

House of Delegates

REPORT ON PROPOSED AMENDMENTS

June 2021 Meetings

(updated as of June 5, 9:00 a.m. EDT)

This report contains proposed amendments to policy recommendations submitted through the [Amending Language Form](#) for consideration at the First Meeting of the House. Delegates may still submit proposed amendments from the floor at the First Meeting of the House.

Council on Therapeutics 1: Universal Influenza Vaccination

No amendments have been proposed for this policy recommendation.

To advocate for universal annual administration of influenza vaccinations to the United States population; further,

To advocate that annual influenza vaccination be a national public health priority; further,

To support the development of safe, effective, and affordable universal influenza vaccination, with the goal of long-term immunity.

Note: This policy would supersede ASHP policy 0601.

Council on Therapeutics 2: Vaccine Hesitancy

Amendment proposed by Rena Gosser (WA):

To recognize the ~~significant negative impact vaccine hesitancy has on~~ importance of vaccination to public health in the United States; further,

To affirm that ~~pharmacists~~ members of the pharmacy workforce are integral members of the interprofessional team to ~~address vaccine hesitancy and~~ promote disease prevention efforts and health equity through vaccine confidence and access; further,

To foster education, training, and the development of resources to assist healthcare professionals in building vaccine confidence ~~identifying factors that lead to vaccine hesitancy and addressing vaccine hesitancy~~; further,

To promote ~~pharmacist~~ pharmacy workforce engagement with ~~vaccine-hesitant~~ patients, healthcare providers, and caregivers, and to educate ~~those populations~~ patients on the risks of vaccine hesitancy and the importance of timely vaccination.

[Note that title will change to “Vaccine Confidence” if amendment is approved.]

Council on Therapeutics 3: Therapeutic Indication in Clinical Decision Support

Amendment proposed by David Hager (WI) and Kevin Marvin (VT):

To encourage healthcare organizations to optimize use of clinical decision support systems with indications-based prescribing; further,

To advocate to the Food and Drug Administration, the National Council for Prescription Drug Programs, and other organizations to select and implement a single standard coding system for labeled therapeutic indications that can be integrated throughout the medication-use process, enabling optimum clinical workflows and decision support functionality; further,

To advocate for federal and state laws and regulations to include diagnosis-based indication(s) on medication order(s) or prescription(s), ~~with the exception of protected classes of drugs~~; further,

To advocate for federal and state laws and regulations to allow withholding of indication on medication prescription labels when patient privacy risk outweighs benefit.

Note: This policy would supersede ASHP policy 1608.

Council on Therapeutics 4: Preventing Exposure to Allergens

Amendment proposed by Katherine Miller (KS):

To advocate for ~~pharmacist~~ pharmacy workforce participation in the collection, assessment, documentation, and reconciliation of a complete list of allergens and intolerances pertinent to medication therapy, including food, excipients, medications, devices, and supplies; further,

To promote the education of the healthcare team and patients on the differences between medication-related allergic reactions and medication intolerances; further, [MOVED FROM BELOW]

To encourage vendors of electronic health records to create readily available and distinct data

fields with consistent designations for medication allergies and intolerances; further,

To advocate that vendors of medication-related databases incorporate and maintain information about medication-related allergens and cross-reactivity; further,

To encourage the accurate and complete documentation of allergens and intolerances within the electronic medical record, including detailed descriptions of the reactions occurring upon exposure, for the purpose of clinical decision-making; further,

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

~~To promote the education of the healthcare team and patients on the differences between medication-related allergic reactions and medication intolerances. [MOVED ABOVE]~~

Note: This policy would supersede ASHP policy 1619.

Council on Therapeutics 5: Tobacco, Tobacco Products, and Electronic Nicotine Delivery Systems

Amendment proposed by Katherine Miller (KS):

To discourage ~~the patient use, of tobacco, tobacco products, and electronic nicotine delivery systems (e.g., vaporizers, vape pens, hookah pens, and electronic cigarettes and pipes) due to their long-term adverse health effects; further,~~

~~To oppose the 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 legislation that supports pharmacist prescriptive authority for tobacco-cessation medications; further,

To promote the ~~role of~~ pharmacist's interdisciplinary role in tobacco-cessation counseling and medication therapy management; further,

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

Council on Therapeutics 6: Use of Race Correction in Clinical Algorithms

No amendments have been proposed for this policy recommendation.

