



# House of Delegates Session—2016

June 12 and 14, 2016  
Baltimore, Maryland

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Proceedings of the 68th annual session  
of the ASHP House of Delegates,  
June 12 and 14, 2016

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**Paul W. Abramowitz, Secretary**

The 68th annual session of the ASHP House of Delegates was held at the Baltimore Convention Center, in Baltimore, Maryland, in conjunction with the 2016 Summer Meetings.

## First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 12, by Chair of the House of Delegates Amber J. Lucas. Chair Lucas introduced the persons seated at the head table: Christene M. Jolowsky, Immediate Past President of ASHP and Vice Chair of the House of Delegates; John A. Armitstead, President of ASHP and Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Susan Eads Role, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 201 delegates representing 49 states and the District of Columbia and Puerto Rico (no delegates from Hawaii were present), as well as the federal services, chairs of ASHP sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents (see Appendix I for a complete roster of delegates).

Chair Lucas reminded delegates that the report of the 67th annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 67th House of Delegates session were received without objection.

**Report of the Committee on Resolutions.** President Armitstead presented the Report of the Committee on Resolutions (Appendix II). Debate and action on the Report took place at the second meeting of the House.

**Report of the Committee on Nominations.** Chair Lucas called on Leigh Briscoe-Dwyer for the report of the Committee on Nominations (Appendix III).<sup>a</sup> Nominees were presented as follows:

## *President 2017–2018*

**Paul W. Bush, Pharm.D., M.B.A., BCPS, FASHP,** Chief Pharmacy Officer, Duke University Hospital, Durham, NC

**Kelly M. Smith, Pharm.D., FASHP, FCCP,** Professor and Interim Dean, University of Kentucky College of Pharmacy, Lexington, KY

## *Board of Directors, 2017–2020*

**Stephen F. Eckel, Pharm.D., M.H.A., BCPS, FASHP,** Associate Dean for Global Engagement, Clinical Associate Professor, and Vice Chair of Graduate and Postgraduate Education, UNC Eshelman School of Pharmacy, Chapel Hill, NC

**Seena L. Haines, Pharm.D., BCACP, BC-ADM, CDE, FASHP, FAPhA,** Professor and Chair, Department of Pharmacy Practice, University of Mississippi School of Pharmacy, Jackson, MS

**Nishaminy Kasbekar, B.S., Pharm.D., FASHP,** Corporate Director of Pharmacy, University of Pennsylvania Health System, Director of Pharmacy Services, Penn Presbyterian Medical Center, Philadelphia, PA

**Linda S. Tyler, Pharm.D., FASHP,** Chief Pharmacy Officer, University of Utah Health Care, Salt Lake City, UT

A “Meet the Candidates” session to be held on Monday, June 13, was announced. Chair Lucas announced the candidates for the executive committees of the five sections of ASHP.

**Policy committee reports.** Chair Lucas outlined the process used to generate policy committee reports (Appendix IV). She announced that the recommended policies from each council would be introduced as a block. She further advised the House that any delegate could raise questions and discussion without having to “divide the question” and that a motion to divide the question is necessary only when a delegate desires to amend a specific proposal or to take an action on one proposal separate from the rest of the report; requests to divide the question are granted automatically unless another delegate objects. Chair Lucas reminded delegates that policies not separated by dividing the question would be voted on en bloc before the House considered the separated items.

Chair Lucas also announced that delegates could suggest minor wording changes (without introducing a formal amendment) that did not affect the substance of a policy proposal, and that the Board of Directors would consider these suggestions and report its decisions on them at the second meeting of the House.

*(Note: The following reports on House action on policy committee recommendations give the language adopted at the first meeting of the House. The titles of policies amended by the House are preceded by an asterisk [\*]. Amendments are noted as follows: italic type indicates material added; strikethrough marks indicate material deleted. If no amendments are noted, the policy as proposed was adopted by the House. For purposes of this report, no distinction has been made between formal amendments and wording suggestions made by delegates.)*

*The ASHP Bylaws [Section 7.3.1.1] require the Board of Directors to reconsider an amended policy before it becomes final. The Board reported the results of its “due consideration” of amended policies during the second meeting of the House; see that section of these Proceedings for the final disposition of amended policies.)*

Timothy R. Brown, Board Liaison to the **Council on Therapeutics**, presented the Council’s Policy Recommendations 1 through 6.

**\*1. Stewardship of Drugs with Potential for Abuse**

To encourage stewardship of drugs with potential for abuse; further,

*To advocate for the inclusion of a clinically appropriate indication of use, the intended duration, and the goals of therapy when prescribing drugs with potential for abuse; further,*

*To encourage pharmacists to engage in interprofessional efforts to promote the appropriate, but judicious, use of drugs with the potential for abuse, including education, monitoring, assessment of clinical progress, and discontinuation of therapy or dose reduction, where appropriate; further,*

*To advocate that pharmacists lead efforts to prevent inappropriate use of drugs with potential for abuse, including engaging in strategies to detect and address patterns of use in patient populations at increased risk for adverse outcomes; further,*

To facilitate the development of best practices for prescription drug monitoring programs and drug take-back disposal programs for drugs with potential for abuse.

**\*2. Appropriate Use of Antipsychotic Drug Therapies**

To advocate for the documentation of appropriate indication and goals of therapy to promote the judicious use of antipsychotic drugs and reduce the potential for harm; further,

To support the participation of pharmacists in the management of antipsychotic drug use, which is an *interdisciplinary interprofessional*, collaborative process for selecting appropriate drug therapies, educating *patients or their caregivers* and monitoring patients, continually assessing outcomes of therapy, and identifying *opportunities for appropriate discontinuation or dose adjustment*; further,

To advocate that pharmacists lead efforts to prevent inappropriate use of antipsychotic drugs, including engaging in strategies to detect and address patterns of use in patient populations at increased risk for adverse outcomes.

**\*3. Safety of Epidural Steroid Injections**

To encourage healthcare providers to 1) inform patients about the significant risks *and potential lack of efficacy of associated with* epidural steroid injections, and 2) request their informed consent, *and 3) inform patients of alternative therapies and their risks and benefits*; further,

To encourage healthcare organizations to prevent adverse events related to epidural steroid injections by having pharmacists involved in the development of protocols that promote the safe use of such injections.

*To recommend pharmacist involvement in the medication-use process associated with epidural steroid injections in cases where medically necessary.*

**\*4. Drug Dosing in Renal Replacement Therapy**

To encourage research on the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy; further,

To support development and use of standardized models of assessment of the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy; further,

To collaborate with stakeholders in enhancing aggregation and publication of data on the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy.

**\*5. Use of Methadone to Treat Pain**

To acknowledge that methadone has a role in pain management and that its pharmacologic properties present unique risks to patients; further,

To oppose the *payer-driven* use of methadone as a preferred treatment option for ~~acute and chronic~~ pain; further,

~~To advocate that all healthcare practitioners who prescribe or dispense methadone complete a standardized educational program specific to the drug; further,~~

To advocate that pain management experts, payers, and manufacturers collaborate to provide educational programs for healthcare professionals on treating ~~acute and chronic~~ pain with opioids, including *the proper place in therapy for* methadone; further,

To advocate that all facilities that dispense methadone, including addiction treatment programs, participate in state prescription drug monitoring programs.

**\*6. Therapeutic Indication of Prescribing**

To advocate that healthcare organizations optimize use of clinical decision support *and prescribing systems by structuring them* to include the *appropriate* indication for ~~high-risk and problem-prone~~ medications.

Donald E. Letendre, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations 1 through 5.

**1. Pharmacy Technician Training and Certification**

To advocate that Pharmacy Technician Certification Board (PTCB) certification be required for all pharmacy technicians; further,

To advocate that all pharmacy technicians maintain PTCB certification; further,

To support the position that by the year 2020, the completion of a pharmacy technician training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required to obtain PTCB certification for all new pharmacy technicians; further,

To foster expansion of ASHP-ACPE accredited pharmacy technician training programs.

*This policy supersedes ASHP policy 1519.*

**\*2. Career Opportunities for Pharmacy Technicians**

To promote the image of pharmacy technicians as valuable contributors to healthcare delivery; further,

To develop and disseminate information about career opportunities that enhances the recruitment and retention of qualified pharmacy technicians; further,

To support pharmacy technician career advancement opportunities, commensurate with training and education; further,

To encourage compensation models for pharmacy technicians that provide a living wage.

(Note: This policy would supersede ASHP policy 0211.)

**3. Developing Leadership Competencies**

To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for pharmacy practitioners to move into leadership roles; further,

To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,

To encourage pharmacy practitioners to obtain the skills necessary to pursue administrative, managerial, and leadership roles; further,

To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,

To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,

To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.

*This policy supersedes ASHP policy 1518.*

**\*4. Interprofessional Education and Training**

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education, mentorship, and professional development for student pharmacists, residents, and pharmacists; further,

To encourage and support pharmacists' collaboration with other health professionals and healthcare executives in the development of *interprofessional*, team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of healthcare professionals.

(Note: This policy would supersede ASHP policy 1014.)

**\*5. Cultural Competency and Cultural Diversity**

To endorse *foster* the development of cultural competency of *within the pharmacy workforce* educators, practitioners, residents, students, and technicians; further,

To educate *healthcare* providers on the importance of providing culturally congruent care to achieve quality care and patient engagement; further,

To advocate for an ethnically and culturally diverse workforce.

(Note: This policy would supersede ASHP policy 1414.)

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Lea S. Eiland, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations 1 through 4.

**\*1. Controlled Substance Diversion and Patient Access**

To enhance awareness by ~~pharmacists~~ *pharmacy personnel*, healthcare providers, and the public of drug diversion and abuse of controlled substances; further,

To advocate that ~~pharmacists~~ *the pharmacy profession* ~~take a leadership role in national~~ *lead collaborative* efforts to reduce the incidence of controlled substance abuse; further,

To advocate that pharmacists lead collaborative efforts by organizations of healthcare professionals, patient advocacy organizations, and regulatory authorities to develop and promote best practices for preventing drug diversion and appropriately using controlled substances to optimize *and ensure* patient access and therapeutic outcomes; further,

To advocate that the Drug Enforcement Administration and other regulatory authorities interpret and enforce laws, rules, and regulations to support patient access to appropriate therapies, minimize burdens on pharmacy practice, and provide reasonable safeguards against fraud, misuse, abuse, and diversion of controlled substances; further,

To ~~encourage healthcare organizations to establish~~ *advocate establishment of* programs to support patients and personnel with substance abuse and dependency issues.

**\*2. Protecting Workers from Exposure to Hazardous Drugs**

To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs; further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of hazardous drugs; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for hazardous drugs that would alert handlers to the potential presence of surface contamination; further,

To encourage healthcare organizations, *wholesalers, and other trading partners in the drug supply chain* to adhere to published standards and regulations, *such as United States Pharmacopeia Chapter 800*, to protect workers from undue exposure to hazardous drugs.

(Note: This policy would supersede ASHP policy 0618.)

**3. Pharmaceutical Distribution Systems (withdrawn)**

In Council on Pharmacy Management (CPM) policy recommendation 3, Pharmaceutical Distribution Systems, the Council revised ASHP policy 1016 to add the following clause:

*To encourage wholesalers and other trading partners in the drug supply chain to implement policies and procedures consistent with United States Pharmacopeia (USP) Chapter 800 in order to mitigate the risk of hazardous drug exposure as products move through the supply chain.*

The House of Delegates determined that the additional language was better suited to CPM policy recommendation 2, Protecting Workers from Exposure to Hazardous Drugs, and amended that policy recommendation to incorporate the concepts in the new clause. Removing the now-redundant language from CPM policy recommendation 3 would result in a policy identical to existing ASHP policy 1016, so CPM policy recommendation 3 was withdrawn, with the result that ASHP policy 1016 will remain ASHP policy.

**\*4. Patient Experience**

To encourage pharmacists to evaluate their practice settings for opportunities to improve the ~~level of satisfaction~~ *experience* patients have with healthcare services and with the outcomes of their drug therapy; further,

To educate pharmacists and pharmacy personnel about the relationship between patient ~~satisfaction~~ *experience* and ~~positive~~ *health* outcomes; further,

To develop or adopt tools that will (1) provide a system for monitoring trends in the quality of pharmacy services to patients, (2) increase recognition of the value of pharmacy services, and (3) provide a basis for making improvements in the process and outcomes of pharmacy services in efforts to engage patients and improve ~~satisfaction~~ *their experience*; further,

To facilitate a dialogue with and *encourage* education of ~~national patient satisfaction~~ *experience* database vendors ~~on the role and value of clinical pharmacy services to include the value of pharmacists and pharmacy services in patient experience.~~

(Note: This policy would supersede ASHP policy 0104.)

Ranee M. Rannebaum, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations 1 through 4.

**\*1. Automated Preparation and Dispensing Technology for Sterile Preparation**

To ~~encourage~~ *advocate that* health systems to adopt automation and information technology for preparing and dispensing ~~compounded sterile~~ preparations when such adoption is (1) planned, implemented, and managed with pharmacists' involvement; (2) implemented with adequate resources to promote successful development and maintenance; and (3) supported by policies and procedures that ensure the safety, effectiveness, and efficiency of the medication-use process; further,

To educate patient safety advocacy groups and regulatory agencies on the capabilities and benefits of automation and technology for preparing and dispensing compounded sterile preparations, and to encourage them to establish expectation of adoption by health systems; further,

To foster further research, development, and publication of best practices regarding automation and information technology for preparing and dispensing sterile preparations.

**\*2. Integrated Approach for the Pharmacy Enterprise**

To advocate that pharmacy department leaders promote an integrated ~~team~~ approach for all pharmacy ~~professionals~~ *personnel* involved in the medication-use process; further,

To advocate a high level of coordination of all components of the pharmacy enterprise across the continuum of care for the purpose of optimizing (1) medication-use safety, (2) quality, (3) outcomes, and (4) ~~the value of drug therapy~~; further,

~~To encourage pharmacy department leaders to develop and maintain patient-centered practice models that integrate into a team all pharmacy professionals engaged in the medication-~~

use process, including general and specialized clinical practice, drug-use policy, product acquisition and inventory control, product preparation and distribution, and medication-use safety and other quality initiatives.

(Note: This policy would supersede ASHP policy 0619.)

**\*3. Preventing Exposure to Allergens**

To advocate for pharmacy participation in the *collection*, assessment, and documentation of a complete list of allergens pertinent to medication therapy, including food, excipients, medications, devices, and supplies, for the purpose of clinical decision-making; further,

To advocate that vendors of medication-related databases incorporate and maintain information about medication-related allergens and cross-sensitivities; further, [clause moved here from lower down]

To advocate that ~~pharmacy departments~~ *pharmacists* actively review allergens pertinent to medication therapy and minimize patient and healthcare worker exposure to known allergens, as feasible; further,

To advocate that ~~pharmacy departments be actively involved soliciting information about patient food and environmental allergies that may indicate a potential for medication interaction or adverse event;~~ further,

To encourage ~~pharmacist~~ *pharmacy personnel* education on medication-related allergens.

**4. Accreditation of Compounding Facilities**

To discontinue ASHP policy 0617 which reads:

To encourage facilities where extemporaneous compounding of medications occurs to seek accreditation by a nationally credible accreditation body.

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Kelly M. Smith, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations 1 through 6.

**\*1. Off-Label Promotion by Pharmaceutical Manufacturers**

To advocate for authority for the Food and Drug Administration (FDA) to regulate the promotion and dissemination of information about off-label uses of medications and medication-containing devices by manufacturers *and their representatives*; further,

To advocate that such off-label promotion and marketing be limited to the responsible FDA-regulated dissemination of unbiased, truthful, ~~non-misleading~~, and scientifically accurate information based on authoritative, peer-reviewed literature not included in the New Drug Approval process.

(Note: This policy would supersede ASHP policy 1120.)

**\*2. Timely State Board of Pharmacy Licensing**

To advocate that the National Association of Boards of Pharmacy (NABP) collaborate with state boards of pharmacy to streamline the licensure process through standardization and improve the timeliness of application approval; further, [clause moved here from lower down]

To advocate that ~~the National Association of Boards of Pharmacy (NABP)~~ collaborate with state boards of pharmacy and any third-party vendor to streamline the licensure reciprocity process; further,

To advocate that state boards of pharmacy grant temporary licensure to pharmacists who are relocating seeking reciprocity from another state jurisdiction in which they hold a license in good standing, permitting them to engage in practice while their application for licensure reciprocity is being processed; further, [clause moved here from higher up]

(Note: This policy would supersede ASHP policy 0612.)

**3. Inclusion of Drug Product Shortages in State Price-gouging Laws**

To urge state attorneys general to consider including shortages of lifesaving drug products within the definition of events that trigger application of state price-gouging laws.

**\*4. Home Intravenous Therapy**

To support the continuation of a home intravenous therapy benefit under federal and private health insurance plans, and ~~expand~~ expansion of the home infusion benefit under Medicare at an appropriate level of reimbursement for pharmacists' patient care services provided, medications, supplies, and equipment.

(Note: This policy would supersede ASHP policy 0414.)

**5. Drug Product Shortages**

To discontinue ASHP policy 1118 which reads:

To advocate that the Food and Drug Administration (FDA) have the authority to require manufacturers to report drug product shortages and the reason(s) for the shortage, and to make that information available to the public; further,

To strongly encourage the FDA to consider, in its definition of "medically necessary" drug products, the patient safety risks created by use of alternate drug products during a shortage; further,

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

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

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

**\*6. Direct-to-Consumer Advertising for Prescription Drugs and Implantable Devices**

To advocate that Congress commission an evidence-based review of direct-to-consumer (DTC) advertising for prescription drugs and implantable medical devices in the United States to determine the impact of such DTC advertising on the patient-prescriber relationship, healthcare costs, health outcomes, and the public health; further,

To advocate that Congress ban *direct-to-consumer* DTC advertising for prescription drugs and *implantable medication-containing* medical devices until the results of such a review are publicly available; further,

To advocate, in the absence of a Congressionally mandated review, that the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries conduct or fund research on the effects of DTC advertising on the patient-prescriber relationship, healthcare costs, health outcomes, and the public health, and make the research results available to the public; further,

To oppose, in the absence of a ban, DTC advertising for prescription drugs and implantable medical devices unless it is educational in nature about prescription drug therapies for certain medical conditions, appropriately includes pharmacists as a source of information, and is conducted so as to mitigate potential harmful effects on the patient-prescriber relationship, healthcare costs, health outcomes, and the public health.

(Note: This policy would supersede ASHP policy 1119.)

President Armitstead then presented the Board’s proposed changed to ASHP Bylaws and Procedures of the House (Appendix V). Delegates approved the bylaws changes.

**Article 4. Officers**

4.1. The officers of ASHP shall be the President, the President-elect, the Immediate Past President, the Treasurer, and the Secretary, all of whom shall be active members of ASHP. The Secretary shall also serve as Executive Vice President of ASHP.

4.1.1. The President-elect shall be elected annually for a term of one year and shall succeed successively to the office of President and then to the office of Immediate Past President, serving for one year in each office.

4.1.2. The Executive Vice President shall be chosen by the Board of Directors.

4.1.3. The candidates for Treasurer shall be nominated by the Board of Directors and elected by the active members for a term of office of three years. No person shall serve more than two successive terms as Treasurer.

~~4.1.4. Each officer shall be installed at the yearly meeting of the House of Delegates.~~

4.1.5. The President, President-elect, Immediate Past President, and Treasurer are not charged with executive or administrative responsibility for the management or conduct of the internal affairs of ASHP.

(Note: strikethrough is House amendment.)

**Report of Treasurer.** Philip J. Schneider presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer’s report (Appendix VI).

The meeting adjourned at 5:00 p.m.

**Second meeting**

The second and final meeting of the House of Delegates session convened on Tuesday, June 14, at 4:00 p.m. A quorum was present.

**Report of the Committee on Resolutions.** President Armitstead again presented the Report of the Committee on Resolutions (Appendix II). Nicole Allcock (MO), one of the Resolution’s submitters, moved that the Resolution be referred to the appropriate ASHP committee or task force, as determined by the Board of Directors, for further study. The motion was seconded and the delegates voted to refer the Resolution.

**Report of President and Chair of the Board.** President Armitstead updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report of the Chair of the Board (Appendix VII).

**Report of Chief Executive Officer.** Paul W. Abramowitz presented the report of the Chief Executive Officer (Appendix VIII).

**Board of Directors duly considered matters.** Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 13 to “duly consider” the policies and proposed Bylaws change amended at the first meeting. Fifteen policy recommendations were amended by the House of Delegates, four had minor editorial changes proposed, and one was withdrawn. The Board agreed with all the amendments, with minor editorial changes to seven of the amended policies to increase their clarity or provide consistency with other ASHP policies.

**New Business.** Chair Lucas announced that, in accordance with Article 7 of the Bylaws, there was one item of New Business to be considered. Chair Lucas called on Scott Takahashi (CA) to introduce the item of New Business, “Intern Hours Required for Board of Pharmacy Licensure” (Appendix IX). Following discussion, the item was approved for referral. It reads as follows:

*Intern Hours Required for Board of Pharmacy (BoP) Licensure*

Motion

ASHP should advocate 50% or more of internship hours required to apply for Board of Pharmacy licensure be obtained outside of IPPE and APPE performed during School of Pharmacy curriculum.

Background

To respond to past pharmacist shortages, the California Board of Pharmacy (BoP) had eliminated the non-academic hours required to permit out of state applicants to sit for the California BoP exam. This was due to the requirement the lack of transferable documentation was difficult or not possible to obtain as the document was for California R.Ph. verification. In addition, in California, there are 15 schools of pharmacy which has/will greatly impact the ability of students to obtain intern positions to gain the “real world” practical experience offered by employment of pharmacy interns. The assumption is that the intern experience as an employee is markedly different from IPPE and APPE-related experience as the employed experience is obtained over years in the pharmacy with all the duties and responsibilities required with that position. New graduates with substantial intern experience are more practice ready compared to their colleagues whose intern experience is solely from APPE and IPPE through their educational curriculum. The graduate with less/no experience forces the employer to train new hires basic pharmacy work ethics and learn how to function in the pharmacy.

Suggested Outcomes

1. Dialogue with the NABP on the issue of internship hour requirements – implement/restore 50% or more of hours to sit for licensure exam be completed outside of pharmacy school curriculum.
2. New practitioner survey on “how prepared are you to start practice” for as many new graduates over the last five years. Elements of the survey include: APPE/IPPE hours submitted for BoP exam, hours required for BoP Exam, year of first attempt BoP exam, subjective assessment of ease to begin practice as a new graduate.
3. Employer survey on hiring of new practitioners over their years of experience. Elements to include: hospital bed

size, state, years with hiring experience, presence of intern program, subjective assessment of new hires reasonably prepared to practice on hire (outside of their own previously employed interns), subjective assessment of changes in probationary period changes, subjective assessment of the need to re-train new hires, subjective assessment of the need to discharge new hire compared to previous years.

**Recommendations.** Chair Lucas called on members of the House of Delegates for Recommendations. (See Appendix X for a complete listing of all Recommendations.)

**Recognition.** Chair Lucas recognized members of the Board who were continuing in office (Appendix XI). He also introduced members of the Board who were completing their terms of office.

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Lucas presented Immediate Past President Armitstead with an inscribed gavel commemorating his term of office. Dr. Armitstead recognized the service of Chair Lucas as Chair of the House of Delegates and a member of the Board of Directors.

Chair Lucas then installed the chairs of ASHP’s sections and forums: Kristy Butler, Section of Ambulatory Care Practitioners; Casey H. White, Section of Clinical Specialists and Scientists; Jennifer Robertson, Section of Inpatient Care Practitioners; Sylvia Belford, Section of Pharmacy Informatics and Technology; Rick Couldry, Section of Pharmacy Practice Managers; Ashley Duty, New Practitioners Forum; and Jenna Fancher, Pharmacy Student Forum. Chair Lucas then recognized the remaining members of the executive committees of sections and forums.

**Installation.** Chair Lucas then installed Lisa M. Gersema as President of ASHP, Todd A. Karpinsky and Jennifer M. Schultz as members of the Board of Directors (Appendix XI), and Amber J. Lucas as Chair of the House of Delegates. (See Appendix XII for the Inaugural Address of the Incoming President.)

**Adjournment.** The 68th annual June meeting of the House of Delegates adjourned at 5:55 p.m.

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<sup>a</sup>The Committee on Nominations consisted of Leigh Briscoe-Dwyer, Chair (NY); Gerald Meyer, Vice Chair (PA); Jill Bates (NC); Erin Fox (UT); John Pastor (MN); Donna Soflin (NE); and David Weetman (IA).

**ASHP HOUSE OF DELEGATES**  
**Baltimore, Maryland**  
**Presiding – Amber J. Lucas**  
**Chair, House of Delegates**

**First Meeting**  
**Sunday June 12, 2016**

<b>OFFICERS AND BOARD OF DIRECTORS</b>			
John Armitstead, President			
Lisa Gersema, President-Elect			
Christene Jolowsky, Immediate Past President			
Amber Lucas, Chair, House of Delegates			
Philip Schneider, Treasurer			
Paul Abramowitz, Chief Executive Officer			
Ranee Runnebaum, Board Liaison, Council on Pharmacy Practice			
Don Letendre, Board Liaison, Council on Education and Workforce Development			
Lea Eiland, Board Liaison, Council on Pharmacy Management			
Kelly Smith, Board Liaison, Council on Public Policy			
Kathy Pawlicki, Board Liaison, Commission on Affiliate Relations			
Tim Brown, Board Liaison, Council on Therapeutics			
<b>PAST PRESIDENTS</b>			
Roger Anderson	Gerald Meyer		
Robert Anderson	Paul Pierpaoli		
Daniel Ashby	Steven Sheaffer		
Jannet Carmichael	Sara White		
Kevin Colgan	T. Mark Woods		
Rebecca Finley			
Diane Ginsburg			
Harold Godwin			
Marianne Ivey			
Stan Kent			
Lynnae Mahaney			
James McAllister			
<b>STATE</b>	<b>DELEGATES</b>		
<b>Alabama (3)</b>	Kimberley Benner Brenda Denson Pamela Stamm		
<b>Alaska (2)</b>	Shawn Bowe Sara Doran-Atchison		
<b>Arizona (3)</b>	Melinda Burnworth Christi Jen Carol Rollins		
<b>Arkansas (2)</b>	Zhiva Brown Rayanne Story		

<b>STATE</b>	<b>DELEGATES</b>
<b>California (8)</b>	Christine Antczak Victoria Ferraresi Steve Gray Brian Kawahara Victoria Serrano Adams Kethen So Scott Takahashi William Yee
<b>Colorado (3)</b>	Ashley Mains Joel Marrs Karen McConnell
<b>Connecticut (3)</b>	Molly Leber Lorraine Lee Stacy Vaeth
<b>Delaware (2)</b>	Francine Farnsworth
<b>Florida (5)</b>	Katelyn Dervay Thomas Johns Richard Montgomery Rebecca Prevost William Terneus, Jr.
<b>Georgia (3)</b>	Leslie Jagers Patricia Knowles Michael Melroy
<b>Hawaii (2)</b>	
<b>Idaho (2)</b>	Michael Dickens Elizabeth Duncan
<b>Illinois (5)</b>	Travis Hunerdosse Jennifer Phillips Carrie Sincak Noelle Chapman Ed Rainville
<b>Indiana (3)</b>	Daniel Degnan John Hertig Amy Hyduk
<b>Iowa (3)</b>	John Hamiel Lisa Mascardo David Weetman
<b>Kansas (3)</b>	Christopher Bell Gregory Burger Joan Kramer
<b>Kentucky (3)</b>	Margo Ashby Vylinda Howard Anne Policastri
<b>Louisiana (3)</b>	Scott Dantonio Joseph Leblanc Jennifer Smith

<b>STATE</b>	<b>DELEGATES</b>
<b>Maine (2)</b>	Paul Barrett Ellie Provisor
<b>Maryland (4)</b>	Patricia Grunwald Emily Pherson Asha Tata Kristen Watson
<b>Massachusetts (4)</b>	Snehal Bhatt Margarita DiVall Karl Gumper Ross Thompson
<b>Michigan (4)</b>	Jesse Hogue Gary Blake Michael Ruffing Paul Walker
<b>Minnesota (4)</b>	Craig Else Kristi Gullickson Paul Krogh John Pastor
<b>Mississippi (2)</b>	Todd Dear Wesley Pitts
<b>Missouri (3)</b>	Nicole Allcock Joel Hennenfent Amy Sipe
<b>Montana (2)</b>	Lonnye Finneman Amanda Patel
<b>Nebraska (2)</b>	Michele Faulkner Donna Soflin
<b>Nevada (2)</b>	Rebecca Kandilian Adam Porath
<b>New Hampshire (2)</b>	Robert Theirault Jennifer Towle
<b>New Jersey (3)</b>	Luigi Brunetti Paul Goebell Timothy Reilly
<b>New Mexico (2)</b>	Melanie Dodd Juliann Horne
<b>New York (5)</b>	Leigh Briscoe-Dwyer Andrew Kaplan Joe Pinto Vickie Powell Elizabeth Shlom
<b>North Carolina (4)</b>	Susan Bear Stephen Eckel Mary Parker
<b>North Dakota (2)</b>	

<b>STATE</b>	<b>DELEGATES</b>
<b>Ohio (5)</b>	Dale English, II Maryellen Hethcox Karen Kier Mark Thomas
<b>Oklahoma (3)</b>	Ann Lloyd Kari McCracken Edna Patatanian
<b>Oregon (3)</b>	Sarah Deines Zach McCall Deanna Moretz
<b>Pennsylvania (5)</b>	Nishaminy Kasbekar Patricia Kienle Bill O'Hara Jean Scholtz Richard Pacetti
<b>Puerto Rico (2)</b>	Meredith Velez-Mercado
<b>Rhode Island (2)</b>	Marco Delbove Alicia ZuWallack
<b>South Carolina (3)</b>	Heather Easterling Joel Meroy Natasha Nicol
<b>South Dakota (2)</b>	Rhonda Hammerquist Tadd Hellwig
<b>Tennessee (4)</b>	Jeffrey Binkley Kelly Bobo Leah Ingram Mark Sullivan
<b>Texas (6)</b>	Diane Fox Shane Greene Patricia Meyer Sidney Phillips Lance Ray Jeffrey Wagner
<b>Utah (3)</b>	Erin Fox Leigh Fritz Elyse MacDonald
<b>Vermont (2)</b>	Jeffrey Schnoor
<b>Virginia (4)</b>	Craig Kirkwood Stephen LaHaye Rodney Stiltner Cindy Williams
<b>Washington, D.C. (2)</b>	John Quinn Vaiyapuri Subramaniam

<b>STATE</b>	<b>DELEGATES</b>
<b>Washington State (4)</b>	Andrea Corona Steve Riddle Janice Roe Roger Woolf
<b>West Virginia (2)</b>	Justin Hare Janet Wolcott
<b>Wisconsin (4)</b>	Terry Audley Arlene Iglar Justin Konkol Ryan Miller
<b>Wyoming (2)</b>	Linda Gore-Martin Kirsi Ludwig
<b>SECTIONS AND FORUMS</b>	<b>DELEGATES</b>
<b>Ambulatory Care Practitioners</b>	Kelly Epplen
<b>Clinical Specialists and Scientists</b>	Curtis Collins
<b>Inpatient Care Practitioners</b>	Emily Alexander
<b>Pharmacy Informatics and Technology</b>	Brandon Ordway
<b>Pharmacy Practice Managers</b>	James Hoffman
<b>New Practitioners Forum</b>	Ashley Duty
<b>Pharmacy Student Forum</b>	Jenna Fancher
<b>FRATERNAL</b>	<b>DELEGATES</b>
<b>U.S. Air Force</b>	Jin Kim
<b>U.S. Army</b>	John Spain
<b>U.S. Coast Guard</b>	
<b>U.S. Navy</b>	Angelica Klinski
<b>U.S. Public Health Service</b>	Ashley Schaber
<b>Veterans Affairs</b>	Julie Groppi

# ASHP HOUSE OF DELEGATES

Baltimore, Maryland

Presiding – Amber J. Lucas

Chair, House of Delegates

Second Meeting

Tuesday June 14, 2016

OFFICERS AND BOARD OF DIRECTORS			
John Armitstead, President			
Lisa Gersema, President-Elect			
Christene Jolowsky, Immediate Past President			
Amber Lucas, Chair, House of Delegates			
Philip Schneider, Treasurer			
Paul Abramowitz, Chief Executive Officer			
Ranee Runnebaum, Board Liaison, Council on Pharmacy Practice			
Don Letendre, Board Liaison, Council on Education and Workforce Development			
Lea Eiland, Board Liaison, Council on Pharmacy Management			
Kelly Smith, Board Liaison, Council on Public Policy			
Kathy Pawlicki, Board Liaison, Commission on Affiliate Relations			
Tim Brown, Board Liaison, Council on Therapeutics			
PAST PRESIDENTS			
Roger Anderson	Lynnae Mahaney		
Robert Anderson	James McAllister		
Daniel Ashby	Gerald Meyer		
Jannet Carmichael	Paul Pierpaoli		
Bruce Canaday	Bruce Scott		
Kevin Colgan	Steven Sheaffer		
Debra Devereaux	Sara White		
Rebecca Finley	T. Mark Woods		
Diane Ginsburg			
Harold Godwin			
Marianne Ivey			
Stan Kent			
STATE	DELEGATES		
<b>Alabama (3)</b>	Kimberley Benner Brenda Denson Pamela Stamm		
<b>Alaska (2)</b>	Shawn Bowe Sara Doran-Atchison		
<b>Arizona (3)</b>	Melinda Burnworth Christi Jen Carol Rollins		
<b>Arkansas (2)</b>	Zhiva Brown Rayanne Story		

<b>STATE</b>	<b>DELEGATES</b>
<b>California (8)</b>	Christine Antczak Victoria Ferraresi Steve Gray Brian Kawahara Victoria Serrano Adams Kethen So Scott Takahashi William Yee
<b>Colorado (3)</b>	Ashley Mains Joel Marrs Karen McConnell
<b>Connecticut (3)</b>	Molly Leber Lorraine Lee Stacy Vaeth
<b>Delaware (2)</b>	Francine Farnsworth
<b>Florida (5)</b>	Katelyn Dervay Thomas Johns Richard Montgomery Rebecca Prevost William Terneus, Jr.
<b>Georgia (3)</b>	Leslie Jagers Patricia Knowles Michael Melroy
<b>Hawaii (2)</b>	
<b>Idaho (2)</b>	Michael Dickens Elizabeth Duncan
<b>Illinois (5)</b>	Travis Hunerdosse Jennifer Phillips Carrie Sincak Noelle Chapman Ed Rainville
<b>Indiana (3)</b>	Daniel Degnan John Hertig Amy Hyduk
<b>Iowa (3)</b>	John Hamiel Lisa Mascardo David Weetman
<b>Kansas (3)</b>	Christopher Bell Gregory Burger Joan Kramer
<b>Kentucky (3)</b>	Margo Ashby Vylinda Howard Anne Policastri
<b>Louisiana (3)</b>	Scott Dantonio Joseph Leblanc Jennifer Smith

<b>STATE</b>	<b>DELEGATES</b>
<b>Maine (2)</b>	Paul Barrett Ellie Provisor
<b>Maryland (4)</b>	Patricia Grunwald Emily Pherson Asha Tata Kristen Watson
<b>Massachusetts (4)</b>	Snehal Bhatt Margarita DiVall Karl Gumper Ross Thompson
<b>Michigan (4)</b>	Jesse Hogue Gary Blake Michael Ruffing Paul Walker
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<b>U.S. Navy</b>	Angelica Klinski
<b>U.S. Public Health Service</b>	Ashley Schaber
<b>Veterans Affairs</b>	Julie Groppi



# House of Delegates

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## **REPORT OF THE COMMITTEE ON RESOLUTIONS**

June 12, 2016

Baltimore, Maryland

John A. Armitstead, Chair  
Lisa M. Gersema, Vice Chair  
Timothy R. Brown  
Lea S. Eiland  
Christene M. Jolowsky  
Donald E. Letendre  
Amber J. Lucas  
Kathleen S. Pawlicki  
Ranee M. Runnebaum  
Philip J. Schneider  
Kelly M. Smith  
Paul W. Abramowitz, Chief Executive Officer

Article 7.2.2.1 of the ASHP Rules of Procedure for the House of Delegates states:

Resolutions not voluntarily withdrawn by the submitter that meet the requirements of the governing documents shall be presented to the House of Delegates by the Committee on Resolutions at the first meeting and acted upon at the second meeting. They shall be submitted to delegates with one of the following recommendations: (a) recommend adoption, (b) do not recommend adoption, (c) recommend referral for further study, or (d) presented with no recommendation of the Committee on Resolutions.

Action by the House of Delegates shall be on the substance of the resolutions and not on the recommendation of the Committee on Resolutions.

Pursuant to the above article, the Committee on Resolutions presents the attached resolution to the House of Delegates. The recommendation of the Committee is to **refer the resolution to the appropriate ASHP committee, as determined by the Board of Directors, for further study**. The Committee recognized the urgency of the topic, as four states have legalized assisted suicide and more than a dozen states are debating similar legislation.

The Committee concluded that ASHP, the pharmacy profession, and the public would benefit from further examination of the evolving issues associated with assisted suicide and ongoing discussions in the 18 states currently considering “death-with-dignity” or physician-assisted suicide laws. The Committee envisions a multimodal process of education, member and expert engagement, and debate, utilizing ASHP’s many educational, publishing, and member engagement resources. The Committee noted that current ASHP policy on the topic – to remain neutral on pharmacist participation in assisted suicide while recognizing the right of pharmacists to refuse to participate in morally or ethically troubling activities without retribution – was reaffirmed in January 2016 after consideration by the Council on Pharmacy Practice and the Board of Directors. The Committee also noted that the American Pharmacists Association reaffirmed its policy of neutrality on assisted suicide in 2015. The Committee concluded that extending the period of study and debate would provide ASHP members an opportunity to explore the issue’s many facets and decide where they would like ASHP to stand on this important and evolving issue.

Delegates are reminded that the substance of the resolution is the amendment of existing ASHP policy 9915, ASHP Position on Assisted Suicide, as described in the resolution. The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion to amend the policy; (b) defeat the motion to amend the policy; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors (**the option recommended by the Committee on Resolutions**); or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

**Resolution: ASHP Position on Assisted Suicide****Submitter # 1:**

Nicole Allcock (MO)

**Submitter # 2:**

Kevin J. Colgan (Past President)

**Supporting Members:**

Kristi Gullickson (MN)

John Pastor (MN)

Peggy Malovrh (MI)

Daniel Good (MO)

Joel Hennenfent (MO)

Desi Kotis (IL)

**Subject:** ASHP Position on Assisted Suicide

**Received:** February 24, 2016

**Motion:** To amend ASHP policy 9915, ASHP Position on Assisted Suicide, to read as follows:

To oppose pharmacist participation in assisted suicide; further,

To reaffirm that pharmacists have the right to decline to participate in assisted suicide without retribution.

**Background:** ASHP policy 9915, ASHP Position on Assisted Suicide, would be amended as follows (~~strikethrough~~ indicates deletions; underscore indicates new text):

**9915****ASHP POSITION ON ASSISTED SUICIDE**

*Source: Council on Legal and Public Affairs*

~~To remain neutral on the issue of health professional participation in assisted suicide of patients who are terminally ill; further,~~

~~To affirm that the decision to participate in the use of medications in assisted suicide is one of individual conscience; further,~~

~~To offer guidance to health system pharmacists who practice in states in which assisted suicide is legal.~~

To oppose pharmacist participation in assisted suicide; further,

To reaffirm that pharmacists have the right to decline to participate in assisted suicide without retribution.

The *Code of Ethics for Pharmacists* states in the Preamble that "Pharmacists are health professionals who assist individuals in making the best use of medications."<sup>1</sup> Killing in any situation, including assisted suicide, cannot be intellectually or morally justified as the best use of medications. ASHP's current policy is in conflict with our own code of ethics.

In addition, we are also at odds with official positions of medicine and nursing on this issue. American Medical Association policy states that "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."<sup>2</sup> The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of the *Code of Ethics for Nurses*. The ANA position states that nurses' participation in assisted suicide would be a violation of the "ethical traditions and goals of the profession, and its covenant with society," noting that "nurses have the obligation to provide humane, comprehensive and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life."<sup>3</sup>

Disability advocacy groups consistently voice their opposition to assisted suicide. Among these are the National Council on Independent Living, The Disability Rights Education and Defense Fund, Americans Disabled Attendant Programs Today (ADAPT), and the National Council on Disability (NCD).<sup>4-7</sup> The NCD states:

The pressures upon people with disabilities to choose to end their lives...are already prevalent and will continue to increase...People with disabilities are among society's most likely candidates for ending their lives, as society has frequently made it clear that it believes they would be better off dead, or better that they had not been born. The experience in the Netherlands demonstrates that legalizing assisted suicide generates strong pressures upon individuals and families to utilize that option, and leads very quickly to coercion and involuntary euthanasia. If assisted suicide were to become legal, the lives of people with any disability deemed too difficult to live with would be at risk, and persons with disabilities who are poor or members of racial minorities would likely be in the most jeopardy of all.<sup>7</sup>

Pharmacy has long been known as a highly trusted profession. In addition, it is the duty of a pharmacist and all healthcare professionals to advocate for vulnerable patients. Condoning pharmacist participation in assisted suicide reduces our trustworthiness as a profession. ASHP's own Statement on Pharmacist's Decision-making on Assisted Suicide states, "The basic tenet of the profession is to provide care and affirm life. The pharmacy profession is founded on a tradition of patient trust."<sup>8</sup> Pharmacists' participation in assisted suicide would redefine the role of pharmacists. If a pharmacist's role is determined only by the will of an individual patient or state, then the pharmacist becomes a mere technical instrument providing a service.

## References

1. Code of Ethics for Pharmacists. American Pharmaceutical Association. October 27th, 1994. Endorsed by the American Society of Health-System Pharmacists House of Delegates June 3, 1996. <https://www.ashp.org/DocLibrary/BestPractices/EthicsEndCode.aspx> (accessed 2016 Feb 20).

2. American Medical Association. Opinion 2.211 - Physician-Assisted Suicide. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page> (accessed 2016 Feb 20).
3. American Nurses Association. Position Statement on Euthanasia, Assisted Suicide, and Aid in Dying. April 24th, 2013. <http://www.nursingworld.org/euthanasiaanddying> (accessed 2016 Feb 20).
4. National Council on Independent Living. Letter regarding California SB 128. [http://noassistedsuicideca.org/images/NCIL\\_Opposition.pdf](http://noassistedsuicideca.org/images/NCIL_Opposition.pdf) (accessed 2016 Feb 20).
5. Disability Rights Education and Defense Fund statement on assisted suicide. <http://dredf.org/public-policy/assisted-suicide/> (accessed 2016 Feb 20).
6. American Disabled for Attendant Program Today (ADAPT). ADAPT and Not Dead Yet File Brief. <http://www.adapt.org/newsletter/1997v31n1/22ndy> (accessed 2016 Feb 20).
7. The National Council on Disability. Assisted Suicide: A Disability Perspective Position Paper. <https://www.ncd.gov/publications/1997/03241997> (accessed 2016 Feb 20).
8. American Society of Health-System Pharmacists. ASHP Statement on Pharmacist's Decision-Making in Assisted Suicide. <http://www.ashp.org/doclibrary/bestpractices/ethicsstsucide.aspx> (accessed 2016 Feb 20).

