House of Delegates

Board of Directors Report:
Policy Recommendations for the
May-June 2024 House of Delegates
(as of February 15)

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# Council on Education and Workforce Development Policy Recommendations

The Council on Education and Workforce Development is concerned with ASHP professional policies, related to the quality and quantity of pharmacy practitioners. 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.

Kristi Gullickson, Board Liaison

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## 1. Opposition to Pharmacy Jurisprudence Examination Requirement

1. To advocate the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure; further,

2. To advocate that employers provide initial and ongoing education of the pharmacy workforce on pertinent federal and state pharmacy laws; further,

3. To acknowledge that it is a professional obligation of a pharmacist to practice in compliance with federal and state laws.

### Rationale

National pharmacy associations have recently joined in advocacy for a more portable pharmacist license. Pharmacist interstate movement and practice are inhibited by the state-specific nature of the pharmacy jurisprudence examination. The pharmacist’s licensing process includes one clinical knowledge exam (the NAPLEX), and in 48 states a jurisprudence exam is required, typically the Multistate Pharmacy Jurisprudence Examination (MPJE) — a 2.5-hour, adaptive, and proctored test. In contrast, physicians take three clinical knowledge exams, and only Texas, Oklahoma, Maine, and Oregon require a jurisprudence exam, which is taken online.
and is open-resource. Nurses are required to take one clinical knowledge exam (the NCLEX), and only Texas and Kentucky require a jurisprudence exam, which is also online and open-resource. A 2017 working paper from the National Bureau of Economic Research found that pharmacists ranked among the lowest in terms of between-state migration, at -47%, compared to nurses (+5.5%) and physicians (+33%). While licensure in multiple states has always been almost a prerequisite for practitioners whose systems are in multi-state areas (e.g., VA, MD, DC), the advances in telehealth have made multistate licensure compulsory for many more pharmacists.

Accreditation Council for Pharmacy Education accreditation standards require pharmacy law as part of the curriculum, but student pharmacists may not practice in the state in which they receive their education, and employers should provide training on pertinent federal and state pharmacy laws. Even absent the state law exams, continuing education requirements and professional responsibility require pharmacists to know the laws in the state(s) in which they are licensed.

**Background**
The Council reviewed licensing requirements across states and professions, the relevance of continued law examination for pharmacists, and potential outcomes of eliminating the MPJE, and determined that ASHP needs a policy advocating the removal of a standalone examination of federal or state pharmacy law as a requirement for licensure. The Council felt eliminating this requirement would allow for greater flexibility regarding interstate movement and practice and align pharmacy with other healthcare professions.

### 2. Pharmacy Technician Education Requirements

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

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

3. To advocate that beyond those requirements, pharmacy technicians working in advanced roles should complete at a minimum an associate of science degree and demonstrate ongoing competencies specific to the tasks to be performed; further,

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

*Note: This policy would supersede ASHP policy 1203.*
Rationale

Pharmacy technician roles have undergone a significant transformation within health systems throughout the years. In today’s intricate healthcare landscape, these pharmacy technicians take on advanced responsibilities beyond their traditional duties. These extended roles include managing information systems, sterile product preparation, handling logistics, and implementing cutting-edge technology. According to the 2022 ASHP National Survey, more advanced pharmacy technician roles are emerging, including 340B Drug Pricing Program management, responsibility for USP chapter 797 (USP <797>) compliance, initiation of medication reconciliation, and supervision of other technicians. Pharmacy administrators have also reported a range of functions that health-system technicians perform, including sterile and nonsterile compounding, inventory management, purchasing, hazardous drug handling, controlled substance system management, medication order distribution, supervisory responsibilities, billing and reimbursement, and technician education and training. These advanced roles will require different skills and competencies, and pharmacy technicians should demonstrate competency before being allowed to perform such tasks, which will require additional, task-specific training.

