would encourage a more extensive role for pharmacists in geriatric health services. The policy also supports innovative models for team-based geriatric care and **encourages the expansion of ASHP-accredited geriatric pharmacy residency programs.**

B. Pharmaceutical Waste

This policy aims to collaborate with different regulatory bodies and organizations to develop standards for the disposal of pharmaceutical waste as defined by the Resource Conservation and Recovery Act. It also encourages pharmaceutical companies and the Environmental Protection Agency to guide and assist in pharmaceutical waste destruction and recycling, as well advocating that the FDA standardize drug product labeling with disposal information. Other goals are to encourage research on the impact of drugs and metabolites excreted in human waste on the environment and public health and to streamline medication packaging to reduce waste materials.

The Council wishes to address ASHP's policies regarding obsolete lists, variability in requirements, labeling, and research. Obsolete lists deal with disposal of drugs not listed or minimally hazardous drugs that create burdensome disposal requirements. Unlisted drugs, especially newer medications, are either disposed of like similar drug classes or have no special disposal method at all.

Benefits:

- Cut down on variability for waste disposal
- Will provide for directions for medications into the proper waste stream
- Provide unified education and directions for waste disposal from health system to health system.

Concerns:

- The language in this policy does not speak to the disposal of controlled substances
- This policy only references waste disposal, and does not directly refer to medication "buy-back" or "take back" programs

Conclusions:

By addressing variability in requirements, the Council wishes to simplify communication and education about waste management, which may vary from state to state or county to county. With regards to labeling, the Council believes it would be more logical and efficient for the manufacturer to include directions for disposal into the proper waste stream. Labeling containers would ensure the information reaches the end user of the product (similar to the symbols used by the National Fire Protection Agency). Last, the Council believes more research and guidance is needed to study the environmental effects of hazardous metabolites excreted in human waste.

C. Automatic Stop Orders

Council members believe that automatic stop orders for medications, without using clinical judgment, are problematic. Automatic stop orders can ultimately **lead to missed doses or treatment interruptions**.

Background:

The Centers for Medicare and Medicaid Services (CMS) Hospital Conditions of Participation states that drugs and biologicals not specifically prescribed with a specific time limit or number of doses should be automatically stopped at a reasonable time predetermined by the medical staff. However, the **CMS does not specify appropriate durations of time**, leading the Council to believe the regulation is outdated (especially in light of The Joint Commission requirement for medication reconciliation and order reviews by pharmacists).

Benefits:

- Policy advocates for pharmacy collaboration with CMS and other regulatory bodies
- Will protect patients from potential adverse drug effects and improper open-ended medication orders
- Ultimately, the policy could help enhance patient safety

Concerns:

- There are issues concerning hard stop orders versus soft stop orders
- If there is not clinical reasoning behind a stop order, should medications be arbitrarily stopped?
- Should there be an automatic review time of medications by clinical pharmacy services rather than an arbitrary automatic stop time?

Conclusions:

The Council recommends that the revision should reflect the inherent risks involved in automatically canceling all medication orders and encourages protecting patients from indefinite, open-ended medication orders. Support for drug, class, or indication-specific automatic stop orders based on monitoring requirements or other organizational policies are recommended. The Council advocates that the CMS revise the requirement in the Hospital Conditions of Participation that all medication orders automatically stop after a period of time to include other options, such as patient protection from indefinite, open-ended medication orders. They also advocate revising the rest of the medication management regulations and guidelines to be consistent with this practice.

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D. ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control

This policy focuses **on updating the pharmacist's role in infection control to reflect more current updates** contained in the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship, which is endorsed by ASHP.

Benefits:

- Pharmacist to be directly involved in antimicrobial stewardship
- Potential expansion of practice for pharmacists, particularly infectious disease clinical pharmacists
- An increased pharmacist role in the fight of infectious disease will positively influence patient outcomes

Concerns:

- Language of policy could be potentially changed to reflect antimicrobial stewardship overall, rather than only in specialty teams

Conclusions:

The Council concluded that the previous ASHP statement, entitled the Statement on the Pharmacist's Role in Infection Control to be updated and aligned with current practice guidelines.

E. ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives

The Council favors the development of a **statement to recommend ways pharmacists can integrate leadership on quality initiatives into their daily practice**. Data collection, analysis, dissemination, and development, implementation, and evaluation of evidence-based practices are unique ways pharmacists can contribute as health care leaders.