**Outcome:** To amend ASHP policy 9915 as described.



# House of Delegates

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## **HOUSE OF DELEGATES**

### **REPORT OF THE**

### **COMMITTEE ON NOMINATIONS**

June 12, 2016

Baltimore, Maryland

Leigh Briscoe-Dwyer (Chair), New York  
Gerald Meyer (Vice Chair), Pennsylvania  
Jill Bates, North Carolina  
Erin Fox, Utah  
John Pastor, Minnesota  
Donna Soflin, Nebraska  
David Weetman, Iowa

## ASHP COMMITTEE ON NOMINATIONS

Madam Chair, Fellow Delegates:

The Committee on Nominations consists of seven members of ASHP who were members of the House of Delegates at the time of their appointment. The Committee is appointed by the Chair of the House of Delegates and is charged with the task of presenting to you our best judgments about those persons who possess the tangible and intangible attributes of leadership that qualify them to serve as our officers and directors. It is a difficult job.

Selection of nominees for ASHP office involves a series of challenging decisions on the part of the Committee. Ultimately, those decisions are intended to permit the membership to select leaders with the professional, intellectual, and personal qualities of leadership that will sustain the dynamism and pioneering spirit that have characterized both ASHP and acute and ambulatory pharmacy practice.

First, the Committee must determine that a prospective nominee for office is an active member as required in the Charter. This is generally the easiest and most straightforward part of the Committee's work. The Committee must ascertain that each prospective nominee can perform the duties required of the office or offices to which he or she has been nominated. All nominees must be able to perform the duties of a Director, set forth in section 5.4 of the Bylaws. Presidential nominees must also be able to perform the duties of that office, set forth in article 4 of the Bylaws.

The more difficult part of the Committee's work is to assess those intangible qualities of leadership, vision, engagement, and professional awareness that characterize the standout candidates – those truly able to provide leadership for ASHP and the profession. The Committee assesses the attributes of prospective candidates for office in areas such as:

- Professional experience, career path, and practice orientation;
- Leadership skills and leadership experience including but not limited to the extent of leadership involvement in ASHP and its affiliates;
- Knowledge of pharmacy practice and vision for practice and ASHP;
- Ability to represent ASHP's diverse membership interests and perspectives; and
- Communication and consensus building skills.

There are no right or wrong answers to these criteria. Certain qualities may be weighed differently at various points in the evolution of the profession.

The Committee's year-long process of receiving nominations and screening candidates is designed to solicit extensive membership input and, ultimately, to permit the Committee to candidly and confidentially assess which candidates best fit ASHP's needs. The Committee has met twice in person since the last session of the House of Delegates: on December 8, 2015, at the Midyear Clinical Meeting in New Orleans, Louisiana; and on April 19, 2016, at ASHP headquarters; and met once via teleconference. Review of nominees' materials was conducted continuously between March and April 2016 solely via secure electronic transmissions. This process has been reviewed for quality

improvement and will be repeated for the 2016–2017 nomination cycle.

As in the past, the Committee used various means to canvass ASHP members and state affiliates for candidates who they felt were most qualified to lead us. All members were invited via announcements in the ASHP *Intersections*, online ASHP NewsLink bulletins, and the ASHP website to submit nominations for the Committee's consideration. Nominations from state affiliate societies were solicited through special mailings and the "state affiliate" edition of the online NewsLink service. At the 2015 Midyear Clinical Meeting, the Chair and Secretary made themselves available to receive nominations personally in a location and at a time that were publicized in ASHP news publications and correspondence.

Based upon recommendations from membership, state affiliates, and ASHP staff, the Committee contacted over 500 individuals identified as possible candidates. Some individuals were invited to accept consideration for more than one office. Of the nominees who responded to the invitation to place themselves in nomination, the breakdown by office is as follows:

PRESIDENT-ELECT: 6 accepted

BOARD OF DIRECTORS: 24 accepted

A list of candidates that were slated was provided to delegates following the Committee's meeting on April 19, 2016.

The Committee is pleased to place in official nomination the following candidates for election to the indicated offices. Names and biographical data have been distributed to the House.

#### **President-Elect**

Paul W. Bush, Pharm.D., M.B.A., BCPS, FASHP (Durham, NC)

Kelly M. Smith, Pharm.D., FASHP, FCCP (Lexington, KY)

#### **Board of Directors**

Stephen F. Eckel, Pharm.D., M.H.A., BCPS, FASHP (Chapel Hill, NC)

Seena L. Haines, Pharm.D., BCACP, BC-ADM, CDE, FASHP, FAPhA (Jackson, MS)

Nishaminy Kasbekar, B.S., Pharm.D., FASHP (Philadelphia, PA)

Linda S. Tyler, Pharm.D., FASHP (Salt Lake City, UT)

Madam Chair, this completes the presentation of candidates by the Committee on Nominations. Congratulations to all the candidates.

**PRESIDENT-ELECT**

**PAUL W. BUSH, Pharm.D., M.B.A., BCPS, FASHP** ([paul.bush@duke.edu](mailto:paul.bush@duke.edu)) is Chief Pharmacy Officer and HSPA/MS Residency Program Director at Duke University Hospital. Previously, he served as Director of Pharmacy at Medical University of South Carolina (MUSC), St. John Hospital and Medical Center (Detroit) and Detroit Osteopathic Hospital. Bush holds faculty appointments at UNC Eshelman School of Pharmacy and Campbell University College of Pharmacy. Additionally, he has held appointments at MUSC and Wayne State University.

Bush has focused his career on improving the scope and quality of patient-centered pharmacy services; implementing and expanding residency programs; and mentoring staff, residents and students.

Bush completed his B.S. in Pharmacy at the University of Michigan and Pharm.D. and M.B.A. at Wayne State University.

His ASHP service includes Board of Directors, Chair of the Section of Pharmacy Practice Managers, Commission on Credentialing, Commission on Goals, multiyear ASHP Delegate, and the Practice Model Summit Advisory Committee.

**KELLY M. SMITH, Pharm.D., FASHP, FCCP** ([kelly.smith@uky.edu](mailto:kelly.smith@uky.edu)) is Interim Dean and Professor, University of Kentucky (UK) College of Pharmacy. A graduate of the University of Georgia and UFHealth Jacksonville residency, she began at UK as a drug information pharmacist and board-certified pharmacotherapy specialist, and was a long-time PGY1 program director. She focuses on aligning workforce capacity and development, residency models, and individual career development with needs of the profession.

ASHP leadership roles include Board of Directors; Chair, Section of Clinical Specialists and Scientists; Chair, Commission on Credentialing; Council on Therapeutics; Council on Education and Workforce Development; Pharmacy Technician Accreditation Commission; state delegate; PPMI delegate; Task Force on Organizational Structure; Task Force on Science; *AJHP* Editorial Board. Others include Chair, UHC/Vizient Executive Committee; Chair, ACCP Drug Information PRN; Chair, AACP Deans' Task Force on Student Recruitment. She has received awards from ASHP, KSHP (Kentucky), KPhA (Kentucky), ACCP, and AACP.

**BOARD OF DIRECTORS**

**STEPHEN F. ECKEL, Pharm.D., M.H.A., BCPS, FASHP** ([seckel@unc.edu](mailto:seckel@unc.edu)) is Clinical Associate Professor at the UNC Eshelman School of Pharmacy, the Associate Dean for Global Engagement, and the division's Vice Chair for Graduate and Postgraduate Education. At UNC Hospitals, he is Associate Director of Pharmacy, Director of Pharmacy Residency Programs and Residency Program Director of a two-year residency in health-system pharmacy administration.

Eckel was educated at UNC and completed a pharmacy residency at Duke.

Eckel has served many years in the ASHP House of Delegates. He was also the chair of the ASHP Council on Pharmacy Practice. He was awarded the Pharmacy Residency Excellence Preceptor Award by the ASHP Foundation. He is a Fellow of ASHP.

Eckel has also been very active in the North Carolina Association of Pharmacists. He was elected as Chair of the Acute Care Practice Forum (ASHP affiliate), Board member, and President.

**SEENA L. HAINES, Pharm.D., BCACP, BC-ADM, CDE, FASHP, FAPhA** ([shaines@umc.edu](mailto:shaines@umc.edu)) is Professor and Chair, Department of Pharmacy Practice at the University of Mississippi School of Pharmacy. Prior, she served as Professor and Associate Dean for Faculty at Palm Beach Atlantic University (PBA) School of Pharmacy.

Haines received over \$750,000 for creation of Integrated Pharmacotherapy Services™ (a pharmacist-run, primary care, indigent clinic for the underserved). She was pharmacy director at four community health centers for seven years. Haines served as co-director of the Diabetes Education and Research Center for three years. She established the PBA ASHP-accredited Pharmacy Practice Residency (PGY1) through 2014. Other achievements include ambulatory care board certification, certified diabetes educator, board certified in advanced diabetes management, Preceptor of Distinction, Hero in Medicine, and inaugural AACP Academic Leadership Fellow.

Haines was Director-at-Large for the ASHP Section of Ambulatory Care Practitioners through 2012 and Chair (2012-2014).

**NISHAMINY (NISH) KASBEKAR, B.S., Pharm.D., FASHP** ([kasbekan@uphs.upenn.edu](mailto:kasbekan@uphs.upenn.edu)) is the Corporate Director of Pharmacy, University of Pennsylvania Health System and the Director of Pharmacy, Penn Presbyterian Medical Center in Philadelphia, PA.

Kasbekar completed a B.S. in Pharmacy and Pharm.D. degrees at the Philadelphia College of Pharmacy and Science and an ASHP-accredited PGY1 Pharmacy Practice Residency and PGY2 Infectious Diseases Residency at the Hospital of the University of Pennsylvania in Philadelphia. Kasbekar began her career as a Clinical Specialist in Infectious Diseases and has focused her career in advancing pharmacy practice through using her clinical background to implement new collaborative practice models.

Kasbekar has served pharmacy organizations as a Past President of PSHP, Chair of the UHC Practice Advancement Committee, and ASHP service as Chair of the Council on Pharmacy Practice, SAG for Pharmacy Practice Managers, Women in Pharmacy Leadership Steering Committee, and as a delegate to the House of Delegates.

**BOARD OF DIRECTORS (continued)**

**LINDA S. TYLER, Pharm.D., FASHP** ([Linda.Tyler@hsc.utah.edu](mailto:Linda.Tyler@hsc.utah.edu)) is the Chief Pharmacy Officer for University of Utah Health Care in Salt Lake City, UT. Prior to assuming the senior pharmacy leader responsibilities, she was director of the Drug Information Service (DIS). Prior to coming the University of Utah, she was a poison control center specialist at the now Nationwide Children’s Hospital and a critical care specialist at University of Wisconsin.

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# House of Delegates

## Board of Directors Report on Policy Recommendations from ASHP Councils

April 11, 2016

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# COUNCIL ON THERAPEUTICS: POLICY RECOMMENDATIONS

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*The Council on Therapeutics is concerned with ASHP professional policies related to the safe and appropriate use of medicines. Within the Council's purview are (1) the benefits and risks of drug products, (2) evidence-based use of medicines, (3) the application of drug information in practice, and (4) related matters.*

Timothy R. Brown, *Board Liaison* (Ohio)

## **Council Members**

Daniel Rackham, *Chair* (Oregon)  
Pamela Phelps, *Vice Chair* (Minnesota)  
Karen Berger (New York)  
Elizabeth Greenhalgh (Illinois)  
Thomas Lupton, *New Practitioner* (California)  
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Amy Sipe (Missouri)  
Kelsey Stephens, *Student* (Mississippi)  
Jodi Taylor (Tennessee)  
Stacey Voils (Florida)  
Shekhar Mehta, *Secretary* (Maryland)

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## **1. Stewardship of Drugs with Potential for Abuse**

- 1 To encourage stewardship of drugs with potential for abuse; further,
- 2 To facilitate the development of best practices for prescription drug monitoring
- 3 programs and drug take-back disposal programs for drugs with potential for abuse.

### **Rationale**

Drug abuse in the U.S. has reached epidemic proportions. In 2011, 110 people died every day from drug poisonings, and prescription drugs were involved in 41,300 deaths. According to the [CDC](#), almost 5% of the U.S. population over 12 years used opioid pain relievers for non-medical reasons in 2010. The CDC estimates the cost to insurance companies to be 70 billion annually. The Centers for Disease Control and Prevention (CDC) and White House continue to prioritize drug abuse issue as a national concern. SAMHSA has released a toolkit on opioid overdose, and state prescription drug monitoring programs are increasingly sharing information among states. In 2013, ASHP and others successfully advocated for the rescheduling of hydrocodone combination products due to safety concerns. ASHP has also [advocates broader access to naloxone for opioid reversal](#) as part of the nation's collective efforts to reduce harm from drugs of abuse.

Drugs of abuse consist of a variety of classes of medications and are not limited to opioids, however. The Substance Abuse and Mental Health Services Administration (SAMHSA) acknowledges that drugs of abuse include sedatives, stimulants, and antidepressants, in addition to opioids. Despite their risk for abuse, prescription medications for short-term symptomatic reliefs are often refilled well beyond recommended treatment time periods. Counseling on chronic long-term therapy is important for those prescribed these drugs, which may require well-planned titration schedules for safe and effective discontinuation. Patients may not have sufficient information on discontinuation of therapy and disposal of agents.

Encouraging stewardship of and disseminating information on use of these drugs, especially those with narrow therapeutic indices, will reduce ill effects and patient harm.

### **Background**

Council members reviewed the [White House Initiative on Prescription Drug Abuse](#) and [National Drug Control Strategy](#). The Council discussed the concept of [corresponding responsibility](#), which can permit the Drug Enforcement Administration (DEA) to limit a pharmacy's inventory if the DEA suspects its pharmacists are not adhering to due diligence in reviewing opioid prescriptions. Council members noted there is a large disconnect between prescribers and the DEA.

The Council acknowledged that drug abuse is broader than simply opioid abuse. Council members noted that methylphenidate, amphetamines, and pregabalin are commonly abused in ambulatory care settings, and diversion of those drugs is a significant concern. The Council observed that components of strategies to discourage drug abuse include education of patients and family members, as well as proper disposal methods for controlled substances. The Council believed educating patients on risks could help decrease abuse, and that this education is an important opportunity for ambulatory care pharmacy practice. The Council considered mechanisms to discourage abuse, such as stewardship of medications. The Council noted that many studies on relief of low back pain showed no significant difference between opioids and non-narcotic agents and emphasized the importance of re-evaluation of patients on both short- and long-term therapy. Council members recognized the value of programs for stewardship of opioids and other drugs of abuse.

Ultimately, the Council concluded that it is important for leadership groups in ASHP (e.g., councils, the Section of Ambulatory Care Practitioners, and others) to collaborate internally and externally to educate vested parties and develop resources on stewardship and disposal of controlled substances and drugs of abuse. The Council suggested developing best practices and tools on assessment, prescription drug monitoring, and drug take-back programs, and stewardship of drugs with potential for abuse.

## **2. Appropriate Use of Antipsychotic Drug Therapies**

- 1 To advocate for the documentation of appropriate indication and goals of therapy to
- 2 promote the judicious use of antipsychotic drugs and reduce the potential for harm;
- 3 further,
  
- 4 To support the participation of pharmacists in the management of antipsychotic drug
- 5 use, which is an interdisciplinary, collaborative process for selecting appropriate drug
- 6 therapies, educating and monitoring patients, continually assessing outcomes of
- 7 therapy, and identifying appropriate discontinuation; further,
  
- 8 To advocate that pharmacists lead efforts to prevent inappropriate use of
- 9 antipsychotic drugs, including engaging in strategies to detect and address patterns
- 10 of use in patient populations at increased risk for adverse outcomes.

**Rationale**

Antipsychotic drugs are often prescribed and continued in nursing homes after transition from other care settings without appropriate justification. Although there is currently no FDA-approved drug for behavioral and psychological symptoms of dementia (BPSD), antipsychotic drugs are consistently used off-label for BPSD. According to the Agency for Healthcare Research and Quality, there is medium-level evidence to suggest effectiveness of olanzapine, risperidone, and quetiapine to reduce agitation and behavioral disturbances for people with dementia. Some nursing homes are turning away patients with these conditions because of changes to the [CMS Five-Star Quality Rating System](#) for nursing homes, which includes two quality measures on antipsychotic drug use. These quality measures exclude patients with schizophrenia, Huntington's disease, and Tourette syndrome.

Antipsychotic drugs have a black-box warning for increased mortality in the elderly population. In certain patients there is a benefit for use, and these patients may require more intense monitoring and assessment. Some studies suggest a significant increase in cognitive function for Alzheimer's patients with aggressive behavior (Vigen 2011). Another study (Bonner 2015) looked at rationales for prescribing and found vague, generalized indications such as anger and agitation, which is not appropriate, according to guidelines. Nonpharmacological interventions are also supported in managing BPSD. These interventions may be more appropriate in the elderly population, despite being time consuming and labor-intensive.

**Background**

Council members described the current issues surrounding antipsychotic drug use and associated risks in the elderly population. For some drugs there are substantial risks of cardiovascular effects, such as QT interval prolongation for quetiapine. The Council acknowledged the continued work on revising the [ASHP Therapeutic Position Statement Use of Second-Generation Antipsychotic Medications in the Treatment of Adults with Psychotic Disorders](#). Council members felt this document primarily focused on classes of drugs, and there would be significant gaps in the statement if it were to cover the topic of use in long-term care settings. Some of the topics necessary would include documentation of goals of therapy, dose-reduction strategies, and communication across the continuum of care. The Council discussed how CMS standards may affect patients' admissions to nursing homes. The Council also discussed discontinuation of therapy for conditions originating in acute care settings, such as therapy for intensive care unit (ICU) delirium.

Council members reviewed a policy position from the American Society of Consultant Pharmacists (ASCP) that suggested support of appropriate use when clinically indicated and safe for the elderly population. Council members valued the importance of documenting goals and acknowledged specific rules and regulations associated with long-term care settings, such as requirements for indications for all medications. Council members were also concerned about inappropriately discontinuing medication at transitions in points of care.

### 3. Safety of Epidural Steroid Injections

- 1 To encourage healthcare providers to 1) inform patients about the significant risks
- 2 associated with epidural steroid injections, and 2) request their informed consent;
- 3 further,
- 4 To encourage healthcare organizations to prevent adverse events related to epidural
- 5 steroid injections by having pharmacists involved in the development of protocols that
- 6 promote the safe use of such injections.

#### **Rationale**

Use of epidural steroid injections to treat low back pain is increasing, despite not being a labeled indication and sparse literature confirming the safety and efficacy of the treatment. These drugs, in this route of administration, have narrow therapeutic indices, and there are quality assurance issues related to the compounding of the preparations used in epidural injections. The safety of epidural steroid injections has been referred to in the [FDA Safe Use Initiative](#) (SUI), in which 13 stakeholders were involved in assessing evidence of neurological complications of injections. Several recommended practices resulted, including a [controversial](#) preference for nonparticulate steroid injections for use in cervical transforaminal injections. In addition to the concerns about particulates in the injections, there are very significant safety concerns due to the proximity of intrathecal, epidural, and subdural spaces and how the injections are administered. Skillful technique is required to appropriately administer these drugs. Radiographic contrast is often used to guide the needle to injection sites. Improper technique can cause vasospasm and stroke, which is not related to particulates in the injection.

In April 2014 the FDA released a [drug safety communication](#) stating that rare and serious neurological effects can result from epidural steroid injections. The safety communication noted that “the effectiveness and safety of epidural administration of corticosteroids have not been established, and FDA has not approved corticosteroids for this use” and recommended that healthcare providers “discuss with patients the benefits and risks of epidural corticosteroid injections and other possible treatments.” ASHP concurs with those recommendations and encourages use of an informed consent process in addition to other institutional protocols to promote the safe use of epidural steroid injections.

#### **Background**

The Council discussed the compounding practices associated with epidural steroid injections as well as the prevalence of use for low back pain. The Council noted that millions of injections are administered each year in outpatient settings, often without pharmacist oversight or verification. These injections are covered by Medicare, but there is not an efficient and mandatory process for reporting adverse events. Council members stated that some insurers require patients to fail therapy with steroids before approving coverage for surgery. It was noted that cervical injections are the type most associated with adverse events, but one Council member stated that there is limited data and conclusions cannot be drawn on safety. Council members agreed on a need to focus on patient-specific assessment prior to therapy.

The Council also discussed the compounding practices associated with epidural steroid injections. The Council reviewed a 2015 [commentary](#) (Manchikanti and Falco, Pain Physician 18: E129-38) that criticized the development of the FDA SUI practices. The authors of that commentary pointed out that the group of experts representing stakeholders was different from those originally selected, the FDA SUI group had not achieved consensus on the recommendations, and the American Society of Interventional Pain Physicians left the group in 2013. The authors of the commentary also stated that no rigorous studies have been done to compare the safety of particulate and nonparticulate injections and that the FDA SUI neglected deaths associated with dexamethasone epidural injections.

Ultimately, the Council concluded that institutional support in the form of protocols is necessary to address the safety concerns associated with epidural steroid injections and that ASHP also needs to advocate for pharmacists involvement in the medication-use process associated with epidural steroid injections.

#### 4. Drug Dosing in Renal Replacement Therapy

- 1 To encourage research on the pharmacokinetics and pharmacodynamics of drug
- 2 dosing in renal replacement therapy; further,
  
- 3 To support development and use of standardized models of assessment of the
- 4 pharmacokinetics and pharmacodynamics of drug dosing in renal replacement
- 5 therapy; further,
  
- 6 To collaborate with stakeholders in enhancing aggregation of data on the
- 7 pharmacokinetics and pharmacodynamics of drug dosing in renal replacement
- 8 therapy.

#### **Rationale**

There are few resources and recommendations for drug dosing in patients receiving forms of renal replacement therapy. Appropriate dosing is a very important issue to optimize patient outcomes and achieve goals of therapy. Often, drug properties are used to make educated guesses on appropriate dosing and are based on estimations of clearance. In the critically ill population, serious infections and renal issues often occur simultaneously. Solute removal has a significant impact on dosing and appropriate dosing. Many patient characteristics and device variables need to be considered when dosing patients undergoing renal replacement therapy. These factors include flow rate, membrane pore size, volume of distribution, and patient status. Protein binding helps sustain the drug in tissue, and drugs with a large molecular weight may clog the porous membranes.

#### **Background**

The Council discussed the specific definitions of *continuous renal replacement therapy*, *renal replacement therapy*, and *hemodialysis* and why the general term *renal replacement therapy* is

preferred. The Council also discussed the lack of information and guidance on dosing medications for renally compromised patients. Council members questioned whether end-stage renal disease dosing should be used as basis for patients with acute kidney injury if no other information is available. Bennet's renal dosing reference was mentioned as a guide. *Drug Prescribing in Renal Failure* (5th ed., Brier and Aronoff) is also available, and there is some gray literature on the topic.

Characteristics of effluents play a significant role in drug dosing. [Kidney Disease: Improving Global Outcomes \(KDIGO\) guidelines](#) attempt to calculate a sieving coefficient for agents. Council members recognized that European Medicines Agency has also been working on the issue. Some Council members mentioned that PhRMA might be aggregating data on drug dosing for specific medications but that this data may be proprietary and protected. Some members considered post-approval predictive modeling using tissue tests such as those for QT interval prolongation. One member stated that education at the college of pharmacy level is not done appropriately and often is overwhelming for students. Council members agreed that this topic is highly specialized.

Ultimately, the Council acknowledged that institution-specific guidelines are very valuable because of the differences in flow rates and effluents of renal replacement therapy. Not all institutions would have the resources for renal replacement therapy, and there are usually two or three different dialysis modes. The Council supported education and collaborative development of practice recommendations. Michael Blantly and Chris Bland were mentioned as experts on drug dosing in renal replacement therapy. The Council also felt development of educational programming should include chronic care issues and pearls of renal replacement therapy, including caveats to extracorporeal membrane oxygenation (ECMO).

## 5. Use of Methadone to Treat Pain

- 1 To acknowledge that methadone has a role in pain management and that its
- 2 pharmacologic properties present unique risks to patients; further,
- 3 To oppose the use of methadone as a preferred treatment option for acute and
- 4 chronic pain; further,
- 5 To advocate that all healthcare practitioners who prescribe or dispense methadone
- 6 complete a standardized educational program specific to the drug; further,
- 7 To advocate that pain management experts, payers, and manufacturers collaborate
- 8 to provide educational programs for healthcare professionals on treating acute and
- 9 chronic pain with opioids, including methadone; further,
- 10 To advocate that all facilities that dispense methadone, including addiction
- 11 treatment programs, participate in state prescription drug monitoring programs.

**Rationale**

Over 16,000 people die each year in the U.S. from opioid overdose. Although methadone accounts for only two percent of opioid prescriptions each year, it is estimated to be responsible for over one third of overdose deaths, according to a 2012 Mortality and Morbidity Weekly Report (MMRW) Vital Signs report. The use of methadone to treat pain and its contribution to overdose deaths is an urgent public health concern.

Methadone was approved in 1947 as an analgesic and antitussive, and in 1972 it received approval for use in treating opioid addiction. In 1995, over 100,000 people in the U.S. received addiction treatment with methadone.

There are significant risks associated with the use of methadone for pain management because of its pharmacokinetic and pharmacodynamic properties. Methadone has a long half-life and short duration of analgesic effect. The respiratory effects last longer, and there is also a risk of QT interval prolongation. In 2006, the FDA released a medication safety alert on the dangers of methadone use for the treatment of pain that included a black-box warning and increased the recommended dosing interval from 3 to 8 hours. In 2008, the Drug Enforcement Agency requested manufacturers to restrict distribution of high-dose formulations to addiction treatment programs and hospitals. Federal regulations restrict the dispensing of methadone; for example, dispensing for opioid addiction treatment is limited to programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and for emergency situations to bridge patients to a treatment program.

Despite these dangers, 30 state Medicaid programs include methadone on the preferred drug list for treatment of pain, primarily due to its low cost. The Centers for Disease Control and Prevention (CDC) has recommended that insurance companies and other payers remove methadone from the preferred lists for treating noncancer pain. Several organizations and federal agencies have recommended against the use of methadone as a first-line agent to treat pain, including the FDA, CDC, the American Academy of Pain Medicine (AAPM), and the American Society of Interventional Pain Physicians. In May 2015, the Energy and Commerce Committee of the U.S. Senate held a hearing to assess what the federal government is doing to combat the opioid abuse epidemic and identified use of methadone for treatment of pain as a concern.

ASHP joins AAPM in advocating that all healthcare practitioners who prescribe methadone complete an educational program specific to the drug, and that pain management experts, payers, and manufacturers collaborate to provide educational programs on best practices for prescribing opioids, including methadone.

**Background**

ASHP has a long history of advocating for the safe and appropriate use of opioids in pain management (e.g., ASHP policy 1106, Pain Management). The Council reviewed existing evidence on the detriments and negative sequelae associated with methadone use for the treatment of pain. The Council felt that ASHP needed a policy that recognizes the risks of using methadone to treat pain and advocates for best practices for methadone use, including education of healthcare providers involved in its use. The Council discussed the unique pharmacologic properties of methadone that contribute to unintentional overdose, such as a respiratory effect that outlasts the analgesic effects and a longer half-life. The Council noted that several organizations, government and private, have policies that discourage use for

methadone as a first-line agent in treating pain. There is significant support in the healthcare community for restricting such use and removing methadone from preferred drug lists for health insurance plans and state Medicaid programs. The Council concluded that education of providers is a key component of influencing inappropriate use and morbidity associated with methadone.

Although the Council concluded that methadone is not a preferred agent for treatment of acute or chronic pain, it recognized that there are specific and rare cases for which use is warranted, such as cancer patients. The Council agreed that a successful pain management plan incorporating methadone should not be altered. The Council also recognized that methadone should not be used for pain management by patients prone to drug abuse or on multiple agents such as benzodiazepines and other sedatives.

The Council was cognizant of the danger of increasing barriers to the appropriate use of methadone in addiction treatment programs. The Council noted that addiction treatment programs are well regulated and that in such controlled environments there are fewer opportunities for negative outcomes. Procedures for administering methadone to treat opioid addiction are rigorous. Patients are allotted an amount of oral liquid that is visibly swallowed at dispensing so that opportunities for diversion and abuse are reduced. Similar barriers are not present when oral methadone is prescribed, dispensed, and administered to treat pain.

Council members also noted that methadone is not required to be submitted to prescription drug monitoring programs but did not feel that language advocating for such a requirement would be an appropriate addition to the policy recommendation at this time.

## 6. Therapeutic Indication of Prescribing

- 1 To advocate that healthcare organizations optimize use of clinical decision support
- 2 systems by structuring them to include the indication for high-risk and problem-prone medications.
- 3

### **Rationale**

Several well-known studies have demonstrated reductions in wrong-patient errors and adverse events with the inclusion of indication on the prescription order. In 2010, Equale<sup>1</sup> described the accuracy of indication information in electronic health records (EHRs). Galanter<sup>2</sup> focused on preventing wrong-patient medication errors with the use of indication-based prescribing. Indication-based alerts resulted in an interception rate of 0.25 interceptions per 1000 alerts. One investigator conducted a trial of inpatient indication-based prescribing using computerized provider order entry (CPOE) with medications commonly used off-label.<sup>3</sup> In a 60-day trial

<sup>1</sup> Equale T, Winslade N, Hanley JA et al. Enhancing pharmacovigilance with systematic collection of treatment indication in electronic prescribing. *Drug Saf* 2010;33: 559-67.

<sup>2</sup> Galanter W, Falck S, Burns M, et al. Indication-based prescribing prevents wrong-patient medication errors in computerized provider order entry (CPOE). *J Am Med Inform Assoc*. 2013;20:477-81.

<sup>3</sup> Walton SM, Galanter WL, Rosencranz H, et al. A trial of inpatient indication based prescribing during computerized order entry with medications used off-label. *Appl Clin Inf*. 2011;2:94-103.

documenting indications in the CPOE system for lansoprazole, intravenous immune globulin, and recombinant Factor VII, the accurate diagnosis rates after validation by a clinician were 9, 16, and 24 percent, respectively. In a study in the *Joint Commission Journal on Quality and Patient Safety*, investigators tracked a total of 140,755 medications filled by pharmacy technicians over a seven-month period in an academic institution. A total of 5,075 (3.6%) contained errors, and 1,059 contained an error that was not detected by the hospital pharmacist. Just over 23 percent of the undetected errors were potential adverse drug events.<sup>4</sup> Addressing these errors can have a large public health impact. Off-label prescription medication use without strong scientific evidence has also been associated with increased rates of adverse drug events, according to an article in *JAMA Internal Medicine*.<sup>5</sup> The authors suggested that use of the electronic health record (EHR) and proper documentation of therapeutic indication can help improve surveillance and safety and decrease risk.

In several countries, including Canada and Spain, the EHR includes indication as part of comprehensive documentation. ASHP first developed official policy on the importance of pharmacists' access to indications in 1993. In 1996, the National Coordinating Council for Medication Error Reporting and Prevention recommended including the purpose of prescription orders because of concerns about safety, unless considered inappropriate by the prescribers. In 1999, the Institute for Safe Medication Practices recommended including the purpose of prescribing on all written orders. In 2004, the National Association of Boards of Pharmacy (NABP) approved a resolution encouraging national and state medical associations to support legislative and regulatory efforts to require prescribers to include indications for all oral, written, and electronically transmitted prescriptions. In 2012, the United States Pharmacopeia made amendments to the standards for prescription container labeling to include "purpose-for-use" language. In 2015, the National Council of Prescription Drug Plans drafted language to recommend diagnosis and SNOMED indication be sent with any prescription.

A project funded by the National Institutes of Health (NIH) project in collaboration with the Agency for Healthcare Research and Quality is underway to assess, evaluate, and make recommendations on optimal communication of the purpose of prescribing. The goal of the project is to improve prescribing safety by redesigning CPOE to incorporate the medication indication into the prescription order. ASHP is a primary partner in this initiative, and almost 100 organizations have already joined the effort. Three phased goals are expected from this project. Phase one consists of a series of webinars. Phase two consists of the development of a white paper that outlines and specifies best practices and ideas obtained from the workgroups and webinars. Finally, phase three consists of the creation of simulated models of ideal systems that can reduce harm and increase efficiency. This project will focus on six domains: medication error prevention and mitigation, facilitating patient education, promoting prescribing drugs of choice, enhanced team communication, organizing the medication list for medication reconciliation, and enabling comparative outcomes research.

### **Background**

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<sup>4</sup> Cina JL, Gandhi TK, Churchill W, et al. How many hospital pharmacy medication dispensing errors go undetected? *Joint Commission Journal on Quality and Patient Safety* 2006; 32:73-80.

<sup>5</sup> Egualé T, Buckeridge DL, Verma A, et al. Association of off-label drug use and adverse drug events in an adult population. *JAMA Internal Medicine* 2016; 176:55-63. doi:10.1001/jamainternmed.2015.6058.

The Council reviewed several studies related to prevention of harm and usefulness of requiring indication in computerized provider order (CPOE) systems. The Council considered ASHP policy 0305, Expression of Therapeutic Purpose of Prescribing, and concluded that there may be significant gaps in the policy, which reads:

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

Electronic prescribing has a prominent role that the current policy may not address. The Council focused on the importance of drug-disease and drug-drug interactions with listed indications. One Council member noted that the Iowa Board of Pharmacy proposed legislation and has made this issue a priority and steppingstone for provider status. Some Council members have implemented programs in their practice sites on high-risk and problem-prone medications, such as antibiotics, oral chemotherapy, and anticoagulants. Several Council members stated that they have used required indications for specific drug classes such as pain medication and for first doses. However, members also noted that compliance and validating accurate information was also a concern. Some Council members acknowledged that this policy would help support autonomy for practices such as discontinuing unnecessary medications by pharmacists after medication reconciliation. Council members noted that in many of the studies they reviewed, significantly fewer pharmacist interventions were needed on electronic prescriptions when indications were included. Council members also noted the importance of indication in documentation on admission to the hospital and as one component of medication reconciliation. One Council member noted from a recent project implementing CPOE in a critical care setting that physicians would bypass the proper procedure to document indication in efforts to get to the final order screen, often entering non-valid indications.

In general, the Council felt that most adverse events occur due to faulty communication and that education is the key to improving rates of adverse events. There are existing ASHP Guidelines on Pharmacy Planning for Implementation of CPOE Systems in Hospitals and Health-Systems. The Council members emphasized the importance of having the same process work with and across all systems in both inpatient and outpatient settings. There continues to be the potential for harm when prescribers select the wrong indication. There is significant evidence demonstrating financial incentives and savings attributable to correct selection of medications, specifically for antibiotics (i.e., correct duration of therapy). From an implementation perspective, the Council felt that high-risk and problem-prone medications warrant an extra level of review and would benefit from inclusion of indication on the prescription order. There are numerous contributing complexities based on billing codes and EHR caveats, and Council members agree the Section on Pharmacy Informatics could provide needed insight and be integrally involved in initiatives about documentation of indications for prescribing in health systems.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing ASHP policies, the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- [Universal Influenza Vaccination](#) (0601)
- [Minimum Effective Dose](#) (0602)
- [Agricultural Use of Hormone and Prohormone Therapies](#) (1102)
- [Direct to Consumer Clinical Genetic Tests](#) (1103)
- [Pharmacogenomics](#) (1104)
- [Safe and Effective Use of IV Promethazine](#) (1105)
- [Pain Management](#) (1106)
- [Patient-Reported Outcomes Tools](#) (1107)

## Other Council Activity

### CPIC Guidelines

The Council voted to recommend endorsement of the CPIC Guidelines on CYP2D6 and CYP2C19 genotypes and dosing of tricyclic antidepressants. The Council also voted to recommend endorsement of the CPIC Guidelines on CYP2D6 and CYP2C19 genotypes and dosing of selective serotonin reuptake inhibitors.

The Council reviewed two [Clinical Pharmacogenomics Implementation Consortium](#) guidelines. The Council acknowledged that the development of these recommendations closely adheres to Institute of Medicine recommendations on developing rigorous and trusted clinical practice guidelines. The Council appreciated the focus on interpretation of genetic tests rather than appropriateness of testing. Previous councils have found value in this type of guidance to aid in practice.

Tricyclic use is decreasing for psychological disorders because of side effects and is increasing for pain management. Genes for the CYP2D6 enzyme are very polymorphic, which creates variability in the level of pharmacokinetic effects. There are 30 subvariants identified for CYP2C19. This document provides scoring of activity for the diplotype of the cytochrome alleles. Phenotypes are then provided and classified as poor metabolizers, intermediate metabolizers, or extensive metabolizers. There is substantial evidence linking CYP2D6 and CYP2C19 genotypes to phenotype variability in side effects and pharmacokinetic profiles of tricyclics and selective serotonin reuptake inhibitors (SSRIs).

The CPIC guidelines for tricyclic antidepressants use amitriptyline and nortriptyline as a model but they suggest applying recommendations to others tricyclic antidepressants (e.g., clomipramine, desipramine, doxepin, imipramine, and trimipramine). The CPIC guidelines on CYP2D6 and CYP2C19 genotypes and dosing of selective serotonin reuptake inhibitors also suggest dose alterations based on phenotype. Supplemental evidence provides pharmacotherapy recommendations for paroxetine, fluvoxamine, citalopram, escitalopram,

and sertraline. The FDA suggests that fluvoxamine should be used cautiously in patients with reduced levels of CYP2D6 activity. For poor metabolizers of substrates for CYP2C19, an alternate SSRI is recommended. Clinical decision support tools can also be found in the supplement with additional information. The Council unanimously voted to recommend endorsement of these guidelines by ASHP.

## Testosterone Replacement Therapy

The Council voted to develop an ASHP therapeutic position statement on the safe and appropriate use of testosterone therapy. The Council acknowledged that the forthcoming results of the National Institutes of Health [Testosterone Trial](#) would provide additional evidence on the risks associated with testosterone replacement therapy. The Council considered the value of additional educational resources on appropriate use, such as confirmed assessment through repeat serum levels taken in the morning. Council members provided their institutional appropriate-use protocols and discussed broader aspects, such as off-label use policies.

Council members agreed that guidance on appropriate therapy would be beneficial to ASHP members and other practitioners. One member also suggested education directed toward patients and family members regarding safe handling and the lack of data on long-term use. Council members had several other suggestions for topics to be addressed in the guidance, including conversions among agents, initiation of therapy, and safety precautions for contact with family members. It was also noted that the current Endocrine Society guidelines do not address transgender patients.

## Pharmacist's Role in the Use of Biosimilars

The Council voted to develop an ASHP statement on the pharmacist's role in the use of biosimilars. The Council discussed the classification of agents as biosimilars, interchangeable biosimilars, and associated impacts on practice and potential drug acquisition and distribution costs. Council members discussed Europe's 10-year history with biosimilar availability, the [Biologics Price Competition and Innovation Act of 2009](#), and [associated FDA guidance](#), and the fact that biologics inherently have variability in make-up and effects on patients.

The Council considered the potential studies needed to characterize an agent as interchangeable with the reference biologic. The delineation between a biosimilar and interchangeable biosimilar can potentially be very narrow. There are significant safety concerns associated with biologics themselves because of the methods of manufacturing and lot-to-lot variability. All of these characteristics can affect immunogenicity. Council members discussed instances of delayed immune responses, such as red cell aplasia.

The Council acknowledged the parallel discussion by the Council on Public Policy on biosimilar naming and labeling requirements. Council members discussed the draft [2012 FDA guidance that provides factors for assessing biosimilarity](#). Manufacturers are required to submit pharmacovigilance plans as part of their marketing application. Members considered how use of the agents is moving toward outpatient settings and primary care.

The Council discussed the potential value of a formulary assessment tool for biosimilar amino acid comparability. Ultimately, the Council supported developing an ASHP statement on the pharmacist's role in the use of biosimilars and acknowledged that outcomes are specific to each individual product.

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# COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT: POLICY RECOMMENDATIONS

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*The Council on Education and Workforce Development is concerned with ASHP professional policies related to the quality and quantity of pharmacy practitioners in hospitals and health systems. Within the Council's purview are (1) student education, (2) postgraduate education and training, (3) specialization, (4) assessment and maintenance of competence, (5) credentialing, (6) balance between workforce supply and demand, (7) development of technicians, and (8) related matters.*

Donald E. Letendre, Board Liaison (Iowa)

## **Council Members**

Kim Jones, *Chair* (Tennessee)  
Meghan Swarthout, *Vice Chair* (Maryland)  
Kevin Anderson, *Student* (North Carolina)  
Nicole Clark (Massachusetts)  
Joseph DiPiro (Virginia)  
Rachael Fleagle, *New Practitioner* (Wisconsin)  
Patricia Knowles (Georgia)  
Richard Montgomery (Florida)  
Mark Sinnott (New York)  
Allison Vecchiet (Ohio)  
Lanita White (Arkansas)  
Whitney White (Alabama)  
JoAnn Harris, *Secretary* (Maryland)

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## **1. Pharmacy Technician Training and Certification**

- 1 To advocate that Pharmacy Technician Certification Board (PTCB) certification be
- 2 required for all pharmacy technicians; further,
  
- 3 To advocate that all pharmacy technicians maintain PTCB certification; further,
  
- 4 To support the position that by the year 2020, the completion of a pharmacy
- 5 technician training program accredited by ASHP and the Accreditation Council for
- 6 Pharmacy Education (ACPE) be required to obtain PTCB certification for all new
- 7 pharmacy technicians; further,
  
- 8 To foster expansion of ASHP-ACPE accredited pharmacy technician training
- 9 programs.

(Note: This policy would supersede ASHP policy 1519.)

### **Rationale**

The partnership between ASHP and the Accreditation Council for Pharmacy Education (ACPE) to accredit pharmacy technician training programs could be an important inflection point leading to profession-wide support for uniform education, training, and credentialing of pharmacy technicians. Such broad support may stimulate more uniform state statutes and regulations

regarding pharmacy technicians. The requirement that pharmacy technicians be graduates of ASHP-ACPE accredited training programs to be certified by the Pharmacy Technician Certification Board (PTCB) mirrors the profession's approach to the education (first) and licensure (second) of pharmacists. Consistent with this model, PTCB will, in 2020, require that an individual sitting for the pharmacy technician certification examination be a graduate of an ASHP-ACPE accredited training program. Although programs currently accredited by ASHP will be granted the joint accreditation, the anticipated increase in demand for enrollment in ASHP-ACPE accredited training programs will require an expansion of the number and distribution of such programs.

### **Background**

The Council voted to recommend amending ASHP policy 1519, Pharmacy Technician Training and Certification, as follows (underscore indicates new text; ~~striketrough~~ indicates deletions):

To advocate that Pharmacy Technician Certification Board (PTCB) certification be required for all pharmacy technicians; further,

To advocate that all pharmacy technicians maintain PTCB certification; further,

To support the position that by the year 2020, the completion of a pharmacy technician training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required to obtain PTCB ~~Pharmacy Technician Certification Board~~ certification for all new pharmacy technicians ~~entering the workforce~~; further,

To foster expansion of ASHP-ACPE accredited pharmacy technician training programs.

The policy recommendation proposed by the 2014 Council that became policy 1519 was specifically intended to require *maintenance* of certification. In the amendment adopted by the 2015 House of Delegates, the requirement for maintenance was deleted. A 2015 House of Delegates recommendation suggested that the Council reconsider the addition for a requirement of maintenance of certification. The 2015 Council discussed the issue and there was strong consensus that maintenance is an important aspect to pharmacy technician competence. The Council specifically restated the intent of the 2014 Council was for pharmacy technicians to maintain their certification throughout their careers. This intent is also consistent with the [ASHP Statement on the Roles of Pharmacy Technicians](#).

