



House of Delegates Session—2013

June 2 and 4, 2013
Minneapolis, Minnesota

Proceedings of the 65th annual session of the ASHP House of Delegates, June 2 and 4, 2013

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PAUL W. ABRAMOWITZ, SECRETARY

The 65th annual session of the ASHP House of Delegates was held at the Minneapolis Convention Center, in Minneapolis, Minnesota, in conjunction with the 2013 Summer Meeting.

First meeting

The first meeting was convened at 1:00 p.m. Sunday, June 2, by Chair of the House of Delegates James A. Trovato. Chair Trovato introduced the persons seated at the head table: Stanley S. Kent, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Kathryn R. Schultz, President of ASHP and Chair of the Board of Directors; Paul W. Abramowitz, Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Joy Myers, Parliamentarian.

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

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

Chair Trovato reminded delegates that the report of the 64th annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 64th House of Delegates session were received without objection.

Chair Trovato called on Kathleen Donley for the report of the Committee on Nominations.^a Nominees were presented as follows:

President-elect

Christene M. Jolowsky, M.S., FASHP, Executive Director for Applied and Experiential Education and Assistant Professor at the University of Minnesota College of Pharmacy, Minneapolis

Janet L. Mighty, B.S., M.B.A., Assistant Director of the Investigational Drug Service, Johns Hopkins Hospital, Baltimore, MD

Board of Directors (2013–2016)

Michael B. Cockerham, M.S., Pharm.D., FASHP, Associate Dean for Academic Affairs, University of Louisiana at Monroe College of Pharmacy

Richard F. Demers, M.S., FASHP, Assistant Executive Hospital Director, Hospital of the University of Pennsylvania, Philadelphia

Donald E. Letendre, Pharm.D., Dean and Professor, University of Iowa College of Pharmacy, Iowa City

Ranee Runnebaum, Pharm.D., Medication Safety Manager, Oregon Health and Science University Hospital, Portland

Chair, House of Delegates

Ernest R. Anderson, Jr., M.S., FASHP, FMSHP, President, Ernest R. Anderson Jr. Consulting Inc., Brockton, MA

James A. Trovato, Pharm.D., MBA, BCOP, FASHP, Associate Professor, Department of Pharmacy Practice & Science, University of Maryland School of Pharmacy, Baltimore

Chair Trovato then presented the Board's two nominees for the office of ASHP Treasurer, as follows:

Eric Hola, M.S., M.L.S., FASHP, Pharmacy Director, Saint Barnabas Medical Center, Livingston, NJ

Philip J. Schneider, B.S., Pharm.D., Director of Pharmacy Services, Olathe Medical Center, Olathe, KS

A "Meet the Candidates" session to be held on Monday, June 3, was announced. Chair Trovato announced the candidates for the executive committees of the five sections of ASHP.

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

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

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

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

Larry C. Clark, Board Liaison to the **Council on Pharmacy Management**, presented the Council’s Policy Recommendations A through F.

A. *Payer Processes for Payment Authorization and Coverage Verification*

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

B. *Interoperability of Patient-Care Technologies*

To encourage interdisciplinary development and implementation of technical and semantic standards for health information technology (HIT) that would promote the interoperability of patient-care technologies that utilize medication-related databases (e.g., medication order processing systems, automated dispensing cabinets, intelligent infusion pumps, electronic health records); further,

To encourage the integration, consolidation, and harmonization of medication-related databases used in patient-care technologies to reduce the risk that outdated, inaccurate, or conflicting data might be used and to minimize the resources required to maintain such databases.

C. *Proliferation of Accreditation Organizations*

To advocate that health care accreditation organizations include providers and patients in their accreditation and standards development processes; further,

To encourage health care accreditation organizations to adopt consistent standards for the medication-use process, based on established principles of patient safety and quality of care; further,

To encourage hospitals and health systems to include pharmacy practice leaders in decisions about seeking recognition by specific accreditation organizations.

D. *Drug Product Reimbursement*

To pursue, in collaboration with public and private payers, the development of improved methods of reimbursing pharmacies for the costs of drug products dispensed, compounding and dispensing services, and associated overhead; further,

To educate pharmacists about those methods.

E. *Principles of Managed Care*

To discontinue ASHP policy 0709, which reads:

To recognize that the principles of managed care have many applications in hospital and health-system pharmacy practice; further,

To continue to include managed care topics in educational programming, publications, and professional-practice-development initiatives; further,

To continue to serve the professional needs of ASHP members who practice in managed care organizations.

F. *Multidisciplinary Action Plans for Patient Care*

To discontinue ASHP policy 9804, which reads:

To support pharmacists as integral participants in the development of multidisciplinary action plans for patient care (care MAPs), disease-management plans, and health-management plans.

Paul W. Bush, Board Liaison to the **Council on Pharmacy Practice**, presented the Council's Policy Recommendations A through C.

**A. Role of Pharmacists in Sports Doping Control*

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

To encourage pharmacists to advise athletic authorities and athletes on *the dangers of* performance-enhancing substances and other products that are prohibited in competition; further,

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

**B. Standardization of Intravenous Drug Concentrations*

To develop nationally standardized drug concentrations and dosing units for commonly used high-risk drugs that are given as continuous infusions *to adult and pediatric patients*; further,

To encourage all hospitals and health systems to use infusion devices that interface with their information systems and include standardized drug libraries with dosing limits, clinical advisories, and other patient-safety-enhancing capabilities; further,

To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units in hospitals and health systems.

C. ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

To approve the ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance.

Thomas J. Johnson, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations A through E.

**A. Pharmacist Recognition as a Health Care Provider*

To recognize that pharmacist participation in interprofessional health care teams as the medication-use expert that provides safe, effective, and high-quality care, resulting in improved patient outcomes and reduced health care costs; further,

To advocate for changes in federal (e.g., *Social Security Act*), state, and third-party payment programs to define pharmacists as *health care providers of direct patient care*; further,

To affirm that pharmacists, as medication-use experts, provide safe, accessible, high-quality care that is cost effective, resulting in improved patient outcomes; further,

To recognize that pharmacists as health care providers improve access to patient care and bridge gaps in health care that exist; further,

To collaborate with key stakeholders to describe the covered direct patient-care services provided by pharmacists; further,

To pursue a standard mechanism for ~~paying~~ *compensating* pharmacists who provide these services.

B. Compounding by Health Professionals

To advocate that state laws and regulations that govern compounding by health professionals adopt the applicable standards of the *United States Pharmacopeia*.

**C. Pharmacists' Role in Immunization and Vaccines*

To affirm that pharmacists have a role in improving public health and increasing patient access to immunizations by promoting and administering appropriate immunizations to patients and employees in all settings; further,

To collaborate with key stakeholders to support the public health role of pharmacists and student pharmacists in the administration of adult and pediatric immunizations; further,

To advocate that states grant pharmacists and *appropriately supervised student pharmacists* the authority to initiate and administer all adult and pediatric immunizations; further,

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

To advocate that state and federal health authorities establish centralized databases for documenting administration of immunizations that are accessible to all health care providers; further,

To ~~strongly encourage~~ *advocate* that state and federal health authorities *require* pharmacists and other immunization providers to report their documentation to these centralized databases when they become available; further,

To strongly encourage pharmacists to educate all patients, their caregivers, parents, guardians, and health care providers about the importance of immunizations for disease prevention; further,

To encourage pharmacists to seek opportunities for involvement in disease prevention through community immunization programs; further,

To advocate for the inclusion of pharmacist-provided immunization training in college of pharmacy curricula.

**D. Regulation of Telepharmacy Services*

To advocate that state governments adopt laws and regulations that standardize telepharmacy practices across state lines and facilitate the use of United States-based telepharmacy services; further,

To advocate that boards of pharmacy and state agencies that regulate ~~pharmacies~~ *pharmacy practice* include the following in regulations for telepharmacy services: (1) education and training of participating pharmacists; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; (3) communication and information systems requirements; (4) remote order entry, prospective order review, verification of the completed medication order before dispensing, and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; (6) licensure (including reciprocity) of participating pharmacies and pharmacists; (7) service arrangements that cross state borders; (8) service arrangements within the same corporate entity or between different corporate entities; (9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; ~~and~~ (10) pharmacist access to ~~minimum required elements of all applicable~~ patient information; ~~and~~ (11) *patient safety, quality, and outcomes measures are developed and monitored*; further,

To identify additional legal and professional issues in the provision of telepharmacy services to and from sites located outside the United States.

E. Regulation of Centralized Order Fulfillment

To advocate changes in federal and state laws, regulations, and policies to permit centralized medication order fulfillment within health care facilities under common ownership.

Steven S. Rough, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendations A through D.

A. Medication Overuse

To define medication overuse as use of a medication when the potential risks of using the drug outweigh the potential benefits for the patient; further,

To recognize that medication overuse is inappropriate and can result in patient harm and increased overall health care costs; further,

To advocate that pharmacists take a leadership role in interprofessional efforts to minimize medication overuse.

B. Drug-Containing Devices

To recognize that use of drug-containing devices (also known as combination devices) has important clinical and safety implications for patient care; further,

To advocate that use of such devices be documented in the patient's medical record to support clinical decision-making; further,

To encourage pharmacists to participate in interprofessional efforts to evaluate and create guidance on the use of these products through the pharmacy and therapeutics committee process to ensure patient safety and promote cost-effectiveness; further,

To advocate that the Food and Drug Administration (FDA) and device manufacturers increase the transparency of the FDA approval process for drug-containing devices, including access to data used to support approval; further,

To encourage research that evaluates the clinical and safety implications of drug-containing devices to inform product development and guide clinical practice.

**C. DEA Scheduling of Hydrocodone Combination Products*

To advocate that the Drug Enforcement Administration (DEA) reschedule hydrocodone combination products to Schedule II based on their potential for abuse and patient harm and to achieve consistency with scheduling of other drugs with similar abuse potential; ~~further~~;

~~To monitor the effect of rescheduling hydrocodone combination products and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the impact of these actions on patient access to hydrocodone combination medications and on the practice burden of health care providers.~~

**D. DEA Scheduling of Controlled Substances*

To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current evidence concerning the abuse potential of these therapies; *further*,

To monitor the effect of DEA scheduling of products under the Controlled Substance Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the impact on patient access to these medications and on the practice burden of health care providers.

President Shultz, on behalf of Michael D. Sanborn, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations A through F.

**A. Pharmacy Resident and Student Roles in New Practice Models*

To promote pharmacy practice and training models that: (1) provide experiential and residency training in team-based patient care; (2) recognize and utilize the skills and knowledge of pharmacy students and residents in providing direct patient care services; (3) augment the patient care services of pharmacists through expanded roles for residents as practitioner learners; and (4) where appropriate, utilize an approach to learning and service in which a supervising pharmacist oversees the services of students, residents, and other pharmacists providing direct patient care; *further,*

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

**B. Education and Training in Health Care Informatics Pharmacy*

~~To foster more effective use of health-system information systems, automation, and technology by promoting the development of and participation in formal health care informatics training programs for pharmacists and pharmacy technicians.~~

To recognize the significant and vast impacts of health-system information systems, automation, and technology changes on safe and effective use of medications; further,

To foster, promote, and lead the development of and participation in formal health care informatics educational programs for pharmacists, pharmacy technicians, and student pharmacists.

**C. Diversity and Cultural Competence*

~~To recognize that having a diverse team of health care providers improves the medication-use process and team-based care; further,~~

~~To foster the cultural competence of pharmacy practitioners, technicians, students, residents, and educators for the purpose of achieving optimal therapeutic outcomes in diverse patient populations.~~

[The House recommended that this policy recommendation be referred to the Council for further consideration.]

D. Standardized Pharmacy Technician Training as a Prerequisite for Certification

To discontinue ASHP policy 0803, which reads:

To advocate that completion of an ASHP-accredited pharmacy technician training program be a prerequisite for the Pharmacy Technician Certification Examination.

E. Entry-Level Doctor of Pharmacy Degree

To discontinue ASHP policy 0805, which reads:

To be an active participant in the Accreditation Council for Pharmacy Education (ACPE) process for the revision of accreditation standards for entry-level education in pharmacy; further,

To actively monitor the long-range impact that the single entry-level degree will have on residency education, availability of experiential training sites, graduate education, and continuing education programs, and the resulting health-system pharmacist applicant pool.

F. Patient-Centered Care

To discontinue ASHP policy 0313, which reads:

To encourage that the principles of patient-centered care be integrated throughout the college of pharmacy curriculum.

President Schultz, on behalf of the Board of Directors, then moved adoption of the policy recommendation from the Section of Pharmacy Informatics and Technology, "ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics." Delegates voted to approve the recommendation.

Statements of Candidates for Chair of House and Treasurer. Candidates for the positions of Chair of the House of Delegates and Treasurer made brief statements to the House of Delegates.

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

The meeting adjourned at 4:00 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 4, at 4:30 p.m. A quorum was present.

Election of House Chair and Treasurer. Chair Trovato announced the appointment of alternate delegates as tellers to canvass the ballots for the election of Chair of the House of Delegates and Treasurer. Those appointed were Justin Hare (WV), Susan Kleppin (WI), Russ Lazzaro (NY), Donald Lynx (IL), T. Morris Rabb (LA), and Trish Wegner (IL).

Chair Trovato instructed tellers on the distribution and collection of ballots to registered delegates. After the balloting process, tellers left the assembly to count the ballots while the business of the House proceeded.

Report of President and Chair of the Board. President Schultz updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report of the Chair of the Board.

Report of Treasurer. Philip J. Schneider presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer's report.

Report of Chief Executive Officer. Paul W. Abramowitz presented the report of the Chief Executive Officer.

Board of Directors duly considered matters. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 4, 2013, to "duly consider" the amended policies. The Board reported on nine professional policies that were amended at the first House meeting. The Board presented its recommendations as follows:

Council on Pharmacy Practice, Policy A, "Role of Pharmacists in Sports Doping Control": The Board agreed that the amended language is acceptable.

Council on Pharmacy Practice, Policy B, "Standardization of Intravenous Drug Concentrations": The Board agreed that the amended language is acceptable.

Council on Public Policy, Policy A, "Pharmacist Recognition as a Health Care Provider": The Board agreed that the amended language is acceptable with a minor editorial change to the third clause. As edited, the policy reads as follows:

To advocate for changes in federal (e.g., Social Security Act), state, and third-party payment programs to define pharmacists as health care providers; further,

To affirm that pharmacists, as medication-use experts, provide safe, accessible, high-quality care that is cost effective, resulting in improved patient outcomes; further,

To recognize that pharmacists as health care providers improve access to patient care and bridge existing gaps in health care; further,

To collaborate with key stakeholders to describe the covered direct patient-care services provided by pharmacists; further,

To pursue a standard mechanism for compensating pharmacists who provide these services.

Council on Public Policy, Policy C, "Pharmacists' Role in Immunization and Vaccines": The Board agreed that the amended language is acceptable with minor editorial changes. As edited, the policy reads as follows:

To affirm that pharmacists have a role in improving public health and increasing patient access to immunizations by promoting and administering appropriate immunizations to patients and employees in all settings; further,

To collaborate with key stakeholders to support the public health role of pharmacists and student pharmacists in the administration of adult and pediatric immunizations; further,

To advocate that states grant pharmacists and appropriately supervised student pharmacists the authority to initiate and administer all adult and pediatric immunizations; further,

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

To advocate that state and federal health authorities establish centralized databases for documenting administration of immunizations that are accessible to all health care providers; further,

To advocate that state and federal health authorities require pharmacists and other immunization providers to report their documentation to these centralized databases if available; further,

To strongly encourage pharmacists to educate all patients, their caregivers, parents, guardians, and health care providers about the importance of immunizations for disease prevention; further,

To encourage pharmacists to seek opportunities for involvement in disease prevention through community immunization programs; further,

To advocate for the inclusion of pharmacist-provided immunization training in college of pharmacy curricula.

Council on Public Policy, Policy D, "Regulation of Telepharmacy Services": The Board agreed that the amended language

is acceptable with minor editorial changes. As edited, the policy reads as follows:

To advocate that state governments adopt laws and regulations that standardize telepharmacy practices across state lines and facilitate the use of United States-based telepharmacy services; further,

To advocate that boards of pharmacy and state agencies that regulate pharmacy practice include the following in regulations for telepharmacy services: (1) education and training of participating pharmacists; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; (3) communication and information systems requirements; (4) remote order entry, prospective order review, verification of the completed medication order before dispensing, and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; (6) licensure (including reciprocity) of participating pharmacies and pharmacists; (7) service arrangements that cross state borders; (8) service arrangements within the same corporate entity or between different corporate entities; (9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; (10) pharmacist access to all applicable patient information; and (11) development and monitoring of patient safety, quality, and outcomes measures; further,

To identify additional legal and professional issues in the provision of telepharmacy services to and from sites located outside the United States.

Council on Therapeutics, Policy C, “DEA Scheduling of Hydrocodone Combination Products”: The Board agreed that the amended language is acceptable.

Council on Therapeutics, Policy D, “DEA Scheduling of Controlled Substances”: The Board agreed that the amended language is acceptable.

Council on Education and Workforce Development, Policy A, “Pharmacy Resident and Student Roles in New Practice Models”: The Board agreed that the amended language is acceptable with minor editorial changes. As edited, the policy reads as follows:

To promote pharmacy practice and training models that: (1) provide experiential and residency training in team-based patient care; (2) recognize and utilize the skills and knowledge of student pharmacists and residents in providing direct patient care services; (3) augment the patient care services of pharmacists through expanded roles for residents as practitioner learners; and (4) where appropriate, utilize an approach to learning and service in which a supervising pharmacist oversees the services of students, residents, and other pharmacists providing direct patient care; further,

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

Council on Education and Workforce Development, Policy B, “Education and Training in Health Care Informatics Pharmacy”: The Board agreed that the amended language is acceptable.

Council on Education and Workforce Development Policy Recommendation C, “Diversity and Cultural Competence”: The Board of Directors concurred with the House action to refer the policy recommendation to the Council for further consideration.

New Business. Chair Trovato announced that, in accordance with Article 7 of the Bylaws, there was one item of New Business to be considered. Chair Trovato called on Dennis Williams (NC) and Scott Meyers (IL) to introduce the item of New Business, “Enhancing the Value of Experiences for Student Pharmacists.” Following discussion, the item was approved for referral. It reads as follows:

Enhancing the Value of Experiences for Student Pharmacists

Motion

ASHP should work with the appropriate entities (e.g., ACPE, NABP, and State Boards of Pharmacy) to optimize the professional practice-related experiences of student pharmacists working under the supervision of pharmacists.

Background

The opportunities related to the task and roles that student pharmacists are allowed to participate in vary among the states. It would be helpful to clearly distinguish that student pharmacists have the ability to participate in all pharmacy-related activities with the appropriate supervision by a pharmacist.

Student pharmacists will benefit from immersion into the practice of pharmacy provided by their preceptors and supervisors, in situations where both have received adequate training and preparation. These opportunities can be facilitated by consistency among state laws and regulations. One possible approach is a separate category of registration or licensure that applies to student pharmacists currently enrolled in a school of pharmacy.

One mechanism to achieve this may be through a separate category of registration or licensure for student pharmacists (versus technicians), although other strategies that allow student pharmacists to benefit from practice-related experiences should be explored.

In some cases, specialized training or certification may be required for a pharmacist to participate in a specific practice activity. In that situation, the student pharmacist should also have the specialized training or certification to participate.

There are many differences among states in how students are registered (possibly as students or technicians) or licensed (as interns) by the State Board of Pharmacy. In some cases, there is no process. Standardization is essential.

In addition, ASHP has numerous policy statements addressing the role and scope of pharmacists that should equally and inherently apply to student pharmacists, with appropriate training. A policy position that supports student pharmacist involvement and participation in all practice activities under the supervision of a pharmacist will facilitate recognition and support of this concept.

There may be components of Policy 1204 which was superseded by a new 2013 policy that should be revisited regarding the role of students in new and evolving practice models.

Suggested Outcomes

The development of policy that supports opportunities to optimize the practice experiences for student pharmacists. It is anticipated that numerous policy recommendations may address various aspects of this issue.

Recommendations. Chair Trovato called on members of the House of Delegates for Recommendations. (See the Appendix for a list of Recommendations.)

Recognition. Chair Trovato recognized members of the Board who were continuing in office. He also introduced members of the Board who were completing their terms of office.

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

Chair Trovato recognized Stan Kent's years of service as a member of the Board, in various presidential capacities, as Chair of the Board, and as Vice Chair of the House of Delegates.

Chair Trovato then installed the chairs of ASHP's sections and forums: Jill Bates, Chair of the Section of Clinical Specialists and Scientists; Seena Haines, Chair of the Section of Ambulatory Care Practitioners; Noelle Chapman, Chair of the Section of Inpatient Care Practitioners; Michael Schlesselman, Chair of the Section of Pharmacy Informatics and Technology; Todd Karpinski, Chair of the Section of Pharmacy Practice Managers; Thomas Achey, Chair of the Pharmacy Student Forum, and Christina Martin, Chair of the New Practitioners Forum.

Chair Trovato then recognized the remaining members of the executive committees of sections and forums.

Recognition of Parliamentarian. Chair Trovato thanked Joy Myers for service to ASHP as parliamentarian.

Results of Elections. Chair Trovato relinquished the gavel to Vice Chair Kent to report the results of the elections. Vice Chair Kent then announced that Philip J. Schneider had been elected Treasurer and that James A. Trovato had been elected as Chair of the House.

Installation. Vice Chair Kent then installed Gerald E. Meyer as President of ASHP, Philip J. Schneider as Treasurer, Don Letendre and Rane Runnebaum as members of the Board of Directors, and James A. Trovato as Chair of the House of Delegates.

Adjournment. The 65th annual session of the House of Delegates adjourned at 6:00 p.m.

^aThe Committee on Nominations consisted of Kathleen Donley (OH), Chair; Diane Ginsburg (TX), Vice Chair; Robert Adamson (NJ), James Klauck (WI), Patricia Knowles (GA), Nancy Korman (CA), and Tommy Mannino (LA).



Recommendations from the 2013 House of Delegates

The delegate[s] who introduced each Recommendation is [are] noted. Each Recommendation is forwarded to the appropriate body within ASHP for assessment and action as may be indicated.

1. Pharmacy Performance Measures

Jerome Wohleb (NE, SOPIT), Kevin Marvin, Michele Faylkner, Donna Soflin, Melinda Burnworth, Dennis Williams, Julie Lienhart, Erin Christensen, Joseph Aloï

Recommendation: That ASHP advocate for and lead development and refinement of standard outcome and performance measures to support the value of pharmacists as health care providers as a replacement for existing productivity metrics.

2. Flexibility for State Delegations

Scott Meyers (IL)

Recommendation: That ASHP's Task Force on Organizational Structure develop a mechanism within the rules of the House whereby very engaged State delegations may, to use a WWE term, "Tap In and Tap Out" alternate delegates for the purpose of discussion of specific agenda items for which an alternate delegate may be more engaged than a sitting delegate.

3. Pharmacy Benchmark Metrics to support C-Suite Healthcare Reform Goals

Melinda Burnworth (AZ), Erin Christensen (SD), Jerome Wohleb (NE)

Recommendation: That ASHP identify and standardize metrics used to support outcome measures that support ongoing pharmacist value to replace current methods and metrics for productivity and clinical outcomes.

4. Creation of Model Credentialing for Pharmacist Provider

Adam Porath (NV)

Recommendation: That ASHP create a model credentialing for pharmacist providers.

5. Statement on the Pharmacist's Role in Informatics

Trish Wegner, Despina Kotis (IHP)

Recommendation: That ASHP, through the Section of Pharmacy Informatics and Technology, review and update the Statement on the Pharmacist's Role in Informatics, adopted in 2006.

6. Guidelines for the Prescribing of Appropriate Quantities of Controlled Substances

John Pastor, Jamie Sinclair, Paul Wittmer (MN)

Recommendation: That ASHP advocate for development of guidelines promoting the prescribing of appropriate quantities of controlled substances to patients.

7. Campaign on the Value of Pharmacists (as Care Providers)

Steve Riddle (SACP)

Recommendation: That ASHP engage relevant stakeholders and explore the creation of a national marketing campaign that communicates the value of pharmacists to increase the awareness of and demand for pharmacy care services.

8. Creation of Pharmacy Practice Registries

Steve Riddle (SACP)

Recommendation: That ASHP investigate the feasibility and value of creating pharmacy practice registries (databases) that foster the exchange of information that supports practice advancement.

9. Training of Preceptors

Donald Lynx (IL)

Recommendation: That ASHP work with the appropriate organizations to develop standards and criteria in order to be a preceptor providing IPPE or APPE rotations for pharmacy students.

10. Adjudication of Resident Concerns

Christi Jen, Melinda Burnworth, Carol Rollins (AZ)

Recommendation: That ASHP develop a formal mechanism for addressing resident concerns confidentially, without repercussions, and expediently through an ASHP forum (e.g., New Practitioner Forum).

11. Pharmacists Role in Pharmacogenomics

Sam Calabrese (OH), James Hoffman (TN)

Recommendation: That ASHP assess the impact of next-generation genomics on health-system pharmacy and develop a statement on the pharmacist's role in pharmacogenomics to assist in optimal medication use.

12. Future Meeting Location

Casey White (TN)

Recommendation: That ASHP consider Nashville as a future Summer Meeting location.

13. Task Force on Compounding

Lynn Eschenbacher (SCIP, SACP, SOPIT, SPMM)

Recommendation: That ASHP develop guidance on stability and sterility testing and how to determine which laboratories to trust related to insourced and outsourced compounded medications.

14. Summer Meeting Location

Dan Degnan, John Hertig, Amy Hyduk (IN)

Recommendation: That ASHP consider Indianapolis as a future Summer Meeting location.

15. Essential Role of the Pharmacy Technician

Tricia Killingsworth (SCIP, SPPM)

Recommendation: That ASHP develop a policy defining the essential roles of the pharmacy technician in managing technology, supply chain, and data management (IT) to support the advancement of pharmacy practice.

16. Sterile Compounding Tools

Leigh Fritz (UT)

Recommendation: That ASHP develop specific tools to help health systems meet USP Chapter 797 requirements for extended beyond-use dating.

17. Centralized Pharmacy Services

Missy Skelton Duke (UT)

Recommendation: That ASHP develop a list of standardized terminology and definitions related to central pharmacy services, including but not limited to order processing, preparation, compounding, repackaging, and other distributive functions.

18. Regulation of Advanced Practice

Steve Gray (CA)

Recommendation: That ASHP create a task force to make recommendations about how Boards of Pharmacy should regulate the advanced practice of pharmacy that has traits more like medical practice.

19. Conflict with Affiliate Business Ventures

Scott Meyers (IL)

Recommendation: That the ASHP Board of Directors and staff conscientiously consider the financial/relational impact of initiating new business ventures that compete with established programs of its affiliates.

20. Timing of ASHP Foundation Breakfast

Eric Hola (NJ)

Recommendation: That ASHP make arrangements for the Foundation Breakfast to start at a more reasonable hour than 6:30 a.m.

21. Exhibitions at Summer Meeting

Frank Sosnowski (NY)

Recommendation: That ASHP explore a reverse expo format during the ASHP Summer Meeting.

22. Large Residency Programs

Stephen Eckel (NC)

Recommendation: That ASHP develop a different organizational structure to assist in the local management of pharmacy residencies with a large number of residents.

23. Task Force on Science, Technology, and Genomics

James Hoffman (TN)

Recommendation: That ASHP evaluate the need for a task force on science and technology (especially genomics) so that health-system pharmacists are positioned as leaders in the introduction of new technologies into health care.

24. Creation of Pharmacy Simulation Research Grants

Daniel Degnan, John Hertig (IN)

Recommendation: That ASHP work with the ASHP Research and Education Foundation to develop, administer, and fund pharmacy simulation research grants.

25. Criteria Clearly Defined for Becoming a New ASHP Section

Daniel Degnan, John Hertig (IN)

Recommendation: That ASHP clearly define the path to establishing new ASHP Membership Sections for new and emerging pharmacy specialties.

26. Direct-to-Consumer Medication Distribution

Amy Hyduk, Daniel Degnan, John Hertig (IN)

Recommendation: That ASHP review recent manufacturer-initiated distribution pathways that sell medication products through a single pharmacy company directly to the patient with minimal pharmacist oversight.

27. Distinctive Labeling of Standardized Drug Concentrations and Dosing Units

John Armitstead (FL)

Recommendation: That ASHP encourage manufacturers to include, and to advocate that the FDA require, distinctive labeling of standardized drug concentrations and dosing units to minimize the risk of medication errors.

28. Development of a Medication Safety Credential

Daniel Degnan, John Hertig (IN)

Recommendation: That ASHP partner with other organizations to develop a medication safety credential that deems a pharmacist an expert in the field of medication safety.

29. Glossary of Terms Used in ASHP Policy

Emily Alexander (TX)

Recommendation: That ASHP be responsible for the development of a glossary of terms for use in policy.

- 30. Standardization of Policy Nomenclature**
Jamie Sinclair, John Pastor, Paul Wittmer (MN)
Recommendation: That ASHP standardize the use of "medication" in policy statements.
- 31. Expansion of Pharmacy Publications into the General Healthcare Executive Literature**
Amanda Hansen (VA)
Recommendation: That ASHP develop strategies to publish appropriate pharmacy practice content describing the ability of pharmacists to positively impact patient care in general health care executive journals or similar media.
- 32. Revision of ASHP Minimum Standard to Include USP Chapter 1066**
Butch Habeger (TX)
Recommendation: That ASHP revise the ASHP Minimum Standard for Pharmacies in Hospitals to incorporate or reference to the USP General Chapter 1066, Physical Environments That Promote Safe Medication Use.
- 33. National Standardization of Oral Liquid Concentrations and Package Sizes**
Kevin Marvin (SOPIT)
Recommendation: That ASHP advocate for the national standardization of oral liquid concentrations and package sizes.
- 34. Timely Drug Database Updates in EHRs**
Kevin Marvin (SOPIT)
Recommendation: That ASHP advocate mandatory and timely updates of medication, decision support, and formulary databases used to support electronic prescribing by physicians and other care providers.
- 35. Amendment of Policy on Standardization of IV Drug Concentrations**
Nancy Korman (CA), Carol Rollins (AZ), Melinda Burnworth (AZ), Christi Jen (AZ), Christine Antczak (CA)
Recommendation: That the ASHP House of Delegates insert the following language as a third clause in ASHP Policy 1306:
"To encourage pharmacists to implement standardized drug concentrations and dosing units in their individual organizations."
- 36. Wellness Activities at ASHP Meetings**
Meghan Swarthout (MD)
Recommendation: That ASHP incorporate more health and wellness activities into meetings to promote healthy living for members while attending ASHP meeting.
- 37. Update of ASHP Policy 1218, Approval of Biosimilar Medications**
Thomas Kirschling (CO)
Recommendation: That ASHP address physician notification as a barrier to interchange of biosimilar products.

38. ASHP Monitoring of Impact of New York I-STOP Legislation

Frank Sosnowski (NY)

Recommendation: That ASHP work closely with New York State Council of Health-System Pharmacists to monitor the New York I-STOP legislation and its impact on patient care and pharmacy workflow in relation to the choice or scarcity of hydrocodone and hydrocodone combination products.

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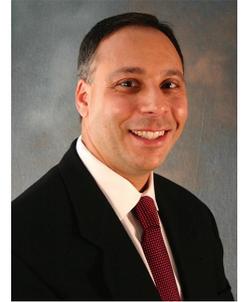
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Professional Policies Approved by the 2013 ASHP House of Delegates

MINNEAPOLIS, MN
JUNE 4, 2013

Am J Health-Syst Pharm. 2013; 70:e16-9

The new professional policies approved by the ASHP House of Delegates at its June 2013 session are listed below. Policies proposed by councils or other ASHP bodies are first considered by the Board of Directors and then acted on by the House of Delegates, which is the ultimate authority for ASHP positions on professional issues.

The background information on these policies appears on the ASHP Web site (www.ashp.org); click on “Practice and Policy” then on “House of Delegates,” and then on “Board of Directors Reports on Councils” (<http://www.ashp.org/DocLibrary/Policy/HOD/Council-Reports.aspx>).

The complete proceedings of the House of Delegates will be provided to delegates and will be posted on the ASHP Web site; a printed copy can be requested from the ASHP Office of Policy, Planning and Communications.

1301

Payer Processes for Payment Authorization and Coverage Verification

Source: Council on Pharmacy Management

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient

processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

This policy supersedes ASHP policy 1206.

1302

Interoperability of Patient-Care Technologies

Source: Council on Pharmacy Management

To encourage interdisciplinary development and implementation of technical and semantic standards for health information technology (HIT) that would promote the interoperability of patient-care technologies that utilize medication-related databases (e.g., medication order processing systems, automated dispensing cabinets, intelligent infusion pumps, electronic health records); further,

To encourage the integration, consolidation, and harmonization of medication-related databases used in patient-care technologies to reduce the risk that outdated, inaccurate, or

conflicting data might be used and to minimize the resources required to maintain such databases.

1303

Proliferation of Accreditation Organizations

Source: Council on Pharmacy Management

To advocate that health care accreditation organizations include providers and patients in their accreditation and standards development processes; further,

To encourage health care accreditation organizations to adopt consistent standards for the medication-use process, based on established principles of patient safety and quality of care; further,

To encourage hospitals and health systems to include pharmacy practice leaders in decisions about seeking recognition by specific accreditation organizations.

1304

Drug Product Reimbursement

Source: Council on Pharmacy Management

To pursue, in collaboration with public and private payers, the development of improved methods of reimbursing pharmacies for the costs of drug products dispensed, compounding and dispensing services, and associated overhead; further,

To educate pharmacists about those methods.

This policy supersedes ASHP policy 0207.

1305 Education About Performance-Enhancing Substances

Source: Council on Pharmacy Practice

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

To encourage pharmacists to advise athletic authorities and athletes on the dangers of performance-enhancing substances and other products that are prohibited in competition; further,

To advocate for the role of the pharmacist in all aspects of sports doping control.

This policy supersedes ASHP policy 0710.

1306 Standardization of Intravenous Drug Concentrations

Source: Council on Pharmacy Practice

To develop nationally standardized drug concentrations and dosing units for commonly used high-risk drugs that are given as continuous infusions to adult and pediatric patients; further,

To encourage all hospitals and health systems to use infusion devices that interface with their information systems and include standardized drug libraries with dosing limits, clinical advisories, and other patient-safety-enhancing capabilities; further,

To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units in hospitals and health systems.

This policy supersedes ASHP policy 0807.

1307 Pharmacist Recognition as a Health Care Provider

Source: Council on Public Policy

To advocate for changes in federal (e.g., Social Security Act), state, and third-party payment programs to define pharmacists as health care providers; further,

To affirm that pharmacists, as medication-use experts, provide safe, accessible, high-quality care that is cost effective, resulting in improved patient outcomes; further,

To recognize that pharmacists, as health care providers, improve access to patient care and bridge existing gaps in health care; further,

To collaborate with key stakeholders to describe the covered direct patient-care services provided by pharmacists; further,

To pursue a standard mechanism for compensating pharmacists who provide these services.

1308 Compounding by Health Professionals

Source: Council on Public Policy

To advocate that state laws and regulations that govern compounding by health professionals adopt the applicable standards of the *United States Pharmacopeia*.

This policy supersedes ASHP policy 0411.

1309 Pharmacists' Role in Immunization

Source: Council on Public Policy

To affirm that pharmacists have a role in improving public health and increasing patient access to immunizations by promoting and administering appropriate immunizations to patients and employees in all settings; further,

To collaborate with key stakeholders to support the public health role of pharmacists and student pharmacists

in the administration of adult and pediatric immunizations; further,

To advocate that states grant pharmacists and appropriately supervised student pharmacists the authority to initiate and administer all adult and pediatric immunizations; further,

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

To advocate that state and federal health authorities establish centralized databases for documenting administration of immunizations that are accessible to all health care providers; further,

To advocate that state and federal health authorities require pharmacists and other immunization providers to report their documentation to these centralized databases, if available; further,

To strongly encourage pharmacists to educate all patients, their caregivers, parents, guardians, and health care providers about the importance of immunizations for disease prevention; further,

To encourage pharmacists to seek opportunities for involvement in disease prevention through community immunization programs; further,

To advocate for the inclusion of pharmacist-provided immunization training in college of pharmacy curricula.

This policy supersedes ASHP policies 1220 and 0213.

1310 Regulation of Telepharmacy Services

Source: Council on Public Policy

To advocate that state governments adopt laws and regulations

that standardize telepharmacy practices across state lines and facilitate the use of United States-based telepharmacy services; further,

To advocate that boards of pharmacy and state agencies that regulate pharmacy practice include the following in regulations for telepharmacy services: (1) education and training of participating pharmacists; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; (3) communication and information systems requirements; (4) remote order entry, prospective order review, verification of the completed medication order before dispensing, and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; (6) licensure (including reciprocity) of participating pharmacies and pharmacists; (7) service arrangements that cross state borders; (8) service arrangements within the same corporate entity or between different corporate entities; (9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; (10) pharmacist access to all applicable patient information; and (11) development and monitoring of patient safety, quality, and outcomes measures; further,

To identify additional legal and professional issues in the provision of telepharmacy services to and from sites located outside the United States.

This policy supersedes ASHP policy 0716.

**1311
Regulation of Centralized Order Fulfillment**

Source: Council on Public Policy

To advocate changes in federal and state laws, regulations, and policies to permit centralized medication order

fulfillment within health care facilities under common ownership.

**1312
Medication Overuse**

Source: Council on Therapeutics

To define medication overuse as use of a medication when the potential risks of using the drug outweigh the potential benefits for the patient; further,

To recognize that medication overuse is inappropriate and can result in patient harm and increased overall health care costs; further,

To advocate that pharmacists take a leadership role in interprofessional efforts to minimize medication overuse.

**1313
Drug-Containing Devices**

Source: Council on Therapeutics

To recognize that use of drug-containing devices (also known as combination devices) has important clinical and safety implications for patient care; further,

To advocate that use of such devices be documented in the patient's medical record to support clinical decision-making; further,

To encourage pharmacists to participate in interprofessional efforts to evaluate and create guidance on the use of these products through the pharmacy and therapeutics committee process to ensure patient safety and promote cost-effectiveness; further,

To advocate that the Food and Drug Administration (FDA) and device manufacturers increase the transparency of the FDA approval process for drug-containing devices, including access to data used to support approval; further,

To encourage research that evaluates the clinical and safety implications of drug-containing devices to inform product development and guide clinical practice.

**1314
DEA Scheduling of Hydrocodone Combination Products**

Source: Council on Therapeutics

To advocate that the Drug Enforcement Administration (DEA) reschedule hydrocodone combination products to Schedule II based on their potential for abuse and patient harm and to achieve consistency with scheduling of other drugs with similar abuse potential.

**1315
DEA Scheduling of Controlled Substances**

To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable criteria and a transparent process for scheduling determinations; further,

To urge the DEA to use such a process to re-evaluate existing schedules for all substances regulated under the Controlled Substances Act to ensure consistency and incorporate current evidence concerning the abuse potential of these therapies; further,

To monitor the effect of DEA scheduling of products under the Controlled Substances Act and other abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the impact on patient access to these medications and on the practice burden of health care providers.

**1316
Pharmacy Resident and Student Roles in New Practice Models**

Source: Council on Education and Workforce Development

To promote pharmacy practice and training models that: (1) provide experiential and residency training in team-based patient care; (2) recognize and utilize the skills and knowledge of student pharmacists and residents in providing direct patient care services; (3) augment the patient care services of pharmacists through

expanded roles for residents as practitioner learners; and (4) where appropriate, utilize an approach to learning and service in which a supervising pharmacist oversees the services of students, residents, and other pharmacists providing direct patient care; further,

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

This policy supersedes ASHP policy 1204.

1317 Education and Training in Health Care Informatics Pharmacy

Source: Council on Education and Workforce Development

To recognize the significant and vast impacts of health-system information systems, automation, and technology changes on safe and effective use of medications; further,

To foster, promote, and lead the development of and participation in formal health care informatics educational programs for pharmacists, pharmacy technicians, and student pharmacists.

1318

ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

Source: Council on Pharmacy Practice

To approve the ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance.*

1319

ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics

Source: Section of Pharmacy Informatics and Technology

To approve the ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics.*

*The ASHP statements approved by the House of Delegates are available on the ASHP Web site (www.ashp.org). Under "Practice and Policy," click on "Policy Positions & Guidelines" and then on "New Guidance Documents."

DOI 10.2146/sp130003

 ASHP REPORTS

*Inaugural address of the Incoming President***Courage**

GERALD E. MEYER

Am J Health-Syst Pharm. 2013; 70:1428-32

Good morning, and thank you for that warm welcome! I would like to begin by acknowledging you—our members. I want to personally thank all of the members who have participated in ASHP's state societies. ASHP could not fulfill its mission without the support and inspired leadership of our affiliates. Yes, being president of ASHP involves a lot of time and travel, but it also comes with a large support staff. The volunteer leaders in our affiliates, on the other hand, *do it all*. You are the membership committee, the program committee, the finance committee, the professional advocacy committee, the strategic planning committee, and so much more. So, to all of you, a great big thanks!

A rich pharmacy history

Many of you may know that I am from Philadelphia, and I am proud of it. Philadelphia has a very rich pharmacy history. We have the first hospital in the United States—Pennsylvania Hospital, founded by Benjamin Franklin in 1751. We have the first college of pharmacy in the United States—the Philadelphia Col-

Let's have the courage to promote an efficient and effective health care system comprising interdependent, synergistic health care providers.



lege of Pharmacy, which opened in 1821. And we had the first hospital pharmacist in the United States. His name was Jonathan Roberts.

We also lay claim to the first hospital pharmacy residency program to be surveyed for ASHP accreditation and the first accredited pharmacy technician training program—both at Thomas Jefferson University Hospital.

We have four past presidents of ASHP currently working in Philadelphia and a fifth in retirement nearby. I have been truly fortunate to have

had access to so many health-system pharmacy leaders.

I am most appreciative for the inspiration, support, and encouragement that I have received from numerous professional colleagues—including more than 230 pharmacy residents—at Thomas Jefferson University Hospital and Thomas Jefferson University with whom I have had the privilege to work. And, most importantly, I am thankful for the wonderful personal support from my wife, Cheryl; my sons, Kevin and

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Presented at the ASHP Summer Meeting, Minneapolis, MN, June 4, 2013.

The author has declared no potential conflicts of interest.

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David; and many family members and friends.

Top priorities

In writing this speech, I definitely had a lot of people to call upon. Yet, as much as I value their wisdom, I did not ask any of them for guidance on what I should talk about today. Rather, I asked you, the members. ASHP is a membership organization. It is owned by you, its members. So I felt it was appropriate to focus our discussion today on those issues that are of greatest importance to you.

We sent out a survey to a random sample of ASHP members and asked, “What question would you like to ask Gerry Meyer?” Well, you did not disappoint. We received 130 questions, many of which spoke to the concept of courage. So, settle back and relax. This may take a while. (OK, they only set aside 25 minutes for this address, so we did narrow it down a bit.)

Our first question is from Fred Bender, Pharm.D., FASHP, director of pharmacy services at Greenville Health System in Greenville, South Carolina, who asked, “What will be your top priorities as incoming president of ASHP?” Fred, I have a list of priorities to share with you. But my priorities are of little value unless they become our priorities. My top priority, therefore, is to be the best leader I can possibly be. And you can’t lead without a vision. So, let’s start there.

What makes a good leader?

- The ability to articulate a vision,
- The ability to motivate others toward that vision, and
- The ability to remove obstacles to promote achievement of the vision.

Now, who among you can recite ASHP’s vision? ASHP’s vision is that “medication use will be optimal, safe, and effective for all people all of the time.” There’s no mention of hos-

pitals or health systems. There’s not even a mention of patients. It says “all people all of the time.”

So, here is my list of priorities for the year. I suggest that we view most of the individual items on this list as obstacles confronting us in our efforts to accomplish ASHP’s vision:

- Build coalitions,
- Implement the recommendations of the Pharmacy Practice Model Initiative (PPMI),
- Pursue provider status,
- Promote interprofessional education and practice,
- Expand training and certification for pharmacists and pharmacy technicians,
- Position ASHP to be as nimble as possible in a rapidly changing environment, and . . .
- World peace!

There is a reason for the last item on the list. Creating an environment in which medication use will be optimal, safe, and effective for all people all of the time is a bold and expansive vision. And just because it is hard to conceptualize, we cannot be deterred from putting our energies toward its achievement. (So, in that respect, our vision is a bit like world peace.)

Becoming strong advocates for our patients and profession

Kevin Aloysius, who just graduated with his Pharm.D. last month from Texas Tech University Health Sciences Center in Lubbock (Congratulations to all new graduates, by the way!) asked the next question: “How do we prevent doctors’ comments such as, ‘Well, if you wanted to give me recommendations on how to treat a patient, why didn’t you go to medical school?’”

