# Board of Directors Report:
## Policy Recommendations for the March 2021 Virtual House of Delegates

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**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.*

Paul C. Walker, *Board Liaison*

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### 1. Direct-to-Consumer Clinical Genetic Tests

1. To support research to validate and standardize genetic markers used in direct-to-consumer clinical genetic tests and guide the application of test results to clinical practice; further,

2. To encourage the Food and Drug Administration (FDA) to continue to regulate direct-to-consumer clinical genetic tests as medical devices and work with the National Institutes of Health to evaluate and approve direct-to-consumer clinical genetic tests; further,

3. To advocate that direct-to-consumer clinical genetic tests be provided to consumers through the services of appropriate healthcare professionals who order tests from laboratories certified under the Clinical Laboratories Improvement Amendments of 1988 (CLIA); further,

4. To support FDA policies and procedures regarding advertising of direct-to-consumer clinical genetic tests, including the following requirements: (1) the relationship between the genetic marker and the disease or condition being assessed is clearly presented, (2) the benefits and risks of testing are discussed, and (3) such advertising is provided in an understandable format, at a level of health literacy that allows the intended audience to make informed decisions, and includes a description of the established patient-
Rationale
Since 2018, the FDA has implemented multiple processes, procedures, and guidance documents surrounding in vitro diagnostics (IVDs), also referred to as direct-to-consumer (DTC) testing. The FDA now reviews DTC tests for moderate- to high-risk medical purposes, to determine the validity of the test claims. The FDA review consists of assessing for analytical validity, clinical validity, and claims made by the company marketing the test about how well it works. Additionally, the FDA reviews descriptive information about the test for accuracy and for an appropriate level of health literacy.

The FDA now regulates DTC tests as medical devices. The specific regulatory requirements depend on the risk classification of the individual IVD. The FDA has been proactive about streamlining the regulation of DTC tests, as well as determining appropriate for use by a consumer without the involvement of a healthcare provider.

In October 2018 and April 2019, the FDA issued a safety communication to alert the public to concerns regarding pharmacogenetic tests with unapproved claims to predict an individual’s response to a specific therapeutic drug, where these claims may not supported by clinical evidence. Warning letters were sent by the FDA to select companies. Patients and providers were advised the FDA has not evaluated genetic tests, which make claims regarding the effects of a specific medication.

As consumer use of DTC testing continues to be prevalent, it is critical healthcare systems develop policies and best practices related to the utilization of data patients may present to their healthcare teams. Providers should be aware for most medications the relationship between genetic variations and a medication's effects has not been established. If a patient provides a test report from a genetic DTC test claiming to predict a person’s response to a specific medication, the healthcare team should seek information in the FDA-approved drug label regarding whether genetic information should be used for determining therapeutic treatment. Confirmatory testing should be ordered by the healthcare team from a CLIA-certified laboratory.

Note: This policy would supersede ASHP policy 1103.
**Background**
The Council reviewed ASHP policy 1103, Direct-to-Consumer Clinical Genetic Testing, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; strikethrough indicates deletions):

To support research to validate and standardize genetic markers used in direct-to-consumer clinical genetic tests and guide the application of test results to clinical practice; further,

To encourage the Food and Drug Administration (FDA) to use existing authority continue to regulate these direct-to-consumer clinical genetic tests as medical devices and to work with the National Institutes of Health to expedite establishment of a process to evaluate and approve direct-to-consumer clinical genetic tests; further,

To advocate that direct-to-consumer clinical genetic tests to support disease diagnosis or management of drug therapy be provided to consumers only through the services of appropriate healthcare professionals who order tests from laboratories that are certified under the Clinical Laboratories Improvement Amendments of 1988 (CLIA); further,

To oppose support FDA policies and procedures regarding advertising of direct-to-consumer clinical genetic tests, including unless the following requirements are met: (1) that the relationship between the genetic marker and the disease or condition being assessed is clearly presented, (2) that the benefits and risks of testing are discussed, and (3) that such advertising is provided in an understandable format, at a level of health literacy that allows the intended audience to make informed decisions, and includes a description of the established patient-healthcare provider relationship as a critical source for information about the test and interpretation of test results; further,

To encourage health systems to create policies and procedures addressing direct-to-consumer genetic testing results as it relates to confirmatory testing, integration of genomic information into the healthcare record, genetic counseling, and clinical decision-making; further,

To encourage pharmacists to educate consumers and clinicians on the appropriate use of potential risks and benefits of direct-to-consumer clinical genetic tests for disease diagnosis and decisions involving drug therapy management.

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2. **Vaccine Hesitancy**

1. To recognize the significant negative impact vaccine hesitancy has on public health in the United States; further,
Council on Therapeutics: Policy Recommendations

Rationale
Immunizations have led to a significant decrease in rates of vaccine-preventable diseases and have had a significant impact on the health of adults and children. In recent years, however, vaccine hesitancy, which is a delay in acceptance or refusal of vaccination despite availability of vaccination services, has increased. Vaccine hesitancy is complex and context specific, varying across time, place, and vaccines, and is influenced by factors such as complacency, convenience, and confidence. The impact of vaccine hesitancy is significant: lower immunization rates observed in various European countries and the U.S. are likely to have contributed to the outbreaks of vaccine-preventable diseases that have been observed over recent years.

Vaccine-hesitant patients, healthcare providers, and caregivers have been found to be responsive to vaccine information, consider vaccination, and are not opposed to all vaccines, and therefore would benefit from counseling. Studies have shown that "presumptive recommendation" (informing patients and caregivers that vaccines are due) is more effective than "participatory recommendation" (asking what patients and caregivers thought about vaccines) in convincing patients and caregiver to accept vaccines. Healthcare providers, including pharmacists across healthcare settings, are trusted advisors and influencers of vaccination decisions, and they must be supported to provide trusted, credible information on vaccines.