## 2. Career Opportunities for Pharmacy Technicians

- 1 To promote the image of pharmacy technicians as valuable contributors to healthcare
- 2 delivery; further,
  
- 3 To develop and disseminate information about career opportunities that enhances
- 4 the recruitment and retention of qualified pharmacy technicians; further,
  
- 5 To support pharmacy technician career advancement opportunities, commensurate
- 6 with training and education; further,
  
- 7 To encourage compensation models for pharmacy technicians that provide a living
- 8 wage.

(Note: This policy would supersede ASHP policy 0211.)

### **Rationale**

As the responsibilities of pharmacy technicians expand and their role as a vital member of the healthcare team is recognized, it is imperative that pharmacy technicians be well trained and competent to perform those responsibilities. Pharmacists cannot achieve their goals for quality patient care without the support of competent pharmacy technicians. To support pharmacists, it is important that pharmacy technician positions be viewed as a career option and not just a job. As such, pharmacy technicians should be given opportunities for life-long advancement and should be compensated a living wage to ensure that being a pharmacy technician is a viable career option. (For the purposes of this policy, a living wage is defined as one sufficient to provide the basic things, such as food and shelter, needed to live an acceptable life.<sup>6</sup>)

The median annual salary of pharmacy technicians in the U.S., \$29,320 in 2012, falls short by approximately \$5,000 per year of the median annual salaries for other health technologists and technicians.<sup>7</sup> Pharmacy technicians do not earn as much as dental hygienists (\$71,530) or radiologic technologists (\$56,760).<sup>8</sup> If a wage and benefits, commensurate with skills and responsibility, were paid to pharmacy technicians, the pharmacy profession could expect a better return on employee investment and reduced turnover rates. Improving wages and benefits would encourage workers to make a career of being a pharmacy technician and reinforce their vital role on the healthcare team.

### **Background**

The Council voted to recommend amending ASHP policy 0211, Image of and Career Opportunities for Pharmacy Technicians, as follows (underscore indicates new text):

<sup>6</sup> Merriam-Webster online ([http://www.merriam-webster.com/dictionary/living wage](http://www.merriam-webster.com/dictionary/living%20wage)).

<sup>7</sup> Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2014-2015 Edition, Pharmacy Technicians. <http://www.bls.gov/ooh/healthcare/pharmacy-technicians.htm> (accessed 2015 Jul 23).

<sup>8</sup> US News and World Report. Best Health Care Jobs 2015, Pharmacy Technician: Salary. <http://money.usnews.com/careers/best-jobs/pharmacy-technician/salary> (accessed 2015 September 8).

To promote the image of pharmacy technicians as valuable contributors to healthcare delivery; further,

To develop and disseminate information about career opportunities that enhances the recruitment and retention of qualified pharmacy technicians; further,

To support pharmacy technician career advancement opportunities, commensurate with training and education; further,

To encourage compensation models for pharmacy technicians that provide a living wage.

The Council agreed that ensuring pharmacy technicians a living wage was a more immediate issue than ensuring pharmacy technicians view their positions as a career with long-term opportunities, especially if ASHP advocates for licensure and certification.

In the retail setting, pharmacy technicians are compensated a median rate of \$13.50<sup>9</sup> per hour, which is less than those who work in health systems. The large chain pharmacies are concerned with salary increases and turnover rates and are not convinced that if they invest in their technicians they will be able to retain them.

To advance the image of pharmacy technicians, the Council also discussed whether pharmacy technician position descriptions within the health system reflect the training, duties, and increased level of responsibility expected of pharmacy technicians. It was suggested that ASHP, perhaps through the Section of Inpatient Care Practitioners Section Advisory Group on Advancing Pharmacy Practice with Technicians, could encourage directors of pharmacy to work with human resource departments to promote increased recognition for the pharmacy technicians' level of responsibilities, including a higher pay scale for certification. There was some discussion of including mention of potential career ladders in the proposed policy, but the Council concluded that the proposed language should be more broadly worded to encourage career advancement opportunities for pharmacy technicians.

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<sup>9</sup> Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2014-2015 Edition, Pharmacy Technicians, on the Internet at <http://www.bls.gov/ooh/healthcare/pharmacy-technicians.htm> (visited July 23, 2015)

### 3. Developing Leadership Competencies

- 1 To work with healthcare organization leadership to foster opportunities, allocate  
2 time, and provide resources for pharmacy practitioners to move into leadership  
3 roles; further,
- 4 To encourage leaders to seek out and mentor pharmacy practitioners in developing  
5 administrative, managerial, and leadership skills; further,
- 6 To encourage pharmacy practitioners to obtain the skills necessary to pursue  
7 administrative, managerial, and leadership roles; further,
- 8 To encourage colleges of pharmacy and ASHP state affiliates to collaborate in  
9 fostering student leadership skills through development of co-curricular leadership  
10 opportunities, leadership conferences, and other leadership promotion programs;  
11 further,
- 12 To reaffirm that residency programs should develop leadership skills through  
13 mentoring, training, and leadership opportunities; further,
- 14 To foster leadership skills for pharmacists to use on a daily basis in their roles as  
15 leaders in patient care.

(Note: This policy would supersede ASHP policy 1518.)

#### ***Rationale***

In their 2013 report, White and Enright anticipated a high rate in turnover of pharmacy directors and middle managers over the coming decade. Healthcare organizations must address this ongoing challenge if there are to be a sufficient number of new directors and managers to fill those positions. Factors that may contribute to a shortage of potential new leaders and managers include:

- New graduates frequently accept clinical positions or positions in drug distribution. After a few years, they may have a desire to assume managerial positions in health-system pharmacies, but training programs may not be convenient for them, and they may not have the resources to obtain training.
- Health-system pharmacy management positions do not turnover often. Prospective managers view those positions as unavailable for the near future, so there is little incentive to obtain training to be ready to move into those positions.
- Job satisfaction among pharmacy managers appears low to prospective managers.
- Frequent turnover in organizational administrative positions (above pharmacy) is frustrating to pharmacy directors, because they continually need to inform new

administrators about the organization's medication-use strengths and weaknesses and the pharmacy department's roles, strategic plans, and priorities for sustaining quality and making improvements. In those turnover circumstances, diligently achieved pharmacy service improvements can sometimes be eroded and reversed. The ensuing frustration can induce pharmacy directors to depart voluntarily from management positions and make those positions unattractive to others.

- Flattening of organizational structures in healthcare organizations has eliminated numerous managerial positions in pharmacies, leaving fewer pharmacists to serve as mentors for prospective managers. Without positive role models, it is difficult for pharmacists to gain good management experience.
- Pharmacy management positions that combine clinical and management responsibilities sometimes allow little time for clinical work.
- Many pharmacists, even those in managerial positions, have no training in personnel administration. Skills such as conflict resolution and negotiation are rarely taught in pharmacy curricula but are very important in leadership positions.
- In some healthcare organizations, managers receive raises predicated on overall organizational or departmental performance. However, the compensation of some staff may be based on individual performance. These differing bases can lead to instances in which the compensation of those supervised is higher than that of their managers. When that occurs, it can be a disincentive to individuals considering management positions.

Leadership and managerial potential in today's student pharmacists and new graduates is as high as it has ever been, but more effort is needed to nurture that potential and develop leadership and management skills in practice. Colleges of pharmacy, state associations, residency programs, and practitioners themselves need to foster the development of leadership and management skills. ASHP can help foster leadership competencies at all levels of practice through actions such as providing education about leadership and management roles, developing Web-based resources, and facilitating networking among leaders, managers, and those aspiring to such roles.

Leadership continues to be a critical area for development, as leadership is a necessary competency in the provision of patient care. There are multiple avenues available to pharmacists for leadership development and ASHP should take the lead in fostering this effort.

### **Background**

The Council voted to recommend amending ASHP policy 1518, Developing Leadership Competencies, as follows (underscore indicates new text):

To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for pharmacy practitioners to move into leadership roles; further,

To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,

To encourage pharmacy practitioners to obtain the skills necessary to pursue administrative, managerial, and leadership roles; further,

To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,

To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,

To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.

During the 2014 Regional Delegate Conferences, the Section of Pharmacy Practice Managers (SPPM) expressed concern with the proposed wording of the policy recommendation that became policy 1518 because they felt an important aspect related to development of opportunities to move into leadership roles was missing. The SPPM supported the policy recommendation; however, the Council agreed to review the newly approved policy to discuss whether revision was necessary.

The SPPM believed the training path for individuals who decide mid-career to pursue formal leadership positions may be less supported and structured than the paths for those who completed formal administrative residency training. The Council noted that ASHP and the ASHP Research and Education Foundation have a plethora of resources available for those interested in assuming leadership roles and that many other leadership training opportunities exist. The Council concluded that lack of time and financial support are significant barriers to individuals obtaining advanced leadership training. The Council decided that it was important that the policy encourage organizations to allocate time off from regular duties if needed as well as financial support for associated costs. The Council also reiterated that mentorship was a significant aspect of leadership development and an important component of this policy.

#### 4. Interprofessional Education and Training

- 1 To support interprofessional education as a component of didactic and experiential
- 2 education in Doctor of Pharmacy degree programs; further,
  
- 3 To support interprofessional education, mentorship, and professional development
- 4 for student pharmacists, residents, and pharmacists; further,
  
- 5 To encourage and support pharmacists' collaboration with other health professionals
- 6 and healthcare executives in the development of team-based, patient-centered care
- 7 models; further,
  
- 8 To foster documentation and dissemination of outcomes achieved as a result of
- 9 interprofessional education of healthcare professionals.

(Note: This policy would supersede ASHP policy 1014.)

#### ***Rationale***

Pharmacist involvement in team-based patient care improves medication-use safety and quality and reduces healthcare costs. For patient-care teams to be effective, they must possess unique skills that facilitate effective team-based interactions. Some pharmacists are exposed to team-based care models through interprofessional education and interaction with students of other disciplines when they are student pharmacists. Some colleges of pharmacy have very effective interprofessional didactic courses that include medical, pharmacy, nursing, and other health professional students. Additionally, most experiential rotations involve interaction with other members of the healthcare team and help students of all disciplines learn about the expertise of other team members. However, not all colleges and schools are effective in providing interprofessional education that facilitates team-based patient care. The reasons vary, but may include differences in teaching philosophies or a lack of access to other health professional schools at the university or campus.

The Hospital Care Collaborative (HCC) has described common principles for team-based care. The HCC principles recognize the knowledge, talent, and professionalism of all team members and support role delineation, collaboration, communication, and the accountability of individual team members and the entire team. The HCC principles note that collaboration of the healthcare team can lead to improved systems and processes that provide care more efficiently and result in better patient outcomes. The HCC states that current undergraduate and postgraduate professional education of team members is inadequate to promote true team functions.

ASHP believes that interprofessional education is important not only for student pharmacists but also throughout one's professional career. Similarly, it is important for other professionals on the team so that collaboration and synergistic relationships can develop. Failure to establish these collaborative working relationships early in one's career can result in

poor interactions in years to come. A positive working relationship, including interprofessional mentorship, with physicians and nurses is productive, while a bad working relationship can be counterproductive and devastating to all parties, including patients.

### **Background**

The Council voted to recommend amending ASHP policy 1014, Interprofessional Education and Training, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education, mentorship, and as a part of professional development for student pharmacists, residents, and pharmacists ~~y practitioners and to foster interprofessional collaboration to facilitate and promote programs that support this goal~~; further,

To encourage and support pharmacists' collaboration with other health professionals and healthcare executives in the development of team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of healthcare professionals.

The Council felt policy 1014 is still relevant but agreed new wording would strengthen the position. The Council acknowledged that interprofessional education and mentorship was important for the training of student pharmacists, residents, and pharmacists. The Council acknowledged the importance of mentorship and wanted to highlight the opportunities for interprofessional mentorship, which may not be thought of routinely. The Council reiterated its support for the HCC principles and suggested that ASHP should make members aware of their existence and seek ways to promote the adoption of team-based care by all hospitals.

## **5. Cultural Competency and Cultural Diversity**

- 1 To endorse the development of cultural competency of pharmacy educators,
- 2 practitioners, residents, students, and technicians; further,
- 3 To educate providers on the importance of providing culturally congruent care to
- 4 achieve quality care and patient engagement; further,
- 5 To advocate for an ethnically and culturally diverse workforce.

(Note: This policy would supersede ASHP policy 1414.)

### **Rationale**

The United States is rapidly becoming a more diverse nation. Culture influences a patient's belief and behavior toward health and illness. The representation of many of these diverse groups within the health professions is far below their representation in the general population. According to the Institute of Medicine, increasing racial and ethnic diversity among healthcare providers is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students.<sup>10</sup>

Cultural competence can significantly affect clinical outcomes. Research has shown that overlooking cultural beliefs may lead to negative health consequences.<sup>11</sup> According to the National Center for Cultural Competency, there are numerous examples of benefits derived from the impact of cultural competence on quality and effectiveness of care in relation to health outcomes and well-being.<sup>12</sup> Further, pharmacists can contribute to providing "culturally congruent care," which can be described as "a process of effective interaction between the provider and client levels" of healthcare that encourages provider cultural competence while recognizing that "[p]atients and families bring their own values, perceptions, and expectations to healthcare encounters which also influence the creation or destruction of cultural congruence."<sup>13</sup>

The underrepresentation of minorities among healthcare providers is often considered to be one of the contributing factors to health disparities in these populations.<sup>14</sup> The [Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence](#)<sup>15</sup> and the [ASHP Statement on Racial and Ethnic Disparities in Health Care](#)<sup>16</sup> support ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations.

### **Background**

The Council voted to recommend amending ASHP policy 1414, Cultural Competency and Cultural Diversity, as follows (underline indicates new text; ~~strike through~~ indicates deletions):

To ~~promote~~ endorse the development of cultural competency of pharmacy educators,

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<sup>10</sup>Smedley BD, Butler AS, Bristow LR, eds. In the nation's compelling interest: ensuring diversity in the health-care workforce. Washington, DC: National Academies Press; 2004.

<sup>11</sup>Administration on Aging. Achieving cultural competence. A guidebook for providers of services to older Americans and their families. Available at: <http://archive.org/details/achievingcultura00admi> (accessed October 17, 2013)

<sup>12</sup>Goode TD, Dunne MC, Bronheim SM. The evidence base for cultural and linguistic competency in health care. The Commonwealth Fund; 2006. Available [http://www.commonwealthfund.org/usr\\_doc/Goode\\_evidencebasecultlinguisticcomp\\_962.pdf](http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf) (accessed October 17, 2013)

<sup>13</sup>Schim SM, Doorenbos AZ. A Three-dimensional Model of Cultural Congruence: Framework for Intervention. *J Soc Work End Life Palliat Care*. 2010; 6:256–70.

<sup>14</sup>Smedley BD, Butler AS, Bristow LR, eds. In the nation's compelling interest: ensuring diversity in the health-care workforce. Washington, DC: National Academies Press; 2004.

<sup>15</sup>Report of the ASHP Ad hoc committee on ethnic diversity and cultural competence. *Am J Health-Syst Pharm*. 2005; 1924-30.

<sup>16</sup>[ASHP Statement on Racial and Ethnic Disparities in Health Care. Am J Health-Syst Pharm. 2008;65:728–33.](#)

practitioners, residents, students, and technicians; further,

To educate providers on the importance of providing culturally congruent care to achieve quality care and patient engagement; further,

~~To foster awareness of the impact that an ethnically and culturally diverse workforce has on improving health care quality.~~

To advocate for an ethnically and culturally diverse workforce.

A 2015 House of Delegates recommendation urged the Council to consider a policy to promote, support, and advocate for developing a diverse workforce and addressing gaps in healthcare including, but not limited to, race and ethnicity as well as other gaps, such as socioeconomic and literacy gaps. The Council reviewed related ASHP policies 1414 and 0510 and decided to recommend amending policy 1414. The Council felt it important to note that the [ASHP Statement on Racial and Ethnic Disparities in Health Care](#) complements the ASHP policy positions, so all three must be considered when determining whether new or revised policy is needed.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing ASHP policies, the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- [Professional Development as a Retention Tool](#) (0112)
- [Quality of Pharmacy Education and Expansion of Colleges of Pharmacy](#) (1108)
- [Residency Equivalency](#) (1109)
- [Pharmacy Internships](#) (1110)
- [State-Specific Requirements for Pharmacist Continuing Education](#) (1111)
- [Innovative Residency Models](#) (1112)
- [Professional Socialization](#) (1113)

## Other Council Activity

### Experiential Education Event

The Council voted to assess the feasibility of and assess stakeholder interest in ASHP conducting a stakeholder event to examine standardization of experiential education experiences, introductory and advanced pharmacy practice experience rotations, and incorporating student learners into the healthcare team.

The Council discussed the impact of training students from different schools and the various specific requirements of each school. Because there is no standardization, it makes it difficult for organizations to utilize the student pharmacists as pharmacist extenders in a consistent manner. Rotation sites should not feel burdened by supporting the mission of training future practitioners. The Council felt strongly that if there were more standardization related to logistics (e.g., scheduling, evaluation, and learning objectives), it would be easier to incorporate student pharmacists into the healthcare team and would provide a better way to train future professionals. Because each school has its own specific requirements, ASHP policy advocating standardization is not sufficient. The Council that a high-level summit with all stakeholders, similar to the ASHP-ASHP Foundation Ambulatory Care Summit, may be the action needed to achieve this goal.

After discussing the lack of standardization of experiential educational evaluations, the Council felt strongly that there are significant barriers to standardization that are not easily overcome. In this recommendation, the Council suggests that ASHP convene a summit of thought leaders and stakeholders, including the American Association of Colleges of Pharmacy, the National Association of Boards of Pharmacy, and the Accreditation Council for Pharmacy Education, to collaborate on developing methods and models to address the following issues (among others):

- Standardizing rotation schedules
- Identifying and implementing universal experiential valuation tools
- Addressing the intersection of residency and student rotation sites
- Examining block rotations versus longitudinal models
- Developing models to integrate students into the healthcare delivery system

### Pharmacist Oversight of Student Pharmacists

The Council voted to request that the Council on Public Policy consider developing policy that would advocate that the National Association of Boards of Pharmacy encourage standardization of state laws and board of pharmacy requirements regarding pharmacist oversight of student pharmacists.

As health-system pharmacies incorporate student pharmacists into the daily workflow, the definition of pharmacist oversight needs to be standardized. Oversight currently varies from state to state, ranging from direct line of sight to inside the four walls of the building. If, for example, student pharmacists are performing medication reconciliation, direct line of sight oversight is more difficult for the preceptor than a dispensing function would be, where direct oversight is more feasible.

Discussion regarding the methods to integrate student pharmacists into the healthcare setting workforce focused on the variety of models currently in place. Citing the Cleveland Clinic's recent effort to reorganize how care was delivered throughout its system, the Council agreed that addressing delivery of service and optimizing the student learner's experience as they transition into the workforce is needed. Several objectives were noted:

- Use students as extenders and make them accountable for patients while on rotation
- Introduce experiential learning early in the curriculum
- Adjust teaching methods from block style to rotational approach
- Broaden instruction for improving communication skills for interacting with patients
- Examine the practicality of the direct line of sight definition of supervision in health systems versus retail settings

The Council suggested that the Council on Public Policy consider developing policy that would advocate that the National Association of Boards of Pharmacy and states work to remove barriers for integrating students into the hospital and health-system workforce. The aforementioned suggestions could also be discussed during the stakeholder event proposed above.

## Statement on Quality of Pharmacy Education and Expansion of Colleges of Pharmacy

The Council voted to draft an ASHP statement on the quality of pharmacy education and expansion of colleges of pharmacy. During sunset review of ASHP policy 1108, Quality of Pharmacy Education and Expansion of Colleges of Pharmacy, several Council members volunteered to develop an ASHP statement on the topic. The Council decided that when the statement is recommended for approval, policy 1108 should be re-evaluated.

## Availability of Preceptor Resources

Greater awareness of and access to preceptor resources is needed. The Council discussed how models of learning that support the growth of residencies may also grow student opportunities. There remain concerns related to quality and consistency of some rotations. The importance of teaching residents how to teach as part of their training was noted. The Council discussed the growing need for standards around a teaching certificate earned during residency training.

## Continuing Professional Development

The Council agreed that the vast majority of pharmacy professionals are not utilizing continuing professional development (CPD) to enrich their careers. An assessment tool should be developed to assess the continuous learning accomplishments of pharmacy professionals over the course of their career path. The Council encourages evaluation of the feasibility of developing a platform where members can upload details about scholarly activities, speaking engagements, and other self-directed, continuous learning accomplishments. This repository

could also serve as a place for background information that could showcase major milestones of the professional careers of ASHP members. Such a repository would be individually maintained and updated, and allow for portability so that a member could showcase their upward career trajectory and commitment to lifelong learning. Several Council members volunteered to explore opportunities to increase the visibility of continuing professional development among pharmacists.

## Preceptor Development for Technician Training

A preceptor development resource for technician training could be modeled on the ASHP residency and pharmacy preceptor programs already in place and may be an attractive incentive for pharmacy technicians to become involved as ASHP members. The Council also noted that there is value in training pharmacy technician preceptors not only as preceptors for pharmacy technicians, but also as preceptors for student pharmacists, and that other types of precepting relationships exist, such as technician-student, technician-technician, and pharmacist-technician. The Council felt topics such as accountability, emotional intelligence, interpersonal communication, and leadership were important topics to be included in technician preceptor development. ASHP staff members in attendance at the Council meeting will take this request to the appropriate staff members at ASHP for further development.

## 2014 Workforce Report

The Council reviewed the 2014 National Pharmacy Workforce Survey, which outlined the following developments since its last edition in 2009:

- The profession is shifting from male- to female-dominated.
- More pharmacies are providing patient care.
- The percentage of pharmacists with Pharm.D. degrees has risen 49% since 2009.
- The increase in new roles and services has led to more stress and dissatisfaction.
- Pharmacists feel less able to change jobs than in the past.

In general, the Council felt the workforce report was positive information and not reflective of the “doom and gloom” perception currently held by some student pharmacists and prospective students. The Council felt it important that ASHP work to disseminate the positive message to counter the incorrect negative perceptions of qualified pharmacy school candidates. The Council encouraged ASHP staff to identify information from the survey to include in news summaries to the membership and the general public by a variety of communication methods, including social media.

## Succession Planning

The Council discussed the importance of succession planning as a wave of retirements may be forthcoming in next few years. It was noted that succession planning is closely related to leadership development. ASHP currently has resources available on succession planning,

including a webinar planned for January 2016 and a position statement. In addition, ASHP hosts a [repository of information on leadership](#) on the ASHP website. In addition, because succession planning should begin early, this topic might be appropriate for inclusion in student leadership programs.

## Generational Differences in the Workforce

The Council discussed how the following groups, with some general attributes, will soon represent five distinct generations working together in the labor force:

- Traditionalists -- Born 1935-46: They have been described as valuing hard work and self-sacrifice, and likely work for one organization for their entire career.
- Baby Boomers -- Born 1946-65: They number upward of 72 million and have witnessed significant social changes, including civil rights, more women in the workforce, and increasing educational requirements (e.g., the pharmacy degree advance to a five-year degree).
- Generation X -- Born 1965-80: This is a relatively small population, which has been described as possessing independence and problem-solving skills, striving to become entrepreneurs and innovators, and seeking well-paying jobs but valuing a work-life balance.
- Millennials -- Born 1980-2000: They have been described as upbeat and team-oriented, close to their parents, and having high expectations for speed and efficiency, having grown up in the mobile digital age.
- Homelanders -- 2000-2020: They were born after 9/11. They are the most ethnically diverse generation to date, and the use of active learning will impact their job expectations.

The Council discussion centered mainly on older pharmacists who may not have kept up on technology and other aspects of patient care and may have limited their careers as a result. Ideas to address the generational issues included educational programming on reverse mentoring, utilizing new practitioners as reverse mentors, or a modified PGY1-type program for seasoned pharmacists with limited direct patient care training and skills.

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# COUNCIL ON PHARMACY MANAGEMENT: POLICY RECOMMENDATIONS

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*The Council on Pharmacy Management is concerned with ASHP professional policies related to the process of leading and directing the pharmacy department in hospitals and health systems. Within the Council's purview are (1) development and deployment of resources, (2) fostering cost-effective use of medicines, (3) payment for services and products, (4) applications of technology in the medication-use process, (5) efficiency and safety of medication-use systems, (6) continuity of care, and (7) related matters.*

Lea S. Eiland, *Board Liaison*

## **Council Members**

Roger Woolf, *Vice Chair* (Washington)  
Mohammed Abdulwahhab, *New Practitioner* (Florida)  
Andrew Albanese (Oregon)  
Rachel Booze, *Student* (Indiana)  
Sam Calabrese (Ohio)  
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Robert Oakley (Kentucky)  
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David Chen, *Secretary* (Maryland)

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## **1. Controlled Substance Diversion and Patient Access**

- 1 To enhance awareness by pharmacists, healthcare providers, and the public of drug
- 2 diversion and abuse of controlled substances; further,
  
- 3 To advocate that pharmacists take a leadership role in national efforts to reduce the
- 4 incidence of controlled substance abuse; further,
  
- 5 To advocate that pharmacists lead collaborative efforts by organizations of
- 6 healthcare professionals, patient advocacy organizations, and regulatory authorities
- 7 to develop and promote best practices for preventing drug diversion and
- 8 appropriately using controlled substances to optimize patient access and therapeutic
- 9 outcomes; further,
  
- 10 To advocate that the Drug Enforcement Administration and other regulatory
- 11 authorities interpret and enforce laws, rules, and regulations to support patient
- 12 access to appropriate therapies, minimize burdens on pharmacy practice, and
- 13 provide reasonable safeguards against fraud, misuse, abuse, and diversion of
- 14 controlled substances; further,
  
- 15 To encourage healthcare organizations to establish programs to support patients and
- 16 personnel with substance abuse and dependency issues.

**Rationale**

Pharmacy managers and pharmacists-in-charge (PICs) have increasing responsibility for ensuring controlled substance management and storage across large healthcare organizations. This responsibility has increased as aquisition of physician office practices, clinics, and other non-hospital business units continue.

Controlled substance abuse is rising in the United States. According to the Drug Enforcement Administration (DEA) [2014 National Drug Threat Assessment Summary](#), deaths involving controlled substances outnumber those involving heroin and cocaine combined. Additionally, the economic cost of nonmedical use of prescription opioids alone in the U.S. totals more than \$53 billion annually. All pharmacies and healthcare organizations that handle controlled substances are required to have storage and distribution systems in place that prevent diversion. Due to the numerous medication-access points embedded within hospital distribution systems, diversion can be difficult to detect. Theft of controlled substances by healthcare professionals remains a serious problem that can lead to patient harm and jeopardize patient safety. Drug addiction among healthcare workers is well documented. One survey found that nurses who reported a perception of easier availability of controlled substances were almost twice as likely as others to divert and use a controlled substance. In another survey, 19% of pharmacists reported use of a controlled substance without a prescription during the preceding 12 months. Even the most conservative estimates are that 8–12% of physicians will develop a substance abuse problem at some point during their career, although the exact rate of substance abuse among physicians is uncertain.

Many challenges exist for healthcare institutions in managing controlled substances. New laws and regulations, including DEA quotas and controlled substances monitoring requirements at retail outpatient dispensing facilities, are meant to decrease diversion and illegal activity but are also impacting patients and pharmacists. In addition, the DEA has allowed hospitals and clinics with an onsite pharmacy and status as an authorized collector to maintain collection receptacles onsite and administer mail-back programs for controlled substances, adding another layer of complexity to controlled substance disposal. Pharmacists in healthcare organizations must meet standards and comply with laws and regulations from a variety of sources, including the DEA, The Joint Commission, Det Norske Veritas, other accreditation organizations, and state and federal governments. The [ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance](#) offers detailed suggestions for pharmacists in addressing substance abuse in their institutions and communities.

**Background**

This topic was considered by the Council in response to the New Business Item from the June 2015 House of Delegates as well as suggestions by Council members and ASHP staff. This policy recommendation was expedited for Board consideration due to its importance to ASHP members, as indicated by the New Business Item, the experience of Council and Board members, and anecdotal evidence.

## 2. Surface Contamination on Packages and Vials of Hazardous Drugs

- 1 To advocate that pharmaceutical manufacturers eliminate surface contamination on
- 2 packages and vials of hazardous drugs; further,
  
- 3 To inform pharmacists and other personnel of the potential presence of surface
- 4 contamination on the packages and vials of hazardous drugs; further,
  
- 5 To advocate that the Food and Drug Administration require standardized labeling
- 6 and package design for hazardous drugs that would alert handlers to the potential
- 7 presence of surface contamination; further,
  
- 8 To encourage healthcare organizations to adhere to published standards and
- 9 regulations to protect workers from undue exposure to hazardous drugs.

(Note: This policy would supersede ASHP policy 0618.)

### **Rationale**

The outer surfaces of vials of hazardous drugs have been shown to be contaminated with hazardous substances, and pharmacy and other personnel handling those vials may unknowingly be exposed. ASHP advocates that individuals involved in drug distribution, receiving, and inventory control adhere to safe handling guidelines to avoid undue exposure to hazardous substances but recognizes the limits of these best practices. Pharmaceutical manufacturers have a responsibility to provide vials that are devoid of surface contamination due to inadequate vial-cleaning procedures, and can reduce contamination by using decontamination equipment and protective sleeves during the manufacturing process.

The purpose of United States Pharmacopeia (USP) Chapter 800 is to establish standards for protecting personnel and the environment when handling hazardous drugs. Each year, approximately 8 million U.S. healthcare workers are potentially exposed to hazardous drugs, according to the Centers for Disease Control and Prevention. USP Chapter 800 includes definitions, processes, and worker responsibilities that enhance understanding of risk and limit exposure. To support workers in protecting their patients, themselves, and the environment, the FDA and manufacturers will need to develop new production and processing standards to mitigate exposures, including labeling and package design that alerts handlers to the possibility of contamination.

### **Background**

The Council voted to recommend amending policy 0618, Elimination of Surface Contamination on Vials of Hazardous Drugs, as follows (underline indicates new text):

To advocate that pharmaceutical manufacturers eliminate surface contamination on packages and vials of hazardous drugs; further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of hazardous drugs; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for hazardous drugs that would alert handlers to the potential presence of surface contamination; further,

To encourage healthcare organizations to adhere to published standards and regulations to protect workers from undue exposure to hazardous drugs.

The Council discussed the proposed USP Chapter 800 and the best practices contained in the [ASHP Guidelines on Handling Hazardous Drugs](#). The Council reviewed the comments ASHP had submitted to the USP, which addressed many of the concerns of ASHP members and the Council. The Council felt there was additional advocacy necessary to aid handlers in identifying hazardous drug products, similar to FDA product labeling of high-concentration electrolytes. The Council suggested that a resource, such as an ASHP white paper or AJHP article, on the critical aspects of medical surveillance and potential impacts on the pharmacy department would be helpful.

### 3. Pharmaceutical Distribution Systems

- 1 To support wholesaler/distribution business models that meet the requirements of
- 2 hospitals and health systems with respect to timely delivery of products, minimizing
- 3 short-term outages and long-term product shortages, managing and responding to
- 4 product recalls, fostering product-handling and transaction efficiency, preserving the
- 5 integrity of products as they move through the supply chain, and maintaining
- 6 affordable service costs; further,
  
- 7 To encourage wholesalers and other trading partners in the drug supply chain to
- 8 implement policies and procedures consistent with United States Pharmacopeia
- 9 Chapter 800 to mitigate the risk of exposure as hazardous drug products move
- 10 through the supply chain.

(Note: This policy would supersede ASHP policy 1016.)

#### **Rationale**

Wholesaler distributors have traditionally contracted with hospitals and health systems for basic drug product distribution and other services. Many wholesalers have made a large portion of their revenue through speculative buying and other business practices that are no longer desirable because of requirements for pedigrees, the risk of buying counterfeit or adulterated products, demands by manufacturers to limit product transactions, and the need to manage drug recalls. These changes, plus the vast diversification of many wholesaler distributors, have resulted in new business models that will affect how hospitals acquire and manage

pharmaceuticals. These changing models for distribution may result in higher costs for hospitals and health systems, as current wholesaler distribution systems have become very efficient. ASHP supports wholesaler/distribution business models that meet the requirements of hospitals and health systems.

### **Background**

The Council voted to recommend amending policy 1016, Pharmaceutical Distribution Systems, as follows (underscore indicates new text):

To support wholesaler/distribution business models that meet the requirements of hospitals and health systems with respect to timely delivery of products, minimizing short-term outages and long-term product shortages, managing and responding to product recalls, fostering product-handling and transaction efficiency, preserving the integrity of products as they move through the supply chain, and maintaining affordable service costs; further,

To encourage wholesalers and other trading partners in the drug supply chain to implement policies and procedures consistent with United States Pharmacopeia (USP) Chapter 800 in order to mitigate the risk of hazardous drug exposure as products move through the supply chain.

The Council discussed the proposed USP Chapter 800 and the best practices contained in the [ASHP Guidelines on Handling Hazardous Drugs](#). The Council reviewed the comments ASHP had submitted to USP which addressed many of the concerns of ASHP members and the Council. The Council felt there was additional advocacy necessary regarding hazardous drugs and how they are transported throughout the supply chain. The Council also recommended that ASHP create a resource paper with checklists regarding critical steps and processes pharmacy leaders should be assessing and implementing regardless of the approval timeline of USP Chapter 800.

## **4. Patient Satisfaction**

- 1 To encourage pharmacists to evaluate their practice settings for opportunities to
- 2 improve the level of satisfaction patients have with healthcare services and with the
- 3 outcomes of their drug therapy; further,
  
- 4 To educate pharmacists and pharmacy personnel about the relationship between
- 5 patient satisfaction and positive health outcomes, further,
  
- 6 To develop or adopt tools that will (1) provide a system for monitoring trends in the
- 7 quality of pharmacy services to patients, (2) increase recognition of the value of
- 8 pharmacy services, and (3) provide a basis for making improvements in the process
- 9 and outcomes of pharmacy services in efforts to engage patients and improve
- 10 satisfaction; further,

- 11 To facilitate a dialogue with and education of national patient satisfaction database
- 12 vendors on the role and value of clinical pharmacy services.

(Note: This policy would supersede ASHP policy 0104.)

### **Rationale**

A major component of quality of healthcare is patient satisfaction, which is critical to how well patients respond and adhere to healthcare. Research has identified a clear link between patient outcomes and patient satisfaction scores. Additionally, patient satisfaction is a key determinant of quality of care and an important component of pay-for-performance metrics. Pharmacy leaders need to continually assess how pharmacists and pharmacy services support improved patient satisfaction with their care across the continuum of practice sites, including how pharmacists contribute to team-based care.

### **Background**

The Council discussed ASHP policy 0104 as part of sunset review. The Council considered the policy to still be relevant but recommended amending the policy as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To encourage pharmacists to evaluate ~~establish mechanisms within~~ their practice settings for opportunities to improve ~~measure~~ the level of satisfaction patients have with healthcare pharmacy services and with the outcomes of their drug therapy; further,

To educate pharmacists and pharmacy personnel about the relationship between patient satisfaction and positive health outcomes; further,

To develop or adopt tools ~~construct such mechanisms in a manner~~ that will (1) provide a system for monitoring trends in the quality of pharmacy services to patients, (2) increase recognition of the value of pharmacy services, and (3) provide a basis for making improvements in the process and outcomes of pharmacy services in efforts to engage patients and improve satisfaction; further,

To facilitate a dialogue with and education of national patient satisfaction database vendors on the role and value of clinical pharmacy services.

The Council felt the original policy was created when patient satisfaction measurement requirements were in the early stages of being required by payers, and pharmacy was focused on ensuring pharmacist's role and influence on these measures needed to be a uniquely captured set of data. With the continued evolution of patient satisfaction measures and understanding on its impact on patient outcomes, the tools in the marketplace have become more team-based and standardized. The Council noted that pharmacists' understanding of the

connection between patient outcomes and satisfaction needs to be enhanced, including knowledge of effective approaches to optimize patient outcomes, with satisfaction being one facet of measures to utilize. The Council also reviewed ASHP policy 1107, Patient-Reported Outcomes Tools, and concluded that that policy, although similar, is more specific to patient tools pertaining to research because it emphasizes that patient-centric reporting of outcomes (e.g., what lifestyle changes to reach certain clinical targets were acceptable) is an important tool to be utilized in any patient-care setting.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing ASHP policies, the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- [Pharmacy Benefits for the Uninsured](#) (0101)
- [Medication Formulary System Management](#) (0102)
- [Gene Therapy](#) (0103)
- [Computerized Prescription Order Entry](#) (0105)
- [Minimizing the Use of Abbreviations](#) (0604)
- [ASHP Statement on Leadership as a Professional Obligation](#) (1123)

## Other Council Activity

### Controlled Substance Diversion and Patient Access

The Council voted to explore the feasibility of ASHP conducting a stakeholder event to evaluate the needs of pharmacists managing controlled substances and providing comprehensive and appropriate care for patients; further, to consider the issues to be addressed by such an event, including: (1) needs assessment on types and level of resources and education for pharmacy leaders, healthcare providers, and the public, (2) evaluation of controlled substance laws and regulations and the impact they have on providing legitimate patient care, (3) establishing best practices to minimize diversion, (4) identifying risk points and lack of harmonization among laws and regulations for improvements and/or advocacy, and (4) best mechanisms to improve sharing of ideas and information between stakeholder groups.

The Council also voted to develop ASHP guidelines describing best practices for controlled substance diversion management and risk reduction, including programs to support patients and personnel with substance abuse and dependency issues.

Controlled substance diversion and abuse has reached the attention at the highest levels in the United States, with even the White House weighing in on the crisis facing the country. In the past 4-5 years, the DEA has levied large fines on chain drugstores, drug wholesalers, and most recently, major hospitals. Pharmacy managers and pharmacists-in-

charge (PICs) have increasing responsibility for ensuring controlled substance management and storage across large healthcare organizations.

The Council discussed the increased risk to organizations as acquisitions of physician office practices, clinics, and other nonhospital-based business units continue, and the many challenges that exist for healthcare institutions in managing controlled substances. Council members also discussed their concern that many pharmacy leaders do not proactively manage controlled substance diversion and that, for those that do have proactive processes, it is tremendously time-consuming and requires strict policies, an interdisciplinary team, and a higher level of understanding of laws and legal ramifications of diversion discovery.

The Council also discussed how new laws have been implemented, including what were described as “DEA quotas” and the controlled substances monitoring requirements at the retail outpatient dispensing facilities that are meant to decrease diversion and illegal activity but which are impacting ASHP members in serving their patients. Pharmacists in healthcare institutions must meet standards and comply with regulations and laws from a variety of sources, including the DEA, The Joint Commission, and state and federal authorities. The Council felt ASHP should take a leadership role in developing best practices on diversion, taking into consideration models in which states have organized coalitions to research the problem of controlled substance diversion and develop best practices. Currently there are no national best practices or guidelines that institutions can adopt to improve controlled substance diversion detection systems.

## Impact of Rising Drug Costs on Pharmacy Budgets and Patient Care

The Council discussed the escalation of drug prices and how they have increased steadily over the past few years. This increase is a multifactorial issue, including the introduction of new medications on the market, drug shortages, and the effect of rising prices of generic drug products. As a result, drug products that used to cost a few dollars a month have increased to sometimes hundreds of dollars a month, causing undue burden on patients who are struggling to afford their therapy. Although some drug companies have introduced patient assistance programs, the significant remaining expense can create a barrier to proper care. Additionally, the high prices of new drugs entering the marketplace can create access issues for patients through large copays or health plan prior authorization requirements. These high costs and barriers to care present not only a formulary and cost management issue for hospitals and health systems but also are rapidly becoming an ethical issue as medications become unaffordable for vulnerable populations. Hospital and health-system leaders have become more concerned about the financial implications of higher outpatient drug costs for patients as health plan deductibles, coinsurance, and copays increase, and some drugs come to market with limited or uncertain benefits for patients. Increases in prices have changed how formularies are discussed and managed at the pharmacy and therapeutics committee level. Strategies to mitigate costs include requiring medications that reach a threshold cost to be triggered for review, proof of efficacy or superiority over an existing formulary agent, and utilizing patient’s-own medication policies. Additionally, pharmacy leaders are often faced with the challenge of managing their budgets as many of these medications are impacting outpatient populations.

The Council acknowledged and reviewed the ASHP policies and guidelines on mitigating drug prices and formulary strategies. The Council suggested that the [ASHP Guidelines on Medication Cost Management Strategies for Hospitals and Health Systems](#) be updated. The Council discussed the need for education and resources for best practices and innovations that could be used to mitigate the impact of rising costs (e.g., alternative therapies), management of hospital committees as more facilities include requirements to review certain drug use based on patient setting and end-of-life care, and management of risks and liability when rising prices and shortages are emergent-care drugs. Additionally, the Council requested that ASHP study the need for policy or advocacy on parity across all drug classes and not just oncology medications.

## Management of Pharmacy Workforce Supply and Demand and Impact on Salaries

The Council discussed how the growth in the number of pharmacy graduates, increased use of pharmacy technicians and technology in retail and institutional dispensing operations, and other factors have converged to produce an ample supply of pharmacists for health-system entry-level positions nationwide. Council members also discussed evidence that there is a downward trend in salaries in parts of the country.

The Council felt ASHP policies were mainly focused on education and preparation of the workforce and not on supply and demand of pharmacists. During the discussions, the Council decided it was not ASHP's role through policy to address supply and demand directly, but it was the quality of the workforce and educating pharmacy leaders on ways to engage colleges of pharmacy to ensure the best-qualified candidates and graduates were created to meet the demands of pharmacy and healthcare.

The Council also discussed the current technician workforce and the pending 2020 Pharmacy Technician Certification Board requirements. The Council expressed concerns that the requirement could have unintended impact on students and potential students for colleges of pharmacy, especially in light of the lack of access and cost of ASHP-accredited technician training programs. The Council suggested ASHP investigate distance learning programs and develop resources to promote the development of ASHP-accredited technician training programs through hospitals and health systems.

## Impact of Bundled Service Payments and Site of Care Trends with Payer

The Council noted that since the passage of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) and other payers have been rapidly moving from a fee-for-service reimbursement system to bundled payment arrangements and alternative payment models. Bundled payment models have been expanded to long-term care, inpatient rehabilitation, skilled nursing, and home health by CMS, and the 2016 inpatient prospective payment system proposed rule contains policies that will continue to increasingly shift Medicare payments from volume to value. Additionally, in a March 2012 Report to Congress, the Medicare Payment Advisory Commission recommended that CMS equalize the rate paid for evaluation and

management visits in hospital outpatient departments and freestanding physician offices. The Department of Health and Human Services Office of the Inspector General has said that CMS could save billions of dollars if the agency reduces hospital outpatient department payment rates for ambulatory surgical center-approved procedures to ambulatory surgical center payment rates.

The Council also noted that while CMS is moving toward bundled payments in the ambulatory care environment, pharmacy chains such as CVSHealth and Walgreens are expanding into primary care. CVS MinuteClinics, staffed by nurse practitioners and physician assistants, are the largest retail medical clinic provider in the United States. Walgreens is utilizing video technology to offer 24/7 access to physicians, while also allowing a health system in Oregon to own and operate its in-store healthcare clinics. Both companies are providing competition in the ambulatory care market, in part by increasing their ability to capture patient prescriptions.

Sites of care that are likely to be impacted by these changes include ambulatory care clinics, federally qualified health centers, patient-centered medical homes, and medication therapy management services performed electronically.