Kevin, there is a serious answer to this question, but if I wanted to be flippant, I’d say to the physician, “If you wanted to be a medication-use expert, why didn’t you go to pharmacy school?” That is an accurate, patient-centric response, isn’t it? A

pharmacist’s unique education focuses on the optimal, safe, and effective use of medication for all people all of the time.

Having said that, let’s remember that physicians build their reputations on high-quality outcomes. Why, then, don’t physicians seek the counsel of pharmacists in all matters of medication use? After all, the rate of medication misadventures in the current system is well documented and not acceptable. I believe physicians’ hesitancy relates to the element of trust.

Physicians trust pharmacists to prepare and dispense medications accurately. They trust pharmacists to offer advice on proper administration. They expect pharmacists to offer suggestions on medication compatibility and dosage adjustments. But some may not trust pharmacists to create optimal, safe, and effective medication-use plans for all people all of the time. How, then, do we build this trust?

We must aggressively pursue all avenues to modify physicians’ perceptions of pharmacists. And not just the perceptions of physicians but those of health care policymakers, decision-makers, and providers, as well as the general public’s understanding about the unique education and training possessed by pharmacists. We must have the courage to be strong advocates for our patients and profession. Historically, we have been far too passive in promoting our value.

Antagonism versus synergism

The next question comes from Jamie Ridley Klucken, Pharm.D., M.B.A., BCPS, an assistant professor of pharmacy practice at Shenandoah University in Ashburn, Virginia: “We see a push to work collaboratively with other health care providers but seem to have a difficult time putting this into practice. Are there ways to accelerate this interprofessional practice—perhaps through phar-

macy education and postgraduate residency programs?”

Jamie, by definition, interprofessional activities clearly cannot be accomplished by one profession. Each profession must be willing to participate.

The good news is that in May 2011, a group called the Interprofessional Education Collaborative—consisting of educators representing pharmacy, medicine, nursing, dentistry, and public health—released a report that summarized the core competencies needed for interprofessional collaborative practice.¹ Those core competencies fall within four domains: (1) values and ethics, (2) roles and responsibilities, (3) interprofessional communication, and (4) teams and teamwork. What this report says is that to build an efficient and effective health care system, health care providers need to have a common understanding of health care ethics and values, understand one another’s roles and responsibilities, learn how to communicate with one another, and learn how to be part of effective teams.

For two years, we have had this guidance document, which delineates the curricular components that should be taught to health care students, interprofessionally. Our profession needs to take a leadership position in incorporating interprofessional competencies into our formal education and training standards. These changes cannot occur fast enough.

Furthermore, to develop this set of skills and knowledge in practicing pharmacists, ASHP must incorporate this critical content within our continuing professional development offerings.

It is important to consider what this report does *not* say. Nowhere does it say that interprofessional education should encompass getting health care students into the same classroom to teach them pathophysiology, pharmacology, diagnosis, or

treatment. So, if those are not our commonalities, then those must be our differences. *Exactly.*

Let’s look at this in pharmacologic terms. Sometimes, we administer two very effective drugs that may compete for the same receptor, and the result is that they become less effective. We call that phenomenon antagonism. On the other hand, sometimes we prescribe two drugs and the positive effect is greater than the anticipated sum of their individual effects. We call that synergism.

Let’s move past interprofessional antagonism. Let’s have the courage to promote an efficient and effective health care system comprising interdependent, synergistic health care providers.

Practicing at the top of our education and training

The next question comes from Cassie Heffern, Pharm.D., a postgraduate year 2 (PGY2) pharmacy resident with CoxHealth in Springfield, Missouri, who asked the following: “In some more rural hospitals, change is almost feared. Despite [the fact] that no one will lose a position by including more [elements integral to the] PPMI, the subject is still feared. How would you suggest to keep moving forward with the PPMI?”

As you may know, ASHP’s Pharmacy Practice Model Initiative—or PPMI—envisions a future in which pharmacists practice at the top of their education and training. The model identifies the roles that pharmacists must assume and then describes the need to maximize the incorporation of enablers—notably, technicians and technology—to help achieve those roles.

Earlier, I stated that leadership encompasses stating a vision, engaging others to embrace the vision, and removing obstacles to promote the achievement of the vision. For 71 years, ASHP has been a leadership organization. This professional

leadership continues. Through the PPMI, ASHP members created a bold vision, and ASHP is committing significant resources to help our members achieve their vision.

Cassie, your question alluded to challenges faced by rural health care providers. We recognize that many of our members cannot leave their workplace to attend live educational offerings. We have begun, and will continue to accelerate, the delivery of educational programming in formats that are accessible to all of our members.

The PPMI envisions advancing pharmacy practice beyond pharmacists offering recommendations for others to implement. It envisions pharmacists as interdependent prescribers who accept accountability for the patient care plans that they personally initiate.

The willingness to expand our scope of accountability to improve our patients’ health is the essence of our envisioned pharmacy practice model. Are we prepared to expand our scope of practice? Are we prepared to accept accountability for prescribing decisions?

Doing so requires courage. It requires the courage to challenge the status quo. It requires the courage to practice at the top of our education and training, not just at the top of our licenses. It requires the courage to practice beyond the borders of established practice. Do not fear change. Fear the lack of change.

Future of residency training

Among the questions I received, more were related to residencies than to any other topic. Two ASHP members, Kent Montierth, Pharm.D., a director of pharmacy for Banner Estrella Medical Center in Phoenix, Arizona, and Erica Maceira, Pharm.D., BCPS, CACP, a clinical pharmacy specialist and student and resident coordinator at Albany Medical Center Hospital in Albany, New York, asked the following questions: “How

does ASHP plan to help grow the number of residency programs and the number of available positions? How can the accreditation process be simplified?"

Although it sometimes may feel like we are making little progress in this area, the numbers tell a different story. From 1995 to 2006 (a 12-year period), the number of available accredited residency programs and the number of available positions in those programs doubled. From 2006 to 2012 (a subsequent 6-year period), the number of accredited residency programs and the number of positions doubled again.

Part of the reason for this rapid growth is that the value proposition for residencies is easily developed for residents, employers, patients, and the profession. The ASHP website contains a number of documents that can assist practitioners in justifying, designing, and conducting residency training programs.

However, one of the greatest barriers to increasing the number of residency training programs cannot be overcome with guidance documents alone. A good training program requires a solid infrastructure.

- Pharmacy services must meet contemporary standards of practice.
- Preceptors must have the ability to impart knowledge and develop critical reasoning skills.
- Residency program directors must be able to mentor and inspire those entering the profession.
- An organization's culture must be supportive of the training mission.

We cannot, and we should not, compromise on these foundational pillars.

There are now more than 1000 residency programs in the United States that have a solid infrastructure. I call on those programs to consider expanding.

For those institutions without a sufficient infrastructure currently in

place, consider collaborating with an existing residency program. In the 1970s, and then again in the 1990s, my institution offered joint residency positions with neighboring institutions. Those joint programs continued until our partners had developed sufficient infrastructure to conduct their residencies independently.

Kent and Erica, you also asked about simplifying the accreditation process. I agree that we must critically evaluate the current standards to ensure that each requirement contributes to the quality of the training process. ASHP's postgraduate year 1 (PGY1) and PGY2 standards for accreditation are currently under revision, which presents us with just such an opportunity. As drafts of proposed revisions to those standards are circulated, I encourage all residency program directors to provide your feedback.

Many of the questions I received about residency training referred to ASHP's position that, by 2020, all pharmacists involved in direct patient care must complete a residency.²

Let me be clear. Residency training is a critical element in enhancing patient care by expanding pharmacists' responsibilities. Residencies instill the confidence in young practitioners to have the courage to drive the profession past its current borders.

ASHP's residency policy is aspirational in nature, and the decision about whether to pursue a residency is a career decision. You also do not need a residency to obtain a pharmacist license. However, you do need a residency to pursue and advance along certain career paths, and the number of those career paths continues to grow every year.

There are four stages to the education and continued training of a pharmacist: prepharmacy undergraduate education, professional doctorate education, formalized training, and continuing professional development.

Coordinating the outcomes of each of these four stages is a professional imperative. Yes, the requirements for the prepharmacy and pharmacy curricula will continue to evolve. But we must recognize that there is only so much that we can accomplish in the classroom because (1) contact time is limited, and (2) students do not have pharmacist licenses.

At some point in time, the profession will need to address the following question: Should residency training be *required* for pharmacists to meet their obligation to their patients? At some point, that answer will be yes. Whether this happens by 2020 or not, it is far better for the profession to prepare for that future than to be unprepared when that future arrives.

Gaining provider status

Zina Gugkaeva, Pharm.D., a PGY1 resident at the University of Iowa Hospitals and Clinics in Iowa City, Iowa, asked the final question: "When are pharmacists finally going to be recognized as providers, and what will it change?"

Many of you may have attended the Provider Status Town Hall at this Summer Meeting where this very issue was discussed. Much of what we heard, we already knew:

- The health care environment is changing.
- Emerging practice models are focused on integrated health care delivery systems.
- Policymakers are seeking ways to make health care more affordable for more people.
- Payment will be focused on quality, not quantity, of care.
- Consumers will demand transparency in the cost of their care.

So, what will happen when pharmacists are recognized as health care providers?

- Pharmacists' patient care services will improve access.

- Pharmacists' patient care services will improve quality.
- Pharmacists' patient care services will help control costs.

There is substantial documentation to support the positive impact of pharmacists on access, quality, and the cost of care. We know it. Now we have to sell it. We must have the courage of our convictions.

The first step toward achieving provider status is to ensure that the profession moves forward with this common message by solidifying these basic principles within the existing coalition of pharmacy organizations. Then, we need to expand the coalition to include other critical stakeholders, including health care provider groups, payers, and patient advocates. We need to draft legislation and seek support by educating legislators, both on a state and national level.

ASHP will serve as your collective voice in formulating the message. ASHP will develop the materials needed to deliver that message. ASHP will tailor those materials for different audiences. And ASHP will train you.

But we need you to deliver the message to your legislators, to your C-suite, to your health system's lobbyists, to your health care colleagues, to your complacent pharmacist colleagues, to your local media, and to your patients.

Access, quality, and cost. The message is clear. The message is focused. The message meets society's needs.

Gaining provider status will ensure that pharmacy is at the table when regulators and other policymakers invite health care providers to help construct new delivery models. And that is why ASHP, the American Pharmacists Association, the American College of Clinical Pharmacy, and other health care organizations have committed significant resources to achieving provider status for pharmacists.

Zina, while no one can predict when we will finally succeed, I am confident that we will succeed if we have the courage to stand strong and united on this issue and if our members get personally involved.

I call upon all pharmacists who believe they are health care providers, on all student pharmacists who believe they are training to become

health care providers, on all people who want their medication use to be optimal, safe, and effective all of the time.

I call on everyone to send the message: "Pharmacists are medication-use experts. Pharmacists improve access, improve quality, and control the cost of health care. Pharmacists are health care providers."

In closing, I want to thank everyone who took the time to submit questions. I invite you to continue to send me your comments and suggestions over the next year to prez@ashp.org.

Finally, I want to thank you for the courage you show every day toward advancing ASHP's vision—"that medication use will be optimal, safe, and effective for all people all of the time."

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2013 Report of the President and Chair of the Board

Focused on the issues that members care about most

KATHRYN R. SCHULTZ

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As I conclude my presidential year, I want you to know what an amazing honor it has been to serve ASHP in this capacity. I also want to acknowledge and thank everyone seated here in the House of Delegates for your ongoing involvement and commitment to our organization and to the profession of pharmacy.

Most of all, I want to thank ASHP's Chief Executive Officer Paul Abramowitz, Pharm.D., Sc.D. (Hon.), FASHP, who has been a wonderful mentor and partner to me as I've navigated through this year. His advice, his humor, and his ability to really understand who our members are and what they need have been priceless to me.

In my inaugural address, I challenged ASHP members to play at the top of their game—to be an MVP, or most valuable pharmacist, within their own health care settings.¹ I can tell you with certainty that I have witnessed hundreds of MVPs throughout my presidential year, including members of this House, ASHP's councils and committees, members who I have met on my travels, and many ASHP staff members.

What a year it has been! Not only did ASHP celebrate its 71st anniversary, but it also created a new Center

At ASHP, we are continually working to stay responsive to the challenges our members face and the needs that they have.



on Pharmacy Practice Advancement, worked to expand pharmacy residency capacity, hosted a record-breaking Midyear Clinical Meeting, became the go-to organization on the issue of pharmacy compounding, and worked to advance new legislation on drug shortages.

Through it all, ASHP remained focused on the issues that its members care about most.

Looking to the future: Pharmacy Practice Model Initiative

ASHP's vision of pharmacy practice is that pharmacists are present in every medication-use decision made

on behalf of patients in every setting where health care is delivered. To get there, we need to close the patient care gaps that we know exist today and embrace a new world in which pharmacists are direct patient care providers. Collaborative practice must evolve even further to capitalize on the pharmacist's therapeutic expertise.

The Pharmacy Practice Model Initiative (PPMI), a joint project of ASHP and the ASHP Research and Education Foundation, is a critical factor in achieving this new world, and we gained some exciting momentum last year with the establish-

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ment of a new Center on Pharmacy Practice Advancement. Steve Nelson, formerly interim director of pharmaceutical care at the University of Iowa Hospitals and Clinics, is the center's director.

As part of our commitment to help members prepare themselves to provide top-quality care to patients across the medication-use enterprise, ASHP continues to broaden and deepen member resources in this area.

For example, the ASHP Research and Education Foundation is fostering the development of a new tool, the Drug Therapy Complexity Index, to help hospitals prioritize patients who require intense, pharmacist-provided drug therapy management.² This will be invaluable in both getting the proper care to medically complex patients and expanding the scope of pharmacy services within institutions.

In addition, the Foundation awarded six \$25,000 PPMI Demonstration Grants in 2013 to further stimulate practice innovation. I am also excited to report that the PPMI Hospital Self-Assessment (HSA) tool is gaining great traction across the country.³ As of today, more than 1200 hospitals have taken the assessment.

State affiliates continue to lead efforts in this area. In Rhode Island, Maine, New Hampshire, and Wisconsin, more than 50% of hospitals have taken the HSA. Texas and Indiana have been real standouts this year, as they actively encourage members to implement the HSA in their institutions.

Many of the hospitals that have completed the HSA are using the results to shine a light on patient care gaps within their institutions. Our goal is to have every hospital in the country take the HSA and develop an action plan based on the results.

The PPMI website hosts a rich variety of tools and information, including C-suite, resources to help members educate their executive teams about the many ways in which

pharmacists can improve safety, outcomes, and efficiency.

The National Dashboard scorecard is a great way to track aggregate data from hospitals across the country and see how your institution stacks up.⁴ And we are continually adding new case studies and spotlights of pharmacy teams who are utilizing the PPMI recommendations to bring about real change.

The success of new practice models will also depend on the availability of an educated, competent pharmacy technician workforce. ASHP continues to collaborate with state affiliates on the Pharmacy Technician Initiative, advocating for a single standard for accredited training, certification, and licensure by state boards of pharmacy.⁵

At ASHP, we also believe that it is crucial to have a place where technicians can go to get top-notch professional education and resources. To further that goal, the Board of Directors in 2012 approved the development of a pharmacy technician education portal on the ASHP website. To ensure that the portal meets the needs of the technician community, ASHP tapped the expertise of an advisory group of pharmacy technicians and pharmacists. The website, which launched in May 2013, offers a unique lineup of on-demand continuing-education (CE) activities and other resources for technicians.

I am happy to report that state affiliates were able to enter into a marketing partnership with ASHP that is a win-win for everyone. This partnership will help ASHP promote the new pharmacy technician education portal while adding value for affiliates through a revenue-sharing arrangement.

We also continue to produce publications such as the new *Pharmacy Calculations: An Introduction for Pharmacy Technicians* to support better technician education.

All of these activities and resources are just the start of the story where

the PPMI is concerned. The real action takes place at the grassroots level, within hospitals and health systems, as ASHP members move forward to transform the medication-use process for patients.

Honing member services and resources

At ASHP, we are continually working to stay responsive to the challenges our members face and the needs that they have. One of the ways we do that is to periodically take a look at the Society's governance, policymaking process, and membership structure. As you may know, we convened a Task Force on Organizational Structure last year that is being led by Past President Sara White. Sara is working with a diverse group of members across the entire spectrum of patient care.

We believe the task force's work will help us hone our services and resources to meet the needs of a changing membership. Stay tuned as this group finalizes its work in the next six months or so.

Update on residencies

This year marks two special anniversaries for ASHP: the 50th anniversary of ASHP accreditation of pharmacy residency programs and the 30th anniversary of ASHP accreditation of pharmacy technician programs. In fact, our President-Elect Gerry Meyer's own institution—Thomas Jefferson University Hospital in Philadelphia—was the very first pharmacy residency program surveyed for accreditation by ASHP in 1963.

Since then, more than 300 pharmacists have completed Jefferson residencies, creating a cadre of highly skilled pharmacists who bring advanced knowledge and expertise to the care of their patients. They join the more than 32,000 pharmacists across the country who have completed ASHP-accredited pharmacy residency programs since 1963.

That's truly an amazing number to contemplate.

In recent years, ASHP has focused its efforts on meeting the growing needs of members for advanced training through postgraduate year 2 (PGY2) residencies, developing 20 different sets of outcomes, goals, and objectives for PGY2 residency programs. PGY2 residency programs in emergency medicine are the most recent addition to the list of PGY2 programs accredited by ASHP.

We know that one of the continuing challenges for students seeking a residency is the limited number of positions available across the country, and ASHP has been working hard to close that gap by fostering the availability of more residency positions.

Since the Pharmacy Residency Capacity Stakeholder Conference in 2011, new models have been developed that significantly increase the number of residency positions at medical centers. These new positions not only boost capacity, they also increase the level of medication-management support to patients within these institutions.

In addition, we are seeing smaller hospitals and health systems implementing new residency programs. Since last year, there has been an increase of 388 residency positions, including 1 position at my own institution, HealthEast Bethesda Hospital in St. Paul, Minnesota. This represents a 13% increase in residency positions offered in the ASHP Resident Matching Program ("the Match").⁶

We continually work to hone the resources and tools that we offer to members seeking residencies and the program directors who run residencies. In October 2012, we launched the Pharmacy Online Residency Centralized Application Service, or PhORCAS.⁷ This program allows applicants to submit and track their applications—and all supporting material—through a single website. Similarly, residency program administrators can receive and organize

those applications through their own electronic portals.

There clearly was a need for this product in the marketplace. Approximately 1500 residency programs in the ASHP accreditation process that recruited for positions in the 2013 Match used PhORCAS. Initial reports show that many residency programs saved a significant amount of time during the selection process due to the implementation of this new tool.

Other popular resources include the Preceptor Skills Resource Center⁸ and the accreditation portion of ASHP's website.⁹ Both offer education modules to help residency directors understand ASHP's accreditation standards. In addition, the RU Ready assessment tool for pharmacy residency programs helps smooth the way for hospitals either considering developing a residency or preparing for an accreditation survey.¹⁰

Students will find support in the numerous educational sessions on networking, resumé development, and job interview skills that we offer at the Midyear Clinical and Summer meetings. A new book, *Get the Residency: ASHP's Guide to Residency Interviews and Preparation*, is helping students learn how to present themselves in the best light during an interview.

As you can see, we are operating on a number of different fronts to expand residency capacity and support members who are seeking or offering a residency. And we are moving in the right direction.

I am happy to report that more than 4400 graduating pharmacy students and new practitioners participated in the 2013 Match,¹¹ the highest number since the program began in 1979. Compared with the 2012 Match, this number represents a 6% increase in postgraduate year 1 applicants and a 10% increase in the number of PGY2 applicants.^{11,12}

Our goal is to ensure that, in the future, every student who is seeking a residency will be able to find one.

Evolution of ASHP CE

Throughout its 71-year history, ASHP has focused on helping pharmacists further their education, training, and clinical knowledge. In today's world, CE comes in many forms, and we are striving to provide what members need, in many types of settings and formats.

Toward that end, ASHP launched an innovative eLearning website in 2012 that provides CE credits and learning modules about a variety of therapeutic-, management-, and practice-related topics.¹³ The site also features resources to help candidates taking Board of Pharmacy Specialties certification exams in pharmacotherapy and ambulatory care.

Of course, no mention of CE would be complete without an acknowledgment of ASHP's popular Midyear Clinical Meeting. Last December's Midyear meeting in Las Vegas broke all records for attendance, with more than 22,000 attendees, including pharmacists from 40 countries.

The meeting featured a new ambulatory care track that was standing-room only, a timely session on the aftermath of the New England Compounding Center (NECC) bacterial meningitis outbreak, and special tracks for students, new practitioners, pharmacists who practice in small and rural settings, and pharmacists who are federally employed.

Of course, our groundbreaking opening session featuring President Bill Clinton as the keynote speaker was a huge success. Approximately 12,000 pharmacists, students, and other attendees came to hear President Clinton talk about the intersection of health, economics, and politics. He also spoke to the critical role of pharmacists, saying that our profession is perfectly poised to bring about better patient care in the United States.

I hope that many of you are taking advantage of the great sessions and information sharing offered by ASHP's first annual Medication

Safety Collaborative. Occurring side-by-side with the Summer Meeting, this new event is targeted to interprofessional team members and administrators who focus on quality and patient safety within their practice sites.

Our goal for the Collaborative is for it to become the premier educational event for hospital and health-system pharmacists, patient and medication safety officers, nurses, physicians, risk managers, and others seeking to improve patient outcomes.

You will also note at this Summer Meeting that we are featuring an educational track dedicated to leading an innovative practice in ambulatory care settings. This is where attendees will learn how to implement quality-improvement initiatives, develop communication and conflict management strategies, and explore ways to develop and expand ambulatory care services.

Pursuing quality in compounding

Issues with quality in compounding continue to make front-page news. The NECC case, in which dozens of patients died and hundreds more were infected with bacterial meningitis, should be a wake-up call for all of pharmacy.

As you know, ASHP has a long history of creating guidelines, policies, and resources for safe compounding. Over the past year, we have also embarked on a targeted approach to the issue of compounding in hospitals and health systems.

In the immediate aftermath of the NECC tragedy, we created a series of communications to inform members and policymakers about the vast array of compounding resources available on both the ASHP and ASHP Research and Education Foundation websites.

We continue to advocate strongly with Congress and the Food and Drug Administration (FDA) for enhanced safeguards to help ensure that what happened at NECC will not

happen again. Kasey Thompson, vice president of ASHP's Office of Policy, Planning, and Communications, testified before a Senate committee in November 2012 and again on May 9 of this year. On behalf of ASHP, he called for stronger communication and collaboration between state boards of pharmacy and FDA.

ASHP also recommended that FDA be given the resources it needs to perform meaningful regulatory oversight of large-scale compounding manufacturers.

This same committee released draft legislation that includes many of the provisions we sought.¹⁴ For instance, it recognizes the role of states in overseeing traditional compounding, including compounding that occurs in hospitals and health systems.

The legislation also creates a new definition of a "compounding manufacturer" that would be overseen by FDA. Entities that engage in interstate commerce and those that compound preparations either without or in advance of a prescription would be considered compounding manufacturers.

ASHP has always advocated for the rights of pharmacists in all practice settings to compound on behalf of their patients. This time-honored ability to create a medication tailored to the specific needs of individual patients is essential to how we provide health care.

We must protect that capability while working with regulators and legislators to oversee those who practice an unregulated version of drug manufacturing.

To support its members, ASHP created a new Sterile Compounding Resource Center on its website.¹⁵ There, members can find a vast number of resources on safe compounding practices, including guidelines on outsourcing sterile compounding services. New video modules on compounding now offer online training and competence assessment tools.

We also developed a C-suite discussion guide to help members educate administrators on the importance of compounding in patient care.¹⁶ The guide clearly states ASHP's position on the difference between compounding and manufacturing.

It is critical that the public understand these issues. So, we ramped up our public relations efforts to educate patients and other stakeholders in 2012 and the first half of this year.

ASHP spokespeople, including many members, conducted hundreds of media interviews throughout the year on issues as diverse as drug shortages, safe compounding practices, and pharmacists' changing health care roles. These interviews led to stories in more than 800 media outlets in which ASHP was mentioned. With these stories, we reached more than 7.5 million consumers with messages about pharmacists' role in safe medication use.

Finally, ASHP held a compounding summit in collaboration with The Pew Charitable Trusts and the American Hospital Association on February 6, 2013, in Washington, DC. We were joined by top government officials, practitioners, professional associations, and nationally recognized experts in compounding and manufacturing.

We explored the scope of sterile compounding and associated risk factors, the differences between sterile production expectations under Current Good Manufacturing Practices and *U.S. Pharmacopeia* chapter 797, and oversight roles for states and the federal government. Recommendations that came out of this summit are now posted in the Sterile Compounding Resource Center.¹⁷

Combating chronic drug shortages

ASHP continues its focused work to help members deal with drug shortages. This issue has become a chronic source of difficulty and stress

for many practitioners, as commonly used medications become scarce.

One particularly heartbreaking example of how shortages affect patients was reported in February of this year, resulting from a critical shortage of drugs for premature infants requiring total parenteral nutrition.¹⁸ The images of zinc deficiency dermatitis that occurred in these vulnerable patients were difficult to view and should never be seen in a country that prides itself on high-quality health care!

As part of our ongoing conversations with FDA, we let officials know how shortages of agents for fluid and electrolyte replacement, emergency care, and solutions used for i.v. nutrition support were affecting patients and caregivers.

The agency is trying to help drug manufacturers who make these critical medications get back to full capacity as soon as possible. And ASHP continues to update members as the situation evolves.

As you may know, ASHP's legislative efforts resulted last year in the passage of Title X of the Food and Drug Safety and Innovation Act, which is designed to prevent and mitigate drug shortages.¹⁹ ASHP helped to secure a number of provisions in the law, including the early notification requirement that compels manufacturers to notify FDA when they stop producing a product due to a quality issue or discontinuation of the product.

I am happy to report that this provision has already resulted in fewer new drug shortages. It has also greatly improved FDA's ability to respond to a potential shortage by securing medications through other U.S. manufacturers or by finding sources abroad.

In addition, the law creates a generic user-fee program that will help shorten the time it takes to approve a generic drug application. Although this program has not been implemented yet, ASHP is working with

FDA and Congress to ensure that this program is funded.

Since the passage of the Food and Drug Safety and Innovation Act, ASHP has conferred with the FDA's internal task force to provide guidance on preventing and mitigating shortages. We recently spoke with the Government Accountability Office about the causes and effects of drug shortages, FDA's response to shortages, and incentives to prevent, alleviate, and resolve shortages.

As great as all of these developments are, we know that they are not a complete answer. To identify more solutions, ASHP continues its work with key partners, including the American Hospital Association, the American Society of Anesthesiologists, the American Society of Clinical Oncology, and the Institute for Safe Medication Practices.

Recently, ASHP cohosted a meeting with those partners, FDA, and a number of other members of the supply chain, including manufacturers, wholesalers, and group purchasing organizations. The meeting resulted in a renewed commitment to work with FDA and other stakeholders to combat this problem.

Finally, as you know, one of ASHP's key roles is to provide resources and information to help members manage drug shortages. Toward that end, we recently revamped the Drug Shortages Resource Center website.²⁰ Users can now search shortage bulletins by a drug's generic name and find links to ASHP's ongoing advocacy efforts to minimize the impact of shortages on patient care.

Rest assured that we are continuing our work on this issue. In fact, the local Minneapolis ABC News affiliate featured a story this week on drug shortages and interviewed Bona E. Benjamin, director of medication-use quality improvement at ASHP, and me.

And we are counting on you to continue your engagement as well!

Conclusion

Although what I have reported on here today comprises highlights of ASHP's accomplishments over the past year, it should give you a sense of our priorities and the many ways in which ASHP is working to support you and all of our 42,000-plus members.

Your work—and the sacrifices you have made in your professional life and at home in order to be here—are critical to this effort. The discussions and policies that emanate from this House of Delegates are essential steps in ASHP's ongoing drive to expand patient care roles for pharmacists and improve medication use for all patients.

Whether it is the policy on provider status, pharmacy compounding, or residency training, I want to thank you for the amazing commitment you have shown to helping us drive practice change forward.

We have strength in numbers. We have unprecedented focus on the things that matter. And we are a community of MVPs working toward a better future for patient care. I hope that you are as proud as I am to be part of ASHP's vision and mission.

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*2013 Report of the Chief Executive Officer***Keeping ASHP and our profession strong:
New vision, strategic plan, and initiatives**

PAUL W. ABRAMOWITZ

Am J Health-Syst Pharm. 2013; 70:1439-43

I'm delighted to be here today to talk to you about some of our accomplishments this year and how we intend to keep ASHP strong.

But, first, I'd like to take a moment to acknowledge the absolutely wonderful job that Kathy Schultz, Pharm.D., FASHP, has done in her role as president.

Among many other accomplishments, Kathy helped lead the development of ASHP's new strategic plan, contributing significantly to a difficult but important process. She has served in her presidential role with real grace and a focus on what matters most to members. Thank you, Kathy, for all you've done for ASHP, for the profession, and for our patients over the past year!

During this, my second year as ASHP chief executive officer (CEO), we've taken a hard look at a number of ASHP initiatives to ensure that they support and further what our organization is all about. We believe that these efforts—which are constructed on the foundation of an exciting new vision and strategic plan—will yield tremendous results for members, for the profession of pharmacy, and for our patients.

We are working hard to transform ASHP into an agile organization that is both proactive in today's changing environment and responsive to challenges that arise.

**A new milestone: 40,000+ members**

Before I go into the details of our new vision and strategic plan, I wanted to talk briefly about two milestone events that occurred this year.

I'm very excited to report to you that as we celebrate our 71st anniversary, we have also reached a new membership milestone. ASHP is now 42,000 members strong and just about to reach 43,000! Our Society, which began in 1942 with 154 charter members, has come such a long way. Our ongoing efforts to attract and

retain a growing membership really shows what an important role ASHP plays in supporting members with excellent resources, continuing education, and advocacy on your behalf.

Headquarters building named for Dr. Oddis

As you know, Dr. Joseph A. Oddis, Sc.D., ASHP's former CEO, has been a huge force for good both within ASHP and throughout our profession. To honor all of his achievements and contributions, ASHP's Board of Directors in January voted

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Presented to the ASHP House of Delegates at the ASHP Summer Meeting, Minneapolis, MN, June 4, 2013.

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to rename our headquarters the Joseph A. Oddis Building. And we held a very moving dedication ceremony in April.

Joe's leadership over nearly four decades helped shape ASHP into the strong, vibrant, growing, and influential organization it is today. Joe's vision for what pharmacists and ASHP could be and the important role we can play in shaping pharmacy practice, improving patient care, and influencing public policy put us on the map as a profession and as an organization.

Dr. Oddis's accomplishments are too numerous to note here, but I urge you to go to *ASHP InterSections* or to ASHP Connect to read my column about his work. We are very lucky to have had Joe leading the profession all of these years.

A productive year

The past year has been an incredibly fruitful and productive one for ASHP. We envision a future for practice in which pharmacists' roles expand across the entire continuum of care, especially in the clinic and ambulatory care settings. We believe that patients need a pharmacist who can serve them throughout the continuum of care, help them manage chronic disease, and focus on health and wellness.

At ASHP, we continue to strive to ensure that pharmacists can fully utilize their knowledge, skills, and influence to improve patient care as members of interprofessional teams. An important part of that future will include pharmacist prescribing; we have already seen its growth in our Veterans Affairs hospitals and clinics. And we are witnessing the evolution of collaborative practice into interdependent prescribing at many other sites.

To help advance these different models of care, ASHP and the ASHP Research and Education Foundation will be hosting a new Ambulatory Care Conference and Summit

in Dallas in March 2014. This event will combine continuing education and a practice model consensus conference focused on ambulatory care and transitions of care. We believe that those of you who practice in the ambulatory care setting, who are interested in connecting care between settings, or who want to know more about moving our profession in that direction should attend this conference. Watch for more information as we finalize the details!

We are working hard to transform ASHP into an agile organization that is both proactive in today's changing environment and responsive to challenges that arise. As you are well aware, we are in an era of swift legislative, regulatory, financial, and technological changes in our health care system, but we are highly focused on meeting your needs in all of these areas.

A new vision and strategic plan

One of the ways that ASHP is able to stay on track and map our future action is through the creation and deployment of a strategic plan. Our new strategic plan, developed over several months under the guidance of the Board of Directors and with the input of a team of Section and Forum Executive Committee members and staff, is a deep and broad document.

One of the most important things to note is that this strategic plan is a significant departure from our former leadership agenda, which focused on professional priorities. This new plan truly integrates all ASHP activities and embodies our passion, our energy, and our unwavering commitment to you—our members—and the patients you serve.

In our work to create a new, dynamic strategic plan, we started by examining ASHP's vision statement. We wanted to make sure that it captured the value that pharmacists bring to patient care.

Our new vision—that medication use will be optimal, safe, and effective

for all people all of the time—is simple, straightforward, and profound. It is also a bold statement whereby we put a stake in the ground and say with absolute certainty that medication use must be held to the highest clinical standards. Note that it does not mention a site of care, thus emphasizing our role in and between all sites of care.

Working from this new vision statement, we then focused on revising ASHP's mission. Here, we moved beyond medications, setting the stage for a future in which pharmacists are patient care providers who follow and treat patients throughout their entire health care experience. It reads

The mission of pharmacists is to help people achieve optimal health outcomes. ASHP helps its members achieve this mission by advocating and supporting the professional practice of pharmacists in hospitals, health systems, ambulatory clinics, and other settings spanning the full spectrum of medication use. ASHP serves its members as their collective voice on issues related to medication use and public health.

This universal new mission encompasses all patients in every care setting. It moves beyond medications to show our members' roles across the spectrum of care, from treating disease to improving and maintaining health. This new mission also helped us to identify the strategic priorities and goals that we believe will drive improvements in patient care, public health, and advancements in pharmacy practice.

To bring our mission to life, we devised three high-level pillars. These include our patients and their care, our members and partners, and our people and performance.

The first pillar—*our patients and their care*—focuses on the central purpose of our work at ASHP and is the source of our inspiration. The

goals and objectives within this pillar provide a roadmap for how ASHP will help members care for their patients now and into the future. They focus on

- Improving medication outcomes,
- Advancing pharmacy practice,
- Helping the pharmacy work force meet patient needs,
- Providing professional development, and
- Advocating for laws, regulations, and standards.

The second pillar—*our members and partners*—highlights those who work to achieve our mission. The goals and objectives within this pillar relate to how we serve our members and how we work with other stakeholders. These goals include

- Maintaining a high level of member satisfaction,
- Growing membership,
- Supporting our state affiliates,
- Engaging members through Sections and Forums,
- Working in collaboration with our various partners in pharmacy and the broader health care community, and
- Publishing timely and innovative resources.

The third and final pillar—focuses on a vital element to our success and is *our people and performance*—the axis that supports us and on which we revolve. ASHP has long been known for its strong and forward-thinking staff team. If we are to meet and exceed the ambitious goals we've set for ourselves, we will need to continue to rely on our staff as an invaluable asset to the organization. Our goals for this pillar include

- Fostering staff excellence, teamwork, and innovation,
- Ensuring a financially strong organization,
- Maintaining an effective and energized governance,

- Effectively managing organizational infrastructure, and
- Fostering high-performance staff leadership.

A high-performance staff combined with a financially strong organization is central to the Society's ability to maintain and grow the member services we offer.

I am very excited about the future that this strategic plan moves us toward. We will use it to guide and direct all ASHP activities, focusing our work on the most important member issues and services. Please visit it in more detail on our website.

Provider status

As clinical practitioners, pharmacists' medication management expertise is unparalleled. And the data are conclusive: Pharmacists improve medication-use outcomes for patients when they are included on patient care teams.

But the laws recognizing the unique pharmacist contribution to interprofessional patient care have not caught up with the reality of pharmacy practice today. So, ASHP is reinvigorating its efforts to achieve provider status under the Social Security Act with new resources, coalitions, and focus.

As many of you know, we made provider status a centerpiece for our annual Legislative Day, and we have done substantial work to identify partners in Congress who may be open to working with us on this issue.

Over the past six months, I have been meeting with the CEOs and staffs of the national pharmacy organizations to determine how we can work together to maximize our collective resources. I am happy to report that we are developing principles for provider status that we will be using in our outreach to Congress and other decision-makers. Furthermore, the ASHP Board of Directors has initially allocated

\$500,000 for provider status efforts this year.

I know that we all agree that pharmacists are already patient care providers who work day in and day out to ensure optimal health outcomes as members of the care team. It is now time for Congress and other policymakers to codify into law the fact that pharmacists are providers so that all patients and health care teams have access to the necessary services that only a pharmacist can provide.

I believe that by working in collaboration with other pharmacy associations, members of the public, other health care organizations, payers, providers, and others, ASHP is on the way to making provider status a reality.

But we cannot do it alone! As President Gerald Meyers did this morning when speaking of the need for pharmacist provider status in his inaugural address, I also challenge everyone here today—and your colleagues back home—to demonstrate to elected officials how you and your organization improve outcomes and reduce costs for your patients and their constituents.

ASHP's members, state affiliates, and pharmacy students can help by seeking partnership opportunities and building state-based coalitions to educate and advocate to our policymakers, health care payers, and the public.

As we go forward, it is important to remember that achieving provider status will take time. This kind of major change to the Social Security Act will be difficult, literally requiring an act of Congress to make it happen. But it is central to the recognition that pharmacists must be an integral part of every health care team! We will keep you involved and informed at every step along the way.

The importance of relationships

Relationships are at the heart of everything that ASHP does, whether we're talking about the important relationships forged right here in the

House of Delegates or about ASHP's relationships with our members, affiliates, and other pharmacy and health care organizations.

Relationships with state affiliates. I mentioned in last year's House of Delegates address how important I believe it is for ASHP to have a direct line of communication with our members. Last year, I reported on attending annual meetings of our state affiliates. Since this House last met, I have visited members at our affiliates in California, Nevada, Oregon, Michigan, Minnesota, and Wisconsin. I will be visiting Mississippi next month and Virginia later in the fall.

Talking with members at the state society annual meetings allows me to better understand your needs and helps to spread the word about what we are doing at the national level to support you.

Relationships with members. I also initiated a new program this year at the Midyear Clinical Meeting called "Coffee with Paul" to help me connect with members. Fifty ASHP members, from various professional backgrounds, were randomly selected to participate in a morning session during which I entertained any questions and comments about our Society or the profession that members wished to put forward.

We had a great conversation. This first event was another opportunity for me to listen and engage with members firsthand about what is impacting them in their practice. I will enlarge and continue this at future Midyear meetings.

In this, my second year as CEO, I've made it a priority to solidify relationships with members in all kinds of health care settings. When I travel, I try to visit hospitals, clinics, and colleges of pharmacy to witness the many ways that pharmacists are working to improve patient care. I continue to see amazing innovations during my travels, and I always get reinvigorated when I meet with our members.

Relationships with other health care organizations. There are all kinds of relationships in pharmacy. For ASHP, this includes relationships with our partner pharmacy organizations.

This year, we joined the American Pharmacists Association and the National Association of Boards of Pharmacy in becoming partners for the governing body of the Center for Pharmacy Practice Accreditation (CPPA). CPPA, which was formed in 2011, is leading efforts to ensure that pharmacists are involved in creating and guiding the implementation of voluntary pharmacy accreditation standards. As many of you know, Past President Lynnae Mahaney was chosen last November as CPPA's first executive director.

It makes sense for ASHP to take a leadership role with CPPA. We've long advocated for the need for accreditation standards to help organizations demonstrate the quality of their care and its delivery. And our involvement in CPPA will ensure that our leadership and experience in hospital and health-system practice influence the creation of such standards for all practice settings.

I am happy to report that CPPA released the first standards for community pharmacy practice accreditation in March, focusing on patient care services, quality improvement, and practice management.¹

Throughout its 71-year history, ASHP has always been on the side of patient safety. Indeed, the safe and effective use of medications is the central focus of our profession. It is important to build relationships and coalitions in this area that strengthen our influence on this issue.

So, we have been exploring with the National Patient Safety Foundation the potential to establish a new medication safety credential. We also continue to work together to find areas of common interest, including offering continuing education and training programs on patient safety.

It is clear that pharmacists are natural leaders in many parts of the health care enterprise, including the management of patients as they move from hospital to home. You may have heard about an important partnership between ASHP and the American Pharmacists Association that I believe will yield positive change as patients move from inpatient care to other settings. The joint Medication Management in Care Transitions Project is focused on identifying best-practice models that involve pharmacists in care transitions.² More than 80 institutions from around the country responded to our professionwide call for best practices in this area. We then assembled expert panels that chose eight of the very best programs. We are sharing these best practices widely, focusing on health care providers and organizations, government agencies, and other interested stakeholders.

Relationships with staff. At ASHP, we take all of our relationships very seriously. And, as many of you who have worked closely with Society staff know, our organization has an unparalleled number of smart, dedicated people who work hard to further ASHP's vision and mission.

To honor that dedication and to incentivize staff to keep striving, we have developed new and innovative ways to celebrate extraordinary staff accomplishments.

One example was the creation of a new CEO Award for Staff Excellence to acknowledge individuals who perform their jobs with excellence and demonstrate exceptional initiative in contributing to the overall goals of the organization.

The first two recipients—Joe Hill, ASHP's director of federal legislative affairs, and Diane McCleskey, ASHP's director of eLearning and logistics—were recognized at the Midyear Clinical Meeting in Las Vegas.

Throughout his time at ASHP, Joe has worked very effectively to enhance

ASHP's reputation among members of Congress, other policymakers, and stakeholders. Diane helped to develop and implement the Society's first learning management system, among many other accomplishments.

Joe and Diane are excellent examples of what members of a high-performing team can accomplish, and we really appreciate their work.

Another initiative that we are tackling is in the area of ASHP's staff culture. We want the Society to continue to be known as a place where staff members are challenged and satisfied in their work and where they are empowered in their efforts to support ASHP members.

To ensure that staff members know firsthand the kind of work that members do and understand the challenges they face, we are increasing our staff visits to our members' hospitals. Groups of staff this year have toured the pharmacies at Shady Grove Adventist Hospital in Rockville, Maryland; Johns Hopkins Hospital in Baltimore; and the University of Maryland Medical System.

Finally, I continue to schedule small group lunches with our staff members. These lunch meetings encourage an open, continuous dialogue in which we talk about challenges before us and share ideas about how to move ASHP forward.

Conclusion

As I conclude my remarks today, I hope that you are as excited about the future of ASHP's work to support members and their patients as I am. Everything we do at ASHP—from our work to develop a new vision statement to the creation of a new strategic plan and all the activities we engage in on a daily basis—is done to support you, our members, and to help you achieve your professional ambitions and dreams.

We are entering a new era in pharmacy—an era in which we must be poised to provide extensive and comprehensive patient care and in which we'll be accompanying all of our patients on their journey through the entire health care continuum.

Our patients need our medication expertise and care. They need our

passion for wellness and the mitigation of chronic disease. ASHP is with you to help pave the way to

- Advance the profession of pharmacy into a new era of interprofessional teams,
- Advocate for you with federal and state legislators and policymakers,
- Provide you with the professional education and drug information resources you need, and
- Grow those career opportunities that are available now and those that will become available in the future.

We were here 71 years ago. We are here for you today. And we'll be here long into the future.

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2013 Report of the ASHP Treasurer

A Strong and Vibrant Organization

PHILIP J. SCHNEIDER

Each year, the ASHP Treasurer has the distinct pleasure of reporting to the membership the financial condition of the Society. The Society's fiscal year is from June 1 through May 31, coinciding with our policy development process and timetable. This report will describe ASHP's financial performance and planning for three periods, providing (1) the final audited prior-year numbers (for fiscal year 2012), (2) current-year (fiscal year 2013) projected performance, and (3) the budget for the fiscal year ending May 31, 2014.

ASHP segregates its finances into two budgets, core and program development. The core budget represents the revenue and expense associated with the core operations of the organization. The program development budget is intended for expenditures that are (1) associated with the initial development of new, enhanced, or expanded programs; (2) associated with time-limited programs; or (3) capital asset purchases. The program development budget is funded only from investment income.

The audit of the May 31, 2012, financial statements of the Society and the Society's subsidiary, the 7272 Wisconsin Building Corp., performed by the firm of Tate & Tryon, resulted in an unqualified opinion. Copies of the audited statements are available by contacting the ASHP Executive Office.

Fiscal Year Ending May 31, 2012—Actual

Last year I reported to you that we were projecting a surplus from core operations (\$815,543) and a loss in the program development budget due to negative investment income from the declining market value in the reserve portfolio (–\$1.7 million). That projection proved true, as the Society's net income before spending from net assets and before a pension adjustment totaled –\$1.8 million (Figure 1). The spending from net assets (a \$500,000 contribution to the ASHP Foundation's Henri R. Manasse Legacy fund) and a –\$3.6 million pension adjustment pushed the Society's 2013 loss to

–\$6.0 million. Nevertheless, the Society's net assets remained at a strong 54% of total expense. Our long-term financial policy is to maintain net assets at 50% of total ASHP and 7272 Wisconsin Building Corp. expenses, with a ceiling of 65% and a floor of 35%.