To recognize that clinical algorithms that only use race or ethnicity as a variable can attribute to inequities and adverse outcomes; further,

To oppose the use of race or ethnicity correction in clinical algorithms unless there is strong evidence to support its use; further,

To advocate that health systems remove algorithms based on race or ethnicity from all sources of therapy decisions, medication information, and the electronic health record, where strong evidence does not support its use; further,

To support further research on the impact of race or ethnicity on drug therapy and outcomes; further,

To advocate that if research includes considerations based on race or ethnicity, the reason for its use as a variable be specified; further,

To provide education on the limitations and appropriate use of race- or ethnicity-corrected clinical algorithms; further,

To support uniform documentation in the electronic health record of a patient-identified designation of race or ethnicity.

Council on Therapeutics 7: Testing and Documentation of Penicillin Allergy as a Component of Antimicrobial Stewardship

No amendments have been proposed for this policy recommendation.

To advocate that state board of pharmacy regulations include penicillin allergy skin testing under pharmacists' scope of practice; further,

To advocate involvement of pharmacists in the clarification and assessment of penicillin allergy, intolerance, and adverse drug events; further,

To advocate for documentation and de-labeling of penicillin allergies, intolerances, reactions, and severities in the medical record when appropriate to facilitate optimal antimicrobial selection; further,

To recommend the use of penicillin skin testing, graded antibiotic challenges, and oral direct challenges in appropriate candidates when clinically indicated to optimize antimicrobial

selection; further,

To support the education and training of pharmacists in the assessment, management, and documentation of penicillin allergies, intolerances, and adverse events; further,

To advocate for reimbursement for pharmacists' patient care services involved in penicillin allergy skin testing; further,

To educate patients, healthcare providers, and the public about the risks of inaccurate penicillin allergy labeling and the role of pharmacists in health-record reconciliation and the value of pharmacist-driven health-record reconciliation, including penicillin skin testing.

Note: This policy would supersede ASHP policy 1921.

Council on Therapeutics 8: Use of Unapproved Gene Therapy Products, Drugs, Biologics, and Medical Devices (Biohacking)

No amendments have been proposed for this policy recommendation.

To advocate for enhanced government oversight and regulation of use of gene therapy, drugs, biologic products, and medical devices created outside of the Food and Drug Administration approval process (i.e., "biohacking"), and aggressive enforcement of those regulations; further,

To oppose use of biohacking on vulnerable and at-risk populations and those unable to provide consent; further,

To promote education of healthcare professionals regarding use of biohacking and its implications in the medical setting; further,

To encourage the pharmacy workforce to include questions about use of biohacking when obtaining medication histories; further,

To encourage the pharmacy workforce to ensure that patients using biohacking are educated about the risks and benefits of these treatments, including lack of regulatory oversight; further,

To recommend that health systems use a consistent method for documenting use of biohacking in the electronic health record.

Council on Education and Workforce Development 1: Professional Identity Formation

Amendment proposed by Katherine Miller (KS):

To encourage the pharmacy workforce and pharmacy education and training programs to foster professional identity formation, 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) service to humanity, (4) a just and inclusive healthcare system and society, (5) analytical thinking and ethical reasoning, (6) continuing professional development, (7) acquisition of personal leadership skills, (8) development of effective interpersonal skills, (9) maintenance of personal well-being and resiliency, and (10) membership and participation in professional organizations.

Note: This policy would supersede ASHP policy 1113.

Council on Education and Workforce Development 2: Career Opportunities for Pharmacy Technicians

No amendments have been proposed for this policy recommendation.

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

To advocate that pharmacy technicians complete an education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE), and maintain Pharmacy Technician Certification Board certification; further,

To advocate that pharmacy technicians complete ACPE-approved certificate programs that provide training for their current or anticipated roles; further,

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

To encourage employers to offer career advancement opportunities (e.g., career ladders) for pharmacy technicians; further,

To urge compensation for pharmacy technicians commensurate with advanced roles and responsibilities.

Note: This policy would supersede ASHP policy 1610.