## Impact of ICD-10 on Pharmacy Practice and Quality of Data and Reimbursement

The Council discussed the implementation of International Classification of Diseases, 10th Revision (ICD-10) codes and the impact they will have on health-system pharmacy practice. ICD-10 coding has been in existence since the early 1990s, but its use has been restricted to death certificates and mortality data. However, starting October 1, 2015, ICD-10 will be used nationwide for coding diagnosis and inpatient procedures in all U.S. health systems and settings. As with most new systems, the pressure to implement and be compliant is daunting, especially if there isn't a feeling of readiness.

Unlike its predecessors, ICD-10 codes are very different from ICD-9 codes, resulting in significant work being required to change to the new standard. For example, ICD-9 has just over 13,000 diagnosis codes, whereas ICD-10 has over 60,000. The new standard will require updates to almost every clinical and administrative process in all healthcare settings. Moreover, the updated codes will include changes in the reimbursement service and how insurance coverage is defined.

The Council noted pharmacy leaders and their informatics experts will need to ensure they are engaged in the implementation of ICD-10 within their organizations, as the implementation will have ramifications for clinical decision support, quality and outcomes reporting, and reimbursement. For example, performance measures are based on ICD-9 and will be converted to more granular and specific ICD-10 codes. Additionally, with many health systems owning and operating prescription benefit management-based outpatient pharmacy services, engaging with payers reliant on National Council for Prescription Drug Programs-based systems will be critical.

The Council felt existing ASHP policy, statements, and guidelines expressed the advocacy and guidance needs for ASHP, but there was significant education necessary for health-system pharmacists to understand the benefits and risks associated with not having pharmacy

representation included in the establishment of new policies and procedures at their organizations. Representatives from the Section of Pharmacy Informatics and Technology (SOPIT) were present during discussions and acknowledged they would develop FAQs and resources for ASHP members, including how ICD-10 coding impacts the revenue cycle, patient safety, automation of prior authorization, and refinement of diagnosis.

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# COUNCIL ON PHARMACY PRACTICE: POLICY RECOMMENDATIONS

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*The Council on Pharmacy Practice is concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners in hospitals and health systems. Within the Council's purview are (1) practitioner care for individual patients, (2) practitioner activities in public health, (3) pharmacy practice standards and quality, (4) professional ethics, (5) interprofessional and public relations, and (6) related matters.*

Ranee M. Runnebaum, *Board Liaison*

## **Council Members**

Julie Groppi, *Chair* (Florida)  
Tate Trujillo, *Vice Chair* (Indiana)  
Lindsey Amerine (North Carolina)  
Abigail Brooks, *New Practitioner* (Minnesota)  
Mark Dunnenberger (Illinois)  
Michael Ganio (Ohio)  
Meghan Garrett, *Student* (Tennessee)  
Sandra Leal (Arizona)  
Christina Martin (Pennsylvania)  
Lisa Mascardo (Iowa)  
LeeAnn Miller (Connecticut)  
Elizabeth Wade (New Hampshire)  
Steven Nelson, *Secretary* (Iowa)

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## **1. Automated Preparation and Dispensing Technology for Sterile Preparations**

- 1 To encourage health systems to adopt automation and information technology for
- 2 preparing and dispensing sterile preparations when such adoption is (1) planned,
- 3 implemented, and managed with pharmacists' involvement; (2) implemented with
- 4 adequate resources to promote successful development and maintenance; and (3)
- 5 supported by policies and procedures that ensure the safety, effectiveness, and
- 6 efficiency of the medication-use process; further,
  
- 7 To foster further research, development, and publication of best practices regarding
- 8 automation and information technology for preparing and dispensing sterile
- 9 preparations.

### **Rationale**

Adoption of automation and information technology for preparing and dispensing sterile preparations is increasing but not evenly distributed among healthcare organizations. A 2014 ASHP survey showed that 40-60% of larger health systems used automated IV compounding technology in compounding nutrition support preparations. Less than 20% of all health systems surveyed employed barcode verification in their IV medication preparation process. A 2013 survey found that less than 10% of all health systems surveyed used drug workflow software to manage IV drug preparation, verification, and dispensing.

The reasons for these disparate rates of adoption are numerous. Each institution has a different break-even point of investment versus return, and challenges of implementation can be daunting. Some organizations have implemented automated compounding technology only

to withdraw it later. The probability of successful adoption of automation and information technology for preparing and dispensing sterile preparations is increased when it is planned, implemented, and managed with pharmacists' involvement and when adequate resources (including time) are planned for and provided not only to develop but also to maintain the technologies. Upfront costs and ongoing investments need to be clear from the start. Use of such technology also requires well-crafted policies and procedures to ensure the safety, effectiveness, and efficiency of the medication-use process. Research, development, and publication of best practices regarding automation and information technology for preparing and dispensing sterile preparations will require efforts not only from vendors but also from those who have experience with the process.

### **Background**

The Council considered this topic upon suggestion from an ASHP member who expressed concern that the highest-risk products that pharmacy handles, injectable drugs, have a lower rate of automation safeguards, such as barcode verification, than oral medications. Council members suggested that more research needs to be done, which could include demonstration grants from manufacturers. Council members also suggested that ASHP could provide case studies or lessons learned and perhaps coordinate virtual site visits (e.g., via Webex).

## **2. Integrated Approach for the Pharmacy Enterprise**

- 1 To advocate that pharmacy department leaders promote an integrated team
- 2 approach for all pharmacy professionals involved in the medication-use process;
- 3 further,
  
- 4 To advocate a high level of coordination of all components of the pharmacy
- 5 enterprise across the continuum of care for the purpose of optimizing (1)
- 6 medication-use safety, (2) quality, (3) outcomes, and (4) the value of drug therapy;
- 7 further,
  
- 8 To encourage pharmacy department leaders to develop and maintain patient-
- 9 centered practice models that integrate into a team all pharmacy professionals
- 10 engaged in the medication-use process, including general and specialized clinical
- 11 practice, drug-use policy, product acquisition and inventory control, product
- 12 preparation and distribution, and medication-use safety and other quality initiatives.

(Note: This policy would supersede ASHP policy 0619.)

### **Rationale**

In November 2004 the Joint Commission of Pharmacy Practitioners adopted a vision for pharmacy practice that states that "pharmacists will be the healthcare professionals responsible for providing patient care that ensures optimal medication therapy outcomes." At the time, ASHP envisioned the pharmacy department as an integrated entity serving as the

nucleus for direct and team-based engagement of all pharmacists who work in the institution in an open feedback loop among various areas that support the overall pharmacy enterprise, including drug-use policy, product acquisition and inventory control, frontline and specialized clinical practice, product preparation and distribution, and medication-use safety and quality. Support for such an integrated model is based on recognition that the medication-use process is a tightly linked continuum in which the activities of one area affect other upstream and downstream processes.

In the decade since, the healthcare enterprise has continued its evolution from single hospitals to integrated systems and networks. These systems have become even more complex as they expand into new businesses, such as physician practices and outpatient care sites. As these organizations seek to standardize operations and gain economies of scale, pharmacy leaders have recognized that the evolving pharmacy enterprise is more far-reaching and sophisticated than in the past, and pharmacy leaders at all levels have to manage their pharmacy services in the context of the overall goals and needs of the organization across a wide array of business units, care settings, and organizations. ASHP continues to believe that the integrated model will optimize the value of drug therapy (i.e., obtaining the most benefit from the resources invested in drug products, taking into account both the cost of drug products and appropriate use of the products); medication-use safety (i.e., avoiding preventable adverse drug events, including medication errors); patient and economic outcomes, and healthcare quality.

Management of pharmacy services is no longer confined to drug distribution and clinical pharmacy but also includes human resources management, integrity of the electronic health record and related patient-care information, and oversight of various business partners. Pharmacy leaders within these evolving health systems confront many new challenges, ranging from communication among the pharmacy management team, decisions on pharmacy infrastructure purchases and contracting, identification of critical services and standardization, succession planning and workforce development, supply chain management, human resource coordination, and strategic planning across diverse healthcare sites within the system. Further challenging health system pharmacy leaders are coordinating pharmacy services across larger geographical regions and organizational boundaries. To cope with these new challenges, pharmacy department leaders need to develop and maintain patient-centered practice models that integrate into a team all pharmacy professionals engaged in the medication-use process of their organizations, including general and specialized clinical practice, drug-use policy, product acquisition and inventory control, product preparation and distribution, and medication-use safety and other quality initiatives.

### **Background**

The Council considered ASHP policy 0619, Integrated Team-Based Approach for the Pharmacy Enterprise, as part of sunset review and recommended amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate that pharmacy department leaders promote an integrated team approach for all pharmacy professionals involved in the medication-use process; further,

To advocate a high level of coordination of all components of the pharmacy enterprise in hospitals and health systems across the continuum of care for the purpose of

optimizing ~~and~~ (1) medication-use safety (2) quality, (3) outcomes, and (4) the value of drug therapy; further,

To encourage pharmacy department leaders to develop and maintain patient-centered practice models that integrate into a team all ~~components of pharmacy professionals engaged in the pharmacy enterprise~~ medication-use process, including general and specialized clinical practice, drug-use policy, product acquisition and inventory control, product preparation and distribution, and medication-use safety and other quality initiatives.

The Council discussed the expansion of healthcare organizations into large systems with responsibility for managing healthcare for large numbers of patients across large geographical areas and many different settings. Council members recognized the challenge of integrating the activities of pharmacists and pharmacy technicians across such a broad spectrum, especially when these activities span business units, but the Council endorsed the vision of patient-centered practice models that integrate into a team all pharmacy professionals engaged in the medication-use process.

### 3. Preventing Exposure to Allergens

- 1 To advocate for pharmacy participation in the assessment and documentation of a
- 2 complete list of allergens pertinent to medication therapy, including food, excipients,
- 3 medications, devices, and supplies, for the purpose of clinical decision-making;
- 4 further,
  
- 5 To advocate that pharmacy departments actively review allergens pertinent to
- 6 medication therapy and minimize patient and healthcare worker exposure to known
- 7 allergens, as feasible; further,
  
- 8 To advocate that vendors of medication-related databases incorporate and maintain
- 9 information about medication-related allergens and cross-sensitivities; further,
  
- 10 To advocate that pharmacy departments be actively involved soliciting information
- 11 about patient food and environmental allergies that may indicate a potential for
- 12 medication interaction or adverse event; further,
  
- 13 To encourage pharmacist education on medication-related allergens.

#### **Rationale**

In 2005, ASHP adopted policy 0501, Mandatory Labeling of the Presence of Latex, and in 2008 adopted policy 0808, Excipients in Drug Products (now ASHP policy 1528). The common theme in these policies is that patients may be exposed to potentially life-threatening allergens in items encountered in the medication-use process (i.e., natural rubber latex, drugs, drug product excipients, devices, and supplies). Pharmacist involvement in assessment and documentation of a complete list of allergens pertinent to the medication-use process, including food, excipients,

medications, devices, and supplies, would assist in clinical decision-making. Pharmacists should also minimize patient and healthcare worker exposure to known allergens, for example by limiting or banning the use of latex gloves in pharmacies and striving for latex-safe medication formularies. Although allergy information is becoming more readily accessible through the electronic health record and clinical decision support systems, some well-known cross-sensitivities are good candidates to be included in medication-related databases.

### **Background**

In 2014, the Council reviewed and reaffirmed ASHP policy 0501, Mandatory Labeling of the Presence of Latex, and recommended a revised policy that became ASHP policy 1528, Excipients in Drug Products. After an ASHP member suggested strengthening pharmacy vigilance regarding latex, the Council decided to broaden their perspective on the issue and recommend a policy that addresses pharmacy vigilance regarding allergens throughout the medication-use process.

## **4. Accreditation of Compounding Facilities**

To discontinue ASHP policy 0617, Accreditation of Compounding Facilities, which reads:

- 1 To encourage facilities where extemporaneous compounding of medications occurs
- 2 to seek accreditation by a nationally credible accreditation body.

### **Background**

The Council discussed the policy as a result of sunset review and concluded that changes in law, regulation, practice, and ASHP policy make ASHP policy 0617 redundant. The Council noted that the intent of encouraging accreditation was to foster uniform standards of compounding practice. The Drug Quality and Security Act (DQSA) of 2013, and implementing guidance from the FDA that created the 503A and 503B regulatory scheme for compounding facilities, accompanied by more stringent state oversight of compounding following the New England Compounding Center tragedy, have achieved the goals that the Council hoped would be achieved through accreditation. In addition, ASHP policy 1406, Federal and State Regulation of Compounding, calls for state adoption of United States Pharmacopeia (USP) compendial standards and mandatory state registration of compounding facilities, further helping address the gaps the Council was concerned about in 2005, when policy 0617 was initially developed. Finally, the different focus of accrediting organizations and the differences in their accreditation standards makes the benefit of meeting such accreditation standards questionable.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing ASHP policies, the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- [Influenza Vaccination Requirements to Advance Patient Safety and Public Health](#) (0615)
- [Safe and Effective Extemporaneous Compounding](#) (0616)
- [Elimination of Surface Contamination on Vials of Hazardous Drugs](#) (0618)
- [Pharmacist Accountability for Patient Outcomes](#) (1114)
- [Ethical Use of Placebos in Clinical Practice](#) (1116)
- [Pharmacist's Right of Conscience and Patient's Right of Access to Therapy](#) (0610)
- [ASHP Position on Assisted Suicide](#) (9915)
- [Safe Disposal of Patients' Home Medications](#) (0614)
- [Just Culture](#) (1115)
- [Pharmacists' Role in Medication Reconciliation](#) (1117)

## Other Council Activity

### Pharmacist's Right of Conscience and Patient's Right of Access to Therapy

The Council reviewed ASHP policy 0610, Pharmacist's Right of Conscience and Patient's Right of Access to Therapy, in response to a recommendation from the House of Delegates that ASHP "should revise position 0610 to remove the requirement of referral and replace it with 'transfer care' in order to place decision-making regarding ethically troubling therapies in the hands of the patient and remove the burden of cooperation on the part of the pharmacist." The Council reviewed the conscientious objection policies of other organizations of healthcare providers and concluded that existing ASHP policy is adequate but that the terms "referral" and "transfer of care" could be clarified in a rationale for the existing policy, which is the following paragraph.

ASHP affirms pharmacists' right to decline to participate in therapies they consider to be morally, religiously, or ethically troubling but recognizes that a right of conscience must balance a pharmacist's deeply held beliefs with his or her professional duty and the patient's right to access legally prescribed and medically indicated treatments. To achieve this balance, systems to protect the patient's right to timely access to therapy should be developed in advance of the presentation of a prescription to a pharmacist or other employee who might exercise the right of conscience. The right of conscience therefore creates an affirmative responsibility on the part of the pharmacist to proactively notify his or her employer about therapies of concern. In addition, a pharmacist exercising the right of conscience must respect and serve the legitimate healthcare needs and desires of the patient and must provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's values, beliefs, or objections. For the purposes of this policy, "referral" is defined in manner similar to that used by the [American Academy of Family Physicians](#) (Consultations, Referrals, and Transfers of Care;

2012 COD): a referral is a request from one pharmacist to another to assume responsibility for management of one or more of a patient's specified problems, for a specified period of time, until the problem(s)' resolution, or on an ongoing basis, and represents a temporary or partial transfer of care to another pharmacist for a particular condition. When conscience requires a pharmacist also to decline to refer the patient to a specific provider who can provide the legally prescribed and medically indicated treatment, the pharmacist should offer impartial guidance to patients about how to inform themselves regarding access to the therapy. The [National Catholic Bioethics Center](#) suggests that healthcare providers declining to refer may assist patients with accomplishing a transfer of care to another provider or institution of the patient's choosing by providing a general list of other providers or institutions based on geographic vicinity or area of specialty, so long as the list is not developed based on the criterion of whether the providers are known or believed to offer the therapy in question. Institutions should have processes in place to ensure that the transfer of care process does not interfere with the patient's right to obtain legally prescribed and medically indicated treatments. Any accommodations made on the basis of a pharmacist's decision to exercise the right of conscience should be nonpunitive.

### **ASHP Position on Assisted Suicide**

The Council reviewed ASHP policy 9915, ASHP Position on Assisted Suicide, in response to a recommendation from the House of Delegates that ASHP "should revise position 9915 to clearly oppose pharmacists' participation in assisted suicide on the basis that it is not consistent with the pharmacists' role in affirming life and assisting patients in making the best use of medications." This issue has also grown in significance with the recent passing of laws legalizing assisted suicide along with court decisions decriminalizing the practice. In the United States this has occurred in Oregon (1997), Washington (2008), Montana (2009), Vermont (2013), and New Mexico (2014). The California legislature recently passed a law legalizing assisted suicide which is currently pending the Governor's decision. The Council considered the ASHP Statement on Pharmacist's Decision-making on Assisted Suicide, the Code of Ethics for Pharmacists, and the positions of the American Medical Association and American Nurses Association in reaffirming the existing policy. The Council concluded that the existing policy was relevant and appropriate, but that it would benefit from a rationale, which is the following two paragraphs.

The [Code of Ethics for Pharmacists](#) states that "a pharmacist promises to help individuals achieve optimum benefit from their medications [and] to be committed to their welfare" and that "a pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health." In pharmacist decision-making about participation in legal assisted suicide, those principles may clash. Patient autonomy dictates that they be free to exercise their ethical and legal right to choose or decline treatment. When legal treatment options conflict with the pharmacist's perceived obligations to the patient, it is essential for him or her to examine the moral and ethical issues of participating in the patient's treatment, but it remains incumbent on the pharmacist to place concern for the well-being of the patient at the center of professional practice, regardless of whether they agree with the values underlying a patient's choice of treatment or decision to forgo any particular treatment. The healthcare provider's duty to provide care and affirm life is interpreted by some to include ensuring the right of competent

patients to receive any legal treatment option, including assistance in dying. The [ASHP Statement on Pharmacist's Decision-making on Assisted Suicide](#) provides an overview of the guiding principles for the pharmacist's decision-making in assisted suicide, including professional tradition, respect for the patient, and professional obligations.

As more fully explored in ASHP policy 0610, Pharmacist's Right of Conscience and Patient's Right of Access to Therapy, pharmacists retain their right to refuse to participate in morally, religiously, or ethically troubling therapies, without retribution. Procedures should be in place to ensure that healthcare organizations can provide mission-compatible care to patients, and that healthcare providers practicing there are not a barrier to the organization's ability to provide that care.

## Safe Disposal of Patients' Home Medications

The Council voted to develop an ASHP resource (e.g., a toolkit or web resource page) for pharmacists on implementing dropbox receptacles or mail-back medication disposal programs. During the sunset review of ASHP policy 0614, Safe Disposal of Patients' Home Medications, the Council identified the need to assist pharmacists in implementing patient-friendly medication disposal programs and voted to recommend development of an ASHP resource (e.g., a toolkit or web resource page) on the subject. The Council suggested that the following topics could be included in the resource: identifying community partners; generating funding; addressing liability; educating patients, prescribers, and administrators; and reducing over-prescribing. Council members suggested that sharps programs could serve as an example.

The Council also voted to request that the Council on Public Policy consider developing policy that would encourage state and federal legislation and regulation that would permit pharmacists to accept controlled substances as part of patient medication disposal programs regardless of onsite pharmacy status.

The Council noted that current DEA regulations limit hospital and clinic participation in patient medication take-back programs to those with an onsite pharmacy ([DEA Rule on Disposal of Controlled Substances \[79 FR 53519\]](#)). This restriction limits the ability of other health-system pharmacists, such as those practicing in clinic pharmacies without an onsite or retail pharmacy, from effectively participating in such patient medication disposal programs (e.g., mail-back programs and collection receptacles). The Council voted to request the Council on Public Policy to consider developing policy that would advocate that hospital and health-system pharmacies be allowed to participate, regardless of onsite pharmacy status.

## Just Culture

The Council voted to request that the Council on Public Policy consider developing policy that would advocate that state boards of pharmacy adopt a *just culture* response when medication errors are reported.

During sunset review of ASHP policy 1115, Just Culture, the Council noted several examples of extreme punishments imposed by state boards of pharmacy in response to medication errors. The Council noted that Just Culture principles encourage the reporting of medication errors by reserving harsh punishments for reckless behavior rather than human or system errors and expressed concern that severe punishments for errors may discourage medication error reporting.

Council members noted that there is a lack of understanding of just culture and that an ongoing educational initiative also may be needed. Council members encouraged ASHP to review current educational offerings (meeting presentations and webinars) and AJHP articles to determine if this need has been addressed adequately by ASHP.

## USP General Chapter 800: Hazardous Drugs – Handling in Healthcare Settings

The Council discussed the implications for members and ASHP of the pending publication of USP Chapter 800, Hazardous Drugs—Handling in Healthcare Settings. According to USP the purpose of the new proposed general chapter is to provide standards to protect personnel and the environment when handling hazardous drugs. The new proposed general chapter defines processes intended to reduce exposure to hazardous drugs to as low a limit as reasonably achievable.

The Council discussed the implications of implementing proposed Chapter 800. Council members recalled that when implementing USP Chapter 797, the ASHP gap analysis tool was very useful and wondered whether a checklist, a set of performance standards, or a similar tool is possible. Council members also expressed support for developing a diagram of the effects on Chapter 800 on the medication-use process. The questions Council members thought should be answered by the ASHP resource included:

- whether organizations should use the National Institute for Occupational Safety and Health (NIOSH) list of hazardous drugs or conduct an individual safety analysis;
- when the NIOSH list will be updated, and how organizations should respond to updates;
- how organizations should address new drugs not on the NIOSH list;
- how to construct a medical surveillance list (i.e., to include everyone who may handle hazardous drugs at any stage);
- whether distributors could be required to label totes that contain hazardous drugs (currently, the contents are not known until they're opened, which presents a hazard or a burden on practice);
- educational resources for staff (e.g., technicians and facilities staff);
- potential disparate impacts on small, rural, and critical access facilities;
- prioritization of risk-reduction actions (i.e., the relative value of specific actions), which could be expressed as a difficulty/resource rating and incorporated into a gap analysis tool, perhaps as add-on feature);
- how to communicate with vendors (i.e., a “Cliff Notes” version of Chapter 800 in “contractor speak”);
- how to implement the Chapter in alternative sites (e.g., physician offices); and
- education of and advocacy with accreditation organizations (e.g., TJC, DNV), administrators, and state board of pharmacy.

## Council Guidance Documents

The Council reviewed the current schedule for development of guidance documents recommended by the Council and made several recommendations regarding continuing, suspending, or discontinuing development.

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## COUNCIL ON PUBLIC POLICY: POLICY RECOMMENDATIONS

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*The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice in hospitals and health systems. Within the Council's purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.*

Kelly M. Smith, *Board Liaison*

### **Council Members**

John D. Pastor, *Chair* (Minnesota)  
Gloria P. Sachdev, *Vice Chair* (Indiana)  
Joe R. Anderson (New Mexico)  
Anna Legreid Dopp (Wisconsin)  
Emily L. Dyer (Virginia)  
Ewa M. Dzwierzynski (Rhode Island)  
Melissa A. Ortega (Massachusetts)  
Kelley L. Ratermann, *New Practitioner*  
(Kentucky)  
Matthew P. Schneller, *Student* (Florida)  
Maria D. Serpa (California)  
Pamela L. Stamm (Georgia)  
Joseph M. Hill, *Secretary*

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### **1. Off-Label Promotion by Pharmaceutical Manufacturers**

- 1 To advocate for authority for the Food and Drug Administration to regulate the
- 2 promotion and dissemination of information about off-label uses of medications and
- 3 medication-containing devices by manufacturers; further,
  
- 4 To advocate that such off-label promotion and marketing be limited to the responsible
- 5 dissemination of unbiased, truthful, non-misleading, and scientifically accurate
- 6 information based on authoritative, peer-reviewed literature not included in the New
- 7 Drug Approval process.

(Note: This policy would supersede ASHP policy 1120.)

### ***Rationale***

Congress is considering significant changes in the way drugs are developed, approved, and marketed in the United States. A provision in the House-passed 21st Century Cures bill (H.R. 6) would allow pharmaceutical manufacturers to promote off-label uses of their products to clinicians. This has raised concerns about the accuracy and sources of such information. Sources of such information, if unreliable, could put patient safety at risk. Despite these concerns about promotion of off-label uses by manufacturers, ASHP has suggested an amendment that would require Food and Drug Administration (FDA) oversight of such promotion and require promotional materials to be unbiased, truthful, non-misleading, scientifically accurate, and based upon peer-reviewed literature not included in the approved labeling of the drug. Materials would therefore require approval by the proper authority (FDA), meet certain requirements, and be truthful, non-biased and scientifically accurate.

**Background**

The Council voted to recommend revising ASHP policy 1120, Regulation of Off-Label Promotion and Marketing, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate for authority for the Food and Drug Administration to regulate the promotion and dissemination of information about off-label uses of medications and medication-containing devices by manufacturers; further,

To advocate that such ~~promotion and dissemination be permitted only if manufacturers submit a supplemental new drug application for new use within a reasonable time after initial dissemination of information about off-label uses~~ off-label promotion and marketing be limited to the responsible dissemination of unbiased, truthful, non-misleading, and scientifically accurate information based on authoritative, peer-reviewed literature not included in the New Drug Approval process.

The Council was clear however, that it is generally concerned with the practice of off-label promotion by manufacturers and felt strongly that such concern be noted. These concerns are similar to those expressed in ASHP policy 1119, Direct-to-Consumer Advertising of Prescription and Nonprescription Medications, which opposes direct-to-consumer advertising of pharmaceuticals.

**2. Timely State Board of Pharmacy Licensing**

- 1 To advocate that state boards of pharmacy grant temporary licensure to pharmacists
- 2 who are relocating from another state in which they hold a license in good standing,
- 3 permitting them to engage in practice while their application for licensure reciprocity is
- 4 being processed; further,
  
- 5 To advocate that the National Association of Boards of Pharmacy (NABP) collaborate
- 6 with state boards of pharmacy to streamline the licensure reciprocity process; further,
  
- 7 To advocate that NABP collaborate with state boards of pharmacy to streamline the
- 8 licensure process through standardization and improve the timeliness of application
- 9 approval.

(Note: This policy would supersede ASHP policy 0612.)

**Rationale**

Pharmacists sometimes face challenges from delays in obtaining licensure by reciprocity when moving their practice from one state to another. Such delay may be due to the need for boards to review pharmacists' licensure records in all states in which they are licensed, administer a state pharmacy law exam, complete a criminal background check, and, in some cases, schedule an interview with the board. To address these challenges, boards of pharmacy should allow pharmacists in good standing to immediately practice in a different state when they change employment or enter a residency program. Granting pharmacists a temporary license for a period of up to six months while the state board completes its review would help meet

workforce demands while continuing to safeguard the public health. In some cases, pharmacists who are unable to obtain a license in a timely manner are unable to fully use the skills in which they have been trained. Without a license, the pharmacist may temporarily have to function as a technician or perform other tasks. For pharmacists participating in residency programs outside their state of licensure, several months of their residency program can elapse before they receive licensure reciprocity. Upon completion of a year-long residency program, many residents move to another state to practice and have to start the reciprocity process again.

Members in several states have reporting that in recent years state boards of pharmacy have been slow to issue pharmacy licenses. This is especially problematic for out-of-state residents who rely on state boards to grant them license prior to performing in a clinical capacity. Given that the licensing period can take several months, this has presented a problem for residents who have a limited timeframe to successfully complete their duties as pharmacy residents, typically one year. In some cases, state boards are urging residents to obtain a pharmacy technician license; however, this is inappropriate given the expertise and education residents have and the level of practice they're expected to engage in. Given its national scope, NABP is well-positioned to explore a broad solution to this problem rather than the current, incremental, state-by-state approach.

### **Background**

The Council recommended amending ASHP policy 0612, Streamlined Licensure Reciprocity, as follows (underscore indicates new text):

To advocate that state boards of pharmacy grant temporary licensure to pharmacists who are relocating from another state in which they hold a license in good standing, permitting them to engage in practice while their application for licensure reciprocity is being processed; further,

To advocate that the National Association of Boards of Pharmacy (NABP) collaborate with state boards of pharmacy to streamline the licensure reciprocity process; further,

To advocate that NABP collaborate with state boards of pharmacy to streamline the licensure process through standardization and improve the timeliness of application approval.

The Council considered the policy in response to a recommendation from the House of Delegates that "ASHP develop a statement to NABP urging them to amend the model state pharmacy practice act to modernize and expedite initial licensing for pharmacists." In addition, the Council suggested that ASHP urge NABP to develop a task force to explore and make recommendations for improved licensing standards, including timeliness, access, and reciprocity.

The ASHP Accreditation Services Division will collaborate with ASHP Government Relations to provide outreach to NABP.

### 3. Inclusion of Drug Product Shortages in State Price-gouging Laws

- 1 To urge state attorneys general to consider including shortages of lifesaving drug
- 2 products within the definition of events that trigger application of state price-gouging
- 3 laws.

#### **Rationale**

Drug product shortages can lead to price gouging and trafficking in counterfeit and diverted drug products through gray-market distributors, which can ultimately result in adverse patient outcomes and increased healthcare costs. Strategies, including specific legislation with stiff penalties for price gouging during drug product shortages, are needed to deter these activities. Thirty-one states currently have price-gouging laws that prohibit price markups on life-sustaining products (e.g., food, water, fuel), usually during a time of disaster, natural or otherwise. In the absence of laws that specifically address price gouging during drug product shortages, ASHP urges state attorneys general to consider including shortages of lifesaving medications within the definitions of disaster or other trigger mechanisms for existing price-gouging laws.

#### **Background**

The Council considered the issue of price gouging during drug product shortages as it reviewed ASHP policy 1118, Drug Product Shortages. The Council concluded that encouraging state attorneys general to use existing laws against price gouging during shortages of lifesaving drug products was a strategy that could help reduce the impact of such shortages.

### 4. Home Intravenous Therapy

- 1 To support the continuation of a home intravenous therapy benefit under federal and
- 2 private health insurance plans, and expand the home infusion benefit under Medicare
- 3 at an appropriate level of reimbursement for pharmacists' patient care services
- 4 provided, medications, supplies, and equipment.

(Note: This policy would supersede ASHP policy 0414.)

#### **Rationale**

The Medicare Modernization Act of 2003 created an outpatient prescription drug benefit for Medicare beneficiaries, Medicare Part D. The new benefit provided prescription drug coverage for Medicare beneficiaries by private health plans and pharmacy benefit managers (PBMs). Although the law requires certain basic coverage packages across the plan continuum, it provides no coverage for services and supplies used in home infusion. The result is that the drug products used in home infusion may be covered, but the supplies (e.g., IV bags, tubing) and services related to providing and administering the drug products are not.

Over the years, efforts have been made to address this gap by moving coverage for the drug products from Part D to Part B, and including supplies and services within that coverage. Initially, this effort resulted in federal legislation to move home infusion coverage from Part D to Part B; however, projected costs to the Medicare program have prevented Congress from

passing the legislation. ASHP supports continuation of a home intravenous therapy benefit under federal and private health insurance plans and expanding the home infusion benefit under Medicare to include supplies and services related to providing and administering the therapy.

### **Background**

The Council voted to recommend amending ASHP policy 0414, Home Intravenous Therapy Benefit, to strike “Part B” as follows (~~strike through~~ indicates deleted text):

To support the continuation of a home intravenous therapy benefit under federal and private health insurance plans, and expand the home infusion benefit under Medicare ~~Part B~~ at an appropriate level of reimbursement for pharmacists’ patient care services provided, medications, supplies, and equipment.

The Council on Public Policy reviewed the policy and agreed that a competing Part B “ask” would be detrimental to two policy objectives: expanding the home infusion benefit to cover related supplies and services as well as pharmacist provider recognition under Medicare Part B. Efforts by the pharmacy profession to obtain provider recognition within the Medicare program under Part B could be viewed as directly competing with the policy goal of Part B coverage of home infusion services and supplies, given that both would be funded through Medicare Part B and would require budget offsets to account for added costs in Part B of the Medicare Program.

In addition, the Council asked for input from ASHP’s Section of Ambulatory Care Practitioners Advisory Group on Home Infusion related to the sunset review of this policy. Those recommendations, and ensuing Council discussion, resulted in the suggestion that the reference to Part B be removed from the policy to keep the policy goal broad. This approach could allow for Part D plans to provide coverage for the supplies and services of home infusion therapy

## 5. Drug Product Shortages

To discontinue ASHP policy 1118, Drug Product Shortages, which reads:

- 1 To advocate that the Food and Drug Administration (FDA) have the authority to
- 2 require manufacturers to report drug product shortages and the reason(s) for the
- 3 shortage, and to make that information available to the public; further,
  
- 4 To strongly encourage the FDA to consider, in its definition of “medically necessary”
- 5 drug products, the patient safety risks created by use of alternate drug products
- 6 during a shortage; further,
  
- 7 To support government-sponsored incentives for manufacturers to maintain an
- 8 adequate supply of medically necessary drug products; further,
  
- 9 To advocate laws and regulations that would (1) require pharmaceutical
- 10 manufacturers to notify the appropriate government body at least 12 months in
- 11 advance of voluntarily discontinuing a drug product, (2) provide effective sanctions
- 12 for manufacturers that do not comply with this mandate, and (3) require prompt
- 13 public disclosure of a notification to voluntarily discontinue a drug product; further,
  
- 14 To encourage the appropriate government body to seek the cooperation of
- 15 manufacturers in maintaining the supply of a drug product after being informed of a
- 16 voluntary decision to discontinue that product.

### **Background**

ASHP policy 1118 was last updated in 2010 to reflect ASHP’s efforts to address drug shortages through legislation. In 2010, there were a record number of drug product shortages nationwide, and many of them involved critical, life-saving medications. In response to the crisis, ASHP led a group of stakeholder organizations in an effort to pass legislation that would give FDA more authority to prevent drug shortages. The legislation has since been enacted and the Council concluded that the policy should be discontinued to reflect the passage of the [Food and Drug Safety and Innovation Act of 2012](#).

ASHP will continue to be involved in ongoing efforts to prevent drug shortages. Title X of the act requires FDA to develop a strategic plan aimed at preventing and mitigating shortages of critical medications. FDA must allow for input from the public on the strategic plan. Further, FDA must establish a task force to study and make recommendations on preventing shortages. The task force is also required to solicit public input from stakeholders, including pharmacy organizations. The Council believed that ASHP policy is not necessary to direct ASHP’s involvement and engagement with the FDA task force and development of the strategic plan.

## 6. Direct-to-Consumer Advertising for Prescription Drugs and Implantable Devices

- 1 To advocate that Congress commission an evidence-based review of direct-to-consumer  
2 (DTC) advertising for prescription drugs and implantable medical devices in the United  
3 States to determine the impact of such DTC advertising on the patient-prescriber  
4 relationship, healthcare costs, health outcomes, and the public health; further,
- 5 To advocate that Congress ban DTC advertising for prescription drugs and implantable  
6 medical devices until the results of such a review are publicly available; further,
- 7 To advocate, in the absence of a Congressionally mandated review, that the FDA, other  
8 appropriate federal agencies, and the pharmaceutical and medical device industries  
9 conduct or fund research on the effects of DTC advertising on the patient-prescriber  
10 relationship, healthcare costs, health outcomes, and the public health, and make the  
11 research results available to the public; further,
- 12 To oppose, in the absence of a ban, DTC advertising for prescription drugs and  
13 implantable medical devices unless it is educational in nature about prescription drug  
14 therapies for certain medical conditions, appropriately includes pharmacists as a source  
15 of information, and is conducted so as to mitigate potential harmful effects on the  
16 patient-prescriber relationship, healthcare costs, health outcomes, and the public  
17 health.

(Note: This policy would supersede ASHP policy 1119.)

### ***Rationale***

Direct-to-consumer (DTC) advertising of prescription drugs and implantable medical devices has [both positive and negative potential effects](#). The positive potential effects include broader public awareness and use of therapies, increased patient engagement in their healthcare, and better return on investment in drug and medical device research. These potential benefits need to be weighed against the potential negative effects, which include increased adverse effects, higher drug and device costs, and inappropriate prescribing of more costly new drugs or devices without any justifying improvement in patient outcomes. In 2015, the American Medical Association (AMA) adopted a [policy](#) calling for a ban on DTC advertising of prescription drugs and implantable medical devices due to its impacts on drug prices and physician prescribing practices.

To properly assess the risks and benefits of DTC advertising, the nation needs an authoritative, evidence-based review of DTC advertising for prescription drugs and implantable medical devices to determine its impact on the patient-prescriber relationship, healthcare costs, health outcomes, and the public health. Until the results of such a review are publicly available, Congress should ban DTC advertising for prescription drugs and implantable medical devices in the interest of protecting the public health. In the absence of such a review, other

responsible stakeholders (e.g., FDA, public interest groups, and pharmaceutical and medical device manufacturers) should conduct research and make their findings publicly available.

In the absence of a ban, ASHP will oppose DTC advertising for prescription drugs and implantable medical devices unless it is educational in nature about prescription drug therapies for certain medical conditions, appropriately includes pharmacists as a source of information, and is conducted so as to mitigate potential harmful effects on the patient-prescriber relationship, healthcare costs, health outcomes, and the public health. The following are required to mitigate those potential harmful effects: (1) such advertising is delayed until postmarketing surveillance data are collected and assessed; (2) the benefits and risks of therapy are presented in an understandable format at an acceptable literacy level for the intended population; (3) such advertising promotes medication and device safety and allows informed decisions; (4) a clear relationship between the product and the disease state is presented; (5) no such advertising or marketing information is directed toward minors; (6) such advertising includes mechanisms that direct consumers to a medication or medical device adverse event reporting system (AERS); (7) the FDA review and pre-approve all such advertisements for prescription drug or implantable medical device products to ensure compliance with federal regulations and consistency with FDA-approved labeling before the advertisements are disseminated; and (8) that the FDA require an AERS reporting link in DTC advertising material available on the Internet.

### **Background**

The Council recommended revising ASHP policy position 1119, Direct-to-Consumer Advertising of Prescription and Nonprescription Medications, which reads as follows:

To oppose direct-to-consumer advertising unless it is educational in nature about prescription drug therapies for certain medical conditions and appropriately includes pharmacists as a source of information; further,

To oppose direct-to-consumer advertising of specific prescription drug products unless the following requirements are met: (1) that such advertising is delayed until postmarketing surveillance data are collected and assessed, (2) that the benefits and risks of therapy are presented in an understandable format at an acceptable literacy level for the intended population, (3) that such advertising promotes medication safety and allows informed decisions, (4) that a clear relationship between the medication and the disease state is presented, (5) that no such advertising or marketing information for prescription or nonprescription medication is directed toward minors, and (6) that such advertising include mechanisms that direct consumers to a medication adverse event reporting system (AERS); further,

To advocate that the Food and Drug Administration require an AERS reporting link in direct-to-consumer advertising material available on the Internet; further,

To support the development of legislation or regulation that would require nonprescription drug advertising to state prominently the benefits and risks associated with product use that should be discussed with the consumer's pharmacist or physician.

In this revision, the Council is recommending adoption of policy similar to that of the AMA, which calls for a ban on DTC advertising but recognizes the need for strong policy regarding the content of such advertising in the absence of a ban. The Council chose to recommend joining AMA in calling for an authoritative study of the effects of DTC advertising and to place ASHP policy toward DTC advertising in that context. The Council also recommended that in the absence of such a study and a ban on DTC advertising, ASHP retain its policy in opposition to DTC advertising in clauses 1-3 of the current policy, placing some of the detail of clauses 2 and 3 in the rationale. The Council further decided to consider a separate new policy on DTC advertising of nonprescription medications at a future meeting, given the complexity of the recommended policy and the distinct regulatory regime for such advertising.

## Board Actions

### Sunset Review of Professional Policies

As part of sunset review of existing ASHP policies, the following were reviewed by the Council and Board and found to be still appropriate. (No action by the House of Delegates is needed to continue these policies.)

- [Regulation of Off-label Promotion and Marketing](#) (1120)
- [Poison Control Center Funding](#) (1121)
- [Generic Pharmaceutical Testing](#) (9010)
- [Redistribution of Unused Medications](#) (0611)
- [Importation of Pharmaceuticals](#) (0413)

## Other Council Activity

### Regulation of Dietary Supplements

A recommendation made by the 2015 ASHP House of Delegates asked ASHP to examine ASHP policy on the regulation of dietary supplements. Relevant ASHP policies include 0801, 1305, 0920, 0811, and 0415.

The Council concluded that existing ASHP policy on the regulation of dietary supplements is adequate. One area of potential concern is the growing use of homeopathic medicines. ASHP has had discussions with FDA on this issue and FDA would be concerned with categorizing homeopathic medications as a form a dietary supplement rather than a medication. After discussion, the Council decided that homeopathic medications are not entirely within the Council's purview and that the Council on Therapeutics may want to investigate this issue further. The discussion resulted in three recommendations:

- 1) The Council will investigate and gather additional information from the delegate who made the recommendation to the House of Delegates.

- 2) The Council will explore options to encourage more education on the use of dietary supplements, possibly through an article in *AJHP*.
- 3) The Council will further investigate the issues regarding homeopathic medications, through further discussion during its February call or by encouraging the Council on Therapeutics to examine the issue.

## Hospital Pharmacy Budgets and Generic Drugs

There is growing concern over recent price spikes of previously low-cost, generic drug products and the impact the price increases is having on hospital pharmacy budgets. A number of national media outlets have been covering the issue as it has gained more attention in recent months. A suggestion by the House of Delegates that ASHP investigate this problem further underscores member concern over what they see as inappropriate price increases, or potential price gouging.

ASHP policy 0222 could be used as background as ASHP advocates for greater use of low-cost generic drug products. However, the policy does not address the pricing issue, but it could be interpreted broadly to link cost and access. In the event of price spikes, access to drug products may be compromised and thus elements of ASHP policy 0222 could be applicable from an access perspective.

In addition, the Council suggested that ASHP continue working with stakeholders such as the American Hospital Association to call attention to the issue and explore reasonable policy solutions. The Council also suggested beginning outreach to other potential stakeholder groups representing self-insured health plans, PBMs, and the health insurance industry to get input on how this issue impacts the payer community.

The Council decided that it needs more information about the subject. The Council also agreed with the House of Delegates recommendation that ASHP form a task force to provide more information on the following sub-topics:

- Pricing related to generic drugs
- Pricing related to brands, including specialty drugs
- Price gouging
- Price transparency



# House of Delegates

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## Proposed ASHP Bylaws Amendments

### 1. Why are there proposed amendments to the ASHP Bylaws?

The Board of Directors is recommending that the ASHP bylaws be amended to remove language requiring that officers and directors be installed at the annual meeting of the House of Delegates. Doing so will provide flexibility for future installations of all officers and directors, as the specific venue and time requirements will be eliminated. The proposed amendment would not preclude the installation of officers and directors at the annual meeting of the House of Delegates; rather, it would simply remove the overly prescriptive requirement for doing so that currently exist in the bylaws.

The proposed bylaw amendments would effectuate the deletion of the following two provisions (also noted in the attached redline of the ASHP Governing Documents):

4.1.4. Each officer shall be installed at the yearly meeting of the House of Delegates.

7.3.3. All officers and Directors of ASHP shall be installed before the House of Delegates at the commencement of their individual terms of office.

### 2. What is the process for voting on ASHP Governing Documents amendments?

Proposed amendments to the ASHP Bylaws must be submitted to the ASHP Board of Directors for review and approval. The Board then submits the amendments to the House of Delegates for approval by a majority of voting delegates then present and voting. Please note that no amendments to the ASHP Charter or Rules of Procedure for the House of Delegates are required by this proposed change in bylaws.