The Society's May 31, 2012, year-end balance sheet (Figure 2) remained impressive despite the reduction in net assets. The May 31, 2012, asset-to-liability ratio stood at \$2.10:\$1.00.

Fiscal Year Ending May 31, 2013—Projected

As of March 31, 2013, the financial performance from core operations for the year ending May 31, 2013, is projected to produce a net income of \$1.9 million (Figure 1). A strong performance in the stock market should return much of the portfolio value lost last year and help produce a program development budget surplus of \$4.4 million. Adding the core net income, the program development budget surplus, and allowing for \$250,000 net asset spending approved by the Board, the Society's total corporate net income is projected at \$6.1 million. If we achieve the year-end projections indicated in Figure 1, the Society's net assets at May 31, 2013, will be \$31.4 million, or 65% of total ASHP and 7272 Wisconsin Building Corp. expense. Our goal is to maintain net assets between 35 and 65% of total expenses.

Fiscal Year Ending May 31, 2014—Budgeted

The Society's 2014 core budget is essentially a balanced budget (Figure 1). Together, the core and program development budgets produce a \$43,965 surplus (Figure 1). Although spending from net assets (\$650,000, allocated primarily for the Provider Status Initiative) will cause an overall deficit for 2014, the Society's total net assets are still projected to be at a strong 59% of total expense.

7272 Wisconsin Building Corp.

The Society's subsidiary, the 7272 Wisconsin Build-

ing Corp., finished the 2012 fiscal year on a positive note, producing net income of \$1.7 million before owner's distribution (Figure 3). The subsidiary owns the headquarters building and derives income from leased commercial and office space.

Conclusion

As I complete my three-year term as your Treasurer, I am

pleased to be a part of a Board of Directors that is committed to advancing and supporting the professional practice of pharmacists in hospitals and health systems. I can say with confidence that ASHP continues to be a strong and vibrant organization from both a membership and financial viewpoint. With its strong financial resources, with the Board, membership and staff resources, ASHP is well positioned to meet the needs of the membership.

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

	Actual Fiscal Year Ended May 31, 2012	Projected Fiscal Year Ended May 31, 2013	Budget Fiscal Year Ended May 31, 2014
CORE OPERATIONS			
Gross revenue	\$ 40,508	\$ 41,907	\$ 42,500
Total expense	(40,537)	(41,629)	(44,054)
Earnings from subsidiary	1,652	1,500	1,425
Investment income subsidy	—	130	130
Core Net Income	\$ 1,623	\$ 1,908	\$ 1
PROGRAM DEVELOPMENT			
Investment income	\$ (1,762)	\$ 6,075	\$ 1,700
Program expenses	(1,691)	(1,627)	(1,658)
Program Development Net Income	\$ (3,453)	\$ 4,448	\$ 42
Programs Funded from Net Assets	\$ (500)	\$ (250)	\$ (650)
ASHP Net Income	\$ (2,330)	6,106	\$ (607)
Pension Plan Adjustment	(3,632)	—	—
ASHP Net Income	\$ (5,962)	\$ 6,106	\$ (607)
Net Assets Beginning of Year	\$ 31,278	\$ 25,316	\$ 30,651
ASHP Net Income	(5,962)	6,106	(607)
Net Assets End of Year	\$ 25,316	\$ 31,422	\$ 30,044
% of Total Expense	54%	65%	59%

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

	Actual as of May 31, 2012	Actual as of May 31, 2011
ASSETS		
Current assets	\$ 3,811	\$ 4,959
Fixed assets	1,288	1,741
Long-term investments (at market)	39,110	41,419
Investment in subsidiary	3,691	3,035
Other assets	434	384
Total Assets	<u>\$ 48,334</u>	<u>\$ 51,538</u>
LIABILITIES		
Current liabilities	\$ 12,968	\$ 12,934
Long-term liabilities	10,050	7,326
Total Liabilities	<u>\$ 23,018</u>	<u>\$ 20,260</u>
NET ASSETS		
Net assets	\$ 25,316	\$ 31,278
Total Net Assets	<u>\$ 25,316</u>	<u>\$ 31,278</u>
Total Liabilities and Net Assets	<u>\$ 48,334</u>	<u>\$ 51,538</u>

Figure 3. 7272 Wisconsin Building Corp. (ASHP subsidiary) statement of financial position and statement of activities for fiscal year 2012 (in thousands).

	Fiscal Year Ended May 31, 2012		Actual As of May 31, 2012
REVENUE AND EXPENSE		ASSETS	
Gross revenue	\$ 6,653	Current assets	\$ 1,384
Operating expense	4,326	Property and plant (net)	16,933
Operating Income	<u>\$ 2,327</u>	Other assets	2,114
		Total Assets	<u>\$ 20,431</u>
Provision for income taxes	\$ 675	LIABILITIES	
Increase in Net Assets	<u>\$ 1,652</u>	Current liabilities	\$ 901
		Mortgage payable	15,262
Owners distribution and capital contributions	\$ (996)	Other liabilities	577
		Total Liabilities	<u>\$ 16,740</u>
Net Increase in Net Assets	<u>\$ 656</u>	NET ASSETS	
		Net assets	\$ 3,691
		Total Net Assets	<u>\$ 3,691</u>
		Total Liabilities and Net Assets	<u>\$ 20,431</u>



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Policy Recommendations

Council on Pharmacy Management

- A. Payer Processes for Payment Authorization and Coverage Verification
- B. Interoperability of Patient-Care Technologies
- C. Effect of the Proliferation of Accreditation Organizations on Pharmacy Practice Management
- D. Drug Product Reimbursement
- E. Principles of Managed Care
- F. Multidisciplinary Action Plans for Patient Care

Council on Pharmacy Practice

- A. Role of Pharmacists in Sports Pharmacy and Doping Control
- B. Standardization of Intravenous Drug Concentrations
- C. ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

Council on Public Policy

- A. Pharmacist Recognition as a Health Care Provider
- B. Compounding by Health Professionals
- C. Pharmacists' Role in Immunization and Vaccines
- D. Regulation of Telepharmacy Services
- E. Regulation of Centralized Order Fulfillment

Council on Therapeutics

- A. Medication Overuse
- B. Drug-Containing Devices
- C. DEA Scheduling of Hydrocodone Combination Products
- D. DEA Scheduling of Controlled Substances

Council on Education and Workforce Development

- A. Pharmacy Resident and Student Roles in New Practice Models
- B. Education and Training in Health Care Informatics Pharmacy
- C. Diversity and Cultural Competence
- D. Standardized Pharmacy Technician Training as a Prerequisite for Certification
- E. Entry-Level Doctor of Pharmacy Degree
- F. Patient-Centered Care

Section of Pharmacy Informatics and Technology

Statement on the Pharmacy Technician's Role in Pharmacy Informatics

Board of Directors Reports on Councils. ASHP councils met in Bethesda, Maryland, on September 17–19, 2012. Each report has three sections: Policy Recommendations (new policies initiated by the council, approved by the Board of Directors, and subject to ratification by the House of Delegates); Board Actions (Board of Directors consideration of council recommendations that did not result in new policies, and actions by the Board in areas for which it has final authority); and Other Council Activity (additional subjects the council discussed, including issues for which it has begun to develop policy recommendations). The House may consider additional policy recommendations presented by the Board of Directors or by the Committee on Resolutions.



Board of Directors Report on the Council on Pharmacy Management

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

Larry C. Clark, *Board Liaison*

Council Members

- James A. Klauck, *Chair* (Wisconsin)
- David B. Weetman, *Vice Chair* (Iowa)
- Colin R. Beatty, *Student* (Texas)
- Deborah A. Brown (Florida)
- Debra L. P. Cowan (North Carolina)
- Daniel Good (Missouri)
- Kayla M. Hansen, *New Practitioner* (North Carolina)
- Karl H. Kappeler (Ohio)
- Despina Kotis (Illinois)
- Scott M. Mark (Pennsylvania)
- Brandon J. Ordway (Minnesota)
- Ross W. Thompson (Massachusetts)
- Patricia J. Killingsworth, *Section of Pharmacy Practice Managers Liaison* (Colorado)
- David F. Chen, *Secretary*

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(Click on title to view section)

Policy Recommendations



A. Payer Processes for Payment Authorization and Coverage Verification

- 1 To advocate that public and private payers collaborate with each other and with health
- 2 care providers to create standardized and efficient processes for authorizing payment
- 3 or verifying coverage for care; further,

- 4 To advocate that payment authorization and coverage verification processes (1)
- 5 facilitate communication among patients, providers, and payers prior to therapy; (2)
- 6 provide timely payment or coverage decisions; (3) facilitate access to information that
- 7 allows the pharmacist to provide prescribed medications and medication therapy
- 8 management to the patient; and (4) foster continuity in patient care.

(Note: This policy would supersede ASHP policy 1206.)

Rationale

Patients and health care providers are required to navigate an array of payment requirements from private and public payers. Private insurers enforce their own prior authorization procedures, state Medicaid programs have their individual program requirements, and Medicare has its local and national coverage determinations. These payment authorization and verification processes vary considerably from payer to payer and are time consuming and needlessly complex. The required data, forms of documentation required, submission processes, coverage verification procedures, and delivery of approval vary widely among payers. These processes are often not integrated into the patient-care process and require manual documentation and submission. The lack of timely review and approval may delay patient care. Payment authorization and verification processes should effectively facilitate communication among both patients and providers, should be standardized and automated, and should result in timely decisions that do not disrupt patient care.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 1206, Prior Authorization, as follows (underscore indicates new text; ~~strike through~~ indicates deletions):

To advocate that public and private payers ~~work together and in collaboration~~ collaborate with each other and with health care providers to create standardized and efficient ~~strategies~~ processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes, ~~such as local and national coverage determinations, that~~ (1) facilitate communication ~~between~~

among patients, providers, and payers prior to therapy; result in (2) provide timely payment or coverage decisions; and do not disrupt (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

The Council discussed the concerns expressed by the 2012 House of Delegates that suggested that the policy should be reassessed to ensure that it captures the full scope and intent of the Council's 2011 discussion, accurately reflects industry terminology, and describes patient and provider needs. The Council reviewed policy 1206 to ensure the policy's appropriateness with respect to (1) achieving the policy's original intent related to patient care, and (2) the terminology and practices of the health insurance industry.

Policy 1206 referred to prior authorization, which is the requirement of third-party payers for providers to obtain approval for certain medical services or use of certain medications in advance. Depending on a health plan's coverage provisions, the necessity of a service or medication or the urgency of care might have no bearing on whether the plan authorizes payment for the service. The Council felt the policy needed to be amended to more clearly distinguish the difference between payment authorizations such as specific prior authorizations by payers and coverage determinations defined by Medicare and its fiscal intermediaries. Additionally, the Council noted the need to more directly recognize the role of the pharmacist as a care provider in the medication management continuum as well as the need to strive toward more efficiencies, such as automating these processes.



B. Interoperability of Patient-Care Technologies

- 1 To encourage interdisciplinary development and implementation of technical and
- 2 semantic standards for health information technology (HIT) that would promote the
- 3 interoperability of patient-care technologies that utilize medication-related databases
- 4 (e.g., medication order processing systems, automated dispensing cabinets,
- 5 intelligent infusion pumps, electronic health records); further,
- 6 To encourage the integration, consolidation, and harmonization of medication-
- 7 related databases used in patient-care technologies to reduce the risk that outdated,
- 8 inaccurate, or conflicting data might be used and to minimize the resources required
- 9 to maintain such databases.

Rationale

There are significant pharmacy management issues associated with the multiplicity of medication databases in hospitals and health systems. Among the issues are lack of standardization in the medication databases used in pharmacy order-processing systems, automated dispensing cabinets, intelligent infusion pumps, electronic health records, and other patient-care-related technologies dependent on accurate and harmonized medication databases. In addition, there is variability in the primary sources of medication information in

these databases and in how the databases are updated. The longstanding issue of lack of interoperability of medication-related information technology compounds the problem. The risk-management implications of this situation are not fully understood, but the urgent need to address this complex issue increases as the dependence on information technologies and the accuracy of associated information proliferates to more aspects of patient care.

Although it is important to recognize the differences among technologies used in patient care, there is a need to have both a standardized format to describe medications as well as means for efficiently managing the medication databases in order to safely populate and update the different technologies that rely on drug information. Coalitions such as the Pharmacy e-Health Information Technology Collaborative are increasingly important in providing expertise, organizing and participating in stakeholder events, and advocating for best practices. It may, however, be necessary for other organizations to convene stakeholders to develop standards for the harmonization of medication-related databases.

Background

The Council discussed the challenges of managing multiple medication databases. The Council and Board agreed that ASHP should establish policy encouraging collaboration between community and health-system pharmacy leaders and other stakeholders to achieve a higher level of medication-system connectivity, harmonization, and integration by advocating for technical and semantic medication standards that support system interoperability. The Council also felt there is a need to address health systems' need to build and strengthen relationships with internal and external stakeholders that influence HIT development. In addition, the Council felt pharmacy leadership is critical in establishing, managing, assessing, and ensuring the accuracy of medication databases used in health systems, and amended the rationale to ASHP policy 1211 to emphasize this important role.



C. Effect of the Proliferation of Accreditation Organizations on Pharmacy Practice Management

- 1 To advocate that health care accreditation organizations include providers and
- 2 patients in their accreditation and standards development processes; further,

- 3 To encourage health care accreditation organizations to adopt consistent standards for
- 4 the medication-use process, based on established principles of patient safety and
- 5 quality of care; further,

- 6 To encourage hospitals and health systems to include pharmacy practice leaders in
- 7 decisions about seeking recognition by specific accreditation organizations.

Rationale

Hospitals and health-system pharmacy leaders have years of experience in managing the demands and challenges of ensuring that pharmacy services meet the standards of

accreditation organizations. In order to be a qualified provider for the Centers for Medicare & Medicaid Services (CMS), hospitals need to be certified and meet the standards of an approved accreditation organization, or be accredited through the CMS state-based survey process. Until recently, this accreditation was predominantly performed by The Joint Commission (TJC). Hospitals with additional ambulatory care services (e.g., home infusion and durable medical equipment) have also had to manage the accreditation process for those business units. If a hospital is accredited by TJC, it is required to have the nonhospital-based business units surveyed by TJC if TJC has a corresponding accreditation process.

Accreditation of hospitals and health systems has improved the quality of and enhanced the services provided by those organizations. ASHP has participated for many years in the TJC standards development process, and TJC medication management standards have supported strong pharmacy services.

Until recently there were relatively few accreditation organizations that hospital and health-system pharmacy leaders needed to be familiar with. Three phenomena in recent years have created challenges for pharmacy leaders: (1) TJC is no longer the only accreditor for hospitals and health systems, (2) health systems are building or acquiring new business units with accreditation processes that need to be integrated into those of the broader health system, and (3) new accreditation processes are being established for operations or entities that pharmacy leaders may be responsible for or are considering.

Outsourcing of pharmacy services and the receipt and handling of prescription drugs for specialty pharmacy patients (“white bagging”) is another facet of the challenges that changes in accreditation have created for hospital and health-system pharmacy leaders. Many of these pharmacy providers may require accreditation, and hospital pharmacy leaders need to consider means to ensure the pharmacy provider is preferably or properly accredited.

The expansion of health systems and the growth of the pharmacy enterprise are creating a new need for pharmacy leaders to manage multiple accreditors and raising the potential challenge of managing overlapping accreditors (e.g., whether a hospital’s URAC-accredited specialty pharmacy also requires TJC review). Another concern is that when new accreditation processes become established as a requirement for providing pharmacy services, they can become a barrier to the creation or expansion of pharmacy servicing, restricting organizations’ growth. For example, it has been reported that four payers require URAC accreditation to be a specialty pharmacy provider. In addition, accreditation processes and standards for community pharmacy are being developed, and pharmacy leaders will need to consider those as well.

Background

The Council discussed the growing number of accreditation processes pharmacy leaders must manage and the effects of accreditation processes on their operations (e.g., additional requirements for information from partners and potential barriers to new pharmacy enterprises.) The Council and Board agreed that hospital and health-system leaders will need to understand the evolving marketplace of accreditation, especially as accreditation gets tied to the ability to provide pharmacy services in a particular business sector. In addition, the Council believed ASHP should develop education and resources addressing all accreditation organizations and the impact they have and will have on health-system pharmacy practice.



D. Drug Product Reimbursement

- 1 To pursue, in collaboration with public and private payers, the development of improved
- 2 methods of reimbursing pharmacies for the costs of drug products dispensed,
- 3 compounding and dispensing services, and associated overhead; further,

- 4 To educate pharmacists about those methods.

(Note: This policy would supersede ASHP policy 0207.)

Rationale

In well-intentioned efforts to reduce health care costs, public and private payers often seek to minimize the reimbursement to pharmacies for drug products. Historically, those reimbursements have sometimes exceeded the simple cost of the drug product to reimburse pharmacies for associated costs (e.g., storage, compounding, preparation, dispensing). Because cost-management efforts are likely to continue to reduce pharmacy reimbursement, other means of compensating pharmacies for those expenses will need to be found, and pharmacists will require education about those reimbursement methods.

Background

The Council discussed ASHP policy 0207 as part of sunset review. The Council and Board considered the policy to still be relevant but agreed to recommend amending the policy as follows in light of Policy Recommendation A from the Council on Public Policy regarding reimbursement for pharmacist patient-care services (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To pursue, in collaboration with public and private payers, the development of improved methods of reimbursing pharmacies for the costs of drug products dispensed, compounding and dispensing services, and associated overhead; further,

To educate pharmacists about those methods; ~~further,~~

~~To pursue, with federal and state health benefit programs and other third-party payers, the development of a standard mechanism for compensation of pharmacists for patient care services and compounding and dispensing services; further,~~

~~To pursue changes in federal, state, and third-party payment programs to (1) define pharmacists as providers of patient care and (2) issue provider numbers to pharmacists that allow them to bill for patient care services; further,~~

~~To educate and assist pharmacists in their efforts to attain provider status and receive compensation for patient care services.~~

The Council on Public Policy reviewed a delegate recommendation seeking a separate ASHP policy that advocates for legislative changes to recognize pharmacists as nonphysician practitioners eligible for compensation for patient-care services and concluded that it was essential that ASHP have a separate policy addressing provider recognition. The Council on Pharmacy Management concurred and revised policy 0207 to avoid redundancy with the new policy recommendation.



E. Principles of Managed Care

- 1 To discontinue ASHP policy 0709, which reads:
 - 2 To recognize that the principles of managed care have many applications in
 - 3 hospital and health-system pharmacy practice; further,
 - 4 To continue to include managed care topics in educational programming,
 - 5 publications, and professional-practice-development initiatives; further,
 - 6 To continue to serve the professional needs of ASHP members who practice
 - 7 in managed care organizations.

Background

The Council discussed policy 0709 as part of sunset review. The Council and Board agreed that the policy was no longer relevant due to changes in ASHP's membership. In addition, managed care and health care reimbursement policies have since been developed that more clearly address the issues outlined in the policy.



F. Multidisciplinary Action Plans for Patient Care

- 1 To discontinue ASHP policy 9804, which reads:
 - 2 To support pharmacists as integral participants in the development of
 - 3 multidisciplinary action plans for patient care (care MAPs), disease-management
 - 4 plans, and health-management plans.

Background

The Council discussed policy 9804 as part of sunset review. The Council and Board agreed that the policy was no longer relevant. The Council reviewed related policies and guidance documents describing the roles, responsibilities, and accountabilities of pharmacists in patient care and as members of multidisciplinary care teams and decided the more current policies and guidance documents are more contemporary and accurate in describing their roles as patient-care providers.

Board Actions

Sunset Review of Professional Policies

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

- [Health-System Use of Medications and Administration Devices Supplied Directly to Patients](#) (0806)
- [Unit Dose Packaging Availability](#) (0309)
- [Technician-Checking-Technician Programs](#) (0310)

Other Council Activity

Medication Misadventures

The Council reviewed ASHP policy 9805, [Medication Misadventures](#), as a part of sunset review of policies and believed the policy should be revised but felt that additional information was required prior to undertaking a revision. The Council voted to request that topic be placed on the agenda for next year's Council on Pharmacy Practice and asked staff to gather further background relating to this policy.

Technician Leadership Development

The Council discussed the expanding role of technicians and the role of leadership development with technicians and voted to develop an ASHP statement on the training and advancement necessary in the roles of pharmacy technicians. Based on the premise that pharmacy practice model change will require the development of leadership skills among pharmacy technicians, the Council reviewed ASHP's related policies and discussed programmatic implications for ASHP.

The Council believed that an attendant need is for technicians to become more professionalized and autonomous over time as their knowledge, skills, and abilities advance. In the Council's review of ASHP's current policies, the Pharmacy Technician Initiative, and the Pharmacy Practice Model Initiative (PPMI), it was felt there was a need to tie together the principles of all of these positions and activities in a statement that addresses the comprehensive expectations and needs of pharmacy technicians. The discussion included aspects of leadership necessary and the responsibilities of health system pharmacy leaders.

Evolving Concerns about Medications and Administrative Devices Supplied Directly to Patients

In conjunction with sunset review of ASHP policy 0806, Health-System Use of Medications and Administration Devices Supplied Directly to Patients, the Council considered new issues that have emerged regarding this topic. The Council also reviewed the comprehensive 2010 [Report](#)

[of the ASHP Task Force on Caring for Patients Served by Specialty Suppliers](#) for its bearing on ASHP policy. Among the new issues is whether state boards of pharmacy might consider it a violation of redispensing prohibitions when specialty pharmacies provide the patient with an injectable medication and then expect a local pharmacy or health care facility to prepare and administer the therapy. In addition, the Council felt there should be a more direct mention of various scenarios commonly described as “brown bagging” and “white bagging” and how these situations affect patient access to medications and risks imposed upon the facility providing the preparation or administration of the medication. The Council felt the existing policy 0806 had adequate policy language to provide direction for advocacy and education, but that without a strong rationale the policy did not fully convey the challenges and risks faced by health system in managing medications and administrative devices supplied directly to patients during their health system admission. The Council agreed to develop such a rationale.

The Council also believed ASHP should continue to develop tools and resources on best practices in managing these patients as well as how to develop practice models in order to provide these services.

Changes in CMS Conditions of Participation

The Council assessed the implications for ASHP policy related to CMS’s broadened definition of “medical staff,” which allows hospitals to privilege pharmacists and others to perform all functions within their scope of practice. The Council believed ASHP needs to determine what assertive actions should be taken (in terms of policy or programs) that will help advance pharmacists’ contributions to patient care in light of this change in federal policy. Changes to the CMS Conditions of Participation (CoP) have the potential to broadly expand the health care delivery role of pharmacists in hospitals and health systems, particularly given the new models of care, such as accountable care organizations (ACOs) and patient-centered medical homes that are being implemented by health systems. As hospitals and health systems include pharmacists as patient-care providers within ACOs, pharmacists recognized as medical staff will be able expand their patient-care roles to the extent permitted by state scope-of-practice laws.

The Council reviewed several papers published in the *American Journal of Health-System Pharmacy (AJHP)* describing the use of credentialing and privileging of pharmacists, the results of the PPMI Summit, and a [position paper](#) published by the [Council on Credentialing in Pharmacy \(CCP\)](#). The Council believed that it would be increasingly important that pharmacists participate in some form of credentialing and privileging process. Physicians and administrators are familiar with board certification and with credentialing and privileging, and the adoption of such models serves to validate pharmacists’ knowledge and skills and advance their practices. Several Council members noted that pharmacists in peer organizations currently participate in a credentialing and privileging process or that such a process was currently being investigated. It was also noted that these processes varied greatly among organizations and there would be value in ASHP defining more clearly the core elements of such a process. In some organizations, pharmacists were credentialed by the medical staff committee, while in others the credentialing process for pharmacists occurred through the pharmacy. The Council also noted that credentialing and privileging processes for pharmacists may be more important in the

future as health systems expand the role of pharmacists in ambulatory care practice environments.

The Council believed that ASHP should develop a commentary on what the new CoP could mean for pharmacy practice and provide guidance on the implications of the changes for ASHP members. The Council noted that the CCP is in the process of updating the white paper on credentialing and privileging and agreed that pursuing ASHP guidelines on the topic should be based on the outcome of this paper. The Council believed ASHP should develop education and resources to assist members in responding to these changes to the CoP.

Transitions of Care

The Council discussed the growing importance and focus on transitions of care. Included in the discussion were the stress on resources needed to implement new services, the challenges of reprioritizing pharmacy services to accommodate new demands on pharmacy departments, the education necessary to prepare pharmacy staff for new roles and responsibilities, and the expansion of pharmacy services beyond traditional hospital based services. The Council also assessed the implications for ASHP policy of provider incentives to improve transitions of care. Among the forces at play on this issue are bundled reimbursement for combined inpatient/outpatient episodes of care, creation of ACOs, and growth in the number integrated health care delivery systems. As health care provider organizations give more attention to improving outcomes when patients move from one care setting to another it is becoming increasingly important for pharmacy leaders to identify how the pharmacy enterprise can contribute to the provider's success.

The Council believed current policies and guidelines adequately covered the various facets of changes in health care reform but that continued education, resources, and advocacy were necessary to support ASHP members in efforts to successfully transition pharmacy resources to meet new demands and opportunities.

Personal Liability Associated with the Position of Pharmacist-in-Charge

The Council discussed whether there are ASHP policy and programmatic implications related to personal liability associated with the position of pharmacist-in-charge (PIC). The concern is that practitioners may lack a complete understanding of all the implications of being a PIC, including the level of accountability associated with this position in health-system pharmacy. There have been reports of PICs being subjected to malpractice suits and regulatory sanctions because of patient harm caused by a pharmacy staff member who was not under the direct supervision of the PIC. These cases have caused some pharmacists to question whether the level of accountability associated with the position of PIC is consistent with the complexity of hospital care, because it is not always clear whether PICs are covered (or the extent to which they are covered) by the institution's liability insurance or the level of personal professional liability insurance PICs should carry. With the expanding roles of pharmacists, there is also concern about being held accountable for the advanced patient care provided by pharmacists in ambulatory care clinics.

The Council discussed cases reported from Florida in which pharmacists are not included under the protections of the state's medical malpractice laws because they are not classified as

health care providers. It was reported that in the state of Wisconsin, however, there are state-level protections of pharmacists consistent with other health care providers. The Council concluded that the ramifications of the position of PIC that are most in need of clarification include (1) appropriate risk-management practices, (2) relationship to regulatory compliance, (3) extent to which professional licensure is at risk, and (4) extent of exposure to malpractice suits related to events not under the PIC's immediate control. The Council recognized that from one perspective, the person in charge of the pharmacy enterprise naturally has obligations related to directing that enterprise in a competent manner, which includes ensuring the competence of staff, establishing appropriate controls and checks on pharmacy activity, and implementing procedures to protect patient safety. There is a measure of liability exposure associated with this position that cannot be avoided. If the PIC fails to perform competently, and that failure results in patient harm, it may be appropriate to hold the PIC liable. On the other hand, if mistakes and patient harm happen within a well-designed and well-controlled pharmacy enterprise, it would be reasonable to expect that the PIC not be held personally liable for those occurrences.

The Council also discussed the need by pharmacy practice leaders to educate hospital executives on the complexities of indirect and direct accountabilities of PICs concerning medication management and the important roles and responsibilities PICs have in their organizations. The Council believed that pharmacists in general did not have a clear understanding of the scope of accountabilities of the PIC role in the current health-system practice setting, and that ASHP should conduct research on the state laws and regulations regarding liability and provide education on the liability and risk associated with PIC roles.

Council Statement and Guidance Proposal Review

The Council reviewed the outstanding proposals for ASHP statements and guidelines. The outstanding proposals were provided to the Council with the original background, and the Council was asked to rank the proposals based on importance of completion. The Council discussed the processes and resources needed to accomplish the completion of these documents and developed a plan to accomplish its goals over the next year.



Board of Directors Report on the Council on Pharmacy Practice

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

Paul W. Bush, *Board Liaison*

Council Members

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- Kristine P. Gullickson, *Vice Chair* (Minnesota)
- James A. Cattin (Maine)
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Policy Recommendations



A. Role of Pharmacists in Sports Pharmacy and Doping Control

- 1 To encourage pharmacists to engage in community outreach efforts to provide
- 2 education to athletes on the risks associated with the use of performance-enhancing
- 3 substances; further,
- 4 To encourage pharmacists to advise athletic authorities and athletes on performance-
- 5 enhancing substances and other products that are prohibited in competition; further,
- 6 To advocate for the role of the pharmacist in all aspects of sports pharmacy and doping
- 7 control.

(Note: This policy would supersede ASHP policy 0710.)

Rationale

The risks of using performance-enhancing substances, more commonly called performance-enhancing drugs (PEDs), are well documented in sports medicine journals and other biomedical literature. The U.S. Anti-Doping Agency (USADA) maintains a comprehensive list of performance-enhancing substances that are banned for U.S. athletes competing in the Olympics. In addition to anabolic steroids, the list includes hormones and hormone-like substances (e.g., insulin, tamoxifen); beta-2 agonists; diuretics; red blood cells (RBC) in any form and RBC enhancers; agents that alter genes or genetic expression; stimulants (including caffeine and nicotine); narcotics; cannabinoids; and glucocorticoids. Certain dietary supplements that are known to contain prohibited substances are also banned. The FDA has also identified dietary supplements that contain pathogens (e.g., *Salmonella*), contaminants (e.g., lead or mercury), or undeclared prescription drug ingredients (e.g., ephedrine, sildenafil, or dexamethasone).

Although such authorities as the National Collegiate Athletic Association and the USADA have implemented bans on use of these agents and drug testing policies to enforce them, these strategies have been only partially effective in curbing sports doping. Physical and emotional developmental changes during adolescence, as well as the desirable celebrity status of professional sports figures, place younger athletes at significant risk for PED use.

The incidence of PED use among young athletes and the lack of guidance on this topic prompted the American Academy of Pediatrics (AAP) to issue a [policy statement](#) in 2005 that provides a working definition of PEDs and strongly opposes their use. The statement also emphasizes the important role of health care professionals in educating younger athletes about the inflated claims and serious risks of sports doping products.

Use of PEDs has spread beyond professional athletes to military personnel, recreational body builders, professional entertainers, and others wishing to lose weight, increase muscle mass, improve alertness, and increase stamina. In 2011, an American College of Gynecology (ACOG) [opinion statement](#) addressed abuse of anabolic steroids, growth hormone, thyroid replacement products, and dietary supplements by women for cosmetic purposes. Risk factors among younger women (negative body image, social pressure to perform in high school or college sports, and risk-taking behaviors) may lead to steroid abuse as early as the late teens. While steroid use among women and girls is far less common than among men, abuse can lead to liver damage, hyperlipidemia, decreased glucose tolerance, increased cardiovascular disease, thrombotic events, psychosis, and infertility. ACOG recommended that health care professionals educate patients about the unfavorable benefit-to-risk ratio of steroid use, encourage cessation in suspected users, or refer them to substance abuse treatment programs.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 0710, Role of Pharmacists in Sports Pharmacy and Doping Control, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

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

To encourage pharmacists to advise athletic authorities and athletes on ~~medications~~ performance-enhancing substances and other products that are prohibited in competition; further,

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

The 2012 House of Delegates voted against the Council's recommendation to discontinue ASHP policy 0710 based on its continued relevance, and further recommended that the section on education be expanded to include other ergogenic (performance-enhancing) substances besides drugs. In reconsidering the policy Council members reviewed current regulations on substances banned in athletic competition and the broad array of other products commercially promoted for ergogenic properties. The Council also reviewed the potential risks associated with the use of these substances, which include chronic health problems, serious adverse events, and death. The Council noted that despite regulation of professional and college sports and the efforts of the USADA, statistics indicate that sports doping is a common practice. Therefore, the Council determined and the Board agreed that policy 0710 should be retained and updated as recommended.

Several Council members commented that pharmacists need more education on this topic to be sufficiently prepared to meet the intent of the policy and suggested that an article or articles in the *American Journal of Health-System Pharmacy (AJHP)* would meet this need. The Council concluded and the Board concurred that the array of substances used for performance enhancement and societal incentives for their use are appropriate topics for additional educational efforts, such as articles in *AJHP* or meeting programs.



B. Standardization of Intravenous Drug Concentrations

- 1 To develop nationally standardized drug concentrations and dosing units for
- 2 commonly used high-risk drugs that are given as continuous infusions; further,

- 3 To encourage all hospitals and health systems to use infusion devices that interface
- 4 with their information systems and include standardized drug libraries with dosing
- 5 limits, clinical advisories, and other patient-safety-enhancing capabilities; further,

- 6 To encourage interprofessional collaboration on the adoption and implementation of
- 7 standardized drug concentrations and dosing units in hospitals and health systems.

(Note: This policy would supersede ASHP policy 0807.)

Rationale

Standardization and simplification are widely accepted methods for reducing variability in processes and risk for error. With increased adoption of intelligent infusion devices, use of standard concentrations has enhanced infusion safety by eliminating most dosing and rate calculations. Standardizing concentrations also simplifies ordering and preparation, and reduces risk of administration error. Attendees at ASHP's 2008 IV Safety Summit affirmed this safety strategy with a similar recommendation. Summit participants also suggested that broader use of standard concentrations might stimulate industry to offer a broader array of ready-to-administer infusions and facilitate the development of drug libraries.

Recent reports indicate, however, that numerous concentrations of high-risk and other drugs are still routinely used. While acknowledging that not all patients can or should be treated with a standard concentration, the Council clarified that the intent of the policy was to advocate limiting the number of standard concentrations to those that serve the needs of the majority of patients.

Council members further suggested that broad adoption of standardized concentrations would not be achieved without the support of the health-system pharmacist community and its active engagement with interprofessional stakeholders.

Background

The 2008–2009 Council recommended and the Board agreed that ASHP should engage stakeholders to develop standardized concentrations of commonly infused high-risk medications and advocate for their use throughout all hospitals and health systems. During sunset review, the Council affirmed that the resulting ASHP policy 0807 was still relevant. However Council members determined, and the Board concurred, that the policy would be strengthened by adding specific language encouraging pharmacists to implement and promote the use of standardized concentrations.

The Council voted and the Board agreed to recommend amending ASHP policy 0807, Standardization of Intravenous Drug Concentrations, as follows (underscore indicates new text):

To develop nationally standardized drug concentrations and dosing units for commonly used high-risk drugs that are given as continuous infusions; further,

To encourage all hospitals and health systems to use infusion devices that interface with their information systems and include standardized drug libraries with dosing limits, clinical advisories, and other patient-safety-enhancing capabilities; further,

To encourage interprofessional collaboration on the adoption and implementation of standardized drug concentrations and dosing units in hospitals and health systems.



C. ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

- 1 To approve the *ASHP Statement on the Pharmacist's Role in Substance Abuse*
- 2 *Prevention, Education, and Assistance* ([Appendix](#)).

Background

Pursuant to requests from the House of Delegates and other ASHP members, the Council considered whether ASHP's current guidance on substance abuse prevention was still relevant and current. After a review of current literature, statistics, and recommendations from federal agencies, and the work of anti-drug abuse advocacy groups, the group determined that ASHP's statement should be revised to:

- align definitions and terminology with the most current *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision, DSM-IV-TR);
- revise substance abuse statistics to include the most recent from the National Household Survey on Drug Use and Health (2010);
- encourage pharmacist engagement with regulatory authorities and promote such efforts as risk evaluation and management strategies, prescription disposal programs, and participation in state prescription drug monitoring programs;
- provide additional data on the prevalence of substance abuse in young adults;
- strengthen ASHP's stance on substance abuse by opposing the sale of both alcohol and tobacco by pharmacists; and
- expand on education and prevention roles for pharmacists.

Council members discussed a number of opportunities for health-system pharmacists to engage in substance abuse prevention, including proactive engagement with other abuse-prevention groups in their communities, peer-to-peer support and education by pharmacy students at their educational institutions and in the community school system, and urging their state to integrate its prescription drug monitoring programs with those of other states.

Board Actions

Sunset Review of Professional Policies

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

- [Disclosure of Excipients in Drug Products](#) (0808)
- [Medications Derived from Biologic Sources](#) (0809)
- [Expression of the Therapeutic Purpose of Prescribing](#) (0305)
- [Pharmacist Support for Dying Patients](#) (0307)
- [Collaborative Drug Therapy Management Activities](#) (9801)
- [Medication Administration by Pharmacists](#) (9820)
- [Pediatric Dosage Forms](#) (9707)
- [ASHP Statement on the Pharmacy and Therapeutics Committee and the Formulary System](#)
- [ASHP-SHM Joint Statement on Hospitalist-Pharmacist Collaboration](#)
- [Code of Ethics for Pharmacists](#)
- [ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System](#)

Other Council Activity

Expression of the Therapeutic Purpose of Prescribing

The Council considered a recommendation from the 2012 House of Delegates to strengthen ASHP policy 0305 by changing the clause advocating that “pharmacists have immediate access to the intended therapeutic purpose of prescribed medications” to advocating that “every medication order or prescription state the indication.” While the Council agreed that inclusion of indication would facilitate counseling in outpatient settings and improve patient safety, they concluded, and the Board agreed, that advocating to mandate this practice likely would not achieve the intent of the policy. In addition, the Council noted there is currently no information systems standard to translate medical terms to layman’s terms for labeling prescription containers with indication for use. Therefore, the Council and the Board declined to revise the policy, considering the current policy to still be relevant.

Discharge Counseling at Transitions of Care

The Council was charged to consider the continued relevance of ASHP's patient education guidance in light of current technology, evidence from care transition initiatives, psychosocial factors that affect patients' readiness for education and counseling, and changes resulting from health care reform legislation. The Council voted to develop ASHP guidelines on the pharmacist's role in care transitions that incorporate the current [ASHP Guidelines on Pharmacist-Conducted Patient Education and Counseling](#). Since those guidelines were last revised in 2006, changes in health care reimbursement include significant financial incentives to keep patients out of the hospital and prevent adverse events. In addition, medication-related adverse events during or after care transitions are common, occurring in up to 50% of patients, according to the literature reviewed the Council. A recent paper identified a strong medication management program in which patient education goals include both behavioral change and factual information as one of the characteristics of programs successfully preventing readmissions in Medicare Coordinated Care Demonstration Projects.

The Council noted a number of gaps or omissions in the current guidelines that should be amended during revision, and several Council members identified a number of effective patient education and counseling strategies from their practice experience. However, the Council stated that discharge counseling is only one component of a much broader planning process. Members emphasized that discharge education, as part of discharge planning, must start at admission. The Council likewise agreed that pharmacist involvement needs to start at admission with medication reconciliation and continue throughout the episode of care and transition to the next caregiver. They suggested that patients should see their pharmacists each time medication therapy is changed, be provided with a real-time medication list, and allowed time to ask questions. Council members suggested that pharmacists might also help anticipate access or payer issues and resolve these prior to discharge. Most of the Council agreed that patients want follow-up after they leave the hospital, especially if there is no "warm hand-off" (i.e., an established infrastructure to which the patient may be seamlessly discharged with support and resources in place).

Council members stated that while current ASHP policy addresses accountable care organizations and the health care medical home, practical guidance on implementing these policies is needed to help members realize opportunities, assume responsibilities, and understand implications for care during transition to ambulatory settings or to home. However, Council members also cautioned that more study is required to develop such guidance, as well as ongoing monitoring of emerging innovative models that improve transitions of care. Council members suggested incorporating the *ASHP Guidelines on Patient Education and Counseling* into broader guidelines that address the continuum of care. The Council encouraged ASHP to examine and define the various roles health-system pharmacists should assume in care transitions in order to achieve the most significant improvements in patient outcomes.

The Council offered a number of suggestions to facilitate the development of guidelines that offer practical strategies for involving pharmacists in transitions of care:

1. Provide educational programming that includes tools and resources to prepare health-system pharmacists for care delivery that takes place mainly outside the

- hospital. Examples of tools include an acuity index and a standardized discharge counseling guide.
2. Examine regulatory and operational implications for the role of pharmacists as agents of the health-system who provide ongoing care of patients post-discharge, including follow-up calls.
 3. Explore ways to work with nurse colleagues to develop a collaborative model of transition management since this has traditionally been a nursing responsibility.

ASHP Statement on the Pharmacist's Role in Medication Reconciliation

The Council received a request from the House of Delegates to expand the current statement on the pharmacist's role to address roles of other pharmacy team members. After discussing the statement, the Council determined its language clearly communicated the expectation that pharmacists should establish roles for "pharmacist extenders," including residents, students, and pharmacy technicians, in medication reconciliation. Council members stated that the current statement is well-written, complete, and sharply focused and declined to recommend revision.

Nonetheless, the Council concurred with the House of Delegates that evidence supporting the effectiveness of "pharmacist extenders" in certain roles is strong and that a separate statement or other policy document on incorporating these individuals into the medication reconciliation process is merited. The Council voted to develop guidelines that define a standardized approach to including pharmacy technicians, students, and residents in the medication reconciliation process. Citing examples of state board regulations that strictly limit what these individuals can do, a number of Council members noted that advocacy for regulatory changes will be crucial.

The Council suggested that the first step in medication reconciliation, obtaining the medication list, should be distinguished from the second, identifying discrepancies, and resolving them, which requires clinical judgment. Studies demonstrate that students and trained technicians perform the list-taking step very well; however, the Council emphasized that identifying and resolving problems should be performed by pharmacists or residents with preceptor guidance. Council members also suggested that ASHP guidance that defines the roles nonpharmacists might assume, as well as education and competencies needed for these roles, would be helpful to members when advocating for changes in state pharmacy law.

The Council also noted that some states prohibit technicians from engaging in even the noncognitive steps in medication reconciliation. Council members suggested that the Council on Public Policy consider a policy recommendation advocating that state boards of pharmacy recognize roles for pharmacy technicians and students in the medication reconciliation process.

Shared Accountability Between Pharmacists and Technicians

The Council discussed PPMI Summit recommendations that identify new and expanded roles for technicians in order to provide the practitioner's perspective to the Council on Public Policy's consideration of professional policy on this issue. The Council considered the implications of an expanded technician role that includes greater responsibility, critical thinking, and independent decision-making with regard to operational matters. Council members cited

examples of complex technician responsibilities that might significantly advance the practice of pharmacy, such as technical workforce supervision, technology management, and participation in medication reconciliation. Council members offered the following perspectives to the Council on Public Policy:

- Highly skilled, competent technicians are essential if the profession of pharmacy is to advance.
- ASHP should set high standards for technician competence and accountability for the quality of their work.
- Technicians will perform critical, complex, highly technical job responsibilities.
- Technicians should have decision-making authority consistent with these responsibilities.
- Technicians, like other health care workers, have a fundamental accountability to the patient for acting in a safe and responsible manner in performance of their duties.

The Council's full comments and recommended language on training were forwarded to the Council on Education and Workforce Development for incorporation into its policy on the topic. Recommended policy language on technician accountability and scope of responsibility was forwarded to the Council on Public Policy for evaluation and possible incorporation into a proposed statement on technician scope of practice.

Guidelines on Controlled Substance Diversion Prevention and Detection

The Council discussed statistics on controlled substance diversion and the results of a 2011 *AJHP* article on diversion prevention practices in hospitals and health-systems that cited significant variance in implementation of recommended best practices. The Council also considered a recommendation from the House of Delegates suggesting ASHP develop guidance on detecting, preventing, and managing controlled substance diversion in health systems and voted in favor of developing this guidance.

ASHP Statement on the Pharmacist's Role in the Care of Patients with HIV Infection

In 2012, the American Academy of HIV Medicine (AAHIV) introduced an HIV Specialist credential (AAHIVM HIV Specialist.) Subsequently, the Section of Clinical Specialists and Scientists recommended that the Council consider collaborating with AAHIV to revise the [ASHP Statement on the Pharmacist's Role in the Care of Patients with HIV Infection](#). The Council agreed with the Section's recommendation and referred revision of the policy to the Section. A work group has begun drafting guidelines on the pharmacist's role in the care of patients with HIV infection.

Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance

As a result of discussion during consideration of the revised *ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance*, the Council predicted that prescription drug abuse, given its current status as a significant public health issue, will worsen and may even become a crisis equivalent to that of drug shortages. The

Council suggested and the Board agreed that ASHP should explore ways to engage with external groups in efforts to curb prescription drug abuse. Board members commented that ASHP efforts should be planned in collaboration with law enforcement, public health, and regulatory groups.

Dispensing Alcoholic Beverages

The Council discussed the not uncommon expectation that the pharmacy department control, secure, and document the use alcoholic beverages when ordered as part of patients' diets. While not opposed to including alcoholic beverages in patient diets, the Council stated that the Council on Therapeutics determined that there is no evidence to support a therapeutic use for alcoholic beverages. Council members emphasized that information on patients with dietary orders for alcoholic beverages must be accessible to pharmacists that are responsible for their medication therapy, similar to other dietary items with potential food or drug interactions. The Council also recommended that ASHP include opposition to the sale of alcoholic beverages by pharmacists, in addition to opposing the sale of tobacco, in the newly revised *ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance* (see [Appendix](#)).