Background
The Council discussed vaccine hesitancy as a part of the sunset review of ASHP policy 0601, Universal Influenza Vaccination. During the course of that discussion, vaccine hesitancy was recognized as a significant barrier to universal administration of the influenza vaccine but not specific to flu vaccination administration, as the measles outbreaks of 2019 were due to vaccine hesitancy regarding childhood immunizations.
3. Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems

- To discourage the use, distribution, and sale of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) in and by pharmacies; further,
- To advocate for tobacco-free environments in hospitals and health systems; further,
- To promote the role of pharmacists in tobacco-cessation counseling and comprehensive medication management; further,
- To join with other interested organizations in statements and expressions of opposition to the use of tobacco, tobacco products, and electronic nicotine delivery systems; further,
- To educate the public and patients on the risks of nicotine consumption through traditional and electronic delivery systems.

Note: This policy would supersede ASHP policy 1625.

Rationale
Pharmacists, as healthcare providers, have long discouraged the use of tobacco and tobacco products as a threat to public health. Electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) are new and unregulated delivery systems for nicotine. The contents of these systems include flavorings, propylene glycol, glycerin, and other unknown ingredients, and the long-term effects of their use have not been studied. Given these uncertainties, pharmacists should discourage their use as well.

Furthermore, pharmacists have a role in recommending and managing drug therapy to support cessation of nicotine-containing products, including tobacco and electronic nicotine delivery systems, as described in the ASHP Therapeutic Position Statement on Cessation of Tobacco Use. Newer therapies, including varenicline, are associated with more and evolving safety risks when compared to nicotine replacement therapies. Given the complexity of drug therapy, pharmacists should play a central role in ensuring the safe and appropriate use of these therapies.

Background
The Council reviewed ASHP policy 1625, Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

- To discourage the use, distribution, and sale of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and
To advocate for tobacco-free environments in hospitals and health systems; further,

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

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

To join with other interested organizations in statements and expressions of opposition to the use of tobacco, tobacco products, and electronic nicotine delivery systems; further,

To educate the public and patients on the risks of nicotine consumption through traditional and electronic delivery systems.

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4. *Use of Antimicrobials in Surgical Wounds and Procedures*

- To oppose the use of antimicrobial agents in surgical wounds and procedures not based on evidence; further,
- To encourage further research to assess the efficacy, safety, and risks of resistance development of antimicrobials used in surgical wounds and procedures; further,
- To foster evidence-based recommendations on the use of antimicrobial agents in surgical wounds and procedures and on how to prepare those agents according to appropriate sterile practices; further,
- To advocate that antimicrobial stewardship programs review and monitor the use of antimicrobial agents in surgical wounds and procedures; further,
- To encourage pharmacists to educate prescribers on adverse outcomes and reactions associated with the use of antimicrobials in surgical wounds and procedures; further,
- To support clear and consistent documentation of antimicrobial agents used for surgical wounds and procedures in the electronic health record.

**Rationale**

The addition of antimicrobials to irrigation solutions during surgical procedures in an effort to prevent surgical site infections has been a long-standing surgical practice. Antibiotics are the
most common additives to surgical irrigation fluids, but recent data has shown no clinical benefit compared with saline irrigation, likely due to the mechanism of antibiotics needing a longer exposure time than is allowed during irrigation. Further, the use of topical antibiotics in the open surgical wound is often not monitored and has not been subject to any evidence-based standardization of care. When mixing practices were surveyed across hospitals and health systems, most respondents from facilities in which the solutions were mixed in the operating room (OR) were unaware of who was doing the mixing; of those who were aware, surgical scrub technicians or OR nurses were the individuals most often reported to be doing the mixing.

The results of numerous surveys of surgeons has indicated that the practice of using topical antibiotics intraoperatively, in both irrigation fluids and powders, is widespread. This practice stemmed from the belief that applying antibiotics locally would minimize toxicity and resistance. However, newer data suggest that there is a potential for toxicities and systemic exposure leading to resistance associated with these practices. Because of this, the Infectious Diseases Society of America, Society for Healthcare Epidemiology of America, Surgical Infection Society, American Society of Health-System Pharmacists, World Health Organization, American College of Surgeons, and the International Consensus on Orthopedic Infections all recommend against the use of topical antimicrobial irrigation. Despite these recommendations, this practice is still prevalent throughout hospitals and health systems. Complicating the picture is that neither the Joint Commission nor the Centers for Medicare and Medicaid Services have addressed the use of topical antibiotics.

Due to the risks of topical use and the lack of evidence supporting it, this practice should be an essential part of antimicrobial stewardship programs. All antibiotics sent from pharmacy to the OR, including those intended for topical use, should be documented clearly in the electronic health record, including type and amount used, and should be part of comprehensive surveillance for patient outcomes for surgical site infections, allergic reactions, resistance trends, management of shortages, and toxicity adverse events related to topical surgical administration of antibiotics.

**Background**

The Council discussed the need for ASHP to promote awareness of the use of antimicrobials in surgical wounds and procedures through multiple channels, including webinars, presentations at ASHP meetings, networking sessions, ASHP Connect, and the ASHP website. The Council suggested that ASHP could reach out to a medical organization (e.g., American Academy of Orthopaedic Surgeons or Infectious Diseases Society of America) to develop best practices regarding use of antibiotic-impregnated delivery systems, including compounding, adverse drug events, and therapeutic monitoring and research.
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.

Julie A. Groppi, Board Liaison

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1. Professional Identity Formation

To encourage the pharmacy workforce and pharmacy education and training programs to foster professional identity formation.

Note: This policy would supersede ASHP policy 1113.

