



## **2012 Issue Summary for New Practitioners and Pharmacy Students**

This document contains the analysis and opinions of ASHP New Practitioners Forum Advisory Group on Public Affairs and Advocacy and Pharmacy Student Forum Advisory Group on Policy and Legislative Advocacy members regarding the 2012 ASHP Board of Directors Report on the Work of the Councils.

The opinions expressed do not necessarily represent the official views of the organization, but are intended to help other members better understand the issues, benefits and concerns of policies to be considered during the 2012 House of Delegates.

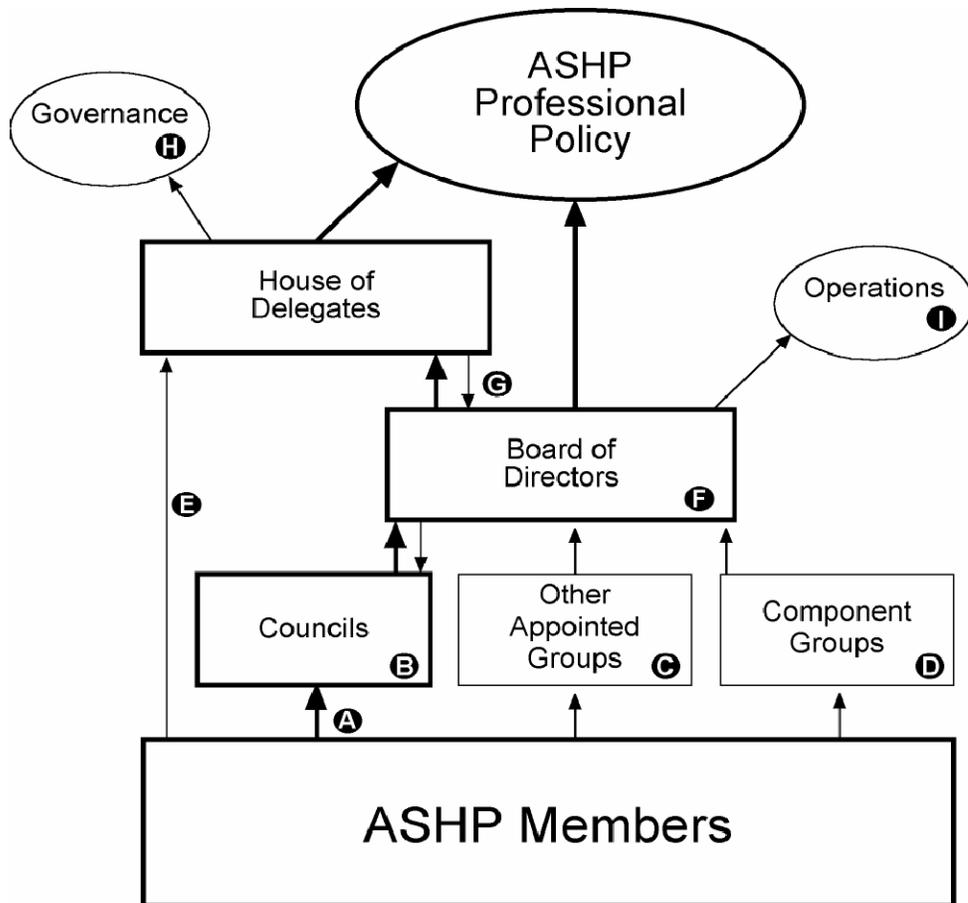
### **ASHP House of Delegates Overview**

The American Society of Health-System Pharmacists (ASHP) is a member-driven association; therefore, the professional policy process is the means by which the voice of the organization is created. In order to best represent the association as a whole, ASHP has developed a process by which the formal positions of the association are shaped. While it might appear to be very complex, it is designed to balance the need of individual members to have their voices heard and represented while still ensuring that professional policy statements are internally consistent and fashioned in such a way that they are interpreted as intended by individuals and groups outside of the association.

The ASHP House of Delegates (HOD) is the ultimate authority over ASHP professional policies. There are 163 voting state delegates and these are allotted to each state as a function of the number of active ASHP members in each state. Delegates are elected from among the active ASHP members of a state. Other voting delegates include officers and directors of ASHP, past presidents, chairs of executive committees of sections and forums, and the five fraternal delegates representing the United States Army, Navy, Air Force, Public Health Service, and Department of Veterans Affairs. Pharmacy students and new practitioners are represented in the HOD by the chairs of the respective Forum Executive Committee.

**From Idea to Policy - The Process of Policy Development**

The formation of ASHP professional policy begins with the members! Members have many opportunities to identify topics for policy development. These topics are vetted through the five Councils. The Councils are the primary bodies that develop the draft policy content and language. ASHP Sections and Forums can also submit professional policies and statements for consideration to the HOD in the form of a New Business Item. The Board of Directors must approve the proposed policy drafts and new business items before being submitted to the HOD for consideration. The draft policy statements and new business items are published in the April 15 issue of AJHP. The delegates and alternate delegates discuss the proposed policies at the Regional Delegate Conferences, and open member discussion occurs on ASHP Connect. At the Summer Meeting, all members can voice their thoughts at the Open Forum, and delegates discuss potential amendments at the Delegate Caucuses. The action crescendos at the first and second meetings of the HOD, and the delegates vote on the policies, Resolutions, and New Business Items.



## HOD Process Diagram

- A. The primary policy process is indicated by heavy arrows.
- B. There are five Councils: Education and Workforce Development, Pharmacy Management, Pharmacy Practice, Public Policy, and Therapeutics. The councils are the primary policy-recommending groups.
- C. Standing committees, commissions, advisory groups, task forces, ad hoc committees.
- D. The executive committees of the Sections and Forums.
- E. Resolutions, which are intended for emergent policy issues, are submitted directly to the House of Delegates.
- F. The Board of Directors has final authority over most practice standards, and it may adopt interim professional policies on any issue when the House of Delegates is not in session.
- G. The House of Delegates also has a role in identifying issues for policy development, which are referred to the Board of Directors. The Board, in turn, may refer an issue to a specific council.
- H. The House of Delegates has final authority over the ASHP Bylaws and the Rules of Procedure for the House of Delegates; amendments to the ASHP Charter require approval by ASHP active members.
- I. The Board of Directors has authority over operations policy, including financial management

## 2012 Policy Recommendations

### Council on Education and Workforce Development

#### A. Preceptor Skills and Abilities

*“To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,*

*To provide tools, education and other resources to develop preceptor skills.”*

The growth of the pharmacy profession and increased number of schools of pharmacy have resulted in a shortage of institutions and preceptors available. These include students for IPPE and APPE sites, as well as, residency positions. There is also a need for national standardization of preceptor training and evaluations to maximize efficacy and proficiency of training future pharmacists.

#### Benefits:

- Ensure proper training of preceptors to maximize potential of future students and pharmacists
- Reassurance to schools of pharmacy that students are being taught skills under quality preceptors

#### Concerns:

- Nationwide evaluations could become very difficult to manage

#### B. Qualifications and Competencies Required to Prescribe Medications

*“To affirm that prescribing is a collaborative process that includes patient assessment, diagnosis, evaluation of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,*

*To affirm that safe prescribing of medications, if performed independently, requires a practitioner who is competent and knowledgeable in all these processes, or, if performed collaboratively, requires that competent, interdependent professionals complement each others’ strengths at each step; further,*

*To explore the creation of prescribing standards that would apply to all who initiate or modify medication orders or prescriptions and that would facilitate development of competencies and training of prescribers; further,*

*To encourage research on the effectiveness of current educational processes designed to train prescribers.”*

There is much debate on health care providers and prescribing authority status in the United States health care system. The increasing complexity of medication use and continued adverse drug events call for the development of standards for prescribing and training requirements. There is a predicted shortage of physicians, which ultimately will lead to certain patient populations being unable to obtain proper health care.