Developing One or Two Safety Metrics

As requested, the Council responded to a House of Delegates request to provide feedback on a potential project by the Section of Inpatient Care Practitioners to develop "dashboard" safety metrics that provide an accurate assessment of the safety of the hospital or health-system medication-use process. Comments will be provided to the Section in a separate document.

Pharmacist-Sensitive Measures

As requested, the Council provided verbal feedback to the ASHP Director of Clinical Quality and Guidelines on proposed indicators that measure the impact of pharmacists on the quality of health care.

Repackaging: Implications for Pharmacy Practice of Section 1007 of Title X, Food and Drug Administration Safety and Innovation Act

The Council was requested for its perspectives on Section 1007, Title X of the Food and Drug Administration Safety and Innovation Act, entitled "Hospital Repackaging of Drugs in Shortage." The new statute permits hospitals operating in a health system under the same corporate entity to repackage shortage drugs in unit of use sizes at a centralized location and distribute them to the health systems and hospitals. The Council requested further clarification of the term "hospitals," which, if defined as within the walls of a hospital building, might exclude settings that located in close proximity and considered part of the hospital. They suggested that ASHP urge the appropriate regulatory body to specifically clarify which entities are eligible to implement this service and to disseminate this information to members.

Pharmacy Drug Theft

The Council discussed the New Business Item submitted by the Council on Pharmacy Management for sunset review of ASHP policy 0303, Pharmacy Drug Theft, which reads:

To support the development of policies and guidelines for health-system pharmacists designed to deter drug product theft and thereby enhance both the integrity of the drug distribution chain and the safety of the workplace; further,

To encourage the development of systems that limit the diversion and abuse potential of medications, including high-cost drugs and controlled substances, and thereby reduce the likelihood that these products will be targets of theft.

The Council on Pharmacy Management requested that the Council on Pharmacy Practice include sunset review of this policy in their discussion of guidelines on controlled substance diversion prevention and detection. The Council deferred action on this suggestion, requesting that a discussion of the policy take place in concert with consideration of the proposed new draft guidelines on controlled substance diversion prevention and detection in next year's Council meeting to ensure that these guidance documents are aligned before recommending for or against policy reaffirmation.

Documents in Development

The Council reviewed documents scheduled for development during the next three years to advise ASHP regarding its document development plan. The Council recommended discontinuation of an ASHP statement on team-based care, recommending that team-based care concepts be incorporated into newly recommended guidelines on the pharmacist's role in patient care. The Council recommended continued development of the following documents:

- ASHP Statement and Guidelines on Standardized Method for Pharmaceutical Care
- ASHP Statement on Use of Medication for Unlabeled Uses
- ASHP Statement on Professionalism
- ASHP Guidelines on Pharmacist Conflict of Interest
- ASHP Guidelines on Preventing Medication Errors with Antineoplastic Agents
- ASHP Guidelines on Sterile Compounding
- ASHP Guidelines on Safe Use of Automated Compounding Devices
- ASHP Guidelines on Hospital Drug Distribution and Control
- ASHP Guidelines on Pharmacist's Role in Medication-Use Evaluation
- ASHP Guidelines on Surgery and Anesthesiology Pharmaceutical Services
- ASHP Guidelines on Adverse Drug Reaction Monitoring and Reporting
- ASHP Guidelines on Compounding Nonsterile Products in Pharmacies

The Council also noted that although the previous Council considered the [ASHP Guidelines on a Standardized Method for Pharmaceutical Care](#) outdated and in need of alignment with recommendations from the PPMI Summit, current members believed this action premature. The term "pharmaceutical care" is integrated in the Centers for Medicare & Medicaid Services Conditions of Participation and still used for teaching and training. The Council deferred comments until next year's meeting.

Appendix



ASHP Statement on the Pharmacist’s Role in Substance Abuse Prevention, Education, and Assistance

Position

1 The American Society of Health-System Pharmacists (ASHP) believes that pharmacists have
2 the unique knowledge, skills, and responsibilities for assuming an important role in
3 substance abuse prevention, education, and assistance. Pharmacists, as health care
4 providers, should be actively involved in reducing the negative effects that substance abuse
5 has on society, health systems, and the pharmacy profession. Further, ASHP supports
6 efforts to rehabilitate pharmacists and other health-system employees whose mental or
7 physical impairments are caused by substance abuse.

Background

8 The term “substance abuse,” as used in this Statement, includes those diseases described
9 by the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental*
10 *Disorders*, fourth edition, text revision (DSM-IV-TR) criteria as “psychoactive substance use
11 disorders.”¹ Psychoactive substances are abused primarily to depress, stimulate, or distort
12 brain activity. Examples include alcohol, tobacco, “street” drugs (e.g., marijuana, lysergic
13 acid diethylamide [LSD], cocaine, methamphetamine, inhalants,
14 methylenedioxymethamphetamine [MDMA], gammahydroxybutyrate [GHB], heroin,
15 K2/Spice, salvia, bath salts), and the nonmedical use or the overuse of psychoactive and
16 other prescription and nonprescription drugs (e.g., oxycodone, ketamine, methadone,
17 dextromethorphan).

18 Substance abuse is a major societal problem. The 2011 National Household Survey on
19 Drug Use and Health (NSDUH), a primary source of statistical information on drug abuse in
20 the U.S. population, estimated that (a) 22.5 million Americans (or 8.7% of the population 12
21 years of age or older) had used an illicit drug* in the past month (b) 2.6 million Americans
22 were classified with dependence or abuse of both illicit drugs and alcohol, (c) 3.9 million
23 had dependence or abuse of illicit drugs but not alcohol, and (d) 14.1 million Americans
24 were dependent on alcohol.² A study of psychiatric disorders in America suggested a
25 lifetime prevalence of substance abuse disorders of 16.4%, of alcohol abuse or dependency
26 of 13.3%, and of other drug abuse or dependency of 5.9%.³ Studies suggest that the
27 prevalence of drug abuse among health professionals appears to be similar to that in the
28 general population.⁴⁻⁶ Given their access, however, health professionals abuse prescription
29 drugs more often and “street” drugs less often than does the general population.

30 Substance abuse frequently coexists with and complicates other psychiatric disorders,
31 and it is a common and often unrecognized cause of physical morbidity. Intravenous drug
32 abuse is a major factor in the spread of human immunodeficiency virus (HIV) and hepatitis.
33

*The National Survey on Drug Use and Health obtains information on nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.

34 Alcohol is a major factor in cirrhosis of the liver, and tobacco is a key contributor to
35 emphysema and lung cancer. Collectively, substance abuse contributes significantly to
36 morbidity and mortality in our population and to the cost of health care.

37 Substance abuse is also a serious workplace problem. The 2010 NSDUH reported that
38 approximately 13.3 million Americans reporting illicit drug use were currently employed full
39 or part-time.² Substance abuse by employees of health care organizations leads to reduced
40 productivity, increased absenteeism, drug diversion, and, almost certainly, increased
41 accidents and medication misadventures. Consequently, it affects the quality of patient
42 care, liability, and operational and health care costs.

43 The abuse, or non-medical use, of prescription medications has also become a prevalent
44 issue. Nonmedical use of prescription drugs among youths aged 12 to 17 and young adults
45 aged 18 to 25 in 2011 was the second most prevalent illicit drug use category, with
46 marijuana being first.² The survey also found that over half of all prescription drug abusers
47 had obtained the prescription medication "from a friend or relative for free" as compared
48 to the 3.9% who had obtained the medication from a drug dealer or other stranger.

49 Pharmacists have unique, comprehensive knowledge about the safe and effective use of
50 medications and about the adverse effects of their inappropriate use. The provision of
51 pharmaceutical care to individual patients involves pharmacists assessing the
52 appropriateness of pharmacotherapy, counseling, and monitoring medication-use
53 outcomes. Health-system pharmacists have responsibilities for ensuring a safe and effective
54 medication-use system, including legal and organizational responsibilities for medication
55 distribution and control across the continuum of practice settings within health care
56 organizations. With this combination of knowledge and organizational responsibilities,
57 pharmacists are prepared to serve in leadership and service roles in substance abuse
58 prevention and education and assist in a variety of patient care, employee health, and
59 community activities.

60 **Responsibilities**

61 The scope of substance abuse responsibilities of pharmacists varies with the health care
62 organization's mission, policies and procedures, patient population, and community. The
63 responsibilities listed below should be adapted to meet local needs and circumstances. Each
64 responsibility is intended to be applicable to any substance of abuse; therefore, specific
65 substances are generally not mentioned. Pharmacists should be involved in substance
66 abuse prevention, education, and assistance by performing the following activities:

67 **Prevention**

- 68 1. Participating in or contributing to the development of substance abuse prevention and
69 assistance programs within health care organizations. A comprehensive program should
70 consist of (a) a written substance abuse policy; (b) an employee education and
71 awareness program; (c) a supervisor training program; (d) an employee assistance
72 program; (e) peer support systems, such as pharmacist recovery networks; and (f) drug
73 testing.⁷
- 74 2. Participating in public substance abuse education and prevention programs (e.g., in
75 primary and secondary schools, colleges, churches, and civic organizations) and stressing
76 the potential adverse health consequences of the misuse of legal and use of illegal drugs.
- 77 3. Opposing the sale of alcohol and tobacco products by pharmacists.

- 78 4. Establishing a multidisciplinary controlled-substance inventory system, in compliance
79 with statutory and regulatory requirements, that discourages diversion and enhances
80 accountability. Where helpful, for example, procedures might require the purchase of
81 controlled substances in tamper-evident containers and maintenance of a perpetual
82 inventory and ongoing surveillance system.
- 83 5. Working with local, state, and federal authorities in controlling substance abuse,
84 including participation in state prescription drug monitoring programs, encouraging
85 participation in prescription disposal programs, complying with controlled-substance
86 reporting regulations, and cooperating in investigations that involve the misuse of
87 controlled substances, especially diversion from a health care organization.
- 88 6. Working with medical laboratories to (a) identify substances of abuse by using drug and
89 poison control information systems, (b) establish proper specimen collection procedures
90 based on knowledge of the pharmacokinetic properties of abused substances, and (c)
91 select proper laboratory tests to detect the suspected substances of abuse and to detect
92 tampering with samples.
- 93 7. Discouraging prescribing practices that enable or foster drug abuse behavior (e.g.,
94 prescribing a larger quantity of pain medication than is clinically needed for treatment of
95 short-term pain).
- 96 8. Collaboration with outpatient and ambulatory care providers to prevent substance abuse
97 after discharge.

98 **Education**

- 99 1. Providing information and referral to support groups appropriate to the needs of people
100 whose lives are affected by their own or another person's substance abuse or
101 dependency.
- 102 2. Providing recommendations about the appropriate use of mood-altering substances to
103 health care providers and the public, including those persons recovering from substance
104 dependency and their caregivers.⁸
- 105 3. Fostering the development of undergraduate and graduate college of pharmacy curricula
106 and pharmacy technician education on the topic of substance abuse prevention,
107 education, and assistance.⁹
- 108 4. Providing substance abuse education to fellow pharmacists, other health care
109 professionals, and other employees of their health care organization.
- 110 5. Instructing drug abuse counselors in drug treatment programs about the pharmacology
111 of abused substances and medications used for detoxification.
- 112 6. Promoting and providing alcohol risk-reduction education and activities.
- 113 7. Maintaining professional competency in substance abuse prevention, education, and
114 assistance through formal and informal continuing education.
- 115 8. Conducting research on substance abuse and addiction.
- 116 9. Educating patients about the correct storage, handling, and proper disposal of
117 prescription medications.

118 **Assistance**

- 119 1. Assisting in the identification of patients, coworkers, and other individuals who may be
120 having problems related to their substance abuse, and referring them to the appropriate
121 people for evaluation and treatment.

- 122 2. Participating in multidisciplinary efforts to support and care for the health care
123 organization’s employees and patients who are recovering from substance dependency.
- 124 3. Supporting and encouraging the recovery of health professionals with alcoholism or
125 other drug addictions. Major elements of an employer’s support program might include
126 (a) a willingness to hire or retain employees; (b) participating in monitoring and
127 reporting requirements associated with recovery or disciplinary contracts; (c)
128 maintaining an environment supportive of recovery; (d) establishing behavioral
129 standards and norms among all employees that discourage the abuse of psychoactive
130 substances, including alcohol; and (e) participating in peer assistance programs.
- 131 4. Collaborating with other health care providers in the development of the
132 pharmacotherapeutic elements of drug detoxification protocols.
- 133 5. Providing pharmaceutical care to patients being treated for substance abuse and
134 dependency.
- 135 6. Maintaining knowledge of professional support groups (e.g., state- and national-level
136 pharmacist recovery networks) and other local, state, and national organizations,
137 programs, and resources available for preventing and treating substance abuse (see
138 “Other Resources”).
- 139 7. Refusing to allow any student or employee, including health professionals, to work,
140 practice, or be on-site for rotations within the health care organization while his or her
141 ability to safely perform his or her responsibilities is impaired by drugs, including alcohol.
142 The refusal should follow the organization’s policies and procedures, the principles of
143 ethical and responsible pharmacy practice, and statutory requirements. Practice should
144 not be precluded after appropriate treatment and monitoring, if approved by the
145 treatment provider or contract monitor (or both, when applicable).

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15. Center for Substance Abuse Prevention (CSAP) Workplace Helpline (for employers). Telephone, 800- 967-5752; e-mail, helpline@samhsa.gov.
16. National Association of State Alcohol and Drug Abuse Directors (NASADAD). The association coordinates and encourages cooperative efforts between the federal government and state agencies on substance abuse. NASADAD serves as a resource on state drug programs and can provide contacts in each state. Web site, www.nasadad.org.
17. Community organizations are available to help with drug or alcohol problems. Treatment counselors may be valuable in developing assistance policies and in providing professional education about treatment and referral systems. Community drug-abuse-prevention organizations may be helpful in prevention efforts, including community drug

education. Check your local telephone directory under headings such as Alcoholism Information and Treatment, Drug Abuse Information and Treatment, and Counselors.

18. Twelve-step groups (usually available locally unless otherwise noted; listed telephone numbers and Web sites are for national headquarters):

- a. Adult Children of Alcoholics (ACOA); for adults who, as children, lived with alcoholic parents. Telephone, 310-534-1815; Website, www.adultchildren.org/.
- b. Al-Anon; provides information on alcoholism and alcohol abuse and refers callers to local Al-Anon support groups established to help people affected by others' alcohol misuse. Telephone, 888-425- 2666; Web site, www.al-anon.org/.
- c. Alateen; for adolescents affected by alcoholics. Web site, www.al-anon.org/alateen.html.
- d. Alcoholics Anonymous (AA); provides information and support to recovering alcoholics. Telephone, 212-870-3400; Website, www.alcoholicsanonymous.org.
- e. Cocaine Anonymous (CA); for individuals with cocaine dependencies. Telephone, 310-559-5833; Web site, www.ca.org/.
- f. International Pharmacists Anonymous (IPA); for pharmacists in recovery (a national group that often holds support-group meetings at national and regional conferences). Contact IPA List Keeper, 319 East 5th Street, Ogallala, NE 69153-2201; telephone, 308-284-8296; Website, <http://mywebpages.comcast.net/ipa/ipapage.htm>.
- g. Nar-Anon; for helping people affected by another's drug misuse. Telephone, 310-547-5800.
- h. Narcotics Anonymous (NA); provides information and support to recovering substance abusers. Telephone, 818-773-9999; Web site, www.na.org.

19. Advocacy and professional substance abuse education:

- a. American Pharmacists Association (APhA) Pharmacy Recovery Program; for information sharing, education, and advocacy. Telephone, 800-237-2742. The American Dental Association, American Medical Association, and American Nurses Association have similar programs.
- b. The Pharmacy Section (cosponsored by APhA and APhA Academy of Students of Pharmacy) of the University of Utah School on Alcoholism and Other Drug Dependencies (a one-week seminar each summer); for learning to deal with substance abuse problems as they affect the profession. Telephone, 801-538-4343; Web site, www.med.utah.edu/ads/.

Developed through the ASHP Council on Pharmacy Practice. Approved by the ASHP Board of Directors on January 11, 2013. This statement supersedes a previous version dated June 1, 2003.



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Board of Directors Report on the Council on Public Policy

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

Thomas J. Johnson, *Board Liaison*

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Policy Recommendations



A. Pharmacist Recognition as a Health Care Provider

- 1 To recognize that pharmacist participation in interprofessional health care teams as the
- 2 medication-use expert that provides safe, effective, and high-quality care, resulting in
- 3 improved patient outcomes and reduced health care costs; further,

- 4 To advocate for changes in federal, state, and third-party payment programs to define
- 5 pharmacists as providers of direct patient care; further,

- 6 To collaborate with key stakeholders to describe the covered direct patient-care
- 7 services provided by pharmacists; further,

- 8 To pursue a standard mechanism for paying pharmacists who provide these services.

Rationale

The Council reviewed a House of Delegates recommendation seeking a separate policy that advocates for legislative changes to the Social Security Act to recognize pharmacists as nonphysician practitioners and be compensated for patient-care services. The Council noted and the Board agreed that although ASHP policy 0207 seeks to advocate for this recognition, it also seeks appropriate reimbursement for the cost of drug products. The Council and Board felt it was essential that ASHP have a separate policy addressing provider recognition to provide clarity to the profession, stakeholders, and policymakers. Council and Board members believed that a new and separate policy was especially timely, given the [report by the Office of the Chief Pharmacist to the Surgeon General](#), who has since expressed her support of that report in recognizing pharmacists as an essential part of the health care team and that compensation models are needed to sustain their patient-oriented and quality improvement services. In addition, the Council noted the recent changes by the Centers for Medicare & Medicaid Services (CMS) to the Conditions of Participation to require hospitals to review pharmacists for potential appointment to the medical staff. The Council and Board also noted that provisions in the Affordable Care Act that require pay for performance (quality measures) and new delivery systems (accountable care organizations, patient-centered medical homes) will function most effectively if pharmacists can fully participate as members of interprofessional teams providing direct patient care. The Council and Board concluded that full pharmacist participation can only be achieved through recognition as health care practitioners under the Social Security Act.

Background

The Council developed this new policy in response to a House of Delegates recommendation to develop a policy to pursue legislative changes in the Social Security Act to recognize pharmacists as nonphysician practitioners. The Council and Board felt that revising existing policy 0207 would not be an effective way to respond to the recommendation and developed a

separate policy explicitly advocating for pharmacist recognition as a health care practitioner. The Council also identified the need to draft a statement that elaborates on the points in the proposed policy as well as existing policies that relate to the credentialing and privileging processes, medication therapy management, and collaborative drug therapy management. (Note that the Council on Pharmacy Management has revised policy 0207 in response to this policy recommendation; see Council on Pharmacy Management Policy Recommendation D, Drug Product Reimbursement.)



B. Compounding by Health Professionals

- 1 To advocate that state laws and regulations that govern compounding by health
- 2 professionals adopt the applicable standards of the *United States Pharmacopeia*.

(Note: This policy would supersede ASHP policy 0411.)

Rationale

The Council revised ASHP policy 0411 by deleting the specific reference to *United States Pharmacopeia (USP)* Chapter 797 but left intact the overall reference to *USP*. The Council and Board believed that all relevant chapters in the *USP* should be considered when health professionals are compounding either sterile or nonsterile preparations.

The Council discussed current policy guidance used by the Food and Drug Administration (FDA) regarding its enforcement of compounded products. The Council and Board noted that since compounding is considered fundamental to the practice of pharmacy, it should be regulated by state boards of pharmacy. However, the Council and Board also noted that there are practice settings (standalone infusion centers, ambulatory clinics, and surgery centers) that are not regulated by state boards of pharmacy. The Council suggested that more research be conducted to determine the extent of compounding performed in these settings to determine the need for consistent regulation and oversight to ensure patient safety. It also suggested that ASHP policy address the issue of compounding by health systems (see discussion of Policy Recommendation E, Regulation of Centralized Order Fulfillment, below).

Further, the Council discussed the potential increase in compounding preparations in order to provide medications that are in shortage. The Council also suggested ongoing monitoring of the prevalence of compounded formulations provided to health care settings across state lines. Finally, the Council noted the importance of including compounding in Doctor of Pharmacy curricula. The Council and Board felt that these various issues with respect to the use of compounded products needed to be thoroughly examined in order to identify any gaps in regulatory oversight in providing safe and effective medications to patients.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 0411, Compounding by Health Professionals, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate the adoption, in all applicable that state laws and regulations that governing health care practice, of the intent of the requirements and the outcomes for patient safety as described in compounding by health professionals adopt the applicable standards of the *United States Pharmacopeia Chapter 797* (“Pharmaceutical Compounding—Sterile Preparations”).

The Council revised policy 0411 in response to recent incidents involving patient harm or death as well as potential revisions by the FDA to its compliance policy guide outlining its enforcement action concerning compounded products. The Council also noted the need for member education about the [ASHP Guidelines on Outsourcing Sterile Compounding Services](#) and the ASHP Foundation’s [online tool](#) to evaluate these entities. In addition, the Council also reviewed [ASHP policy 0616](#) and provided suggested revisions to the Council on Pharmacy Practice. Those suggestions are intended to underscore the importance of providing compounded formulations in accordance with *USP* standards. (Note: The Council’s discussions occurred prior to the announcement by FDA and Centers for Disease Control and Prevention concerning contaminated medications prepared by the New England Compounding Center.)



C. Pharmacists’ Role in Immunization and Vaccines

- 1 To affirm that pharmacists have a role in improving public health and increasing
- 2 patient access to immunizations by promoting and administering appropriate
- 3 immunizations to patients and employees in all settings; further,
- 4 To advocate that states grant pharmacists the authority to initiate and administer all
- 5 adult and pediatric immunizations; further,
- 6 To advocate that only pharmacists who have completed a training and certification
- 7 program acceptable to state boards of pharmacy and meeting the standards
- 8 established by the Centers for Disease Control and Prevention may provide such
- 9 immunizations; further,
- 10 To advocate that state and federal health authorities establish centralized databases
- 11 for documenting administration of immunizations that are accessible to all health
- 12 care providers; further,
- 13 To strongly encourage pharmacists and other immunization providers to report their
- 14 documentation to these centralized databases; further,
- 15 To strongly encourage pharmacists to educate all patients, their caregivers, parents,
- 16 guardians, and health care providers about the importance of immunizations for
- 17 disease prevention; further,
- 18 To encourage pharmacists to seek opportunities for involvement in disease
- 19 prevention through community immunization programs; further,
- 20 To advocate for the inclusion of pharmacist-provided immunization training in college
- 21 of pharmacy curricula.

(Note: This policy would supersede ASHP policies 1220 and 0213.)

Rationale

Increasing adult and pediatric patients' access to immunizations is an important public health challenge. Pharmacists' unique training and expertise in all aspects of the medication-use system can help expand patients' access to immunizations and promote disease prevention in all practice settings. Hospital and health-system pharmacists provide care to a patient population that is vulnerable and often critically ill, and such patients are especially dependent on herd immunity. Patients in rural areas, where a pharmacy may provide the only convenient access to a health care professional, will benefit from increased pharmacist immunization authority.

Although all states permit pharmacist administration of some vaccines, state laws differ in the range of vaccines pharmacists may administer and the patient populations they are permitted to vaccinate. Allowing trained and certified pharmacists to initiate and administer all adult and pediatric vaccines (e.g., by eliminating the requirement that some pharmacist-provided immunizations to be conducted within a collaborative drug therapy management agreement) would encourage standardization of pharmacy immunization practice within and among states.

Only pharmacists who undergo appropriate training and certification should be authorized by state boards to provide immunizations. To ensure their consistency and quality, those training and certification programs should meet Centers for Disease Control and Prevention (CDC) standards. To aid in sharing important patient immunization information, centralized databases of patient immunizations should be established, and all authorized immunization providers, including pharmacists, should be encouraged to document their immunizations in those databases.

Pharmacist and pharmacy educators should embrace their role in this important public health effort by providing education about the importance of immunization in disease prevention, participating in community immunization programs, and training immunization providers.

Background

The Council reviewed four ASHP policies (0601, 0615, 1220, and 0213) in response to a House of Delegates recommendation to consolidate them into one policy. The Council believed and the Board concurred that combining all four would dilute the impact of the policies. Instead, the Council identified two policies (1220 and 0213) that related to promotion and administration of vaccines, and two other policies (0601 and 0615) that related to the importance of the influenza vaccine. The Council combined ASHP policies 1220 and 0213, which delineate the role for pharmacists in providing immunizations to improve the public health, and suggested that the Council on Therapeutics and the Council on Pharmacy Practice combine policies 0601 and 0615 and consider specific revisions.

Policy 0213 was originally developed by the Council on Educational Affairs. This new combined policy was also considered by the Council on Education and Workforce Development, which concurred in the combined revision. The Council felt the revised policy includes the intent of both policies to affirm the pharmacist's role in improving public health and patient access, advocating that states grant pharmacists the authority to initiate and administer all

adult and child immunizations, patient and caregiver education, and advocacy for the inclusion of pharmacist-provided immunization training in college of pharmacy curricula. The Board agreed and added a clause to strongly encourage reporting documented immunization to centralized databases.

For ease of reference, policies 1220, Standardized Immunization Authority to Improve Public Health, and 0213, Pharmacists' Role in Immunization and Vaccines, are provided below.

Standardized Immunization Authority To Improve Public Health

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

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

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

Pharmacists' Role in Immunization and Vaccines

To affirm that pharmacists have a role in promoting and administering proper immunizations to patients and employees in all settings; further,

To encourage pharmacists to seek opportunities for involvement in disease prevention through community immunization programs; further,

To advocate the inclusion of the pharmacist's role in immunization in college of pharmacy curricula; further,

To strongly encourage pharmacists to use available opportunities and materials to educate at-risk patients, their caregivers, parents, guardians, and health care providers about the importance of immunizations.



D. Regulation of Telepharmacy Services

- 1 To advocate that state governments adopt laws and regulations that standardize
- 2 telepharmacy practices across state lines and facilitate the use of United States-based
- 3 telepharmacy services; further,

- 4 To advocate that boards of pharmacy and state agencies that regulate pharmacies
- 5 include the following in regulations for telepharmacy services: (1) education and
- 6 training of participating pharmacists; (2) education, training, certification by the
- 7 Pharmacy Technician Certification Board, and licensure of participating pharmacy
- 8 technicians; (3) communication and information systems requirements; (4) remote
- 9 order entry, prospective order review, verification of the completed medication order
- 10 before dispensing, and dispensing; (5) direct patient-care services, including medication
- 11 therapy management services and patient counseling and education; (6) licensure
- 12 (including reciprocity) of participating pharmacies and pharmacists; (7) service
- 13 arrangements that cross state borders; (8) service arrangements within the same
- 14 corporate entity or between different corporate entities; (9) service arrangements for
- 15 workload relief in the point-of-care pharmacy during peak periods; and (10) pharmacist
- 16 access to minimum required elements of patient information; further,

- 17 To identify additional legal and professional issues in the provision of telepharmacy
- 18 services to and from sites located outside the United States.

(Note: This policy would supersede ASHP policy 0716.)

Rationale

In light of continuing advances in technology, there is an increasingly urgent need for state board of pharmacy regulation of the provision of pharmacist care services from off-site locations through electronic technology (telepharmacy). It is important to acknowledge the regulatory purview of state boards of pharmacy regarding the use of telepharmacy and recognize that the intent of such regulations should be to balance protection of the public health with the increased patient access to the patient care services of pharmacists provided by telepharmacy. Although such regulations should allow for various arrangements across state borders and within or between health systems, they all need to address a number of common concerns.

The Council revised ASHP policy 0716 to address the provision of medication therapy management and other direct patient-care services in any regulation of telepharmacy services. It also revised the policy to include advocacy to state governments to harmonize the practice of pharmacy across state lines and to update requirements for technician functions in the provision of telepharmacy services to be performed by technicians that are certified by the Pharmacy Technician Certification Board (PTCB) and licensed by the state board of pharmacy.

The revised policy also calls on ASHP to continue efforts to identify additional legal and professional issues in the provision of international telepharmacy services.

Background

The Council voted and the Board agreed to recommend amending ASHP policy 0716, Regulation of Telepharmacy Services, as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To advocate that state governments ~~boards of pharmacy~~ adopt laws and regulations that standardize telepharmacy practices across state lines and facilitate ~~enable~~ the use of United States-based telepharmacy services ~~for all practice settings~~; further,

To advocate that boards of pharmacy and state agencies that regulate pharmacies ~~include~~ consider the following ~~when drafting in~~ regulations for telepharmacy services: (1) education and training of participating pharmacists and technicians; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; ~~(2)~~(3) communication and information systems requirements; ~~(3)~~(4) remote order entry, remote prospective order review, remote double-checking verification of the completed medication order before dispensing, actual and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; ~~(4)~~(6) licensure (including reciprocity) of participating pharmacies and pharmacists; ~~(5)~~(7) service arrangements that cross state borders; ~~(6)~~(8) service arrangements within the same corporate entity or between different corporate entities; ~~(7)~~(9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; and ~~(8)~~(10) pharmacist access to minimum required elements of patient information; further,

To ~~acknowledge the need to explore and resolve~~ identify additional legal and professional issues in the provision of ~~international~~ telepharmacy services to and from sites ~~not located in~~ outside the United States.

The Council revised policy 0716 in response to increased provision of direct patient care services (including medication therapy management) via telepharmacy and other remote means. These services are also being provided to patients across state lines, prompting regulation by multiple state boards of pharmacy. The Council felt and the Board agreed a revision was warranted in order to advocate for harmonization of a regulatory scheme across state lines.

The Council acknowledged the existing [ASHP Guidelines on Remote Medication Order Processing](#) and the need to address the use of telepharmacy services in any revision to the guidelines. In addition, the Council also discussed the interstate regulation of centralized order fulfillment (see Policy Recommendation E below). The Council identified the potential to develop a statement that addresses the issues dealing with the interstate regulation of the practice of pharmacy. Such a statement would expand on the concept and position in ASHP policy 0909, [Regulation of Interstate Pharmacy Practice](#), and further discuss the regulation of telepharmacy, direct patient care services (including medication therapy management), and centralized order fulfillment.



E. Regulation of Centralized Order Fulfillment

- 1 To advocate changes in federal and state laws, regulations, and policies to permit
- 2 centralized medication order fulfillment within health care facilities under common
- 3 ownership.

Rationale

The Council discussed the increased use of centralized order fulfillment within health systems as well as fulfillment by contracted entities. Health systems use centralized facilities to provide a range of medications in order to improve efficiency, decrease redundancy, optimize preparation expertise, and decrease overhead and inventory costs. Importantly, health systems use centralized facilities to provide medications that are in short supply or are difficult to compound safely.

The Drug Enforcement Administration prohibits central repackaging and distribution of controlled substances to other facilities that are part of the same health system. Moreover, health systems with facilities in multiple states find additional requirements in each state by boards of pharmacy and other state regulators when providing medications across state borders from a centralized facility.

The Council and Board recognized the importance of maintaining practice standards and related safeguards to assure patient safety. In fact, health systems use centralized facilities in order to have the most-qualified personnel prepare these medications in the safest facility. The Council and Board identified the need to seek regulatory changes at the state and federal level in order to optimally use centralized facilities that are under the common ownership and therefore quality control of the health system.

Background

The Council's discussion of this issue was a response to an increased use of centralized order fulfillment by hospitals and health systems. In particular, state boards of pharmacy were continuing to regulate this practice, including the provision of these medications across state borders. The Council noted the need to identify all the relevant state and federal regulatory bodies that have an interest in this issue, including medications that contain controlled substances. In addition, the Council wanted to emphasize the importance of maintaining quality control by allowing health care facilities under common control and ownership to provide centralized order fulfillment.

Board Actions

Sunset Review of Professional Policies

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

- [Education, Prevention, and Enforcement Concerning Workplace Violence](#) (0810)
- [Regulation of Dietary Supplements](#) (0811)
- [Appropriate Staffing Levels](#) (0812)
- [Medicare Prescription Drug Benefit](#) (0813)
- [Federal Review of Anticompetitive Practices by Drug Product Manufacturers](#) (0814)
- [Licensure for Pharmacy Graduates of Foreign Schools](#) (0323)
- [Public Funding for Pharmacy Residency Training](#) (0325)
- [Regulation of Automated Drug Distribution Systems](#) (9813)
- [Size, Color, and Shape of Drug Products](#) (8310)
- [ASHP Statement on Principles for Including Medications and Pharmaceutical Care in Health Care Systems](#)

Other Council Activity

Statement on Recognition of the Pharmacist as a Health Care Provider

In its discussion concerning recognition by federal, state, and third-party payers, the Council voted to develop a statement that combined a number of existing policies dealing with recognition, compensation, credentialing and privileging, and the direct patient-care services of pharmacists (e.g., medication therapy management and collaborative drug therapy management). The Council felt a unified statement would help the profession and other stakeholders easily comprehend the policy that was being advocated in support of the recommendations of the Pharmacy Practice Model Initiative.

340B Program

The Council reviewed recent reports by the Government Accountability Office (GAO) and congressional offices concerning the drug discount program available to eligible hospitals and other covered entities administered by the Office of Pharmacy Affairs (OPA) in the Health Resources and Services Administration. The GAO suggested additional oversight by OPA to ensure the integrity of the program. Provisions in the Affordable Care Act allow audit and related authority to monitor compliance by covered entities as well as manufacturers. OPA is currently utilizing that authority. Congressional offices were interested in any relationship between prices available to covered entities and drug shortages. To date, there has been no data to suggest that 340B discounts are a contributing factor in shortages of drugs. The Council reviewed existing policies [0506](#), [0222](#), and [1219](#) and found them to be adequate. It noted that policy 0506 should be revised to reflect that all appropriate covered entities with inpatient settings should be included in any advocacy seeking expansion of discounts to the inpatient

setting. The Council also suggested that the Section of Pharmacy Practice Managers could consider researching or monitoring the impact of shortages on 340B entities as well as the impact of new audit authority by the OPA, perhaps including a member survey.

Reimbursement for Self-Administered Drugs

The Council discussed increased member interest in reimbursement challenges associated with patients who are categorized with outpatient observation status for up to 72 hours before being admitted as an inpatient or being discharged. One particular challenge for pharmacy is the CMS reimbursement policy concerning medications that are considered self-administered and are therefore not covered by the Hospital Outpatient Prospective Payment System. Patients covered by Medicare Part D who receive self-administered medications need to file an out-of-network claim with their Part D prescription drug plan. Alternatively, patients may bring their own medications and self-administer while in observation status. The Council noted the associated safety concerns with respect to interactions and medication reconciliation. In addition, subsequent admission as an inpatient would require reimbursement by the hospital to the patient for self administration of their own medication. The Council discussed additional concerns with respect to the impact on chain of custody and integrity of the product, eligibility for Medicare, compliance with CMS conditions of participation, and lack of integration into the hospital's bar coding system and electronic medical record.

The Council voted to conduct a member survey to assess the extent of the issue, collaborate with other organizations (e.g., American Hospital Association) to identify solutions as part of the larger problem of benefit design and hospital payment systems. From this additional research and collaboration, education and advocacy to policymakers (CMS and Congress) could be developed.

Third-Party Accountability for Delay in Therapy

The Council discussed a House of Delegates recommendation regarding advocacy for accountability by third-party payers for delays in therapy. Council members noted experiences in the prior authorization process and the impact on patient access, particularly if medication therapy is changed, which begins that process all over again. The Council also noted that the Council on Pharmacy Management was reviewing [ASHP policy 1206](#) that was recently approved by the House of Delegates. The Council concluded that policy 1206 adequately addresses the issues raised by the recommendation. It further noted that the impact of policy 1206 should be researched as well as consider collaboration with other stakeholders (including the Academy of Managed Care Pharmacy) to improve processes and decrease or avoid delays in therapy.

Limits on PBM Audits of Outpatient Pharmacies

The Council discussed this issue in response to a House of Delegates recommendation to support regulations that would limit the scope of pharmacy benefits manager (PBM) audits of outpatient pharmacies. Council members observed that PBMs may expand penalties or recoupment based on relatively small instances into larger awards. The Council felt that ASHP should confer with other pharmacy organizations regarding their position on this issue and also the level of priority and engagement by ASHP.



Board of Directors Report on the Council on Therapeutics

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

Steven S. Rough, *Board Liaison*

Council Members

- Catherine D. Johnson, *Chair* (Wisconsin)
- Joel A. Hennenfent, *Vice Chair* (Missouri)
- Juan Manuel Hincapie Castillo, *Student* (Florida)
- Curtis D. Collins (Michigan)
- Jeffrey Gildow (Nebraska)
- Joel C. Marrs (Colorado)
- Margaret E. McGuinness (Oregon)
- Daniel M. Rackham, *New Practitioner* (Oregon)
- Rachel A. Ranz (Indiana)
- Christina W. Rivers (Illinois)
- Kersten Weber Tatarelis (Illinois)
- Casey H. White (Tennessee)
- Lea S. Eiland, *Section of Clinical Specialists and Scientists Liaison* (Alabama)
- Cynthia Reilly, *Secretary*

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Policy Recommendations



A. Medication Overuse

- 1 To define medication overuse as use of a medication when the potential risks of using
- 2 the drug outweigh the potential benefits for the patient; further,
- 3 To recognize that medication overuse is inappropriate and can result in patient harm
- 4 and increased overall health care costs; further,
- 5 To advocate that pharmacists take a leadership role in interprofessional efforts to
- 6 minimize medication overuse.

Rationale

The Council considered efforts of The Joint Commission (TJC) and the National Priorities Partnership (NPP) that are focused on reducing overuse as a mechanism to improve patient safety and increase the efficiency of care. The concept of overuse applies to a broad range of medical interventions including, but not limited to, overuse of laboratory tests, procedures, and medications. The Council's discussion focused on medication overuse as a significant patient safety issue that occurs when the risks of using a medication outweigh potential benefits. Several challenges were noted in addressing this issue, including lack of a widely accepted definition and difficulty in definitively identifying and measuring overuse. The Council and Board believed that medication overuse (which is a component of inappropriate use) includes, but is not limited to, the following concepts: medication use without an indication, therapeutic duplication, inappropriate therapy duration, or a specific instance where the potential risks outweigh the potential benefits for the patient. In addition to potential adverse drug events and other patient harm, the Council and Board noted that medication overuse represents a significant system burden through increased overall health care costs and wasted time and resources spent preparing and administering medications that are unnecessary. The Council strongly believed that pharmacists should take a leadership role in interprofessional efforts to address medication overuse, and the Board agreed. This leadership includes accepting accountability for patients' medication therapy management outcomes by providing patient care that considers drug-, disease-, and patient-specific characteristics. The Council stated that providing patient care that considers these characteristics should be a cornerstone of efforts to minimize medication overuse, and the Board agreed. The intent of developing this policy was to draw attention to this important issue. It was noted that this policy could assist pharmacy leaders in justifying the need for staffing and other resources to address overuse as well as to assist in overcoming practice barriers.

Background

The Council considered efforts by national accreditation and quality improvement organizations to address the issue of overuse. The intent of these initiatives is to reduce overuse of medical interventions, including laboratory tests, procedures, and medications, as a mechanism to improve patient safety and increase the efficiency of care. While improvements have been made, these efforts have been hindered by lack of a widely accepted definition for overuse and difficulty in definitively identifying and measuring overuse. In 2011, TJC considered development of a National Patient Safety Goal (NPSG) on overuse, but did not issue a goal due to challenges in drafting standards. [The Council noted that TJC and the Physician Consortium for Performance Improvement were holding a summit on September 24, 2012, to continue efforts to address this issue. The outcomes of that summit were not available when the Council discussed the issue on September 1, 2012.] An overuse initiative of the NPP, a collaborative coordinated by the National Quality Forum, includes several medication components, including efforts to eliminate inappropriate antibiotic use, chemotherapy within the last 14 days of life, and polypharmacy for the treatment of psychotic disorders and multiple chronic conditions.

The Council considered whether the terms “medication overuse” and “inappropriate prescribing” were interchangeable, but noted that inappropriate prescribing is a broader concept that also includes therapy omission and failure to optimize therapy. However, the Council stated that medication overuse could be defined by many of the same concepts used to define inappropriate medication use, including use without a therapeutic indication, therapeutic duplication, inappropriate therapy duration, or a specific instance in which the potential risks outweigh the potential benefits of drug use. Other examples include when a medication is used to address side effects caused by another therapy that might be avoided through better management of the initial therapy (e.g., concomitant use of benzodiazepines and stimulant therapies). The Council and Board described medication overuse as a significant patient safety issue because the expected negative consequences of using these therapies outweighs the expected benefits. Increased overall health care costs and burden to clinicians and patients through the preparation, distribution, administration, and monitoring of medications that are unnecessary were also noted.

Certain therapeutic classes, including antimicrobials, proton pump inhibitors, and opioid analgesics, are closely associated with overuse. However, the Council emphasized that any drug may be inappropriate for a specific patient and recommended that strategies to address overuse focus on the assessment of drug-, disease-, and patient-specific characteristics that determine appropriateness of a given therapy for an individual patient. Patient-specific characteristics important to overuse include considerations of effectiveness of previous treatments, adherence, and access to care. For example, a medication should not be prescribed if the patient had previously failed treatment with that therapy, cannot adhere to monitoring requirements, or is unable to obtain the product due to cost issues. It was noted that off-label use of medications, which is necessary due to limited studies in certain patient populations, increases the challenge of identifying medication overuse. Pharmacists were encouraged to be vigilant in efforts to ensure there is adequate evidence to support off-label use. The impact of direct-to-consumer advertising was also briefly discussed and noted as an area where education could reduce medication overuse.

Given their role as medication experts, the Council and Board encouraged pharmacists to take a leadership role in addressing medication overuse. Strategies that consider drug-, disease-, and patient-specific characteristics, such as medication reconciliation and medication therapy management, were highlighted as key components of strategies to minimize overuse. The success of antimicrobial stewardship programs in minimizing overuse of antimicrobials was discussed with an emphasis on how these strategies might be used to minimize overuse of other therapeutic classes. Several Council members noted that their practice sites had implemented similar programs to improve use of proton pump inhibitors or other therapies that have been associated with overuse. The Council recommended development of a guidance document to provide additional detail about the significance of medication overuse and describe how stewardship and other strategies can be used to address it, and the Board supported this recommendation. The Council and Board believed that this policy statement and the proposed guidance would be useful tools to pharmacy leaders looking to justify the need for staffing and assist in overcoming practice barriers, including resistance to change. Council members noted that other ASHP policies, such as 0816, Pharmacist's Leadership Role in Anticoagulation Therapy Management, had been useful for this purpose.



B. Drug-Containing Devices

- 1 To recognize that use of drug-containing devices (also known as combination devices)
- 2 has important clinical and safety implications for patient care; further,
- 3 To advocate that use of such devices be documented in the patient's medical record
- 4 to support clinical decision-making; further,
- 5 To encourage pharmacists to participate in interprofessional efforts to evaluate and
- 6 create guidance on the use of these products through the pharmacy and therapeutics
- 7 committee process to ensure patient safety and promote cost-effectiveness; further,
- 8 To advocate that the Food and Drug Administration (FDA) and device manufacturers
- 9 increase the transparency of the FDA approval process for drug-containing devices,
- 10 including access to data used to support approval; further,
- 11 To encourage research that evaluates the clinical and safety implications of drug-
- 12 containing devices to inform product development and guide clinical practice.

Rationale

The Council considered the rapid growth in FDA-approved devices and other products that contain drug therapies. As defined by the FDA, a combination product is “a product comprised of two or more regulated components, i.e., drug/device, biologic/device, drug/biologic, or drug/device/biologic, that are physically, chemically, or otherwise combined or mixed and produced as a single entity” or “two or more separate products packaged together in a single

package or as a unit and comprised of drug and device products, device and biological products, or biological and drug products.” Examples include, but are not limited to, antibiotic-loaded bone cement (ALBC), drug-eluting catheters and stents, and hemostatic sponges and other products used for wound care. The Council stated that drugs in these products have a therapeutic effect, impact overall patient care, and in some instances may result in drug interactions and adverse drug events, and the Board agreed. For these reasons, the Council and Board advocated for documentation of the use of these products in patients’ medical records.

Pharmacists usually are not involved in decisions about how these products will be used within the health system. In addition to patient safety concerns, other shortcomings of this approach include lost revenue because these products are frequently not accurately billed or tracked as inventory. The Council and Board strongly encouraged pharmacists to participate in interprofessional discussions concerning use of these products and suggested that the pharmacy and therapeutics (P&T) committee may provide the ideal mechanism to conduct these evaluations.