Rationale
The terms "professionalism" and "professional identity" are sometimes mistakenly used interchangeably. Professionalism is defined by behaviors that are often outwardly visible (e.g., credentialing, continuing education, efforts to advance the profession). In contrast, professional identity formation (PIF) is defined as the process of internalizing a profession’s core values and beliefs. PIF incorporates the three domains of thinking, feeling, and acting. PIF in pharmacy may be described as the process of developing a commitment to: (1) high professional standards of pharmacy practice, (2) high personal standards of integrity and competence, (3) serving humanity, (4) creating a just and inclusive healthcare system and society, (5) analytical thinking and ethical reasoning, (6) continuing professional development, (7) acquiring personal leadership skills, (8) developing effective interpersonal skills, (9) maintaining personal well-being and resiliency, and (10) membership and participation in professional organizations.
Pharmacy professionals and educators have a direct or indirect responsibility to support the growth and success of others in the pharmacy workforce through mentorship and modelling. As pharmacy professionals interact with learners, new practitioners, and even seasoned colleagues, they have the ability to model professional behavior, integrity, ethical standards, and service to the community. Pharmacy professionals who serve in formal or informal leadership roles are in a unique position to mentor others in leadership skills. Pharmacy professionals should mentor others in the various career paths they may pursue as well as encourage them to elevate their practice level and education.

Some of the barriers to PIF include mentors and preceptors being pressured into a role rather than being allowed to decide whether they choose to do so voluntarily, increased pharmacy workload, and staff burnout. Developing student professionalism (sometimes referred to as “professional socialization”) has been part of pharmacy education for decades, but a broader focus on PIF more generally will better serve the profession of pharmacy during a time of practice transformation than the current approach to teaching professionalism. Colleges of pharmacy, other providers of education and training programs, and employers could promote PIF by providing mentorship programs and other resources.

**Background**

The Council reviewed ASHP policy 1113, Professional Socialization, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To encourage pharmacists the pharmacy workforce and pharmacy education and training programs to serve as mentors to students, residents, and colleagues in a manner that fosters professional identity formation, the adoption of: (1) high professional standards of pharmacy practice, (2) high personal standards of integrity and competence, (3) a commitment to serve humanity, (4) analytical thinking and ethical reasoning, (5) a commitment to continuing professional development, and (6) personal leadership skills.

2. **Professional Development as a Retention Tool**

1. To recognize that pharmacy workforce development is an essential component of staff recruitment, retention, and well-being; further,

2. To recognize that pharmacy workforce development encompasses more than formal education programs and includes informal learning among colleagues, mentoring, participation in activities of professional organizations, and other types of learning; further,

3. To encourage healthcare executives to support pharmacy workforce development programs, including leadership succession planning, as an important benefit that aids in recruiting and retaining qualified staff; further,
Rationale
Workforce development can take many forms, including formal education, informal mentoring, participation in certification programs, career ladder implementation, and expanded experiences. The need for job growth and career advancement is an important motivator for job satisfaction among those entering the workforce, such as student pharmacists and residents. Evidence suggests that staff development programs are associated with increased pharmacist retention. There is also a growing need to provide education on topics, such as clinical management, that are not taught in education and training programs and nurture the workforce to provide continuous succession planning.

Background
The Council reviewed ASHP policy 0112, Professional Development as a Retention Tool, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

  To recognize that pharmacy department staff workforce development is an essential component of staff recruitment, and retention, as well as quality of work life and well-being; further,

  To recognize that staff pharmacy workforce development encompasses more than formal in-service or external education programs and includes informal learning among colleagues, mentoring, participation in activities of professional organizations, and other types of learning; further,

  To strongly encourage pharmacy directors and health-system administrators healthcare executives to support staff pharmacy workforce development programs, including leadership succession planning, as an important benefit that aids in recruiting and retaining qualified staff practitioners; further,

  To assist support pharmacy directors healthcare executives with staff pharmacy workforce development initiatives by providing a variety of educational programs, services, and resources materials.

3. Fostering Leadership Development

  To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for members of the pharmacy workforce to move into leadership roles; further,
Rationale
In their 2013 report, Is there still a pharmacy leadership crisis? A seven-year follow-up assessment (Am J Health-Syst Pharm. 2013; 70:443–7), 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, pharmacy technicians, 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, pharmacy technician training 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 reviewed ASHP policy 1611, Developing Leadership Competencies, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

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

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

To encourage pharmacy practitioners members of the pharmacy workforce 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,
Council members reaffirmed that this policy fills a void between the ASHP Statement on Leadership as a Professional Obligation and ASHP policy 0918, Pharmacist Leadership of the Pharmacy Department. Council members recommend updating the language to be consistent with other pharmacy workforce-related policy.

4. Interprofessional Education and Training

1. To advocate for interprofessional education as a component of didactic and experiential education in pharmacy workforce education and training programs; further,

2. To support interprofessional education, mentorship, and professional development for healthcare professionals and learners; further,

3. To urge collaboration with other healthcare professionals and executives in the development of education and training models for interprofessional, team-based, patient-centered care; further,

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

*Note: This policy would supersede ASHP policy 1612.*

**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 healthcare 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
professorial 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 reviewed ASHP policy 1612, Interprofessional Education and Training, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To support advocate for interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree pharmacy workforce education and training programs; further,

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

To encourage and support pharmacists’ urge collaboration with other healthcare professionals and healthcare executives in the development of education and training models for 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.

The Council recommended changing the first clause to advocate to provide a basis for ongoing advocacy for interprofessional education and training.

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**5. Pharmacy Education and Training Models**

1. To promote pharmacy education and training models that: (1) provide experiential and residency training in interprofessional patient care; (2) use the knowledge, skills, and
Rationale
Pharmacy training models are continuously evolving. The ideal training model includes characteristics such as flexibility to be useful in all patient care settings, providing patient care through an interprofessional team, and allowing team members to practice at the top of their licenses. Many healthcare organizations are successfully employing innovative and contemporary training models. One such model is the layered learning approach to residency and student pharmacist training, in which a pharmacist oversees multiple residents, student pharmacists, and sometimes generalist pharmacists. Each member of this pharmacy team is integrated into a patient care team, with specific roles and responsibilities, but each also has accountability to the supervising pharmacist. The layered learning model may be more practical in larger institutions, however, because they have more staff, residents, and student pharmacists than smaller hospitals. ASHP recognizes that it is important to individualize the training program to the practice site and its corresponding practice model, and supports the assessment of the impact of these pharmacy training models on the quality of learner experiences and patient care outcomes.