The advancement of the pharmacy technician workforce includes credentialing, licensing, and on-the-job training. Moreover, engaging in formal education such as an associate of science degree equips pharmacy technicians with the necessary skill set to excel in these multifaceted roles, aids human resources departments in assigning an appropriate job code and pay grade, and elevates the pharmacy profession more broadly. Furthermore, other technical personnel in the healthcare sector (e.g., radiology technicians, respiratory therapist, laboratory technicians) are moving towards requiring a minimum of an associate degree and completion of an accredited training program, and aligning pharmacy technician requirements with other professions provides another pathway for enhanced remuneration. In addition, these measures would promote recruitment and retention of the pharmacy technician workforce within hospitals and health systems.

Background

The Council reviewed ASHP policy 1203, Qualifications of Pharmacy Technicians in Advanced Roles, as part of the discussion of pharmacy technician formal education requirements for health systems. The Council voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

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

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

To advocate that beyond those requirements, pharmacy technicians working in
advanced roles should have additional training complete at a minimum an associate of science degree and should demonstrate ongoing competencies specific to the tasks to be performed; further,

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

3. **Implications of Artificial Intelligence for Professional Integrity**

1. To encourage hospitals, health systems, and colleges of pharmacy to adopt policies regarding the appropriate use of artificial intelligence and ongoing surveillance of these tools.

**Rationale**

The rapid advancement of generative artificial intelligence (AI) technologies, such as ChatGPT, has introduced new possibilities and challenges across society, particularly in the realm of education. These technologies appear to offer innovative ways to assist learners, enhance educational experiences, and streamline administrative processes. However, the integration of AI tools raises concerns about academic integrity, plagiarism, and the potential for unethical use that could undermine the educational process. As such, hospitals, health systems, and colleges of pharmacy should adopt policies regarding the appropriate use of AI across the continuum of learning from didactic to experiential and within the clinical learning environment.

AI tools require extensive education and ongoing surveillance about their potential utility and limitations. Ethical and regulatory implications must be considered, as AI is increasingly incorporated into practice, education, and training. Furthermore, pharmacists must be prepared to engage in the development, validation, and implementation of AI to ensure such tools are being leveraged appropriately to support optimal patient care.

**Background**

At its Policy Week meeting, the Council reflected on the implications of ChatGPT and AI for academic integrity and guidance to student pharmacists, pharmacy residents, educators, and preceptors. The Council identified a need for ASHP policy on this issue.
COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

The Council on Therapeutics is concerned with ASHP professional policies related to medication therapy. 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.

Vickie L. Powell, Board Liaison

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Vicki Basalyga, Secretary

1. Testing for Pregnancy Status

1. To affirm that pregnancy testing should occur only with informed consent and only when the test results would change medical management; further,

3. To affirm that a positive pregnancy test should not compromise the integrity of evidence-based, patient-centered care.

Rationale
Screening and testing for the pregnancy status of patients prior to admission to a hospital or surgical center or before initiation of a teratogenic drug therapy has long been a routine practice, as the pregnancy status of a patient has many ethical and legal considerations when medical management is considered for patient care. Chief pharmacy officers often oversee laboratory medicine departments, and pharmacists are often involved in creating protocols and order sets in which pregnancy testing and screenings are embedded and as a result are key stakeholders.

It is important to note that this policy pertains to testing without informed consent when therapy may need to be changed due to a positive test. The balance between unnecessary testing and testing when initiating a medication therapy is supported by a 2015 study that found that pregnancy assessment was underutilized in the emergency department when patients were prescribed a pregnancy category D or X drug. This policy does not advocate that healthcare professionals should not include pregnancy screening as a part of a patient
history, only that pregnancy testing should occur only with informed consent and not be a requirement for care. The incidence of unknown pregnancy in adult women presenting to a hospital for surgical procedures varies from 0.125 to 1.2%, depending on the procedure.

This policy also aligns ASHP with the American Society of Anesthesiologists statement that recommends “pregnancy testing may be offered to female sex patients of childbearing age and for whom the result would alter the patient’s management, but testing should not be mandatory. Informed consent or assent of the risks, benefits, and alternatives related to preoperative pregnancy testing should ideally be obtained. Best practice may employ shared decision-making between patients and providers.”