Council on Education and Workforce Development 3: Zero Tolerance of Harassment and Discrimination

Amendment proposed by Rena Gosser (WA):

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~~ with zero tolerance for all forms of harassment, and discrimination, including but not limited to sexual harassment and malicious behaviors; further,

To commit to a culture of responsibility and accountability within the profession, and promote anti-retaliation policies and timely follow-up with zero tolerance of harassment and

~~discrimination~~; further,

To ~~foster the development of~~ tools, education, and other resources to ~~promote~~ ensure such a culture.

Council on Pharmacy Management 1: Minimizing the Use of Abbreviations

Amendment proposed by Jesse Hogue (MI) and Kevin Marvin (VT):

To support efforts to standardize and minimize the use of abbreviations in healthcare; further,

To oppose use of abbreviations when communicating with patients to enhance transparency and understanding; further,

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.

Council on Pharmacy Management 2: Optimal Pharmacy Staffing

No amendments have been proposed for this policy recommendation.

To encourage pharmacy leaders to work in collaboration with physicians, nurses, health-system administrators, and others to outline key pharmacist services that are essential to safe and effective patient care and employee engagement; further,

To encourage pharmacy leaders to be innovative in their approach and to factor into their thinking the potential benefits and risks of flexible staffing models, telehealth practices, legal requirements, accreditation standards, professional standards of practice, and the resources and technology available in individual settings; further,

To encourage pharmacy leaders to develop contingency plans for changes in staffing models to accommodate rapid changes in the healthcare environment and the needs of patients and staff; further,

To encourage pharmacy leaders to develop key performance indicators to support safe staffing models.

Note: This policy would supersede ASHP policy 2034.

Council on Pharmacy Management 3. Patient Access to Pharmacist Care Within Provider Networks

Amendment proposed by Roger Woolf (WA) and Steven Gray (CA):

To advocate for laws and regulations that require healthcare payer provider networks to include pharmacists and pharmacies providing patient care services within their scope of practice when such services are covered benefits; further,

To advocate for laws and regulations that require healthcare payer provider networks to ~~include~~ consider all qualified pharmacists and pharmacies who apply to participate as a provider in the network and to reimburse all participating providers fairly and equitably for services that are a covered benefit; further,

To acknowledge that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality and viability of healthcare services provided; further,

To advocate for laws and regulations that would help ensure the same level of patient care within a payer network by requiring healthcare payers to (1) disclose to participating providers and those applying to participate the criteria used to include, retain, or exclude providers; (2) ensure that those criteria are standardized across all network providers; and (3) collect data on how well providers meet those criteria and report that data to providers; further,

To advocate for comparative, transparent sharing of performance and quality measure data based on those criteria.

Note: This policy would supersede ASHP policy 1808.

Council on Pharmacy Management 4. ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

Amendment proposed by Don Kishi (CA):

To approve the ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive (please see Appendix A for proposed amendments).

Council on Pharmacy Practice 1: Role of the Pharmacist and Pharmacy Technician in Pandemic Preparedness and Response

Amendment proposed by Jesse Hogue (MI):

To advocate that all healthcare organizations include pandemic preparedness in emergency preparedness planning; further,

To encourage all healthcare organizations to be actively engaged with their regional healthcare coalitions and to promote collaboration and communication among healthcare workers, healthcare organizations, government agencies, industry, and other stakeholders in pandemic preparedness and response; further,

To promote pharmacy workforce involvement in networks at the federal, state, local and institutional levels for emergency response; further,

To advocate that pharmacy personnel be included as leaders on teams responsible for pandemic preparedness planning and response at the federal, state, local, and institutional levels, and that they integrate such planning into emergency preparedness planning for their workplaces; further,

To encourage all healthcare organizations to establish criteria for evidence-based medication-use decisions, even when such evidence is scarce, incomplete, or conflicting, and recognize the unique role that pharmacy personnel have in ensuring the safe and effective use of medications based on best available evidence and resources; further,

To advocate that healthcare organizations recognize the unique and collective stress a pandemic places on healthcare workers and provide suitable resources to maintain workers' well-being and resilience; further,

To support research on and provide resources and education to aid the pharmacy workforce in preparing for and responding to pandemics.

[Note that title will change to “Role of the Pharmacy Workforce in Pandemic Preparedness and Response” if amendment is approved.]

Council on Pharmacy Practice 2: Role of the Pharmacy Workforce in Supporting Patient Access to Medical Supplies

No amendments have been proposed for this policy recommendation.