Background
The Council reviewed ASHP policy 1829, Pharmacy Training Models, at the request of a Council member and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To promote pharmacy education and training models that: (1) provide experiential and residency training in interprofessional patient care; (2) use the knowledge, skills, and abilities of students pharmacists and residents in providing direct patient care; and (3) promote use of innovative and contemporary learning models; further,

To encourage the collaboration between colleges of pharmacy and residency programs with accreditation agencies on innovative education and training models; further,

To support the assessment and dissemination of the impact of these pharmacy education and training models on the quality of learner experiences and patient care outcomes.

Note: This policy would supersede ASHP policy 1829.
The Council recognized that pharmacy training models are continuously evolving. Pharmacy educators, especially those involved with student pharmacist and pharmacy resident learning experiences, are facing increased challenges as they continue to care for patients and concurrently act as preceptors to learners. They are being asked to approach COVID-19 challenges as an opportunity for innovation in teaching and constructing learning models. The pharmacy workforce, especially preceptors and educators, require tools to create valuable distance-learning experiences and engage learners to meet rotation requirements.

At its July 2020 meeting, the Council requested re-examining ASHP policy 1829, Pharmacy Training Models, while reflecting on lessons learned during the pandemic, and voted to recommend revising the policy. The Council reflected on recent lessons emerging from the COVID-19 pandemic. Council members noted the opportunity for ASHP to advocate for practice innovations to the accrediting bodies involved with workforce education, training, and licensure; collaborate on what innovations meet the intent of accreditation standards; and then share those innovations that meet the standards.

### Rationale

State boards of pharmacy vary with respect to the pharmacy internship requirement. Some state boards of pharmacy allow internship hour requirements to be completed as part of the pharmacy curriculum. Other state boards of pharmacy require students to complete internship hours outside of the pharmacy curriculum. Inconsistencies in internship requirements among states have had significant implications for pharmacy residents. Pharmacy graduates from a state with minimal internship requirements may relocate to a state post-graduation for employment with stringent internship requirements, sometimes delaying their eligibility for licensure until they can complete internship requirements. Greater standardization would prevent these issues as new graduates relocate to other states.

#### 6. Pharmacy Internships

1. To encourage state boards of pharmacy to adopt the standardized pharmacy internship hour requirements recommended in the National Association of Board of Pharmacy Model Rules for Pharmacy Interns; further,
2. To support structured requirements, goals, and objectives for pharmacy internship experiences, in alignment with requirements for introductory and advanced pharmacy practice experiences; further,
3. To promote new staffing models that offer expanded roles for pharmacy interns, providing work experiences that build upon their knowledge and help them develop as future pharmacists.

*Note: This policy would supersede ASHP policy 1110.*
The National Association of Boards of Pharmacy Model Rules for Pharmacy Interns requirements coincide with the ACPE Accreditation Standards and Guidelines. In the rule, boards of pharmacy are strongly encouraged to utilize these Accreditation Standards and Guidelines as a basis for the establishment and revision of board standards for pharmacy practice experiences.

**Background**

The Council reviewed ASHP policy 1110, Pharmacy Internships, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

- To encourage the National Association of Boards of Pharmacy to develop standardized pharmacy internship hour requirements that would be used uniformly by all state boards of pharmacy to adopt the standardized pharmacy internship hour requirements recommended in the National Association of Board of Pharmacy Model Rules for Pharmacy Interns; further,

- To support structured requirements, goals, and objectives for pharmacy internship experiences, in alignment with requirements for introductory and advanced pharmacy practice experiences; further,

- To promote and expand new staffing models that foster expanded roles for pharmacy interns, providing work experiences that build upon their knowledge and help them develop as future pharmacists.

The Council recommended amending the first clause to recognize the work of the National Association of Boards of Pharmacy in developing Model Rules for Pharmacy Interns. The Council recognizes that the development piece has been accomplished and there is opportunity for all state boards of pharmacy to adopt the full recommendations for pharmacy internship hours outlined in the National Association of Boards of Pharmacy Model Act.

### 7. Zero Tolerance of Harassment and Discrimination

1. To assert that the pharmacy workforce has a right to expect and responsibility to ensure a profession in which all individuals are treated with respect and civility, free of all harassment and discrimination, including but not limited to sexual harassment and malicious behaviors; further,

2. To commit to a culture of responsibility and accountability within the profession with zero tolerance of harassment and discrimination; further,

3. To foster the development of tools, education, and other resources to promote such a culture.
Rationale
The Code of Ethics for Pharmacists states that “A pharmacist acts with honesty and integrity in professional relationships.” The ASHP Statement on Professionalism includes among the elements of professionalism pride in and service to the profession, conscience and trustworthiness, and ethically sound decision-making. All forms of discrimination (e.g., race, color, sex, national origin, religious, sexual orientation/identity, age, disability), harassment (including sexual harassment), and malicious behaviors such as bullying, intimidation, or exploitation go against the core beliefs of the profession. All members of the pharmacy workforce have a professional responsibility to create and sustain a culture of responsibility and accountability within the profession in which all individuals are treated with respect and civility, with zero tolerance of harassment and discrimination.

A culture of responsibility and accountability requires that employers and organizations establish mechanisms for retaliation-free reporting of harassment and discrimination. For such a culture to thrive, the pharmacy workforce must recognize its professional obligation to not only follow institutional policies regarding prevention, reporting, and consequences for such behaviors but to seek out ways to improve the effectiveness of those policies and procedures. This culture of responsibility and accountability includes the workplace and learning environments but extends even to such personal but quasi-public conduct as interactions on social media. As stated in the ASHP Statement on the Use of Social Media by Pharmacy Professionals, the “higher standards of conduct expected of professionals, even in personal behavior” imply that “[p]ostings on social media should be subject to the same professional standards and ethical considerations as other personal or public interactions.”