**Background**
The Council reviewed and discussed ASHP policy positions 2315, Responsible Medication-Related Clinical Testing and Monitoring; 0013, Patient’s Right to Choose; and 2320, Pharmacoequity, in their discussion about this topic, and concluded that a standalone policy is needed.

### 2. 5-HT₂ Agonist, Entactogen, and Empathogen (Psychedelic) Assisted Therapy

1. To recognize that psychedelic-assisted therapy (PAT) has demonstrated therapeutic potential and should be further researched; further,

2. To recognize that in PAT there is not a standardized product subject to the same regulations as a prescription drug product, and to support the development of standardized formulations of psychedelics that would provide consistent potency and quality; further,

3. To encourage state boards of pharmacy, regulatory agencies, and safety bodies with an interest in PAT to promote research best practices and regulatory standards for medication preparation, compounding, and administration to ensure safety and quality; further,

4. To advocate that when psychedelics are used for PAT, healthcare providers, including pharmacists, should assess patients for medical, pharmacologic, and psychosocial contraindications prior to use and provide medical assistance as needed.

**Rationale**
There has been growing interest in the therapeutic potential of psychedelic drugs for use in the treatment of conditions such as depression, posttraumatic stress disorder, substance use disorders, and other conditions. The U.S. Food and Drug Administration (FDA) includes among these psychedelic drugs the “classic psychedelics,” typically understood to be 5-HT₂ agonists such as psilocybin and lysergic acid diethylamide (LSD), as well as entactogens or empathogens such as 3,4-methylenedioxymethamphetamine (MDMA). As a result of the growing interest, the
FDA issued guidance that provides general considerations to sponsors developing psychedelic drugs for treatment of medical conditions.

Many studies report that psychedelic compounds are associated with few adverse events in trials, but the populations studied are not generalizable to the larger population. Psychological safety is a potential concern, and psychological distress is common, though not necessarily harmful in the long term. Increased blood pressure and heart rate due to the distress experienced during the administration session may put individuals with uncontrolled blood pressure or coronary artery disease at risk of ischemic events and may be considered a relative contraindication. Psychiatric illnesses, including schizophrenia, psychosis, and bipolar disorder, are considered a likely contraindication to psychedelic therapy. Drug-drug interactions of psilocybin, including tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and QT interval-prolonging medications, are of concern and underscore the importance of pharmacists in the management of policies and practices related to the use of psychedelic compounds. Small sample sizes, a lack of diversity in enrollment, a lack of effective blinding, varied doses studied, and selective enrollment are just some of the critiques of trials assessing the use of psychedelic compounds. Psilocybin has been studied mainly in the treatment of psychological distress associated with life-threatening illnesses and major depressive disorder, while MDMA has been studied most extensively in the treatment of posttraumatic stress disorder. Despite promising results of some of the studies, the limitations of the studies prevent firm conclusions from being drawn.

In 2023, the American Medical Association also released new Current Procedural Terminology (CPT) III codes for Continuous In-Person Monitoring and Intervention During Psychedelic Medication Therapy. The code will provide a mechanism to track and report on the delivery of psychedelic treatments and will cover multiple psychedelic compounds with psychological support models, if approved, as well as various staffing structures, and numbers and credentials of qualified healthcare professionals.

Currently, psychedelic compounds with proposed therapeutic benefit, including psilocybin and MDMA, remain Schedule I substances, with no recognized therapeutic uses. Two states, Oregon and Colorado, have passed laws allowing the legal consumption of psychedelic compounds. Medical organizations have expressed concern about state efforts to circumvent federal laws through this approach, particularly when in the guise of medical treatment. In Oregon, for example, the administration of psychedelics is accompanied by assisted psychotherapy to maximize the possible therapeutic benefits. Prior to administration of the psychedelic compound, the individual will meet with a facilitator in a “preparation” session to review safety and support planning, transportation, and expectations for the administration of the psychedelic compound. The individual is then administered the dose under the supervision of the facilitator. Although these individuals are encouraged to share their past medical histories with the facilitator, it is not required, and the screening needed to ensure an appropriately selected client may fail to detect contraindications or significant drug-drug interactions. Furthermore, facilitators are required to have only a high school diploma and are not required to undergo medical training. This lack of training is of particular concern because individuals who are not trained medical professionals are likely unable to distinguish between medical emergencies and the side effects of the psychedelic compounds.