The FDA provides recommendations for drug-device development in [Guidance for Industry and Staff: Early Development Considerations for Innovative Combination Products](#), including a suggestion that additional preclinical or clinical studies may be needed to evaluate “the potential for change in the established or understood safety, effectiveness, and/or dosing requirements” when a previously approved drug product is incorporated into a combination device. However, the Council emphasized that these studies are recommended, not required, by the FDA. In addition, the Council noted that even when these studies are completed, information from these studies is not widely available or easily accessible. Finally, the Council stated that it is not always apparent why a specific combination product receives a primary product assignment as a device or drug, which is important because this assignment can impact the approval pathway. Advocacy to the FDA and manufacturers of drug-containing devices was recommended by the Council and Board to improve the transparency of the approval process and access to information.

The Council stated that there is often little research concerning the interplay of drugs and devices (e.g., the rate and extent of drug release from the device) or pharmacodynamics once these devices are administered, applied, or implanted in the patient. Further, little is known about the contribution of ALBC or antibiotic beads and spacers to antimicrobial resistance. Therefore, the Council and Board encouraged research that could inform product manufacturers during the development process and provide information to clinicians about use of these products in patient care.

Background

The Council discussed the growth in FDA approval of drug-containing devices, also known as combination products. Drugs commonly included in combination products are antimicrobials, hemostatic therapies, collagen, and cell growth inhibitors. The Council noted that the duration of drug delivery varies by type of product. Some drug-containing devices are designed to deliver a bolus dose of the drug in the first 24 to 48 hours after administration, application, or implantation followed by prolonged release at a lower level. Often the exact duration of drug exposure is unknown. In the case of implanted therapies, even less may be known about the effects of extended exposure or integrity of the delivery device. For example, cracks and leaks

may develop in ALBC, and chronic exposure to low levels of the drug may lead to the development of antimicrobial resistance. These unknown variables can be amplified when products are compounded by pharmacies or specialty suppliers, rather than obtained as commercially available products. In these scenarios, use of different excipients and the expertise of the compounding staff can alter drug release as compared to the commercially available product.

Concerns about these products include the potential for adverse drug events and other safety issues. For example, there have been case reports of gentamicin- and vancomycin-induced acute renal insufficiency from use of devices that contain antimicrobials. Drug interactions, drug allergies, and cumulative toxicity are also a concern. For these reasons, the Council and Board advocated for documentation of this information in patient medical records in a manner that is retrievable (i.e., coded rather than part of procedure summary that may not be readily available). Despite these safety concerns, the Council noted that pharmacists are rarely involved in deciding how these products will be used in health systems. Instead, these products are managed by other departments, including central supply, wound care, and surgery. Based on these concerns, the Council and Board strongly encouraged pharmacists to participate in interdisciplinary discussions evaluating the use of these products to ensure patient safety and promote cost-effective use, including revenue capture. The Council believed assessments of drug-containing devices should be conducted with the same rigor as the drug formulary process and recommended the P&T committee as the ideal mechanism for conducting this assessment, and the Board agreed. While pharmacists may be less familiar with device principles, medication expertise was considered essential to ensuring the safe use of the products.

The Council believed that drugs are often added to devices as an afterthought, meaning that the device was not initially developed with the intent of incorporating a drug component. For example, sirolimus and paclitaxel were added to drug-eluting stents to enhance device effectiveness after these devices were initially brought to market. This add-on approach is especially common with older combination products. Market assessments project that moving forward a greater balance will be sought in the development of drug-containing devices, with more emphasis given to the interplay of these components. The Council also noted that it was often unclear whether a specific drug-containing device had received a primary product assignment from the FDA as a drug or device. The Council believed this distinction was important as it might affect the amount and types of data required for FDA approval. The Council and Board expressed concern about the clarity and transparency of these processes and recommended that ASHP advocate to the FDA and manufacturers that they address these shortcomings.

In regard to formulary decisions, the Council noted that there is limited evidence to support these assessments, either from product approval or post-approval studies. This lack of information prompted the Council and Board to encourage additional research in this area. In turn, it was expected that additional research would support the development of guidance for clinicians. In the interim, the Council and Board recommended that ASHP provide education to members about approaches for evaluating these products via an article in the *American Journal of Health-System Pharmacy (AJHP)* or educational programming.



C. DEA Scheduling of Hydrocodone Combination Products

- 1 To advocate that the Drug Enforcement Administration (DEA) reschedule
- 2 hydrocodone combination products to Schedule II based on their potential for abuse
- 3 and patient harm and to achieve consistency with scheduling of other drugs with
- 4 similar abuse potential; further,

- 5 To monitor the effect of rescheduling hydrocodone combination products and other
- 6 abuse-prevention efforts (e.g., prescription drug monitoring programs) to assess the
- 7 impact of these actions on patient access to hydrocodone combination medications
- 8 and on the practice burden of health care providers.

Rationale

The Council discussed proposals to reschedule Vicodin (hydrocodone and acetaminophen) and other hydrocodone combination products to Schedule II under the Controlled Substance Act. These therapies are currently under Schedule III. A meeting of FDA's Drug Safety and Risk Management Advisory Committee was scheduled for October 29 and 30, 2012, to address the public health benefits and risks of these therapies, including the potential for abuse. The Council was asked to advise ASHP on these topics to support the Society's participation in that discussion. The Council considered this issue at its September meeting and during a follow-up teleconference that was convened on December 21, 2012, to evaluate information released by the FDA after the Council developed the proposed policy in September. The new information, which was released as a pre-meeting report, included data on prescribing trends, abuse potential, and patient harms. This summary reflects both discussions, as noted throughout. [Note: The initial FDA advisory committee meeting was postponed due to inclement weather and rescheduled for January 24 and 25, 2013. At the conclusion of that meeting, the advisory committee voted 19 to 10 in favor of rescheduling hydrocodone combination products to Schedule II].

The Council's September assessment initiated with a review of the DEA's criteria for drugs in Schedule II and Schedule III, and reports from the Centers for Disease Control and Prevention (CDC) and other entities concerning the extent of abuse and patient harm from these and other opioid analgesics. As defined by the DEA, Schedule II controlled substances are those that "have a high potential for abuse which may lead to severe psychological or physical dependence." Hydrocodone as a single-ingredient product, if commercially available, would be included in Schedule II. However, at lower dosages and with the addition of acetaminophen, these combination products are assigned to Schedule III. In contrast, oxycodone is designated as Schedule II regardless of dosage or whether the drug is provided as single ingredient or as a combination product with acetaminophen. Schedule III controlled substances are those that "have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence." Recent data from the CDC show that every year since 2003 more deaths have occurred from overdoses of opioid

pain relievers, including hydrocodone combination products, than from overdoses of cocaine and heroin combined. In addition to this morbidity and mortality data, the Council reviewed clinical guidelines on pain management, opioid prescribing trends, and research on the relative addictive potentials of opioid products. The Council found no evidence that the lower dose of hydrocodone contained in these combination products, or the addition of acetaminophen, lowered the abuse potential of hydrocodone. The Board supported this assessment.

During the December conference call, the Council discussed data contained in the FDA pre-meeting report on prescribing trends (e.g., prescriber type, indication, duration of therapy), abuse potential, and patient harms. The Council found this data informative, but questioned whether it reflected the true extent of abuse of these therapies given the high prevalence of pill sharing and diversion of legal prescriptions. The Board agreed. The Council noted that adverse drug events and other patient harms may be underreported when these products are misused or obtained illegally. The Council also stated that the FDA data provided no insight as to whether these prescriptions were appropriate (i.e., issued according to evidence-based guidelines for appropriate indications and durations of use). Given these variables, the Council stated that the data are difficult to interpret and apply to a rescheduling decision, and the Board agreed. Central to the Council's deliberation were criteria used by DEA to determine whether to control or reschedule a drug, which include (a) the drug's actual or relative potential for abuse; (b) scientific evidence of its pharmacological effect, if known; (c) the state of current scientific knowledge regarding the abuse of the drug or other substance; (d) its history or current pattern of abuse; (e) the scope, duration, significance of abuse; (f) what, if any, risk there is to public health; (g) its psychic or physiological dependence liability; and (e) whether the substance is a precursor of a substance already controlled under the law. Based on an assessment using these criteria, the Council and Board believed that hydrocodone combination products were similar to other controlled substances found in Schedule II and should therefore be assigned to Schedule II. Of note, the Council stated that these criteria were never intended to take into account potential administrative and other burdens on pharmacists and other clinicians (e.g., stricter recordkeeping and security processes).

The Council also addressed concerns that rescheduling hydrocodone combination products may not decrease abuse. While it is difficult to predict the impact rescheduling would have on abuse, a majority of Council members believed that abuse would decrease, stating that the current extent of abuse is supported by easy access to, and excessive supply of, these therapies. The Board agreed with this assessment. The Council also considered a recommendation from the FDA to delay a decision on rescheduling until more data are available concerning the impact of alternative strategies, such as prescription drug monitoring programs, risk evaluation and minimization strategies (REMS), prescriber and patient education, and enforcement actions. The Council stated that these strategies can be effective, but noted that these approaches are largely reactive, not proactive. The Council believed that many of these strategies have been in place for years, yet there has been limited scientific evaluation of their effectiveness despite the costs and burdens they impose. In addition, clinician willingness to follow clinical guidelines and other measures to ensure appropriate medication use of all therapies has historically been low. Overall, the Council questioned whether more or better information would be gained by further delaying a decision on

rescheduling these therapies. In light of these findings, the Council and Board believed that continued inaction was inappropriate given the public health concern.

In proposing this policy, the Council and Board weighed the potential public health benefit of rescheduling these therapies against concerns about restricting patients' access to treatment and increasing administrative and other burdens on pharmacists and other clinicians. The proposed change to a more restrictive schedule would require stricter recordkeeping and security processes, which could in turn make providers reluctant to prescribe these therapies for patients who need pain management. The Council and Board believed that these were very significant and valid concerns. However, in balancing these concerns, the Council and Board concluded that increased control of drugs with high abuse potential is in the best interests of patients and public health. In addition, the Council questioned whether the inability to prescribe refills (which would be a primary impact of rescheduling) would have as broad an impact on patient access as initially feared. The Council highlighted data from the FDA pre-meeting report demonstrating that a majority of prescriptions for these products were issued for treatment of acute pain. The FDA's evaluation of the 131 million prescriptions issued in 2011 found that these products were most commonly prescribed for diseases of the musculoskeletal system and connective tissues, diseases of the respiratory system (for hydrocodone combination products that are used as antitussives), and fractures, sprains, contusions, and injuries. The average duration of therapy was 14 days. The Council stated that this information indicates that the burden on patients and providers should be less than feared because prescriptions for acute pain treatment would have no refills (or limited refills). The Council also noted several factors that would address concerns about access and burden, including the ability to predate prescriptions, proposed changes to e-prescribing standards that would permit electronic prescribing for these therapies, and the ability to fax prescriptions in many instances. However, the Council did acknowledge that existing state practice acts could prevent some mid-level practitioners from prescribing these drugs should a schedule change be implemented. The Council and Board encouraged DEA and others to monitor the impact of this scheduling change on patient access and practice, as well as to monitor the impact of other strategies that have been implemented to minimize the abuse and diversion of these therapies.

As part of their discussion, the Council also expressed concern about the current process used by the DEA to determine abuse potential for all controlled substances. A separate policy recommendation was developed to address this topic.

Background

The Council noted that the United States consumes 99% of the world's supply of hydrocodone. Given the drug's extensive use, there has been ongoing debate about whether Vicodin and other hydrocodone combination products should be assigned to a more restrictive schedule to curb abuse of these therapies. Early drafts of legislation to reauthorize the Prescription Drug User Fee Act (PDUFA) would have moved hydrocodone combination products to Schedule II. While rescheduling was not included in the final legislation, the law directed the Drug Enforcement Administration (DEA) and Food and Drug Administration (FDA) to consider the scientific and medical aspects of this proposal. At the request of DEA, the FDA scheduled a meeting of the Drug Safety and Risk Management Advisory Committee as part of this evaluation. The Council was asked to advise ASHP regarding the public health benefits and risks

of hydrocodone combination products to support the Society's participation in that meeting [Note: This meeting, which was initially scheduled for October 29 and 30, 2012, was postponed until January 24 and 25, 2013 due to inclement weather. At the conclusion of the rescheduled meeting, the advisory committee voted 19 to 10 in favor of rescheduling hydrocodone combination products to Schedule II].

While hydrocodone as a single-agent dosage form, if available, would be included in Schedule II, hydrocodone combination products are Schedule III drugs. A commonly held belief is that these combination products were placed in Schedule III based on the assumption that fears of liver toxicity from the acetaminophen content would limit abuse; the Council and Board noted that this assumption has not been realized. Recent data from the CDC show that every year since 2003 more deaths have occurred from overdoses of opioid pain relievers, including hydrocodone combination products, than from overdoses of cocaine and heroin combined. This epidemic, combined with ongoing FDA efforts to limit acetaminophen toxicity, have caused many to call for another look at the safety and effectiveness of hydrocodone combination products in their current schedule.

The Council initiated discussion by considering definitions for the DEA schedules and example drugs in each schedule. As defined by the DEA, Schedule II controlled substances are those that "have a high potential for abuse which may lead to severe psychological or physical dependence." Example products in this schedule include morphine, opium, hydromorphone, methadone, meperidine, oxycodone, and fentanyl. The Council noted that if hydrocodone were available as a single-ingredient product, it would be designated a Schedule II substance. Schedule III controlled substances are those that "have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence." Examples of Schedule III narcotics include buprenorphine and hydrocodone-acetaminophen combination products containing less than 15 milligrams of hydrocodone per dosage unit. The Council and Board acknowledged the lower dosage limit for Schedule III, but stated that there is no evidence that the lower dose or addition of acetaminophen lowers the abuse potential of hydrocodone. Even with available studies, the Council stated that small sample size and the subjective nature of assessments of pain and addiction make absolute comparisons of the abuse potential of these therapies difficult. Despite that limitation, the majority of Council members determined that available literature suggests that the abuse potential of hydrocodone combination products is similar to the abuse potential of several drugs already assigned to Schedule II, including pure hydrocodone products. A key consideration in the Council's deliberations were criteria used by DEA to determine whether to control or reschedule a drug, which include (a) the drug's actual or relative potential for abuse (b) scientific evidence of its pharmacological effect, if known, (c) the state of current scientific knowledge regarding the abuse of the drug or other substance, (d) its history or current pattern of abuse, (e) the scope, duration, significance of abuse, (f) what, if any, risk there is to public health, (g) its psychic or physiological dependence liability and (e) whether the substance is a precursor of substance already controlled under this law. On the basis of all this evidence, in order to maintain consistency and end confusion over the relative known safety of these therapies, the Council and Board recommended that hydrocodone combination products be reassigned to Schedule II. The Council also highlighted the fact that the FDA report recommends oxycodone, a Schedule II substance, as a comparator product

based on what it described as equal potency and abuse liability on a milligram per milligram basis. The Council believed this statement provided further support for proposals to reschedule hydrocodone combination products.

During the December conference call, the Council noted that earlier proposals to reschedule hydrocodone combination products were postponed because of data limitations. In 2004, the FDA initiated a similar assessment at the request of DEA that resulted in a recommendation against rescheduling in 2009, stating that these products have less potential for abuse due to the addition of acetaminophen and that there was less data demonstrating abuse of these drugs when compared to abuse of Schedule II drugs. In the most recent report issued as background prior to the FDA advisory committee meeting, the FDA again cautioned against rescheduling hydrocodone combination products in light of the inherent complexity in determining their abuse potential and the potential impact on patient care. Instead, the FDA recommended further research to determine the abuse potential of hydrocodone combination products. The Council did not disagree with the FDA's assessment that existing data are imperfect, but believed that further delays are unlikely to generate evidence that provides a clear-cut answer to this complex question. The Board concurred with this assessment.

During the September and December discussions, the Council debated whether rescheduling hydrocodone combination products would deter abuse and prevent patient harm. The Council believed the impact was difficult to predict. However, a majority of Council members believed that abuse would decrease, stating that the current extent of abuse is supported by easy access to, and excessive supply of, these therapies. The Board agreed with this assessment. It was noted that a study by Spiller, et al. published in *Annals of Pharmacotherapy* found the number of calls to poison control centers for potential tramadol overdose decreased in two states following placement of that therapy in Schedule IV as compared to two states where access was not restricted. The ratio of calls per tramadol prescription issued did not change. The Council also considered a recommendation from the FDA report that suggested delaying a decision on rescheduling until more data are available concerning the impact of alternative strategies, such as prescription drug monitoring programs, REMS, prescriber and patient education, and enforcement actions. Overall, the Council and Board questioned whether more or better information would be gained by further delaying a decision on rescheduling these therapies. In light of these findings, the Council and Board believed that continued inaction was inappropriate given the public health concern.

The Council also reviewed clinical guidelines for pain management and agreed that there is a role for these therapies in managing acute and chronic pain, a role that may not be adequately filled by alternative therapies such as nonsteroidal anti-inflammatory drugs that present a higher risk of adverse drug events and tramadol or acetaminophen with codeine, which are less effective for treating pain. Evidence supporting use of hydrocodone combination therapies in chronic cancer pain is substantial. However, the Council stated that there is less evidence about the effectiveness and safety of these therapies when used for extended periods to treat acute pain. Of note, data contained in the FDA report indicate that of the 131 million prescriptions issued for these products in 2011, most were prescribed for acute conditions, including diseases of the musculoskeletal system and connective tissues (ICD-9 codes 710 through 739), diseases of the respiratory system (ICD-9 codes 462 through 493 [for

hydrocodone combination products that are used as antitussives]), and fractures, sprains, contusions, and injuries (ICD-9 codes 800 through 999).

There was significant discussion of the impact this schedule change will have on patient access to treatment. The Council recognized that moving hydrocodone combination products to Schedule II will make it more difficult for clinicians to prescribe and patients to obtain these therapies. Patient access was a significant concern. While transmission via telephone would be restricted as a general rule, the Council did note that prescriptions for Schedule II controlled substances can be provided via telephone in emergency situations. The Council also noted that predated prescriptions, proposed changes to e-prescribing standards, and faxed prescriptions could lessen the practice burden. Many states have specifically defined facsimile allowances to address emergency situations and long-term care, hospice, and home care settings. [Only ten states fully prohibit faxing of Schedule II drugs according to the 2012 NABP Survey of Pharmacy Law.] However, the Council did acknowledge that existing state practice acts could prevent some mid-level practitioners from prescribing these drugs should a schedule change be implemented. [The FDA report states that the following number of states place restrictions on prescribing of Schedule II drugs by practitioner type: physician assistants, 12 states; nurse practitioners, 14 states; optometrists, 30 states.]

Related to practitioner burden, the Council reviewed comment letters submitted by several organizations in response to a proposal to reschedule these products that was included in early drafts of the legislation to reauthorize PDUFA. The Council noted that comments from the American Pharmacists Association, the Food Marketing Institute, International Academy of Compounding Pharmacists, National Association of Chain Drug Stores, National Community Pharmacists Association, and the American Medical Association had merit, but focused predominantly on logistics, rather than clinical, patient safety, and public health concerns. Issues raised by those organizations included barriers to patient access for those with a legitimate need for pain therapy and the administrative burden on clinicians, including increased paperwork and costs to meet more stringent storage requirements. The American Society of Addiction Medicine supported rescheduling these drug products, calling it the “single most important intervention the federal government could implement” to address what was described as an epidemic.

Rescheduling hydrocodone combination products will present a significant challenge to pharmacies to accommodate the increased administrative work and ensure appropriate patient access. However, the Council and Board believed that the current processes associated with dispensing these therapies as Schedule III controlled substances may be contributing to abuse due to the lack of a paper trail and other safeguards. Overall, the Council and Board believed this increased burden is balanced against the decreased potential of patient and public harm through tighter controls against abuse. The Council noted that it would not have been in favor of rescheduling if the intent was merely to shift drug enforcement burden to pharmacists. However, given the individual and societal health impacts of prescription drug abuse and from the perspective of optimal patient care and safety, the Council believed increased controls on drugs with high abuse potential are in the best interests of patients and public health. It was also noted that proposals that would allow electronic prescribing of Schedule II drugs, which are currently in flux, could alleviate many of these burdens if implemented. The Council recognized that the impact of rescheduling hydrocodone combination products was difficult to

predict. Therefore, the Council and Board recommended that stakeholders monitor the impact of this and other strategies that have been implemented to minimize the abuse and diversion of these therapies to determine the impact on patient care and pharmacy practice.

There was also significant discussion of the lack of clarity in the DEA's classification structure of high, moderate, and low abuse potential, and the Council acknowledged difficulty in evaluating available data of relative abuse potential within that context. Therefore, the Council developed a separate policy recommendation advocating that the DEA create clear and measurable criteria for assessing a drug's abuse potential, and for the DEA to use those clarified criteria and current data to reassess existing schedule assignments for all controlled substances.



D. DEA Scheduling of Controlled Substances

- 1 To advocate that the Drug Enforcement Administration (DEA) establish clear, measurable
- 2 criteria and a transparent process for scheduling determinations; further,
- 3 To urge the DEA to use such a process to re-evaluate existing schedules for all substances
- 4 regulated under the Controlled Substances Act to ensure consistency and incorporate
- 5 current evidence concerning the abuse potential of these therapies.

Rationale

The Council discussed the DEA's current classification structure used to determine the schedule of controlled substances as part of their discussion of proposals to reschedule hydrocodone combination products. The Council believed that the current stratification of abuse potential into low, moderate, and high categories lacks clarity and contributes to perception of inconsistency in assigning schedules. The Board concurred. The Council also noted that the existing schedules do not appear to take into account evolving evidence about the abuse potential of these drugs. Therefore, the Council and Board recommended that ASHP advocate that the DEA establish clear, measurable criteria, to the extent possible for this complex area, and a transparent process for scheduling determinations. Further, the DEA was encouraged to use those criteria to re-evaluate current schedule assignments for all controlled substances based on the most recent evidence.

Background

The Council considered the current process used by the DEA for scheduling controlled substances as part of their discussion of proposals to reschedule hydrocodone combination products. As defined by the DEA, Schedule II controlled substances are those that "have a high potential for abuse which may lead to severe psychological or physical dependence." Schedule III controlled substances are those that "have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence." The Council believed there is a lack of clarity in the DEA's classification structure of high, moderate, and low abuse potential, stating that it was difficult

to evaluate available data of the relative abuse potential of these therapies within that context, and the Board agreed. Therefore, the Council and Board recommended that ASHP advocate for the DEA to create clear and measurable criteria for assessing a drug's abuse potential, and called on the DEA to use those clarified criteria and current data to reassess existing schedule assignments for all controlled substance.

Board Actions

Endorsement of Clinical Pharmacogenetics Implementation Consortium (CPIC) Guidelines for Codeine Therapy in the Context of Cytochrome P450 2D6 (CYP2D6) Genotype

The Council recommended and the Board voted to endorse the [CPIC Guidelines for Codeine Therapy in the Context of Cytochrome P450 2D6 \(CYP2D6\) Genotype](#). The Clinical Pharmacogenetics Implementation Consortium (CPIC) was formed by the National Institutes of Health's Pharmacogenomics Research Network and the Pharmacogenomics Knowledge Base. One goal of CPIC is to provide peer-reviewed, evidence-based, and freely accessible guidelines for drug-gene pairs to support the translation of pharmacogenomic information from research to clinical practice. In 2011, the Council recommended endorsement of another CPIC guideline on pharmacogenomic testing to manage clopidogrel and other antiplatelet therapies. Overall, the Council stated that the guideline being considered for endorsement, which addresses codeine metabolism via the cytochrome P450 2D6 enzyme, provides valuable information about managing therapy, and the Board agreed. Of note, an August, 2012 FDA Drug Safety Communication reported four instances of death or life-threatening adverse effects in children who received usual dosages of codeine for pain relief after tonsillectomy and/or adenoidectomy procedures. The communication noted that these children were likely rapid metabolizers of codeine.

While the Council supported the intent of the document they did question why codeine was selected given that the CYP450 2D6 enzyme affects the metabolism of numerous drugs. One possible explanation is that this drug was chosen because, as a prodrug, its activity is largely dependent on metabolism by CYP450 2D6. The Council also expressed some concern about the recommendation for preemptive testing. This was considered less neutral than the approach CPIC took in the clopidogrel guidelines, which did not recommend whether the test should or shouldn't be used, but rather focused on how to interpret the test if it is done. The Council had preferred that approach, given ongoing debate about the use of pharmacogenomic tests and barriers to their use, including variable insurance coverage, limited access outside of academic medical centers, and the extended time frame required to receive results. The Council considered whether pharmacy departments would be held responsible if the test were completed and a patient experienced an adverse event to another drug metabolized by CYP450 2D6. Despite these concerns, the Council and Board believed the document provided useful information and recommended endorsement.

CPIC was encouraged to update the guidelines as evidence evolves and to include pharmacoeconomic information whenever possible. The Council also noted that codeine is used more frequently in children as an antitussive or antidiarrheal treatment rather than pain

therapy. These uses were not described in the guidelines. To increase the practical application, it was suggested that CPIC acknowledge all common uses of drugs addressed in future guidelines in order to reflect the range of clinical practice. ASHP was encouraged to provide a webinar, editorial, or other information to members to describe strategies for using this and other CPIC guidelines.

Sunset Review of Professional Policies

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

- [Pharmacist's Leadership Role in Anticoagulation Therapy Management](#) (0816)
- [Generic Substitution of Narrow Therapeutic Index Drugs](#) (0817)
- [ASHP Statement on Criteria for an Intermediate Category of Drugs](#)

Other Council Activity

Considerations for Formulary Management and Naming of Biosimilars

Biosimilars will soon move from concept to reality following establishment of a pathway for approval of these products via passage of the Biologics Price Competition and Innovation Act and subsequent issuance of guidance from the FDA. It is projected that the first biosimilars will come to market in 2013. The Council noted that biosimilars are expected to result in a 20–25% reduction in cost compared to the innovator product, which is significantly less than cost savings achieved with traditional generic drugs. However, overall savings to a health system will still be substantial, given the high cost and utilization of these products. The Council advised ASHP on approaches interdisciplinary P&T committees could use to determine how these products will be used within the health system. The FDA approval process provides some insight on how biosimilars will be used, including establishing a two-step process via which first biosimilarity and then interchangeability will be achieved. According to this process, a product that has achieved biosimilarity would mirror the innovator product in terms of mechanism of action and immunogenicity. However, these products could differ in terms of inactive ingredients, purification processes, and other areas that are proprietary. Therefore, a product that achieves only biosimilarity will not be considered a therapeutic equivalent and will not be eligible for direct substitution without prescriber notification and approval. Once a product achieves the second phase, interchangeability, it would likely be substitutable in a manner similar to other drugs (i.e., a “dispense as written” or “do not substitute” option would be available). The Council was supportive of the processes established by the FDA.

The Council believed the drugs approved at the first level of biosimilarity could be substituted via the formulary process if reviewed by the P&T committee and deemed eligible for therapeutic interchange. Considerations for this process include evaluating what is meant when a drug is deemed to have no clinically significant differences and developing processes for interchange, if warranted. Pharmacodynamic studies in actual patients should be used in this evaluation whenever available. The Council noted that FDA intends to recommend these

studies, but they may not be required. Application of evidence to unique populations (e.g., pediatric patients) that are not usually included in clinical studies will be especially challenging. Whether FDA approval for one indication could be extended to use for unlabeled indications is another area that P&T committees must consider. How these decisions will be incorporated in purchasing contracts should also be addressed. While the P&T committee processes for these decisions may mirror that used for other drugs, increased scrutiny will be required. The Council stressed that patient outcomes and safety should be the primary consideration in these decisions, with cost benefits relegated to secondary status.

The Council also commented on current proposals for naming biosimilars, which include identical names or related but unique names (e.g., use of suffixes or prefixes). Pros and cons of these approaches were considered as described in comment letters from (1) the Generic Pharmaceutical Association, (2) the Pharmaceutical Research and Manufacturers of America and the Biotechnology Industry Organization (BIO), (3) the National Council for Prescription Drug Programs, and (4) the American Pharmacists Association, the National Association of Chain Drug Stores, and the National Community Pharmacists Association. Using unique names has been proposed because of patient safety concerns. However, the Council noted that much of this concern is based on conjecture about potential patient harm. Again, the Council restated their support of the approval processes established by FDA. It was noted that past concerns that other products might result in different patient outcomes have not been realized. The example of converting animal- to human-based insulins was cited. The Council recommended that it was essential that biosimilars be given the same root name following standards for nonproprietary names established by the United States Adopted Name Council (USANC) and approved by the International Nonproprietary Name (INN) Expert Panel. While the Council supported this process, it also acknowledged that the higher complexity of biosimilars warrants increased pharmacovigilance. The National Drug Code (NDC) should support pharmacovigilance efforts, but the Council noted some challenges to that approach (e.g., reuse of NDC numbers). Therefore, the Council did not oppose addition of suffixes (e.g., alpha, beta) to the INN name if experts believed this approach was needed to facilitate pharmacovigilance. Use of prefixes was not recommended because it would introduce confusion and add unnecessary complexity to programming of information systems. The Council was hesitant to recommend development of patient registries or other stringent processes in the absence of information supporting the need for such programs for all biosimilars. However, there was support for product-specific programs when deemed necessary by the FDA and the drug manufacturer.

ASHP was strongly encouraged to provide education and information to members via *AJHP*, live and web-based educational programming, and the Emerging Sciences Web Resource Center. This education should provide general information about biosimilars and recommended processes for evaluating data supporting their approval and use. It will also be important to advocate that pharmacists take a leadership role in educating prescribers, patients, and other stakeholders about biosimilars, including appropriate processes for interchange, and emphasize the importance of pharmacovigilance. The Council noted that this education was important because shortcomings in spontaneous adverse drug reaction reporting for all drugs will likely occur with biosimilars as well.

Strategies to Address Medication Overuse

As part of the medication overuse discussion, the Council recommended that ASHP develop guidelines on strategies to address this issue. The proposed guidance is expected to be a useful tool for facilities trying to address medication overuse and will also provide valuable information to justify resource needs. It was recommended that the guidance emphasize how strategies to address overuse align with national quality and safety initiatives. Topics addressed by the guidelines will include the clinical and financial implications of medication overuse, the role of pharmacists in addressing overuse, and example strategies to minimize the problem, including principles of antimicrobial stewardship, medication reconciliation, and medication therapy management. It was noted that pharmacists' leadership in this area is consistent with the Pharmacy Practice Model Initiative and principles of medication therapy management, medication reconciliation, and transitions of care.

ASHP Guidelines on Provision of Medication Information by Pharmacists

The Council reviewed the [ASHP Guidelines on Provision of Medication Information by Pharmacists](#) as follow-up to a discussion by the Council on Pharmacy Practice. The Council was asked to determine if the topic addressed by this 1996 guidance was still relevant, and if so, to identify topics that should be included in a revision. The Council stated that the existing guidelines did not adequately address current practice or the growing complexity of providing drug information. Therefore, a substantial update to the existing guidance was recommended to provide a more useful tool to support the provision of drug information, staff development, and education of students, residents, and external stakeholders. Significant revisions were suggested, including a shift in focus to highlight the importance of pharmacy leadership in these activities. Other topics that were recommended for inclusion include system-based approaches to providing drug information (as opposed to responding to one-off requests), archiving, and staff development activities. The Council noted that specific details about technology (or the lack of it) were characteristics that made the existing document outdated. Therefore, it was recommended that the revision address the use of technology, but avoid being so specific as to outdate the guidance quickly. In light of these substantial changes, the Council stated that the title of the guidelines should be updated to better reflect the content once the manuscript is developed.

ASHP Therapeutic Position Statement on Antithrombotic Therapy in Chronic Atrial Fibrillation

The Council discussed the *ASHP Therapeutic Position Statement on Antithrombotic Therapy in Chronic Atrial Fibrillation* as part of sunset review. This therapeutic position statement (TPS) was published in 2007 to address the appropriate use of antithrombotic therapies for primary and secondary prevention of stroke in patients with atrial fibrillation. Risk stratification, selection of warfarin or aspirin therapy based on patient characteristics, and drug therapy management are focal points of the existing guidance. The Council stated that the current guidance is significantly outdated following publication of [Antithrombotic Therapy and Prevention of Thrombosis](#), 9th edition: American College of Chest Physicians Evidence-Based

Clinical Practice Guidelines (CHEST guidelines) in February 2012. Updates to the CHEST guidelines include information about new drug therapies, revised risk stratifications, and a new system to grade recommendations. The Council advised ASHP to revise the TPS to address these changes. Revisions should focus on currency as well as providing a unique perspective that supplements rather than duplicates the information contained in the CHEST guidelines. To achieve this, the Council recommended that the TPS provide practical advice on interpreting the new grading of recommendations and include an update to the existing table that compares available guidelines. In light of the extensive changes required, the Council recommended that ASHP remove the existing document from the ASHP website while the revision occurs.

American Academy of Managed Care Pharmacy Format for Formulary Submission

The Council reviewed the Academy of Managed Care Pharmacy (AMCP) [Format for Formulary Submissions Version 3.1](#) to provide feedback to ASHP staff on its applicability in the health-system setting. This dossier format was developed to provide a structured and standardized process for submission of clinical and economic data by drug product manufacturers in response to unsolicited information requests. The intent of the dossier format is to support formulary and reimbursement decisions by facilitating comparisons of clinical information and providing models for pharmacoeconomic considerations. Health plans and pharmacy benefit managers are the primary users of dossiers that follow this format. However, this approach may be useful in other health care settings (e.g., hospitals, integrated health systems) that use an evidence-based approach to determining drug use. The inclusion of information that describes the drug's place in therapy, comparisons to other drugs in the same therapeutic class, applicable clinical guidelines, and data on file were viewed favorably by the Council. The Council also noted that the AMCP format may provide an understanding of how these drug products are detailed to prescribers by providing an overview of information the drug manufacturer believes is most relevant. Identified limitations of the AMCP format included less-than-optimal information on off-label uses and pharmacoeconomics. The Council appreciated that the AMCP format includes economic models, but believed that use of these models would be challenging because of the unique nature of purchasing contracts established by each facility.

Overall, the Council believed that the AMCP format was a useful tool that could be used to support the formulary process. Dossiers may be especially useful for smaller facilities that have limited staff resources to gather initial information. However, the Council stated that dossiers should only be used as a starting part for the formulary process and should be considered one of many pieces of information needed to support decision-making. The Council also questioned whether drug manufacturers could make the information available in the timeframes frequently needed for P&T committee meetings. One study reviewed by the Council noted several weeks as the average time to receive a dossier once it is requested. Meanwhile, Council members reported that this information is often needed within a week. The Council recommended that ASHP increase member awareness of the AMCP format as a tool to support formulary decision-making. A live or web-based educational program or

editorial in *AJHP* was recommended as supplemental information to provide guidance on proper use of the AMCP format and its limitations.

Conducting and Communicating Information from Post-Approval Safety Evaluations

The Council considered the Institute of Medicine (IOM) report, [*Ethical and Scientific Issues in Studying the Safety of Approved Drugs*](#), which was developed at the request of FDA to guide processes for post-approval drug safety evaluations and regulatory actions. The Council believed that the importance of post-approval safety studies was heightened following the approval of some medications based on surrogate markers that were later found to be associated with safety issues. Clarification of the roles that different information types (e.g., observational studies, randomized clinical trials, expert opinions) should play in regulatory decisions was considered an especially valuable aspect of the report. The Council appreciated the dual focus on ethics and scientific issues, noting that it was important to select a study design that was reasonably certain of obtaining the desired information given the risks inherent in having patients participate in postmarketing safety studies. The Council stated that informed consent processes were especially important in studies where enrollment of human subjects was deemed necessary.

The Council viewed favorably the IOM's recommendation to create a comprehensive benefit and risk assessment and management plan (BRAMP). The BRAMP would be a single document that spans the life cycle of the drug and provides information about the processes used to assess the risks and benefits of the drug, all regulatory actions and labeling changes, and the plan or schedule for future reviews. Much of this information is currently publicly available, but it is usually contained in disparate documents, difficult to locate, and provided in highly technical language that is difficult for many audiences to understand. The Council believed the BRAMP was an important step to improving the transparency of the process of post-approval safety evaluations. However, the Council did recommend that FDA consider using a name that would be more reflective of the content and easily identifiable by the intended audiences.



Board of Directors Report on the Council on Education and Workforce Development

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

Council Members

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- Dale E. English, *Vice Chair* (Ohio)
- Philip Brummond (Michigan)
- Morton P. Goldman (Ohio)
- Nicole M. Grimmer, *Student* (Minnesota)
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Policy Recommendations



A. Pharmacy Resident and Student Roles in New Practice Models

- 1 To promote pharmacy practice and training models that: (1) provide experiential and
- 2 residency training in team-based patient care; (2) recognize and utilize the skills and
- 3 knowledge of pharmacy students and residents in providing direct patient care services;
- 4 (3) augment the patient care services of pharmacists through expanded roles for
- 5 residents as practitioner learners; and (4) where appropriate, utilize an approach to
- 6 learning and service in which a supervising pharmacist oversees the services of
- 7 students, residents, and other pharmacists providing direct patient care.

(Note: This policy would supersede ASHP policy 1204.)

Rationale

Hospitals and health systems are currently dealing with the issue of how to best integrate residents and students into new or evolving practice models. Distinguishing the resident as a licensed practitioner learner rather than as an observer learner has been challenging, but it lends itself to team-based care. As practice sites consider how to change their practice models, the role of residents must be integral to the changes and not added on as an afterthought. The role of students, how they interface with residents, and with the rest of the patient care team is also important. These changes also require consideration of who should be preceptors and what their qualifications should be.

Some health systems are employing an “attending pharmacist” model or a “layered learning” approach to residency training, both of which designate a pharmacist who oversees multiple residents, students, 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 (referred to as an “attending” pharmacist in some organizations). Sites that have implemented such a model have reported positive results, including improved satisfaction by all participants in the model as well as opportunities to expand pharmacy services with existing resources. The need to ensure patient outcomes are improved by this model is noted, as well as the imperative to not compromise patient safety.

The number of pharmacists, residents, and students the lead pharmacist might reasonably oversee is determined by the type of patients being treated. When the patient care demanded is highly complex, acute, or otherwise unique, the number is much lower. Other services, such as internal medicine, allow the lead pharmacist to oversee more trainees. When the pharmacy resident is the point of contact for the service for the month, such a model also results in a better use of time for the attending pharmacist. In addition, when the resident is supervising students, the resident’s development is enhanced as well, since their knowledge

will be tested as students ask questions. The attending pharmacists and residents also provide role models for students, which may spark an interest in completing a residency.

The “attending pharmacist” or “layered learning” model might be more practical in larger institutions, which have more staff, residents, and students than smaller hospitals. It is important to individualize the training program to the practice site and its corresponding practice model. Some rotations may utilize this type of a team-based model, others may not.

Utilizing residents in this way presents new challenges with schedules, especially in months in which residents are new or when there are few students available. These and other issues will require creative solutions. Quicker orientation for new residents, different scheduling schemes for students, staggered start dates, and simulation may be strategies that could make these new roles successful.

By structuring resident activities within new and evolving practice models as more independent practitioner learners, resident training can be improved and a greater level of pharmacist patient care services can be achieved. The roles of students and the structure of their participation are also critical to the success of these models in training and in providing patient care services.

Background

The Council discussed specific Pharmacy Practice Model Initiative (PPMI) recommendations, such as the recommendation that all patients deserve the drug therapy management services of a pharmacist. The Council also considered ASHP policy 1204, Role of Students in Pharmacy Practice Models, which reads:

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

The Council felt that a new policy should include reference to both students and residents, and therefore policy 1204 would be redundant and no longer needed as a standalone policy. They also discussed concerns over how to optimally provide residents with feedback, as well as the challenges of supervising at multiple levels.



B. Education and Training in Health Care Informatics Pharmacy

- 1 To foster more effective use of health-system information systems, automation, and
- 2 technology by promoting the development of and participation in formal health care
- 3 informatics training programs for pharmacists and pharmacy technicians.

Rationale

With growing use of automation and technology, there is a growing need for informatics-trained pharmacists and pharmacy technicians, yet there are few training programs or

residencies. This shortage of trained individuals has led to on-the-job training and potentially less-than-optimal implementation of new information systems and technology. New educational programs, or adaptation of existing ones, would help ease this lack of trained individuals and lead to better technology outcomes.

Background

The Council discussed currently training available programs and how students are trained in informatics within the current pharmacy curriculum. The level of informatics education within colleges of pharmacy varies widely, but Accreditation Council for Pharmacy Education (ACPE) standards specifically require baseline training in informatics. Council members perceived that most colleges are effective in giving students a basic understanding of information systems by the time they graduate. Fewer institutions, however, provide elective courses focusing on advanced topics in informatics or graduate degrees in this area.

The Council discussed other programs that are available, including those developed for health care disciplines, such as the American Medical Informatics Association (AMIA) 10 x 10 courses. The AMIA courses have been developed through partnerships with universities and target specific health care professionals who are seeking additional training in informatics, with the goal of teaching 10,000 professionals within 10 years. Most are delivered through distance education, and training in many subspecialties is also offered. There are other distance-learning courses and graduate degree programs available.

There are a limited number of accredited, postgraduate year two (PGY2) residencies in pharmacy informatics. While the number of programs, positions, and graduates is likely to increase over time, Council members questioned whether residencies would be the solution for the broad challenge of training thousands of health care informatics pharmacists needed in the future. Additionally, in many small to medium-sized hospitals, the pharmacist responsible for informatics-related issues also has other unrelated responsibilities and is unlikely to commit to a year-long residency in informatics.

The development of core competencies for health care informatics pharmacists, as has been done in biomedical informatics, was also discussed. Currently, pharmacist knowledge and development in informatics is often vendor-system-specific and needs to be broadened around established competencies.

The lack of a defined scope of practice for health care pharmacy informatics adds to difficulties in designing and offering training. There are many pharmacists involved in informatics, but they often work in diverse settings, requiring very different skills and knowledge. The Section of Pharmacy Informatics and Technology (SOPIT) has been discussing these many practice areas, including hospitals, health systems, consulting firms, and the information technology industry. While each area has its own specific educational needs, there are also broad topics, such as project management skills, that apply to all settings. In addition to scope of practice, terminology around “pharmacy informatics” is not well defined or standardized, adding to the challenge.

Often there are many nonpharmacists working on medication-related information systems and technology. In many cases, these individuals outnumber the pharmacists involved and have even more diverse backgrounds, some beginning as pharmacy technicians while others are trained in information systems but have little health care or pharmacy experience.

Determining what level of informatics-related knowledge is needed by these individuals, much less by entry-level pharmacists or pharmacist informatics experts, is very difficult.

The supply and demand for informatics pharmacists is important, given the expected growth in technology. The demand is high and will be even greater as funding from the Centers for Medicare & Medicaid Services (CMS) related to meaningful use starts, leaving hospitals with lower reimbursement if they have not implemented specific information technology capacity. Hospitals will need pharmacist involvement for effective implementation. On the supply side, in addition limited training opportunities, the level of interest from pharmacy students and pharmacists in these positions has not been high. A few years ago, residency positions in informatics were sometimes difficult to recruit for and fill, although this challenge has lessened in recent years. Greater promotion and communication to students, residents, and practitioners on the increasing demand for and career opportunities in informatics would be helpful.

The Council suggested that there may be a need for a profession-wide summit on pharmacy informatics, since the issues affect all pharmacy practice settings.



C. Diversity and Cultural Competence

- 1 To recognize that having a diverse team of health care providers improves the
- 2 medication-use process and team-based care; further,
- 3 To foster the cultural competence of pharmacy practitioners, technicians, students,
- 4 residents, and educators for the purpose of achieving optimal therapeutic outcomes
- 5 in diverse patient populations.

(Note: This policy would supersede ASHP policies 0314 and 0409.)

Rationale

There continues to be a strong need for cultural competence in the health-system pharmacy workforce, as in other health care professions, as well as recognition that diversity of health care providers enhances patient care.

Background

As part of sunset review, the Council discussed ASHP policy 0314, Cultural Competence, which reads:

To foster cultural competence among pharmacy students, residents, and practitioners and within health systems for the purpose of achieving optimal therapeutic outcomes in diverse patient populations.

The Council concluded that the issue is important and that ASHP should have policy on the topic. The Council also reviewed ASHP policy 0409, Cultural Diversity Among Health Care Providers, which reads:

- To foster awareness of the cultural diversity of health care providers; further,
- To foster recognition of the impact that cultural diversity of health care providers may have on the medication-use process; further,
- To develop the cultural competencies of pharmacy practitioners, technicians, students, and educators.

The Council felt that these policies were both important and needed, but that they should be combined into a single policy. They also recommended that pharmacy technicians be added, since they are part of the pharmacy team.



D. Standardized Pharmacy Technician Training as a Prerequisite for Certification

- 1 To discontinue ASHP policy 0803, which reads:
- 2 To advocate that completion of an ASHP-accredited pharmacy technician
- 3 training program be a prerequisite for the Pharmacy Technician Certification
- 4 Examination.