As stated in the ASHP Statement on Professionalism, “[o]ne of the fundamental services of a professional is recruiting, nurturing, and securing new practitioners to that profession’s ideals and mission.” Formal and informal mentorship relationships are fundamental to the growth and health of any profession, and abuses of those positions of trust are especially injurious to victims and the profession. These relationships should be subjected to the strictest scrutiny and oversight to ensure they are held to the highest standards of conduct.

To further the goal of creating and sustaining a culture of responsibility and accountability regarding harassment and discrimination, ASHP commits to fostering the development of tools, education, and other resources to help members, employers, and other organizations address these important issues.

Background
Recent events in society and the pharmacy profession have drawn attention to sexual harassment, discrimination, and malicious behaviors. The Council reviewed ASHP policy position 1916, Intimidating and Disruptive Behaviors, and the ASHP Statement on Professionalism to determine whether ASHP policy fully addresses these issues. Although these policies include relevant elements, the Council concluded that ASHP and its members would benefit from policy that more directly and clearly expresses ASHP’s stance on sexual harassment, discrimination, and malicious behaviors. The Council recognized the ASHP’s webinar series “Creating Respectful Organizations: Your Rights and Responsibilities” served as an example of how ASHP is already providing resources to help members, employers, and other organizations address these important issues.
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.

Jamie S. Sinclair, Board Liaison

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Daniel Dong (California)
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Bonnie Levin (Maryland)
Christopher Scott (Indiana)
Eric Maroyka, Secretary

1. Patient Experience

To encourage the pharmacy workforce 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 the pharmacy workforce 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 promote use of interactive patient technology (e.g., self-learning teaching resources) to augment patient experience and help prioritize and improve the effectiveness of pharmacy services; further,

To facilitate a dialogue with and encourage education of patient experience database vendors to include the value of pharmacy services in the patient experience.
Rationale
A major component of quality of healthcare is patient satisfaction (often referred to as “the patient experience”), which is critical to how well patients respond and adhere to healthcare. Research has identified a clear link between patient outcomes and a positive patient experience. Additionally, the patient experience 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 an improved patient experience with their care across the continuum of practice sites, including how pharmacists contribute to team-based care.

A study detailed in a white paper by The Beryl Institute found that hospitals using interactive technology to communicate with patients saw improvement in patient satisfaction scores. Interactive patient technology gives patients faster access to hospital staff and services, including access to health education information about the care they receive and the steps they need to take after discharge. Hospitals using interactive technology realize tangible benefits, which translate into significant, measureable improvements in patient outcomes, the hospital’s financial performance, and greater patient engagement, making for an exceptional patient experience.

Background
The Council reviewed ASHP policy 1616, Patient Experience, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To encourage pharmacists the pharmacy workforce 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 the pharmacy workforce 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 promote use of interactive patient technology (e.g., self-learning teaching resources) to augment patient experience and help prioritize and improve the effectiveness of pharmacy services; 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.

The Council made several minor changes throughout the policy to make it more inclusive of the entire pharmacy workforce to recognize their contributions to the patient experience.

2. Minimizing the Use of Abbreviations

1. To support efforts to minimize the use of abbreviations in healthcare; further,

2. To encourage education of healthcare professionals and learners (e.g., residents, students) on minimizing the use of abbreviations across all patient care settings.

Note: This policy would supersede ASHP policy 0604.

Rationale

Although there are anecdotal examples of medical abbreviations causing harm to patients, there is little good clinical evidence to demonstrate that medical abbreviation use is dangerous or is causing problems in the delivery of care. Nevertheless, minimizing or even eliminating the use of medical abbreviations in healthcare has been encouraged for decades. The Institute of Safe Medication Practices regularly receives reports of errors, some of which have resulted in adverse events, due to misinterpretation of medical abbreviations. The Joint Commission has regularly issued updates and guidance on the safe use of medical abbreviations and has also published a short list of dangerous medical abbreviations and dose expressions that should never be used. However, despite many key organizations discouraging the use of medical abbreviations, they continue to be used at an alarming rate. Such use can place new practitioners at great risk when they have to interpret the abbreviations, as the new practitioner may have limited knowledge about what the abbreviations mean.

Background

The Council reviewed ASHP policy 0604, Minimizing the Use of Abbreviations, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

To support efforts to minimize the use of abbreviations in health care; further,

To collaborate with others in the development of a lexicon of a limited number of standard drug name abbreviations that can be safely used in patient care.

To encourage education of healthcare professionals and learners (e.g., residents, students) on minimizing the use of abbreviations across all patient care settings.
The Council suggested ASHP provide education and resources for healthcare professionals, students, and residents to help ensure they are equipped to identify and minimize or even eliminate the use of medical abbreviations in practice. The Council reviewed ASHP policy 0720, Standardizing Prefixes and Suffixes in Drug Product Names, as part of the background for this topic discussion and proposed that ASHP heighten its advocacy regarding its collaborative efforts to standardize drug prefixes and suffixes.

3. Pharmacy Services for Uninsured and Underinsured Patients

1. To support the principle that all patients have the right to receive care from pharmacists; further,

2. To declare that pharmacists should play a leadership role in ensuring access to pharmacists' services for indigent or low-income patients who lack insurance coverage or are underinsured; further,

3. To encourage the pharmacy workforce to work with organizational patient assistance, case management, and care coordination teams to ensure seamless patient care transitions for all patients, including uninsured and underinsured patients; further,

4. To advocate better collaboration among health systems, community health centers, state and county health departments, and the federal Health Resources and Services Administration in identifying and addressing the needs of indigent and low-income patients who lack insurance coverage or are underinsured.

Note: This policy would supersede ASHP policy 0101.