ASHP policy also aligns with the American Psychiatric Association position that
recognizes the emerging scientific evidence for using psychedelic drugs within the context of approved investigational studies and that “clinical treatments should be determined by scientific evidence in accordance with applicable regulatory standards and not by ballot initiatives or popular opinion.”

It is important to recognize that mushrooms containing psilocybin have long been used for rituals and religious ceremonies around the world. As this use is falls within indigenous cultural and religious traditions and is not intended as a medical treatment, this policy does not address those uses.

**Background**

The Council reviewed the current evidence supporting the use of psychedelics along with the federal and state laws surrounding their use. Council members also discussed the trend of state law circumventing federal law for Schedule I substances and acknowledged that, despite promising results, the state approach to permitting use is concerning. The Council also recognized that although the ideal approach to PAT would be through controlled studies, PAT outside of investigational studies is already expanding, so the policy is written to reflect this reality and to encourage the presence of a medical professional at sites where PAT is provided. The Council also suggested that since more states are enacting legislation permitting the use of psychedelics, ASHP could provide resources on drug-drug interactions, toxicology, and education on PAT.
COUNCIL ON PHARMACY PRACTICE
POLICY RECOMMENDATIONS

The Council on Pharmacy Practice is concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners. 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.

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Anna Legreid Dopp, Secretary

Jennifer Tryon, Board Liaison

1. Prehospital Management of Medications

1. To assert that variation in the prehospital management and use of medications is a risk to patient safety and continuity of care; further,

2. To advocate for pharmacy workforce involvement in clinical and operational decision-making for prehospital management and utilization of medications; further,

3. To encourage the pharmacy workforce to assume responsibility for medication-related aspects of ensuring the continuity of care as patients transition from prehospital care to other care settings; further,

4. To collaborate with stakeholders involved in prehospital medication-use cycle decisions to improve patient safety, minimize variation, and reduce inefficiencies.

Rationale
ASHP advocates that the pharmacy workforce “assume responsibility for medication-related aspects of ensuring the continuity of care as patients move from one care setting to another” (ASHP policy 2205). Prehospital management and utilization of medications varies greatly through patient emergency services, transport, and transfers. The pharmacy workforce has
established clinical and operational expertise across the spectrum of medication use, which would add value and safety measures to the prehospital management and utilization of medications. That expertise could inform decision-making regarding standardization, management of medication shortages, and prevention of medication errors, among other things. Ensuring pharmacy workforce involvement in these medication-related activities and decisions would optimize medication use, improving prehospital care and patient safety during emergent situations and patient transfers.

**Background**
The Council examined this topic in response to a recommendation from the 2023 House of Delegates. Council members noted that a similar gap in ASHP policy led to the development of ASHP policy 2317, Emergency Medical Kits, and agreed that an ASHP policy position was needed to fill this gap.

### 2. Role of Artificial Intelligence in Pharmacy Practice

1. To recognize artificial intelligence (AI) as a tool with tremendous potential to improve patient care and the medication-use process, which should be implemented with caution due to potential unforeseen risks; further,

2. To encourage healthcare organizations to develop policies, procedures, and guidelines to determine which care settings, medications, and patient populations are appropriate candidates for the use of AI; further,

3. To advocate for pharmacy workforce involvement and transparency in the decision-making, design, implementation, and ongoing evaluation of AI-related applications and technologies that affect medication-use processes and tasks; further,

4. To oppose any use of AI that compromises human interaction or replaces ethical decision-making, professional judgment, or critical thinking or is implemented solely to reduce healthcare staffing and resources; further,

5. To advocate for regulations and standards that permit the use of AI in circumstances in which it has proven safe and effective.