### 3. How will the Bylaws amendments be introduced and voted on at the ASHP House of Delegates?

The bylaws amendments will be introduced to the House of Delegates during the first meeting of the House by ASHP President John Armitstead. The Chair of the House of Delegates will then request that the delegates vote to approve the amendments.

Please see changes on pages 6 and 13.

# Governing Documents of the American Society of Health-System Pharmacists

## ASHP CHARTER

**First.** The undersigned, whose names and post office addresses are set forth at the end of this document, each being at least 18 years of age, do hereby form a corporation under the general laws of the state of Maryland.

**Second.** The name of the corporation is American Society of Health-System Pharmacists, Inc. (ASHP).

**Third.** The purposes for which ASHP is formed are as follows:

1. To advance public health by promoting the professional interests of pharmacists practicing in hospitals and other organized health care settings through:
  - a. Fostering pharmaceutical services aimed at drug-use control and rational drug therapy.
  - b. Developing professional standards for pharmaceutical services.
  - c. Fostering an adequate supply of well-trained, competent pharmacists and associated personnel.
  - d. Developing and conducting programs for maintaining and improving the competence of pharmacists and associated personnel.
  - e. Disseminating information about pharmaceutical services and rational drug use.
  - f. Improving communication among pharmacists, other members of the health care industry, and the public.
  - g. Promoting research in the health and pharmaceutical sciences and in pharmaceutical services.
  - h. Promoting the economic welfare of pharmacists and associated personnel.
2. To foster rational drug use in society such as through advocating appropriate public policies toward that end.
3. To pursue any other lawful activity that may be authorized by ASHP's Board of Directors.

**Fourth.** The post office address of the principal office of ASHP in Maryland is 7272 Wisconsin Avenue, Bethesda (Montgomery County), Maryland 20814. The name and post office address of the resident agent of ASHP in Maryland is C.T. Corporation Systems, Inc., 32 South Street, Baltimore, Maryland 21202. The resident agent of ASHP is a Maryland corporation.

**Fifth.** ASHP shall be a not-for-profit corporation and shall not be authorized to issue capital stock. No part of the net earnings of ASHP, current or accumulated, shall inure to the benefit of any private individual, nor shall ASHP be operated for the primary purpose of carrying on a trade or business for profit. ASHP intends to avail itself of any and all tax benefits or exemptions to which it may be entitled under Section 501 of the Internal Revenue Code of 1954, and it shall not operate or engage in any activity nor shall it possess or exercise any power that would substantially risk the loss of such benefits under that Code.

**Sixth.** The number of Directors of ASHP shall be 12, which number may be increased or decreased only by amendment to this Charter. The Board of Directors shall consist of six Directors who shall be elected at large by a majority of votes cast by active members; the Chair of the House of Delegates; and the officers of ASHP, to wit, the President, the President-elect, the Immediate Past President, the Treasurer, and the Secretary. The Directors, who shall act until the first annual meeting or until their successors are duly chosen and qualified, as set forth in the Bylaws, are Roger W. Anderson, John A. Gans, Thomas J. Garrison, Clifford E. Hynniman, Marianne F. Ivey, Herman L. Lazarus, Harland E. Lee, Arthur G. Lipman, Joseph A. Oddis, Judith A. Patrick, Paul G. Pierpaoli, and Marilyn L. Slotfeldt. The Directors of ASHP shall manage its business affairs. All Directors shall be active members of ASHP.

**Seventh.** The following provisions are hereby adopted for the purposes of defining, limiting, and regulating the internal affairs of ASHP:

1. The membership of ASHP shall consist of active members, associate members, honorary members, and such other categories as may be established in the Bylaws. Active members shall be licensed pharmacists who support the purposes of ASHP as stated in the Article Third of this Charter; the other requirements for active membership shall be stated in the Bylaws. Only active members may (a) vote as individual members on amendment to this Charter as provided in Charter item 11, (b) serve as state delegates to the House of Delegates, (c) elect the Directors of ASHP, and (d) serve as a Director of ASHP. The definition, rights, powers, and obligations of each class of members not set forth herein shall be established and limited by the Bylaws.
2. ASHP shall have a House of Delegates that shall meet yearly to review, consider, and ultimately approve or disapprove the professional policies recommended to it by its Directors and to review the affairs of ASHP; voting delegates in the House of Delegates shall consist of the following classes: state delegates, who shall be active members and shall be deemed to represent the aliquot portion of the active membership of ASHP, plus Directors, plus eligible Past Presidents of ASHP, plus fraternal delegates, plus the chair of each Section and Forum created by the Board pursuant to Article 6.1.6 of the bylaws.
  - 2.1. The House of Delegates shall have at least two state delegates from each state.
  - 2.2. The House of Delegates shall elect a Chair to preside at all of its meetings.
3. ASHP may establish and shall try to promote and strengthen ongoing cooperative relationships with other domestic and international organizations when such relationships further the purposes of ASHP.

4. ASHP shall try to formally recognize, promote, and strengthen relationships with groups of pharmacists in the various states and possessions of the United States when such groups promote and foster the purposes of ASHP.

**Eighth.** Upon termination, dissolution, or winding up of ASHP, any assets that remain after payment or provision for payment of all of its liabilities, debts, and obligations shall be distributed by the Board of Directors only to one or more organized charitable, educational, scientific, or philanthropic organizations duly qualified as exempt under Section 501(c)(3) of the Internal Revenue Code of 1954 (or under such successor provision of the Internal Revenue Code as may be in effect at the time of termination, dissolution, or winding up of ASHP). Under no circumstances shall any assets be distributed to any member of ASHP.

**Ninth.** The private property of the members, officers, Directors, and employees of ASHP shall not be subject to payment of any debts or obligations of ASHP.

**Tenth.** The Bylaws shall delineate the authority of the Board of Directors and govern the internal affairs of ASHP. The Bylaws may be amended as provided therein.

**Eleventh.** Any proposed amendment to this Charter must first be submitted to the Board of Directors. Upon review, the Board shall submit the proposed amendment to the House of Delegates. Upon approval of a majority of the voting delegates of the House of Delegates then present and voting, it shall be submitted to the entire active membership for vote by mail ballot in the same manner as in the election of officers as provided in the Bylaws and shall be sent out as part of the ballot for officers.

**Twelfth.** The duration of ASHP shall be perpetual.

## BYLAWS

### Article 1. Name and Seal

- 1.1. The name of the corporation shall be the “American Society of Health-System Pharmacists, Inc.,” which will be referred to as ASHP.
  - 1.1.1. The official corporate seal of ASHP, which shall be used as needed to authenticate documents of ASHP, shall consist of the word “Seal” as authorized by Section 1-304 of the Corporations and Associations Article of the Code of Maryland.
- 1.2. ASHP may adopt and use such trade names, trademarks, service names, and service marks as, in its judgment, are necessary or appropriate to identify or designate its products and services and to carry on its business.
  - 1.2.1. No member, chapter, organizational component, or third party may use any name or mark of the ASHP unless such use conforms to the standards established by the Board of Directors and unless the Board has specifically approved such use in writing.

### Article 2. Offices and Agent

- 2.1. ASHP shall continuously maintain, in the state of Maryland, a registered office at such place as may be established by the Board of Directors. The Board of Directors may establish ASHP’s principal place of business and other offices and places of business either inside or outside the state.
- 2.2. ASHP shall continuously maintain a registered agent within the state of Maryland, which shall be designated, from time to time, by the Board of Directors.

### Article 3. Membership

- 3.1. The classifications of membership in ASHP are as follows:
  - 3.1.1. *Active Members*: Pharmacists licensed by any state, district, or territory of the United States who have paid dues as established by ASHP; practice in the jurisdictions of the United States, the District of Columbia, or Puerto Rico; and who support the purposes of ASHP as stated in the Article Third of the ASHP Charter.
    - 3.1.1.1. Only active members may vote on amendment to the Charter, serve as state delegates, and elect or serve as a Director of ASHP.
  - 3.1.2. *Associate Members*: Persons who have paid the dues as established by ASHP and who, by virtue of vocation, training, education, and interest, wish to further the purposes of ASHP. Associate members shall consist of the following categories:
    - 3.1.2.1. *Supporting*: Individuals, other than those who qualify as active members, who by working in the health services, teaching prospective pharmacists, or otherwise contributing to pharmacy services provided in organized health care systems, make themselves eligible for membership.



**Article 4. Officers**

- 4.1.** The officers of ASHP shall be the President, the President-elect, the Immediate Past President, the Treasurer, and the Secretary, all of whom shall be active members of ASHP. The Secretary shall also serve as Executive Vice President of ASHP.
- 4.1.1.** The President-elect shall be elected annually for a term of one year and shall succeed successively to the office of President and then to the office of Immediate Past President, serving for one year in each office.
- 4.1.2.** The Executive Vice President shall be chosen by the Board of Directors.
- 4.1.3.** The candidates for Treasurer shall be nominated by the Board of Directors and elected by the active members for a term of office of three years. No person shall serve more than two successive terms as Treasurer.
- STRIKE** → ~~**4.1.4.** Each officer shall be installed at the yearly meeting of the House of Delegates.~~
- 4.1.5.** The President, President-elect, Immediate Past President, and Treasurer are not charged with executive or administrative responsibility for the management or conduct of the internal affairs of ASHP.
- 4.2.** The President shall serve as the principal elected official of ASHP; serve as Chair of the Board of Directors; serve as Chair of the Committee on Resolutions; at the House of Delegates, communicate to the delegates on the actions of the Board of Directors and on important new activities that affect and further the purposes of ASHP; and communicate with members of ASHP, affiliated chapters, and the public on the activities and policies of ASHP.
- 4.2.1.** With the approval of the Board of Directors, the President shall annually appoint Chairs and members of the councils, commissions, committees, and other appropriate components set forth in Article 6 of these Bylaws and any ad hoc committee or groups that the Board of Directors establishes.
- 4.2.2.** The President shall be an ex-officio member of all councils and committees of the Board of Directors and all ad hoc committees.
- 4.2.3.** The President shall report to the Board of Directors on official activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.3.** The President-elect shall perform the duties of the President in the President's absence; succeed to that office upon the death, resignation, or inability of the President to perform the duties of that office; serve as Vice Chair of the Board of Directors; and assist in communicating the policies and activities of ASHP to its affiliated chapters, members, and the public.
- 4.3.1.** The President-elect shall communicate to the House of Delegates and the membership on those issues and activities that may affect and further the purposes of ASHP.
- 4.3.2.** The President-elect shall report to the Board of Directors on official activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.3.3.** A President-elect who succeeds to the office of President as provided in Section 4.3 shall serve out both the unfinished term to which he or she has succeeded and the term to which he or she would have succeeded in due course.

- 4.3.4.** The President-elect shall be nominated by the Committee on Nominations of the House of Delegates and elected by the active membership of ASHP as set forth in Article 7 of these Bylaws.
- 4.4.** The Immediate Past President shall perform the duties of the President in the temporary absence of both the President and President-elect, serve as Vice Chair of the House of Delegates, and serve in such other capacity as may be designated by the Board of Directors.
- 4.4.1.** The Immediate Past President shall report to the Board of Directors on his or her activities and shall advise the Board of Directors on such matters as may further the purposes of ASHP.
- 4.5.** The Treasurer shall serve as the Chair of the Committee on Finance, as specified in Section 5.2; be responsible for overseeing conservation and prudent investment of the assets and funds of ASHP; assure expenditure of funds is in accord with the programs, priorities, and budget established by the Board of Directors; and regularly inform the Board of Directors, members, and House of Delegates on the financial strength and needs of ASHP.
- 4.5.1.** No monies shall be disbursed except upon signature of the Treasurer and the Executive Vice President. The Treasurer shall periodically review and approve internal controls designed to assure proper control of funds and disbursements and make sure that current and projected income and expenses meet the budget of ASHP.
- 4.5.2.** The Board of Directors may, at all times, inspect and verify the books and accounts of ASHP.
- 4.5.3.** The Treasurer shall review and report upon the long-term financial projections and plans of ASHP.
- 4.6.** The Executive Vice President shall serve as the chief executive officer and as Secretary of ASHP.
- 4.6.1.** The Executive Vice President shall be responsible for administration of ASHP; direction of all operations, programs, and activities of ASHP; and hiring, firing, and the compensation and benefits of staff, subject to establishment of general salary and benefit policies by the Board of Directors. The Executive Vice President shall, at all times, carry out the policy aims and programs as generally determined by the Board of Directors.
- 4.6.2.** As Secretary, the Executive Vice President shall keep and maintain an accurate record of the meetings of the Board of Directors, the House of Delegates, and such other activities of ASHP as the Board of Directors may direct. The Executive Vice President shall give all notices required by law. The Executive Vice President shall have authority to affix the corporate seal to any document requiring it and attest thereto by his or her signature.
- 4.6.3.** The Executive Vice President may appoint an Assistant Secretary to attest to documents.
- 4.6.4.** The Executive Vice President shall, by virtue of the office, be a nonvoting member of all councils, commissions, and committees of the Board of Directors; committees of the House of Delegates; and any other committee or component group established by the Board of Directors.

- 4.6.5.** The Executive Vice President shall be chosen by and serve at the pleasure of the Board of Directors. The Board of Directors may, on behalf of ASHP, enter into a contract with the Executive Vice President with such terms and for such fixed period as the Board of Directors deems reasonable and in the best interests of ASHP. Failure of a person to continue in the office of Executive Vice President will not affect contract rights, except as the terms of that contract may so provide.
- 4.7.** The manner of filling vacancies of any office shall be as follows:
- 4.7.1.** The provision of Sections 4.3 and 4.3.3 shall apply.
- 4.7.2.** If both the President and the President-elect shall become permanently unable to perform the duties of their offices, the Board of Directors shall appoint, from the Board of Directors, a President Pro Tempore to serve for the remaining portion of the unexpired term. At the next yearly meeting of the House of Delegates, the Committee on Nominations shall present nominations for the offices of President and President-elect, and an election shall be conducted in accordance with the provisions of Article 7 of these Bylaws.
- 4.7.3.** If the Executive Vice President or the Treasurer becomes unable to perform the duties of his or her office, the Board of Directors is empowered to fill that vacancy.
- 4.7.4.** If the Immediate Past President is permanently unable to perform the duties of that office, the Board of Directors shall appoint a Director of ASHP to perform the duties of that office.
- 4.8.** The following miscellaneous provisions shall apply:
- 4.8.1.** To the extent not prohibited by these Bylaws, the officers may also exercise the powers that, by statute or otherwise, are customarily exercised by officers holding such offices or that may be established by the Board of Directors. However, only the Executive Vice President or an individual appointed by the Executive Vice President may execute, on behalf of ASHP, contracts, leases, debt obligations, and all other forms of agreement. An officer of ASHP may sign an instrument that must be executed by the Executive Vice President and that other officer. The Board of Directors may authorize any two officers to jointly execute a specific document or instrument.
- 4.8.2.** Except to the extent specifically authorized by the Board of Directors, no officer shall be entitled to any compensation for services. In accordance with policies established by the Board of Directors, officers may be reimbursed for reasonable expenses incurred in discharging the functions of the office.

## **Article 5. Board of Directors**

- 5.1.** The Board of Directors shall consist of 12 persons: the officers of ASHP, the Chair of the House of Delegates, and six Directors at large.
- 5.1.1.** The term of office for a Director, who also serves as an officer or as Chair of the House of Delegates, shall be the term for that office, and the manner of election and filling vacancies in such offices shall be as specified in the Bylaws dealing with those offices.
- 5.1.2.** Directors at large shall be nominated by the Committee on Nominations of the House of Delegates and elected as set forth in Section 7.4.

- 5.1.3.** Elected Directors shall serve for one term of three years beginning with installation at the yearly meeting of the House of Delegates following their election. Elected Directors may not serve more than one term as a member at large.
- 5.1.4.** If the office of an elected member of the Board of Directors shall become vacant between yearly meetings of ASHP because of resignation, death, or otherwise, the Board of Directors may fill the vacancy. At the next yearly meeting of the House of Delegates, the Committee on Nominations shall present candidates for election to serve for the remaining portion of the unexpired term.
- 5.2.** The Committee on Finance shall report to the Board and shall consist of the President, the President-elect, the Immediate Past President, the Executive Vice President, and the Treasurer; the Treasurer shall be its Chair. The Committee on Finance shall prepare a budget for the forthcoming year and submit it to the Board of Directors for approval; review, assess, and monitor operations of ASHP to assure that budget objectives are met or that appropriate changes thereto are made; review and assess performance of investments and assets of ASHP; review all investment policies and financial policies of ASHP; oversee the responsibilities of the Treasurer set forth in Section 4.5; and oversee the financial operations of ASHP.
- 5.3.** The Board of Directors shall meet annually, in conjunction with the yearly meeting of the House of Delegates, and at such other times as the Board may determine. A special meeting shall be held upon written application of any three Directors or of the President.
- 5.3.1.** The Secretary shall establish the time and place of scheduled and special meetings and shall give the Directors reasonable advance notice thereof by mail or other mode of transmittal.
- 5.3.2.** No Director shall be entitled to any compensation for services. Pursuant to policies adopted by the Board, Directors may be reimbursed for reasonable expenses incurred in attending meetings of the Board of Directors and in discharging functions at the direction of the Board.
- 5.4.** The Board of Directors shall manage the affairs of ASHP, establish policies within the limits of the Bylaws, actively pursue the purposes of ASHP, and have discretion in the control, management, investment, and disbursement of its funds. The Board of Directors, through its Committee on Finance, shall develop and approve an annual budget, establish financial goals for ASHP, and oversee the financial operations of ASHP. The Board of Directors shall establish and review long-term objectives of ASHP and establish the priority of all programs and activities. The Board may establish whatever rules and regulations for the conduct of its business it deems advisable and may appoint whatever agents it considers necessary to carry out its powers.
- 5.4.1.** The Board of Directors may establish committees and task forces and designate representatives to other organizations.
- 5.4.2.** The Board of Directors may make contributions of ASHP assets to other organizations for research and education activities of benefit to pharmacists practicing in organized health care systems. The Board may also accept

grants, contributions, gifts, bequests, or devices to further the purposes of ASHP.

- 5.4.3.** The Board of Directors shall create, review, and modify the professional policies of ASHP and submit those policies to the House of Delegates for such action as the House of Delegates may choose to take under Article 7. The Board of Directors shall approve or disapprove all recommendations of the components of ASHP set forth in Article 6 and any committee or group created by, or which reports to, the Board of Directors. Further, the Board of Directors shall report annually to the House of Delegates how it has handled such recommendations so that the House of Delegates can take final action as required or appropriate under Article 7.
- 5.4.4.** The Board of Directors shall approve all nominations to all committees, councils, and commissions, except as membership is specified in Article 6.
- 5.4.5.** The Board of Directors may establish and modify administrative policies, not inconsistent with these Bylaws, for the conduct of its business and for the conduct of the business of ASHP and its components, except for the House of Delegates, which may establish its own regulations.
- 5.4.6.** The Board of Directors and the officers shall tender reports at such times and in such manner as are required by law.

## **Article 6. Components**

- 6.1.** The Board of Directors may establish councils, commissions, committees, joint committees, sections, forums and other appropriate component groups of ASHP, and such components shall operate to further the purposes of ASHP. The Board of Directors may modify, change, or eliminate components based on the needs of ASHP and its membership.
  - 6.1.1.** The Commission on Credentialing shall consist of a Chair and as many ASHP members and individuals from other disciplines as may be deemed necessary. The Commission shall formulate and recommend standards for accreditation of pharmacy personnel training programs, administer programs for accreditation of pharmacy personnel training programs, and perform such other functions as related to the development and recognition of pharmacy personnel and areas of pharmacy practice as may be assigned by the Board of Directors.
    - 6.1.1.1.** One or more members shall be appointed from the public sector.
    - 6.1.1.2.** The term of appointment shall not exceed three years. Commission members may be appointed to subsequent terms.
  - 6.1.2.** ASHP shall have councils that report to the Board of Directors and recommend professional policy positions within their areas of concern. Councils may also review ongoing activities of ASHP and recommend new programs within their areas of interest. The councils shall consist of a Chair and those members appointed by the President, with the approval of the Board of Directors. The President shall appoint a Director to each council who shall attend all meetings of the council as an observer and present council recommendations to the Board of Directors.

- 6.1.3.** The President, with the approval of the Board of Directors, may establish and appoint joint committees with other organizations. Joint committees shall meet to discuss and recommend to each parent organization solutions to problems of mutual interest.
- 6.1.4.** Sections and Forums are components of ASHP established by the Board of Directors. The Board of Directors may also establish rules and criteria (including financial criteria) to join and maintain enrollment in a Section or Forum for the administration of the affairs of the Section or Forum. ASHP members who meet the criteria may be members of the Section or Forum.
- 6.1.4.1.** Sections and Forums shall be operated to further the purposes of ASHP by fostering the development, enhancement, and recognition of pharmacy practice as represented by the Section or Forum.
- 6.2.** The components of ASHP established pursuant to this Article 6 shall have only those powers granted herein. The Board of Directors may establish administrative guidelines for the scope and operation of these components.
- 6.2.1.** In no case shall a component independently contact other organizations, seek or attempt to secure funds from outside ASHP, or commit any funds of ASHP without prior authorization from the ASHP Board of Directors.

## **Article 7. House of Delegates**

- 7.1.** The House of Delegates shall consist of 163 voting state delegates, who shall represent a proportionate number of active members in each state; plus all Directors of ASHP; plus Past Presidents (if active members) after completing the term of office of Immediate Past President; plus five (voting) fraternal delegates; plus the (voting) chair of each Section and Forum. Each delegate shall have one vote, and no delegate may have more than one vote by virtue of any dual capacity in the House of Delegates.
- 7.1.1.** Delegates shall be chosen as follows:
- 7.1.1.1.** As soon as convenient after July 1 in every fourth year beginning with the year 1983, the Board of Directors shall apportion 163 delegates among the states in proportion, as nearly as can be, to the total of active ASHP members in each state as recorded. Each state shall have at least two delegates. For the purpose of computing the reapportionment, the Board of Directors shall use the total number of active members during the immediately preceding year. This apportionment shall prevail until the next quadrennial apportionment, whether the ASHP membership from a particular state increases or decreases.
- 7.1.1.2.** Affiliated state chapters shall administer the election of voting state delegates for the House of Delegates. The chapter shall conduct an election to elect voting state delegates from among the active members of ASHP within that state; only active members shall vote in that election. Each state shall certify and transmit, to the Executive Vice President of ASHP, the names and addresses of the elected delegates, and such delegates shall be deemed thereupon to be duly qualified. Delegates shall continue in office until the next election and

certification. Any issue or question relating to qualification or eligibility of any delegate or alternate shall be referred to and resolved by the ASHP Board of Directors.

- 7.1.1.3.** In those states where no affiliated state chapter exists, the President of ASHP shall appoint, from among the active members of ASHP in the state, a committee of three, designating a Chair and a Secretary, for the purpose of conducting an election for delegates and alternates from active members in the state.
- 7.1.1.4.** The United States Army, Navy, Air Force, Public Health Service, and Veterans Administration shall each be entitled to designate one voting fraternal delegate.
- 7.1.1.5.** Alternates for voting state delegates shall be chosen in the same manner as that designated for choosing voting state delegates. Alternates shall not be entitled to any of the rights or privileges for delegates until, pursuant to the Rules of Procedure of the House of Delegates, the alternate replaces a voting state delegate.
- 7.1.2.** The House of Delegates shall elect a Chair who shall be installed immediately upon election and serve a three-year term.
  - 7.1.2.1.** The Chair shall be elected by written or electronic ballot of a majority vote of the delegates present and voting in the House of Delegates. The Chair may not serve for more than one three-year term.
  - 7.1.2.2.** The Chair shall serve as liaison between the submitter of resolutions for consideration by the House of Delegates and the Committee on Resolutions.
- 7.1.3.** The Immediate Past President shall serve as Vice Chair of the House of Delegates.
- 7.1.4.** The Executive Vice President of ASHP shall serve as Secretary of the House of Delegates.
- 7.1.5.** Members of ASHP shall have no right to vote in the House of Delegates except by virtue of status hereunder.
- 7.2.** A yearly session (consisting of at least two meetings) of the ASHP House of Delegates shall be held at such time and place as may be established; the House of Delegates shall conduct such business as may come before it. Special online sessions of the House of Delegates may be called by the Board of Directors or by the Chair of the House of Delegates, provided that such request contains the specific topic or topics to be considered at that meeting.
  - 7.2.1.** The Secretary shall notify each member selected as a delegate to the House of Delegates at least 30 days in advance of its yearly session and any special session.
  - 7.2.2.** ASHP shall use reasonable means to notify the membership of yearly and special sessions and to encourage their participation therein, to the extent authorized by these Bylaws.
  - 7.2.3.** A majority of voting members of the House of Delegates who have enrolled for that session shall constitute a quorum at any session or meeting duly convened. In the absence of a quorum, the Chair may recess any session or meeting until such time as a quorum is present.

**7.3.** The House of Delegates shall conduct its business at its yearly or special online session.

**7.3.1.** The House of Delegates shall review and oversee the professional affairs of ASHP to further its purposes.

**7.3.1.1.** ASHP professional policy, as approved by the Board of Directors, shall be submitted to the House of Delegates for its review, consideration, modification, approval, or disapproval. In the event the House of Delegates fails to approve a matter as submitted to it, the House shall note the reason in its proceedings and return the matter to the Board of Directors for review, modification, or other action. The Board of Directors shall consider, during its interim meeting between meetings of a House of Delegates session, actions of the House of Delegates that resulted in amendment or modification of an issue presented in the first House meeting. The Board shall report its recommendations pertaining to these amendments or modifications during its report in the second meeting of the House session. If, after Board reconsideration, the House disagrees with the Board recommendation pertaining to disposal of an issue, the House may, by two-thirds vote of certified and registered delegates, reconsider the issue for approval. If, on reconsideration, the House fails to approve the matter as previously amended or modified, the House shall note the reason in its proceedings and return the matter to the Board of Directors for review, modification, or other action. The Board of Directors shall then duly report its action thereon at the next session of the House of Delegates.

**7.3.1.2.** Individual delegates may make recommendations to the Board of Directors on such matters as each delegate deems appropriate.

**7.3.1.3.** As to any resolution or item of business presented to the House, the Board shall normally certify that it has duly considered the matter. However, if the House of Delegates should debate a matter that the Board of Directors has not so considered, action taken by the House will be by vote to refer the proposed matter to the Board of Directors for review before the House of Delegates takes action on that matter or to reject the issue. The Board shall report on that matter for consideration by the House at the next session of the House of Delegates. If the Board of Directors rules that bona fide, extraordinary circumstances require immediate action and if a majority of the delegates present and voting concur, the House of Delegates may exercise extraordinary authority and amend, modify, or substitute any matter placed before it.

**7.3.2.** By majority vote, the House of Delegates may establish its Rules of Procedure, to be effective at the next meeting of the House.

~~**7.3.3.** All officers and Directors of ASHP shall be installed before the House of Delegates at the commencement of their individual terms of office.~~

**7.3.4.** The House of Delegates shall, except as is otherwise specifically provided for in these Bylaws, have no authority over the financial affairs of ASHP.

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- 7.3.5.** The Chair of the House of Delegates shall preside at all sessions and meetings of the House of Delegates, shall be a member of the Board of Directors, and shall represent the House of Delegates at all Board meetings.
- 7.4.** Election of Directors of ASHP shall be conducted by, or under the auspices of, the Committee on Nominations of the House of Delegates.
- 7.4.1.** The Treasurer shall be elected by written or electronic ballot of a majority vote of the active membership in the same manner as members at large as provided in Section 7.4.3.2 every third year before the term of that office begins. Only nominations for the office of Treasurer from the Board of Directors shall be accepted.
- 7.4.2.** The Chair of the House of Delegates shall be elected by written or electronic ballot of the House of Delegates as provided in Section 7.1.2.
- 7.4.3.** The Chair shall appoint a Committee on Nominations consisting of seven active members who shall have been delegates to the House of Delegates within the last five years at the time of their appointment to serve as a Committee of the House. The Committee shall solicit names of possible candidates for office using such means as it determines to be appropriate.
- 7.4.3.1.** The Committee shall submit to the House of Delegates one or more reports nominating two candidates for the office of President-elect, two candidates for each Director to be elected, and two candidates each for Chair of the House of Delegates. The reports of the Committee shall not be subject to amendment and shall be the exclusive source of nominations for these offices.
- 7.4.3.2.** The names of the candidates for President-elect, Treasurer, and Directors of ASHP shall be submitted by mail or electronic transmission to every active member of ASHP within 60 days after nomination. The active member shall indicate on the ballot a choice of candidates for the offices to be filled and return the same by mail or electronic transmission within 30 days of the date on the ballot.
- 7.4.3.3.** The ballots, postmarked or electronically transmitted within 30 days of the date printed on the ballot, will be submitted to the Board of Canvassers who shall oversee counting of the ballots. The Board of Canvassers shall certify the results of the election to the Executive Vice President. The Executive Vice President shall notify all candidates of the results of the election, and the results of the election shall also be disseminated to the membership.
- 7.4.3.4.** The Board of Directors shall fill all vacancies in the list of candidates that may occur by death or resignation after the adjournment of the annual meeting of ASHP and before the issuance of mail ballots.
- 7.5.** The Committee on Resolutions shall be composed of the Board of Directors and chaired by the President of the Society. The Committee shall review all resolutions. Once duly considered, the Committee shall submit them to the House of Delegates.

## **Article 8. Affiliated State Chapters**

- 8.1.** ASHP shall recognize groups of pharmacists practicing in organized health care systems within the states when such groups promote the purposes of ASHP.

- 8.1.1. Only one group in each state (hereafter, affiliated state chapter) shall be affiliated with ASHP.
    - 8.1.2. ASHP shall establish standards and criteria that a state group must meet to be affiliated with ASHP.
  - 8.2. ASHP shall promote and strengthen affiliations with affiliated state chapters in order to support and fulfill the mission of ASHP and its affiliates.
    - 8.2.1. Affiliated state chapters shall promote the standards and policies of ASHP within the state.
    - 8.2.2. Affiliated state chapters may use the official Society logo and note its affiliation with ASHP under such terms and conditions as may be established by the Board of Directors.
    - 8.2.3. Within the limits of its resources, ASHP shall endeavor to provide services, benefits, and programs to assist affiliated state chapters in furthering the purposes of ASHP and in furthering the organizational strength of affiliated state chapters.
    - 8.2.4. Affiliated state chapters shall administer the election of voting state delegates to the House of Delegates.
    - 8.2.5. Affiliated state chapter involvement is critical to ASHP and should advance the best interests of the membership at the national and state levels, encourage and facilitate two-way information exchange and support between ASHP and the affiliate, and provide benefits to ASHP and the affiliate.
  - 8.3. Affiliation shall not limit the rights of ASHP or the affiliated state chapter.
    - 8.3.1. Affiliated state chapters may not adopt, publicize, promote, or otherwise convey any policy or principle in the name of the American Society of Health-System Pharmacists that has not been officially adopted by ASHP.
    - 8.3.2. Acts of affiliated state chapters shall in no way commit or bind ASHP.
    - 8.3.3. Dues in affiliated state chapters may be set at the discretion of the chapter. Dues in ASHP shall be established pursuant to these Bylaws.

## **Article 9. International Cooperation**

- 9.1. ASHP shall endeavor to promote and foster relationships with pharmacy organizations from other countries and with international pharmacy and health organizations when such furthers the purposes of ASHP.

## **Article 10. Miscellaneous**

- 10.1. The following terms used in these Bylaws shall mean the following:
  - 10.1.1. “Notice” shall be delivered personally, electronically, or by mail to the primary address of the person to receive such notice. If such notice is given by mail, it shall be deemed delivered when deposited in the United States mail properly addressed and with postage paid thereon.
  - 10.1.2. “State” shall mean the 50 jurisdictions of the United States customarily called states, plus the District of Columbia and Puerto Rico.
- 10.2. At the direction of the Board of Directors, any officer or employee of ASHP shall furnish, at the expense of ASHP, a fidelity bond in such a sum as the Board shall provide.

- 10.3.** ASHP may indemnify each Director, officer, former Director, and former officer of ASHP against expenses (including attorneys' fees), judgments, fines, penalties, and settlements actually and necessarily incurred by that person in connection with or arising out of any proceeding in which that person may be involved as a party or otherwise by reason of being or having been such Director or officer.
- 10.3.1.** No indemnification shall be made until the Board of Directors or ASHP shall have determined that indemnification is proper.
- 10.3.2.** The procedure and standard for indemnification shall be governed by the applicable sections of the Corporations and Associations Article and the Annotated Code of Maryland.
- 10.4.** If any provision of these Bylaws should, for any reason, be held to be invalid, the validity of any other provision is not thereby affected.
- 10.5.** Whenever the Board of Directors is given authority with respect to any matter, that authority shall include the ability to modify, change, stop, or eliminate that matter at any time.
- 10.6.** The business of the House of Delegates shall be conducted in accord with such Rules of Procedure as the House of Delegates may establish and, to the extent not covered therein, by the latest edition of Robert's Rules of Order. In no case shall any rule of the House conflict with the Charter or these Bylaws.
- 10.7.** The fiscal year of ASHP shall be a 12-month period beginning on June 1 and ending on May 31.
- 10.8.** The *American Journal of Health-System Pharmacy* shall be the official publication of ASHP. The proceedings of the House of Delegates and the Board of Directors and other official business of ASHP shall be published in the *American Journal of Health-System Pharmacy*.
- 10.9.** ASHP will support a research and education foundation to further development of the profession and as a means to meet the purposes of ASHP; the research and education foundation will, at all times, be a separate and independent entity.

## **Article 11. Amendment**

- 11.1.** Any proposed amendment to these Bylaws must first be submitted to the Board of Directors. Upon review, the Board shall submit the proposed amendment to the House of Delegates. Upon approval of a majority of the voting delegates of the House of Delegates then present and voting, the amendment shall become effective.

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The ASHP Charter and Bylaws were approved by the ASHP House of Delegates on June 6, 1984, and by active members of the Society in the 1984 mail ballot annual election. These documents, as subsequently amended, replace the Society's former Articles of Incorporation, Constitution, and Bylaws, effective January 1, 1985. The Regulations for the ASHP House of Delegates were not a part of the 1982–84 governing documents modernization project. These Bylaws and the Rules of Procedure for the House of Delegates were further revised by the ASHP Board of Directors and approved by the ASHP House of Delegates on June 3, 2014; these versions supersede previous versions. The ASHP Charter was not amended in that revision.

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# ASHP Rules of Procedure for the House of Delegates

## Article 1. Summary and Authority

- 1.1. *Summary:* These Rules of Procedure establish basic rules under which the ASHP House of Delegates operates and conducts its business. These Rules of Procedure are subject to the ASHP Charter and Bylaws but supersede any contrary or inconsistent rule in *Robert's Rules of Order*.
- 1.2. *Authority:* ASHP Bylaws, Section 7.3.2.

## Article 2. Rules of Order

- 2.1. The latest edition of *Robert's Rules of Order* shall govern proceedings of the House of Delegates when not inconsistent or in conflict with these ASHP rules; in such cases, these ASHP rules will govern.
  - 2.1.1. In order of precedence, the ASHP Charter and then the ASHP Bylaws, at all times, supersede these ASHP rules and *Robert's Rules of Order*.
  - 2.1.2. The House should be guided by formal interpretation of the governing documents as announced by its Chair and by precedent.

## Article 3. Seating of Delegates

- 3.1. Delegates and alternates duly certified and qualified under Section 7.1 of the Bylaws shall be enrolled by the Secretary in advance of a yearly or special session. After the first meeting of a yearly or special session has been called to order, the Secretary shall call the roll of enrolled delegates; those answering the roll shall be recognized as delegates.
  - 3.1.1. Any delegate who, at the first meeting of a House of Delegates session, is recognized and enrolled as a delegate of the House shall remain a delegate of the House until such time as replaced pursuant to this rule.
  - 3.1.2. The place of a recognized and enrolled delegate will not be taken by any other person, except that at the commencement of each meeting the House may, by majority vote, recognize and enroll an alternate delegate (in order of precedence, if designated by the state) if presented, who shall then remain a delegate (in place of the replaced delegate).
  - 3.1.3. In the event neither a delegate nor alternate from a state appears at the commencement of a session of the House, the Secretary shall enroll and the Chair shall recognize the first certified delegate or alternate appearing before the House as the enrolled and recognized delegate from such state.

## Article 4. Meetings

- 4.1. All meetings of the House of Delegates shall be open unless the House of Delegates, by a vote of two-thirds of the total House, as defined in Section 7.1 of the Bylaws, votes to go into executive session. When in executive session, the following only shall be admitted to the room in which the meeting is held: members of the House

of Delegates (as defined in Section 7.1 of the Bylaws), the parliamentarian, and others specifically authorized by a majority vote of the House of Delegates.

### **Article 5. Open Hearing**

**5.1.** An open hearing shall be conducted, in conjunction with any in-person House of Delegates session, to provide a forum for members to express their opinions on matter of concern to them and on matters to be considered by the House of Delegates.

**5.1.1.** At the call of the Chair of the House of Delegates, and with approval of the Board of Directors, additional open hearings may be scheduled.

**5.1.2.** The Chair of the House of Delegates shall preside at any open hearing and may request assistance from members of the Board of Directors, officers of the Society, and council Chairs.

### **Article 6. Privilege of the Floor**

**6.1.** The privilege of the floor (which may include the right to participate in debate on a matter), during a meeting of the House of Delegates, may be extended by either the Chair or the House of Delegates.

### **Article 7. Conduct of Business of the House**

**7.1.** The Business of the House of Delegates shall be as follows, unless the Chair of the House of Delegates determines that the business or matters for the House require a different order or that additional items to the order are required:

- a. Call to order.
- b. Roll call of delegates.
- c. Reports of officers and the Board of Directors.
- d. Recommendations of delegates.
- e. Reports of councils and committees.
- f. Resolutions.
- g. Unfinished business.
- h. New business.
- i. Triennial Election of the Chair of the House of Delegates.
- j. Installation of officers and Directors.
- k. Adjournment.

**7.2.** Any matter upon which action is to be taken by the House of Delegates will be presented to delegates in writing and in advance. The Secretary will distribute copies of the proposed action to the House. Action of the House is, at all times, subject to Section 7.3 and, in particular, Section 7.3.1.3 of the Bylaws.

**7.2.1.** Any matter to be presented as new business shall be presented to the Chair of the House in writing no later than four o'clock in the evening before the day of the meeting in which new business is on the agenda. If any such matter will include the offering of a motion, the writing required by this rule shall state explicitly the motion to be offered.

**7.2.2.** Resolutions to be considered by the House of Delegates must be presented in writing to the Secretary of the House of Delegates at least 90 days in advance of the session and be signed by at least two active members of ASHP.

**7.2.2.1.** Resolutions not voluntarily withdrawn by the submitter that meet the requirements of the governing documents shall be presented to the House of Delegates by the Committee on Resolutions at the first meeting and acted upon at the second meeting. They shall be submitted to delegates with one of the following recommendations: (a) recommend adoption, (b) do not recommend adoption, (c) recommend referral for further study, or (d) presented with no recommendation of the Committee on Resolutions.

Action by the House of Delegates shall be on the substance of the resolutions and not on the recommendation of the Committee on Resolutions.

**7.2.2.2.** The House shall be informed of resolutions not presented to it and the reasons therefore.

**7.3.** Any item presented for action by the House of Delegates shall, unless the Bylaws or these rules specify to the contrary, require for passage the vote required by *Robert's Rules of Order*. Except for election of the Chair, no vote shall be by secret ballot.

**7.3.1.** Any matter not acted upon by the House of Delegates, upon adjournment of the session, shall die.

**7.4.** Matters of an emergent nature must be acted upon in accord with Section 7.3.1.3. of the Bylaws.

## **Article 8. Nominations and Elections**

**8.1.** Nominations of Directors of ASHP (including the Chair of the House of Delegates) shall be by the Committee on Nominations in accordance with Section 7.4 of the Bylaws.

**8.1.1.** A written biography on each nominee shall be prepared and distributed at the appropriate meeting of the House of Delegates session.

**8.1.2.** The Chair shall appoint three delegates to serve as election tellers for elections conducted in the House of Delegates. Tellers shall supervise the election, count ballots, and report to the Chair the results thereof. The Chair shall share the election results with each nominee but shall announce only the name of the candidate receiving the majority of votes cast for Chair of the House of Delegates.

**8.1.3.** The Chair shall be elected by written or electronic secret ballot of the House of Delegates and need receive only a majority of votes cast.

**8.1.4.** The Committee on Nominations shall issue a separate report containing two nominees for each Director and the office of President-elect.

## **Article 9. Amendments**

**9.1.** Every proposed amendment to the Rules of Procedure for the House of Delegates shall be submitted in writing at one meeting of the House of Delegates and may be acted upon at a subsequent meeting of the session, when upon receiving a majority

of votes cast, it shall become a part of these rules, effective as of the following session of the House of Delegates.

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Developed by the ASHP Council on Organizational Affairs. Approved by the ASHP Board of Directors, November 20–21, 1985, and by the ASHP House of Delegates, June 4, 1986. Supersedes the previous document, Regulations for the ASHP House of Delegates. Revised by the ASHP Board of Directors and approved by the ASHP House of Delegates, June 3, 2014. Supersedes previous versions of this document.

Revised: 06/03/14

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## 2016 Report of the ASHP Treasurer

**Am J Health-Syst Pharm.** 2016; 73: 1275-7

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DOI 10.2146/sp160003

Each year, the ASHP Treasurer has the responsibility to report to the membership the financial condition of the Society. The Society's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report will describe ASHP's financial performance and planning for three periods, providing (1) the final audited prior-year numbers (for fiscal year 2015), (2) current-year (fiscal year 2016) projected performance, and (3) the budget for the fiscal year ending May 31, 2017.

ASHP segregates its finances into two budgets, core operations and the development budget. The core budget represents the revenue and expense associated with the core operations of the organization. The development budget is intended for expenditures that are (1) associated with new, enhanced, and expanded programs; (2) associated with time-limited programs; (3) capital asset purchases; or (4) supplemental operating expenses. The development budget is funded primarily with investment income. Because of the Society's strong financial base, a third funding source—programs funded

With its strong financial resources, a proactive Board and membership, and an exceptional CEO and staff, ASHP is well positioned to meet the needs of the membership for many years to come.



from net assets—is occasionally used. These programs are reviewed on a case-by-case basis and approved by the Board of Directors.

The audit of the May 31, 2015, financial statements of the Society and the Society's subsidiary, the 7272 Wisconsin Building Corp., performed by the firm of Tate & Tryon, resulted in an unqualified opinion. Copies of the audited statements are available by contacting the ASHP Executive Office.

### Fiscal Year Ending May 31, 2015—Actual

Last year I reported to you that we were projecting a surplus from core operations and from programs in the development budget. That projection proved true as the Society's surplus from the core and development budget totaled \$856,128 (Figure 1). However, spending from net assets (\$1.1 million) and a pension adjustment (\$3.0 million) resulted in an overall reduction in the Society's net assets of \$3.3 million. Nevertheless, even with the reduction, the Society's net assets at May 31, 2015, represented 75% of total expense. Our long-term financial policy is to maintain net assets at a target of 50% of total ASHP and 7272 Wisconsin Building Corp. expenses.