Benefits:

- Hopes for a decrease in the number of adverse drug events, which would drive down the overall cost of medical care
- Optimal drug therapy for patients that would be therapeutic and cost efficient
- Pharmacists and other health care professionals would be able to ensure patient care to those populations with needed medical requirements due to physician shortages

Concerns:

- Resistance among established health care professionals that would think other providers were taking business away from them

C. Qualifications of Pharmacy Technicians in Advanced Roles

*“To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,*

*To reaffirm that all pharmacy technicians should complete and ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,*

*To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate competencies specific to the tasks to be performed; further,*

*To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.”*

The council believes that having pharmacy technicians performing advanced tasks benefits the pharmacy practice models and therefore ultimately benefits patients. There is discussion on the need to limit these roles with specific boundaries, such as allowing advanced technicians to make clinical judgment calls.

Benefits:

- Allowing advanced pharmacy technicians to perform advanced roles would allow pharmacists more time to perform clinical and/or specialized responsibilities

- This would allow for advancement in the pharmacy technician career, which could motivate certain individuals wanting to advance

Concerns:

- Would have to be very comfortable with allowing advanced technicians to make certain judgment calls as they would potentially be detrimental to patient outcomes if not correct

D. Role of Students in Pharmacy Practice Models

*“To encourage pharmacy practice leaders to incorporate students, including those in introductory and advanced pharmacy practice experiences and interns, into active, meaningful roles in new and evolving practice models.”*

Pharmacy practice models are being changed to utilize pharmacists, pharmacy technicians, and automation to ensure safe and effective medication use. Some pharmacy departments have altered the role of pharmacy students to improve their IPPE, APPE, and internship experiences. Pharmacy students would then be able to contribute more significantly to the pharmacy department, patient care, and learn through activities such as drug-therapy management services, discharge counseling, and medication reconciliation.

Benefits:

- Pharmacy students will be able to participate in pharmacy department responsibilities as an extension of the pharmacist.
- IPPE, APPE, and internship hours would entail a more engaged patient experience for pharmacy students and their responsibilities will gradually increase as their skills develop.
- Students will be able to more actively contribute to the roles of a pharmacist

Concerns:

- There are currently limited internship positions available so staffing models will have to be flexible with their scheduling to establish programs to accommodate pharmacy students in this capacity.
- Some state laws may be restrictive as they require “direct supervision” of students which could limit the tasks that students can conduct.

E. ASHP Statement on the Role of the Medication Safety Leader

*“To approve the ASHP Statement on the Role of the Medication Safety Leader.”*

This policy statement was drafted by the ASHP Section of Inpatient Care Practitioners Advisory Group on Medication Safety and was later endorsed by the Section’s Executive Committee. The role of the medication safety leader is different at different institutions. As such, this policy would standardize and define the role of the medication safety leader to include duties such as leadership, medication safety expertise, influencing practice change, research and education.

Benefits:

- Standardization of the role of a medication safety officer would help ensure that all institutions have the same basic level of attention given to the safety of medication-use systems to ensure patient safety.

Concerns:

- In order to institute such standards, many institutions will have to be flexible and willing to change the roles of their pharmacy leaders.

F. “P.D.” (Pharmacy Doctor) Designation for Pharmacists

*“To discontinue ASHP policy 0217, which reads:*

*To oppose the use of “P.D.” or any other designation that implies an academically conferred degree where none exists.”*

ASHP policy 0217 was initially introduced during the transition to the Doctor of Pharmacy degree; the Council no longer believes that designations such as P.D. are necessary. The use of arbitrary designations to describe pharmacists or imply an academic degree could lead to confusion and are no longer appropriate.

Benefits:

- The use of different designations to signify pharmacists could lead to confusion and the discontinuation of P.D. and other designations would help alleviate these issues.

Concerns:

- It could take some pharmacists time to transition away from designations that they have used.

G. Substance Abuse and Chemical Dependency

*“To discontinue ASHP policy 0209, which reads:*

*To collaborate with appropriate professional and academic organizations in fostering adequate education on substance abuse and chemical dependency at all levels of pharmacy education (i.e., colleges of pharmacy, residency programs, and continuing-education providers); further,*

*To support federal, state, and local initiatives that promote pharmacy education on substance abuse and chemical dependency; further,*

*To advocate the incorporation of education on substance abuse and chemical dependency into the accreditation standards for Doctor of Pharmacy degree programs and pharmacy technician training programs.”*

As part of the sunset review, the Council has decided that ASHP policy 0209 is no longer necessary. The Council has concluded that the *ASHP Statement on the Pharmacist’s Role in*

*Substance Abuse Prevention, Education, and Assistance* is more comprehensive and a better representation of ASHP's position on the matter. The Council and Board voted to discontinue this policy.

Benefit:

- The discontinuation of ASHP policy 0209 will help consolidate ASHP's position on substance abuse and chemical dependency.

### **Council on Pharmacy Management**

#### A. A Revenue Cycle Compliance and Management

*“ To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,*

*To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,*

*To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,*

*To investigate and publish best practice in medication-related revenue cycle compliance and management.”*

Medication-related revenue cycle compliance has increasingly become an important focus area for pharmacists. There is a need to develop consistent billing and reimbursement policies due to increased frequency of audits. Strategies to help optimize billing, finances and prior authorization procedures through enhancing information technology (IT) will help develop best practices in medication-related revenue cycle compliance and management.

Benefits

- Consistency in billing and reimbursement practices that would facilitate improved compliance and enable the development of effective technology solutions to facilitate billing.
- A more fluent and organized system to maximize revenue and decrease revenue erosion.

Concerns

- Improper billing and increased requirements before an insurer will pay for a claim has lead to an increase in the number and nature of audits.
- Current IT does not adequately capture all information to facilitate in billing and audits.
- Audits can have a huge financial impact on an organization.

## Conclusions

Pharmacists need to be involved in optimizing revenue capture and avoiding revenue erosion due to improper billing or inadequate documentation. Pharmacy experience and expertise is important for organizational success, clinical coverage decisions and information integration in order to be successfully reimbursed for services. New roles and positions are being established to optimize roles in revenue cycle compliance such as expanded technician responsibilities and business manager positions. ASHP and the Section of Pharmacy Practice Managers (SPPM) are striving to develop and share best practices and provide education to support pharmacists in optimizing their role in revenue cycle.

## B. Prior Authorization Process

*“To advocate that public and private payers work together and in collaboration with providers to create standardized and efficient prior authorization processes that facilitate communication between patients, providers, and payers prior to therapy; result in timely coverage decisions; and do not disrupt patient care.”*

Currently, there is no collaborative system between health care providers that ensures an efficient prior authorization process. A lack of standardized prior authorization process leads to delay in therapies, ultimately disrupting patient care.

## Benefits

- A standardized prior authorization process.
- Efficient and effective communication between providers and patients.

## Concerns

- Acceptance of standardized prior authorization procedures across health care systems and organizations.

## Conclusions

-This new policy will help decrease the delay in patient care in hospitals and health systems. The current processes for prior authorizations can be time consuming and can lead to a decrease patient compliance.