**Rationale**
Artificial intelligence (AI) is an emerging technology described as intelligent computer programs or software capable of learning human cognition and processes. AI falls under two categories: machine learning (ML) for data set analysis and natural learning processes for information extraction from existing data. In recent years, AI technology has evolved at an immense speed, and healthcare has been increasingly digitizing data, raising two questions: how to best use both to improve patient-specific care on a grand scale without compromising patient safety and
outcomes, and how to retain the expertise, autonomy, and humanity (e.g., empathy and compassion) of the interprofessional care team.

The healthcare community recognizes the potential benefit and risk of AI in patient care. Examples of opportunities include but are not limited to optimizing patient health, reducing variation in patient care services, translating evidence to practice, streamlining workflows and creating efficiencies, and reducing cognitive load on the interprofessional care team. Risks may include potential for breaches in patient privacy and safety; failure to incorporate ethical and moral decision-making; lack of transparency; automation biases; and narrow algorithm development that does not account for diverse populations, widening health disparities in undeserved or underrepresented patient populations. Given these risks, pharmacists and other healthcare professionals must retain oversight of AI applications and their implementation. Even if there comes a time when AI technology can account for every possible variable, the healthcare team must retain the right to make the final decisions on patient care to mitigate its inherent risks.

Pharmacy should take a leading role on the interprofessional healthcare team to research, develop, implement, and improve the quality of AI/ML-based clinical models that affect medication-use processes and tasks. The potential for improvement of care, lower costs, and comprehensive medication management could significantly impact healthcare, but healthcare providers must recognize the need for sufficient purview and monitoring to guarantee patient safety and effective therapy. Pharmacists, as leaders in AI health technology, can guide healthcare professionals and future generations on the implementation of AI in healthcare.

Background
The Council discussed AI following the Joint Council and Commission Meeting on the Role of Artificial Intelligence in Pharmacy. Their initial focus was on the ethical considerations in AI; however, the Council felt there was a need to discuss how AI impacts pharmacy practice more broadly. The Council agreed on the need for new ASHP policy. The Council also agreed that the ASHP Statement on the Use of Artificial Intelligence in Pharmacy should be revised to address ethical considerations for AI in healthcare and pharmacy practice, such as what tasks should always be performed by a human and never be replaced by AI, and what ethical considerations are needed for initial evaluation, implementation, and ongoing quality assurance of AI technologies.
# COUNCIL ON PHARMACY MANAGEMENT
## POLICY RECOMMENDATIONS

The Council on Pharmacy Management is concerned with ASHP professional policies related to the leadership and management of pharmacy practice. 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.

Kim Benner, *Board Liaison*

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## 1. Documentation of Patient-Care Services in the Permanent Health Record

1. To advocate for public policies that support documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,

2. To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization’s clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of patient care provided by the pharmacy workforce on patient outcomes and cost of care; further,

3. To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

*Note: This policy would supersede ASHP policy 1419.*
Rationale
Documentation in the patient record is critical for a complete record for patient care and communication among members of the healthcare team. Documentation should be done within an electronic health record (EHR). Organization-based privileging is the process used by a healthcare organization, after evaluating a practitioner’s credentials, to assure stakeholders that the healthcare professional has the competencies and experience to provide certain direct patient care services. Privileging grants that individual practitioner permission to deliver those patient care services and document the rendering of those services in the permanent health record. ASHP supports the use of use of post-licensure credentialing, privileging, and competency assessment, in a manner consistent with other healthcare professionals, to practice pharmacy as a direct patient-care practitioner (see ASHP policies 2011, Credentialing and Privileging by Regulators, Payers, and Providers of Collaborative Practice, and 1415, Credentialing, Privileging, and Competency Assessment). Pharmacy technicians, within their scope of practice, have documented activities (e.g., medication history documentation) in the record as part of team-based care documentation. When documenting electronically, use of standardized and coded formats allows for improved measurement of patient outcomes.