The Society's May 31, 2015, year-end balance sheet (Figure 2) remained impressive. The May 31,

2015, asset-to-liability ratio stood at 2.55:1.00.

### Fiscal Year Ending May 31, 2016—Projected

As of March 31, 2016, the financial performance from core operations for the fiscal year ending May 31, 2016, is projected to produce a net income of \$2.1 million (Figure 1). A negative performance (fiscal year to date) in the investment market is contributing to a projected development budget deficit of \$2.0 million. Combining the core net income and the development budget deficit, and allowing for \$1.1 million in net asset spending, the Society's net assets are projected to decrease by \$1.0 million this fiscal year. If the year-end projections provided in Figure 1 prove accurate, the Society's net assets will represent 70% of the total ASHP and 7272 Wisconsin Building Corp. expense.

### Fiscal Year Ending May 31, 2017—Budgeted

The Society's 2017 core budget is essentially a balanced budget (Figure 1) with the core and development budgets combined producing a \$165,949 surplus (Figure 1) before spending from net assets. Thanks to the Society's strong financial position, \$650,000 spending from net assets has been budgeted to complete the redesign of the ASHP website and purchase of a new web content manage-

ment system. Although this spending will cause an overall deficit for 2017, the Society's total net assets are still budgeted to be at a strong 74% of total expense.

**7272 Wisconsin Building Corporation**

The Society's subsidiary, the 7272 Wisconsin Building Corp., owns the ASHP headquarters building and derives income from leased commercial and office space. In 2015, the subsidiary retired the remaining debt on the building, incurring a \$2.9 million prepayment penalty. The debt retirement will save the subsidiary \$2.2 million annually in monthly mortgage payments and unrelated business income taxes. The prepayment penalty, al-

though planned, was the primary reason the subsidiary produced a \$98,286 deficit for the year (Figure 3).

It is important to note that at the time this report was written, the Society was in negotiations to sell the headquarters building to a local developer. If the sale occurs, the Society will be moving its headquarters operation four blocks away, leasing 65,000 sq ft. in a new office building.

**Conclusion**

This is my final report to the House of Delegates as your Treasurer and I am extremely pleased to tell you that the Society is in excellent financial condition. I am also pleased to have served these past six years with a Board of Directors that is committed

to advancing healthcare and supporting the professional practice of pharmacists. I can say with confidence that ASHP continues to be a strong and vibrant organization from both a membership and financial viewpoint. With its strong financial resources, a proactive Board and membership, and an exceptional CEO and staff, ASHP is well positioned to meet the needs of the membership for many years to come.

**Disclosure**

The author has declared no potential conflicts of interest.

**Additional information**

Presented at the ASHP Summer Meetings, Baltimore, MD, June 12, 2016.

**Figure 1.** ASHP condensed statement of activities (in thousands).

	<b>Actual Fiscal Year Ended May 31, 2015</b>	<b>Projected Fiscal Year Ended May 31, 2016</b>	<b>Budget Fiscal Year Ended May 31, 2017</b>
<b>CORE OPERATIONS</b>			
Gross revenue	\$ 44,778	\$ 46,664	\$ 48,975
Total expense	(44,764)	(46,557)	(49,122)
Earnings from subsidiary	(98)	2,000	0
Investment income subsidy	101	0	150
<b>Core Net Income</b>	<b>\$ 17</b>	<b>\$ 2,107</b>	<b>\$ 3</b>
<b>PROGRAM DEVELOPMENT</b>			
Investment income	\$ 1,973	\$ (607)	\$ 1,272
Program expenses	(1,134)	(1,400)	(1,109)
<b>Program Development Net Income</b>	<b>\$ 839</b>	<b>\$ (2,007)</b>	<b>\$ 163</b>
<b>Programs Funded from Net Assets</b>	<b>\$ (1,077)</b>	<b>\$ (1,120)</b>	<b>\$ (650)</b>
<b>Increase in Net Assets</b>	<b>\$ (221)</b>	<b>\$ (1,020)</b>	<b>\$ (484)</b>
Pension Plan Adjustment	(3,031)	-	-
<b>Net Increase in Net Assets</b>	<b>\$ (3,252)</b>	<b>\$ (1,020)</b>	<b>\$ (484)</b>

**Figure 2.** ASHP statement of financial position (in thousands).

	<b>Actual as of May 31, 2015</b>	<b>Actual as of May 31, 2014</b>
<b>ASSETS</b>		
Current assets	\$ 4,051	\$ 4,200
Fixed assets	\$ 597	\$ 1,107
Long-term investments (at market)	\$ 34,668	\$ 49,602
Investment in subsidiary	\$ 21,730	\$ 6,115
Other assets	\$ 249	\$ 216
<b>Total Assets</b>	<b>\$ 61,295</b>	<b>\$ 61,240</b>
<b>LIABILITIES</b>		
Current liabilities	\$ 16,548	\$ 15,590
Long-term liabilities	\$ 7,462	\$ 5,112
<b>Total Liabilities</b>	<b>\$ 24,010</b>	<b>\$ 20,702</b>
<b>NET ASSETS</b>		
Net assets	\$ 37,285	\$ 40,537
<b>Total Net Assets</b>	<b>\$ 37,285</b>	<b>\$ 40,537</b>
<b>Total Liabilities and Net Assets</b>	<b>\$ 61,295</b>	<b>\$ 61,240</b>

**Figure 3.** 7272 Wisconsin Building Corporation (ASHP subsidiary) statement of financial position and statement of activities for fiscal year 2015 (in thousands).

	<b>Fiscal Year Ended May 31, 2015</b>	<b>Actual As of May 31, 2015</b>
<b>REVENUE AND EXPENSE</b>		
Gross revenue	\$ 7,002	
Operating expense	\$ (4,142)	
Prepayment Penalty	\$ (2,878)	
<b>Operating Income</b>	<b>\$ (18)</b>	
Provision for income taxes	\$ (80)	
<b>Increase (Decrease) in Net Assets</b>	<b>\$ (98)</b>	
Owners distribution and capital contributions	\$ 15,714	
<b>Net Increase in Net Assets</b>	<b>\$ 15,616</b>	
		<b>ASSETS</b>
		Current assets
		\$ 4,026
		Property and plant (net)
		\$ 16,696
		Other assets
		\$ 1,497
		<b>Total Assets</b>
		<b>\$ 22,219</b>
		<b>LIABILITIES</b>
		Current liabilities
		\$ 230
		Mortgage payable
		\$ 0
		Other liabilities
		\$ 259
		<b>Total Liabilities</b>
		<b>\$ 489</b>
		<b>NET ASSETS</b>
		Net assets
		\$ 21,730
		<b>Total Net Assets</b>
		<b>\$ 21,730</b>
		<b>Total Liabilities and Net Assets</b>
		<b>\$ 22,219</b>

## 2016 Report of the Chief Executive Officer

Am J Health-Syst Pharm. 2016; 73: 1270-4

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DOI 10.2146/ajhp160486



ASHP members are leaders, innovators, and agents of change who are constantly looking for ways to improve patient care and advance pharmacy practice.

It is my pleasure to report that ASHP has had another very successful year. Because of you—our members—ASHP has continued to lead the advancement of pharmacy practice and pharmacist-provided patient care in all care settings across the United States.

This year marked the 50th anniversary of the ASHP Midyear Clinical Meeting and Exhibition. It was a wonderful celebration that really highlighted how much pharmacy has changed over the years and the many ways in which ASHP has advanced the profession. As we look forward to the 75th anniversary of ASHP in 2017, we will again have many opportunities to reflect on how much ASHP has done to support that professional growth and change.

You and your fellow ASHP members are the reason that ASHP has been and continues to be such a relevant, forward-facing organization. The policies that are developed in this House and the ongoing work that ASHP does each year—advocacy, public health initiatives, work force issues, and supporting members' needs for clinical information and professional development—all of these ultimately benefit the patients under our care.

Before I move on to my remarks, I would like to recognize the commitment and hard work of our president, John Armitstead. John has been an exceptional leader, and his commitment to ASHP and our profession is unparalleled. John, you have done a fantastic job; thank you. Likewise, I want to recognize and thank the ASHP Board of Directors. This amazing group of people is focused every day on creating a future that ensures that pharmacists work to provide the best medication therapies possible for patients. I would also like to recognize our past presidents who have contributed so much to our profession and continue to do so.

Last but not least, I would like to recognize ASHP's wonderful staff of over 200 professionals who work every day to support you and the patients you serve.

I now would like to take a few minutes to summarize a number of important accomplishments over the past year and to share some of our plans for the future.

### An evolving pharmacy work force

According to the 2014 National Pharmacist Workforce Survey, nearly 46% of pharmacists practice in hospitals and patient care settings, such as clinics, home infusion, specialty pharmacy, and long-term care.<sup>1</sup>

More and more pharmacists are providing advanced medication-

use knowledge and services to their patients. As clinicians, we are living and working in a unique time that presents unprecedented professional opportunities.

I constantly speak with ASHP members around the country about their efforts to ensure optimal medication therapy outcomes, and I am also always impressed by how hard members are working to improve patient care quality measures that link payment with performance. They—and you—are very well positioned to handle the practice evolution that is happening.

We are also seeing an evolution in the demographics of the pharmacy work force. More and more women are following a pharmacy career path, and ASHP is focused on helping to meet their professional and leadership development needs.

Although women represent the majority of pharmacists practicing today, they occupy far too few leadership positions in our profession and in healthcare at large. Without women occupying key senior leadership positions, we miss out on the robust benefits a diverse work force can bring.

Through ASHP's new Women in Pharmacy Leadership Steering Committee—chaired by ASHP Past President Sara White—we are exploring how to minimize cultural factors and create an environment for focused mentoring and leadership

development of a new generation of women pharmacy leaders.

The committee, which is actively seeking input from members, has drafted recommendations and will meet throughout the year to advise ASHP on next steps. Already, we are seeing outcomes of the committee's work, including a great podcast series; a new ASHP Connect community; special networking sessions offered at the Conference for Pharmacy Leaders, the Midyear Clinical Meeting, and here in Baltimore this week; and a series about women pharmacy leaders in our member magazine, *ASHP InterSections*.

ASHP is committed to finding the kinds of innovative solutions that advance our growing work force and to embracing diversity in all areas. We believe that a strategic focus will help us all benefit from the positive outcomes that a diverse work force brings to our profession and the patients we serve.

### Provider status

I would like to update you on ASHP's biggest advocacy effort—the push to enact provider status. As you know, ASHP and the Patient Access to Pharmacists' Care Coalition succeeded in getting pharmacists' provider status legislation, H.R. 4190, introduced in 2014. This legislation, which enjoyed bipartisan support, was designed to amend the Social Security Act. It would have recognized pharmacists as Medicare Part B providers working within their states' scopes of practice to care for patients in ambulatory care settings in medically underserved areas throughout the United States.

The good news is that the legislation, now known as H.R. 592—the Pharmacy and Medically Underserved Areas Enhancement Act—was reintroduced by Representatives Brett Guthrie, G. K. Butterfield, Todd Young, and Ron Kind. We now have 287 cosponsors of this bill. Concurrently, Senators Charles Grassley, Mark Kirk, Sherrod Brown, and Robert Casey introduced S. 314, a companion bill, in

the Senate. That legislation now has 45 cosponsors.

This successful push to get more cosponsors is a testament to our ongoing work with the Patient Access to Pharmacists' Care Coalition. We are now focused on moving the legislation to the next stage of the legislative process—receiving a Congressional Budget Office score on the legislation that assesses the legislation's cost to taxpayers over 10 years.

Once a Congressional Budget Office score is assigned, we will work with our cosponsors to schedule a hearing of the House Energy and Commerce Committee, which has jurisdiction over Medicare programs. This hearing will provide an opportunity for elected officials to call a panel of experts on the legislation's details and its positive effects on patient care. Meanwhile, we are seeking potential legislative vehicles to carry the bill in both the House and the Senate.

ASHP and our members have taken a major leadership role in bringing this legislation to fruition and helping to advance it through Congress. The exceptional care that all ASHP members provide to their patients is the foundation for this effort. Every day, our members provide clear examples to Congress of what pharmacists can do to improve outcomes, reduce costs, and expand access.

This is no time to take a breather, however. In this difficult national election year, it is important that we keep up the pressure. Legislators need to see pharmacists providing the types of patient care services for which we are seeking recognition and payment. It is absolutely vital that all ASHP members continue to reach out to their representatives and senators. Members need to express support and either ask their legislators to cosponsor this important legislation or thank them if they have already signed on as cosponsors. We need you to keep telling your stories through local media, blogs, and social media channels.

Spend some time attending political rallies this summer, and find ways to support the campaigns of your senators and representatives. Tell them how this vital legislation will help patients both locally and within your state, and ask for their support.

Even though so much is in play with this presidential election cycle as Congress determines its priorities and prepares for a big election, we must keep moving forward.

That said, I would like to pause for a moment to recognize and thank ASHP's exceptional staff team that has worked relentlessly with Congress, the Centers for Medicare and Medicaid Services, and other stakeholders for more than a decade to create the framework for this historic moment in time. We couldn't have gotten as far as we have without their exceptional commitment and effort. Thank you!

### Opioid addiction

According to the Centers for Disease Control and Prevention (CDC), the quantity of prescription analgesics dispensed to Americans—and deaths from overdoses—quadrupled from 1999 to 2013. During 2013, nearly 2 million Americans either abused or were dependent on opioids. More people died from drug overdoses in 2014 than in any year on record, and the majority of overdose deaths involved an opioid.<sup>2</sup>

We clearly have a devastating public health challenge in the United States, and the only way we can start to get a handle on it is through a multichannel approach that involves healthcare providers, federal and state government officials, regulators, and other stakeholders. ASHP and its members are focused first and foremost on ensuring appropriate pain management for our patients while ensuring appropriate safeguards against addiction, misuse, abuse, and diversion.

As this concerted fight to reduce opioid addiction takes shape, I am pleased to report that ASHP is front and center in the effort. We are clearly

seen as a national player in the realm of safe and appropriate medication use.

For example, ASHP participated in a meeting in late May with several senior White House officials to discuss the Obama administration's efforts to address the opioid overdose and misuse epidemic. The session, coordinated by the Office of National Drug Control Policy, is the first in a series of meetings with healthcare provider and patient advocacy groups working to expand access to opioid treatment, prevention of abuse, and recovery resources.

We also were previously invited to a special White House summit on the issue. ASHP staff represented our members at this event and shared our commitment to a number of activities that we believe will go a long way toward increasing awareness of opioid addiction.

For example, ASHP is working with the Food and Drug Administration, CDC, the Department of Health and Human Services, and other stakeholders to develop interprofessional education materials about the appropriate use of opioids and other alternatives to pain management.

We will be highlighting the issues and resources related to opioid misuse, abuse, and access at ASHP's national meetings and engaging with our state affiliates and members about the issue. Of course, our members are working every day to see that the most appropriate pain management is afforded their patients such that opioids are not overused when other effective alternatives can be used. We also are supporting the development of a fully integrated national prescription drug monitoring program to help prevent abuse and diversion while ensuring appropriate patient access.

ASHP is developing comprehensive guidelines on controlled substances diversion prevention that are in the process of being sent out for external review and will be published in September. The ASHP Controlled Substances Diversion Prevention

Guideline will provide guidance and best practices for healthcare organizations to consider when improving their systems to address common risk points and methods of diversion of controlled substances. It will include a suggestion to establish an inter-professional controlled substances diversion prevention program and committee as well as a 160+-element self-assessment tool for organizations to use.

Pharmacists can and should play a key role in ensuring appropriate opioid prescribing and overall pain management and are extremely well positioned to work with prescribers to ensure that these important drugs are reserved and used effectively for the patients who need them. Ensuring appropriate opioid prescribing and use is one of the many things pharmacists do to ensure optimal health outcomes and patient safety.

I believe that ASHP's commitment to this issue will go a long way toward helping our nation begin to solve this devastating public health crisis.

### Rising drug prices

We all know that rapidly rising medication costs are placing a significant, unsustainable burden on our healthcare system, our individual organizations, and our patients. According to IMS Health, spending on medicines increased by double digits for a second straight year in 2015, reaching \$425 billion.<sup>3</sup> After adjusting for manufacturer rebates and other price concessions, net spending was \$310 billion, up 8.5% over 2014 levels.

To help lead the way for solutions to skyrocketing pharmaceutical costs, ASHP in February started working as part of the steering committee of the Campaign for Sustainable Rx Pricing. We are partnering with the campaign's diverse stakeholders to identify market-based solutions to ensure that patients have affordable access to needed medications.

In late April, the campaign released a number of these solutions

that we think will go a long way toward combating the problem. These ideas focus on transparency, competition, and value.

ASHP is also working on Capitol Hill on this issue. We advised Representative Buddy Carter, the only pharmacist in Congress, on his testimony before the House Committee on Oversight and Government Reform about the effect of price spikes on patients and the healthcare system. We are encouraging the committee to explore ways to stimulate an enhanced presence in the marketplace for generic manufacturers. I am proud of the work that ASHP is doing on this complex public health issue.

### State leadership and national partnerships

I would like to take a moment to recognize the important role that ASHP state affiliates play in supporting ASHP's vision, mission, and strategic plan. The work of state affiliates magnifies and multiplies the impact of ASHP's national efforts on the most important professional and patient care issues of our time.

I greatly enjoy visiting with our state affiliates. Since the last House of Delegates meeting, I have had the pleasure of providing the keynote addresses at the annual meetings of the Kansas, Missouri, Florida, and Georgia affiliates. I also have plans to visit Connecticut this fall.

ASHP is constantly examining how to make our affiliate relationships more effective and efficient. A notable example is the work that the Commission on Affiliate Relations is currently doing to streamline the reaffiliation process.

I am extremely thankful for all that our affiliates do, and I look forward to continuing to work with them to advance ASHP's vision.

In addition to our state affiliates, the partnerships that ASHP has forged at the national level help us to advance our vision and mission. There are too many organizations to note here, but I would like to give you a sense

of the breadth and depth of our relationships by mentioning a few here: various medical, nursing, and other healthcare professional organizations; agencies and regulating entities; consumer groups; manufacturer groups; the White House; the U.S. Congress; and many more.

These connections reflect the important and diverse relationships that ASHP members cultivate as they care for patients in all healthcare settings and are critical to ASHP's future successes and to the success of pharmacists as patient care providers.

### A reimagined clinical journal

ASHP's clinical journal, *AJHP*, has gone through some dramatic and exciting changes over the past year. Under the leadership of Editor in Chief Daniel Cobaugh, *AJHP* launched a new design in January that has significantly improved the journal's readability, usefulness, and appeal to clinical pharmacists. The changes in the journal reflect its new mission: "Advancing Science, Pharmacy Practice, and Health Outcomes."

This broader focus supports *AJHP*'s role as a source of the latest scientific evidence, practice information, news, and opinion pieces. We believe that this new publication will help pharmacists guide medication use for individual patients as well as contribute significantly to the national discourse about healthcare policy.

In terms of processes, *AJHP* has accelerated its publication of enhanced, high-impact content; has revitalized its approach to the editorial page, with 14 highly relevant editorials in fiscal year 2016; and is well on its way with a series of theme issues that will spotlight topics ranging from specialty pharmacy to precision medicine.

*AJHP* has always been the nation's premier scientific and clinical journal for pharmacists. With these innovations, we have achieved a new level of excellence and relevance that ensures our members have access to the best content available to support their

healthcare practices. We should all be proud of ASHP's scholarly publication.

### Staff changes

We have had several key staff retirements and new staff appointments over the past year that I'd like to share with you.

As many of you know, Dave Edwards, ASHP's longtime chief financial officer, is retiring this summer. Dave has been with ASHP for over 25 years and has been a guiding force in managing the Society's finances with the highest degree of integrity and ethics. Although Dave's work has been mostly behind-the-scenes, I can tell you that his focus every day has been on serving ASHP members and ensuring that ASHP is financially positioned to continue to offer unparalleled levels of member services. In addition, Dave's financial acumen was absolutely essential in the sale of our building, which I will speak about in a few minutes. Dave will always be a huge part of the ASHP family.

David Witmer, who has been with ASHP for over 20 years in different capacities—most recently as ASHP's chief operating officer (COO)—will also be retiring at the end of this calendar year. We wish David all the best and thank him for his leadership in helping to create our membership Sections and Forums, growing membership and member satisfaction, and advancing pharmacy specialties, to mention just a few of his accomplishments. As COO, David has overseen multiple initiatives, not the least of which was planning and overseeing the sale of ASHP's current headquarters building and our move into the new one.

With David's retirement, Kasey Thompson was recently promoted to COO and senior vice president. Kasey has served in numerous capacities during his 17-year career at ASHP, helping the Society to increase its engagement and visibility in the healthcare, media, and broader stakeholder communities as well as in the realm of public health policy with Congress,

the White House, and key federal agencies.

In recent years, Kasey has played an essential role in implementing the new ASHP Strategic Plan, instituting a renewed ASHP brand, growing ASHP's government relations capacity and overall scope and influence on legislation and regulation affecting pharmacists and patients, and modernizing ASHP's policy development program. I'm very excited to be working with Kasey as we address the critical issues facing our members and the patients they serve. Kasey has hit the ground running and has quickly demonstrated his ability to lead and continue to advance ASHP's mission.

### Headquarters move update

ASHP has made its home in Bethesda, Maryland, for five decades, and we have been at our current building at 7272 Wisconsin Avenue for 24 of those years.

We renamed our building at 7272 the Joseph A. Oddis Building in January 2013 in honor of Joseph A. Oddis, who served as ASHP's chief executive officer (CEO) for 37 years and whose vision and leadership led to ASHP acquiring the building in 1992.

The Joseph A. Oddis Building has served ASHP well as a "touch point" for members who travel to Bethesda and as a work home for many of ASHP's 200+ employees. It also is a tangible real estate asset whose value has grown dramatically over the years.

Our current building sits on top of the south end of the Bethesda Metro station. Over the course of the past few years, Montgomery County, Maryland, has been developing plans to construct a new light-rail system project called the Purple Line that would connect to the Metro.

ASHP was approached by a major developer who was interested in redeveloping our property as part of the Purple Line construction project. The sale of the building has given us a unique opportunity to obtain new and more modern offices to serve our fu-

ture needs at an alternate location in downtown Bethesda.

ASHP's consideration for selling our building centered on two concerns: our members and our staff. Because ASHP is a not-for-profit professional society dedicated to advancing healthcare and pharmacy practice, any consideration for selling our building must put ASHP in a position to continue providing the high level of service that our members deserve and a location that is accessible and accommodating to our wonderful staff. Further, it must ensure that ASHP remains financially strong long into the future to support the organization's robust public health and membership mission.

The building sale, which was approved by the ASHP Board of Directors last year, has moved forward successfully, and a portion of our staff has now moved into temporary space within the new headquarters building at 4500 East-West Highway. Our plan is to have the top three floors of our new space completely designed and constructed—and all staff moved in—by early 2017. The new building is beautiful. It is the first LEED Platinum-certified building in Bethesda, and it will provide members and stakehold-

ers who visit and the staff who work there easy access to public transportation, hotels, and restaurants.

I think you'll be impressed by how well this new headquarters reflects ASHP's new brand of "Pharmacists Advancing Healthcare."

### Conclusion

I would like to conclude my remarks with another thank you, to you, our members, for everything that you do for your patients and for ASHP. ASHP's lifeblood resides in our wonderful members who provide patient care services across the entire continuum of care in every state and all around the world. I am humbled and excited during my travels when I see the many, many advancements that ASHP members are making in every practice setting imaginable.

ASHP members are leaders, innovators, and agents of change who are constantly looking for ways to improve patient care and advance pharmacy practice. Seeing what you do and knowing how passionate you are about the roles you play on patient care teams make my job as CEO of ASHP an absolute pleasure.

Please accept my sincere gratitude to all of you for being part of this won-

derful organization and profession. You are truly improving the lives of patients everywhere and are continuing to make ASHP the best and fastest-growing pharmacy organization in the world.

### Disclosure

The author has declared no potential conflicts of interest.

### Additional information

Presented at the ASHP Summer Meetings, Baltimore, MD, June 14, 2016.

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## 2016 Report of the President and Chair of the Board

**Am J Health-Syst Pharm.** 2016; 73: 1266-9

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DOI 10.2146/ajhp160487



ASHP's strategic plan, professional policies, and advocacy efforts to gain provider status showcase the need for more pharmacists who can provide specialized patient care services on interprofessional teams.

Before I begin my remarks, I want to express how grateful I am for the past year. I appreciate having the opportunity to serve ASHP and our over 43,000 members as president. I also want to thank you, as members of the House of Delegates, for all that you do for the pharmacy profession, for patients, and for ASHP. Your work here provides a critical framework for the provision of safe and effective medication use in this country.

It is impossible to quantify the number of hours that each of you has devoted to ensure that ASHP policies meet the needs of members, patients, and practice. The work of this House, along with that of ASHP's councils, Sections, Forums, and state affiliates, truly showcases your commitment to improving patient care.

On behalf of the Board of Directors, I also want to thank Dr. Abramowitz for his support and leadership throughout the year. His friendship and guidance have made this year a true pleasure. Thank you, Paul.

In my inaugural address, I talked about the importance of building bridges—to bridge gaps in continuity of care, in our relationships with patients and peers, and in the work that ASHP does every day to further

our professional aspirations and goals.

One of the best benefits of being president is having the opportunity to witness firsthand the important role that ASHP plays in building bridges for pharmacy practice. I have traveled across the country, meeting with seasoned pharmacists and new practitioners, residents, technicians, and student pharmacists. It is clear to me that pharmacy practice is advancing in leaps and bounds all across the United States and throughout the continuum of care. The policies endorsed by this House are helping to support and push that evolution.

Today, I want to share with you a few updates on how ASHP is both driving and reflecting changes in practice, engaging with a new generation of pharmacy practitioners, expanding pharmacy training and certification opportunities, advocating on the issues that you care about most, encouraging more members to get involved in ASHP, and supporting your continuing professional development needs.

### Practice Advancement Initiative

As you know, ASHP has always led the way on practice change and innovation. The member-driven Pharmacy Practice Model Initiative (PPMI) focused on a vision of pharmacists being present and accountable for every

medication-use decision made in every setting where healthcare is delivered. This year, the PPMI evolved even further to embrace and reflect what is happening across the continuum of care. We renamed the PPMI to the Practice Advancement Initiative, or PAI, to reflect the comprehensive nature of the program. This new name and an accompanying website reflect pharmacists' expanding patient care roles in both acute and ambulatory care settings as clinical specialists and generalists. The PAI also focuses more broadly on transitions across settings.

As part of our commitment to help members provide top-quality care to patients across the medication-use enterprise, ASHP continues to broaden and deepen PAI member resources. In addition to the hospital assessment tool, the PAI now offers an ambulatory care self-assessment tool to help pharmacists gauge how practice change should proceed within their care settings.

As of today, more than 1700 hospitals have completed the hospital self-assessment, and more than 275 ambulatory care sites have taken self-assessments. State affiliates are among the best champions for practice change, continuing to lead efforts across the country. Rhode Island, North Dakota, Maine, Wisconsin, and Iowa have all achieved a rate of more than 60% hospital participation.

ASHP continues to support members in a variety of PAI activities, from providing speakers at affiliate meetings to offering advice to members on how to use the findings from their hospital and ambulatory care self-assessments. Over the past year, the ASHP Research and Education Foundation funded six state affiliate grants—for Alabama, Wisconsin, Missouri, Oregon, Pennsylvania, and Ohio—to support PAI planning and implementation. And the PAI website features an array of resources, including progress measures that provide aggregated practice change data from hospitals and clinics across the United States.

### Residency update

To ensure that our work force is ready for today's challenges and those to come, ASHP is continuing its work to grow the capacity of residency programs. I am happy to report that over the past few years, we have seen exciting growth in the numbers of both candidates and available positions in the United States.

Residencies have grown by 9% since 2015, which represents 322 new positions. This is great news, because it tells me that ASHP's focused efforts to build residency program capacity across the nation are working.

To help ensure that we maintain an orderly process for matching candidates with positions, ASHP instituted a new two-phase Match process this year. At the conclusion of both phases, more than 4200 applicants had matched with more than 2000 programs.

This year's Match accomplished what we wanted to accomplish: compared with 2015, 45% fewer unmatched applicants and 90% fewer unfilled positions had to turn to the informal post-Match scramble process to connect. ASHP also offered a virtual career fair to help those candidates who still needed to find positions at the end of the Match process.

We are currently evaluating the Match process to ensure that it is as

easy to use as possible next year. Programs and applicants liked the additional structure of the second phase of the Match but suggested that ASHP extend the time between the first and second phases. Rest assured that we will be addressing that for the 2017 Match. Overall, I couldn't be more pleased with the outcome.

The Match is not the only avenue through which we support residents' professional growth. In addition to offering excellent targeted educational programming, ASHP has rapidly grown the readership of the new *AJHP Residents Edition*. From June 2015 to January of this year, total access to abstracts and full-text articles totaled more than 62,000.

*AJHP Residents Edition* serves as an essential knowledge base and "touch point" for residents. It increases engagement in ASHP by residents, preceptors, and program directors, and it offers pharmacists a fantastic avenue to publish the results of projects they completed during their residencies.

I am also happy to report that *AJHP* will be featuring a theme issue about innovative residency programs as a way to highlight best practices. Clearly, this topic resonates with members, because the journal received many submissions for the issue. Stay tuned!

ASHP also held a successful advocacy training and legislative day for residents in October. It was a special event that dovetailed a successful student advocate training and legislative day in February. We believe it is important to engage this new generation of practitioners in advocacy as we work on important public health issues such as provider status, drug pricing, track-and-trace technology, and much more.

### Importance of advocacy

Paul will update you on where ASHP currently stands with provider status. But I want to acknowledge that provider status is just one of many advocacy issues that we are consistently pursuing on behalf of members.

ASHP has been at the forefront of many national patient safety initia-

tives, from compounding safety and drug shortages to issues such as how to combat opioid addiction and rising pharmaceutical prices.

ASHP is a well-known leader in the area of antimicrobial stewardship, offering members a large array of resources, including webinars, traineeships, and Web-based tools. Last June, we made a commitment at the White House Forum on Antibiotic Stewardship to work with other stakeholders in developing standardized metrics for pharmacy antibiotic stewardship programs. We also promised to foster the development of education, research, and interprofessional collaboration on this important public health issue.

In 2015, ASHP partnered with the Infectious Diseases Society of America (IDSA) and the Society of Infectious Diseases Pharmacists to issue a statement on the Essential Role of the Pharmacist in Antimicrobial Stewardship. We endorsed IDSA Guidelines on Implementing Antibiotic Stewardship Programs, and we were one of five professional groups tapped by the Centers for Disease Control and Prevention to consult on a new antimicrobial stewardship standard.

Finally, no discussion of advocacy would be complete without a mention of the importance of ASHP's political action committee (PAC) in supporting these efforts; over the past year, ASHP members contributed nearly \$100,000. This new level of PAC funding allowed us to better support candidates who are aligned with our advocacy goals and to support even more candidates.

Even with these numbers, there is always room for growth. Think about what we could do if every ASHP member contributed just \$10 a year, which would almost quadruple our current PAC funds and allow us to be even more effective in advocating for provider status and many other issues that affect pharmacy practice.

If you haven't already contributed to the PAC, I hope you will take the opportunity to do so soon.

## Continuing education

As you may know, I am a strong believer in the value of continuing professional development (CPD). As I said in my inaugural address, CPD is the means by which people maintain, develop, and advance their professional skills and knowledge. This structured approach to learning helps ensure that we as practitioners advance our capabilities and are able to practice at the top of our licenses.

ASHP has been a leader in this area for many years, providing excellent, cutting-edge continuing education and opportunities for CPD. In fact, ASHP just launched a new series of online professional certificate programs to help pharmacists and pharmacy technicians improve patient care.

The Teaching Certificate for Pharmacists helps practitioners who want to expand their roles as educators in residency programs, patient care environments, and other instructional settings. It was developed in partnership with the University of Kentucky and features 16.5 hours of pharmacy continuing education. The Pharmacy Informatics Certificate and the Sterile Product Preparation Training and Certificate Program launched last month, and two more programs are scheduled to debut in fiscal year 2017: (1) advanced sterile product preparation and training and (2) medication safety.

We believe this suite of new programs will help pharmacists differentiate themselves in an increasingly competitive and challenging profession.

ASHP's focus on helping members achieve their professional goals and aspirations is unmatched, as evidenced by the endorsement of external organizations.

For example, the Accreditation Council for Pharmacy Education (ACPE) this year awarded ASHP continued accreditation until January 31, 2022. ACPE commended ASHP for our excellence in educational needs assessment; faculty, teaching, and learning methods; educational materials; learning assessment; and achieve-

ment and impact of our mission and goals.

ASHP Summer Meetings offer a plethora of learning opportunities through our four boutiques. Clearly, many members are finding something to like about this set of meetings, as total attendance for last year's Summer Meetings exceeded 2000, the highest it has been since 2009. We appreciate the support we receive from our six partners: the Institute for Safe Medication Practices, Medication Safety Officer Society, National Council for Prescription Drug Programs, Case Management Society of America, Heart Failure Society of America, and Purdue College of Pharmacy Center for Medication Safety Advancement.

This year, we also celebrated the 50th Midyear Clinical Meeting and Exhibition in New Orleans, featuring a number of special anniversary activities. Paul honored ASHP Chief Executive Officer Emeritus Dr. Joe Oddis at the opening session for his work to launch the Midyear meeting and all he has done over the years to build ASHP into the strong and influential organization it is today.

The 2015 Midyear meeting was the second-largest ever, with a projected net income of more than \$13 million. The number of exhibitor booths grew 13% over 2014, and we saw continuing growth in the Residency Showcase, Personnel Placement Service, and posters.

Others outside of pharmacy are taking note of the Midyear meeting success story. Trade Show Executive awarded the Midyear meeting its coveted "Trade Show Executive Fastest 50" award (among the 50 fastest-growing shows by growth of exhibit programs), and Trade Show News Network listed the ASHP Midyear meeting on its 2015 Top 250 Trade Shows List.

## Privileging and credentialing

Of course, no discussion of professional development would be complete without a mention of ASHP's support for specialty certification for

pharmacists who wish to provide advanced patient care services. ASHP's strategic plan, professional policies, and advocacy efforts to gain provider status showcase the need for more pharmacists who can provide specialized patient care services on interprofessional teams. Specialty certification is an important path to provide those services.

Since the founding of the Board of Pharmacy Specialties in 1976, ASHP has strongly supported petitions for new and emerging specialty certification programs. We were the original petitioners for the oncology and psychiatric specialties, and we partnered with the American Society of Parenteral and Enteral Nutrition to seek a pharmacy specialty in nutrition.

In recent years, ASHP also successfully petitioned for certifications in ambulatory care, pediatrics, and critical care. In 2015, ASHP was named a recertification provider in the five Board of Pharmacy Specialties areas of ambulatory care, critical care, oncology, pediatrics, and pharmacotherapy, as well as for geriatrics under the Commission for Certification in Geriatric Pharmacy.

We have enjoyed many successful content partnerships through the years as well, working with the American Pharmacists Association on ambulatory care and with the American College of Clinical Pharmacy on oncology.

To help members achieve and maintain these important certifications, we have focused our energies on developing quality, application-based review and recertification courses, including for pediatrics and critical care, the newest specialties. We also developed a Resident Review and Recertification Program that offers residents special incentives for the seven-year cycle of recertification.

We believe that these programs round out ASHP's core strengths in education and residency accreditation and that they are the best programs available to propel pharmacists to the next level of professional practice.

## Member engagement

ASHP's commitment to our members is what sets us apart from many other pharmacy organizations. We constantly strive to provide the resources, services, and support that members need to successfully care for their patients in any practice setting.

It is a great symbiotic relationship, because members also help ASHP to further its mission and vision in many ways. Members help with meeting programming, educational webinars, editorial input to *AJHP* and other ASHP publications; as active members of our state affiliates; and with policy development here at the House of Delegates. You, along with your fellow members, are incredibly generous with your time, expertise, and creativity. ASHP can be successful in supporting pharmacy practice and advancing patient care only with your assistance.

Our Sections and Forums also provide many different ways to engage with ASHP. To give you a sense of the

numbers, in 2015 and through the first half of 2016, ASHP's Sections provided opportunities for more than 500 members to volunteer with advisory groups and committees—that equals a whopping 8000 hours of volunteer time!

At the Midyear Clinical Meeting in New Orleans, at last year's Summer Meetings, and at the ASHP Conference for Pharmacy Leaders, Sections conducted 40 networking sessions. More than 4000 ASHP members participated in these important, engaging events.

ASHP clearly has some of the most involved and passionate members of any professional organization. Thank you for all that you do!

## Conclusion

I want to express again how much I appreciate your leadership, time, and attention to the most important issues facing pharmacy today. ASHP can only be the dynamic, growing organization that it is with your help. By being a

member and by giving so generously of your time and best thinking, you ensure that ASHP continues to be the relevant membership organization that has served so many practitioners so well for many years.

The policies that you work on in the House of Delegates are absolutely critical to our efforts to expand professional opportunities for pharmacists and to improve care for all of our patients.

We appreciate all that you do for ASHP, for the profession, and for patients. I look forward to many more years of working with you on the most important healthcare issues of our time.

## Disclosure

The author has declared no potential conflicts of interest.

## Additional information

Presented at the ASHP Summer Meetings, Baltimore, MD, June 14, 2016.



# House of Delegates

## **2016 NEW BUSINESS SUBMISSION FORM**

PLEASE RETURN BY 4PM ON MONDAY, JUNE 13, TO THE  
EXECUTIVE OFFICE IN ROOM 333, BALTIMORE CONVENTION CENTER

**ASHP  
HOUSE OF DELEGATES  
JUNE 14, 2016  
BALTIMORE, MARYLAND**

*To be completed by the Office of the  
Secretary of the House of Delegates*

*Date Submitted:*

*Time Submitted:*

**INTRODUCED BY (NAME):  
Scott Takahaski, PharmD, FCSHP, FASHP**

**SUBJECT:  
Impact of Intern Hours changes required for BoP Licensure**

**MOTION:  
ASHP examine the impact on non-academic earned intern hours on the readiness of new practitioners and residents to practice on granting Registered Pharmacist Licensure.**

**BACKGROUND:**  
To respond to past pharmacist shortages, the California Board of Pharmacy had eliminated the non-academic hours requirement to permit out of state applicants to sit for the CA BoP exam. This was due to the requirement the lack of transferable documentation was difficult to not possible to obtain as the document was for CA RPh verification. In addition, in CA, there are 15 schools of pharmacy which has/will greatly impact the ability of students to obtain intern positions to gain the “real world” practical experience offered by employment of pharmacy interns. The assumption is that the intern experience as an employee is markedly different from IPPE and APPE-related experience as the employed experience is obtained over years in the pharmacy with all the duties and responsibilities required with that position. New graduates with substantial intern experience are more practice ready compared to their colleagues whose intern experience is solely from APPE and IPPE through their educational curriculum. The graduate with less/no experience forces the employer to train new hires basic pharmacy work ethics and learn how to function in the pharmacy.

**SUGGESTED OUTCOMES:**  
1. Dialogue with the NABP on the issue of internship hour requirements to sit for licensure exam with

regards to the value of hours completed outside of pharmacy school curriculum.

2. **New practitioner survey on “how prepared are you to start practice” for as many new graduates over the last 5 years. Elements of the survey include: APPE/IPPE hours submitted for BoP exam, hours required for BoP exam, year of first attempt BoP exam, subjective assessment of ease to begin practice as a new graduate.**
3. **Employer survey on hiring of new practitioners over their years of experience. Elements to include: hospital bed size, state, years with hiring experience, presence of intern program, subjective assessment of new hires reasonably prepared to practice on hire (outside of their own previously employed interns), subjective assessment of changes in probationary period changes, subjective assessment of the need to retrain new hires, subjective assessment of the need to discharge new hires compared to previous years.**

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## Recommendations from the 2016 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

### 1. Opioid Infusion Monitoring

Dan Degnan (IN)

**Recommendation:** Recommend that ASHP work with the Association for the Advancement of Medical Instrumentation (AAMI) and the Promise to Amanda Foundation to develop policy regarding the continuous monitoring of patients receiving opioid infusions.

**Background:** AAMI has developed a report regarding the need for continuous **electronic** monitoring of opioid infusions in hospitals. AAMI worked with a family from Indiana who lost their daughter due to an opioid overdose and have since established a foundation to prevent the same issue from happening to someone else. The AAMI website contains the report and the Promise to Amanda Foundation can be found at [www.promisetoamanda.org](http://www.promisetoamanda.org).

### 2. Drug Removal by Extracorporeal Modalities

Kim Benner (AL)

**Recommendation:** To encourage research of drug removal by extracorporeal means to facilitate drug dosing.

**Background:** Similar to the new COT Policy 4 on drug dosing in renal replacement therapy, more research is needed on drug removal by extracorporeal means, such as ECMO and plasmapheresis, to aid in drug dosing when these modalities are used in patients. Even less is known about drug removal by these modes than RRT.

### 3. ASHP Sponsored 5K Run/Walk

Kim Benner (AL), Steve Riddle (WA)

**Recommendation:** To propose that ASHP host a 5K run/walk at a future Summer Meeting.

**Background:** As many pharmacists promote and sustain healthy lifestyles, a health promotion-oriented event such as a run/walk would be a welcomed addition to the Summer Meeting. Other organizations have successfully implemented such activities at their meetings.

### 4. ASHP Position Statement on Assisted Suicide

Dan Degnan (IN)

**Recommendation:** That ASHP use the virtual House process and year-long Council review process to address the ASHP resolution that was referred at this meeting of the House of Delegates.

**Background:** Past President Gerry Meyer made a good point at the ASHP Open Forum about the need to bring some clarity to the issue quickly through the use of the new processes used by ASHP for policy development. The background regarding the specific issue can be found in the proposed resolution from Nicole Allcock.

#### 5. **Projection of Policy Language During Chair-led Caucus**

Carol Rollins (AZ)

**Recommendation:** That an electronic method be used to project Council wording of policies during caucus led by the Chair of the House (and amended language agreed upon through Connect).

**Background:** Takes too much time and is too confusing to only read the policy. Pulling up on phones, I-pads, etc., is sometimes significantly delayed real time so you may not be able to see the policy as it is discussed. Just having slides would be a big help. As an aside, it would also be helpful to have the room set up with much shorter aisles (or use round tables) so participants can easily get up/out to the microphone to comment.

#### 6. **Restricted Access to Medications Due to Pharmaceutical Company Initiatives Affecting Patient Care**

Brian I. Kawahara (CA)

**Recommendation:** ASHP should develop a position regarding pharmaceutical companies restricting the purchase and distribution of agents based upon a social policy or initiative of the pharmaceutical company that may affect patient care.

**Background:** Recently a major wholesaler mandated pharmacies to sign an agreement that they would not purchase for or resell certain agents to prisons because several pharmaceutical manufacturers were mandating this. If the agreement was not signed, the pharmacy would not be allowed to purchase these agents for their patients. This sets a dangerous precedent and has major implications on patient care for healthcare systems that do not agree with pharmaceutical company's positions.

#### 7. **Notification of Outcomes of Delegates Recommendations**

Diane Fox (TX)

**Recommendation:** ASHP should continue to inform delegates and/or recommendation generators on the outcomes of their recommendations.

**Background:** A number of delegates have stated that they did not receive any feedback on the outcome of recommendations presented to ASHP in past years.

#### 8. **Inclusion of Small Hospitals in ASHP Surveys**

Diane Fox (TX)

**Recommendation:** ASHP should include rehabilitation hospitals, LTACs and small hospitals in their survey process to ensure all size hospitals can use the information obtained in surveys to improve services.