## C. Financial Management Skills

*“To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) pharmacoeconomic analysis, (5) diversified pharmacy services, (6) compensation for pharmacists’ patient-care services, and (7) revenue cycle compliance and management; further,*

*To encourage colleges of pharmacy to incorporate these management areas in course work and clerkships.”*

Along with standard pharmacy responsibilities, it is essential that pharmacists develop management skills in a variety of areas. This will not only improve revenue cycle compliance and financial outcomes, but also help advance the profession.

#### Benefits

- Pharmacists can use their leadership skills to help ensure financial success in health care.
- Increase knowledge and understanding of business operations that are vital to revenue cycle compliance.

#### Conclusion

It is important for pharmacists to recognize their roles as leaders in managing medication-related revenue cycle compliance to help ensure financial success and uphold necessary business operations of hospitals and health systems.

#### D. Transitions 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 information systems that facilitate sharing of patient-care data across care settings and providers; further,*

*To advocate the payers and health systems provide sufficient resources to support effective transitions of care; further,*

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

Effective transitions of care are a professional responsibility to help ensure appropriate medication use and increase patient education. Advocacy is key to support the encouragement of having fluid transitions across health care systems and address gaps when noticed.

#### Benefits

- Increase the role of pharmacists at transitions of care.
- Reduced admissions.
- Effectively educate patients about their medications.

## Concerns

- Lack of financial incentives, resources and support that encourage the role of pharmacists in transitions of care.

## Conclusion

Due to health care reform and changes in health care reimbursement there likely will be increased focus on pharmacists playing an important role on the transition from the acute care environment to other settings. It is important for ASHP to advocate for improvements in IT to help give greater access to patient information across a variety of health care settings.

## E. Value-Based Purchasing

*“To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,*

*To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.”*

An estimated 3,092 hospitals nationwide are expected to participate in the Medicare VBP program in fiscal year 2013 that is designed to improve health care services by making incentive payments to hospitals that reach performance measures. ASHP policy 0708 needs to be broadened to incorporate the concepts of clinical outcomes and patient satisfaction in addition to quality.

## Benefits

- Future measures that will be considered for VBP are very broad and give pharmacists a chance to make a big impact in a leadership role on an interdisciplinary team.

## Concerns

- Pharmacists are in a great position to make an impact on many of the measures and should not be overlooked.
- It may be challenging to decide which VBP measure would best be improved with a pharmacist leading the way due to the diversity of the measures.

## Conclusion

Pharmacists have an opportunity to make a significant impact in the area of VBP by taking the lead in the design and interdisciplinary implementation of medication-related initiatives.

## F. Role of Corporate Pharmacist Leadership in Multi-facility Organizations

*“To advocate that a pharmacist must be responsible for leadership and have responsibility for standardization and integration of pharmacy services in multiple business units across the entire pharmacy enterprise of multi-facility health systems and integrated delivery networks; further,*

*To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications.”*

The healthcare enterprise is evolving from single hospitals to integrated systems and networks. Therefore, leadership of the pharmacy must evolve from a department leader in a single facility to an effective corporate leader. Also, the business model for health care is evolving and pharmacy leaders will need to become familiar with changing business imperatives and align the pharmacy business plan with that of the health system.

#### Benefits

- Pharmacy managers of integrated systems can have a larger financial impact through their decisions
- Pharmacy managers will be responsible for the development and implementation of effective drug-use policy across their enterprise

#### Concerns

- Transitioning from a leadership role of a single hospital to an integrated system of hospitals may require a new skill set that could involve further training.

#### Conclusion

The business model for health care is evolving and pharmacy leaders need to become familiar with changing business imperatives.

#### G. Pharmacist’s Role in Health Care Information Systems

*“To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of medication-use information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,*

*To advocate for incentives to hospitals and health systems for the adoption of patient-care technologies; further,*

*To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,*

*To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process, including the successful deployment of medication-use information systems.”*

Health IT is evolving and it is important for pharmacists to be involved in the design and implementation of technology that supports medication-use processes. It is also important that this is an interdisciplinary effort. Pharmacists also must have accountability for the medication-use process, including deployment of these information systems.

## Benefits

- Pharmacists have a wealth of first-hand knowledge in dealing with medication-use information systems, therefore using them to help design and implement new systems will allow their insight to be taken into consideration when developing such complex systems.

## Concerns

- The approach to developing health care information systems must be kept an interdisciplinary process due to the technical skills required to create such systems.

## Conclusion

It is important to focus on the interdisciplinary nature of developing technology that supports the medication-use process.

## H. Clinical Decision Support

*“To advocate for the development of clinical decision support (CDS) systems that are proven to improve medication-use outcomes and that include the following capabilities: (1) alerts, notifications, and summary data views based on (a) a rich set of patient-specific data, (b) standardized, evidence-based medication-use best practices, and (c) identifiable patterns in medication-use data in the electronic health record; (2) audit trails of all CDS alerts, notifications, and follow-up activity; (3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and (4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes.”*

Current clinical decision support systems do not provide the functionality that is required in the future practice model that participants envisioned at the PPMI Summit. ASHP should advocate for improvements in clinical decision support systems that provide actionable data analytics and support the medication-use process.

## Benefits

- Improve medication-use outcomes
- Easy to access audit trails
- Clinical documentation functionality linked to individual CDS alerts and notifications
- Highly accessible and detailed management reporting capabilities

## Concerns

- Current CDS systems are not advanced enough to meet PPMI Summit participant goals.

## Conclusion

A more advanced system that focuses on clinical decision making is required to accomplish what participants at the PPMI Summit envisioned.

## **Council on Pharmacy Practice**

### A. Pharmacist Prescribing in Interdisciplinary Patient Care

*“To define pharmacist prescribing as follows: the selection, initiation, monitoring, and adjustment of medication therapy pursuant to diagnosis of a medical disease or condition; further,*

*To advocate that health care organizations establish credentialing and privileging processes that delineate the scope of pharmacist prescribing within the hospital or health system and to ensure that pharmacists who prescribe are competent and qualified to do so.”*

The Pharmacy Practice Model Initiative (PPMI) Summit recommended that “pharmacists should include in their scope of practice prescribing as part of the collaborative practice team.” (Recommendation B14) Unlike physician prescribing, which is commonly understood to be the diagnosis and treatment of diseases and conditions, pharmacist prescribing has yet to be clearly and concisely defined.

In the proposed definition, pharmacist prescribing differs from that by other authorized prescribers and from medication therapy management (MTM) and CDTM in three significant aspects. First, prescribing by pharmacists requires active participation in the patient’s health care team or active engagement and coordination with other individual practitioners responsible for the patient’s care. Second, pharmacist prescribing must take place in concert with assessment, diagnosis, and other clinical findings contributed by the patient’s other care providers, and changes in the patient’s medication therapy must be communicated to these individuals in a readily available and timely manner. Third, pharmacists who prescribe are accountable to patients and to the health care team for exercising professional judgment in pharmacotherapy and medication-use decision-making according to their defined scope of services, as well as for the outcomes of those services. While many pharmacists may currently order medications under protocols for MTM or CDTM, prescribing entails a higher degree of autonomy and is a role for advanced practitioners with demonstrated competency and expertise.