To support patient access to medical supplies as part of a comprehensive treatment plan; further,

To advocate for policies that empower pharmacy personnel to facilitate patient access to and effective use of medical supplies, including reimbursement policies; further,

To educate pharmacists, other healthcare professionals, payers, and policymakers about the role of pharmacy personnel in helping patients obtain and use medical supplies; further,

To collaborate with other healthcare professional and patient advocacy organizations to advocate for expanded patient access to medical supplies.

Note: For purposes of this policy, “medical supplies” includes durable medical equipment, Food and Drug Administration-approved medical devices, and other nondurable disposable healthcare materials.

Council on Pharmacy Practice 3: Standardized Documentation and Attribution of Clinical Interventions by Pharmacists

Amendment proposed by David Hager (WI) and Kevin Marvin (VT):

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

To advocate that documentation by pharmacists in the medical record be used for billing and attribution of value without additional documentation from other clinicians; further,

To advocate for ~~the standardization in the~~ standardized measurement of ~~clinical interventions by pharmacists~~ care provision ~~on~~ and the attribution of those activities to ~~through~~ patient-centered outcomes.

[Note that title will change to “Documentation of Pharmacist Patient Care” if amendment is approved.]

Council on Pharmacy Practice 4: Influenza Vaccination Requirements to Advance Patient Safety and Public Health

Amendment proposed by Gregory Burger (SICP):

To advocate that hospitals and health systems require healthcare workers to receive an annual influenza vaccination in accordance with U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices guidelines ~~except when (1) it is contraindicated, or (2) the worker has religious objections, or (3) the worker signs an informed declination;~~ further,

To encourage the hospital and health-system ~~pharmacists~~ pharmacy workforce to take a lead role in developing and implementing policies and procedures for vaccinating healthcare workers and in providing education on the patient safety benefits of annual influenza vaccination; further,

To work with the federal government and others to improve the vaccine development and supply system in order to ensure a consistent and adequate supply of influenza virus vaccine.

Note: This policy would supersede ASHP policy 0615.

Council on Pharmacy Practice 5: Safe and Effective Extemporaneous Compounding

Nonsubstantive amendments proposed by Mindy Burnworth (AZ):

To affirm that extemporaneous compounding of medications, when done to meet immediate or anticipatory patient needs, is part of the practice of pharmacy and is not manufacturing; further,

To support the principle that medications should not be extemporaneously compounded when ~~they~~ drug products are commercially and readily available in the form necessary to meet patient needs; further,

To encourage ~~pharmacists~~ the pharmacy workforce members who compound medications to use only drug substances that have been manufactured in Food and Drug Administration-registered facilities that have been inspected within the past two years and that meet official United States Pharmacopeia (USP) compendial requirements where those exist; further,

To advocate that all compounding activities meet applicable USP standards and federal and state regulations; further,

To support the principle that ~~pharmacists~~ the pharmacy workforce be adequately trained and have sufficient facilities and equipment that meet technical and professional standards to ensure the quality of compounded medications; further,

To encourage USP to develop drug monographs for commonly compounded preparations; further,

To educate prescribers and other healthcare professionals about the potential risks associated with the use of extemporaneously compounded preparations.

Note: This policy would supersede ASHP policy 0616.

Council on Pharmacy Practice 6: Universal Immunization for Vaccine-Preventable Diseases in the Healthcare Workforce

Amendment proposed by Michelle Eby (WM), Gregory Burger (SICP), and Mindy Burnworth (AZ):

To support policies that promote universal vaccination ~~against~~ for preventable infectious diseases among healthcare workers, including all members of the pharmacy workforce, as a safeguard to patient and public health; further,

To encourage the use of evidence-based risk assessments to determine inclusions and exemptions for mandatory vaccine requirements; further,

To support employers in establishing mandatory vaccine requirements for vaccines approved by the Food and Drug Administration (FDA) and encouraging the use of vaccines that have received FDA emergency use authorization if risk assessments determine it would promote patient and public health; further,

To urge healthcare organizations to have policies that address additional infection prevention practices required for exempted healthcare workers; further,

To ~~foster the development of~~ tools, education, and other resources to ~~reduce~~ promote vaccine confidence ~~hesitancy~~, increase vaccination rates, and prevent vaccine-preventable diseases among healthcare workers.