**Background:** Inclusion of small hospitals in ASHP surveys will help their leaders analyze and improve services based on best practices.

**9. Automated Preparation and Dispensing Technology for Nonsterile Preparations**

Mike Storey, Karen Kier (OH)

**Recommendation:** ASHP advocate for best practices for the safe and efficacious use, preparation, and dispensing of nonsterile and compounded products including research of these best practices.

**Background:** Many institutional pharmacy settings involve extensive use of nonsterile compounded products that can have the same inherent risks related to safety and efficacy as sterile products. Similar to CPHP Policy #1.

**10. That ASHP Only Invite Current State Affiliate Members to Serve on Councils for ASHP**

Natasha Nicol (SC, OR, SD, OH)

**Recommendation:** That ASHP only invite current state affiliate members to serve on councils for ASHP

**Background:** Those writing national policy should support their state societies.

**11. Brown Bagging/White Bagging**

Nishaminy Kasbekar (PA)

**Recommendation:** ASHP develop a policy to prohibit brown bagging/white bagging and endorse health systems insourcing of these products.

**Background:** None supplied.

**12. Evaluation of ASHP Staffing Model Service and Metrics for Health Systems**

Sidney Phillips (TX)

**Recommendation:** ASHP develop and advanced staffing model/metrics and/or a comparative service for health systems that would provide interactive comparisons based on actual pharmacy services provided.

**Background:** Groups such as Action OI develop comparative staffing models based on data feed into the systems from client health systems. These models are developed by non-pharmacy professionals who give little to no benefit to clinical services by pharmacy or increased operational requirements such as IV services. Recommend ASHP advance the work done by the ASHP survey of pharmacy practice into a service providing comparative staffing models/metrics with true data and a clinical focus.

**13. Generational Leadership Steering Committee**

John Hertig, Dan Degnan, Amy Hyduk (IN)

**Recommendation:** Recommend that ASHP move forward with establishing a leadership steering committee to explore leadership development needs for different generations of pharmacists.

**Background:** Given the productive work of the ASHP Women in Pharmacy Leadership Steering Committee, additional gaps and needs have been identified in growing and sustaining leaders from differing generations. A specific effort is needed to address this issue.

**14. Responsible Prescribing and Use of Medications with Abuse Potential**

Michael Dickens, Elizabeth Duncan, Diane Fox (ID, TX)

**Recommendation:** We recommend that ASHP, in cooperation with stakeholders at the federal and state level, develop evidence-based prescribing and fully fund prescription monitoring programs (PMPs) throughout all states relating to all medications with abuse potential (i.e., opiate analgesics, sedative hypnotics, skeletal muscle relaxants, stimulants, anxiolytics).

**Background:** Abuse of prescription medications continues to be a national problem as referenced by the AMA. Opioid misuse, abuse, overdose, and death have recently received the most attention. However, our concern is that the other medications with abuse potential are also misused and abused to the same extent. Enhanced education for prescribers and patients about appropriate prescribing practices (type of therapy, quantity needed, and anticipated duration of therapy) needs to be developed to ensure patient safety. This nationwide epidemic requires a comprehensive public-health approach to prevent continued misuse while ensuring access to these medications for patients with legitimate needs.

**15. Automation of the “De-Prescribing Process”**

Gregory P. Burger, Joan Kramer (KS, IL, IN, WI, AK, TX, WA, SOPIT)

**Recommendation:** ASHP should advocate for electronic prescribing systems to require automation of the de-prescribing process by two-way communication ability to discontinue, stop, or cancel electronic prescriptions (and for retail pharmacies to receive and manage this information).

**Background:** Our background includes the proposed Illinois House Resolution 0944 to modernize and automate the de-prescribing process, to providing more seamless communication between prescribers and pharmacies, saving providers time, reducing the incidence of medication errors, and improving documentation.

**16. Waiver of Summer Meeting Registration Fees for Voting House of Delegate Attendees**

Paul Goebel, President, NJSHP (NJ)

**Recommendation:** We request that the ASHP Board of Directors explore a waiver for the regular registration fee for voting House of Delegates attendees to the ASHP Summer Meetings.

**Background:** Individual delegates and/or state affiliates bear the financial burden for attendance at the Summer Meetings. Delegates primarily attend the Summer Meetings to conduct the official business of ASHP. Delegates also attend Regional Delegate Conferences and donate their time to ASHP to consider policy, resolutions, and other business. Waiving the registration fee to the Summer Meetings is an appropriate measure to allow for cost-sharing between ASHP and its affiliate delegates for conducting the official business of the Society.

**17. ASHP Working with NASPA**

Dan Degnan (IN)

**Recommendation:** That ASHP actively participate in the activities of the National Alliance of State Pharmacy Associations (NASPA) as a method to support ASHP state affiliates.

**Background:** Although ASHP has traditionally been invited to attend a meeting with other leading national pharmacy organizations to an annual meeting to orient presidents of state pharmacy organizations, ASHP has not participated. Other participating organizations have included AACP, APhA, NACDS, AMCP, etc.

**18. Pharmacy Technician Membership**

Emily Alexander (SICP)

**Recommendation:** Conduct a workforce survey and work with state affiliates and other organizations to determine best practices and models to increase pharmacy technician membership within ASHP.

**Background:** The Section of Inpatient Care Practitioners believes that the pharmacy profession will be best advanced with the input of pharmacy technicians on important issues such as pharmacy technicians as a career, advanced roles of technicians, and training and education of technicians. We believe these issues would be best addressed with representation of greater numbers of technicians in ASHP.

**19. Standardization of IV Push Medications: Concentrations, Rate, and Terminology**

Gregory P. Burger (KS, IN, WS, TX, WA)

**Recommendation:** ASHP should collaborate with professional organizations, accrediting bodies, and other stakeholders to determine and standardize optimal IV push rates, concentrations, and terminology for IV push medications.

**Background:** IV push rates, concentrations, and terminology in medication administration references are ambiguous. Standardization of concentrations given IV push will not only improve patient safety for administration (e.g., avoiding dilution at the patient bedside and potential for administration errors), but will also encourage pharmaceutical manufacturers to produce standardized products (e.g., ISMP Safe Practice Guidelines for Adult IV Push Medications).

**20. Evidence-based Policies, Guidelines, and Recommendations**

Jeff Wagner (TX)

**Recommendation:** Advocate that recommendations of regulatory and healthcare related organizations are based on rigorous objective evidence and systematic review of available research.

**Background:** There is concern that recommendations such as USP <800> are difficult and costly to implement, are not based on sound scientific evidence, and are industry driven rather than evidence-based. We would like to see the same standards held with all guidelines that are endorsed and referenced by ASHP.

**21. Ongoing and Consistent Information Exchange Among State Boards of Pharmacy**

Christi Jen, Carol Rollins, Melinda Burnworth (AZ)

**Recommendation:** To advocate that all state boards of pharmacy maintain ongoing and real-time/expedited information exchange regarding status of their licensees for reciprocity, particularly on disciplinary action.

**Background:** It was determined that there is a delay of communication of information regarding the status of licenses among state boards of pharmacies. Licensees, who are currently in good standing but under investigation, may be able to gain reciprocity and/or temporary licenses at another jurisdiction. However, when disciplinary action has occurred, there is a delay in this communication to other state boards of pharmacy where licensee has attained reciprocity, thereby increasing patient safety risk.

**22. E-Prescribing and CDTM**

Adam Porath (NV)

**Recommendation:** Recommend that ASHP advocate that state laws and regulations concerning e-prescribing consider pharmacists CDTM protocols.

**Background:** In Nevada, pharmacists are not considered authorized to transmit a prescription electronically but can do so telephonically. This introduces several unnecessary steps and potential for error in the medication use process.

**23. Pharmacist Prescribing of Naloxone**

John Pastor (MN)

**Recommendation:** That ASHP advocate with Boards of Pharmacy to allow pharmacists to prescribe naloxone to expand access to this lifesaving medication.

**Background:** Refer Policy 1510 back to Council to strengthen language.

**24. Timely Board of Pharmacy Licensing**

Daniel M. Ashby, (ASHP Past President, MD)

**Recommendation:** The Council on Public Policy should review additional options to address timely licensure by state Boards of Pharmacy including but not limited to strategies used by other professions including the Nursing License Compact, now a 25-state program supporting a single license.

**Background:** Nursing has established a program for licensure as a “Nurse License Compact States.” NurseTogether has confirmed that 25 states are part of the compact state nurse licensure (NLC). A nurse with a permanent residency in a NLC state has a multistate nursing license and is eligible to work in other states that participate as a “compact state.” The program started in 1999 and now includes 22 states. Is this a strategy to establish and grow between NABP and state Boards of Pharmacy an expedited licensure process?

**25. Enhancing the U.S. Public Health Efforts in Health Promotion through Public-Private Collaboration**

Steve Riddle (WA, KS, AL, OR)

**Recommendation:** To encourage ASHP to engage the FDA, office of the CDC related to public health, healthcare professional organizations (e.g., AMA, APhA) and notable commercial healthcare entities that produce medications and other treatment modalities (e.g., pharmaceutical manufacturers, biomedical companies) to explore enhancements to public health awareness and education system including funding to support identified improvements.

**Background:** Marketing and advertising are powerful tools to influence behavior, however, health-related marketing and advertising have traditionally been used by companies promoting specific products or services; often supported by significant financial expenditures. Healthcare companies currently engaged in direct-to-consumer (DTC) advertising claim that these media activities and outreach improve public health by expanding public awareness about medication conditions and/or potential treatments that may have gone unrecognized or undertreated. If DTC is banned, as recommended by the AMA and ASHP and other groups, a new public-private partnership/collaboration could be established that seeks to (1) share with public health entities industry-based knowledge in marketing and advertising that is known to impact human behavior and (2) create a funding channel from the private sector that supports a more robust public health communications program. In this collaboration, all advertising and other messaging share with the public could be controlled by noncommercial interests to ensure objective, unbiased, and properly prioritized information around health conditions and treatments. Health promotion advertising should be seen by public health policy makers as a potentially effective means of educating the public on health-related conditions and treatments, improving the quality of interactions with healthcare providers and encouraging uptake of healthful behaviors.

**26. Update Statement on Cultural Diversity to Explicitly Include LGBT in the Statement**

Tim Brown (ASHP Board Member)

**Recommendation:** Update statement on cultural diversity to explicitly include LGBT in the statement.

**Background:** Current statement does not reflect our workforce and the needs of our profession for the patients that we care for in our practice models. Need expansion to be more inclusive.

**27. Policy 9820 Update**

Curtis Collins (SCSS)

**Recommendation:** Update Policy 9820 Medication Administration by Pharmacists to advocate for changes in state practice acts to include pharmacist administration of all medications.

**Background:** Update to have ASHP work with state affiliates to advocate change in state practice acts to include pharmacist administration of all medications. Additionally, that ASHP develop a competency tool and training materials on appropriate administration of all medications and IV access devices. Important component of the PAI, particularly regarding provider status and the mid-level practitioner. State practice acts are diverse in recommendations.

**28. Safety of Compounded Products**

Brian I. Kawahara (CA)

**Recommendation:** ASHP should look to expand the ideas presented in the Safety of Epidural Steroid Injection policy to include those products (medications and diagnostic agents) that are being used or compounded with little evidence to support their efficacy or safety (e.g., radiologic mixed together or with food). Patients should be informed about: the risks and benefits of using, combining, or administering agents in a manner; and proven or lower risk alternative.

**Background:** Procedural areas such as radiology often mix agents with other pharmaceutical, diagnostic, or other solutions prior to administration. However, these combinations have little or no clinical evidence to support their use. This is a patient safety issue and could have effects on medical therapies.

**29. ASHP to Explore a Standardized Framework for Licensure and Credentialing Nationally**

Julie Groppi, Mary Parker, Katelyn Dervay (Veterans Affairs, NC, FL)

**Recommendation:** Through partnership with NABP and State Board of Pharmacy, ASHP should explore development of a standardized framework for licensure and credentialing of pharmacists nationally.

**Background:** ASHP should explore the benefits of a national credentialing body of pharmacists that promotes timeliness of licensure and access to pharmacist services. Utilizing the national credentialing process for physician assistants and nurse practitioners as a base as well as strong practices in pharmacist credentialing at the VA and PHS, ASHP should review pros/cons of this approach as a means to support pharmacist provider roles, reciprocity, and consistent requirements for licensure.

**30. Consolidate Similar Policies**

Carol Rollins (AZ)

**Recommendation:** Consolidate policies for individual drugs/drug classes into a single policy when the activities within the individual policies are consistent with general pharmacy activities.

**Background:** Using the new antipsychotic policy as an example, you could substitute “antipsychotic agent” with antibiotic, anticoagulant, or any other drug since everything listed in the policy is part of a pharmacist’s “usual” professional responsibility. Policies addressing specific issues such as drug diversion would stand alone.

**31. Culturally and Ethnically Diverse Workforce**

Diane Fox, Jen Phillips, Joan Kramer (TX, IL, KS)

**Recommendation:** The Council on Education and Workforce Development should develop a policy advocating for an ethnically diverse workforce.

**Background:** The House of Delegates recently approved dividing a policy on Cultural Competence and Cultural and Ethnic Diversity in the 2016 House of Delegates session. Development of the policy advocating a culturally and ethnically diverse workforce to meet the strategies for reducing and racial and ethnic disparities in healthcare.

**32. Interstate Patient-Specific Pharmacists Cognitive (Non-dispensing) Service Practice  
Steven Gray (CA)**

**Recommendation:** Form a task force to study and make recommendations to resolve the barriers to interstate patient-specific cognitive services practice.

**Background:** Patients are being denied their choice of pharmacist care source, including therapy management, care recommendations, and even patient education, because of states’ and Board of Pharmacy attitudes when patients are not in the same state as the pharmacist. These factors also cause financial practice barriers.

**33. Partnership Between ASHP and State Affiliates to Provide BPS Continuing Education**

Ryan Miller (WI, AZ, MO, OH, VT, NC, IL, CT, MT, NV, CO, MA, IA, TN, PA, MN, OR, TX, UT, ME, KS, CA, OK, WA, MI, MS)

**Recommendation:** Collaborate with BPS and state affiliates to develop a mutually beneficial and sustainable pathway to facilitate the provision of BPS approved continuing education credit at the state affiliate level.

**Background:** As the number of BPS certified pharmacists increases, spurred by policies like those of ASHP, the rigor of CE credit provided must also rise to meet the needs of the average ASHP pharmacist member. As ASHP is a recognized provider of BPS approved CE, the formation of mutually beneficial partnerships between ASHP and state affiliates provides an avenue for ASHP to meet member needs and if implemented properly, could spur ASHP and state affiliate membership.

**34. Consider Indianapolis as a Location for ASHP Summer Meetings**

Dan Degnan, John Hertig, Amy Hyduk (IN, WA, MO, CA, MN, CT, WI, ME, ID, SD, UT, MA, OH, IA, VA, IL, MS, NH, PR, FL, MI, NPF, PSF, SICP)

**Recommendation:** That ASHP consider Indianapolis, host of Super Bowl 46 and the largest one day sporting event in the world, as a host city for the Summer Meetings.

**Background:** This recommendation has been presented at the House of Delegates for many years. Will provide background as required.

**35. Edit Policy 1608 on Adding Indications to Provider Orders/Prescriptions**

Gregory Burger (KS)

**Recommendation:** Edit out “clinical decision support.” Edit in “entire medication use process.” Forty-six percent of the House of Delegates thought the language was fuzzy. What will our membership think? Most are not IT folks and will not understand clinical decision support will include prescribing process.

## ASHP Board of Directors, 2016–2017

Am J Health-Syst Pharm. 2016; 73:e528



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## INAUGURAL ADDRESS OF THE INCOMING PRESIDENT

## Pharmacy's true north

**Am J Health-Syst Pharm.** 2016; 73: 1261-5

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DOI 10.2146/ajhp160485

No ASHP president-elect has achieved this position without help from others. Many names come to mind as I think of all the family, friends, and colleagues who have guided me on my professional journey. I want to take a moment to say thank you to everyone who has inspired, mentored, challenged, influenced, or educated me during my professional and life journey.

Although I cannot mention everyone, there are a few people I would like to name.

Three individuals became trusted mentors and colleagues during key junctures of my career: Mark Woods, during my first job at St. Luke's Hospital in Kansas City; Bruce Scott, who hired me at United Hospital in St. Paul where I have spent the past 20 years; and Sara White, during my transition from clinical manager to director. It goes without saying that all three continue to assist me as I now embark on my latest journey as ASHP president.

Thank you to my ASHP Board of Directors colleagues—both current and past—especially Lynnae Mahaney, Janet Mighty, Janet Silvester, and Diane Ginsberg. Of course, I wish to thank

We must accept full accountability for patient care outcomes due to medication-use decisions in every healthcare setting.



my fellow Minnesotans, Chris Jolowsky and Kathy Schultz. I am grateful to Henri Manasse and Paul Abramowitz for their outstanding leadership of ASHP and wisdom about pharmacy.

To all of my Allina colleagues—you are an exceptional group of leaders. I would especially like to thank Kristi Gullickson for her many years of friendship and professional collaboration. I must thank the pharmacists, technicians, and pharmacy residents at United Hospital who are my daily source of inspiration. I have a wonderful group of past and current managers who epitomize teamwork; thanks to Deb, JoAnne, Shane, Kat, Jay, and Brenda.

I would also like to thank Mandy Richards, my boss and vice president of patient care at United Hospital. I appreciate her support of me as director of pharmacy and especially during my pursuit of ASHP activities.

I would like to thank my friend Mary Fran Tracy, who has joined us here today. Mary Fran and I grew up in the same hometown and went to high school and college together, and our families were friends. She has given me a great deal of insight on nursing practice and the value and importance of serving in professional organizations. And, one of the most important things of all: she usually watches my beagle, Maddie, while I

am away at ASHP events (except on this trip)!

Finally, I would like to say thank you to my parents, Clarence and Louise, and to my siblings, Dave, Faye, and Kathy and their families. Their unconditional love and support have given me such a solid foundation on which to grow. I am so pleased that Kathy and my brother-in-law Jeff are with us today—it certainly makes the day more special.

Although my parents are no longer with us, I know that this would be a very proud day for them. I suspect that somewhere my dad is beaming from ear to ear, and my mom is whispering to him, "Can you believe this is our little farm girl from Iowa?"

To be able to stand before you today—a group of dedicated and inspiring individuals who I am so proud to call my friends and colleagues—is such an honor.

Being elected president of ASHP is a wonderful yet humbling feeling. When I first became involved with ASHP in 1999, being part of the leadership was not on my mind. Rather, I joined ASHP to meet other practitioners, learn how I could be a better patient care provider, and expand my professional horizons.

Seventeen years later, ASHP has become a cornerstone of my practice. The connections and friendships I have made, as well as the op-

portunities for learning and sharing that ASHP has afforded me, have made an incredible difference in my professional life.

### Advancing pharmacy

Since its founding 74 years ago, ASHP has contributed to practice advancement in more ways than many of us know. Consider ASHP's work to advance clinical pharmacy through the establishment of the doctor of pharmacy degree and its support for residency training and specialty certification. ASHP has advocated for enhanced roles for pharmacy technicians, developed standards for compounding and for pharmacy practice, and pushed for safe and effective medication-use technologies.

Let us stop to consider how different practice looks today than it did in 1942:

- We have moved from multiday dispensing in bulk bottles to barcoded unit dose packages dispensed from automated cabinets.
- We have moved from nurses admixing on patient care units to *United States Pharmacopeia* chapter 797-compliant cleanrooms.
- We have moved from pharmacists being hidden away in a basement to pharmacists being accepted as valued members of the patient care team.
- And now, we are moving far beyond traditional inpatient care to expand our care of patients across the healthcare continuum.

But we cannot talk about the past without linking it to the future. What will guide us on our professional journey in the coming months and years? We should be very proud of what we have already accomplished. But we must keep asking ourselves, "What's next?"

To achieve greatness, we must focus our energy and passion to get to the next level of practice. Yes, we will achieve provider status—it is just over the proverbial hill. We must be

prepared for the journey that lies beyond that.

We must accept full accountability for patient care outcomes due to medication-use decisions in every healthcare setting.

We must be prepared to successfully collaborate with other healthcare team members.

We must embrace a culture of excellence in practice, and we must seek out avenues to lead patient care in our organizations.

These goals are the true north of our collective journey as pharmacists.

Along the way, we must expect distractions—additional healthcare reforms, regulatory challenges, limited resources—but our professional compass must be trained on our true north. We must not veer off the path by going where others may point.

As I began to think about my remarks today, four critical attributes of pharmacy's true north came to mind: accountability, collaboration, excellence, and leadership. All have been critical guideposts throughout my career.

If we strive consistently to achieve these attributes throughout our professional journeys, the prospects for pharmacists will be bright.

### Accountability

The first construct of pharmacy's true north—accountability—can be challenging to define. It is frequently interchanged with "responsibility" or "ownership." Some may even associate it with liability.

Let me give you an example that helped shape my understanding of accountability for pharmacists.

Early in my career at St. Luke's Hospital in Kansas City, our senior surgery resident shared his dislike of our aminoglycoside dosing service. (Yes, this was more than 25 years ago!) I was very proud of this program. I considered it our launching pad for clinical services at the hospital, and I had worked very hard to teach our staff this skill. You can imagine my dismay when the surgical resident said that he did not like the service.

He went on to explain why he felt this way. Apparently, even though he thought the recommendation for a dose change was reasonable, he might challenge the pharmacist—just to see how the pharmacist would respond. He was amazed when the pharmacist did not push back but instead said, "OK," and hung up the phone.

The resident then said to me, "If you believe in what you are doing, you have to fight for it." Although I did not realize it at the time, this conversation was one of my first lessons in accountability, and it propelled me to teach our pharmacists how to respectfully fight for what they believe in.

It was true then, and it is true now.

This conversation struck me again several years later during an ASHP Policy Week. I was chair of the Council on Pharmacy Practice, and one of our agenda items was titled "Pharmacist Accountability." At first blush, this seemed like a daunting topic. The content of the scholarly articles that were provided as background reading was complex, and the discussion was insightful and energizing.

On that day, I had an epiphany: Unless we, as a pharmacy profession, accept full accountability for medication management and every related issue, our personal career aspirations and larger goals for the pharmacy profession will be difficult to achieve. After that discussion, no action or recommendation made sense to me unless it was prefaced by pharmacists accepting accountability for their actions.

On the face of it, the word accountability seems to have a simple definition: "the obligation of one party to provide a justification and be held responsible for its actions by another interested party."<sup>1</sup> But when you start to break the definition into its components, it becomes more nuanced and complex:

- *One party* refers to each of us as a pharmacist and collectively as a pharmacy department and profession.

- *Another interested party* clearly refers to our patients, but it also represents our employers, other healthcare providers, the legal system, and society as a whole.
- *Action* is two pronged. We have to either do something, or we have to consciously not take action.
- *Provide a justification* means that we need to be able to support and defend our action or lack thereof.
- *Held responsible* points to the fact that we must accept the consequences of our decisions and actions.
- *Obligation* refers to a sense of duty, a promise to act.

This definition is quite complex for a word that, on its face, seems simple.

You know, one thing that particularly strikes me about accountability is the requirement to look at our decisions through the lens of “another interested party.” This is a daunting prospect, isn't it? We must constantly ask ourselves: Are we doing the right thing? Are we available enough? Do we embrace a sense of duty to help our patients?

Over the years, I have questioned certain aspects of our traditional pharmacy staffing models. For instance, do your pharmacy staffing and services look different at 2 a.m. on a Saturday compared with 10 a.m. on a Wednesday? I bet they do. I know mine does, and yet I doubt that the patient admitted early on a Saturday morning has fewer medication issues or challenges than another patient admitted on Wednesday at 10 a.m.

What is our accountability to our patients, no matter when they arrive in our healthcare settings and institutions?

ASHP has a unique perspective on pharmacist accountability. In 2010, the Council on Pharmacy Practice developed a policy statement on pharmacist accountability for patient outcomes.<sup>2</sup> It had taken several years of discussion and feedback to develop a statement that captured all of the critical components.

When I placed the statement into a word cloud, I saw something interesting. The size of each word reflects the number of times that it is stated in the document. It was no surprise what words stood out. These keywords said all that needs to be said about the importance of accountability for pharmacists.

Accepting accountability can be challenging and a bit frightening. But the rewards and recognition that come our way when we exhibit accountability to our patients, our healthcare partners, our profession, and our entire society are incredibly rewarding.

### Collaboration

I imagine that some of you may be thinking, “We do take ownership of issues. Pharmacy owns the medication-use system. Isn't that accountability?” The answer to that may be yes, but could the outcomes be even better?

Indeed, how pharmacy-centric are we, and what are we missing if we do not seek highly collaborative relationships?

Like accountability, the word *collaboration* is a complex behavior that is often misunderstood. Collaboration originates from Latin and means to labor together. To be collaborative means to value opinions and experiences of others that differ from our own.

The good news is that pharmacists have never had more opportunities to collaborate as members of interdisciplinary patient care teams, with pharmacy colleagues in different settings across the continuum of care, and among professional disciplines as we develop programs, policy, and care approaches together.

I truly believe that a strong and effective medication management system cannot be orchestrated by pharmacy alone. This system actually consists of a triad of pharmacists, nurses, and physicians. Each discipline is responsible for one side of the triangle—with the patient located safely in the middle.

Each discipline owns a unique set of knowledge and responsibilities that

contributes to the safe and effective use of medications for our patients. When we focus to develop a shared pool of understanding, we create a trust and synergism that result in the best care for patients.

The key question is how do we, as pharmacists, interact with our partners in patient care? Are we occasionally dismissive of their requests? After all, we are the medication experts, and we know best. Or do we back down in the face of a colleague's challenge when we should step up?

I recall a situation from several years ago when I jumped to conclusions before understanding a situation. This involved an error when a nurse had administered vasopressin to run at 400 mL/hr to a critically ill patient. Yes, that's right, 400 mL/hr.

When I heard this, I immediately questioned how any nurse—especially one in the intensive care unit (ICU)—would ever think that 400 mL/hr was an acceptable rate for any medication-containing infusion. I certainly had preconceptions about assigning blame.

Clearly, this was a serious error, but the list of issues that contributed to it was very revealing. Here is a list of just a few:

1. The nurse was a new hire and had floated from a different ICU midway through his shift, and he was unfamiliar with vasopressin.
2. Instead of paging the pharmacist, the nurse checked his own resources for information on vasopressin.
3. The intensivist gave a verbal order to the pharmacist but wrote the order differently; the nurse administered the order as written.
4. The electronic charting system was not programmed to match how our intensivists typically ordered vasopressin.

This was a serious medication error simply waiting to happen. Yes, it was the classic example of “Swiss cheese” issues. But I also wondered how things might have been different if this nurse

had felt comfortable enough to collaborate with the pharmacist.

What would have changed if the pharmacy department had effectively collaborated with the medical and nursing staff to establish safe processes for the prescribing and administration of vasopressin? Better accountability and collaboration would have avoided a serious medication error.

Research demonstrates that team-based care and clear communication are the keys to medication safety and good patient outcomes. Indeed, the Joint Commission has suggested that over 60% of sentinel events related to medication errors are the result of poor communication.<sup>3</sup>

Other studies confirm this finding, including one that evaluated the outcomes of over 5000 patients receiving care in 13 tertiary care hospitals.<sup>4</sup> The study discovered that the level of inter-professional interaction and coordination of care had greater impact on positive patient outcomes than the number of specialized services available at each hospital. That is astonishing, isn't it?

Clearly, everyone wins through collaboration. When we join forces, we view the situation through many eyes, and we are able to gain new insights and better understanding of the big picture. This partnering must occur at all levels—obviously during patient care but also during policy and program development and strategic planning.

I imagine that many of you have experienced being part of a high-performing team. You can feel its synergy—the trust and positive energy. Your contributions are valued, and you respect the other team members. It is an incredible feeling.

That does not mean that this process is easy. We must always maintain the delicate balance between sharing our expertise and advocating for what we believe. We also must learn from members of the team with different expertise who may hold a different view of the same situation. That diversity helps us to move beyond a rela-

tively narrow and pharmacy-centric view on the world.

As author Nancie O'Neill<sup>5</sup> once said, “When different talents and ideas rub up against each other, there is friction, yes. But also sparks, fire, light, and eventually brilliance.”

### Excellence

The third construct of pharmacy's true north is excellence.

Now, more than ever, we must be able to effectively justify our actions to ourselves and to others. To do so, we must demonstrate an excellence in our practice and our medication knowledge that is second to none. Of course, with today's advanced technology, we have a plethora of data at our fingertips. But without pharmacists' professional insights and ability to apply these data to a specific patient or situation, they are just that—data.

One of the most important skills that pharmacists have learned in terms of patient care is our ability to defend the rationale behind personalized medication care plans. We must anticipate occasional pushback. We may even hear statements like, “I've never done it that way” or “I haven't seen that in my experience.”

But we must be confident and skilled enough to demonstrate our clinical excellence by effectively and efficiently sharing the rationale supporting our actions with the patient and other members of the healthcare team. We must be resolute. We must stand behind our recommendations.

On a broader scale, if we want to be seen as healthcare providers, we need to understand that other healthcare professionals, administrators, credentialing departments, third-party payers, and our patients will look for evidence that a pharmacist is qualified to accept this important medication management responsibility.

That's why I believe that advanced training with residency programs and completion of board certification are essential external validations.

Another aspect of being excellent practitioners is to recognize and value the importance of lifelong learning and skills development. Consider that, on average, human knowledge is doubling about every 12 months<sup>6</sup> and that the scientific route from a pioneering discovery to a new drug—which once took decades—now takes years, and in some cases, only months.<sup>7</sup>

Let me illustrate what this pace of change has been like for me personally. During pharmacy school, my professors taught me about how cytochrome P-450 acts as an important enzyme for drug interactions, but we had little to no information about subtypes of this enzyme. The medical field was just becoming aware of HIV and its devastating effects. There were no “mAb” drugs. I am not even sure that *genomics* was a recognized term!

Contrast that with our keynote speaker yesterday, futurist Michio Kaku, who, in talking about the future, noted the potential uses of three-dimensional printing in medicine. In just a few years, the ability to print personalized medications will be a reality.

The pace of change in our world today is so fast that it is almost intimidating. Nevertheless, we must learn to adapt, and adapt quickly, or we risk becoming dinosaurs.

So, how do we maintain our clinical excellence, our ability to justify our actions to an interested third party? A personalized plan for continuous professional development is essential. To do this, (1) start with an objective and thoughtful self-reflection, (2) seek feedback from a trusted colleague or mentor, and (3) after preparing your self-improvement plan, be sure to hold yourself accountable for making it happen.

Now, this can definitely be a challenging process. But the rewards for you, your patients, and your colleagues are well worth the effort.

### Leadership

So, I've talked about accountabil-

ity, collaboration, and excellence as three of the four constructs of pharmacy's true north. But I cannot leave out the one that will help power us on this exciting professional journey: leadership.

Leadership is not granted. It does not come with a promotion. It does not automatically happen at the upper echelons of practice, such as in pharmacy administration or at the C-suite level. Leadership is an opportunity.

I believe strongly that every one of us can be a leader in our own right. I urge you to ask yourself, "What are the areas within my sphere of influence and scope of practice that I can change to improve patient care?"

Where can you make a difference? How can you lead the way to better patient care? These actions demonstrate leadership.

If we find ourselves in a position of formal leadership, we must

- Quantify the value that we bring to patients and share this information with administrators and payers,
- Expand our practice sites to include transitions of care and ambulatory care practice,
- Embrace the changing demographics of pharmacy and develop insight into the value of leadership style based on gender or generational differences,
- Establish a vision of where we are going as a profession by encouraging our staff members to adapt to change, be accountable, collaborate, and seek excellence, and
- Know how to effectively collaborate with the many leaders outside of pharmacy, knowing when to push and when to pull back.

If we strive to reach these goals, we will start to see extraordinary results for our patients and for ourselves as practitioners.

As author Jim Collins<sup>8</sup> wrote, "The good-to-great leaders never wanted to become larger-than-life heroes. They never aspired to be put on a pedestal or become unreachable icons. They were seemingly ordinary people quietly producing extraordinary results."

I know many pharmacists who are "seemingly ordinary people" who are constantly and quietly "producing extraordinary results." Let's start shouting those results from the rooftops!

What will be your role in the future of patient care and the pharmacy profession? Moving out of our collective comfort zones can be challenging, frightening, and sometimes painful, but accepting the status quo will inevitably lead to our personal and professional stagnation. We have so much to offer; our patients need what we know.

The future requires all of us to lead through accountability, collaboration, and excellence.

## Conclusion

We must accept accountability for our patient outcomes, both positive and negative.

We must embrace new roles as collaborative members of the healthcare team by moving beyond a pharmacy-centric perspective.

We must be willing to demonstrate our commitment to professional excellence by becoming board certified and by committing to continuous professional development.

Finally, we must seek opportunities to lead medication-use and patient care policies, approaches, and initiatives within our practice settings.

This profession is a challenging one. We face obstacles of all kinds on the road to better patient care, but if we become accountable, if we learn to collaborate fully, if we achieve excellence in our professional knowl-

edge and work, and if we embrace opportunities to lead, we will find our true north and achieve our goals.

## Disclosure

The author has declared no potential conflicts of interest.

## Additional information

Presented at the ASHP Summer Meetings, Baltimore, MD, June 14, 2016.

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# House of Delegates

## REPORT ON IMPLEMENTATION OF 2015

### ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

#### Council on Public Policy (1501): Pharmacist Participation in Health Policy Development

To advocate that pharmacists participate with policymakers and stakeholders in the development of health-related policies at the national, state, and community levels; further,  
 To develop tools and resources to assist pharmacists in fully participating in health policy development at all levels.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP continues to be actively involved with health-related policies such as provider status, opioid abuse, FDA, and drug safety issues.

#### Council on Public Policy (1502): Pharmacist Recognition as a Healthcare Provider

To advocate for changes in federal (e.g., Social Security Act), state, and third-party payment programs to define pharmacists as healthcare providers; further,  
 To affirm that pharmacists, as medication-use experts, provide safe, accessible, high-quality care that is cost effective, resulting in improved patient outcomes; further,  
 To recognize that pharmacists, as healthcare providers, improve access to patient care and bridge existing gaps in healthcare; further,  
 To collaborate with key stakeholders to describe the covered direct patient-care services provided by pharmacists; further,  
 To advocate for sustainable compensation and standardized billing processes used by payers for pharmacist services by all available payment programs.

*This policy supersedes ASHP policy 1307.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP maintains a leadership role in the Patient Access to Pharmacists Care coalition that is supporting provider status legislation. We currently have 285 cosponsors in the House and 44 in the Senate and are working on securing a hearing for the legislation and a Congressional Budget Office (CBO) Score.

#### Council on Public Policy (1503): Pharmaceutical Product and Supply Chain Integrity

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

To encourage FDA and relevant state authorities to develop and implement regulations to (1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers, and manufacturers) from purchasing legend drugs from unlicensed entities and (2) ensure accurate documentation at any point in the distribution chain of the original source of drug products and chain of custody from the manufacturer to the pharmacy;

further,

To advocate for the establishment of meaningful penalties for companies that violate current good manufacturing practices (cGMPs) intended to ensure the quality, identity, strength, and purity of their marketed drug product(s) and raw materials; further,

To advocate for improved transparency so that drug product labeling include a readily available means to retrieve the name and location of the facility that manufactured the specific lot of the product; further,

To advocate that this readily retrievable manufacturing information be available prospectively to aid purchasers in determining the quality of a drug product and its raw materials; further,

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

*This policy supersedes ASHP policy 0907.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP continues to work with FDA on implementation of the track and trace law which requires drug products to be traced through the supply chain.

#### **Council on Public Policy (1504): Patient Adherence Programs as Part of Health Insurance Coverage**

To advocate for the pharmacist's role in patient medication adherence programs that are part of health insurance plans; further,

To advocate those programs that (1) maintain the direct patient pharmacist relationship; (2) are based on the pharmacist's knowledge of the patient's medical history, indication for the prescribed medication, and expected therapeutic outcome; (3) use a communication method desired by the patient; (4) are consistent with federal and state regulations for patient confidentiality; and (5) permit dispensing of partial fills or overfills of prescription medications in order to synchronize medication refills and aid in medication adherence.

*This policy supersedes ASHP policy 0116.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. Patient medication adherence programs represent direct patient care services that pharmacists can perform under provider status.

#### **Council on Public Policy (1505): Statutory Protection for Medication-Error Reporting**

To collaborate with other healthcare providers, professions, and stakeholders to advocate and support state and federal legislative and regulatory initiatives that provide liability protection for the reporting of actual and potential medication errors by individuals and healthcare providers; further,

To provide education on the role that patient safety organizations play in liability protection.

*This policy supersedes ASHP policy 0011.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. Most states already have or will soon be incorporating these protections.

#### **Council on Public Policy (1506): Premarketing Comparative Clinical Studies**

To advocate that the Food and Drug Administration have the authority to impose a requirement for comparative clinical trials.

*This policy supersedes ASHP policy 0514.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Public Policy (1507): Funding, Expertise, and Oversight of State Boards of Pharmacy**

To advocate appropriate oversight of pharmacy practice and the pharmaceutical supply chain through coordination and cooperation of state boards of pharmacy and other state and federal agencies whose mission it is to protect the public health; further,

To advocate adequate representation on state boards of pharmacy and related agencies by pharmacists who are knowledgeable about all areas of pharmacy practice (e.g., hospitals, health systems, clinics, and nontraditional settings) to ensure appropriate oversight; further,  
 To advocate for dedicated funds for the exclusive use by state boards of pharmacy and related agencies including funding for the training of state board of pharmacy inspectors and the implementation of adequate inspection schedules to ensure the effective oversight and regulation of pharmacy practice, the integrity of the pharmaceutical supply chain, and protection of the public; further,  
 To advocate that inspections be performed only by pharmacists competent about the applicable area of practice.

*This policy supersedes ASHP policy 0518.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP continues to advocate that state boards provide timely licensing, and dedicate necessary funds to inspect and adjust regulations on compounding to reflect the new federal law.

#### **Council on Public Policy (1508): Support for FDA Expanded Access (Compassionate Use) Program**

To advocate that the Food and Drug Administration (FDA) Expanded Access (Compassionate Use) Program be the sole mechanism for patient access to drugs for which an investigational new drug application (IND) has been filed, in order to preserve the integrity of the drug approval process and assure patient safety; further,  
 To advocate for broader patient access to such drugs under the FDA Expanded Access Program; further,  
 To advocate that IND applicants expedite review and release of drugs for patients who qualify for the program; further,  
 To advocate that the drug therapy be recommended by a physician and reviewed and monitored by a pharmacist to assure safe patient care; further,  
 To advocate for the patient's right to be informed of the potential benefits and risks via an informed consent process, and the responsibility of an institutional review board to review and approve the informed consent and the drug therapy protocol.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP supported inclusion of this provision in H.R. 6 passed by the House as the 21st Century Cures Act.

#### **Council on Public Policy (1509): 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 the intervention of the prescriber; further,  
 To oppose the implementation of any state laws regarding biosimilar interchangeability prior to finalization of FDA guidance; further,  
 To oppose any state legislation that would require a pharmacist to notify a prescriber when a biosimilar deemed to be interchangeable by the FDA is dispensed; further,  
 To require postmarketing 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.

*This policy supersedes ASHP policy 1409.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP has developed and supported a biosimilar naming policy. In addition, ASHP has expressed concerns to FDA over the agency's approach to biosimilar naming.

#### **Council on Therapeutics (1510): Naloxone Availability**

To recognize the potential public health benefits of naloxone for opioid reversal; further,  
To support efforts to safely expand access to naloxone; further,  
To advocate that individuals other than licensed healthcare professionals be permitted access to naloxone after receiving education; further,  
To foster education on the role of naloxone in opioid reversal and its proper administration, safe use, and appropriate follow-up care; further,  
To support state efforts to authorize pharmacists' prescribing authority for naloxone for opioid reversal.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP offered a networking session on pain management at the 2015 Midyear that provided information about outpatient naloxone programs.

#### **Council on Therapeutics (1511): Complementary and Alternative Medicine in Patient Care**

To promote awareness of the impacts of complementary and alternative (CAM) products on patient care, particularly drug interactions, medication safety concerns, and the risk of contamination and variability in active ingredient content; further,  
To advocate for the documentation of CAM products in the health record to improve patient safety; further,  
To advocate for the inclusion of information about CAM products and their characteristics in medication-related databases; further,  
To provide education on the impacts of CAM products on patient care in healthcare organizations; further,  
To foster the development of up-to-date and readily available resources about CAM products.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1512): Development of Abuse-Resistant Narcotics**

To advocate that the Food and Drug Administration investigate the efficacy of abuse-resistant formulations in preventing prescription drug abuse.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1513): Quality Patient Medication Information**

To support efforts by the Food and Drug Administration (FDA) and other stakeholders to improve the quality, consistency, and simplicity of written patient medication information (PMI); further,  
To encourage the FDA to work in collaboration with patient advocates and other stakeholders to create evidence-based models and standards, including establishment of a universal literacy level, for PMI; further,  
To advocate that research be conducted to validate these models in actual-use studies in pertinent patient populations; further,  
To advocate that FDA explore alternative models of PMI content development and maintenance that will ensure the highest level of accuracy, consistency, and currency; further,  
To advocate that the FDA engage a single third-party author to provide editorial control of a highly structured, publicly accessible central repository of PMI in a format that is suitable for ready export; further,

To advocate for laws and regulations that would require all dispensers of medications to comply with FDA-established standards for unalterable content, format, and distribution of PMI.

*This policy supersedes ASHP policy 1012.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1514): Safety and Effectiveness of Ethanol Treatment for Alcohol Withdrawal Syndrome**

To oppose the use of oral or intravenous ethanol for the prevention or treatment of alcohol withdrawal syndrome (AWS) because of its poor effectiveness and safety profile; further,  
To support hospital and health-system efforts that prohibit the use of oral or intravenous ethanol therapies to treat AWS; further,

To educate clinicians about the availability of alternative therapies for AWS.

*This policy supersedes ASHP policy 1010.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1515): Research on Drug Use in Obese Patients**

To encourage drug product manufacturers to conduct pharmacokinetic and pharmacodynamic research in obese patients to facilitate safe and effective dosing of medications in this patient population, especially for medications most likely to be affected by obesity; further,

To encourage manufacturers to include in the Food and Drug Administration (FDA) – approved labeling detailed information on characteristics of individuals enrolled in drug dosing studies; further,

To advocate that the FDA develop guidance for the design and reporting of studies that support dosing recommendations in obese patients; further,

To advocate for increased enrollment and outcomes reporting of obese patients in clinical trials of medications; further,

To encourage independent research on the clinical significance of obesity on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms.

*This policy supersedes ASHP policy 1013.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1516): Chemotherapy Parity**

To advocate that all insurance payers design plans so that patient cost sharing for-chemotherapy be equivalent regardless of route of administration; further,

To continue to foster the development of best practices, including adherence monitoring strategies, and education on the safe use and management of chemotherapy agents regardless of route of administration.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Therapeutics (1517): Documentation of Penicillin Allergy as a Component of Antimicrobial Stewardship**

To advocate involvement of pharmacists in the clarification of penicillin allergy, intolerance, and adverse drug events; further,

To advocate for documentation of penicillin allergy, intolerance, reactions, and severity in the medical record to facilitate optimal antimicrobial selection; further,

To recommend the use of penicillin skin testing in appropriate candidates when clinically indicated to optimize antimicrobial selection.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Education and Workforce Development (1518): Developing Leadership Competencies**

To work with healthcare organization leadership to foster opportunities for pharmacy practitioners to move into leadership roles; further,  
 To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,  
 To encourage pharmacy practitioners to obtain the skills necessary to pursue administrative, managerial, and leadership roles; further,  
 To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,  
 To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,  
 To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.  
*This policy supersedes ASHP policy 0509.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. This policy is being updated and presented as a slightly revised version in the 2016 House of Delegates.