Background
The Council reviewed ASHP policy 1419, Documentation of Patient-Care Services in the Permanent Health Record, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To advocate for public and organizational policies that support pharmacist documentation of patient-care services provided by the pharmacy workforce in the permanent patient health record; further,

To promote inclusion of the pharmacy workforce in organization-based credentialing and privileging processes and in collaboration with an organization’s clinical informatics team to ensure accurate and complete documentation of the care provided to patients and to validate the impact of pharmacist patient care provided by the pharmacy workforce on patient outcomes and total cost of care; further,

To advocate that electronic health records be designed with a common documentation space to accommodate all healthcare team members and support the communication needs of pharmacy.

The Council discussed the lengthy first clause in the existing policy and felt advocating for public policies seems reasonable but not so for organizational policies. Promoting incorporation in an organization-based credentialing and privileging process and in collaboration with an organization’s clinical informatics team seem practical and actionable. There is some crossover with ASHP policy 2137, Documentation of Pharmacist Patient Care, but that policy focuses more on documentation, billing, and attribution for services rendered. There was some discussion about a need for advocacy to support documentation of activities by pharmacy technicians.
within their scope of practice (e.g., medication history documentation) as part of team-based care documentation.

2. Supporting High Reliability in Pharmacy Practice

   1. To state that a commitment to the principles and science of high reliability, with the goals of zero medication errors and zero harm, are foundational to pharmacy excellence;
   2. further,
   3. To encourage hospitals and health systems to commit to high-reliability principles;
   4. further,
   5. To encourage research that informs the creation of best practices in high reliability and progress toward implementation of high-reliability principles in all pharmacy services.

*Rationale*
High reliability is an ongoing process or an organizational frame of mind, not a specific structure. The Agency for Healthcare Research and Quality has outlined practical strategies for healthcare organizations aiming to become highly reliable in their report of practices employed by hospitals in the High Reliability Organization Learning Network. This mindset is supported by five characteristic ways of thinking: preoccupation with failure; reluctance to simplify explanations for operations, successes, and failures; sensitivity to operations (situation awareness); deference to frontline expertise; and commitment to resilience. High-reliability organizations work to create an environment in which potential problems are anticipated, detected early, and virtually always responded to early enough to prevent catastrophic consequences. The Joint Commission suggests that hospitals and healthcare organizations work to create a strong foundation before they can begin to mature as high-reliability organizations. Such foundational work includes developing a leadership commitment to zero-harm goals, establishing a positive safety culture, and instituting a robust process improvement culture. The Joint Commission also provides metrics and tools for assessing the maturity of an organization’s leadership, safety culture, and process improvement culture as preconditions to high reliability. Structured analysis of work processes can eliminate inefficiencies, increase value-added time spent with patients, reduce staff stress, and optimize the use of supplies and other resources. Reliable information technology systems are critical to ensure care quality and improve efficiency in administrative and process measures. ASHP’s PAI 2030 includes a recommendation that states: “C9. Pharmacy should employ high-reliability principles when designing and selecting health information technology.” Given the rising cost of healthcare and internal competition for finite capital dollars, it is important to identify solutions that will improve quality and safety while being fiscally responsible. Research is needed to evaluate tasks and processes to identify better approaches that will reduce waste, improve outcomes, and yield significant savings. Continuous improvement on the delivery of high-value care requires healthcare institutions to continually monitor and improve reliability and performance (see ASHP policy 2206, Continuous Performance Improvement).
**Background**
The Council acknowledged the concept of high reliability is attractive for healthcare due to the complexity of operations and the risk of significant consequences when failures occur. Supporting high reliability in pharmacy practice to improve efficiency and reduce susceptibility to human error can aid in areas such as automating order entry and reducing paperwork; optimizing staffing levels and scheduling; managing equipment and resources; defining care protocols and providing clinical decision support; managing billing and revenue cycles; reducing adverse drug events and duplicate tests; and improving care coordination. The Council suggested that ASHP could help members by promoting knowledge-sharing about high reliability through education and publications and a value analysis through research. Development of a resource to help hospitals and health systems develop a strong foundation before they can begin to mature as high-reliability organizations (HRO) is desired. Some members of the Council stated the ASHP PAI 2030 Self-Assessment Tool addresses aspects of this but an HRO-specific resource would be of value.