Background

As part of sunset review, the Council reviewed policy 0803. Although the policy was considered to still be relevant and important, the Council concluded that the policy was redundant with ASHP policy 1216, which reads:

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

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that all pharmacy functions be performed under the general supervision of a licensed pharmacist and that licensed pharmacists and technicians be held accountable for the quality of pharmacy services provided.

(Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.)

The Council felt that the language included in policy 1216 was similar to that in policy 0803, and that therefore there was no longer a need for policy 0803.



E. Entry-Level Doctor of Pharmacy Degree

- 1 To discontinue ASHP policy 0805, which reads:
 - 2 To be an active participant in the Accreditation Council for Pharmacy
 - 3 Education (ACPE) process for the revision of accreditation standards for entry-
 - 4 level education in pharmacy; further,
 - 5 To actively monitor the long-range impact that the single entry-level degree
 - 6 will have on residency education, availability of experiential training sites,
 - 7 graduate education, and continuing education programs, and the resulting
 - 8 health-system pharmacist applicant pool.

Background

As part of sunset review, the Council discussed policy 0805. The policy was originally developed when the doctor of pharmacy degree became pharmacy's entry-level degree. Since then, ASHP has been, and continues to be, actively engaged with ACPE on practice issues. ASHP is actively involved in the revision to ACPE accreditation standards and collaborates regularly with ACPE on other issues of mutual interest. ASHP also regularly tracks residency positions and takes steps to increase the number and quality of experiential training sites. Since the intentions of the policy are in place and active, it was deemed no longer necessary, and the Council recommended discontinuing the policy.



F. Patient-Centered Care

- 1 To discontinue ASHP policy 0313, which reads:
- 2 To encourage that the principles of patient-centered care be integrated
- 3 throughout the college of pharmacy curriculum.

Background

As part of sunset review, the Council discussed policy 0303 and concluded that, since patient-centered care is clearly a focus of pharmacy education and is included in ACPE accreditation standards, this policy is no longer needed and therefore recommended its discontinuation. Patient-centered care is included in the ACPE accreditation standards and is widely addressed in contemporary pharmacy curricula. Because the concept is now well established, this policy is no longer needed.

Board Actions

Sunset Review of Professional Policies

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

- [Collaboration Regarding Experiential Education](#) (0804)
- [Image of and Career Opportunities for Hospital and Health-System Pharmacists](#) (0703)
- [Residency Programs](#) (0704)
- [Practice Sites for Colleges of Pharmacy](#) (0315)

Other Council Activity

ASHP Guidelines on Pharmacist Privileging and Credentialing in Hospital and Health Systems

The Council discussed their previous request for ASHP guidelines on pharmacist privileging and credentialing. The Council on Credentialing in Pharmacy (CCP) is developing a similar document. ASHP, being a founding member of CCP, will likely endorse the new guidance document. The Council concluded that two very similar documents are not needed, and that resources could be better spent on education and other ways to implement these systems. They recommended that ASHP discontinue development of guidelines.

Need for a Medication Safety Specialist Credential

The Council discussed the significant growth in the number of pharmacists serving as medication safety officers (or in similar positions, regardless of title) in health systems. Currently, there are few structured training programs for these types of positions and no way for individuals to distinguish themselves and demonstrate their knowledge and competency in this area of expertise. Some have suggested that there would be value in having a specialty certification specifically for medication safety. Several credentialing programs exist for patient safety, but none specifically in medication safety. There are no safety-related certifications from the Board of Pharmacy Specialties (BPS).

Many Council members thought that medication safety is too new and evolving to have a specialty credential. It was not clear whether there is an identifiable body of knowledge specific to medication safety. This area is evolving too rapidly to develop or endorse a single credential or certification. Pharmacists with specialty credentials have added credibility, but Council members did not perceive a sufficient need for a credential at this time; there is no compelling case from accreditors, payers, or employers. The Council recommended that ASHP continue to evaluate existing patient safety credentials to determine if there is alignment that might lead to ASHP endorsing, partnering, or collaborating with such organizations in the future.

Developing Pharmacists for Future Practice

The Council discussed how the delivery of health care will change in the next 25 years and how to ensure that new graduates are being trained for the future and that practicing pharmacists will adapt to the changing needs of health care delivery. There was concern that we may not be able to anticipate future needs very well, and that pharmacists need to be adaptable and nimble. Council members discussed the crossover between inpatient and outpatient settings and how pharmacists need to be able to follow patients between the two settings seamlessly. Pharmacists need to be trained to be able to function across settings.

The Council suggested that ASHP look at care models from the perspective of starting with a clean slate and not be encumbered by today's models. We should expect that there will be models in which pharmacists serve as providers for patients with chronic diseases. Those pharmacists will serve patients as their primary care provider, and if there are issues beyond managing their chronic disease and medication therapy, other providers would be called in. Pharmacists will need more training in physical assessment, and they also need to be well trained in managing chronic diseases and general drug therapy management skills. Good communication skills, both with the team, but also with the patient, will be imperative.

The impact of technology on clinical care was also discussed. Electronic health records, computerized order entry, tech-check-tech, and bar coding are already having an impact on what pharmacists and technicians do, and the expected growth in all types of technology will only compound this impact. Understanding these systems, as well as their use, design, implementation, and maintenance, will require additional skill sets for pharmacists.

The Council suggested that ASHP consider developing a tool that can be used by pharmacists to assess their own knowledge gaps, and identify specific programs to develop their skills. There is a broad range of skills and knowledge with existing practitioners, and no

one approach will work for retooling. The Council recommended that ASHP develop a toolkit that could be used by Directors of Pharmacy to evaluate the readiness of their existing staff, and then individualize a professional development program for each pharmacist to prepare them for new practice models and future practice.

Role of Non-BPS Specialty Certification

The Council discussed the role of board certification as a method of recognizing expertise in many clinical and nonclinical specialties. ASHP has policy supporting specialization through BPS (ASHP policy 1225, [Board Certification of Pharmacists](#)). ASHP does not have a position, however, on the many specialty certifications that do not fall within the realm of BPS. The Council discussed existing guidance from the Council on Credentialing in Pharmacy (CCP), such as the [CCP Guiding Principles for Post-licensure Credentialing of Pharmacists](#) and the [CCP Guiding Principles for Certification of Individuals in Pharmacy](#). The Council felt that they provide adequate information for pharmacists seeking non-BPS certification at this time.

Pharmacist Skills in Supervising Pharmacy Technicians and Other Staff

The Council discussed the discomfort felt by many new and practicing pharmacists when they supervise pharmacy technicians. A common pharmacist duty is to oversee or supervise technicians during the course of their shifts, but since the pharmacists often lack authority over the technicians and may not want to supervise them, the responsibility can result in a difficult and ineffective relationship. Rarely do pharmacists have any training in how to supervise others, and new practitioners especially lack supervisory experience.

The evolving role of the pharmacy technician, along with the specific recommendations from PPMI, indicates that there will likely be continued need for pharmacists to supervise technicians. Council members felt that all pharmacists must be effective as a supervisor in order to be successful.

There were differences of opinion on how these skills are best taught. Some Council members described how colleges have restructured their curricula to include leadership and management. Others felt that the skills are not best taught as part of the pharmacy curriculum, that they need to be learned in real-life situations, and that until there is a real relationship with a co-worker, these skills are difficult to learn.

ASHP currently offers many tools, resources, and educational programs aimed at developing management and leadership skills. Most of these offerings are structured for pharmacy directors, so some questioned whether ASHP could develop a primer on technician supervision, or something broader, that could be used locally by new graduates. Case-based scenarios, prompting the user to respond to different supervisory situations, would be helpful, along with the legal issues related to supervisory actions.

The Council also reviewed existing ASHP policy 0509, [Developing Leadership and Management Competencies](#), and did not recommend any additional policy language for ASHP.

ASHP Statement on Continuing Education

As part of sunset review, the Council discussed the [ASHP Statement on Continuing Education](#). They concluded that the statement is important but does need revision. It was suggested that the revision include continuing professional development (CPD), the need for continuing education for pharmacy technicians, and be less directed at ASHP's role as a continuing education provider.

ACPE Accreditation Standards Revision

Since ACPE is initiating a revision of accreditation standards for colleges of pharmacy that will last over the coming year, the Council provided advice on what will need to be addressed in the revised standard. Some of the topics that Council members suggested: continued emphasis on patient-care services and drug therapy management skills; informatics and technology; business skills; physical assessment; skills that facilitate ability to work across settings (ambulatory and inpatient); communication skills (with the team, and with the patient); and empathy.



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

ASHP Statement on the Pharmacy Technician's Role in Pharmacy Informatics

Position

1 The American Society of Health-System Pharmacists (ASHP) believes that specially trained
2 pharmacy technicians can assume important supportive roles in pharmacy informatics. These
3 roles include automation and technology systems management, management of projects,
4 training and education, policy and governance, customer service, charge integrity, and
5 reporting. Such roles require pharmacy technicians to gain expertise in information technology
6 (IT) systems, including knowledge of interfaces, computer management techniques, problem
7 resolution, and database maintenance. This knowledge could be acquired through specialized
8 training or experience in a health science or allied scientific field (e.g., health informatics). With
9 appropriate safeguards and supervision, pharmacy technician informaticists (PTIs) will manage
10 IT processes in health-system pharmacy services, ensuring a safe and efficient medication-use
11 process.

Background

12 The National Library of Medicine defines health informatics as the “the interdisciplinary study
13 of the design, development, adoption and application of IT-based innovations in healthcare
14 services delivery, management and planning.”¹ Health informatics is a discipline at the
15 intersection of information science, health care, and computer science that designs and delivers
16 information to improve clinical care, individual and public health care, and biomedical research.
17 Health informatics optimizes the usability, acquisition, and processing of health-related
18 information, using resources and tools that span the IT spectrum, from people to processes,
19 from information to knowledge, and from algorithms to data. The broad definition of health
20 informatics and the number of disciplines involved present an opportunity for the growth of
21 subspecialties within the field. One of these subspecialties is pharmacy informatics, which has
22 been defined as “the use and integration of data, information, knowledge, technology, and
23 automation in the medication-use process for the purpose of improving health outcomes.”²
24 ASHP believes that pharmacists have the unique knowledge, expertise, and responsibility to

25 assume a significant role in health informatics.² A properly trained and qualified pharmacy
26 technician may assume a supporting role in the field of informatics as well.³

27 The potential for health informatics to improve health outcomes has prompted the
28 health care industry, large health care purchasers, and state and federal governments to
29 undertake sweeping health information technology (HIT) initiatives. These initiatives have
30 greatly increased the demand for a highly skilled HIT workforce. The Bureau of Labor Statistics
31 estimates that 37,700 new medical records and HIT technician jobs will be created between
32 2010 and 2020.⁴ This tremendous increase will affect organizations' ability to recruit and retain
33 the qualified personnel necessary for health care operations. Although not all pharmacy
34 technicians are qualified to fill this pressing need, an emerging cadre of specialized PTIs will
35 help fill these important roles. The purpose of this statement is to provide a preliminary
36 description of the potential roles and responsibilities of the PTI in the evolving HIT landscape as
37 well as the knowledge, skills, and abilities required to assume those roles and responsibilities.

Roles and Responsibilities

38 In general, the PTI will be a health care professional, working under the supervision of a
39 registered pharmacist, who uses his or her knowledge to influence and adapt IT systems to
40 improve the effectiveness and efficiency of the health system. The roles of PTIs will vary,
41 depending on the needs of the health care institution and the knowledge, skills, and abilities of
42 the individual. A PTI specializing in the management of health-system pharmacy IT services
43 may, for example, perform workflow assessment and optimization in clinical, administrative,
44 educational, or research domains; adapt software controls to existing workflow; provide
45 subject-matter expertise for new technology assessment and usability; or serve as a resource
46 for pharmacist informaticists when mission-critical updates are needed or problems are
47 identified. The areas of responsibility of the PTI will also vary considerably but may include
48 automation and technology systems management, management of projects, end-user training
49 and education, policy and governance, customer service, charge integrity, and reporting.

50 **Automation and technology systems management.** With training and experience in
51 health informatics, the PTI can serve as a knowledgeable expert for placement, configuration,
52 monitoring, maintaining, and troubleshooting automation and technology systems and
53 provides users and staff with consultative support. The PTI participates in assessing the
54 functions, benefits, and constraints of technology and automation systems for drug
55 procurement, pharmacy inventory management, prescribing medications, order processing,
56 distribution and dispensing of medications, administering and documenting administration of
57 medications, and effects monitoring. The PTI consults, advises, and educates staff on methods
58 and means to make automation and technology systems more effective and efficient. The PTI's

59 functions include integration of information and workflow processes to achieve successful
60 adoption and application of new technologies to support health care operations and systems.

61 The PTI provides relevant technological or administrative data to identify, quantify, and
62 resolve organizational or operational problems. PTIs integrate software applications for
63 technological services by: (1) evaluating the unique needs of the specific services in conjunction
64 with the capabilities of the software and coordinating required modifications; (2) reviewing the
65 effectiveness of the systems and procedures to assure optimum benefit to patient-care
66 activities; and (3) determining the cause of and the solution to problems when functionality is
67 compromised.

68 Using the applicable software manager menu systems and tools, the PTI develops,
69 modifies, and tests components specific to fields and data that individualize or customize
70 applications to user roles or needs while maintaining integrity among multiple software
71 packages. The PTI also provides for the maintenance and updating of site parameters and site-
72 specific files to ensure proper functioning of complex, interrelated, and interdependent
73 software applications, effectively and efficiently managing multiple competing priorities.

74 **Management of projects.** The PTI collaborates with the pharmacist informaticist in
75 managing technology and information systems based on a shared understanding of system
76 requirements, capabilities, and limitations. The PTI serves as an interdisciplinary team member
77 to complete HIT system initiatives using analytical and evaluative techniques to assess the
78 effectiveness of results and other related programs. For example, the PTI may contribute to
79 planning for acquisition and implementation of a technology or automation system by assisting
80 the pharmacist informaticist in developing a plan for the evaluation of the system; writing a
81 request for proposal (RFP) for the system; assessing responses to the RFP; or developing a plan
82 for implementation, testing, or maintenance of the system. The PTI may participate in the
83 implementation of a technology or automation system by contributing to system installation
84 (including supplemental build-outs), testing, and training of staff for use of the system, as well
85 as maintaining the system according to an established plan. The PTI may also participate in
86 development of a contingency plan for failure or compromise of technology or automation
87 systems.

88 **End-user training and education.** The PTI identifies end-user educational requirements
89 and training needs and develops educational programs, instructional materials, and appropriate
90 tools to educate users and support staff at all levels of the organization. In collaboration with
91 the pharmacist informaticist, the PTI monitors end-user satisfaction to drive enhancements and
92 increase performance. The PTI functions in a supportive role with the pharmacist informaticist
93 to ensure the technological changes are aligned with the organizational needs and participates
94 on process improvement, root cause analysis, and system redesign teams.

95 **Policy and governance.** The PTI maintains state-of-the-art knowledge of changes in
96 technology and the clinical environment to identify, propose, formulate, and support new or
97 revised major technological policies and directives for automation and systems technology. PTIs
98 collaborate with pharmacist informaticists on the structure of programmatic and security
99 requirements for data access in IT to ensure that best practices are applied to operational
100 requirements.

101 The PTI applies statistical analyses and interprets their significance, including evaluation
102 of the validity of measures used to generate outcomes related to patient management systems.
103 PTIs will work cooperatively with the pharmacist informaticist to develop recommendations for
104 improving clinical data management methods, follow-up procedures, and timely compliance
105 with regulatory guidelines. Finally, the PTI instructs staff members in the proper use of
106 information management tools in compliance with policy, regulations, and best practices.

107 **Customer service.** The PTI maintains an ongoing personal relationship with onsite peers,
108 pharmacist informaticists, technical support staff, administrative staff, and health care
109 professionals within the facility. The PTI will frequently need to contact offsite technical support
110 personnel and clinical and subject-matter experts as needed. External contacts may include
111 contract developers, for whom the PTI can serve as a primary contact and knowledge resource.

112 **Charge integrity.** The PTI maintains appropriate charging controls to ensure accurate
113 patient and third-party billing. The PTI will be engaged with pharmaceutical wholesalers and
114 distributors to validate price files in clinical and automation systems, as well as Healthcare
115 Common Procedure Coding System (HCPCS) coding, units, and quantities. The PTI will also
116 monitor charging and transaction interfaces for errors in charge application, quantities, or
117 amounts.

118 **Reporting.** The PTI extracts, compiles, and analyzes standard reports from clinical and
119 automation systems to facilitate organizational and individual decision-making. An advanced
120 PTI customizes reports and provides advanced database management (e.g., via SQL or
121 Microsoft Access) to address organizational needs not addressed through standard reporting
122 tools.

Knowledge, Skills, and Abilities

123 The PTI is uniquely qualified to serve in these roles because of the combination of technological
124 knowledge, skills, abilities, experience, and training. The PTI will be required to understand IT
125 systems, including interfaces, computer management techniques, problem resolution, and
126 database maintenance. The PTI will need to be familiar with pharmacy, medication, and
127 medical terminologies as well as medication-use workflow processes, including drug
128 procurement, pharmacy inventory, medication ordering, order management, dispensing, drug
129 preparation, distribution, and billing systems.

130 The PTI will require a thorough knowledge of the clinical environment, including
131 practices, procedures, policies, strengths, and weaknesses in order to effectively use data to
132 track and manage patient care. Thorough and current knowledge of emerging and state-of-the-
133 art technology, regulations, programs, and processes related to health informatics will be
134 necessary for the PTI to propose and formulate administrative and clinical policies and
135 directives, instruct practitioners on the changes and application of new policies and directives,
136 and provide leadership on informatics committees or teams.

137 The PTI must have practical, in-depth knowledge of automation and software systems
138 that affect clinical practice, as well as knowledge of technologies that may benefit health care
139 delivery processes. The PTI should be able to troubleshoot functionality issues and develop
140 solutions, and to ensure quality management of clinical operations.

141 The PTI should have comprehensive knowledge of the data life cycle, including data
142 design, collection, and management, in order to input, retrieve, analyze, summarize, and
143 present information effectively. The required knowledge base is extensive and includes
144 usability, data standards, data validation, understanding content relationships, and
145 interoperability among systems.

146 The PTI should understand common network standards and network architectures and
147 the functions and purposes of common hardware components and configurations. The PTI
148 should also understand the design of safe technology and automation systems. Finally, the PTI
149 should possess the database skills to successfully create patient and medication information
150 data sets and successfully construct reports.

151 The PTI should be skilled in communicating both orally and in a variety of written media
152 for a variety of audiences, from information technology and clinical experts to end-users. As a
153 specialist with training and experience in health informatics, the PTI guides the evolution of
154 automation technology and processes using creative and well-developed interpersonal skills to
155 achieve effective communication with end users and management.

Conclusion

156 The ASHP Pharmacy Practice Model Initiative provides several recommendations regarding use
157 of technology to ensure medication safety. Meeting these recommendations will require an
158 expansion of pharmacy resources devoted to the implementation and maintenance of HIT. A
159 trained and educated PTI has unique skill sets that combine technical knowledge with an
160 understanding of medication vocabulary and pharmacy operational workflow. Through these
161 specialized skills, the PTI is able to support and coordinate pharmacy technologies under the
162 direction of the pharmacy department or an accountable pharmacist. The PTI possesses a
163 working knowledge of the technology and automation systems and processes that support the
164 medication-use system and can contribute to ensuring their safety and efficiency.

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Reports on Sections and Forums

ASHP sections consist of members within five well-defined areas of health-system pharmacy who collaborate to advance professional practice in their respective areas.

ASHP members may enroll in as many sections as they wish; practitioner members are asked to select one section as their primary “home,” which allows them to vote for the chair and members of the executive committee of that section.

The ASHP Pharmacy Student Forum consists of all student members. The New Practitioners Forum consists of all practitioner members who are within five years of graduation from a school or college of pharmacy.

Each section and forum is led by an Executive Committee elected (sections) or appointed (forums) from the ASHP membership. Each Executive Committee met face to face June 8 and December 1 or 2, 2012, to review the past year’s activities and plan for the coming year. The committees also met by telephone periodically during the year to assess progress on initiatives and discuss new trends or events that warranted section or forum activity. Each section and forum has its own mission, vision, goals, and objectives.

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NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the New Practitioners Forum

The New Practitioners Forum is led by a five-member Executive Committee appointed each year by the ASHP President-elect and approved by the Board of Directors. The Executive Committee is responsible for advising the Board and ASHP staff on the overall direction of the Forum, including member services, programs, and resources. The Executive Committee Chair participates in ASHP's strategic planning process and serves as a voting new practitioner member in the ASHP House of Delegates. Each Executive Committee member serves as a liaison to at least one of the Forum's seven advisory groups.

Recognizing that recent pharmacy graduates have unique and diverse professional needs, the ASHP New Practitioners Forum seeks to provide a community and collective voice for new practitioners as they transition into hospital and health system pharmacy practice. Through innovative programming, educational resources, advocacy tools, networking events, and leadership opportunities, the Forum supports the integration of new practitioners into ASHP and empowers members to lead the future of pharmacy practice.

The ASHP New Practitioners Forum seeks to be the preferred organizational home for new practitioners practicing in hospitals and health systems. Through our dynamic programs and services, our knowledgeable and respected members will collaboratively develop, promote, and lead best practices supporting innovative practice models that provide optimal care to patients.

Executive Committee

Katherine A. Palmer, *Chair* (California)
Christina Y. Martin, *Vice Chair* (Pennsylvania)
Holly E. Causey (North Carolina)
Luke A. Markham (Ohio)
Arpit Mehta (Pennsylvania)
Paul W. Bush, *Board Liaison*
Jill L. Haug, *Secretary*

Strategic Goals and Objectives. The Executive Committee established five strategic goals, with accompanying objectives, to direct the Forum's operations:

1. ***Serve the unique and evolving educational and informational needs of new practitioner members.*** Objectives: (1) Conduct continual assessment and analysis of evolving needs and the effectiveness of Forum programs to meet these needs. (2) Provide programs and publications that meet the educational and informational needs of new practitioner members. (3) Utilize social media to effectively communicate with new practitioner members.
2. ***Support the development of leadership skills and professionalism in new practitioner members.*** Objectives: (1) Promote leadership and engagement opportunities for new practitioner members within the Forum and ASHP. (2) Provide programs and resources that promote leadership skill development and foster professionalism in new practitioner members.
3. ***Promote membership and active involvement in the ASHP New Practitioners Forum.*** Objectives: (1) Recruit, retain and promote active involvement in the Forum. (2) Enhance visibility and awareness of Forum membership benefits. (3) Expand collaboration between Forum members and others in ASHP, including section and Pharmacy Student Forum members. (4) Promote initiatives and accomplishments of Forum members.
4. ***Facilitate greater understanding and participation in professional policy development and advocacy by new practitioner members.*** Objectives: (1) Generate awareness and encourage participation of new practitioner members in professional policy development. (2) Create awareness and support involvement of new practitioner members in advocacy.
5. ***Support new practitioner engagement in practice advancement initiatives.*** Objectives: (1) Create awareness and support for the Pharmacy Practice Model Initiative (PPMI). (2) Support and promote initiatives focused on increasing residency capacity. (3) Develop and promote programs that support Forum members preparing for board certification.

2012–2013 Forum Highlights. Landmark achievements consistent with these goals and objectives in 2012–2013 included (1) continuing to host and evolve the *Great eXpectations eXperience* program by hosting the seventh *Great eXpectations Live* program for the fourth consecutive year at the Midyear Clinical Meeting, lengthening the program to a two-day event, and expanding the web-based, on-demand *Great eXpectations Video* program; (2) awarding the sixth New Practitioners Forum Distinguished Service award; (3) launching a career development initiative, including online and live curriculum vitae (CV) review programs and a live mock interview event; (4) continuing to spotlight the professional accomplishments of new practitioner members through web-based spotlights; (5) actively engaging Forum members in activities related to the Pharmacy Practice Model Initiative (PPMI) and residency capacity expansion efforts; and (6) collaborating with others in ASHP to support members pursuing board certification. These activities demonstrate the commitment of

ASHP and the Forum to meeting the unique needs of over 6000 new practitioner members. The continual creation and provision of career development tools, leadership opportunities, practice resources and identification of opportunities for collaboration with the ASHP practice sections also show support for this membership group. By meeting new practitioner needs, ASHP hopes to foster professional development in new practitioners that extends into greater involvement in ASHP and state and local health-system pharmacy organizations.

Distinguished Service Award. The Forum selected John Hertig as the winner of the New Practitioners Forum Distinguished Service Award. Established in 2007, the ASHP New Practitioners Forum Distinguished Service Award recognizes a member of the Forum whose volunteer activities have supported the Forum's mission and helped advance the profession. The award was presented at the 2012 Midyear Clinical Meeting.

Advisory Groups. The Chair of the New Practitioners Forum Executive Committee appoints Forum members to advisory groups in June, placing nearly 80 new practitioners in leadership positions. The advisory groups are charged with providing feedback, guidance, and assistance in achieving the Forum's strategic goals. A returning advisory group member is appointed annually to the chair position and executive committee members serve as liaisons to each advisory group.

Communications and Technology Advisory Group. This group is charged with enhancing the Forum's image and outreach using various electronic communication tools. Priorities this year included developing an article on ASHP Connect for the daily News & Views publication at the Midyear Clinical Meeting, contributing to the development of the Forum needs assessment, actively stimulating discussions within ASHP Connect and ongoing recommendations to increase utilization and benefit of ASHP Connect and other Forum Web resources.

Leadership and Career Development Advisory Group. This group is charged with advancing the objectives set forth in goal 2. Priorities this year included developing questions for the Forum's Mock Interview exhibit during the Midyear Clinical Meeting, exploring options to support the concept of leadership certificates in residencies, brainstorming ways to engage on multiple career development issues, and recommending ways to promote the rich resources available from the ASHP Research and Education Foundation's Center for Health-System Pharmacy Leadership.

Membership and Outreach Advisory Group. This group is charged with advancing the objectives set forth in strategic goal 3 and focused on projects that might expand collaboration between Forum members and the broader ASHP membership. Priorities this year included developing an article about the Forum for the daily News & Views publication at the Midyear Clinical Meeting, creating a poster to promote the activities of the Forum that was showcased during the Pharmacy Student Forum's Student Society Showcase and Awards Ceremony and at the regional residency conferences, developing a membership toolkit that will be shared with all new and existing members in a variety of ways, proposing the new SSHP Mentoring Program

implemented in February, and actively engaging in a variety of existing ASHP and Forum initiatives.

Practice Advancement Initiatives Advisory Group. A new advisory group for the Forum, the development of this group was initiated to further develop the Forum's strategic engagement in PPMI and other practice advancement initiatives. This group is charged with advancing the objectives set forth in goal 5. Priorities this year included getting acclimated as a new advisory group and establishing a relationship with the new Center on Pharmacy Practice Model Advancement, and contributing case studies and spotlights for the PPMI Web site.

Professional Practice Advisory Group. This group is charged with advancing the objectives set forth in goal 1, specific to professional practice issues, and goal 5. Priorities this year included developing a clinical pearls session for the Pharmacy Student Forum programming at the 2012 Midyear Clinical Meeting, compiling career management resources that can be promoted to members, and exploring ways residents can be utilized in an integrated practice model.

Public Affairs and Advocacy Advisory Group. This group is charged with advancing the objectives set forth in goal 4. Priorities this year included finalizing advocacy toolkits initiated during the previous year, updating an existing new practitioner advocacy webinar, and collaborating with the Pharmacy Student Forum to produce a summary of the issues being considered during the 2013 House of Delegates as well as initiating a follow-up communication to members highlighting outcomes.

Science and Research Advisory Group. This group is charged with advancing the objectives set forth in goal 1, specific to science and research issues. Priorities this year included developing a process for promoting and facilitating discussion on landmark trials, promoting the Forum's research excellence spotlight program, collaborating with and promoting a new FDA pharmacovigilance webinar series, and exploring ways to effectively promote research resources from the ASHP Research and Education Foundation.

Meetings and Programming. For the fourth consecutive year, *Great eXpectations Live* was held at the Midyear Clinical Meeting and was enormously successful. It was expanded to two days with one day focused on career management and replacing the resident seminar supported by Amgen for many years. The *Great X* program allows new practitioners the opportunity to learn, network, and present with more seasoned colleagues on subjects that will assist in their career advancement. This live event offered skill-building sessions in two learning tracks: Fine Tuning Your Clinical Skills and Career Management. Attendees also had many opportunities to mix and mingle with fellow new practitioners from across the country.

Completing the *Great eXpectations eXperience* portfolio, *Great eXpectations Video* was launched in 2011 with an initial offering of two continuing education video programs focusing on effectively presenting a professional poster and influencing change as a member of the healthcare team. Three additional videos were added this year: *Preceptee to Preceptor: Mastering the Art of Effective Feedback*; *The Elevator Speech: Prepare, Pitch and Persuade*; and *Strategies for Successful Presentations*:

Controlling the Messages, Creating an Impact. These continuing education videos are available on-demand on the New Practitioners Forum website.

The *Great eXpectations eConference*, the first virtual conference offered in the pharmacy association world, was held for the second time in May 2012. Due to relatively low attendance each year, it has been discontinued.

The 2012 Midyear Clinical Meeting offered a variety of programs and opportunities for new practitioners. New practitioners participated in the residency showcase and personnel placement service. The 2-day *Great eXpectations Live* program provided 14 hours of continuing education targeted at new practitioners. The Forum spearheaded the ASHP Advance Your Career Theme Center in the Exhibition Hall, hosting live CV Review and Mock Interview sessions. ASHP's Board Certification preparatory product line and PhORCAS were also featured and demonstrated in the theme center. Executive Committee members represented the Forum at *Great eXpectations Live* and in the theme center.

The Forum continues to host a robust webinar library. Forum webinars are recorded educational sessions on relevant practice topics, available for new practitioners to view at their convenience.

Communications. The Forum relies on ASHP Connect for new practitioner members to communicate on practice and career development issues. ASHP Connect provides members the convenience of only participating in discussions of interest and in ways they prefer to communicate.

All Forum members receive the ASHP New Practitioners Forum NewsLink once a month. This service provides information relevant to recent graduates, communicates deadlines, and helps recruit members for greater involvement in the Forum. The NewsLink has enabled the Forum to recruit new practitioner authors, advisory group members, and volunteers for various outreach efforts and identify new practitioners to highlight on the webpage. In addition, Forum members receive an electronic Message from the New Practitioners Forum Executive Committee once a month that highlights key program and initiatives as well as provides an ongoing update of what the Executive Committee and Forum Advisory Groups are doing on behalf of members. The Forum was excited to adopt a new, more contemporary format this year for these messages.

The Forum has its own area on the ASHP website where new practitioners can find information pertinent to their needs, such as updates on Forum activities, career development resources, leadership opportunities, and a personal message from the Forum Executive Committee. Efforts have focused on making the site a clearinghouse for career development, advocacy, clinical, precepting, and administrative and management resources to meet new practitioners' varying informational needs. This section of the website also highlights each member of the Executive Committee and allows Forum members to communicate directly with these leaders. Additionally, the Forum hosts a number of web-based member spotlights, including those members who have demonstrated excellence in research, with state affiliates, and other professional accomplishments.

New Practitioners Forum Column. Members of the Forum are contributing authors for the New Practitioners Forum column in the *American Journal of Health-System Pharmacy*. The topics, pertinent to the needs of practitioners just starting their careers, have included a variety of career and professional development topics, such as residency training, legislative advocacy, and developing clinical practices. The column offers new graduates the chance to learn about writing for a professional journal and increases their awareness of opportunities for new practitioners in ASHP.

Outreach. Forum members desire to mentor students and share experiences with peers. To this end, Forum leaders volunteer to participate in various student outreach initiatives throughout the year to promote ASHP membership, provide information on pursuing residencies, promote the value of involvement in professional organizations, and explain how to become more engaged in professional endeavors on the local, state, and national level. In the spring, the Forum launched an SSHP Mentoring Program with the Pharmacy Student Forum where new practitioners are matched up with a SSHP and present on a health system topic that fulfills a requirement for the SSHP to achieve ASHP-SSHP Recognition.

Forum leaders also represented the Forum at seven of the regional residency conferences during the spring, promoting the Forum and encouraging peers to become involved in the many opportunities ASHP offers exclusively for new practitioners. This year, an engaging poster developed by the Membership and Outreach advisory group was used at each of these conferences to enhance the in-person outreach effort.

For the fifth year, the New Practitioners Forum Executive Committee charged all advisory groups to participate in a Targeted Recruitment Initiative. This initiative focuses on identifying peers who are either currently members of ASHP but not involved or who are not members of ASHP and recommending them for an involvement opportunity in the Forum. Due to the previous success of this program, it was modified this year to focus on various engagement activities instead of the leadership opportunities it previously highlighted. Each nominee was sent a personalized message encouraging them to consider greater involvement in these activities at the recommendation of their peer.

Section Collaboration. Forum members share common professional and career development needs, but their varied practice needs are addressed through involvement in the ASHP pharmacy practice sections. Many new practitioners hold positions on section committees and advisory groups. The Forum has discussed the need to increase new practitioner's awareness of opportunities in small and rural settings with the Section of Inpatient Care Practitioners and is currently promoting various resources and information to members in an effort to address this issue.

ASHP Resident Visit Program. For many years ASHP has invited residents in accredited programs to visit ASHP headquarters. These all-day visits give residents an inside glimpse of ASHP operations and an opportunity to learn about the many ways to get

involved in ASHP and the resources available to them as new practitioner members. Three visits were scheduled this year, with over 100 residents registering. Unfortunately, one visit was canceled due to a severe weather event. ASHP has redesigned this program in recent years. Now, participants not only learn but actively participate and provide feedback to ASHP on issues of importance.

Recognizing that not all residency programs can send their residents to ASHP headquarters for this visit experience, the Forum has developed a web-based virtual resident visit program that provides a series of webinars reflective of the information presented during the live resident visits. This new resource has been and will continue to be heavily promoted to all ASHP-accredited residency program directors.

Curriculum Vitae (CV) Review Program. In response to the increasingly competitive job market and a desire to provide our members with resources that will assist in their career development, the Forum launched a multifaceted CV Review Program in September and was pleased when nearly 600 students and new practitioners submitted their CVs electronically for review. Approximately 200 members volunteered to review these CVs and feedback from both the reviewers and submitters was very positive. A second phase of the program took place live at the Midyear Clinical Meeting when the Forum hosted CV Reviews and Mock Interviews in the Advance Your Career Theme Center booth in the Exhibition Hall. The Forum launched a third phase of the online CV Review program in the spring and is currently modifying the program based on feedback.

Resident Rotation Program. ASHP hosts residents on rotation throughout the year at ASHP headquarters and has noted an increased interest in this experience from residents around the country. Most residents participating in this program focus on medication safety, government affairs, professional practice, membership, and or meeting management.

Board Certification Preparation Virtual Study Group. In support of ASHP's new board certification preparation product line and to support our members pursuing board certification, the Forum launched a virtual study group within ASHP Connect in June 2012. Subject matter experts were scheduled and available on a weekly basis to answer questions in real-time and members could pose questions and answer colleague's questions as convenient for them. This resource was open to all who participated in ASHP's review courses or purchased core therapeutics modules.

Advisory Group on Communications and Technology

Samm Anderegg, Chair (Missouri); Holly Causey, Executive Committee Liaison (North Carolina); Amanda Kelly (Tennessee); Charles Darling (South Carolina); Colleen Teevan (Connecticut); David Seki (California); Elizabeth Clements (Florida); Garrett B. Aikens (Alabama); Hany S. Edward (Virginia); James Chai Wang (Maryland); T. Vivian Liao (Georgia); W. Russell Laundon (North Carolina)

Advisory Group on Leadership and Career Development

Stephen Davis, Chair (Texas); Katherine Palmer, Executive Committee Liaison (California); Chantel McMMain (Missouri); Codee Marie Peterson (Wisconsin); Jillian Descourouez (Wisconsin); Joe Maki (North Carolina); Joshua W. Fleming (Mississippi); Karen Bronson (Oregon); Kisha O'Neal Gant (Louisiana); Nick Ladell (Wisconsin); Rachael Ng (Ohio); Shamama Burney (Oklahoma)

Advisory Group on Membership and Outreach

Elva Angelique Van Devender, Chair (Oregon); Arpit Mehta, Executive Committee Liaison (Pennsylvania); Brett A. Read (Pennsylvania); Diana Isaacs (Illinois); Elizabeth Perry (Louisiana); Fatima Ali (Illinois); Joe Krushinski (North Carolina); Kristen Pate (Louisiana); Kyle Mulloy (Ohio); Mindy Parman (Tennessee); Neha Mangini (Connecticut); Stephanie Root (Wisconsin)

Advisory Group on Practice Advancement Initiatives

Lindsey Childs, Chair (Texas); Christina Martin, Executive Committee Liaison (Pennsylvania); David Kaland (Massachusetts); Erick Sokn (Wisconsin); Erinn Rowe (North Carolina); Jennifer G. Smith (Louisiana); Jessie Winter (Ohio); Jill Logan (Maryland); Raymond Lamore (Maryland); Rodney Brigg Turner (West Virginia); Stacy Elder (Pennsylvania); Tiffany R. Bish (Virginia)

Advisory Group on Professional Practice

Adam Pate, Chair (Louisiana); Luke Markham, Executive Committee Liaison (Ohio); Branden Nemecek (South Carolina); Claire Markway (Kansas); Darlene Chaykosky (Pennsylvania); Elizabeth Dow (Wisconsin); Emily Pherson (Maryland); Jill M. Comeau (Louisiana); Mallory Lind (Minnesota); Nadia Awad (New Jersey); Sarah Johannes (North Carolina); Stacy Livingston (Wisconsin)

Advisory Group on Public Affairs and Advocacy

Melissa A. Ortega, Chair (Massachusetts); Katherine Palmer, Executive Committee Liaison (California); Christy Gorbach (Texas); Elaine Mebel (Pennsylvania); Elizabeth Gorski (Illinois); Gavin Magaha (North Carolina); Jason Babby (New York); Jennifer Pierpont (Ohio); Jessica W. Skelley (Alabama); John Blee (Texas); Lindsay Massey (Missouri); Megan Hartranft (Michigan)

Advisory Group on Science and Research

Lindsey Elmore, Chair (Alabama); Holly Causey, Executive Committee Liaison (North Carolina); Brandon Shank (Maryland); Calvin J. Meaney (New York); David Zimmerman (Pennsylvania); Jeffrey Endicott (Vermont); Joshua Swan (Texas); Mary Giouroukakis (New York); Michael A. Smith (Pennsylvania); Patrick McDanel (Massachusetts); Sarah Amering (Louisiana); Tiffany Pon (California)



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the Pharmacy Student Forum

The Pharmacy Student Forum serves to prepare the next generation of health-system pharmacists to be leaders in their schools and communities and to advance the future of the pharmacy profession. The Forum volunteer leadership is composed of five student members of the ASHP Pharmacy Student Forum Executive Committee who are appointed each year by the ASHP President-elect and approved by the Board of Directors. Each Executive Committee member serves as a liaison to one of the five Forum advisory groups. The Executive Committee is responsible for advising the ASHP Board of Directors and staff on the overall direction of the Forum, including member benefits and services. The Chair of the Executive Committee serves as the voting student representative to the ASHP House of Delegates. The Executive Committee also assists in building relationships between ASHP and schools of pharmacy by serving as liaisons, providing information to student society leaders, and helping to strengthen the student society of health-system pharmacy (SSHP) activities and programs on each campus.

Executive Committee

Lisa A. Scherkenbach, *Chair* (Minnesota)

Thomas S. Achey, *Vice Chair* (Alabama)

Samar Chakar (Massachusetts)

Jacalyn M. Jones (Ohio)

Thomas J. Lupton (Kansas)

Michael D. Sanborn, *Board Liaison*

Diana L. Dabdub, *Secretary*

Strategic Goals. The 2012–2013 Executive Committee established a strategic plan with five core goals to direct Forum operations:

1. Cultivate a community of pharmacy students who are actively engaged and participating in ASHP as their primary professional home.
2. Grow the number of SSHPs and improve the effectiveness of these campus-based organizations in achieving the goals and requirements of ASHP recognition.
3. Expand the engagement of students and faculty in important professional issues and the ASHP programs and initiatives that address these issues.
4. Encourage and support the development of leadership skills across the continuum of students' education.
5. Assist students in career planning and their successful transition from student to new practitioner.

2012–2013 Forum Highlights. The past year was successful for the Pharmacy Student Forum, marked by continued growth in membership, student involvement, and the ASHP-SSHP Recognition Program. Forum membership exceeds 18,000 students, from schools of pharmacy across the nation. The consistent growth trend in the Forum is attributed to the growing number and expansion of pharmacy programs, the structure and strength of the ASHP-SSHP Recognition Program, as well as the wealth of valuable member benefits that help students achieve their professional goals.

The Forum continually strives to meet the needs and exceed expectations of student members. This goal was accomplished through increasing awareness of career opportunities within health-system practice; providing information regarding residencies and other postgraduate education programs; and encouraging professional development by fostering student leadership development and involvement in ASHP, state, and local health-system pharmacy organizations.

The Forum Executive Committee and advisory groups focused efforts on the strategic goals established at the start of the year and made significant progress. Some highlights include the collaboration with the New Practitioners Forum on the ASHP Curriculum Vitae (CV) Review Program, re-launch of our ASHP Featured Student Bloggers, the creation of a new advisory group to focus on Advancing Pharmacy Practice, and heightened training and investment in SSHP leaders to strengthen campus-level membership.

ASHP-SSHP Recognition Program. In 2007, the Forum devoted resources to advance the development of strong SSHPs. As a result of these efforts, the ASHP-SSHP Recognition Program was developed. SSHPs nationwide have the opportunity to earn this official annual recognition from ASHP based on programming and activities completed each year. Criteria for recognition encourage SSHP activities that promote membership in local, state, and national health-system organizations; stimulate interest in health-system pharmacy careers; and encourage career development and professionalism among students aspiring to careers in health-system pharmacy. In 2012, 113 SSHPs met the criteria for recognition and received benefits, including a complimentary student registration to the Midyear and Summer meetings, awards for incoming and outgoing officers, a custom SSHP logo, and a certificate of recognition.

Outreach, Connection, and Engagement. The Pharmacy Student Forum strives to engage students who have an interest in hospital and health-system careers. Our aim is to reach every school of pharmacy every year to inform students about member benefits, including leadership training and opportunities, educational programming, professional development resources, and career preparation tools. Our outreach efforts are multifaceted, consisting of campus visits by ASHP staff and volunteer leaders and virtual visits using web-based conferencing technology.

With the growing number of members and activity in the Forum, creating a sense of community and connection is critical to foster engagement with the organization. The Forum facilitates connections with and between students by leveraging a wide variety of communication vehicles, such as the student pages of the ASHP website, the monthly NewsLink email service to provide deadline reminders and updates, and our newest resource, ASHP Connect. This tool provides students with a multitude of ways to directly connect with ASHP and with each other through the discussion board. Additionally, students can connect with ASHP through the ASHP Facebook Fan Page, LinkedIn, Twitter, YouTube, and more.

Meetings and Programming. ASHP offers programming designed specifically for student members at both the Midyear Clinical Meeting (MCM) and Summer Meeting. The 47th annual ASHP MCM in Las Vegas, Nevada attracted more than 6000 pharmacy students. This meeting offered a wealth of options for students, including the Residency Showcase, Personnel Placement Service, and research posters. In addition, students took advantage of a full day of educational programming tailored for their unique needs, with topics including residency preparation, resume writing and interviewing, and financial management. A highlight of the week was the Clinical Skills Competition, where a record number of schools from across the nation participated. A special awards ceremony was held in conjunction with the Student Society Showcase to recognize the outstanding contribution and leadership of several ASHP and SSHP student members.

The Student Leadership Development Principles and Case Study Workshop session at the 2012 Summer Meeting was a success and allowed students to learn about leadership development in an interactive manner. Additionally, the ASHP Meet and Greet with Pharmacy Leaders session was continued and allowed students to speak with key leaders in pharmacy. Students were also encouraged to get involved in ASHP policy by attending key House of Delegates events.

Clinical Skills Competition. The 17th Annual ASHP Clinical Skills Competition, supported by the ASHP Research and Education Foundation, was held at the 2012 MCM. Teams from 120 schools of pharmacy throughout the nation competed. This two-day competition offered students the opportunity to analyze patient cases; demonstrate their skills in assessing a patient's medical history; identify drug therapy problems and treatment goals; and recommend a pharmacist's care plan, including monitoring desired patient outcomes. The national title was awarded to Jennifer Lee and Elizabeth Jackson from the University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences.