Rationale
Consistent with ASHP Practice Advancement Initiative 2030 themes for change, patients must have access to: 1) a pharmacist in all settings of care; 2) a collaborative, interprofessional care team that coordinates seamless, convenient, and cost-effective care transitions; and 3) a collaborative, interprofessional care team that identifies, assesses, and resolves barriers to medication access, adherence, and health literacy. These principles apply even for patients who lack insurance coverage or are underinsured. Pharmacists and pharmacy technicians should take leadership roles in ensuring access to pharmacists' services for these patients, working with organizational patient assistance, case management, and care coordination teams to ensure seamless patient care transitions for this vulnerable population. Further, community health centers, state and county health departments, and the federal Health Resources and Services Administration should collaborate in identifying and addressing the needs of these patients.
### Background

The Council reviewed ASHP policy 0101, Pharmacy Benefits for the Uninsured, as part of sunset review and voted to recommend amending it as follows (underline indicates new text; strikethrough indicates deletions):

- To support the principle that all patients have the right to receive care from pharmacists; further,

  - To declare that health-system pharmacists should play a leadership role in ensuring access to pharmacists' services for indigent or low-income patients who lack insurance coverage and for patients who or are underinsured; further,

  - To encourage the pharmacy workforce to work with organizational patient assistance, case management, and care coordination teams to ensure seamless patient care transitions for all patients, including uninsured and underinsured patients; further,

  - To advocate better collaboration among health systems, community health centers, state and county health departments, and the federal Health Resources and Services Administration (HRSA) in identifying and addressing the needs of indigent and low-income patients who lack insurance coverage and for patients who or are underinsured.

The Council suggested the title be revisited to include the underinsured population and to reflect that the policy concerns pharmacy services rather than benefits.
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.

Kristina L. Butler, Board Liaison

Council Members
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Amanda Hansen, Vice Chair (Ohio)
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Karl Gumpper (Massachusetts)
Barbara Hintzen (Minnesota)
Molly Leber (Connecticut)
Karen McConnell (Colorado)
Alex Mersch (Iowa)
Christopher Pack (Oklahoma)
Kuldip Patel (North Carolina)
Brittany Riley (West Virginia)
Jamielynn Sebaaly (North Carolina)
Kenny (Jon) Wilson, Student (Alabama)
Anna Legreid Dopp, Secretary

1. Standardized Documentation and Attribution of Clinical Interventions by Pharmacists

1. To promote the use of standardized documentation of clinical interventions by pharmacists in a patient’s health record to improve patient outcomes and allow for the attribution of pharmacist services across the continuum of care; further,

2. To advocate for the standardization in the measurement of clinical interventions by pharmacists on patient outcomes.

Rationale
ASHP has advocated for the importance of documentation of pharmacist care in patient medical records to ensure accurate and complete documentation of the care and services provided to the patient. However, differences in pharmacy practice within and across health systems make it hard to standardize such documentation in the electronic health record (EHR). The differences are caused by diverse clinical practices, EHR permissions, and documentation elements of the clinical interventions made by pharmacists. Documentation by the pharmacist may change depending on care settings, the value of intervention, or in respect to reimbursement. As a result, it is hard to validate and evaluate pharmacists’ impact on patient outcomes due to the incomplete measurement and attribution of such interventions and lack of standardized documentation.
Other healthcare providers have released similar statements on documentation within their fields. The American College of Physicians states that physicians should define professional standards regarding clinical documentation and use macros and templates appropriately (Kuhn T, Basch P, Barr M et al. Clinical documentation in the 21st century: executive summary of a policy position paper from the American College of Physicians. *Ann Intern Med.* 2015; 162:301-3). The American Nurses Association (ANA) Principles for Nursing Documentation states that if patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient’s care to use the documentation (ANA’s Principles for Nursing Documentation: Guidance for Registered Nurses. 2010. www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf). The American Speech-Language-Hearing Association (ASHA) states that speech-language pathologists should participate in the development of the templates that they will use for billing and clinical documents so that the information that is necessary is provided (ASHA. Documentation in health care. www.asha.org/PRPSpecificTopic.aspx?folderid=8589935365&section=References).

Other healthcare providers have recognized the benefits of requiring their documentation to be recorded in a standardized form that allows other healthcare stakeholders to quickly access the information. Employing accessible, standardized documentation improves communication and knowledge sharing between providers. Pharmacists are valuable members of the healthcare team that contribute significantly to patient care. More consistency and standardization of a pharmacist’s documentation can provide essential information on a patient’s care, such as therapeutic drug monitoring, appropriateness and effectiveness of patient’s medications, or pain and antibiotic management, for example. Standardized notes enable healthcare team members to review the pharmacist note and become aware of the medication plan. Implementing standardized documentation across all healthcare providers, especially pharmacists, will allow for increased interactions and information to be shared between healthcare providers to improve overall patient care.

Implementing a standardized clinical pharmacy documentation system will also inform and enable a measurement approach for evaluation of the impact of pharmacist services. Many institutions use different tools for operational internal and external benchmarking to meet these measures; however, the tools are limited in their use for clinical benchmarking (Rough SS, McDaniel M, Rinehart JR. Effective use of workload and productivity monitoring tools in health-system pharmacy, pt 1. *Am J Health Syst Pharm.* 2010; 67:300–11). Institutions have tried to implement their own clinical pharmacy productivity measures tools to help demonstrate the value of de-centralized pharmacists on patient care teams. However, no current measure or measure set accurately identifies the impact pharmacists have on patient care outcomes or allows comparison and benchmarking across institutions. In response to this need, the ASHP Pharmacy Accountability Measures (PAM) Work Group seeks to identify pharmacy-related clinical quality measures that institutions could use for benchmarking (Andrawis MA, Carmichael J. A suite of inpatient and outpatient clinical measures for pharmacy accountability: recommendations from the Pharmacy Accountability Measures Work Group. *Am J Health Syst Pharm.* 2014; 71:669-78).
The PAM Workgroup evaluated quality measures endorsed by the National Quality Forum (NQF) and curated those selected into six therapeutic areas, which include antithrombotic safety, cardiovascular control, glycemic control, pain management, behavioral health, and antimicrobial stewardship (Andrawis M, Ellison C, Riddle S et al. Recommended quality measures for health-system pharmacy: 2019 update from the Pharmacy Accountability Measures Work Group. *Am J Health Syst Pharm*. 2019; 76:874–87). Using the NQF-endorsed measures along with appropriate documentation of these interventions may allow institutions to more readily benchmark performance.