Benefits:

- Many national healthcare quality measures are aimed at medication use. Thus, pharmacist input in the health-system environment into quality medication use further implants pharmacists as the medication experts in the health system
- Pharmacists will have direct input on the means to increasing the quality of patient care
- Health system pharmacists can help align medication use and quality measures with the national healthcare quality agenda

Concerns:

- Pharmacists need to be at the table of healthcare providers as the new administration revamps the standards that determine quality in healthcare

Conclusions:

The Council believes pharmacists can be more involved in achieving and exceeding national quality indicators that directly involve medication use. Pharmacy departments should also integrate quality improvement initiatives into their strategic plan and make themselves more known to health-systems administrators so they become more knowledgeable about the role pharmacists can play in improving quality.

Council on Public Policy

Summary prepared by Nick Rogers, North Dakota State University, Yuli Chang, University of Southern California

A. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management

Federal legislation (H.R. 5780) was introduced that would allow Medicare payment to pharmacists for CDTM services that are designated by state law as a “clinical pharmacist practitioner” or “pharmacist clinician.”

ASHP Policy 0318 supports CDTM but explicitly states that licensure should be the only state requirement. Therefore ASHP was unable to support H.R. 5780, although it would have served to move the profession forward. A New Business item passed in the House of Delegates in June 2008 noted the need to **revise policy 0318 in order to provide more flexibility for ASHP to achieve its goal of attaining recognition of pharmacist CDTM services by Medicare.**

Benefits:

- A means of recognizing pharmacists as “providers,” which will inevitably advance the profession
- Advocates for direct payment for pharmacist clinical services
- National standardization of clinical privileging would allow pharmacists to move practices from state to state without requiring different credentialing
- Another means of gaining recognition by CMS

Concerns:

- Standardization between states will be extremely difficult
- There will be issues with how these new privileges will be monitored once the expanded CDTM is in place

Conclusions:

This recommendation is a revision of policy 0318, **enabling ASHP to support and advocate for the expansion of CDTM.** The policy acknowledges that payers may require additional competence for pharmacists to perform CDTM. It also supports a professional initiative to develop national standards to determine pharmacist competence and the use of these standards by clinical privileging systems, government, and public or third-party payers.

B. Approval of Follow-on Biological Medications

This recommendation is a change to current policy that already supports the development of a process to allow follow-on (generic) versions of biological medications to be brought to market. The change is largely focused on updating terminology and adding support for post-marketing surveillance as well as pharmacist education regarding the interchangeability of follow-on biologicals. Language was also added to ensure that when these products are dispensed, providers are adequately reimbursed.

Benefits:

- Policy is simply updating language used in previous ASHP policies to language being utilized by other healthcare groups

Conclusions:

This policy is important in light of current discussions in Washington to make health care more affordable. Since a process for bringing generic version of traditional pharmaceuticals to market, many legislators are pushing for a similar program, e.g. the development of follow-on biologics to compete with the more expensive originally patented biological medications.

C. Pharmaceutical Product and Supply Chain Integrity

This policy is an amendment of policy 0722 to emphasize the need for FDA resources and authority to **enforce adherence to current good manufacturing practices (cGMP) by suppliers** in the supply chain.

Benefits:

- Increased patient safety through cGMP enforcement

- Manufacturers would be held to a higher standard for product integrity

Concerns:

- Language (specifically lines 9-16) in the policy needs to be strengthened (in the House of Delegates possibly pass the policy but reference it back with a recommendation to strengthen language)
- Language could be added to also address supplements and food products

Conclusions:

The concern stemmed primarily from the heparin product contamination by raw goods from China. Due to the fact that foreign facilities have little incentive to maintain cGMP as inspections are announced in advance, the Board and Council believed that holding the manufacturer of the finished product responsible for the compliance of all its suppliers would provide that incentive. Additionally, establishment of meaningful penalties of cGMP violations may also enhance enforcement and ensure supply chain integrity, and encourage companies to maintain ongoing surveillance of its products and manufacturing process.

D. Pharmacist Role in the Health Care (Medical) Home

This policy is being recommended to **establish an ASHP position regarding the inclusion of pharmacists in proposed models of the health care home**. The proposal asserts the importance of adequate reimbursement for pharmacy services and that pharmacists should be included when demonstration projects are conducted by the Centers for Medicare and Medicaid Services (CMS). The last paragraph of the policy supports the use of “comparative effectiveness” research for pharmacy services. Comparative effectiveness has been supported by the Obama administration and involves the combined use of clinical, economic, quality, and access outcomes when evaluating health services.