Council on Public Policy 1: Pharmacist Engagement in and Payment for Telehealth

Amendment proposed by Gregory Burger (SICP):

To advocate for pharmacists' provision of telehealth in all sites of care; further,

To advocate that reimbursement for telehealth be commensurate with the complexity and duration of service and consistent with other healthcare providers ~~sufficient to support the practice.~~

Council on Public Policy 2: Pharmacy Services in a State of Emergency

Amendment proposed by Bernice Man (IL):

To advocate that states ~~boards of pharmacy grant temporary licensure to pharmacists and~~ temporary licensure, registration, or any other necessary state-mandated credential to ~~pharmacy technicians~~ eligible pharmacies and members of the pharmacy workforce during states of emergency; further,

To encourage the expedient licensure or registration for eligible members of the pharmacy workforce during states of emergency; further,

To advocate that state and federal regulatory agencies allow for drug distribution flexibilities necessary to provide patient care during a declared state of emergency.

Task Force on Racial Diversity, Equity, and Inclusion: Bylaws Amendments

No amendments have been proposed for the proposed bylaws amendments.



ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive

1 **Position**

2 Leading hospitals and health systems must have a strategic and innovative pharmacy executive
3 who plans and oversees the design and operation of the entire and complex medication-use
4 process throughout the system. It is essential that this leader report to an executive who can
5 help the leader execute the practice models of tomorrow that include business outside normal
6 hospital practice.

7 As the most knowledgeable leader of the medication-use process, this leader (may be
8 referred to as the “chief pharmacy officer” but hereafter “the pharmacy executive”) proactively
9 aligns pharmacy goals with strategic organizational initiatives to advocate for pharmacy
10 practice advancement and improved patient care. The intrinsic value a pharmacy executive
11 brings to the organization’s enterprise and executive leadership includes the following:

- 12 • Ensuring the enterprise’s strategic planning leverages pharmacy services across the
13 continuum of care to improve health outcomes.
- 14 • Ensuring pharmaceuticals and pharmaceutical benefit designs focus on total health through
15 the formulary, with procurement driven by clinical efficacy.
- 16 • Collaborating with healthcare executives within and external to the health system to foster
17 and build cross-functional relationships and to align interdisciplinary services with initiatives

18 such as quality metrics and financial performance.

19 • Advancing patient care services through the promotion of pharmacy best practices by the
20 creation and adoption of emerging technologies and innovative services.

21 • Ensuring the pharmacy workforce is provided an environment that is free of discrimination
22 and harassment and supportive of diversity, equity, and inclusion.

23

24 **Background**

25 Significant changes in pharmacy practice, healthcare, and health-system management over the
26 past 20 years have dramatically transformed the traditional role of the pharmacy director.¹

27 More widespread use of the title “chief pharmacy officer” was first proposed in 2000 in an
28 attempt to meet these new transformations and to enhance the contribution pharmacy makes
29 to patient care by creating organizational parity between the pharmacy executive and other
30 executive officers (e.g., chief nursing, medical, and information officers).²

31

32 **Responsibilities and value of the pharmacy executive**

33 The pharmacy executive assesses the ever-changing healthcare environment for emerging
34 trends and identifies opportunities to leverage the pharmacy team’s expertise to improve the
35 value of care across the healthcare continuum. Success as a pharmacy executive is predicated
36 on building and maintaining relationships with diverse groups of people in order to be part of
37 setting the overall strategy for the organization. Navigating solid and dotted-line reporting
38 relationships, such as in a matrix organizational structure, requires the pharmacy executive to
39 exercise a wider range of influence and persuasiveness rather than relying on traditional
40 hierarchy and formal control to accomplish objectives. As it relates to patient care and clinical

41 services, the pharmacy executive leads all pharmacists and pharmacy staff across the
42 organization. The pharmacy executive ensures that pharmacists are optimally positioned and
43 resourced to improve the quality, safety, and efficiency of medication management and
44 patient outcomes in the most cost-effective manner. The pharmacy executive leads the
45 pharmacy's financial performance within the context of the broader health system through
46 the evaluation of medication expenditure patterns and reimbursement trends, including
47 value-based reimbursement and purchasing. As reimbursement and revenue capture become
48 increasingly complex, the pharmacy executive can provide leadership across multiple
49 disciplines (e.g., finance, nursing, medicine, pharmacy) to optimize reimbursement from
50 involved government and commercial payment programs and meet metrics for value-based
51 contract requirements.^{3,4} She or he is also responsible for medication access in their
52 organization to ensure patients have the most effective and affordable medications.