ASHP Student Leadership Award Program. The ASHP Student Leadership Award program prominently recognizes and celebrates the contributions of students who represent the very best attributes and accomplishments of ASHP student members. The highly competitive program consists of up to 12 annual awards for up to four student members in each professional year of pharmacy school, beginning with the second professional year. Award recipients receive a plaque, an ASHP drug information reference library, and a cash award provided by the ASHP Research and Education Foundation and funded through the Walter Jones Memorial Student Financial Aid Fund. The objective of the program is to encourage personal and professional development through a formal program providing well-deserved recognition to student leader role models who have demonstrated an interest in health-system practice and displayed exemplary student involvement in professional organizations.

2012 ASHP Student Leadership Award recipients were as follows:

Class of 2012: Eunice Rhee, University of Southern California; Kenneth Worsham II, Hampton University; Krystal Canally, The Ohio State University; Ryan Costantino, Massachusetts College of Pharmacy and Health Sciences

Class of 2013: Calvin Ice, Ohio Northern University; Casey Combs, University of Kentucky; Catherine Floroff, Virginia Commonwealth University; Melissa Erin, University of Colorado; Phuoc Anh (Anne) Nguyen, University of Texas at Austin

Class of 2014: Brady McNulty, Texas A&M University; Molly Trayah, Albany College of Pharmacy and Health Sciences; Tolulope Akinbo, Lake Erie College of Osteopathic Medicine School of Pharmacy

Experiential Education Program. ASHP offers an elective advanced pharmacy practice experience (APPE) in national association management. The purpose of the program is to provide students with an understanding of the importance of pharmacy associations to the profession and the value of participation in local, state, and national pharmacy organizations. The rotation also provides an opportunity for pharmacy students with an interest in association management to experience a professional association's practices and procedures in furthering its mission, vision, and goals. The program also identifies potential leaders in the pharmacy profession. In 2012–2013, the following students were selected to participate in this program:

- David Kaland, University of Maryland
- Anish Choksi, Chicago State University
- Melonie Blake, Howard University
- Elizabeth Dow, University of Minnesota-Duluth
- Adrienne Noelle Nedved, Drake University
- Salma Srour, Notre Dame of Maryland University
- Han Feng, Shenandoah University
- Kristine Widboom, University of Minnesota
- Kimberlyn Ariwodo, Chicago State University
- Brian Ikeda, Notre Dame of Maryland University

Summer Internship Program. ASHP offers a 10-week training program in national association management. The interns, students early in their pharmacy education, are introduced to the role of pharmacy associations to the profession while being exposed to ASHP's practices and procedures in furthering its mission, vision, and goals. In 2012, two interns joined ASHP in the Office of Member Relations:

- Jessica Libuit, Virginia Commonwealth University; focus areas: Student Forum, New Practitioners Forum, Pharmacy Technician Initiative, and Pharmacy Practice Model Initiative (PPMI)
- Andy Liu, Notre Dame of Maryland University; focus areas: Student Forum, New Practitioners Forum, Pharmacy Technician Initiative, and PPMI

Student Society Development Grant Program. ASHP offers grants to aid in the development of SSHPs. The grants are intended for use by the ASHP state affiliate and college of pharmacy partners to establish a new SSHP, or to strengthen an existing SSHP, ultimately aiding the SSHP to achieve official ASHP Recognition. In 2012, grants were awarded to the following pharmacy programs:

- Florida A&M University College of Pharmacy & Pharmaceutical Sciences
- Lipscomb University College of Pharmacy
- Notre Dame of Maryland School of Pharmacy
- Philadelphia College of Osteopathic Medicine - Georgia Campus
- South Dakota State University - Brookings Campus
- South University School of Pharmacy – Columbia, South Carolina Satellite Campus
- Touro New York College of Pharmacy
- University of South Florida College of Pharmacy

Student Research Award. Through the ASHP Research and Education Foundation's annual Literature Awards Program, a Student Research Award is presented to a pharmacy student for a published or unpublished paper or report of a completed research project related to pharmacy practice in a health system. The Foundation provides a plaque and an honorarium to the award recipient, as well as an expense allowance to attend the MCM to receive the award. The 2012 recipient was Ronak Savla from Rutgers, The State University of New Jersey, Ernest Mario School of Pharmacy as the leading author of a paper published in the *Journal of Controlled Release*, titled "Tumor Targeted Quantum Dot-Mucin 1 Aptamer-Doxorubicin Conjugate for Imaging and Treatment of Cancer."

Advisory Group Appointments. The five advisory groups of the Forum serve to offer feedback to ASHP on areas of specific interest to pharmacy students, while expanding the opportunity for student leadership at the national level. For the 2012–2013 academic year, 55 students from the first through fourth professional years were appointed to these advisory groups. The groups completed their work via electronic communications, conference calls, and one in-person meeting immediately preceding the 2012 MCM.

Community and eCommunications Advisory Group. The advisory group has focused efforts on continuing to leverage ASHP Connect to engage and increase student member participation. The group provided suggestions regarding the functionality of ASHP Connect and recommendations for improvements. The group developed blog postings on ASHP Connect on the myths of ASHP Connect and also about PPMI. They will continue these blogs as part of the Student Forum Journal Club. The advisory group is developing a Twitter schedule document that will include twitter posts regarding student relevant topics in order to expand the content on the Student Twitter account. This group will be collaborating with the New Practitioners Forum on revising the *ASHP Statement on Professionalism*.

Education and Programming Advisory Group. The advisory group provided detailed guidance in the preparation of programming and collateral materials for the MCM. The group recommended expanding the current leadership journal club to an overall Student Forum journal club, where each advisory group will focus on a hot topic. The advisory group is currently developing a PhORCAS guide for students to increase awareness about PhORCAS and provide a resource with information about the new application process. The group is finalizing a pharmacy advocacy brochure to increase awareness of MTM and medication adherence and to inspire students to get involved in advocacy. Recommended actions to improve the student experience at the Summer Meeting were also provided.

Leadership Development Advisory Group. The advisory group made significant progress to expand leadership development resources available to ASHP student members. The advisory group conducted a series of journal club activities via the ASHP Connect Discussion Board centered on leadership topics. The leadership journal club will become part of the overall Student Forum journal club as one of the hot topics to be discussed in ASHP Connect. A recommendation was developed for the creation of a student leader spotlight to highlight outstanding student leaders. A PPMI video contest to spread awareness and importance of PPMI is in development. The group is evaluating results from a survey regarding mentoring that gathered information about how students form mentoring relations. The group will identify ideas for resources that may aid students in developing mentoring relationships.

Policy and Legislative Advocacy Advisory Group. The advisory group made significant strides to engage student members in ASHP policy and advocacy efforts. They provided a recommendation to improve the content and increase the utilization of the web-based Advocacy Toolkit. Included in the recommendation were new resources to assist SSHPs in planning and implementing advocacy-related initiatives that address the SSHP recognition requirement for a professional development project. The advisory group is asking SSHPs that have a policy and legislative related professional development project to submit a share and reapply document to be posted on the Student Forum web site. The advisory group also created a letter writing campaign toolkit to assist SSHPs.

Student Society Development Advisory Group. The advisory group has made efforts to further strengthen the relationship between ASHP, ASHP state affiliates and the ASHP student liaisons

on each campus. This group developed a collaboration document that outlines ideas on how SSHPs can work more closely with their state affiliates. The group will continue work on developing a second professional development project requirement for SSHP recognition to focus on letter writing to state legislatures. To highlight outstanding SSHP professional development projects, the group developed a recommendation for implementing a SSHP professional development project award at the Student Society Showcase during the MCM.

Community and eCommunications Advisory Group

Ryan Birk, Chair, Southern Illinois University Edwardsville; David Aguero, Virginia Commonwealth University – Richmond; Holly Berry, South Carolina College – MUSC; Janet Lee, University of Maryland – Baltimore; Jennifer Cui, University of Michigan; Jessica Poehls, Drake University; Kiara Williams, Hampton University; Laura Meleis, University of North Carolina – Chapel Hill; Matthew Madurski, Lake Erie College of Osteopathic Medicine – Erie; Monica Yu, Lake Erie College of Osteopathic Medicine – Bradenton; Norman Fenn, University of Colorado; Jackie Jones, Executive Committee Liaison, Northeast Ohio Medical University

Career Development and Education Advisory Group

Phuoc Anne Nguyen, Chair University of Texas at Austin; Bushra Muraywid, University of Missouri, Kansas City – Columbia; Caitlin Brown, Thomas Jefferson University; Courtney Reed, Presbyterian College; Joseph Hai Trang, University of Florida – Orlando; Kimberly Sanders, Purdue University; Lauren Rupp, Ohio Northern University; Linda Lee, Harding University; Rachelle Albay, Washington State University; Steve D. Erickson, University of Washington; Susan Atkins, Hampton University; Samar Chakar, Executive Committee Liaison, University of New England

Leadership Development Advisory Group

Calvin Ice, Chair, Ohio Northern University; Bryant Torkelson, University of Minnesota; Danielle N. Smidt, University of Colorado; Elaine Nguyen, University of Iowa; Heidi Brink, University of Nebraska; Karolyn Horn, University of Michigan; Kelli Shae' Michael, Campbell University; Molly Hayes, Temple University; Nisha Bhide, Rutgers, The State University of New Jersey; Sebastian Biglione, Creighton University; Tolulope Akinbo, Lake Erie College of Osteopathic Medicine – Bradenton; Thomas Achey, Executive Committee Liaison, Auburn University

Policy and Legislative Advocacy Advisory Group

Grayson K. Peek, Chair, University of Tennessee – Knoxville; Alexandra Malinowski, University of New England; Amanda Meeker, Oregon State University – Portland; Amanda Woods, University of North Carolina – Chapel Hill; Daniel Kudryashov, University of Southern California; Halena Leah Sautman, Palm Beach Atlantic University; Jacqueline King, University of Florida – Orlando; James Connelly, University of Cincinnati; Jamie Elsner, University of Maryland – Baltimore; Shyla Rider, The Ohio State University; Susan Suchomel, Pacific University; Lisa Scherckenbach, Executive Committee Liaison, University of Minnesota

Student Society Development Advisory Group

Hannah Suh, Chair, Harding University; Andrea New, South Dakota State University – Sioux Falls; Caroline Small, University of New Mexico; Joe Gandy, South Carolina College – MUSC; Kayla Uganski, Ferris State University – Grand Rapids; Kristopher Leja, Chicago State University; Meghan Tolan, University of the Sciences Philadelphia; Morgan Sherritt, Northeast Ohio Medical University; Namrata Thakkar, University of Maryland – Baltimore; Nola Finke, Texas A&M University Health Science Center; Sunaina Rao, University of Houston; Thomas Lupton, Executive Committee Liaison, University of Kansas



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the Section of Ambulatory Care Practitioners

The mission of the ASHP Section of Ambulatory Care Practitioners is to improve patient care and patient health outcomes by advancing and supporting the professional practice of pharmacists who are medication-use specialists, patient care providers, and operational specialists in ambulatory care settings. The ASHP Section of Ambulatory Care Practitioners dedicates itself to achieving a vision of pharmacy practice in which pharmacists are the medication-use specialists accountable for optimization of medication-related outcomes in the ambulatory care setting and engage relevant stakeholders across the continuum of care to improve both the individual and overall process of medication use. The Section Executive Committee has developed a strategic plan linked to the mission and goals of the Section. These goals are to (1) maximize communications, interactions, and networking with and among Section members; (2) foster a sense of professional community in ambulatory care practitioners based on their common mission of improving patient care and patient health outcomes through improvements in continuity of care and transitions in care; (3) support members with services, resources, education, and information to help them establish and advance patient-focused practices in ambulatory care settings; (4) ensure that ambulatory care pharmacists are leaders in and advocates for the safe and effective use of medication and are recognized as the experts in facilitating positive patient care outcomes; and (5) foster optimal models for interdisciplinary, patient-centered care that includes the pharmacist as the expert on medication therapy management in ambulatory care settings.

Executive Committee

Steven M. Riddle, *Chair* (Washington)
Seena L. Haines, *Chair-elect* (Florida)
Pamela L. Stamm, *Immediate Past Chair* (Alabama)
Cathy Johnson, *Director-at-Large* (Ohio)
Gloria P. Sachdev, *Director-at-Large* (Indiana)
Sandra Leal, *Director-at-Large-elect* (Arizona)
Christene M. Jolowsky, *Board Liaison* (Minnesota)
Justine K. Coffey, *Secretary*

2012–2013 Section Highlights. In 2012, the Section focused on building ambulatory services and addressing and overcoming barriers as ambulatory care pharmacists participate in accountable care organizations (ACOs) and patient-centered medical homes.

As of December 2012, there were 9,969 members in the Section, with 2,634 choosing the Section as their primary section. Overall, the Section membership is up more than 10% since December 2011, and the Section's membership numbers continue to grow. Section members elected Dr. Haines as Chair and Dr. Leal as Director-at-Large, and both individuals will be installed at the June 2013 ASHP Summer Meeting.

The Section selected Marc Stranz as the winner of the Section of Ambulatory Care Practitioners' Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections' Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the section's mission and helped advance the profession. The award was presented at the 2012 Midyear Clinical Meeting (MCM).

In addition to the activities outlined below, the Section has been extremely active in meeting its goals. Dr. Haines took the lead on updating the draft *ASHP Guidelines on Ambulatory Care Pharmacy Services* to reflect recommendations of the Pharmacy Practice Model Initiative (PPMI). These draft guidelines are currently under review by a work group to ensure consistency with the new *ASHP Minimum Standards for Pharmacies in Hospitals*. Additionally, Dr. Haines coordinated a work group that developed Entry-Level Competencies for Ambulatory Care, which are currently posted on the Section's web page.

Each Section advisory group has been tasked with, and is successfully completing, Tips of the Month and news items that are included in the Section's Newslink. They have drafted, or are in the process of drafting, Member Spotlights, and are continuing to post discussions to the Section's community on ASHP Connect. All Section advisory groups are ensuring PPMI goals are considered and incorporated into projects and deliverables. The Section also continues to update the Risk Evaluation and Mitigation Strategies (REMS) Resource Page on the ASHP website and led a Task Force on Accountable Care Organizations that met at ASHP in June 2012. The Task Force's report was published in the *American Journal of Health-System Pharmacy (AJHP)*. The Section is involved in the Pharmacist Services Technical Advisory Coalition (PSTAC), and the Section's Executive Committee is developing a project to ensure the execution of the Section's strategic goals in a manner that delivers the most value around important practice development areas.

Educational and Networking Opportunities. The Section's Educational Steering Committee is charged with developing programming that will be of interest to ambulatory care practitioners. The Committee is also charged with identifying programming priorities. The 2011–2012 Committee planned over 17 hours of 2012 ASHP MCM educational programming specifically for ambulatory care practitioners. Topics included pain management and developing ambulatory care clinical services.

The Section also planned four networking sessions at the 2012 MCM, one in partnership with the Section of Clinical Specialists and Scientists. Topics covered at the networking sessions included home infusion, pain management, current issues for ambulatory care pharmacists, and ambulatory care pharmacist reimbursement opportunities.

The Section's electronic NewsLink is distributed once a month to over 9,000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, and reimbursement issues. The Section Chair's Message is also distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section's electronic discussion group on ASHP Connect provides a forum for Section members to exchange information and ideas on a wide variety of topics related to ambulatory care.

The Section provided two webinars in 2012, one developed by the Home Infusion Section Advisory Group, one by the Clinical Business Development Section Advisory Group.

Ambulatory Care Specialty Credential. In 2011, 511 candidates passed the Board of Pharmacy Specialties' (BPS) first Ambulatory Care Pharmacy exam, and are now BPS Board Certified Ambulatory Care Pharmacists (BCACP). In 2012, approximately 480 candidates passed the BPS Ambulatory Care Pharmacy exam.

ASHP, along with the American College of Clinical Pharmacy and the American Pharmacists Association (APhA), supported the process for establishing an ambulatory care specialty credential. With the specialty now approved, BPS announced a collaboration between ASHP and APhA as approved providers of continuing professional development programs for the BCACP. A number of Section leaders serve as faculty for the ASHP Ambulatory Care Pharmacy Review Course, and will continue to serve as faculty for the review course and recertification educational programming.

Advocacy. Many Section members represent ASHP on various coalitions and committees, including The National Quality Forum, The Pharmacy Quality Alliance, The Pharmacy Services Technical Advisory Coalition workgroups, The Joint Commission Professional and Technical Advisory Committees on Ambulatory Care and Home Care, and the National Asthma Education and Prevention Program. Section members on these committees provide the health-system pharmacist's perspective in discussions that have an impact on patient care nationwide. Section members continue to support ASHP's efforts in fostering optimal models for interdisciplinary, patient-centered care that includes the pharmacist as the expert on medication therapy management in ambulatory care settings.

Additionally, the Pain Management and Palliative Care Section Advisory Group has been extremely active in responding to requests for feedback from ASHP's Government Affairs Division relating to comments from the Society to government agencies.

Advisory Group on Clinical Business Development. This Section advisory group was established in 2009 to address the growing number of issues challenging pharmacists in their ability to be reimbursed for clinic-based patient-care services. This advisory group is focusing on the business and advocacy elements necessary to support and expand pharmacy services into the ambulatory setting.

This group is developing a database of individuals who responded to the 2010 Ambulatory Care Practice Model Survey, and planned and executed a networking webinar titled "Designing Sustainable Ambulatory Pharmacist Patient Care Services." The group is currently developing an FAQ document on pharmacist billing for Medicare patients in physician offices,

and hosted a networking session at 2012 MCM, titled “Ambulatory Care Pharmacist Reimbursement Opportunities: Hospital-Based, Physician-Based and Retail Pharmacy-Based.”

Advisory Group on Clinical Practice Advancement. The charge of the Section Advisory Group on Clinical Practice Advancement is to develop resources to promote clinical practice advancement and reimbursement in the ambulatory setting and across the continuum of care. This advisory group developed a 2012 MCM program on “Developing Ambulatory Care Clinical Services: Financial Incentives and Service Value,” as well as a 2012 MCM networking session titled: “Current Issues for Ambulatory Care Pharmacists: Provider Status, Collaborative Practice, Health-Homes, and Billing for Services.” The group also developed a “Spotlight on Medicare Wellness Visits: A New Reimbursable Services Model,” published on the Section’s website.

Advisory Group on Home Infusion. This Section advisory group has updated the draft *ASHP Guidelines on Home Infusion Pharmacy Services*. The guidelines are currently in draft form, with expected completion and approval in 2013. Additionally, the advisory group developed and conducted a live networking webinar titled “FDA Mandated REMS and Medication Guides – Implications For and Application to Home Infusion and Specialty Pharmacy Providers.” The Section advisory group also developed a networking session on home infusion for 2012 MCM, and collaborated with the Pain Management and Palliative Care Section Advisory Group on 2012 MCM programming relating to transitions of care in pain management. The group further developed 2012 MCM programming on “Why a PIC isn’t a PICC, and Other Things You Should Know About Lines, Drains, and Tubes.

Advisory Group on Pain Management and Palliative Care. This advisory group was successful in having a number of educational proposals accepted by ASHP for the 2012 MCM, including programming on alternative opinions on a controversial pain topic, vignettes in complicated pain management, and transitioning patients to palliative care. The group also collaborated with the Home Infusion Section Advisory Group to develop 2012 MCM programming on transitions of care in pain management, and collaborated with the Section of Clinical Specialists and Scientists to develop a 2012 MCM networking session on pain management.

Advisory Group on Clinical Business Development

Kimberly Braxton Lloyd, Chair (Alabama); Binita Patel, Vice Chair (Wisconsin); Shameem Aadam (Wisconsin); Jeffrey M. Brewer (New York); Tim Brown (Ohio); Stephanie Burns (Oklahoma); Douglas (Doug) Covey (Florida); Starlin Haydon-Greatting (Illinois); Ted Grabarczyk (Maryland); Amy K. Kennedy (Arizona); Mary Ann Kliethermes (Illinois); Santhi Masilamani (Texas); Ashley Parrott (Ohio); Melanie R. Smith (Maryland); Allison Trawinski (New York); Zach Weber (Indiana); Glorida Sachdev, Executive Committee Liaison (Indiana)

Advisory Group on Clinical Practice Advancement

Richard L. Stambaugh, Chair (Minnesota); Laura Traynor, Vice Chair (Wisconsin); Melody L. Berg (Minnesota); Martin Bishop (Maryland); Laura Britton (Utah); Kristy Butler (Oregon); Jaclyn “Paige” Carson (North Carolina); Sarah C. Deines (Oregon); Monica Green (Texas); Sandra Leal,

Chair (Arizona); Huzefa Master (Illinois); Daniel Riche (Mississippi); Mollie Scott (North Carolina); Betsy Bryant-Shilliday (North Carolina); Erika E. Smith (Wisconsin); Amy L. Stump, (Indiana); Brad Wright (Alabama); Seena Haines, Executive Committee Liaison (Florida)

Advisory Group on Home Infusion

Barbara Petroff, Chair (Michigan); Carol J. Rollins, Vice Chair (Arizona); Michael Fadeyi (Texas); Donald J. Filibeck, (Ohio); Kurt Harlan (California); R. Stephen Olsen (Idaho); Melisa Tong (California); Anna Nowobilski-Vasilios (Illinois); Yolanda Williams (Tennessee); Cathy Johnson, Executive Committee Liaison (Ohio)

Advisory Group on Pain Management and Palliative Care

Ernest Dole, Chair (New Mexico); Lee Kral, Vice Chair (Iowa); Michaela M. Almgren (South Carolina); Robin Cooke (Alaska); David Craig (Florida); Maria Foy (Pennsylvania); Virginia Ghafoor, (Minnesota); Christopher Herndon, (Illinois); Michele Matthews (Massachusetts); Mary Lynn McPherson (Maryland); Pamela S. Moore (Ohio); Douglas Nee (California); Suzanne A. Nesbit (Maryland); James Ray (Virginia); Mark Stanfield (Oregon); Scott Strassels (Texas); Jennifer Strickland (Florida); Cathy Johnson, Executive Committee Liaison (Ohio)

Committee on Nominations

Pamela L. Stamm, Chair (Alabama); Jeffrey M. Brewer (New York); Tim R. Brown (Ohio); Ernest Dole (New Mexico); Marc Stranz (Pennsylvania)

Educational Steering Committee

Tracy A. Martinez, Chair (Michigan); Melody Hartzler, Vice Chair (Ohio); Jenny A. Van Amburgh (Massachusetts); Jennifer A. Buxton, (North Carolina); Juliana Chan (Illinois); Jennifer L. Clemente (Michigan); Lindsey Elmore (North Carolina); Amy Henneman (Florida); David Hoang (Minnesota); Kristi Kelley (Alabama); Jeannie Kim Lee (Arizona); Kristy H. Lucas (West Virginia); Lisa Lundquist (Georgia); Adraine L. Lyles (Virginia); Nga Pham (Pennsylvania); Gina Ryan (Georgia); Anne Teichman (West Virginia); Fei Wang (Connecticut); Pamela Stamm, Executive Committee Liaison (Alabama)



NEW HORIZONS

**ASHP House of Delegates 2013
June 2 and 4, 2013**

Report on the Section of Clinical Specialists and Scientists

The mission of the Section of Clinical Specialists and Scientists is to advocate for practice advancement and improvement in patient care by creating and translating scientific advances into practice. The Section Executive Committee has developed a strategic plan linked to the Section's mission and goals. These goals are to (1) create member value by developing and providing education, creating tools and resources, providing networking opportunities, and creating a home for faculty and preceptors; (2) participate in advocacy by creating timely groups to address key issues affecting Section members; seeking greater input in policy and advocacy efforts, including practice initiatives; increasing participation in policy implementation and ASHP initiatives; and collaborating with internal and external organizations to communicate and advocate the interests of the Section; (3) promote member involvement by developing a process to simplify the path for involvement; increasing diversity of member involvement with educational sessions, network facilitators, committees, advisory groups, and policy development; encouraging Section members to run for Executive Committee office; and encouraging and facilitating recommendations of Section members for ASHP office; (4) communicating the value of the Section and ASHP by increasing recognition of Section activities and advocacy, communicating ASHP advocacy activities, and recognizing member contributions to ASHP and the profession. The Section offers members a sense of identity within ASHP and an organizational home dedicated to meeting their specialized practice, scientific, and research needs. The Section will continue to grow and expand its activities largely because of the efforts of its enthusiastic members and dedicated leaders.

Executive Committee

Lea S. Eiland, *Chair* (Alabama)
Jill S. Bates, *Chair-elect* (North Carolina)
Erin R. Fox, *Immediate Past Chair* (Utah)
Tricia A. Meyer, *Director-at-Large* (Texas)
Michelle E. Allen, *Director-at-Large* (California)
Daniel P. Hays, *Director-at-Large-elect* (Arizona)
James A. Trovato, *Board Liaison* (Maryland)
Angela Raval, *Secretary*

2012–2013 Section Highlights. Section membership reached 14,056 in 2012. Approximately 33% (4,662) of the Section’s members have selected the Section as their primary membership group. There still is strong interest in the Section among students. Section members elected Dr. Bates as Chair and Dr. Hays as a Director-at-Large; both will be installed at the June 2013 ASHP Summer Meeting. The Section selected Kelly Smith as the winner of the Section of Clinical Specialists and Scientists Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the section’s mission and helped advance the profession. The award was presented at the 2012 Midyear Clinical Meeting (MCM).

The Section’s proposed policy on “Board Certification for Pharmacists” supporting the Pharmacy Practice Model Initiative (PPMI) was approved at the House of Delegates meeting in June 2012. In addition, a number of Section leaders were active in the PPMI with the Joint Section and Forum PPMI Coordination Committee. The Section will continue to provide support to ASHP and ASHP Foundation education and advocacy efforts related to the PPMI.

Educational and Networking Opportunities. The Section’s Educational Steering Committee is charged with developing programming at an advanced level that will be of interest to clinical specialists and scientists. Ericka Breden served as the 2012–2013 Committee Chair. The 2011–2012 Committee developed more than 22 hours of educational programming on pediatric botulinum immune globulin review, antipsychotics review, drug-induced disorders, cardiopulmonary resuscitation in the emergency department (ED), new oral anticoagulant safety, precepting, and antimicrobial therapy for gram-negative infections. The Committee also planned a session devoted to debates in areas of therapeutic controversy and coordinated the Clinical and Emergency Pharmacy Clinical Pearls sessions. The 2012–2013 Committee has identified Section member educational needs for the 2013 MCM, which include the following topics: PPMI and pharmacists’ roles in reducing 30-day readmission rates and in transitions of care; obesity guidance for dosing in special populations; updates in solid organ transplantation; antimicrobial stewardship in special patient populations; alcohol withdrawal in the inpatient setting; antifungal management, including prophylaxis in immunocompromised hosts and new medications; pain, sedation, and delirium management in the intensive care unit; antiplatelet and anticoagulant therapies in special patient populations; reversal of new anticoagulants; preceptor development; stress ulcer prophylaxis updates and guidelines; hypertension, lipid, and obesity guideline updates; geriatric safety issues: how not to harm the geriatric patient; updates on treating hepatitis C, with or without HIV co-infection; drug shortages; and oral chemotherapy. Committee members were charged with developing proposals or seeking out individuals to submit proposals for MCM consideration.

The Section’s electronic NewsLink is distributed once a month to over 12,000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, clinical leadership, preceptor skills development, emergency care, therapeutics, pharmacogenetics, and pharmacogenomics. The Section Chair’s Message is also distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section continues to facilitate an electronic discussion group utilizing ASHP Connect. The electronic discussion group provides a forum for Section members

to exchange information and ideas on a wide variety of topics related to clinical practice and patient care challenges.

The Section has 15 specialty networks encompassing most areas of specialty pharmacy practice. The networks meet regularly at the MCM, with over 1,300 meeting attendees participating. In addition, the Advisory Groups on Preceptor Skills Development and Clinical Leadership held networking sessions to discuss issues in their interest areas. Facilitators are appointed for a two-year period in each network by the Section's Chair. The network facilitators monitor developments and trends in their therapeutic areas and advise ASHP and the Section's membership of these developments through the Section's electronic discussion group, NewsLink, networking meetings, and other avenues. The facilitators also serve ASHP and its members as therapeutic experts and contribute to ASHP advocacy and educational efforts.

Specialty Certification. The Section submitted a policy recommendation to the June 2011 House of Delegates meeting that was approved by the 2012 House of Delegates, becoming ASHP policy 1225, [Board Certification for Pharmacists](#).

Continuing to support the petitioning and specialty recognition process is a way to keep high-level clinical practitioners engaged with the organization by making appointments to specialty councils and development of examination review course and recertification materials. At the same time, the Committee noted the substantial financial and time commitment for a petitioning organization and suggested that ASHP prioritize involvement in the petitioning process based on the number of practitioners and postgraduate year 2 (PGY2) residency programs in the specialty. This prioritization will help identify the largest areas of practice and training, current pressing needs in caring for patients, and help establish credibility and authority in the practice area outside of the profession.

Resources for Clinical Specialists and Scientists. The Section continues to enhance its resources for pharmacy practitioners in different specialty areas and to use multiple communication pathways to notify Section members of new resources. The "Clinical Consultation" column in the *American Journal of Health-System Pharmacy (AJHP)*, created by the Section, continues to be a popular resource for members. The Section continues to host the Anticoagulation Resource Center on the ASHP website, a compilation of educational materials, policies, best practices, and links to other organizations for practitioners looking for resources in the area of anticoagulation management as well as the Preceptor Skills and Emergency Care Resource Centers. The Section also launched the Emerging Sciences Resource Center in the summer of 2012. This Resource Center contains information for pharmacists on gene therapy, pharmacogenomics, translational research, nanotechnology and biosimilars.

Advocacy. The Section advocates for recognition and development of specialty pharmacy practice areas, development of clinical practitioners into pharmacy clinical leaders, and the use of evidence-based therapeutic guidelines and medication use in patient care as a responsibility of all pharmacists and pharmacy departments.

Advisory Group on Clinical Leadership. The advisory group conducted a networking session at the 2012 MCM addressing clinical leadership in pharmacy, team building, accountability, and

the impact of measuring metrics on clinical leadership. The group has prioritized project initiatives and work has begun on the various projects. Advisory group helped to develop the [Leadership Rotation/Longitudinal Experience for Students, Interns, Residents and Pharmacists-Sample Leadership Syllabus](#) in collaboration with the ASHP Section of Pharmacy Practice Managers, Section of Inpatient Care Practitioners, and the New Practitioners Forum. In addition, the group provided an education session at 2012 MCM, *What's Your Definition of Clinical Pharmacy Leadership*, and hosted a live webinar based on the topic. These programs were developed based on member needs identified through the Section Needs Assessment Survey and electronic communication postings.

Advisory Group on Emergency Care. As a follow-up to the *ASHP Statement on Pharmacy Services to the Emergency Department* developed in 2010 and the *ASHP Guidelines on Emergency Medicine Pharmacist Services* developed in 2011, the advisory group developed [ASHP Accreditation Standards for PGY2 Emergency Medicine Pharmacy Specialty Residencies](#). The advisory group reviewed the American College of Emergency Physicians (ACEP) Clinical Policy on Prescribing Opioids in the Emergency Department and provided comments to the College. The group also hosted a successful emergency care networking session at the 2012 MCM that drew more than 100 participants and developed a webinar to meet the needs of emergency care practitioners, *Coming to a Hospital Near You: Current Trends in Drugs of Abuse*. The group planned educational sessions at the 2012 MCM and is conducting an educational session at the 2013 Summer Meeting, *ID in the ED*. The Emergency Care Resource Center on the ASHP website was updated, and group members are writing articles pertinent to emergency care practitioners for submission to *AJHP*. In addition, the group is preparing an emergency medicine educational series to include 20–30 minute recordings of up to 20 topics pertinent to emergency medicine pharmacy practice. The recorded educational series will be placed on the emergency care resource center for member access.

Advisory Group on Emerging Sciences. The group is charged with advising the Section and ASHP on the emerging sciences and implementing recommendations of the 2008 Task Force on Science. The group launched the Emerging Sciences Resource Center, which contains information for pharmacists on gene therapy, pharmacogenomics, translational research, nanotechnology, and biosimilars. The group also conducted a webinar, *Gene Therapy – Is This Pharmacy's Future? A member from the group is collaborating with the National Institutes of Health on developing genetic educational competencies and resources for pharmacists on the [Genetics and Genomics Competency Center for Education](#) (G2C2) website. In addition, the group is working on articles for submission to *AJHP*.*

Advisory Group on Preceptor Skills Development. This group continues to develop webinars to help residency programs develop a preceptor development program, including the 2012 webinar *Preceptor Development Pearls*. The group also planned a networking session at the 2012 MCM discussing the topics of managing job responsibilities and patient care activities; differentiating learner needs (IPPE vs. APPE, PGY1 vs. PGY2), and measuring preceptor performance. The group has the opportunity to submit proposals and topic ideas for the August 2013 National Pharmacy Preceptors Conference. The group has updated the resource center in

preceptor skills development that was launched in 2011. The Preceptor Skills Resource Center will be a main focus as the group continues to consolidate ASHP resources for preceptors and identify new tools and resources for ASHP members.

Advisory Group on Clinical Leadership

John Clark, Chair (Michigan); Linda Gore Martin, Vice Chair (Wyoming); Lori Dupree (Virginia); Lauren Faragalli (Ohio); Jenna M. Huggins (North Carolina); Allison Jun (California); Teena Sam (Connecticut); Jason Schafer (Pennsylvania); Teresa H. Seo (Connecticut); Douglas Slain (West Virginia); Aaron Steffenhagen (Wisconsin); Tricia Meyer, Executive Committee Liaison (Texas)

Advisory Group on Emergency Care

Alison Jennett-Reznek, Chair (Massachusetts); Michael C. Thomas, Vice Chair (Georgia); Megan Corrigan (Illinois); Katelyn Dervay (Florida); Christopher Edwards (Arizona); Joseph Halfpap (Wisconsin); Christi Jen (Arizona); Laurimay L. Laroco (North Carolina); Jennifer Denise Mando-Vandrick (North Carolina); Shannon Manzi (Massachusetts); Philippe Mentler (North Carolina); Megan Musselman (Missouri); Derek Polly (Georgia); Suprat Saely (Michigan); Brittany L. Warrick-Riley (Kentucky); Melinda Ortmann, Network Facilitator (Maryland); Erin Fox, Executive Committee Liaison (Utah)

Advisory Group on Emerging Sciences

John Valgus, Chair (North Carolina); Christine Formea, Vice Chair (Minnesota); Wesley G. Byerly (North Carolina); Sarah Gaffney (Virginia); Christine (Tina) Gegeckas (Florida); Cyrine Haidar (Tennessee); R. Donald Harvey (Georgia); Ali McBride (Ohio); Pamala Pawloski (Minnesota); Ashley E. Simmons (North Carolina); Orly Vardeny (Wisconsin); Casey Williams (South Dakota); Vivian Zhao (Georgia); Michelle E. Allen, Executive Committee Liaison (California)

Advisory Group on Preceptor Skills Development

Phil Ayers, Chair (Mississippi); Kate Farthing, Vice Chair (Oregon); Sara Brouse (Kentucky); Brian D. Buck (Georgia); Laura N. Bullock (Tennessee); Bethany DiPaula (Maryland); Elizabeth Sebranek Evans (Utah); Anita M. Hosac-Harrison (Texas); Nicole L. Metzger (Georgia); Rima A. Mohammad (Pennsylvania); Sarah F. Pfaehler (Indiana); Holly Philips (Colorado); Carol J. Rollins (Arizona); Samaneh Wilkinson (Kansas); Lea S. Eiland, Executive Committee Liaison (Alabama)

Committee on Nominations

Erin Fox, Chair (Utah); Justine Gortney (Michigan); Mary Hess (Pennsylvania); Susannah E. Koontz (Texas); Robert Page (Colorado); Shaunta M. Ray (Tennessee)

Educational Steering Committee

Ericka L. Breden, Chair (Virginia); Joel C. Marrs, Vice-Chair (Colorado); Jill Bates (North Carolina); Kimberly Benner (Alabama); Kimberli Burgner (Virginia); Sarah Bush (South Carolina); Chad Coulter (Kentucky); Freddy Creekmore (Tennessee); J. Russell May (Georgia); Linda A. Nelson (Rhode Island); Matthew Strum (Mississippi); Paul M. Szumita (Massachusetts); Catherine D. Johnson, Council on Therapeutics Liaison (Wisconsin)

Network Facilitators

Anticoagulation: Lynn Blecher (Oregon)

Cardiology: Christopher Betz (Kentucky)

Critical Care: Stacey Folse (Georgia)

Emergency Medicine: Melinda Ortmann (Maryland)

Geriatrics: Dawn Knudsen Gerber (Arizona)

Hematology/ Oncology: Bradley L. Burton (Maryland)

Immunology/ Transplant: Amy Krauss (Tennessee)

Infectious Diseases: Jason Schafer (Pennsylvania)

Nutrition Support: Lisa G. Hall Zimmerman (Michigan)

Pain Management: Virginia Ghafoor (Minnesota)

Pediatrics/ Neonatal: Jennifer Hamner (Colorado)

Pharmacoeconomics and Drug Policy Development: Elyse MacDonald (Utah)

Primary Care/Pharmacotherapy: Kristi Kelley (Alabama)

Psychopharmacy/Neurology: Cherry W. Jackson (Georgia)

Women's Health: Fancy G. Manton (Louisiana)



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the Section of Inpatient Care Practitioners

The mission of the Section of Inpatient Care Practitioners is to improve inpatient care by supporting the professional development and interests of pharmacists who integrate clinical, distributive, and operational services. The Section dedicates itself to achieving a vision of pharmacy practice in which pharmacists practicing in an inpatient setting safely integrate clinical, distributive, and operational functions while focused on improving inpatient and transitional care. To achieve this vision, the Section will (1) serve as a voice for inpatient care practitioners and Section members, including ASHP governance and policy; (2) facilitate the integration of drug distribution and clinical practice for inpatient care practitioners; (3) assist in a concerted rural health care strategy that strengthens ASHP's rural health care advocacy efforts, facilitates promotion of ASHP's policies and agenda in rural and frontier America, and elevates ASHP's standing in rural communities; (4) promote the professional development of inpatient care practitioners through education and skills development; (5) increase communication with Section members on key issues for both the Section and the profession; (6) encourage, facilitate, and educate for the application of ASHP best practices and evidence-based guidelines at the inpatient care practitioner level; and (7) identify and promote the development of inpatient care leaders and preceptors within the Section and mentor students by encouraging their active participation on Section advisory groups.

Executive Committee

Lynn E. Eschenbacher, *Chair* (North Carolina)

Noelle R.M. Chapman, *Chair-elect* (Illinois)

Jennifer Edwards Schultz, *Immediate Past Chair* (Montana)

Joanne G. Kowiatek, *Director-at-Large* (Pennsylvania)

Emily Alexander, *Director-at-Large* (Texas)

Lois Parker, *Director-at-Large-elect* (Massachusetts)

Steven S. Rough, *Board Liaison* (Wisconsin)

Anthea V. Francis, *Secretary*

2012–2013 Section Highlights. Now in its tenth year, the Section of Inpatient Care Practitioners has enjoyed a 6% growth in its total membership and an increase of greater than 7% in its primary membership since January 2012. This increase has made the Section the largest of the five pharmacy practice sections, a distinction it has maintained since December 2011. Through educational programming, networking, advocacy, and volunteer opportunities, the Section's Executive Committee has worked to develop member services that support the needs of the Section's core membership component groups: frontline and inpatient care practitioners, investigational drug service pharmacists, medication safety officers, operating room (OR)/anesthesiology pharmacists, rural health care practitioners, and technician educators. Advocacy efforts for rural health care initiatives have been enhanced and collaborative partnerships have been expanded. The Section authored an executive summary and subsequent report, *ASHP's Rural Portfolio and Footprint*, that provides an overview of pharmacy practice in rural areas, the effect of health care reform on rural health and ASHP's services, past and present, regarding rural healthcare. The report serves as a potential blueprint for future efforts for the Society to pursue as regards to rural health.

The mentoring of students and new practitioners, one of the Section's strategic goals, was enhanced by increasing representation of both groups on the Section's advisory groups. The Section's Advisory Group on Medication Safety continues to assist in the development of educational content for the medication safety track at the Summer Meeting and for the Medication Safety Collaborative for the 2013 Summer Meeting. The section hosted several networking sessions during the 2012 Midyear Clinical Meeting (MCM). All advisory groups, including specialty practice areas Investigational Drug Services and OR/Anesthesiology were represented.

The Executive Committee selected Debby Cowan as its sixth recipient of the Section's Distinguished Service Award. Dr. Cowan received her award at the Distinguished Service Award reception during the 2012 MCM.

The Section continues to keep the Pharmacy Practice Model Initiative (PPMI) a focus of its strategic priorities through education and advocacy efforts. The Section has been encouraging individuals at their respective institutions and state affiliates to participate in the PPMI Hospital Self-Assessment Survey. The combined efforts of the four advisory groups and the educational steering committee have yielded numerous webinars that are available to members on the ASHP website. This effort speaks to the commitment the Section has in addressing the needs of its diverse membership. The Section's Committee on Nominations works to aggressively recruit highly qualified candidates for nomination and develop a slate of candidates that will serve to fulfill Section initiatives.

Educational Programming. The Section conducted over 10 hours of successful educational sessions at the 2012 MCM. Additionally, the Section Advisory Group on Small and Rural Hospitals hosted its seventh Programming for Small and Rural Hospitals. This all-day program, traditionally held on the Sunday during the MCM, is targeted to rural health care practitioners and focuses on the issues facing health care facilities in rural and frontier areas of the country. The Advisory Group on Medication Safety hosted its seventh pearls session, *Safety and Quality Pearls 2012*. The Section's Educational Steering Committee met during the 2012 MCM to discuss and select potential topics for educational programming for the 2013 MCM. The

committee utilized the Section's Needs Assessment Survey, electronic discussion group reports, networking session discussions, and conversations with peers to guide them in their topic selections. Other significant educational content developed by the Section was the educational content for the 2012 Summer Meeting medication safety track, planned in collaboration with the Section Advisory Group on Medication Safety. Additionally, this committee has engaged with ASHP's Public Relations Division to consistently contribute to Safemedications.com, the Society's consumer drug information resource.

Resources for Inpatient Care Practitioners. The Section's web page on the ASHP website features information pertinent to the needs of its membership. The information includes recent news, practical tools, webinars, and member spotlights. All Section members receive a monthly Chair's Message and NewsLink containing information relevant to the Section's membership. These communication vehicles also serve to notify members of opportunities within the Section and ASHP. To facilitate member interaction and networking, the Section maintains three ASHP Connect communities: Inpatient Care Practitioners, Small and Rural Hospitals, and Medication Safety. The Section's main community, Inpatient Care Practitioners, is the most active and engaged of all the ASHP Connect communities. These discussion groups continue to be an effective networking mechanism and serve as a necessary resource for diverse membership components.

Advocacy. The Section Advisory Group on Medication Safety continues to advocate for robust education and training for medication safety officers and seeks to align its efforts to support ASHP initiatives, as well as the organization's leadership, in the area of medication safety. Additionally, the advisory group's annual safety webinar series remains involved in drug shortage advocacy efforts as well.

Upon the recommendation of the Section Advisory Group on Small and Rural Hospitals, the Executive Committee has sought ways to expand its network with rural health care organizations and agencies. ASHP staff has facilitated efforts to strengthen ASHP's relationship with the National Rural Health Association (NRHA), the Office of Pharmacy Affairs (OPA), the Office of Rural Health Planning (ORHP), and other rural organizations and agencies. Additionally, the Section has sought unique opportunities for collaboration with the Institute for Safe Medication Practices (ISMP). The Section Advisory Group on Small and Rural Hospitals has used its MCM Sunday *Programming for Small and Rural Hospitals* and the Section's web page to help communicate efforts of the HRSA/OPA Patient Safety Pharmacy Collaborative and the IHI 5 Million Lives Campaign. Partnerships with ISMP and NRHA have included appointing ISMP staff representatives and member liaisons, respectively, to the Section's Advisory Groups on Medication Safety and Small and Rural Hospitals. It is the Executive Committee's belief that a concerted rural health care strategy will strengthen ASHP's rural health care advocacy efforts, facilitate promotion of ASHP's policies in rural and frontier America, and elevate ASHP's standing in rural health care centers, organizations, and communities.

Advisory Group on Medication Safety. Now in its eighth year, the Section Advisory Group on Medication Safety is charged with providing tools and resources for medication safety officers or pharmacists who have medication safety responsibility as a component of their positions.

This advisory group recently authored ASHP's first statement on the role of the medication safety officer, which was passed by the 2012 House of Delegates. The group provided educational content for the 2012 MCM in the form of its sixth *Safety and Quality Pearls* session and collaborated with the Section's Advisory Group on Pharmacy Practice Experiences in developing a student medication safety rotation template. The advisory group has continued its safety webinar series on hot topics in medication safety and recently hosted its fifth annual webinar. Included in its webinar series is a timely and nationally relevant webinar that focuses on pharmacy outsourcing of compounding.