Benefits:

- Medical home model will strengthen primary care model and how pharmacists are involved in direct patient care
- Demonstration projects for the medical home model could display to CMS and other interested parties that pharmacists are integral members of the healthcare team as providers of medication expertise
- Healthcare stakeholders and the Obama administration will discuss the medical home model, as soon as this summer, and this policy would allow ASHP to lobby for the inclusion of health system pharmacists at the reform discussions

Concerns:

- Delegates at RDC emphasized that this policy needs to be passed in 2010 before new healthcare projects in the Obama administration are initiated

Conclusions:

The concept of the Health Care Home has strong support from many key stakeholders in the health care industry, so it is important that ASHP support the inclusion of pharmacists in any adaptation of this model.

E. Regulation of Interstate Pharmacy Practice

New technologies have allowed for increased interstate pharmacy practice but there is limited coordination between states.

Current ASHP policies, including those that concern automation, information technology, and telepharmacy, require a policy that would advocate for coordination between state governments to develop and **adopt model language to provide a framework for pharmacy practice across states**.

Benefits:

- This could potentially have implications on students completing APPE rotations, as well as new residents
- Laws to harmonize the practice of pharmacy between states would make it easier for students to work in different states for summer internships and as student interns in their APPE rotations
- Such laws could also allow for new graduates to gain licensure in an easier fashion in the states where they will be practicing as pharmacy residents

Concerns:

- Could be difficult to align pharmacy practice across states
- While laws and regulations are intended to harmonize pharmacy practice, pharmacists in certain states might initially be subject to a more restrictive practice as some less progressive states attempt to catch up

Conclusions:

This policy would advocate for coordination between state governments to develop and **adopt model language to provide a framework for pharmacy practice across states.**

F. Reporting Medication Errors

This recommendation is a minor language change to current policy. It calls for the removal of the words “and adverse drug reactions” from the policy on reporting medication errors.

The Council felt that reporting on adverse drug reactions has been handled in separate ASHP policy, and since this policy was focused on medication errors, the language should be removed.

Benefits:

- Simplifies the language of an existing policy to focus on medication errors only
- Advocates for streamlining the manner in which medication errors are reported

Concerns:

- Removing the language “adverse drug reactions” is potentially concerning because oftentimes adverse drug reactions can lead to medication errors, and thus it is difficult to distinguish one from the other

Conclusions:

The revised policy will **still affirm ASHP’s support for error reporting procedures that are non-punitive and focus on improving processes to prevent future errors.** ASHP also supports all stakeholders in healthcare reporting medication errors to a “single, comprehensive medication error-reporting program.”

G. Stable Funding for Office of Pharmacy Affairs

The Health Resource and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) administers the 340B Drug Pricing Program. OPA also helps administer innovative pharmacy models, including the Patient Safety and Clinical Pharmacy Services Collaborative. Currently the funding for OPA has come from funding sources for HRSA but there is no dedicated line item for OPA in the HRSA budget.

Benefits:

- Endorsing this policy will essentially endorse oversight of the 340B Drug Pricing Program
- Oversight of the 340B program will ensure that indigent patients receive affordable access to medications and healthcare

Conclusions:

The Board and Council believe that it is **important to support the need for a dedicated and stable source of funding to maintain the 340B Drug Pricing Program,** clinical pharmacy services, and other patient safety initiatives in order to maintain program integrity and affordable access by indigent patients.

Council on Therapeutics

Summary prepared by Shirley Lee, University of Maryland, and Daniel Crona, University of Colorado

A. The Safe and Effective Use of Heparin in Neonatal Patients

Saline has become the standard of care to maintain peripheral lines and devices in many patient populations. But, heparin continues to be the medication to maintain peripheral lines in the neonatal population. But, fatal medication errors involving the use of heparin in neonates has made this a hot-button issue in the media and in the minds of the public because of the perception that the use of heparin outweighs the benefits.

The Council on Therapeutics reviewed evidence that weighed the use of heparin versus normal saline. The Council determined that the advantages and disadvantages of using saline over heparin.

Benefits:

- Greater compatibility than heparin with concurrently administered drug therapies
- Reduced product costs
- Avoidance of adverse events (i.e. heparin-induced thrombocytopenia)
- Potential to avoid errors caused by improper selection or dilution of heparin products

Concerns:

- Loss of extended line patency
- Loss of beneficial antithrombotic effect at the insertion site

Conclusion:

The Council and the ASHP Board of Directors concluded data is not currently sufficient to support using saline in the neonatal population. In addition, they maintain that a need exists to develop standardized concentrations of heparin to decrease practice variation, and to increase the safe use of heparin in neonatal patients.