53 In performing these responsibilities, the pharmacy executive must bring continuous and
54 evergreen value to the pharmacy team, the health system's executive team, and the
55 organization as a whole. The pharmacy executive establishes key relationships with both
56 internal multidisciplinary executives and external vendors, group purchasing organizations, and
57 manufacturers to elevate services and optimize the pharmaceutical supply chain, respectively.
58 In addition to optimizing the supply chain, the pharmacy executive plays a key role in
59 developing a vision for information and technology solutions in the medication-use process and
60 must work collaboratively with the chief information officer to advance pharmacy informatics
61 and technology. During all phases of a public health emergency or disaster event, pharmacy
62 executive presence in a hospital or health system's emergency operations center is pivotal for
63 proactive planning and maintaining secure, functional, and resilient health and public health

64 critical infrastructure. The pharmacy executive is integral in advancing pharmacy services in the
65 midst of rising competitors, ensuring the vitality of the organization as healthcare transforms.5-
66 7 She or he must maintain a focused effort to acquire, share, and reinvest in their own self-
67 development and the development of the leadership team striving for a continuous pursuit of
68 practice advancement.

69 The pharmacy executive must commit to ensuring a culture in which all individuals are
70 treated with respect and civility and that is conducive to the highest levels of patient care for
71 the organization's workforce. This commitment includes leading a workplace that fosters
72 diversity, equity, and inclusion, with zero tolerance for discrimination and harassment. Ensuring
73 the pharmacy workforce is working in a safe environment and one that is supportive of growth,
74 wellness, and resilience is a critical factor in organizational success in meeting its patient care
75 mission, employee retention, training and recruitment, and ability to advance pharmacy
76 practice.

77

78 **Experience and education of the pharmacy executive**

79 The pharmacy executive is a professionally competent, legally licensed pharmacist with a broad
80 level of experience in health-system pharmacy practice and management and with a strategic
81 vision for the profession. Additional qualifications may include an advanced management
82 degree; a clearly evident successful record of leading people, operations, finance, and clinical
83 services; and completion of a pharmacy residency program accredited by ASHP (e.g., health-
84 system pharmacy administration and leadership residency).

85 What distinguishes the pharmacy executive from the established director of pharmacy
86 position is the increased breadth and depth of the involvement in the health system's strategic

87 planning and decision-making processes at the most senior levels. The pharmacy executive has
88 experience in leading the medication-use process, including optimizing the pharmaceutical
89 supply chain, making evidence-based systematic clinical decisions, supporting medication-
90 management systems and policies, implementing technology to elevate patient care, and
91 optimizing financial performance. The pharmacy executive, therefore, provides pharmacy's
92 unique clinical and business perspectives in decisions related to changes in the medication-
93 management system.⁸⁻¹⁰ To support these changes, the pharmacy executive leverages
94 technology to develop the most cost-effective labor model.

95

96 **Reporting structure**

97 The pharmacy executive has a market-competitive title internally consistent with others
98 reporting at that organizational level, reports directly to the organization's principal executive
99 (e.g., chief executive officer [CEO], chief operating officer [COO]), participates as a member of
100 the medical executive committee, and routinely engages with the health system's executive
101 leadership as well as the board of directors. By working collaboratively with others at this most
102 senior executive level, the pharmacy executive ensures that health-system pharmacy services
103 are optimally positioned to most effectively contribute to the organization's strategic initiatives
104 and address systemwide opportunities. A structure in which pharmacy leadership reports
105 directly to the principal executive rather than through layers of management allows the
106 pharmacy executive to engage in critical decision-making and be more effective and influential
107 in helping the health system anticipate and address rapid change.

108

109 **Conclusion**

110 Optimal patient care, quality health outcomes, and pharmacy practice advancement requires
111 progressive hospitals and health-systems that have an educated pharmacy executive
112 responsible for the strategic planning, design, operation, and improvement of the
113 organization’s pharmacy services across the care continuum. Because of these expected
114 contributions, the pharmacy executive must be properly positioned within the health system’s
115 senior executive management team to ensure that health-system pharmacy services are best
116 leveraged to meet the ever-changing demands of the future of healthcare delivery.

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