#### **Council on Education and Workforce Development (1519): Pharmacy Technician Training and Certification**

To support the position that by the year 2020, the completion of a pharmacy technician training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required to obtain Pharmacy Technician Certification Board certification for all new pharmacy technicians entering the workforce; further,  
 To foster expansion of ASHP-ACPE accredited pharmacy technician training programs.  
*This policy supersedes ASHP policies 1015 and 0702.*

This policy was revised by the Council on Education and Workforce Development in response to a recommendation from the House of Delegates (see CEWD Policy Recommendation 1).

#### **Council on Pharmacy Management (1520): Impact of Insurance Coverage Design on Patient Care Decision**

To advocate that all health insurance policies be designed and coverage decisions made in a way that preserves the patient–practitioner relationship; further,  
 To oppose provisions in health insurance policies that interfere with established drug distribution and clinical services designed to ensure patient safety, quality, and continuity of care; further,  
 To advocate for the inclusion of hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.  
*This policy supersedes ASHP policy 1017.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The ASHP Foundation 2016-2020 Pharmacy Forecast included a chapter dedicated to healthcare financing. This topic was included in ASHP's Multi-Hospital Health System Pharmacy Executives Symposium which focused on the impact of site of care challenges in the marketplace. In January 2016 the Council on Pharmacy Management continued its analysis on this issue and its impact on limited distribution drugs and insurance design.

#### **Council on Pharmacy Management (1521): Identification of Prescription Drug Coverage and Eligibility for Patient Assistance Programs**

To advocate that pharmacists or pharmacy technicians ensure that the use of patient assistance programs is optimized and documented to promote continuity of care and patient access to needed medications;

further,

To advocate that patient assistance programs should incorporate the pharmacist-patient relationship, including evaluation by a pharmacist as part of comprehensive medication management; further,  
To support the principle that medications provided through manufacturer patient assistance programs should be stored, packaged, labeled, dispensed, and recorded using systems that ensure the same level of safety as prescription-based programs that incorporate a pharmacist-patient relationship.

*This policy supersedes ASHP policy 0603.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Management (1522): Disposition of Illicit Substances**

To advocate that healthcare organizations be required to develop procedures for the disposition of illicit substances brought into a facility that ensure compliance with applicable laws and accreditation standards; further,

To advocate that healthcare organizations be required to include pharmacy leaders in formulating such procedures.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Management (1523): Pharmacist's Role in Population Health Management**

To recognize the importance of medication management in patient-care outcomes and the vital role of pharmacists in population health management; further,  
To encourage healthcare organizations to engage pharmacists and pharmacy leaders in identifying appropriate patient cohorts, anticipating their healthcare needs, and implementing the models of care that optimize outcomes for patients and the healthcare organization; further,  
To encourage the development of complexity index tools and resources to support the identification of high-risk, high-cost, and other patient cohorts to facilitate patient-care provider panel determinations and workload balancing; further,  
To promote collaboration among members of the interprofessional healthcare team to develop meaningful measures of individual patient and population care outcomes; further,  
To advocate for education to prepare pharmacists for their role in population health management.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. ASHP's 2015 Conference for Pharmacy Leaders provided population health plenary and workshop speakers. ASHP's 2016 Conference for Pharmacy Leaders will provide additional programming on business approaches and case studies on the expanding the role of pharmacists in population health management. ASHP Foundation's 2016-2020 Pharmacy Forecast included a chapter dedicated to population health management. In addition, ASHP Foundation initiated its first class for Medical Home Traineeship and *AJHP* is planning a dedicated edition on population health.

#### **Council on Pharmacy Practice (1524): Support for Second Victims**

To acknowledge that the patient is the primary victim in any medical error, unanticipated adverse patient event, or patient-related injury; further,  
To acknowledge that involvement by healthcare personnel in such events may cause them to become second victims; further,  
To recognize that a just culture and a healthy culture of safety embrace a support system for second victims; further,  
To encourage healthcare organizations to establish programs to support second victims; further,  
To educate healthcare professionals (including those in training), health organization administrators, and regulatory agencies about the second-victim effect and available resources.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice (1525): Standardization of Doses**

To recognize that standardization of medication doses reduces medication errors and improves information technology interoperability, operational efficiency, and transitions of care; further,  
 To encourage development of universal standardized doses for specific patient populations; further,  
 To encourage healthcare organizations to adopt standardized doses and to promote publication and education about best practices.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The Standardize 4 Safety initiative will focus on oral liquid doses and on oral chemotherapy agents in a later phase.

#### **Council on Pharmacy Practice (1526): Prescription Drug Abuse**

To affirm that pharmacists have leadership roles in recognition, prevention, and treatment of prescription drug abuse; further,  
 To promote education on prescription drug abuse, misuse, and diversion-prevention strategies.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice (1527): Pharmacist's Role in Urgent and Emergency Situations**

To affirm that pharmacists should participate in planning and providing emergency treatment team services; further,  
 To advocate that pharmacists participate in decision-making about the medications and supplies used in medical emergencies; further,  
 To advocate that pharmacists serve in all emergency responses, and that those pharmacists receive appropriate training and maintain appropriate certifications.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice (1528): Excipients in Drug Products**

To advocate that manufacturers remove unnecessary, potentially allergenic excipients from all drug products; further,  
 To advocate that manufacturers declare the name and derivative source of all excipients in drug products on the official label; further,  
 To advocate that vendors of medication-related databases incorporate information about excipients; further,  
 To foster education on the allergenicity of excipients and documentation in the patient medical record of allergic reactions to excipients.  
*This policy supersedes ASHP policy 0808.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice (1529): Online Pharmacy and Internet Prescribing**

To support efforts to regulate prescribing and dispensing of medications via the Internet; further,  
 To support legislation or regulation that requires online pharmacies to list the states in which the pharmacy and pharmacists are licensed, and, if prescribing services are offered, requires that the sites (1) ensure that a legitimate patient-prescriber relationship exists (consistent with professional practice standards) and (2) list the states in which the prescribers are licensed; further,  
 To support mandatory accreditation of online pharmacies by the National Association of Boards of Pharmacy Verified Internet Pharmacy Practice Sites or Veterinary-Verified Internet Pharmacy Practice Sites; further,  
 To support appropriate consumer education about the risks and benefits of using online pharmacies; further,

To support the principle that any medication distribution or drug therapy management system must provide timely access to, and interaction with, appropriate professional pharmacist patient-care services.

*This policy supersedes ASHP policy 0523.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Practice (1530): Standardization of Small-Bore Connectors To Avoid Wrong-Route Errors**

To support the use of medication administration device connectors and fittings that are designed to prevent misconnections and wrong-route errors; further,

To encourage healthcare organizations to prepare for safe transition to use of medication delivery device connectors and adapters that meet International Organization for Standardization standards; further,

To identify and promote the implementation of best practices for preventing wrong-route errors.

*This policy supersedes ASHP policy 1018.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. The use of the Enfit syringe is being led by GEDSA and production of the oral syringe has commenced. Hospitals can choose when to implement although California has already mandated implementation.

#### **Council on Pharmacy Practice (1531): Pharmacist Role in Capital Punishment**

To acknowledge that an individual's opinion about capital punishment is a personal moral decision; further,

To oppose pharmacist participation in capital punishment; further,

To reaffirm that pharmacists have a right to decline to participate in capital punishment without retribution.

*This policy supersedes ASHP policy 8410.*

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts.

#### **Council on Pharmacy Management (1532): ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive**

To approve the *ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive*.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. This statement was finalized and approved by the ASHP Board of Directors. The final statement is available at the following address:

<http://www.ashp.org/DocLibrary/BestPractices/MgmtStPharmExec.aspx>

#### **Council on Pharmacy Practice (1533): ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance**

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

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. This statement was finalized and approved by the ASHP Board of Directors. The final statement is available at the following address:

<http://www.ashp.org/DocLibrary/BestPractices/SpecificStSubstance.aspx>

#### **Section of Pharmacy Informatics and Technology (1534): ASHP Statement on the Pharmacist's Role in Clinical Informatics**

To approve the *ASHP Statement on the Pharmacist's Role in Clinical Informatics*.

This policy has been published in *ASHP Best Practices* (print and online editions) and used in ongoing ASHP advocacy, education, and communication efforts. This statement was finalized and approved by the ASHP Board of Directors. The final statement is available at the following address:

<http://www.ashp.org/DocLibrary/BestPractices/AutoITStInformatics.aspx>

**Revise ASHP Position (0610) Pharmacist's Right of Conscience: Nicole Allcock (MO)**

ASHP should revise position 0610 to remove the requirement of referral and replace it with "transfer care" in order to place decision making regarding ethically troubling therapies in the hands of the patient and remove the burden of cooperation on the part of the pharmacist.

The Council on Pharmacy Practice considered this recommendation at its September meeting and recommended that ASHP policy 0610 be reaffirmed; the Board concurred.

**Specific Gravity Data (Recommendation): Robert Granko (NC)**

Ask manufacturers to provide specific gravity for IV products to promote utilization of gravimetric analysis.

The ASHP Section of Pharmacy Informatics and Technology has [examined this issue](#). ASHP has made this a topic of advocacy with manufacturers and other stakeholders.

**Need to Update ASHP Guidelines on Providing Pediatric Pharmaceutical Services (Recommendation) : Kim Benner (AL)**

It is time to update the 1994 statement on providing pediatric pharmaceutical services as the health care model has changed for the care of pediatric patients in a health system.

A team of ASHP experts is revising the guidelines. Peer review is expected in early 2016, with publication shortly thereafter.

**Definition of Medication History and Medication Reconciliation (Recommendation): Wes Pitts, Kristie Gholson (MS)**

Develop standard definitions for "medication history" and "medication reconciliation" and promote proper use of each.

This recommendation was discussed by the Council on Pharmacy Practice during the September 2015 Policy Week meeting of the Councils and has been published in the Proceedings of the 67<sup>th</sup> Annual Session of the House of Delegates.

**Survey and Distribute to Members Employment and Salary Information Broken Down by City, State and Job Function; Discuss Trends in the Supply and Demand of Pharmacists (Recommendation): John Quinn (DC)**

One commonality of all ASHP members is interest in their careers and trends within the profession. This is especially true today where we see an oversupply of pharmacists in some markets. ASHP is in a unique position to find and interpret market trend information and to take a leadership role in a conversation about future supply of pharmacy professionals.

ASHP has explored doing such a survey in the past and the feedback we have received has been mixed with regards to the value, willingness of members to share confidential salary information with ASHP, and the desirability of having information that could potentially be made available to HR departments, consultants, and other non-pharmacy groups. ASHP has also received advice for legal counsel expressing concerns about violating federal antitrust laws given ASHP's status as a tax exempt not for profit professional organization. ASHP understands and appreciates the reasons behind this recommendation.

**Increased Financial Support for Local Affiliates To Send Representatives to the ASHP House of Delegate Meetings (Recommendation): John Quinn (DC)**

That ASHP increase the stipend to support local affiliates who attend the ASHP House of Delegates.

ASHP recognizes the financial commitments delegates and their supporting organizations make to facilitate RDC participation and is committed to assisting participation. In April 2016, the ASHP Board of Directors approved an increase in the RDC delegate reimbursement for 2017 by \$100 per apportioned delegate.

**Affordability of Medications Task Force (Recommendation): Jerome Wohleb (NE sponsored) (State supported: NE, AZ, CO, OR, MN, CA, ID, CT, IL, UT, WA, VA, RI, LA, DC, MA, MD, ME, SD, PA, KY, WA, WI, OH, TN, MT, SC, VT) (One delegate: NH, MI, DE, FL)**

That ASHP appoint a task force to address the affordability of medications in conjunction with other organizations (e.g., AARP, AMCP, APhA, AHIP, etc.).

ASHP has limited ability to influence pricing decisions by pharmaceutical manufacturers, and legal antitrust concerns constrain our advocacy. Nonetheless, this is an extremely important issue, and one that ASHP has made a top priority to address. ASHP is the only pharmacy organization on the steering committee of the [Campaign for Sustainable Rx Pricing](#). As a member of the steering committee, ASHP has worked with many leading healthcare and industry organizations, including the American College of Physicians, American Hospital Association, America's Health Insurance Plans, Anthem, Federation of American Hospitals, Kaiser Permanente, and Walmart. ASHP was invited by the Secretary of the Department of Health and Human Services to participate in an invitation-only event on drug pricing.

#### **Epidural Steroid Injections (Recommendation): Emily Dyer (VA)**

To advocate for pharmacist oversight of medications used during epidural steroid injection procedures.

The Council on Therapeutics considered this recommendation at its September meeting and recommended ASHP policy (see Council on Therapeutics Policy Recommendation 3).

#### **Developing Educational/Training/Guidance Materials for the New Role of Pharmacy Technicians as Medication History Technicians (Recommendation): Tricia Meyer (TX)**

To supplement the current ASHP website for medication reconciliation materials with specific information to further develop the pharmacy technician's role in taking patient medication histories. This should include information on communication skills, interview skills to help determine patient compliance, and how to manage barriers during the interview.

This item was referred to the Section of Inpatient Care Practitioners' Section Advisory Group (SAG) on Advancing Pharmacy Practice with Technicians. Promoting new roles for pharmacy technicians is the primary charge of this SAG, so the toolkit described in the recommendation is the type of resource the SAG would develop. The Section of Inpatient Care Practitioners' Section Advisory Group (SAG) on Advancing Pharmacy Practice with Technicians is finalizing materials for a resource center on Medication History Technician. This resource center should be available in the summer. Additionally, a webinar, The Medication History Technician: Developing a Current Medication List to Improve Medication Safety, was held on May 12, 2016, with almost 600 participants. The webinar recording will be available on the ASHP eLearning site for one year.

#### **Regulation of Dietary Supplements (Recommendation): Denise Fields, Jennifer Phillips, Steve Riddle (IN, IL, WA)**

That ASHP increase advocacy efforts around dietary supplements by collaborating with Congress, other healthcare organizations and patient advocacy groups with the goal of amending the Dietary Supplement Health and Education Act or enacting other legislation that ensures the safety and integrity of dietary supplements.

The Council on Public Policy examined existing ASHP policies on dietary supplements, and found them to be up-to-date and relevant. ASHP uses these existing policies in its ongoing advocacy efforts.

#### **Sharing and Obtaining Medication Histories Through Transitions of Care (Recommendation): Christi Jen (AZ)**

For ASHP to advocate for the education of pharmacists and pharmacy technicians, and increased awareness on HIPAA Patient Privacy laws as they pertain to obtaining and sharing medication histories to facilitate the medication history process and ensure optimal and safe care through transitions of care.

This recommendation was discussed by the Council on Pharmacy Practice during the September 2015 Policy Week meetings. The Council evaluated current information on this topic and assessed gaps and actions ASHP may take in addressing the issue.

**Amendment to ASHP Policy 1519, Pharmacy Technician Training and Certification (Recommendation): Lonnye Finneman (MT, AZ, WI, MI, NE, SD)**

Council on Education and Workforce Development consider an additional statement to the newly revised policy on Pharmacy Technician Training and Certification to advocate that pharmacy technicians initially obtain Pharmacy Technician Certification Board certification and that a mechanism be in place to maintain competency (such as state licensure or certification).

ASHP policy 1519 was revised by the Council on Education and Workforce Development in response to a recommendation from the House of Delegates (see CEWD Policy Recommendation 1).

**Use of Meeting Technology for Section and SAG meetings (Recommendation): Dan Degnan (Section of Inpatient Care Practitioners)**

That ASHP make available web-based meeting technology for ASHP Section and SAG meetings.

ASHP has increased the number of ASHP's GoToMeeting accounts so that each Section has access to this technology to enhance the experience of Section Executive Committee and/or Section Advisory Group meetings.

**Development of Residency Models in Small and Rural Health Settings (Recommendation): Dan Degnan (Section of Inpatient Care Practitioners)**

That ASHP foster the development of viable residency models in small and rural health settings with consideration for both the cost and quality of such programs.

ASHP regularly works with small and rural institutions to help develop residency programs to meet their specific needs. In addition, ASHP will host an [open forum discussion session](#) on residency programs in these settings at the National Pharmacy Preceptors Conference in August.

**Policy on Equitable Care (Recommendation): Annet Arakelian (CA)**

Recommend ASHP develop a policy to promote, support, and advocate for developing a diverse workforce and addressing gaps in healthcare, including but not limited to race and ethnicity but also other gaps such as socioeconomic and literacy.

The Council on Education and Workforce Development has drafted a new policy recommendation to be presented to the 2016 House of Delegates on cultural competency and diversity.

**Specialty Pharmacy Service Center (Recommendation): Ross Thompson (MA)**

ASHP to develop and maintain a service to support ongoing management of specialty pharmacy service delivery provided by health systems.

ASHP convened an expert panel on Specialty Pharmacy in early 2015, resulting in the development of a [Specialty Pharmacy Resource Guide](#) released at the 2015 Midyear and a [Specialty Pharmacy Web Resource Center](#).

**Education of Members on 503A and 503B Regulations and Entities (Recommendation): Ross Thompson and Ernie Anderson (MA)**

Recommendation that ASHP educate its members on all aspects of 503A and 503B compounding pharmacies and provide a tool to vet such facilities which members can utilize to ensure medication safety, further to educate members on the utilization of 503B facilities as an option to meet various patient care needs for sterile products by health systems.

The revised [ASHP Guidelines on Outsourcing Sterile Compounding Services](#) was published in June 2015, and ASHP educational efforts have continued since then with educational sessions at the 2015 Midyear and 2016 Summer Meetings.

**Antipsychotic Drug Use (Recommendation): Victoria Ferraresi (CA)**

That ASHP support efforts to prevent the inappropriate use of antipsychotics in nursing home and other care settings but also advocate that this not interfere with their appropriate use of prevent patients needing these medications from residing in nursing homes.

The Council on Therapeutics considered this recommendation at its September meeting and recommended new ASHP policy (see Council on Therapeutics Policy Recommendation 2). In addition, ASHP is updating its Therapeutic Position Statement on Use of Second-Generation Antipsychotic Medications in the Treatment of Adults with Psychotic Disorders. The authors of the manuscript have been advised to assess, evaluate, and provide guidance on the use of antipsychotics in nursing homes with respect to current changes in payment reform.

**Hazardous Medication Identification (Recommendation): Kathleen Donley, Margaret Huwer, Karen Kier, Scott Knoer, Julie Zaucha (OH)**

At the request of Rob Mains, we recommend that ASHP advocate for the FDA capture and maintenance of the accurate identification of hazardous medication products in the structured product label of the FDA daily med database. In support of the NIOSH and proposed USP 800 recommendations for handling hazardous medications, we need accurate identification of products containing these ingredients. The current system does not currently identify hazardous medications.

ASHP advocacy efforts are ongoing on this issue.

**Electronic Voting (Recommendation): Carol Rollins (AZ, IL, ID, CO, MT, MI, WA, CT)**

That ASHP use electronic voting for all votes in the House of Delegates.

ASHP has explored and tested the concept of using electronic voting for all votes during the House and have determined that it still adds significant time to the House agenda, especially when considering the number of votes that are taken on amendments. However, the Chair of the House has the authority either independently or at the request of any delegate during the House session to call for an electronic vote for any vote. ASHP continually explores and tests new technological applications, and will routinely reassess whether a more efficient and desirable platform for electronic voting might be available.

**Using Indianapolis as a Host Site for a Future Summer Meeting (Recommendation): John Hertig (IN)**

That ASHP consider Indianapolis, the host of Super Bowl 46 and numerous amateur sporting events, as a future site for the ASHP Summer Meeting.

ASHP understands the importance of rotating the host city of our various meetings, conferences, and specialty courses each year. I want to assure you that ASHP will explore the potential viability of this venue for one of our meetings. Several criteria are considered in selecting a location and we must keep the following in mind along with other intangibles:

- geography
- ease of access for travel
- venue – meeting space and hotel access
- availability of preferred dates
- price
- previous experience/evaluation data
- potential for weather impacting success of meeting

**Improved FDA Management of Medication Structured Product Data (Recommendation): Kevin Martin (VT)**

That ASHP advocate for the FDA to take greater ownership of the maintenance of the Structured Product Label (SPL) database contents with regards to: 1. Maintenance of accurate and unique identifiers for each product/product ingredient 3. Enforcement of accurate coding of the standardized data elements in the SPL, 4. Integration of the SPL with RxNorm, and 5. Direction to the industry on how quickly SPL data updates should be made available within EHR systems.

Advocacy is ongoing on this issue.

**Criteria and Education for Appropriate Use of Drugs with Abuse Potential (Recommendation): Michael Dickens (ID), Julie Nelson (TX), Elizabeth Thompson (ID), Diane Fox (TX)**

That ASHP in cooperation with medical organizations develop criteria for appropriate prescribing and monitoring of refills for drugs with abuse potential (i.e., opiates, sedative hypnotics, skeletal muscle relaxants and stimulants, and anxiolytics).

The Council on Therapeutics discussed this topic during Policy Week meetings in September 2015. The Council evaluated current information on this topic and assessed gaps and actions ASHP may take in addressing the issue.

**Task Force on Pain Management and Opioid Analgesic Access, Use and Abuse (Recommendation): Steve Riddle, Patricia Gunwald, Denise Fields, Julie Nelson, Rich Pacitti, Joan Kramer, Diane Fox, Vicky Ferraresi (WA, MD, IN, TX, PA, KS, TX, CA)**

That ASHP create a task force to examine critical national issues related to pain management and opioid analgesic access, use and abuse and that this group engages internal and external stakeholders with a goal of optimizing ASHP policy positions and advocacy efforts.

This is a top-priority issue for ASHP. The ASHP Council on Pharmacy Practice Management discussed this issue during its September 2015 meeting and proposed ASHP policy (see Council on Pharmacy Practice Management Policy Recommendation 1). ASHP developed and conducted a webinar entitled “Clinical Pharmacist Chronic Pain Services: Implementing Interprofessional Care for Complex Patients and Improving Outcomes” to support the American Hospital Association’s efforts to provide information for physicians. An ASHP networking session, “Pain Management,” covered topics such as opioid conversions and calculations, precepting students and residents, medical marijuana, outpatient naloxone programs, and outcomes in pain management. ASHP participated in the Department of Health and Human Services Healthcare Pharmacy Roundtable Discussion on Opioids and was invited to participate in two White House events: a Champions of Change event to recognize leaders who have made a difference in combating opioid abuse and misuse, and an event in West Virginia where President Obama spoke about the need for specific actions regarding the opioid epidemic. ASHP provided comments on an FDA proposal on development and regulation of abuse-deterrent formulations of opioid medications and testified at the FDA Science Board on Pain Management. ASHP has an internal opioid taskforce that is focusing on education, patient specific pain plan, and advocacy work. Webinars on diversion, opioid indications and use, alternative pain therapies to opioids, recognizing drug addiction as a disease state, and the use of naloxone are planned. The internal taskforce has provided the ASHP Section of Inpatient Care Practitioners SAG on Pain Management and Palliative Care with a strategic plan for implementing these projects.

**Establishment of Ongoing Online Preceptor Development Courses (Recommendation): Kathy Donley (OH)**

That ASHP develop ongoing online preceptor courses to enable smaller hospitals to meet the requirements of the residency accreditation standards.

ASHP understands the importance of providing a variety of educational materials to support our members. In the area of preceptor development, we currently offer both online and live development activities, including:

1. Preceptor’s Playbook: Tactics, Techniques, & Strategies

Available on the [ASHP website](#)

- 31 modules, approximately 15 minutes each
  - 11 focused on tradition skills
  - 20 featuring softer skills
- 7.75 hours of continuing education credit

2. Preceptor Skills Resource Center

Available on the [ASHP website](#)

Features:

- ASHP Connect Community
- Preceptor Toolkit

- Articles
  - Education
  - Guidelines, Policies, Best Practices
  - Books and External Resources
  - Accreditation
3. National Pharmacy Preceptors Conference  
Held annually in August (<http://connect.ashp.org/nppc15>)  
13.5 hours of continuing education credit

Features include:

- RPDC workshops
- Posters
- Network dinners
- New PGY1 Residency Standards
- Preceptor Pearls

ASHP is committed to supporting the growth and development of preceptors through programs and services aimed at assisting their development and improvement and will continue to explore educational opportunities in this area.

**Revise ASHP Position 9915 to Oppose Pharmacists' Participation in Assisted Suicide (Recommendation): Nicole Allcock (MD), Desi Kotis (IL), Kevin Colgan (Past President), John Pastor (MN), Kristi Gullickson (MN), Peggy Malovith (MI), Joel Hennenfent (MO), Daniel Good (MO)**

ASHP should revise Position 9915 to clearly oppose pharmacists' participation in Assisted Suicide on the basis that it is not consistent with the pharmacists' role in affirming life and assisting patients in making the best use of medications.

The Council on Pharmacy Practice considered this recommendation at its September meeting and recommended that ASHP policy 9915 be reaffirmed; the Board concurred. Revision of this policy is the subject of a Resolution in the 2016 House of Delegates.

**Chair-elect and Treasurer-elect Years (Recommendation): Mark Woods, Phil Schneider (Past Presidents, BOD)**

To study the feasibility of sequencing the elections of the treasurer and chair of the house so as to allow for treasurer-elect and chair-elect periods around the board table.

ASHP will consider this recommendation carefully since it would involve an amendment to the Bylaws.

**Electronic Voting on Political, Religious, or Culturally Sensitive Topics in the House (Recommendation): Dave Weetman (IA, WI, AZ)**

Request that "clicker only" voting be considered when the House of voting on a topic of politically, religious, or culturally sensitive nature, such as capital punishment, abortifacients, medical marijuana, or assisted suicide.

The ASHP House of Delegates has established a custom of a voice voting to expedite its proceedings and to provide transparency. Electronic voting, which is used at the Chair's discretion when the outcome of a voice vote is not clear and for Chair elections, takes longer than a voice vote. In addition, a voice vote allows other members of a delegation to observe how their colleagues are voting, which provides a level of accountability to their constituents. Any delegate may make a motion to deviate from the custom of a voice vote on an item before the House, and that motion must be approved by a majority of delegates to proceed to an electronic vote. This policy empowers the delegates themselves to determine which items they wish to consider by electronic vote.

**CMS Medication Billing Coding Requirements (Recommendation): Jeanne Ezell (TN)**

Recommend that ASHP advocate for changes in CMS medication billing coding to reduce the complexity and confusion involved, particularly with units for various dosage strengths and forms of medications.

The complexity of CMS medication billing coding is among the topics on which ASHP has ongoing advocacy with CMS.

**Pharmacist Oversight of Medical Marijuana Dispensaries (Resolution)**

**Motion:** To amend ASHP policy 1101, Medical Marijuana, to read as follows:

**MEDICAL MARIJUANA**

*Source: Council on Therapeutics*

To oppose state legislation that authorizes the use of medical marijuana until there is sufficient evidence to support its safety and effectiveness and a standardized product that would be subject to the same regulations as a prescription drug product; further,

To recognize that where medical marijuana is legal, pharmacists should apply their expertise in medication management and use to ensuring safe and effective use of medical marijuana; further,

To encourage research to further define the therapeutically active components, effectiveness, safety, and clinical use of medical marijuana; further,

To advocate for the development of processes that would ensure standardized formulations, potency, and quality of medical marijuana products to facilitate research; further,

To encourage the Drug Enforcement Administration to eliminate barriers to medical marijuana research, including review of medical marijuana's status as a Schedule I controlled substance, and its reclassification, if necessary to facilitate research; further,

To support state health department efforts to compile research on dosing of medical marijuana to provide guidance for healthcare providers; further,

To support the procurement, storage, preparation, or distribution of medical marijuana by licensed pharmacies or health care facilities for purposes other than research in states where medical marijuana is legal; further,

To support laws and regulations that would permit pharmacists to provide medication therapy management, track patient outcomes, and manage medications to optimize safety and efficacy at state-approved medical marijuana dispensaries; further,

To support, in states where medical marijuana is legal, mandatory continuing education that prepares pharmacists to respond to patient and clinician questions about the therapeutic and legal issues surrounding medical marijuana use; further,

To advocate for the creation of a national accreditation program for medical marijuana dispensaries that would require counseling of patients and certification of healthcare providers practicing in them; further,

To support efforts to develop national credentialing or certificate programs for pharmacists whose practices involve medical marijuana; further,

To oppose the smoking of marijuana in settings where smoking is prohibited.

ASHP staff is collaborating with USP to explore the feasibility and advisability of [developing standards for medical cannabis](#) (a key element of ASHP policy), is closely following DEA deliberations on [rescheduling marijuana](#) to make it more available for research (another key element of ASHP policy), and is advocating further research on the safety and efficacy of a standardized product. The Council on Pharmacy Practice will examine ASHP policy and other options this cycle (2016-2017).

**Controlled Substance Accessibility (New Business): Diane Fox (TX), Julie Nelson (TX), Jim Wilson, (TX), Lance Ray (TX) Patricia Meyer (TX), Lourdes Cuellar, TX, Shane Steven Green (President TSHP), Larry Egle (Immediate-Past President TSHP)****Motion:**

ASHP should collaborate with other national healthcare organizations, the Drug Enforcement Administration, the National Wholesale Drug Association, the National Association of Chain Drug Stores, and other stakeholders to investigate the inconsistencies in patient access to pain medications and develop strategies to meet legitimate pain care needs for patients.

The Council on Pharmacy Practice Management discussed this issue during its September 2015 meeting and proposed ASHP policy (see Council on Pharmacy Practice Management Policy Recommendation 1). ASHP developed and conducted a webinar, "Clinical Pharmacist Chronic Pain Services: Implementing Interprofessional Care for Complex Patients and Improving Outcomes," to support the American Hospital Association's efforts to provide information for physicians. An ASHP networking session, "Pain Management," covered topics such as opioid conversions and calculations, precepting students and residents, medical marijuana, outpatient naloxone programs, and outcomes in pain management. ASHP participated in the Department of Health and Human Services Healthcare Pharmacy Roundtable Discussion on Opioids and was invited to participate in two White House events: a Champions of Change event to recognize leaders who have made a difference in combating opioid abuse and misuse and an event in West Virginia where President Obama spoke about the need for specific actions regarding the opioid epidemic. ASHP provided comments on an FDA proposal on development and regulation of abuse-deterrent formulations of opioid medications and testified at the FDA Science Board on Pain Management.

# Professional Policies Approved by the 2016 ASHP House of Delegates

Baltimore, MD  
June 14, 2016

Am J Health-Syst Pharm. 2016; 73:e529-33

The new professional policies approved by the ASHP House of Delegates at its June 2016 meeting are listed below. Policies proposed by councils or other ASHP bodies are first considered by the Board of Directors and then acted on by the House of Delegates, which is the ultimate authority for ASHP positions on professional issues.

The background information on these policies appears on the ASHP Web site ([www.ashp.org](http://www.ashp.org)); click on "Practice and Policy" then on "House of Delegates," and then on "Board of Directors Reports on Councils" (<http://www.ashp.org/DocLibrary/Policy/HOD/CouncilReports.aspx>).

The complete proceedings of the House of Delegates will be provided to delegates and will be posted on the ASHP Web site.

## 1601

### Safety of Intranasal Route as an Alternative Route of Administration

Source: Council on Therapeutics

To encourage the development of institutional guidance and advocate for further research on the pharmacokinetic and pharmacodynamic characteristics of drugs not approved for intranasal administration; further,

To foster the development of educational resources on the safety of intranasal administration of drugs not approved for that route.

## 1602

### Drug Product Supply Chain Integrity

Source: Council on Pharmacy Management

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

To encourage FDA and relevant state authorities to develop and implement regulations to (1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers, and manufacturers) from purchasing legend drugs from unlicensed entities and (2) ensure accurate documentation at any point in the distribution chain of the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

To advocate for the establishment of meaningful penalties for companies that violate current good manufacturing practices (cGMPs) intended to ensure the quality, identity, strength, and purity of their marketed drug product(s) and raw materials; further, To advocate for improved transparency so that drug product labeling include a readily available means to retrieve the name and location of the facility that manufactured the specific lot of the product; further,

To advocate that this readily retrievable manufacturing information be available prospectively to aid purchasers in determining the quality of

a drug product and its raw materials; further,

To foster increased pharmacist and public awareness of drug product supply chain integrity; further,

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

This policy supersedes ASHP policy 1503.

## 1603

### Stewardship of Drugs with Potential for Abuse

Source: Council on Therapeutics

To advocate for the inclusion of a clinically appropriate indication of use, the intended duration, and the goals of therapy when prescribing drugs with potential for abuse; further,

To encourage pharmacists to engage in interprofessional efforts to promote the appropriate, but judicious, use of drugs with the potential for abuse, including education, monitoring, assessment of clinical progress, and discontinuation of therapy or dose reduction, where appropriate; further,

To advocate that pharmacists lead efforts to prevent inappropriate use of drugs with potential for abuse, including engaging in strategies to detect and address patterns of use in patient populations at increased risk for adverse outcomes; further,

To facilitate the development of best practices for prescription drug monitoring programs and drug take-back disposal programs for drugs with potential for abuse.

## 1604

### Appropriate Use of Antipsychotic Drug Therapies

Source: Council on Therapeutics

To advocate for the documentation

of appropriate indication and goals of therapy to promote the judicious use of antipsychotic drugs and reduce the potential for harm; further,

To support the participation of pharmacists in the management of antipsychotic drug use, which is an interprofessional, collaborative process for selecting appropriate drug therapies, educating patients or their caregivers, monitoring patients, continually assessing outcomes of therapy, and identifying opportunities for discontinuation or dose adjustment; further,

To advocate that pharmacists lead efforts to prevent inappropriate use of antipsychotic drugs, including engaging in strategies to detect and address patterns of use in patient populations at increased risk for adverse outcomes.

## 1605

### Safety of Epidural Steroid Injections

*Source: Council on Therapeutics*

To encourage healthcare providers to 1) inform patients about the significant risks and potential lack of efficacy of epidural steroid injections, 2) request their informed consent, and 3) inform patients of alternative therapies and their risks and benefits; further,

To recommend pharmacist involvement in the medication-use process associated with epidural steroid injections when such injections are medically necessary.

## 1606

### Drug Dosing in Renal Replacement Therapy

*Source: Council on Therapeutics*

To encourage research on the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy; further,

To support development and use of standardized models of assessment of the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy; further,

To collaborate with stakeholders in enhancing aggregation and publication of data on the pharmacokinetics and pharmacodynamics of drug dosing in renal replacement therapy.

## 1607

### Use of Methadone to Treat Pain

*Source: Council on Therapeutics*

To acknowledge that methadone has a role in pain management and that its pharmacologic properties present unique risks to patients; further,

To oppose the payer-driven use of methadone as a preferred treatment option for pain; further,

To advocate that pain management experts, payers, and manufacturers collaborate to provide educational programs for healthcare professionals on treating pain with opioids, including the proper place in therapy for methadone; further,

To advocate that all facilities that dispense methadone, including addiction treatment programs, participate in state prescription drug monitoring programs.

## 1608

### Therapeutic Indication in Clinical Decision Support Systems

*Source: Council on Therapeutics*

To advocate that healthcare organizations optimize use of clinical decision support systems by including the appropriate indication for medications.

## 1609

### Pharmacy Technician Training and Certification

*Source: Council on Education and Workforce Development*

To advocate that Pharmacy Technician Certification Board (PTCB) certification be required for all pharmacy technicians; further,

To advocate that all pharmacy technicians maintain PTCB certification; further,

To support the position that by the year 2020, the completion of a pharmacy technician training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required to obtain PTCB certification for all new pharmacy technicians; further,

To foster expansion of ASHP-ACPE accredited pharmacy technician training programs.

*This policy supersedes ASHP policy 1519.*

## 1610

### Career Opportunities for Pharmacy Technicians

*Source: Council on Education and Workforce Development*

To promote pharmacy technicians as valuable contributors to healthcare delivery; further,

To develop and disseminate information about career opportunities that enhances the recruitment and retention of qualified pharmacy technicians; further,

To support pharmacy technician career advancement opportunities, commensurate with training and education; further,

To encourage compensation models for pharmacy technicians that provide a living wage.

*This policy supersedes ASHP policy 0211.*

## 1611

### Developing Leadership Competencies

*Source: Council on Education and Workforce Development*

To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for pharmacy practitioners to move into leadership roles; further,

To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,

To encourage pharmacy practitioners to obtain the skills necessary to

pursue administrative, managerial, and leadership roles; further,

To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,

To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,

To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.

*This policy supersedes ASHP policy 1518.*

## 1612

### Interprofessional Education and Training

*Source: Council on Education and Workforce Development*

To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education, mentorship, and professional development for student pharmacists, residents, and pharmacists; further,

To encourage and support pharmacists' collaboration with other health professionals and healthcare executives in the development of interprofessional, team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of healthcare professionals.

*This policy supersedes ASHP policy 1014.*

## 1613

### Cultural Competency

*Source: Council on Education and Workforce Development*

To foster the ongoing development of cultural competency within the pharmacy workforce; further,

To educate healthcare providers on the importance of providing culturally congruent care to achieve quality care and patient engagement.

*This policy supersedes ASHP policy 1414.*

## 1614

### Controlled Substance Diversion and Patient Access

*Source: Council on Pharmacy Management*

To enhance awareness by pharmacy personnel, healthcare providers, and the public of drug diversion and abuse of controlled substances; further,

To advocate that the pharmacy profession lead collaborative efforts to reduce the incidence of controlled substance abuse; further,

To advocate that pharmacists lead collaborative efforts by organizations of healthcare professionals, patient advocacy organizations, and regulatory authorities to develop and promote best practices for preventing drug diversion and appropriately using controlled substances to optimize and ensure patient access and therapeutic outcomes; further,

To advocate that the Drug Enforcement Administration and other regulatory authorities interpret and enforce laws, rules, and regulations to support patient access to appropriate therapies, minimize burdens on pharmacy practice, and provide reasonable safeguards against fraud, misuse, abuse, and diversion of controlled substances; further,

To advocate establishment of programs to support patients and personnel with substance abuse and dependency issues.

## 1615

### Protecting Workers from Exposure to Hazardous Drugs

*Source: Council on Pharmacy Management*

To advocate that pharmaceutical manufacturers eliminate surface con-

tamination on packages and vials of hazardous drugs; further,

To inform pharmacists and other personnel of the potential presence of surface contamination on the packages and vials of hazardous drugs; further,

To advocate that the Food and Drug Administration require standardized labeling and package design for hazardous drugs that would alert handlers to the potential presence of surface contamination; further,

To encourage healthcare organizations, wholesalers, and other trading partners in the drug supply chain to adhere to published standards and regulations, such as ASHP guidelines and United States Pharmacopeia Chapter 800, to protect workers from undue exposure to hazardous drugs.

*This policy supersedes ASHP policy 0618.*

## 1616

### Patient Experience

*Source: Council on Pharmacy Management*

To encourage pharmacists to evaluate their practice settings for opportunities to improve the experience patients have with healthcare services and with the outcomes of their drug therapy; further,

To educate pharmacists and pharmacy personnel about the relationship between patient experience and outcomes; further,

To develop or adopt tools that will (1) provide a system for monitoring trends in the quality of pharmacy services to patients, (2) increase recognition of the value of pharmacy services, and (3) provide a basis for making improvements in the process and outcomes of pharmacy services in efforts to engage patients and improve their experience; further,

To facilitate a dialogue with and encourage education of patient experience database vendors to include the value of pharmacists and pharmacy services in the patient experience.

*This policy supersedes ASHP policy 0104.*

1617

### Automated Preparation and Dispensing Technology for Sterile Preparations

Source: Council on Pharmacy Practice

To advocate that health systems adopt automation and information technology for preparing and dispensing compounded sterile preparations when such adoption is (1) planned, implemented, and managed with pharmacists' involvement; (2) implemented with adequate resources to promote successful development and maintenance; and (3) supported by policies and procedures that ensure the safety, effectiveness, and efficiency of the medication-use process; further,

To educate patient safety advocacy groups and regulatory agencies on the capabilities and benefits of automation and technology for preparing and dispensing compounded sterile preparations, and to encourage them to establish expectation of adoption by health systems; further,

To foster further research, development, and publication of best practices regarding automation and information technology for preparing and dispensing sterile preparations.

1618

### Integrated Approach for the Pharmacy Enterprise

Source: Council on Pharmacy Practice

To advocate that pharmacy department leaders promote an integrated approach for all pharmacy personnel involved in the medication-use process; further,

To advocate a high level of coordination of all components of the pharmacy enterprise across the continuum of care for the purpose of optimizing (1) medication-use safety, (2) quality, (3) outcomes, and (4) drug therapy.

This policy supersedes ASHP policy 0619.

1619

### Preventing Exposure to Allergens

Source: Council on Pharmacy Practice

To advocate for pharmacy participation in the collection, assessment, and documentation of a complete list of allergens pertinent to medication therapy, including food, excipients, medications, devices, and supplies, for the purpose of clinical decision-making; further,

To advocate that vendors of medication-related databases incorporate and maintain information about medication-related allergens and cross-sensitivities; further,

To advocate that pharmacists actively review allergens pertinent to medication therapy and minimize patient and healthcare worker exposure to known allergens, as feasible; further,

To encourage education of pharmacy personnel on medication-related allergens.

1620

### Promotion of Off-Label Uses

Source: Council on Public Policy

To advocate for authority for the Food and Drug Administration (FDA) to regulate the promotion and dissemination of information about off-label uses of medications and medication-containing devices by manufacturers and their representatives; further,

To advocate that such off-label promotion and marketing be limited to the FDA-regulated dissemination of unbiased, truthful, and scientifically accurate information based on peer-reviewed literature not included in the New Drug Approval process.

This policy supersedes ASHP policy 1120.

1621

### Timely Board of Pharmacy Licensing

Source: Council on Public Policy

To advocate that the National Association of Boards of Pharmacy (NABP) collaborate with boards of pharmacy to streamline the licensure process through standardization and improve the timeliness of application approval; further,

To advocate that NABP collaborate with boards of pharmacy and third-party vendors to streamline the licensure transfer or reciprocity process; further,

To advocate that boards of pharmacy grant licensed pharmacists in good standing temporary licensure, permitting them to engage in practice, while their application for licensure transfer or reciprocity is being processed.

This policy supersedes ASHP policy 0612.

1622

### Inclusion of Drug Product Shortages in State Price-Gouging Laws

Source: Council on Public Policy

To urge state attorneys general to consider including shortages of life-saving drug products within the definition of events that trigger application of state price-gouging laws.

1623

### Home Intravenous Therapy

Source: Council on Public Policy

To support the continuation of a home intravenous therapy benefit under federal and private health insurance plans and expansion of the home infusion benefit under Medicare at an appropriate level of reimbursement for pharmacists' patient care services provided, medications, supplies, and equipment.

This policy supersedes ASHP policy 0414.

**1624****Ban on Direct-to-Consumer Advertising for Prescription Drugs and Medication-Containing Devices***Source: Council on Public Policy*

To advocate that Congress ban direct-to-consumer advertising for prescription drugs and medication-containing devices.

*This policy supersedes ASHP policy 1119.*