After determining the most appropriate pharmacy quality measures, the documentation of the interventions should be standardized and efficient. Implementing standardized templates and more retrievable data fields in the documentation process has been shown to improve workflow for pharmacists. One study demonstrated that by implementing EHR note templates that allowed retrievable data to be incorporated, pharmacists increased the amount of time providing value-added services from 47% to 72% and in providing direct patient care from 27% to 53% (Ekstrand MJ, Kobany JM, Pestka DL. Leveraging quality improvement principles in comprehensive medication management pharmacy practice: a case example. *J Am Pharm Assoc*. 2020; 60:509-15.e1.).

Finally, pharmacists must also be properly educated on how to use a standardized pharmacy documentation system. In one study, a health system that had implemented an improved pharmacist clinical intervention documentation system found that a focused education initiative increased the number of pharmacy clinical interventions 120%, and associated cost avoidance dollars increased proportionally (Rector KB, Veverka A, Evans SK. Improving pharmacist documentation of clinical interventions through focused education. *Am J Health-Syst Pharm*. 2014; 71:1303–10). Overall, research has shown that focused education has helped increase the number of clinical interventions documented in a standardized way, leading ultimately to better care for patients and demonstrating the value of pharmacy services.

**Background**

The Council considered the topic at the suggestion of ASHP members and staff. Dr. McConnell reviewed a presentation she gave on the topic at the 2019 Midyear Clinical Meeting. Dr. Pack also pointed to similar approaches used for clinical pharmacy services in the Indian Health Service. Council members reviewed ASHP Policy 1419, *Documentation of Patient Care Services in the Permanent Health Record*, and felt a new policy was still warranted based on the topic of interest. The Council saw a great deal of alignment between the work of the PAM Workgroup and efforts to implement standardized documentation of clinical pharmacist interventions. The Council also voted to work with other ASHP component bodies to establish a workgroup to develop standardized clinical pharmacy documentation and metrics (e.g., key performance indicators) and to write a commentary for submission to *AJHP* regarding the need for standardized clinical pharmacy documentation and metrics.
2. Patient Access to Pharmacy Services in Small and Rural Hospitals

To advocate that critical-access hospitals (CAHs) and small and rural hospitals meet national medication management and patient safety standards, regardless of size or location; further,

To provide resources and tools to assist pharmacists who provide services to CAHs and small and rural hospitals in meeting standards related to safe medication use; further,

To promote allocation policies that address the unique challenges faced by CAHs and small and rural hospital pharmacies in procuring medications and supplies.

Note: This policy would supersede ASHP policy 1022.

Rationale
State legislation has sometimes exempted small or rural hospitals from requirements applied to others. For example, Texas has exempted hospitals with fifty or fewer beds in remote locations from requiring prospective medication order review by a pharmacist. Pharmacist prospective order review is a well-supported safety practice that is required by the Centers for Medicare & Medicaid Services Conditions of Participation, Joint Commission accreditation standards for hospitals, and in state practice acts. ASHP policy supports pharmacist prospective order review as a minimum standard for pharmacies in hospitals and a consistent standard of care for all patients regardless of where that care is provided. Furthermore, ASHP encourages under-resourced facilities, including rural settings, to employ alternative strategies, such as expanded use of telehealth and pharmacy technicians, to meet the challenges they face. In addition, ASHP recognizes that one of the challenges faced by these hospital is industry allocation practices (e.g., allocations based on previous purchases) and restrictive distribution criteria (e.g., requiring specific facilities, equipment, or staff) that reduce access to medications and other resources in times of critical need. ASHP advocates that those allocation practices be made more flexible to meet patient needs, especially in times of crisis.

Background
The Council reviewed ASHP policy 1022, Patient Access to Pharmacy Services in Small and Rural Hospitals, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text):

To advocate that critical-access hospitals (CAHs) and small and rural hospitals meet national medication management and patient safety standards, regardless of size or location; further,

To provide resources and tools to assist pharmacists who provide services to CAHs and small and rural hospitals in meeting standards related to safe medication use; further.
To promote allocation policies that address the unique challenges faced by critical-access hospitals (CAHs) and small and rural hospital pharmacies in procuring medications and supplies.

The Council recognized that one of the foremost challenges facing CAHs and small and rural hospitals, especially in a time of pandemic, is medication and supply allocation policies that prevent them from responding as needed in times of crisis and recommended amending the policy to promote more flexible industry allocation policies.

### 3. Integrated Approach for the Pharmacy Enterprise

To discontinue ASHP policy 1618, Integrated Approach for the Pharmacy Enterprise, which reads:

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

2. 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.

#### Background

The Council reviewed the policy as part of sunset review and recommended discontinuing it because it is redundant with the *ASHP Minimum Standard for Pharmacies in Hospitals*, *ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive*, *ASHP Statement on Leadership as a Professional Obligation*, and *ASHP–SHM Joint Statement on Hospitalist–Pharmacist Collaboration*.

### 4. Pharmacist Role in Medication Reconciliation

To discontinue ASHP policy 1117, Pharmacist Role in Medication Reconciliation, which reads:

1. To affirm that an effective process for medication reconciliation reduces medication errors and supports safe medication use by patients; further,

2. To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in interdisciplinary efforts to develop, implement, monitor, and maintain effective medication reconciliation processes; further,
To encourage community-based providers, hospitals, and health systems to collaborate in organized medication reconciliation programs to promote overall continuity of patient care; further,

To declare that pharmacists have a responsibility to educate patients and caregivers on their responsibility to maintain an up-to-date and readily accessible list of medications the patient is taking and that pharmacists should assist patients and caregivers by assuring the provision of a personal medication list as part of patient counseling, education, and maintenance of an individual medical record.