#### Benefits:

- Creates a standard definition of pharmacist prescribing that will facilitate future discussions on the role of pharmacists in interdisciplinary health care, help delineate health care team roles, enhance collaborative patient care, and clarify the meaning of pharmacist prescribing for other health care providers.
- Improved patient outcomes, as demonstrated by pharmacists who practice with near-independent authority to manage drug therapy, such as in anticoagulation management, solid organ transplant, and nutrition.
- Improved access to prescriptions in settings where a primary care provider is limited.

Concerns:

- The American Medical Association and the American Academy of Family Physicians have publicly and staunchly opposed any expansion of pharmacist scope of practice perceived to encroach on the practice of medicine
- Development of a credentialing process to establish pharmacist’s competency to prescribe is most likely necessary

Conclusion:

Establishing a definition for pharmacist prescribing will promote a common understanding of this term in the health care community.

B. Pharmacist’s Role in Accountable Care Organizations

*“To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,*

*To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,*

*To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,*

*To advocate that pharmacists be included as health care providers in demonstration projects for ACOs; further,*

*To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,*

*To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.”*

The Affordable Care Act of 2009 encourages the formation of accountable care organizations (ACOs). Similar in concept to health maintenance organizations, these entities consist of alliances between physicians, other health care providers, and hospitals that provide comprehensive and coordinated health care to a population of patients. ACOs emphasize primary and preventive care, are provider-led, and receive reimbursement linked to increasing health care quality and lowering per capita costs. Integrated systems present an important opportunity for pharmacists to demonstrate their value to the quality of care. Pharmacists could contribute to the success of ACOs by providing the following patient care services: Developing, implementing, and monitoring patient-specific, evidence-based drug therapy as an active participant in team-based care; improving transitions in care with coordinated MTM services for patients in the hospital as well as post-discharge in ambulatory clinics and physician practices; monitoring the therapy of patients with multiple chronic conditions or complex medication regimens; preventing and managing adverse drug events.

Benefits:

- The ACO model provides fewer barriers for pharmacist participation because reimbursement is tied to quality and reduced costs rather than specific services
- Provides an opportunity for pharmacists to demonstrate their value to the quality of care

Concerns:

- Not much is known about the elements of success for ACOs, and implementation is likely to be challenging.

Conclusion:

Although more information is required to determine the elements of success for ACOs, ASHP policy is needed now to establish the role of pharmacists in ACOs and demonstrate ways pharmacists can contribute to quality of care while lowering costs.

C. Pharmacist's Role in Team-Based Care

*"To recognize that pharmacist participation in interdisciplinary health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,*

*To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,*

*To urge pharmacists on health care teams to collaborate with other team members in establishing quality measures for care provided by those teams."*

The PPMI Summit recommendations are based on a growing consensus among health care providers and payers that patient-centered care by a collaborative team is the optimal model of care. A collaborative care model provides pharmacists with an opportunity to contribute their expertise in medication use to improving patient outcomes. This policy recommendation sets the expectation for other providers that teams with pharmacists will improve the quality, safety, and efficiency of care; and supports advocacy to the broader health care community on the value of care delivery by teams that include pharmacists.

Benefits:

- Unifies the profession's approach to team-based care
- Provides guidance on the fundamental roles and responsibilities of pharmacists in various care settings

Concerns:

- Detailed practice guidelines need to be developed to accomplish the unified approach to team-based care

## Conclusion

ASHP support for pharmacist participation in interdisciplinary care teams is longstanding. Detailed practice guidelines are required to unify the profession's approach to team-based care. Topics such as how teams operate in various care settings, how communication determines team success, the use of national guidelines and core measures, how to adapt the team or its services to meet patient needs, and using measures of team performance for continuous improvement, will need to be addressed. These data are important if pharmacists are to continue to be relevant in light of a future health care delivery system that emphasizes coordinated care that is accessible, effective, less expensive, and safer.

## D. ASHP Statement on the Pharmacist's Role in Medication Reconciliation

*"To approve the ASHP Statement on the Pharmacist's Role in Medication Reconciliation."*

The Joint Commission (TJC) requires medication reconciliation be performed by pharmacists. ASHP policy was recently updated to include affirmation of the value of this service to patient care and safety. The statement was revised following the December 2011 in response to the comments of more than 25 ASHP members as well as representatives of the Academy of Managed Care Pharmacy, the American College of Physicians, and the Canadian Society for Hospital Pharmacists.

### Benefits:

- Support from TJC to make goal of requiring medication reconciliation more achievable
- Opportunity for pharmacists to educate patients and maintain an updated medication list in order to provide optimal care

### Concerns:

- Pharmacists not currently required to compile a list of medications, which is seen as central to the goal of medication reconciliation
- Pharmacists could be perceived as solely responsible for the service

## Conclusion

Pharmacists should promote medication reconciliation to ensure positive patient outcomes.

## E. New and Emerging Medication Ordering and Distribution Systems

*"To discontinue ASHP policy 0522, which reads:*

*To support the use of new and emerging medication ordering and distribution systems (e.g., via the World Wide Web) when such systems (1) enable pharmacists to provide patient care services, (2) ensure that patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, or non-FDA-approved drug products, (3) provide appropriate relationships among an authorized prescriber, pharmacist, and patient, (4) enhance the continuity of patient care, (5) support the pharmacist's role as a patient care advocate, and (6) provide for data security and confidentiality."*

As part of sunset review, this policy was found to be redundant with Plank 3 of the ASHP Leadership Agenda, Pharmacist Leadership in Health Information Technology.

#### F. Role of Pharmacists in Sports Pharmacy and Doping Control

*“To discontinue ASHP policy 0710, which reads:*

*To encourage pharmacists to engage in community outreach efforts to provide education to athletes on the risks associated with the use of performance-enhancing drugs; further,*

*To encourage pharmacists to advise athletic authorities and athletes on medications that are prohibited in competition; further,*

*To advocate for the role of the pharmacist in all aspects of sports pharmacy and doping control.”*

As part of sunset review, the Council reviewed policy 0710 and concluded that the policy is no longer needed due to stricter regulations and testing for drug abuse in sports.

#### G. Pharmacist’s Responsibility for Patient Safety

*“To discontinue ASHP policy 0227, which reads:*

*To affirm that individual pharmacists have a professional responsibility to ensure patient safety through the use of proven interventions and best practices; further,*

*To affirm that employee performance measurement and evaluation systems should incorporate measures that support and encourage a focus on patient safety by pharmacists.”*

As part of sunset review, the Council reviewed policy 0227 and determined that the concepts in this policy are adequately addressed by ASHP policy 1114, Pharmacist Accountability for Patient Outcomes.

### **Council on Public Policy**

#### A. Licensure of Pharmacy Technicians

*“To advocate that pharmacy move toward the following model with respect to technicians as the optimal approach to protecting public health and safety: (1) development and adoption of uniform state laws and regulations regarding licensure of pharmacy technicians, (2) mandatory completion of an ASHP-accredited program of education and training as a prerequisite to pharmacy technician certification, (3) mandatory certification by the Pharmacy Technician Certification Board as a prerequisite to licensure by the state board of pharmacy, and (4) licensure of pharmacy technicians by state boards of pharmacy granting the technician permission to engage in the full scope of responsibilities authorized by the state; further,*

*To advocate licensure of pharmacy technicians by state boards of pharmacy; further,*

*To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited*

*program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,*

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

*(Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. 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.)*

(Note: This policy would supersede ASHP policy 0815.)