### 3. Safe Medication Sourcing, Preparation, and Administration in All Sites of Care

1. To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, and administration to ensure safety and quality.

   *Note: This policy would supersede ASHP policy 1914.*

**Rationale**
Globally, health spending as a share of the overall economy has been steadily increasing since the 1980s, as spending growth has outpaced economic growth across all high-income countries, the United States included. This growth is multifactorial but is largely due to advances in medical technologies, including specialty medications; exponential and disparate price increases in the health sector across all markets; and higher demand for services, especially from a growing, aging population (Commonwealth Fund, Peterson-KFF). Based on data from 2021, the United States spent 18.3% of gross domestic product (GDP) on healthcare, nearly twice as much as the average country in the Organisation for Economic Co-operation and Development (Peterson-KFF, CMS). Over 2022-2031, average growth in national health expenditures (5.4%) is projected to outpace that of average GDP growth (4.6%), resulting in an increase in the health spending share of GDP, from 18.3% in 2021 to 19.6% in 2031 (CMS). This increasing cost of healthcare in the United States has motivated stakeholders across the care paradigm to search for strategies to curtail costs. Over the last decade, payers have implemented strategies that fragment providers’ comprehensive care management of the patient. These strategies include but are not limited to site-of-care (SOC) optimization, which shifts care away from hospitals, and payer-directed drug distribution models (see ASHP policy 2309, Payer-Directed Drug Distribution Models), which undermine hospitals’ patient safety protections and jeopardize patient care. The payers’ overarching goal is cost containment, while maintaining access to the prescribed therapy. Cost containment efforts have shifted
beyond the traditional pharmacy point-of-sale management intended for self-administered medications under the pharmacy benefit, such as formulary tiering, prior authorization requirements, drug exclusions, and step therapy implementation. These newer payer strategies targeting provider-administered medications under the medical benefit present risks to patient care and safety. Patients are increasingly being required to receive care at lower-cost nonhospital SOCs, rather than at traditional venues, such as hospital outpatient infusion centers. Alternative or nonhospital SOCs include nonhospital-affiliated outpatient infusion centers, physician’s offices, ambulatory infusion centers, or patients’ homes. Payer-imposed SOC restrictions and policies jeopardize the continuity of care for the patient by introducing incongruent providers and systems (see ASHP policy 2031, Continuity of Care in Insurance Payer Networks). These same policies also create additional logistical challenges for the patient to navigate and can impede timely access to care for patients who require additional special assistance or services, such as access to emergency staff in the event of an adverse reaction. Further, the level of infrastructure required to adequately address regulatory and accreditation requirements focused on quality and safety (e.g., United States Pharmacopeia Chapters 797 and 800, state board of pharmacy regulations, and the standards of accreditors such as The Joint Commission and Det Norske Veritas Healthcare) varies across SOCs, with hospitals carrying the greatest administrative burden and costs. As a result, health systems should collaborate with pharmacy leadership when exploring ways to optimize medication access and appropriate utilization in nonhospital SOCs.

**Background**

The Council reviewed ASHP policy 1914, Safe Medication Preparation, Compounding, and Administration in All Sites of Care, as part of sunset review and in response to recommendations made by an ASHP member advisory panel and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

> To advocate that all sites of care be required to meet the same regulatory standards for medication sourcing, preparation, compounding, and administration to ensure safety and quality.

The Council discussed opportunities to make the policy recommendation and associated rationale reflective of current practice, healthcare trends, and pharmacy opportunities to ensure optimal patient care. The Council proposed ASHP continue advocacy in opposition to specific payer strategies that restrict access points, interfere with shared provider-patient decision-making, and jeopardize patient care.