**Background**
The Council reviewed the policy as part of sunset review and recommended discontinuing it because it is redundant with the *ASHP Statement on the Pharmacist’s Role in Medication Reconciliation*. 
The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice. 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.

Nishaminy Kasbekar, Board Liaison

Council Members
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Rusol Karralli, Vice Chair (Texas)
Charzetta James (Florida)
Brian Kawahara (California)
Bernice Man (Illinois)
Emily McTish (South Carolina)
Luke Miller (Texas)
Matthew Pond (Arizona)
Adam Porath (Nevada)
Jeffrey Schnoor (Vermont)
Elizabeth Shlom (New York)
Elizabeth Rodman (Maryland)
Jillanne Schulte Wall, Secretary

1. Pharmacist Involvement in the Strategic National Stockpile

To advocate for the inclusion of pharmacist expertise in the development and maintenance of the Strategic National Stockpile (SNS); further,

To advocate for transparency and improvement of SNS processes, including standardization of the request process and enhanced periodic review of SNS contents; further,

To advocate that pharmacists lead distribution of medications and related supplies requested from the SNS.

Rationale
The depletion of the Strategic National Stockpile (SNS) during the COVID-19 pandemic presents an opportunity to significantly improve SNS operations. Pharmacists should be engaged in determining which medications and supplies are included in the SNS, as well as how to maintain quality and ensure the stock remains up to date.

At the outset of the pandemic, hospitals and health systems struggled to make requests to the SNS for both medications and supplies. Because there was not a clear mechanism for making requests, with the process varying among states, even sharing tips and best practices between providers was not always helpful. The SNS should increase transparency regarding
stock and should implement a single consistent process for making requests. Providers should not have to devote huge amounts of time to making SNS requests in the midst of an emergency – and there should be a mechanism for quickly checking on the status of SNS requests to avoid additional wasted time.

Finally, to streamline processes, the SNS should have a standard distribution logistics process for medications and related supplies centered on pharmacists. Ensuring that pharmacists receive distributions of medications and related supplies will allow them time to prepare storage space (e.g., freezer space for remdesivir) and ensure proper storage and handling of products.

**Background**

Based on experiences trying to make requests to the SNS during the pandemic, the Council considered policy regarding pharmacist engagement in the stocking and maintenance of the SNS, as well as policy regarding provider preparation of stock in emergency situations. With no existing ASHP policy specific to the SNS, the Council felt the time was ripe for a new policy devoted to pharmacist engagement and overall transparency. In addition to discussing their own experiences with SNS requests, the Council’s discussion was also informed by presentations during the Joint Council and Commission Meeting, which bluntly covered the shortfalls of the current SNS system, including the lack of a coherent, singular request process.

In addition to the proposed policy, the Council also provided other recommendations for ASHP action on SNS, including:

- Development of a tool kit for pharmacy enterprise leaders;
- Appointment of a dedicated ASHP liaison for SNS relations and requests; and
- Revision of the *ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness* to reflect SNS engagement, and/or publish an *AJHP* article regarding pharmacist engagement in the SNS.

### 2. Medication Price-Gouging Laws

1. To advocate for price-gouging laws that include medications.

   *Note: This policy would supersede ASHP policy 1622.*

**Rationale**

Price gouging, whether due to shortages or other causes, can result in trafficking in counterfeit and diverted 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 on medications, 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. ASHP advocates for laws that specifically address price gouging on medications at any time, rather than predicking action on a triggering event, such as a disaster or shortage.


**Background**
The Council reviewed ASHP policy 1622, Inclusion of Drug Product Shortages in State Price-Gouging Laws, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; strikethrough indicates deletions):

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

Although the Council felt that advocacy is still needed to combat price gouging, they agreed that the focus on drug shortages felt too narrow. They also questioned the somewhat passive language of the policy and the focus on working with attorneys general to amend existing laws. They were particularly concerned that changing existing laws would result in a patchwork effect, as not all states have price-gouging laws on the books. The Council recommended that the policy be simplified to apply broadly, and to advocate simply for new laws against price gouging on medications in any situation.

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**3. Redistribution of Unused Medications**

To discontinue ASHP policy 0611, Redistribution of Unused Medications, which reads:

1. To advocate that any program for the return and reuse of medications comply with all federal and state laws (including laws regarding controlled substances); further,

   - To advocate that in order to ensure patient safety and provide an equal standard of care for all patients, such a program should include the following elements: (1) compliance with practice standards, accreditation standards, and laws related to prescription dispensing; (2) a requirement that these medications must not have been out of the possession of a licensed health care professional or his or her designee; (3) protection of the privacy of the patient for whom the prescription was originally dispensed; (4) inclusion of only those drug products that are in their original sealed packaging or in pharmacy-prepared unit-of-use packaging that is not expired and has been properly stored; (5) the presence of a system for identifying medications for the purpose of a drug recall or market withdrawal; (6) a definition of patient eligibility for participation in the program; and (7) adequate compensation of participating pharmacists for any associated costs.

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**Background**
The Council devoted significant time to reviewing this policy and felt that, as currently written, it opens pharmacists up to liability. For that reason, they voted to discontinue the policy, with a plan to develop new policy during its winter 2021 call.

Specifically, the Council was very concerned that the “return and reuse” language in the
first clause could create risk for pharmacists. The Council was concerned that the language was inconsistent with clause two requiring that “medications must not have been out of the possession of a licensed health care professional or his or her designee.” It was unclear how a medication could be “returned” if it had always been in the possession of a healthcare professional. There were also concerns about how medication could be redispensed without proper documentation of provenance/pedigree. Overall, after extensive discussion, the Council felt that even with due diligence, under the current policy, it would be impossible to keep patients safe, and therefore the policy should be discontinued.

The Council will revisit this issue during its winter 2021 call. The Council has suggested that rather than creating a new policy, a better approach would be to have a best practice guide that can provide a more in-depth overview of what is acceptable in terms of redistribution policy. Additionally, more information must be provided in either a new policy statement or new best practice guide regarding transparency to the patient regarding the provenance of any redistributed medication.