This policy would create a standardized procedure for licensing pharmacy technicians throughout the country. ASHP would act as an accrediting body to make sure that an appropriate level of training was given to technicians before being licensed. With this increased level of training and standardization, pharmacy technicians would be held accountable for the services they provide for patients.

#### Benefits:

- An increase in training for technicians will lead to a more competent work force.
- Holding technicians accountable for the services they provide will increase patient safety by not putting so much reliance on the pharmacist and allow the pharmacy to function better as a team.

#### Concerns:

- The cost to accredit every technician training program will be high.
- In many settings technicians can learn to perform their job by on the job training as opposed to a formal technician training program.
- This policy may deter individuals from pursuing a license as a pharmacy technician.

#### Conclusion:

This policy would increase patient safety by providing a higher level of training to our pharmacy technicians. As pharmacy technicians are asked to do more and more, it is crucial that we increase and standardize the training that they receive to match the increased level of functioning. Using technicians in a greater capacity if they are trained to do so will ultimately free time up for pharmacists to complete more clinical tasks which is what pharmacists are trained to do. Requiring licensure of technicians will also allow state boards to discipline technicians for their actions which will decrease the reliance on pharmacists to catch every error.

## B. Opposition to Creation of New Categories of Licensed Personnel

*"To discontinue ASHP policy 0521, which reads:*

*To reaffirm the following statement in the White Paper on Pharmacy Technicians (April 1996) endorsed by ASHP and the American Pharmacists Association:*

*"Although there is a compelling need for pharmacists to expand the purview of their professional practice, there is also a need for pharmacists to maintain control over all aspects of drug product handling in the patient care arena, including dispensing and compounding. No other discipline is as well qualified to ensure public safety in this important aspect of health care." Further,*

*To oppose the creation of new categories of licensed pharmacy personnel; further,*

*To advocate that all professional pharmacy functions be performed under the supervision of a licensed pharmacist to avoid confusion regarding the roles of pharmacy personnel within health systems."*

In order to support policy "A" above, this policy must be discontinued.

## C. Pharmacy Technicians

*"To discontinue ASHP policy 8610, which reads:*

*To work toward the removal of legislative and regulatory barriers preventing pharmacists from delegating certain technical activities to other trained personnel."*

The council concluded that this policy is no longer needed.

## D. Collaborative Drug Therapy Management

*"To pursue the development of federal and state legislative and regulatory provisions that authorize collaborative drug therapy management by pharmacists; further,*

*To advocate expansion of federal and state legislative and regulatory provisions that optimize pharmacists' ability to provide the full range of professional services within their scope of expertise; further,*

*To acknowledge that as a part of these advanced collaborative practices, pharmacists, as active members in team-based care, must be responsible and accountable for medication-related outcomes; further,*

*To support affiliated state societies in the pursuit of state-level collaborative drug therapy management authority for pharmacists."*

(Note: This policy would supersede ASHP policy 9812.)

This policy urges the expansion in clinical opportunities for pharmacists through collaborative drug therapy agreements. Not all states (43 states currently) utilize collaborative drug therapy agreements and to a varying degree. There is a large benefit by allowing pharmacists to practice with a wider scope in their areas of expertise. This policy also discusses the increased level of responsibility and accountability pharmacists will have on the overall health of their patients if collaborative drug therapy agreements are implemented.

Benefits:

- Increase patient’s access to care by allowing pharmacists to practice with more autonomy through collaborative drug therapy agreements.
- Improve health outcomes by allowing pharmacists to take on a larger role in medication therapy management.
- Reduce the overall cost of healthcare by using pharmacists in place of physicians when appropriate.

Concerns:

- No specific requirements for which pharmacists are able to practice under collaborative drug therapy agreements; RPh, PharmD, residents, etc.
- Reimbursement for pharmacist’s time. Getting pharmacists recognized as providers that can bill for clinical services.

Conclusion:

This policy aims to expand collaborative drug therapy management at the federal and state level. This policy ultimately would allow pharmacists greater opportunity to practice to the level of our education and would improve health outcomes for patients while freeing up physicians time to focus on other parts of patient care than medication management. As healthcare continues to change there will need to be clearer ways for pharmacists to be compensated for these clinical services.

E. Approval of Biosimilar Medications

*“To encourage the development of safe and effective biosimilar medications in order to make such medications more affordable and accessible; further,*

*To encourage research on the safety, effectiveness, and interchangeability of biosimilar medications; further,*

*To support legislation and regulation to allow Food and Drug Administration (FDA) approval of biosimilar medications; further,*

*To support legislation and regulation to allow FDA approval of biosimilar medications that are also determined by the FDA to be interchangeable and therefore may be substituted for the reference product without intervention of the prescriber; further,*

*To require post marketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,*

*To advocate for adequate reimbursement for biosimilar medications that are deemed interchangeable; further,*

*To promote and develop ASHP-directed education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,  
To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.”*

(Note: This policy would supersede ASHP policy 0906.)

This policy aims to improve the development and safety of biosimilar medications in order to ultimately reduce healthcare costs. This policy would provide a way for hospitals and health systems to automatically interchange biosimilar medications with their reference products much like we already do with common brand and generic substitutions of small molecule drugs. There would also be an increase in post market surveillance to ensure that the biosimilar products achieve a certain level of quality to be considered biosimilar.

#### Benefits:

- Reduced cost of often times extremely expensive biologic drugs.
- Increase the safety of biosimilar medications by encouraging research and requiring post marketing surveillance of these medications.

#### Concerns:

- Adding additional research may increase the amount of time it takes a drug to reach the market
- Increasing post marketing surveillance will add more costs to the manufacturer which will in turn raise the price of the medication.

#### Conclusions:

This policy intends to make it safer and less expensive to obtain a biosimilar product of a biologic medication by advocating for a standardized process implemented by the FDA. Biologic medications account for an increasing portion of health care expenditures and finding a way to allow generic or biosimilar manufacturing of these products will decrease the cost of these extremely costly medications and increase patient’s access to them as well. The only problem could be creating so many barriers that it deters manufacturers from producing a biosimilar medication due to a lack of profitability with all of the regulations.

#### F. Stable Funding for HRSA Office of Pharmacy Affairs

*“To advocate for a sustainable level of funding, including appropriations, sufficient to support the public health mission of the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs; further,*

*To support initiatives of the Office of Pharmacy Affairs, including the 340B Drug Pricing Program and innovative pharmacy service models in HRSA-funded programs; further,*

*To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.”*

(Note: This policy would supersede ASHP policy 0911.)

This policy addresses the need for more stable funding of the Office of Pharmacy Affairs so it can offer the 340B Drug Discount Program. The proposed way of funding this program is through user fees of 0.1% of the 340B drug purchases paid by participating covered entities. This mechanism of funding would provide a more reliable stream of funding and allow the program to meet its public health goals by providing medications to those that have the lowest access.

Benefits:

- Improving funding will allow the program to expand and function at a higher capacity, which will allow underserved populations a way to acquire medications much cheaper through the 340B Drug Discount Program.

Concerns:

- In these economic times, adding fees to any product or service may result in underutilization of the program to avoid the fees.

Conclusions:

With more stable funding the Office of Pharmacy Affairs would be able to accomplish its public health mission by continuing the 340B Drug Discount Program. The proposed funding would only add a small cost to all participating entities but would allow much more flexibility for the program. However, there could be some push back over these added fees and possibly lead to underutilization of the program.

G. Standardized Immunization Authority to improve Public Health

*“To advocate that, to improve public health and patient access to immunizations, states grant pharmacists the authority to initiate and administer all adult and child immunizations through a universal protocol developed by state health authorities; further,*

*To advocate that only pharmacists who have completed a training and certification program acceptable to state boards of pharmacy and meeting standards established by the Centers for Disease Control and Prevention may provide such immunizations; further,*

*To advocate that state health authorities establish a centralized database for documenting administration of immunizations that is accessible to all health care providers.”*

This policy calls for a standardized administration protocol of pharmacist-administered vaccines in all states. While all states allow pharmacist administered vaccines there are varying degrees of this practice in each state with regards to the type of vaccines and the specific patient populations. Increasing the ability of pharmacists with regards to immunizations would dramatically improve public health measures of immunizations for all ages.

#### Benefits:

- Increase access to immunizations not only to patients in rural areas but to all patients including those in hospitals.
- Standardization of training will ensure safety of patients and allow patients to be confident in pharmacist’s skills to administer vaccines.

#### Concerns:

- A centralized database would create a massive cost burden on states in times of financial struggles on the state and federal level.
- Immunizations can be administered by medical assistants and nurses so pharmacists should focus their time on more clinical tasks of medication management.

#### Conclusions:

Standardizing immunization authority and training for pharmacists among states would allow for considerable improvements in vaccination rates which in turn will save lives. Creating a database to log patient’s vaccine history into would be a wonderful tool to improve patient safety and reduce wasting vaccines but the start-up cost and training might be too expensive to get rolling at this point and time.

#### H. Automated Systems

*“To discontinue ASHP policy 9205, which reads:*

*To support the use of current and emerging technology in the advancement of pharmaceutical care; further,*

*To encourage a review and evaluation of the state and federal legal and regulatory status of new technologies as they apply to pharmacy practice.”*

#### I. Medical Devices

*“To discontinue ASHP policy 9106, which reads:*

*To support public and private initiatives to clarify and define the relationship among drugs, devices, and new technologies in order to promote safety and effectiveness as well as better delivery of patient care.”*

### **Council on Therapeutics**

#### A. Criteria for Medication Use in Geriatric Patients

*To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug*

*therapy to geriatric patients; further,*

*To oppose use of the Beers criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as an indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the development of that tool and evidence suggesting a lack of association between use of medications listed in the Beers criteria and subsequent adverse drug events; further,*

*To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,*

*To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,*

*To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,*

*To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.*

The Council and the Board believe that current tools, in particular the Beers Criteria, lack sufficient evidence that they prevent harm in geriatric patients. Therefore they do not encourage the use of such criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities to evaluate the prescribing practices in this patient population. In particular, current research has failed to show that the Beers Criteria reduces the number of adverse medication events. New and existing criteria should be further studied, but these tools should be viewed as augmentation to the clinical judgment of a pharmacist or other clinician, not a replacement. Additionally the Council and Board identify pharmacists as the ideal clinician to provide thorough medication therapy management for geriatric patients.

#### Benefits:

- Pharmacists are superior to explicit criteria, such as the Beers criteria, as they can take into account pharmacokinetic and pharmacodynamic factors, as well other drug-, disease-, and patient-specific issues.
- The Screening Tool of Older Persons' Potentially Inappropriate Prescriptions or STOPP is a new tool that has been shown in a small number of studies to have a positive impact on patient outcomes. The policy allows for the inclusion of this screening tool and other validated tools in clinical practice.

#### Concerns:

- Geriatric patients are vulnerable to adverse medication events, and currently there are few tools to prevent such events.

- Currently accreditation and quality improvement entities are lack ways to encourage improvement of prescribing practices in the elderly.
- The Beers Criteria is simple to use, however it is very “black and white” and studies of its use have not demonstrated that it decreases adverse events.
- Pharmacists may lack adequate knowledge to provide geriatric patients with complex drug regimens effective medication therapy management.

## Conclusion

Pharmacist provided medication therapy management should be the primary mechanism for preventing adverse medication events in geriatric patients. Additional studies are necessary to determine which criteria are useful to aid in the prevention of adverse medication events in geriatric patients.

## B. Medication Adherence

*“To recognize that improving medication adherence should be a key component of strategies to improve the quality and safety of patient care only when adherence improvement efforts include the following as required elements: (1) assessing the appropriateness of therapy, (2) providing patient education, and (3) ensuring patient comprehension of information necessary to support safe and appropriate use of prescribed therapies; further,*

*To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in multidisciplinary efforts to develop, implement, monitor, and maintain effective strategies for improving medication adherence; further,*

*To recognize that clinicians, patients, and caregivers share accountability for the outcomes of medication therapies, and that the central role patients and their caregivers have in disease management includes responsibility for following instructions for safe and effective medication use; further,*

*To encourage development, evaluation, and dissemination of models that improve adherence, including those that combine existing strategies that have demonstrated effectiveness; further,*

*To support the development of mechanisms to document medication adherence interventions, including information technology solutions; further,*

*To advocate for payment models that facilitate an expanded role for pharmacists in medication adherence efforts. “*

The Council and the Board recognize the importance of medication adherence to prevent avoidable hospitalizations which cost the healthcare system an estimated \$100 billion annually. The Council and Board support efforts to improve adherence upon the condition they (1) assess the appropriateness of therapy, (2) provide patient education, and (3) ensure patient comprehension of information necessary to support safe and appropriate use of prescribed

therapies. Pharmacists, due to their drug therapy expertise, are identified as the ideal clinician to lead medication adherence efforts, but emphasis was placed on working with other healthcare disciplines to make full use of their varied skill sets.

#### Benefits

- Improve patient outcomes and decrease cost and burden to the healthcare system.
- Approaches that incorporate a number of strategies frequently achieve better results.
- Educate pharmacists about the pros and cons of existing measures of medication adherence

#### Concerns

- Traditional efforts to improve medication adherence focus too heavily on whether the patient is taking a medication, ignoring issues such as whether the therapy is appropriate, or if the patient understands the reason for therapy.
- Patient adherence is a multifaceted issue, and patients and caregivers must be recognized as integral components of an effective adherence improvement strategy.
- Currently there are numerous approaches to measuring adherence; however investigators do not consistently use any of these measures.

#### Conclusion

Pharmacists should lead multidisciplinary medication adherence efforts, use existing tools to measure outcomes, and support the development of new technologies to help document and improve medication adherence.

#### C. Globalization of Clinical Trials

*“To encourage the Food and Drug Administration (FDA) to use its existing authority to increase monitoring and inspection of foreign clinical trials to ensure the integrity and quality of those studies; further,*

*To advocate that the FDA expand its oversight of clinical trials conducted abroad by continuing to pursue innovative strategies, such as increased collaboration with foreign regulatory agencies and changes in domestic regulatory processes that support timely submission of foreign clinical trial information; further,*

*To encourage the FDA to establish a standardized electronic format and reporting standards that would be required for submission of data from foreign clinical trials; further,*

*To support the ethical treatment of patients in foreign clinical trials in accordance with international standards designed to protect human subjects; further,*

*To encourage public and private research to study the impact of the globalization of clinical trials on patient care.”*

More than 80% of marketing applications for drugs approved in fiscal year 2008 were supported by data from foreign clinical trials, and more than 50% were based on data from trials that were conducted entirely outside of the United States. Manufacturers are required to submit clinical trial protocols to the FDA pursuant to their investigational new drug (IND) application only if the studies are to be conducted within the US. This requirement, however, does not apply to trials conducted outside the US prior to IND submission. While the Council believes that drug manufacturers are ultimately responsible for ensuring the integrity of their clinical trials, FDA's efforts to improve the efficiency of current reporting processes may encourage manufacturers to be more forthcoming with trial design data.

Benefits:

- Existing FDA authority allows for oversight of foreign clinical trials, including a requirement for mandatory reporting.
- Clinical trials conducted in foreign countries have greater access to treatment-naïve patients and reduced costs.

Concerns:

- Limited experience with clinical trials in some countries could affect data integrity (Does the foreign sample population accurately reflect the US population?).
- There are no requirements or incentives for manufacturers to submit study protocols for foreign trials to the FDA if they are conducted prior to the IND submission.
- Ethical concerns related to informed consent, financial compensation, and access to conventional treatment are often not addressed in foreign trials.

Conclusion:

Extended FDA oversight of foreign clinical trials will improve the integrity of data obtained from these studies. Additional research is necessary to assess the impact of this globalization effort on patient care in the US.

D. Tobacco and Tobacco Products

*“To discourage the use and distribution of tobacco and tobacco products in and by pharmacies; further,*

*To advocate for tobacco-free environments in hospitals and health systems; further,*

*To seek, within the bounds of public law and policy, to eliminate the use and distribution of tobacco and tobacco products in meeting rooms and corridors at ASHP-sponsored events; further,*

*To promote the role of pharmacists in tobacco-cessation counseling and medication therapy management; further,*

*To join with other interested organizations in statements and expressions of opposition to the use of tobacco and tobacco products.”*

(Note: This policy would supersede ASHP policy 0713.)

The previous policy statement (ASHP policy 0713) emphasized the role of pharmacist in limiting tobacco product distribution, promoting tobacco free environments and legal efforts, and patient counseling and education. Given the evolution of more complex drug therapy, the new position statement was modified to better reflect the role of the pharmacist in the increasingly complex medication therapy management of tobacco cessation.

Benefits:

- Better define expanded roles of pharmacists in recommending and managing drug therapy to support tobacco cessation in ASHP policy 0713.

Concerns:

- Newer therapies associated with more and evolving safety risks when compared to nicotine replacement therapies, which the Council believed required greater engagement by pharmacists beyond cessation counseling.
- Electronic cigarettes are associated with safety risks due to the presence of harmful chemicals such as propylene glycol.

Conclusion:

Pharmacists should play a central role in ensuring safe and appropriate use of tobacco cessation therapies.

E. Removal of Propoxyphene from the Market

To **discontinue** ASHP policy 0723, which reads:

*“To advocate that the Food and Drug Administration remove propoxyphene from the market because of its poor efficacy and poor safety profile and because more effective and safer alternatives are available to treat mild to moderate pain.”*

Due to the withdrawal of propoxyphene and propoxyphene-containing products from the market, it was discussed and recommended that ASHP policy 0723 be discontinued. The active efforts of ASHP (advocacy and evidence/data gathered) and the active drug therapy management roles taken on by pharmacists were recognized as contributing to the minimization of patient care issues associated with the discontinuation of propoxyphene-containing products.

Benefits:

- Council played a pivotal role in the withdrawal of propoxyphene products by proposing policy 0723 and developing a guidance document outlining the poor evidence and safety of the drug.
- The Council provided recommendations for therapeutic alternative for the treatment of mild to moderate pain.

- The success of the transition from propoxyphene can be associated in part with the active roles pharmacists played in drug therapy management.

Concerns:

- The policy was never published due to the earlier withdrawal of the drug.
- The policy is no longer needed due to the withdrawal of propoxyphene and propoxyphene-containing products.

Conclusion:

ASHP policy 0723 should be discontinued due to the withdrawal of propoxyphene and propoxyphene-containing products from the market.

### **Section of Clinical Specialists and Scientists**

#### A. Board Certification for Pharmacists

*“To support the principle that pharmacists who practice where a pharmacy specialty has been formally recognized by the profession should become board certified in the appropriate specialty area; further,*

*To recognize the Board of Pharmacy Specialties (BPS) as an appropriate organization through which specialties are formally recognized and specialty pharmacy certification should occur; further,*

*To advocate prioritization for recognition of new specialties in those areas where sufficient numbers of postgraduate year two residency training programs are established and where adequate numbers of pharmacists are completing accredited training programs to prepare them to practice in the specialty area; further,*

*To advocate for standardization of credentialing eligibility and recertification requirements to include consistent requirements for advanced postgraduate residency training; further,*

*To promote a future vision encouraging accredited training as an eventual prerequisite for board certification; further,*

*To encourage BPS to be sensitive to the needs of current practitioners as prerequisites evolve; further,*

*To actively encourage and support the development of effective training and recertification programs that prepare specialists for certification examination and ensure the maintenance of core competencies in their area of specialization.”*

The need for specialized pharmacy expertise is growing as drug therapy regimens become increasingly complex. ASHP has been an advocate for pharmacist certification whenever possible. The ASHP Long Range Vision for Pharmacy Work Force in Hospitals and Health

Systems states that pharmacists who provide services in an area where specialty certification exists should be certified in that specialty, and the ASHP Supplemental Standards for Postgraduate Training require such certification of residency program directors.

The National Commission for Certifying Agencies (NCCA) is an accreditation body that ensures high quality standards in the professional certification industry. Although other pharmacy organizations have developed specialization credentials, BPS is currently the only pharmacist-certifying organization accredited by the NCCA. Eligibility requirements also vary among different specialties and ASHP advocates the development of standardized credentialing requirements. Eventually, postgraduate year two residency training should become the prerequisite in obtaining Board certification.

Benefits:

- Increased training for pharmacists
- Better care for patients
- Decreased health care costs

Concerns:

- Not enough residency positions available
- Lack of quality residency programs

Conclusion:

The pharmacy profession should continue to grow and develop new specialties. Pharmacists who practice in these specialties should become board certified. The pharmacy profession must work together to develop standardized credentialing eligibility and requirements. ASHP policy supports Board certification training and views specialty training as a vital requirement to the future of pharmacy specialists.

### **Pharmacy Student Forum and Section on Pharmacy Informatics**

#### A. Use of Social Media by Pharmacy Professionals

*“To advocate the use of social media in a professional, responsible, and respectful manner in the hospital or health system setting*

*To consider the purpose and potential of social media*

*To develop pharmacy professionals’ skills and strategies to use social media effectively*

*To advocate the exercise of professional judgment when participating in social media*

*To advocate the adherence to professional and legal requirements in private and public social media.”*

Social media, defined as online tools to interact with individuals, is quickly becoming an emerging means of communication on a professional, public, and personal level. Some examples of social media include ASHP Connect, LinkedIn, Facebook, Twitter, PharmQD, The

Pharmacist Society, and SERMO. The American Society of Health-System Pharmacists (ASHP) encourages pharmacy professionals to utilize social media in the health care setting. If used properly, it can enhance relationships with patients, caregivers, other health care professionals, and the public. It is crucial to stress that all health care professionals should remain highly respectful and professional when communicating by means of social media. “Pharmacist’s responsibilities should include: advancing the well-being and dignity of their patients, acting with integrity and conscience, and collaborating respectfully with health care colleagues.”

### Benefits

- Reducing barriers when conveying information
- Increasing the amount of communication and number of people who can participate
- Providing opportunities to educate patients and practitioners, seek advice from and provide advice to colleagues
- Optimizing medication use in patients and the public

### Concerns

- Communicating by means of social media may not always meet the health care needs of patients compared to alternate forms of communication (ie: phone or office visit)
- Disclosing sensitive patient health information
- Providing medical advice or recommendations without full knowledge of current patient history

### Conclusion:

Medical professionals such as pharmacy professionals are held to a higher standard of personal, professional, ethical and moral conduct than the public and are responsible for using social media appropriately. Hospitals or health systems that choose to allow their health care professionals to communicate by means of social media should have policies in place that: 1) balance the benefits and liabilities social media can create and 2) encourage the development and application of best practices

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Please direct any questions or feedback regarding this resource to [newpractitioners@ashp.org](mailto:newpractitioners@ashp.org) or [students@ashp.org](mailto:students@ashp.org). We appreciate your comments, feedback and suggestions as we strive to capture issues and challenges affecting new practitioners and pharmacy students.

## Glossary of Terms and Procedures

**Caucuses:** Caucuses are particularly valuable for airing ideas about potential amendments to policies and for refining amending language. Only delegates will be granted the privilege of the floor to speak at caucuses. Information on the process for scheduling caucuses is distributed to delegates in advance of RDCs. Delegate caucuses are typically scheduled before the first meeting and between the first and second meetings of the HOD.

**Council Meetings:** The five councils—Education and Workforce Development, Pharmacy Management, Pharmacy Practice, Public Policy, and Therapeutics meet annually in September. After two days of thoughtful deliberations, each council submits a report with policy recommendations that are acted upon by the Board of Directors in January. Policy recommendations approved by the Board for ratification by the House of Delegates are placed on the ASHP website in mid-March and published in the April 15 issue of AJHP.

**Discussion of Issues by the House of Delegates:** All business before the House is open for discussion upon introduction at the specified point in the agenda. (An exception is Recommendations, which are merely introduced and not discussed.) Each Board report on councils is presented by the Board liaison to the council. The policy recommendations in each report are introduced as a block. Delegates may discuss any policy recommendation after the report is introduced. Delegates may request a separate vote on any individual recommendation; such requests are automatically accepted by the Chair unless any delegate objects, in which case a majority of delegates must vote in favor of separate consideration.

**Due Consideration of Amendments to Professional Policy Proposals:** If the House amends a professional policy proposal presented to it by the Board, the Board must reconsider the matter before it becomes official policy. This step is required in the ASHP Bylaws and ensures that policies adopted by the House meet legal requirements, are consistent with existing policies and organizational commitments, and are financially feasible. Typically, the Board schedules a brief meeting between the first and second meeting of a House session for purposes of “duly considering” any amended proposals. Occasionally, an issue may require more time for due consideration than is available between meetings of the House, in which case the matter will be referred by the Board to a council or other body for further study. The Board reports the results of its due consideration of amended proposals during the second meeting of the House. After hearing the Board’s report on due consideration of amendments, the House has the option of reconsidering a matter, which requires the approval of two-thirds of delegates. This option is raised if the Board does not accept an amendment and the House wishes to reconsider the original language approved by the Board. The ASHP Bylaws permit the House of Delegates to take final action on any matter placed before it if the Board of Directors rules that bona fide extraordinary circumstances require immediate action, and if a majority of delegates concur.

**House Meetings:** The HOD is composed of two meetings, held on Sunday and Tuesday during the ASHP Summer Meeting.

**House Session:** A House Session refers to the yearly HOD. There are two house meetings within each session.

**New Business:** New Business items may be introduced by any delegate at the second meeting of the House. New Business can also be proposed by a Section or Forum. New Business items may be proposed by delegates and require a second before consideration by the House. New Business must be submitted in writing by 4:00 p.m. the day before the second meeting of the House, and must include appropriate background information. The Board is not able to “duly consider” New Business items before the House considers them. Hence, the House has only two options, namely, referring a New Business item to the Board for review or rejecting the item. The Board reports all action taken on New Business at the next session of the House.

**Open Forum for Members:** This session serves as both the “Open Hearing of the House of Delegates” and a time for discussion by ASHP members of any matter of concern related to pharmacy practice in hospitals and health systems. The session is held at the Summer Meeting before the first meeting of the House, and discussion is facilitated by the Chair of the House. The Open Forum is an excellent opportunity for practitioners to bring emerging issues to the attention of ASHP leaders.

**Recommendations:** Recommendations, another avenue for members to identify a topic for further review by ASHP, may be presented at the House session by any delegate. Recommendations are the simplest and most direct way for a delegate to identify topics for further review and policy development. At the designated point in the House agenda, any delegate may present a Recommendation by simply approaching a microphone and voicing it. A written copy of the Recommendation should be presented to the Secretary of the House. Recommendations do not require a second, are not debatable, and are received without a vote. Recommendations are automatically referred to the appropriate ASHP body for consideration. The outcome of a Recommendation is reported both to the originator and to the House at the next session.

**Regional Delegate Conferences:** The Regional Delegate Conferences (RDCs) are designed for delegates and alternate delegates to review upcoming House business with ASHP officers and staff. The RDCs are usually held every year in early May. The RDCs are also a forum for informal discussion of issues related to hospital and health-system pharmacy practice, state society operations, and ASHP activities. State society officers are welcome to attend RDCs. The time between the RDCs and the House session provides delegates an opportunity to discuss items on the House agenda with colleagues. Such dialogue gives delegates insight into various points of view on issues and helps ensure well-rounded debate in the House. Many of these discussions occur on ASHP Connect.

**Resolutions:** Annually in November, a “call for Resolutions” is sent to affiliate state societies and publicized to all ASHP members. Resolutions require two ASHP active members, not necessarily delegates, as sponsors and must be submitted 90 days in advance of the House session. Resolutions are submitted to the House with a recommended course of action from

the Board, although the House's action is on the Resolution itself, not on the Board's recommendation. The House may adopt, amend, reject, or refer the Resolution. If a Resolution is passed with amendments, the Resolution must be duly considered by the Board, as required by the Bylaws.

**Section and Forum Executive Committees:** New professional policies may be recommended to the Board of Directors by the Executive Committees of Sections and Forums. The items come forward to the HOD as New Business Items. This track in policy development is relatively new and is expected to be used more frequently in the coming years.

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Please direct any questions or feedback regarding this resource to [newpractitioners@ashp.org](mailto:newpractitioners@ashp.org) or [students@ashp.org](mailto:students@ashp.org). We appreciate your comments, feedback and suggestions as we strive to capture issues and challenges affecting new practitioners and pharmacy students.

## **House of Delegates Timeline**

### ***How it all fits together: from idea to official ASHP policy***

#### **September:** Council Meetings

- The five councils meet in September to make policy recommendations to the Board of Directors.

#### **November:** “Call for Resolutions” is sent to state affiliates

- Resolutions require two ASHP active members—not necessarily delegates—as sponsors and must be submitted 90 days in advance of the HOD session. Resolutions, which are intended for emergent policy issues, are submitted directly to the HOD.

#### **December/January:** State delegate elections

#### **January:** Delegate and Alternate Delegate credentials due to ASHP

#### **March:** Policy recommendations approved by the Board for ratification by the HOD are placed on the ASHP website

#### **April:** ASHP professional policy recommendations approved by the Board of Directors are published in the April 15 issue of AJHP

#### **May:** Regional Delegate Conferences

#### **June:** Summer Meeting

- Open Forum for members
- Delegate Caucuses
- House of Delegates

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