Advisory Group on Pharmacy Practice Experiences. This advisory group provides tools and resources for frontline pharmacist preceptors and potential preceptors that foster favorable student experiences as students matriculate through their pharmacy rotations. The group continually updates and maintains its primary resources, *How to Start a New Student Rotation* and the *ASHP Preceptor Tool Kit*. Both are posted on the Section's web page. The group collaborated with the Student Forum and launched a survey to assist health-system pharmacists and pharmacy students to identify ideal qualities of a preceptor or pharmacy student and how to incorporate best qualities into practice to create a more successful learning and teaching experience. This survey served as the basis for a collaborative effort with the Section of Clinical Specialists and Scientists for an educational session during the 2012 MCM that addressed strategies for preceptors to ensure positive experiences for students and residents. The advisory group was successful in creating three templates for its student rotation portfolio: medication safety (in collaboration with the Section Advisory Group on Medication Safety), informatics (in collaboration with the Section on Pharmacy Informatics and Technology), and Leadership (in a collaborative effort among the Sections of Clinical Specialists and Scientists and Pharmacy Practice Managers and the New Practitioner Forum). In addition, the group has commenced work on a template for investigational drug service rotations.

Advisory Group on Pharmacy Support Services. Formed in 2009, this advisory group works to assist and support ASHP's Pharmacy Technician Initiative (PTI). The advisory group assisted in the development of a general-use PowerPoint presentation that addresses the alignment of two of ASHP's primary initiatives: PPMI and PTI. The group also developed its first webinar addressing the professional imperative for standardization of pharmacy technician education and training. The group recognizes the importance of conducting surveys and gap analyses to address the value of pharmacy technicians and the needed practice resources for pharmacy personnel support and their supervisors. Consequently, the advisory group conducted a survey to investigate innovative roles for pharmacy support personnel as it relates to PPMI, and some of the results were reported in the pharmacy literature. The advisory group also hosted another successful and well-attended networking session during the 2012 MCM.

Advisory Group on Small and Rural Hospitals. The Section Advisory Group on Small and Rural Hospitals planned a successful educational track featuring eight hours of pharmacist continuing education for its seventh consecutive *Programming for Small and Rural Hospitals* during the 2012 MCM. The session's keynote speaker, Lance Keilers, was the current President of the NRHA and is CEO for a critical access hospital in Ballinger, Texas. Other rural program topics

included chronic disease states prevalent with rural residents and tactics to address drug shortages. Additionally, the advisory group organized a networking session at the 2012 MCM. The advisory group hosted a webinar that discussed how ASHP state affiliates can help small and rural hospitals and is collaborating with external rural health organizations to develop a rural health care webinar series to highlight pharmacists' value in rural health care. The advisory group has been very active in the areas of advocacy, educational programming, publications, and health policy. The group collaborated with the Department of Health and Human Services and Centers for Medicare & Medicaid Service Innovation Center to develop a webinar educating members about the Partnership for Patients, a federal initiative aimed at improving quality, safety, and affordability of health care for all Americans through public-private partnerships. For the first year, the advisory group was represented at NRHA's 2012 Critical Access Hospital Conference in Kansas City, Missouri. The efforts of the Society and the Section regarding rural health care accomplishments were captured in an executive summary and report, titled *ASHP's Rural Portfolio and Footprint*. This report will serve as a basis for future strategic priorities of the advisory group to engage ASHP members that practice in rural and frontier areas of the country. The advisory group remains committed to contributing to the literature, as evidenced by recent articles accepted for publication in the *American Journal of Health-System Pharmacy* by its former and current members. The Executive Committee will continue to advocate on behalf of small and rural hospitals, critical access hospitals, and other rural health care institutions.

Advisory Group on Medication Safety

Dan Degnan, Chair (Indiana); Dean Bennett, Vice Chair (Delaware); Beverly "Jane" Adams (Texas); Peggy S. Bickham (Illinois); Jennifer Burgess (North Carolina); Jorge D. Carillo (Texas); Angela Cassano (Virginia); Calvin Euler (Arkansas); John Farringer (Tennessee); Beth Ferguson (Minnesota); Molly Billstein Leber (Connecticut); Lynne M. Lee (New York); Marie Link (Ohio); Jeannell M. Mansur (Illinois); Kymberlee Moline (Michigan); Jason Nickisch (Montana); John Petrich (Ohio); Elizabeth McGowan Rebo (North Carolina); James Rinehart (Indiana); Jennifer Robertson (Tennessee); Jeffrey Schnoor (Vermont); Victoria (Vicki) Tamis (Washington); Michele Thomas (Maryland); Gwendolyn H. Thompson (Texas); Allen Vaida, ISMP Liaison (Pennsylvania); Deborah Wagner (Michigan); Ambra King, New Practitioner (Georgia); Juan M. Hincapie Castillo, Student Member-University of Florida, Class of 2013 (Florida); Joanne Kowiatek, Executive Committee Liaison (Pennsylvania); Bona E. Benjamin, ASHP Staff (Maryland)

Advisory Group on Pharmacy Practice Experiences

Lijian "Leo" Cai, Chair (Wisconsin); Dale E. English II, Vice Chair (Ohio); David Bowyer (West Virginia); Aaron Burton (Pennsylvania); John E. Clark (Florida); Davina Dell-Steinbeck (Missouri); Paul Driver (Idaho); Nicole M. Glasser (Massachusetts); Ericka Hylick (District of Columbia); Joseph Lassiter (Oregon); Phillip H. Lee (Tennessee); Michele M. Loudy (Florida); Lori Prater (New Mexico); Rachael Y. Prusi (Illinois); Kim Redic (Michigan); Shailly K. Shah (North Carolina); Ryan D. Tabis (North Carolina); Laura Watcher (Maryland); Rony Zeenny (Lebanon); Sali

Mahmoud, New Practitioner (Maryland); Joseph Dikun, New Practitioner (Mississippi); Ayotunde Ayoola, Student Member-Howard University, Class of 2013 (Washington DC); Noelle R.M. Chapman, Executive Committee Liaison (Illinois)

Advisory Group on Pharmacy Support Services

Terri K. Mundy, Chair (Louisiana); Trish Wegner, Vice Chair (Illinois); Sylvia Q. Banzon (California); Helen M. Calmes (Louisiana); Matilda Clark (Virginia); Kathleen Conway (Ohio); Cynthia (Cindy) Jeter (Arkansas); Stephen M. Kessinger (Florida); Daniel Kudryashov (California); Barbara E. Lacher (North Dakota); Gayle A. Mayer (Iowa); Jeffrey S. Reichard (North Carolina); Robert Sobolik (Montana); Angela Stephan (Colorado); Aubrey Wynn (Texas); Jennifer Edwards Schultz, Executive Committee Liaison (Montana)

Advisory Group on Small and Rural Hospitals

Debbie Sisson, Chair (Minnesota); Navy Chaay, Vice Chair (Wisconsin); Becky C. Barr (Texas); Ann M. Carder (Iowa); Shawna K. Cook (Pennsylvania); Debra L. Cowan (North Carolina); Matthew P. Fricker, Jr., ISMP Liaison (Pennsylvania); Todd Lemke (Minnesota); Neil J. MacKinnon (Arizona); Wendy Mobley (Iowa); R. Steve Olsen (Idaho); Jerry Reed (Tennessee); Timothy S. Seeley (Wyoming); Ralph Thonstad (Oregon); John Worden NRHA Liaison (Kansas); Bissy Obi, New Practitioner (Texas); Emily Alexander, Executive Committee Liaison (Texas)

Committee on Nominations

Brian D. Benson, Chair (Iowa); Jennifer Edwards Schultz, Vice Chair (Montana); Helen Calmes (Louisiana); Debra L. Cowan (North Carolina); Dale English (Ohio); Randy L. Kuiper (Montana); Deb Saine (Virginia)

Educational Steering Committee

Wes Pitts, Chair (Mississippi); Jacqueline L. Olin, Vice Chair (North Carolina); Terri Albarano (Pennsylvania); Michael J. Cawley (Pennsylvania); Lori Dupree (Virginia); Susan Flaker (Missouri); Shishir Gupta (Virginia); Trisha LaPointe (Massachusetts); Tyrone Lin (Washington); Darlette G. Luke (Minnesota); Richard Pacitti (Pennsylvania); Lois F. Parker (Massachusetts); Susan Jean Skledar (Pennsylvania); Linda Spooner (Massachusetts); Sarah S. Stephens (Utah); Lori Tsukiji (California); Michelle Abalos, ASHP Staff (Maryland); Pamela Hsieh, ASHP Staff (Maryland)



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the Section of Pharmacy Informatics and Technology

The mission of the Section of Pharmacy Informatics and Technology is to improve health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. In that role, the Section continually seeks to define and promote the optimal synergy between technology and the pharmacy professional in an effort to enhance and support practice models that bring the full benefit of the pharmacist's training and experience to the medication-use process. The Section is dedicated to achieving a vision in which members will (1) be enabled by technology to focus on providing optimal pharmaceutical care to each patient; (2) participate in all aspects of medical informatics that support the medication-use process through multidisciplinary collaboration across the entire health care system; (3) collaborate domestically and internationally with other organizations and governmental agencies to promote the use of medical informatics in the provision of quality health care; (4) take a leadership role in medical informatics, at all levels of health care, to ensure that health information technology (HIT) supports safe medication use; (5) promote the development of a set of practical medical informatics competencies to manage medication-related data and information challenges across the continuum of care; and (6) stimulate an environment that focuses on setting the agenda for designing and conducting research to expand medical informatics knowledge and its use in supporting patient care.

Executive Committee

Kevin C. Marvin, *Chair* (Vermont)
Michael D. Schlesselman, *Chair-elect* (Connecticut)
Allen J. Flynn, *Immediate Past Chair* (Indiana)
Sylvia M. Thomley, *Director-at-Large* (South Dakota)
Gwendolyn R. Volpe, *Director-at-Large* (Indiana)
Trinh T. Le, *Director-at-Large-elect* (North Carolina)
Larry C. Clark, *Board Liaison* (Colorado)
Karl F. Gumpper, *Secretary*

2012–2013 Section Highlights. During 2012, the Section added more than 6900 members. About 20% of the Section’s members have selected this group as their primary membership group. Total Section membership has increased by 15% from the previous year. Nearly one third of the Section membership is student members. In the 2012 elections, the Section’s membership elected Dr. Schlesselman as Chair-elect. Ms. Le was elected as a Director-at-Large; both will be installed at the June 2013 ASHP Summer Meeting. The Section also selected Brent I. Fox as the winner of the Section of Pharmacy Informatics and Technology Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of a section whose volunteer activities have supported the mission of the section and helped advance the profession. The award was presented at the 2012 Midyear Clinical Meeting (MCM). Mr. Marvin represents the Section in a Joint Section/Forum Coordination Committee of the Pharmacy Practice Model Initiative (PPMI) Summit. The Section will continue to provide support to ASHP, the Center on Pharmacy Practice Advancement, and the ASHP Foundation education and advocacy efforts related to the PPMI. The Section is working on a guidance document for the use of telepharmacy within pharmacy practice.

ASHP continues to participate with the Pharmacy e-Health Information Technology Collaborative (the Collaborative). The Collaborative was formed by the Academy of Managed Care Pharmacy (AMCP), American Pharmacists Association (APhA), ASHP, and the National Community Pharmacists Association (NCPA). These four organizations form the steering committee for the Collaborative, and they work with the other organizations to meet the objectives of the Collaborative. The other organizations that participate in the Collaborative are the American Association of Colleges of Pharmacy (AACP), American College of Clinical Pharmacy (ACCP), and American Society of Consultant Pharmacists (ASCP). The Collaborative continues to recruit associate members to support the work of the Collaborative.

The Collaborative has accomplished the following in 2012:

- Provided 12 written comments to Office of National Coordinator for HIT (ONC), Centers for Medicare & Medicaid Services (CMS), and Health and Human Services (HHS).
- Worked with National Library of Medicine (NLM) to publish 274 medication-management-specific SNOMED clinical terms.
- Submitted and gained approval of the Pharmacist Electronic Health Record (EHR) Functional Profile standard to American National Standards Institute (ANSI).
- Submitted a ballot for MTM Electronic Structured Document (Medication Action Plan, MAP) Implementation Guide (IG) to HL7 and NCPDP, which was approved.
- Shared Collaborative updates and activities during 8 national presentations, and represented the Collaborative interests at 20 pharmacy, government, or technology meetings.

Educational Programming. The Section’s programming for the 2012 MCM consisted of over 15 hours of continuing education. Topics that were presented included advancing pharmacy practice models through automation, EHR implementations, clinical decision support, and HIT team structures. Laura Tyndall of the Section’s Educational Steering Committee coordinated the Informatics Bytes: Pearls Session. Armen Simonian was the Chair of the Section’s 2012–2013 Educational Steering Committee.

Planning for the 2013 MCM is currently in progress. The Educational Steering Committee is searching for proposals that include implementing clinical decision support (CDS) to meet meaningful use of the EHR, creating effective CDS rules, managing optimization with the EHR and computerized provider order entry (CPOE) systems, developing order sets to drive evidence based practice, and utilizing a closed-loop barcode medication use process. Susan Kleppin of the Section's Educational Steering Committee will coordinate the Informatics Bytes: Pearls Session.

Brent Fox, Christopher Fortier, and Leslie Mackowiak are working with the ASHP Educational Services Division to plan an informatics series at the 2013 Summer Meeting. An informatics session is scheduled during five of the meeting's educational opportunities. The Section is conducting a joint session on medication safety with the Medication Safety program chairs. Topics that are scheduled for presentation include aligning CDS with Meaningful Use; how to identify informatics safety metrics, collect the data, and create a metrics dashboard; where others are in customizing CDS and how they are sharing rules; and where pharmacy informatics is headed on a national level.

The Section also planned and implemented five networking sessions at the 2012 MCM. Each of the Section's advisory groups planned a thematic program related to its primary charge. A networking session is planned for the 2013 Summer Meeting, to be facilitated by the Executive Committee.

Electronic Networking Opportunities. The Section's electronic NewsLink is distributed monthly to more than 6900 ASHP members. The NewsLink provides information on current issues relating to informatics and technology, research, legislative and regulatory facts, and health policy and health care news. The Section has promoted ASHP Connect to its members over the past year. The most visited websites of the Section were Pharmacy Informatics Job Descriptions, Pharmacy Informatics Career Development, and Bar Code Medication Administration Resources. The Section will continue to monitor the use of the Section's website and promote its available resources to members. The Executive Committee is interested in expanding the Section's presence utilizing existing social media tools (e.g., Twitter, FaceBook, linkedIn, etc.) and developing new tools and strategies.

Charges for Section Advisory Groups. The Section's Executive Committee has formalized and standardized the charge of each of the four advisory groups. Each advisory group will share eight common charges: (1) contribute to the "Informatics Interchange" column in the *American Journal of Health-System Pharmacy (AJHP)*, (2) coordinate a webinar for the Section membership on a related topic area, (3) review the relevant content area on the Section's website on an annual basis, (4) develop programming for the MCM, (5) appoint a working group to manage the frequent calls for comments for various government and regulatory groups, (6) encourage members to contribute and post to ASHP Connect, (7) coordinate a networking session at the MCM on a topic relevant to the advisory group's purview, and (8) coordinate a spotlight on a member's contribution to the Section for the Section's website. Each Section advisory group and committee will further have projects and deliverables focused on the group's scope and content knowledge.

Advisory Group on Ambulatory Care Informatics. Activities of the Section Advisory Group on Ambulatory Care Informatics include developing resources for members on electronic prescribing (ePrescribing), personal health records (PHRs), medication reconciliation, and electronic reimbursement issues (MTM-clinical services documentation and billing for medications). Current projects of the Section Advisory Group are developing a commentary around electronic prescribing, updating Section web resources on e-prescribing, developing quality measures for ambulatory care informatics, and determining best practices for allergy list management. The commentary that was developed by the Section Advisory Group, "Clinical Decision Support for Drug-Drug Interaction Checking: What Pharmacists Say They Want Changed," will be published in *AJHP* in early 2013.

Advisory Group on Clinical Information Systems. Activities of the Section Advisory Group on Clinical Information Systems include supporting pharmacy involvement in Meaningful Use; developing recommendations on the content of CDS for medication ordering and dispensing systems; educating in regards to considerations and processes to create and implement CDS rules; identifying sites in which pharmacists are using data to enhance practice (e.g., PPMI), for surveillance, to add efficiency to rounding models, for clinical drug use changes and quality monitoring; continuing to define pharmacy informatics roles and responsibilities; and promoting original research within clinical information systems and patient safety. The Section Advisory Group is focusing on the following areas for 2012-2013: Meaningful Use, quality outcomes, and measures; use of informatics to enhance the pharmacy practice model; CDS alerts and alert fatigue; and CDS rules and data warehouse. The Section Advisory Group's commentary, "Clinical Decision Support Alerts: The Need for Collaborative Engagement," was published in January 2013. The Section Advisory Group met with EHR and knowledge vendors at the MCM to discuss areas of collaboration and to implement the recommendations of the commentary.

Advisory Group on Pharmacy Informatics Education. Activities of the Section Advisory Group on Pharmacy Informatics Education include defining the scope and standards of practice for pharmacy informatics practitioners, continuing to identify and enroll new authors for the "Informatics Interchange" column, determining a means to highlight key pharmacy informatics research that may include a journal club via ASHP Connect on informatics topics, developing awareness and opportunities regarding careers in pharmacy informatics, assessing the professional educational needs of pharmacy informaticists, and determining a strategy for pharmacy informaticist professional certification. With the establishment of the "Informatics Interchange" column in *AJHP*, there have been over 24 publications since June 2008. The Section Advisory Group launched a survey in January 2013 to determine the scope of practice of an informatics pharmacist. The survey was developed by assessing the *ASHP Statement on the Role of the Pharmacist in Informatics* and the PGY-2 Pharmacy Informatics Outcomes, Goals, and Objectives. The results of the survey will determine the direction of the Section Advisory Group. Updating the statement and the residency training standards will be discussed once the results of the survey have been evaluated.

Advisory Group on Pharmacy Operations Automation. Activities of the Section Advisory Group on Pharmacy Operations Automation include investigating specifications and requirements to ensure interoperability and standardization for communication of data across databases, technology and information systems; developing a pharmacy self-assessment for safety related to distribution utilizing technology which includes robots, carousels, packagers, tracking systems, and IV workflow systems; developing a training guideline to ensure competency for pharmacy technicians related to technology to include understanding databases, concepts of FMEA/RCA, medication safety, optimization, and testing; developing resources on current state of IV workflow systems and IV preparation robotics; and updating smart pump resources. The Section Advisory Group is addressing the following topics: Formulary Interoperability, developing self-assessments for automation procurement, developing checklists and training competencies for automation, a resource guide on IV automation, updating resources on smart pumps, and continued work on telepharmacy resources. The advisory group conducted a networking webinar in August 2012, titled "Interoperability of Multiple Electronic Medication Formularies." The advisory group is working with the Association for the Advancement of Medical Instrumentation (AAMI) to develop standardized utilization of smart pumps and management of drug libraries. The Section Advisory group was responsible for publishing two articles in *AJHP*: a Commentary, "Robotics in acute care hospitals," and an ASHP Report, "Suggested definitions for informatics terms: Interfacing, integration, and interoperability."

Advisory Group on Ambulatory Care Informatics

Kathleen Vieson, Chair (Florida); George A Robinson, Vice Chair (Indiana); Denny C Briley (Kansas); C. David Butler (Missouri); Betsy Davis (Michigan); Jeffrey P. Firlik (Vermont); J. Chad Hardy (Texas); Julie S. Horne (Tennessee); Juhi Jain (Indiana); Andy Laegeler (Texas); Holly Shields Lilly (Florida); Patrick Mcdonnell (Pennsylvania); Larry W. Oliver (Washington); Matthew Olson (Oklahoma); Brad T Rognrud (Minnesota); James A Russell (Wisconsin); Catherine Sharafanowich (Connecticut); Mark Siska (Minnesota); Scott H Takahashi (California); Nathan Thompson (Maryland); Yao Hua Lin, Student Representative (Texas)

Advisory Group on Clinical Information Systems

Franklin P. Crownover, Chair (Massachusetts); Maren Everton, Vice Chair (Utah); Benjamin Anderson (Minnesota); Mark Baumgart (Indiana); Christene M Beuning (Washington); Lynn Boecler (Illinois); Robert Boswell (Georgia); Bruce W Chaffee (Michigan); Raymond C Chan (Virginia); DeWayne Davidson (Texas); Amy Davis (Florida); Van T Do (Maryland); Lynn Ethridge (South Carolina); John Farringer (Tennessee); Rick Fischer (Illinois); Genevieve Hayes (South Carolina); Staci A Hermann (Massachusetts); John R Horn (Washington); Michael A. Jones (Colorado); Joan Kapusnik-Uner (California); Melissa A Kennedy (Minnesota); Trinh Le (North Carolina); Wing Liu (Tennessee); Leslie Mackowiak (Tennessee); Daniel C. Malone (Arizona); Brad Marlar (Mississippi); Greg Matsuura (Washington); Joy Meier (California); David P Mulherin (Tennessee); Christy Nielsen (Washington); Arthur L (Butch) Parks (Florida); Shobha Phansalkar (Massachusetts); Rane M. Runnebaum (Oregon); Lynn C. Sanders (District of Columbia); Pamela K Schindler (Alabama); Michael Schlesselman (Connecticut); Falguni Shah

(Illinois); Mohammad Aslam Siddiqui (Kentucky); Nancy R Smestad (North Dakota); Andrew Smith (North Carolina); Victoria Tamis (Washington); David Troiano (Texas); Lolita White (District of Columbia); John L. Woon (Washington); Craig Wright (Ohio); Mick Schroeder, Informatics Resident (Oregon)

Advisory Group on Pharmacy Informatics Education

Joseph Lassiter, Chair (Michigan); Maritza Lew, Vice Chair (California); Silvana Balliu (Ohio); Louis D Barone (Ohio); Clarissa Borst (Oregon); Elizabeth A Breeden (Tennessee); Kevin Clauson (Florida); Jason Crawford (Texas); Tony Dao (California); Anna Dreger (Minnesota); Helen Figge (New York); Jonna Fink (Illinois); Brent Fox (Alabama); Carol J. Hope (Utah); Marla Husch (Illinois); Stephen Kung (Kentucky); William T. Lee (Virginia); Ryan Markham (Oregon); Sean Mirk (Illinois); Gina Moore (Colorado); Eric C. Nemece (Connecticut); Beth E Prier (Ohio); Mohammad A. Rattu (New York); William Steel (New York); Phillip W. Stewart (Tennessee); Elsbeth Thurston (Virginia); Hong Wei (California); Kathy M. Yount (Virginia); Adelaide Quansah-Arku, Technician Representative (District of Columbia); David A. Agüero, Student Representative (Virginia)

Advisory Group on Pharmacy Operations Automation

Kavish Choudhary, Chair (Utah); Brandon Ordway, Vice Chair (Minnesota); Michael J Ankenbruck (South Carolina); Jeff Brittain (South Carolina); Leslie Brookins (Missouri); Ron Burnette (Florida); Wendy E. Bussard (Michigan); Mark P Chabot (Virginia); Thomas W. Cooley (Massachusetts); Seth A. Cohen (Maryland); James A Della Rocco (New York); Doina Dumitru (Texas); Darren S. Ferer (New York); Barbara Giacomelli (New Jersey); Craig C Herzog (Utah); Jennifer Howard (California); Matthew T. Jenkins (Florida); Isha S. John (Maryland); James Lund (Wisconsin); Tommy Mannino (Louisiana); Silvia Maranian (Colorado); Michael McGregory (Indiana); Rhonda B. McManus (South Carolina); Nancy A. Nickman (Utah); Kevin A Scheckelhoff (Virginia); Allen Seiger (Oklahoma); Steven Silverstein (Illinois); Chad S. Stashek (Massachusetts); David A Tjho (Illinois); Dennis A Tribble (Florida); Christopher J Urbanski (Indiana); Adam S. Wolfe (North Carolina); Robynn Wolfschlag (Colorado); Marc Young (Texas); Truong Nguyen, Informatics Resident (Utah)

Committee on Nominations

Allen J. Flynn, Chair (Michigan); Christopher J. Urbanski (Indiana); Brent Fox (Alabama); J. Chad Hardy (Texas); Kevin A. Scheckelhoff (Ohio)

Educational Steering Committee

Armen Simonian, Chair (California); Laura Tyndall, Vice Chair (Pennsylvania); Anne M Bobb (Illinois); Alan Chung (District of Columbia); Kelly Duarte (West Virginia); Patricia E. Grunwald (Maryland); Susan M. Kleppin (Wisconsin); John Manzo (New York); Anne Teichman (West Virginia)



NEW HORIZONS

ASHP House of Delegates 2013
June 2 and 4, 2013

Report on the Section of Pharmacy Practice Managers

The mission of the Section of Pharmacy Practice Managers is to be the professional community of ASHP members that fosters management skills and effective leadership. The Section dedicates itself to a vision in which it helps its members manage pharmacy resources, maximize the safety of medication-use systems, develop future leaders, and promote the pharmacist's role in patient care. The Section Executive Committee has developed a strategic plan linked to the mission and goals of the Section. These goals are to (1) maximize communications and interactions with and among Section members; (2) enhance effectiveness of managers and leaders through development of education, training, and cultivating mentoring relationships; (3) recommend professional policy and advocacy on issues of importance to Section members; (4) define strategies to enhance the stature of the pharmacy enterprise within the health care delivery system and demonstrate the value of the profession; and (5) drive the advancement of the future practice model to support health care reform. The ASHP Section of Pharmacy Practice Managers represents ASHP's continued commitment to meeting the needs of pharmacists who lead and manage departments of pharmacy. The Section provides pharmacy directors and managers with a sense of identity within ASHP and an organizational home dedicated to meeting their special needs.

Executive Committee

Patricia J. Killingsworth, *Chair* (Colorado)

Todd A. Karpinski, *Chair-elect* (Wisconsin)

Michael F. Powell, *Immediate Past Chair* (Nebraska)

James M. Hoffman, *Director-at-Large* (Tennessee)

Laura K. Mark, *Director-at-Large* (Pennsylvania)

Rick Couldry, *Director-at-Large-elect* (Kansas)

Thomas J. Johnson, *Board Liaison* (South Dakota)

David Chen, *Secretary*

2012–2013 Section Highlights. The Section has 9435 members, with approximately 44% of the Section’s members having selected the Section as their primary membership group. Section members elected Dr. Karpinski as Chair and Mr. Couldry as a Director-at-Large; both will be installed at the June 2013 ASHP Summer Meeting. The Section recognized Kathleen Pawlicki as the winner of the Section of Pharmacy Practice Managers Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the Section’s mission and helped advance the profession. The award was presented at the 2012 Midyear Clinical Meeting (MCM).

In addition, a number of Section leaders were very active in the Pharmacy Practice Model Initiative (PPMI), as contributors to the *Pharmacy Forecast 2013-2017: Strategic Planning Advice for Pharmacy Departments in Hospitals and Health Systems*, webinar presenters, and document authors. The Section will continue to provide support to ASHP and ASHP Foundation education and advocacy efforts related to the PPMI and the Center for Pharmacy Practice Model Advancement. The Section has also established an advisory group for multi-hospital health-system pharmacy executives to lead section efforts supporting member needs in the evolving market place.

Educational and Networking Opportunities. Under the leadership of Thomas Kirschling, the 2011–2012 Educational Steering Committee designed educational sessions for pharmacy managers and directors that were presented at the 2012 MCM. Topics included the expansion of student roles, leadership in the new pharmacy enterprise, building collaborative work places, developing real-time dashboards, updates on reimbursement rules, workload and productivity, and management pearls. All of these sessions were recorded and synchronized with the presentation slides so that they can be made available to members. For the 2013 MCM, the committee is planning sessions on patient-focused services in the pharmacy enterprise (transitions of care and value-based purchasing), competency of pharmacy staff to meet future patient care needs, use of real time data in pharmacy operations, specialty pharmacy business models, emergency department (ED) service implementation and managing free-standing EDs, student experience practice models and nontraditional residency development, 340B audit success strategies, compounded sterile products outsourcing, benchmarking practices, supply chain management across health systems (cost, integrity, and standardization, and remodeling and construction best practices). The Section also planned and implemented networking sessions through the leadership of the Section’s advisory groups at the 2012 MCM addressing issues and opportunities with administrative residencies, pharmacy enterprise management, practice model innovations, specialty pharmacy integration, and multi-hospital pharmacy leaders.

The Section continues to distribute a monthly electronic NewsLink that serves over 9000 ASHP members. The NewsLink provides Section information, business information, leadership and management information, relevant research, legislative updates, regulatory alerts, and health policy/health care news. The Section also continues to facilitate an electronic discussion group utilizing ASHP Connect. The electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy management and leadership.

Conference for Leaders in Health-System Pharmacy. The Section, in collaboration with ASHP Advantage, planned and implemented another successful Conference for Leaders in Health-System Pharmacy. This event again reached capacity in 2012 with over 400 participants, and included key programs in areas such as enterprise management, insights to the C-suite (remarks presented by Thomas Dolan, President and Chief Executive Officer of the American College of Healthcare Executives), developing practice models within multi-hospital health systems, compliance strategies, transitions of care models, supply chain management, and managing information effectively within today's eHIT environment. The overarching theme of the Conference was leading the pharmacy enterprise and advancing pharmacy practice with the many transitions in health care. In addition, a pre-conference Managers' Boot Camp was conducted for its fifth year as a freestanding workshop focusing on key drivers resulting from health reform, financial management skills, leading an accountable culture, strategic planning, and alignment of skills and strengths when developing teams. In addition, 16 section leaders provided facilitation for networking tables on hot topics. As part of the conference proceedings, the John W. Webb Lecture Award was presented to Toby Clark.

Advocacy. The Section continues to be very active in advocacy in the areas of workload and productivity measures, the expansion of restricted drug distribution systems, the affordability of drugs, specialty pharmacy, supply chain management, and reimbursement. In addition, the Section will continue to be engaged in promoting, fostering, and expanding the opportunities for pharmacy leadership and the benefits of pharmacist leadership in improving the medication use system.

Advisory Group on Communications and Publications. This advisory group was sunset in 2012 as it had successfully met its charge. The advisory group had worked on coordinating communication of the Section's activities and the completion of publications focused on the needs of pharmacy practice managers. The group oversaw the Section's communication and marketing plan, including the facilitation of submissions for the "Manager's Consultation" column in the *American Journal of Health-System Pharmacy (AJHP)* and the Section's Member Spotlights for the Section web page to recognize Section members that have been active in achieving Section goals. These activities have been integrated into the other Section advisory groups and committees.

Advisory Group on Leadership Development. This advisory group has been working on various aspects of leadership development, including the role of credentialing and privileging in advancing pharmacists and the future needs to support and mentor technicians. Group members successfully published a column in *AJHP* on technician leadership development. The group continues to oversee the Student Leadership Development (SLD) Workshop. This workshop is a three-hour program to introduce students to leadership opportunities and to facilitate networking with other students interested in leadership. The program has been implemented at 18 ASHP state affiliates and one college of pharmacy. The advisory group is working in collaboration with the ASHP Affiliate Relations Division, Pharmacy Student Forum, and the Center for Health-System Pharmacy Leadership to continue the expansion of the program. The advisory group partnered with the Section's Advisory Group on Pharmacy

Practice Model Initiative to organize the 2012 MCM networking sessions on promoting leadership and innovation when advancing pharmacy practice models. The group has also been engaged with the ASHP Foundation and its efforts to identify opportunities for new practitioner and student leadership development.

Advisory Group on Manager Development. This advisory group focused on tools and education to support health-system pharmacy manager development. Members of the group successfully had published *AJHP* "Management Consultations" columns addressing managing peak performers, managing underperformers, and the nonpharmacist business manager. The advisory group also assisted in coordinating the fifth annual Managers' Boot Camp held prior to the Conference for Leaders in Health-System Pharmacy.

Advisory Group on Multi-Hospital Health-System Pharmacy Executives. This group of Section members is a growing area of membership. The Section appointed an Advisory Group on Multi-Hospital Health-System Pharmacy Executives in 2012. For the fourth year the Section has organized a networking session at the MCM for these practitioners, now coordinated by this group. The Section leadership is working on developing additional services and resources to meet the needs of members associated with multi-hospital health systems. Members of the group led a workshop at the 2012 Conference for Leaders in Health-System Pharmacy addressing practice models for multi-hospital systems as well as a networking session.

Advisory Group on Pharmacy Business Development. This advisory group participated in the development of the ASHP/ASHP Foundation C-suite Resource Center. The group's efforts in collecting example business cases and return on investment models were utilized in providing content for this important resource center. As the compounding tragedy unfolded in 2012, members of the group assisted in creating and served as faculty for a webinar sharing how their organizations were managing through the various issues. The group also led a 2012 MCM networking session addressing the effective use of clinical and quality dashboards.

Advisory Group on Pharmacy Practice Model Initiative. This advisory group was established in 2011 to guide the Section in its effort to support the PPMI. The group was successful in determining priorities for the group to focus on, including educational programming, networking, and PPMI-focused case studies. The group will be working with the newly established Center for Pharmacy Practice Model Advancement to provide additional member feedback for the Center. The advisory group partnered with the Section's Advisory Group on Leadership Development to organize the 2012 MCM networking sessions on promoting leadership and innovation when advancing pharmacy practice models. The efforts of this advisory group have also been incorporated into the Joint Section and Forum PPMI Coordination Committee.

Advisory Group on Quality and Compliance. This advisory group was very active with issues surrounding tech-check-tech programs, reimbursement compliance, and Medicare Conditions of Participation challenges. At the 2012 MCM an educational session on reimbursement compliance and the new inpatient and outpatient prospective payment systems (IPPS and

OPPS) rules was provided for the fourth year. The advisory group is continuing work on creating a “Tip of the Month” that will provide members with ideas and resources on how to improve their compliance and success with quality and regulatory goals. The group was instrumental in working with ASHP staff on seeking a more patient-safe interpretation of the Centers for Medicare & Medicaid Services (CMS) “30-minute” rule, which in collaborative efforts with the Institute for Safe Medication Practices has resulted in changes in CMS’s interpretative guidelines. The group also conducted a webinar on different models of tech-check-tech programs to provide examples for members seeking to advance the role of technicians as we strive to fulfill the recommendations of PPMI. The group also organized a networking session at 2012 MCM on compliance issues and models for tech-check-tech programs.

Advisory Group on Leadership Development

Jennifer Cimoch, Chair (Pennsylvania); Glen Albracht, Vice Chair (North Carolina); Steven Allison (North Carolina); John Clark (Michigan); Arash Dabestani (California); Susan Flaker (Missouri); John Hertig (Indiana); Jenna M. Huggins (North Carolina); Brian Kawahara (California); Justin Paul Konkol (Wisconsin); Julie Lenhart (California); Joanna Lewis (North Carolina); Kelly Martin (Wisconsin); Naomi M. Martin (Indiana); Veena Rajanna (Michigan); Erin Taylor (Massachusetts); Jennifer D. Van Cura Frame (Kentucky); Jeffrey Wagner (Texas); Korby Lathrop, New Practitioner – Resident (Wisconsin)

Advisory Group on Manager Development

Robert P. Granko, Chair (North Carolina); Mark Sullivan, Vice Chair (Tennessee); Lindsey R. Kelley, Immediate Past Chair (Michigan); Trent A. Beach (Delaware); Osmel Delgado (Florida); Mark Fondriest (Ohio); Bonnie A. Labdi (Texas); Carisa Masek (Nebraska); Adam Orsborn (North Carolina); Melissa Ortega (Wisconsin); Kate Schaafsma (Wisconsin); Meghan Davlin Swarthout (Maryland); Jacob Thompson (New York); Crystal Tom (Massachusetts); Alex Varkey (Texas); Andrew J. Wilcox (Wisconsin); Jorge Joanh Garcia, New Practitioner – Resident (Florida); Meghann Voegeli, New Practitioner – Resident (Wisconsin)

Advisory Group on Multi-Hospital Health-System Pharmacy Executives

Ernest Anderson, Chair (Massachusetts); Bonnie Levin, Vice Chair (Maryland); Gregory S. Burger (Indiana); Tammy Cohen (Texas); Edward Jai (California); Alan Kiyohara (California); Scott Knoer (Ohio); Richard Montgomery (Florida); Michael C. Nnadi (North Carolina); Priyesh G. Patel (Washington); Kathleen S. Pawlicki (Michigan); Bonnie L. Senst (Minnesota); Virginia Torrise (District of Columbia); Thomas W. Woller (Wisconsin); Karol Wollenburg (New York)

Advisory Group on Pharmacy Business Management

Michael DeCoske, Chair (North Carolina); Tim W. Lynch, Vice Chair (Washington); Philip Brummond, Immediate Past Chair (Michigan); Timothy S. Anderson (Oklahoma); Lisa Baird (Washington); Corwin “Lee” Brower (Virginia); Christopher Fortier (South Carolina); Maxie Friemel (Wisconsin); Nicholas C. Ladell (Wisconsin); Erin Maroyka (Virginia); Patrick McMahan (Massachusetts); Brian C. O’Neal (Kansas); Majid Tanas (Oregon);

Cedric Terrell (California); Cynthia Williams (Virginia); David Wolfrath (Florida); John Worden (Kansas); Matthew Lamm, New Practitioner – Resident (North Carolina); Ryan M. Moore, New Practitioner – Resident (North Carolina)

Advisory Group on Pharmacy Practice Model Initiative

Stephen Eckel, Chair (North Carolina); Brian Marden, Vice Chair (Maine); Jennifer Brandt (District of Columbia); Sam Calabrese (Ohio); Anita Harrison (Texas); Todd Karpinski (Wisconsin); Pamela Phelps (Minnesota); Steve Pickette (Washington); Rita Shane (California); Jennifer Tryon (Washington); Suzanne Turner (Florida); Samaneh Wilkinson (Kansas); Julie Williams (Indiana)

Advisory Group on Quality and Compliance

Christine Manukyan, Chair (California); Sam Calabrese, Vice Chair (Ohio); Margaret A. Huwer, Immediate Past Chair (Ohio); Tanya Barnhart (Minnesota) Jennifer Burgess (North Carolina); Kristine Gullickson (Minnesota); Kayla Hansen (North Carolina); Genevieve Hayes (South Carolina); Tara K. Jellison (Indiana); Brook S. Kawchak (Wisconsin); Carla Kennedy (North Carolina); Bonnie Kirschenbaum (Colorado); Ben Lopez (Ohio); Kim Mason (Tennessee); Lee Murdaugh (Tennessee); John Petrich (Ohio); Leslie A. Pires (Rhode Island); Monica Puebla (Texas); Maria Serpa (California); Doris Wong (California); Erick M. Sokn, New Practitioner – Resident (Wisconsin)

Committee on Nominations

Michael Powell, Chair (Nebraska); Scott Knoer (Ohio); Greg Polk (Michigan); James R. Rinehart (Indiana); Rita Shane (California); Andrew L. Wilson (Virginia); Karol Woollenburg (New York)

Educational Steering Committee

Rebecca Taylor, Chair (Ohio); Rabiah Dys, Vice Chair (Massachusetts); Thomas E. Kirschling, Immediate Past Chair (Colorado); John A. Armitstead (Florida); John Armitstead (Florida); Doina Dumitru (Texas); Matthew Eberts (Pennsylvania); Ryan Forrey (Ohio); Roy Guharoy (Massachusetts); Nishaminy Kasbekar (Pennsylvania); John D. Pastor III (Minnesota); Bob Ripley (Iowa)



REPORT ON IMPLEMENTATION OF 2012

ASHP HOUSE OF DELEGATES ACTIONS AND RECOMMENDATIONS

Council on Education and Workforce Development A (1201): Preceptor Skills and Abilities

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

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

ASHP staff discussed preceptor development needs with Pharmacy Deans attending the Midyear Clinical Meeting (MCM) in December 2012 and convened a staff committee to assess existing and additional tools that ASHP might offer for preceptor development.

Council on Education and Workforce Development B (1202): Qualifications and Competencies Required to Prescribe Medications

To affirm that prescribing is a collaborative process that includes patient assessment, understanding of the patient's diagnoses, evaluation and selection of available treatment options, monitoring to achieve therapeutic outcomes, patient education, and adherence to safe and cost-effective prescribing practices; further,

To affirm that safe prescribing of medications, performed independently or collaboratively, requires competent professionals who complement each others' strengths at each step; further,

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

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

This policy has been used in ongoing ASHP advocacy. Other specific actions are under consideration.

Council on Education and Workforce Development C (1203): Qualifications of Pharmacy Technicians in Advanced Roles

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

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

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

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

This policy has been used in ongoing ASHP advocacy and communications related to pharmacy technicians.

Council on Education and Workforce Development D (1204): Role of Students in Pharmacy Practice Models

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

ASHP staff is seeking ways to promote innovative models that involve pharmacy students.

Council on Pharmacy Management A (1205): Revenue Cycle Compliance and Management

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

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

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

To investigate and publish best practices in medication-related revenue cycle compliance and management.

ASHP staff established a group of member experts to develop guidelines on revenue cycle management. ASHP has continued its involvement with the e-HIT Collaborative, which works to ensure health-system pharmacies' interests are addressed in the development of electronic health records (EHRs) and the associated billing and reimbursement functions. ASHP conducted [webinars](#) and developed educational content addressing billing and compliance in the ambulatory care settings and continues to send "Tips of the Month" related to issues with medication billing, patient care billing, and other related compliance issues. ASHP also continues efforts to preserve ASP plus 6% pricing for covered drugs.

Council on Pharmacy Management B (1206): Payment Authorization and Verification Processes

To advocate that public and private payers work together and in collaboration with providers to create standardized and efficient strategies for payment authorization and verification processes, such as local and national coverage determinations, that facilitate communication between patients, providers, and payers prior to therapy; result in timely coverage decisions; and do not disrupt patient care.

ASHP continues to maintain the ASHP REMS Web Resource Center and established a group of member experts to develop guidelines on managing specialty pharmacies, including approaches for dealing with prior authorizations.

Council on Pharmacy Management C (1207): Financial Management Skills

To foster the systematic and ongoing development of management skills for health-system pharmacists in the areas of (1) health-system economics, (2) business plan development, (3) financial analysis, (4) metrics for clinical and distributive services, (5) pharmacoeconomic analysis, (6) diversified pharmacy services, (7) compensation for pharmacists' patient-care services, and (8) revenue cycle compliance and management; further,

To encourage colleges of pharmacy to incorporate these management areas in course work and experiential education; further,

To encourage financial management skills development in pharmacy residency training programs and new practitioner orientation.

ASHP launched a [C-Suite Web Resource Center](#) at the 2012 MCM. ASHP staff established a group of member experts to develop guidelines on managing specialty pharmacies, including approaches for dealing with prior authorizations. ASHP organized a [webinar](#), "Financial Basics: Justification of New Pharmacy Programs," that was presented in late April. In addition, the Section of Pharmacy Practice Managers (SPPM) Managers Boot Camp includes financial basics lecture and workshop activities. The ASHP Foundation's [Pharmacy Forecast 2013-2017: Strategic Planning Advice for Pharmacy Departments in Hospitals and Health Systems](#) providing important health care economic trends, in collaboration with the Pharmacy Practice Sections. The Section of Ambulatory Care Pharmacists (SACP) had a networking sessions at the 2012 MCM on "Current Issues for Ambulatory Care Pharmacists: Provider Status, Collaborative Practice, Health-Homes, and Billing for Services" and "Ambulatory Care Pharmacist Reimbursement Opportunities: Hospital-based, Physician-based, and Retail Pharmacy-based." (See additional notes under the recommendation regarding ASHP SPPM website resource offerings [Steve Novak] below.)

Council on Pharmacy Management D (1208): Transitions of Care

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further,

To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further,

To encourage the development, optimization, and implementation of information systems that facilitate sharing of patient-care data across care settings and providers; further,
 To advocate that payers and health systems provide sufficient resources to support effective transitions of care; further,
 To encourage the development of strategies to address the gaps in continuity of pharmacist patient care services.

ASHP conducted a workshop on transitions of care business development at the 2012 [Conference for Leaders in Health-System Pharmacy](#). ASHP created a Task Force on Accountable Care Organizations (ACOs), with an emphasis on new models and practitioner skills needed to achieve goals of ACOs. ASHP issued the [ASHP/APhA Medication Management Transitions of Care Best Practices](#) report in February 2013, which showcases eight model programs to improve patient outcomes and prevent readmissions. Winning programs were highlighted at the 2012 MCM, 2012 Conference for Leaders in Health-System Pharmacy, and 2013 APhA Annual Meeting. ASHP is exploring potential collaboration on phase 2, which might include a dedicated web site on this topic, grants for pilot programs, and collection of models on specific program aspects (e.g., use of technology). A “Leading an Innovative Practice in Ambulatory Settings” learning community is planned for the 2013 Summer Meeting. ASHP continues its involvement with the e-HIT Collaborative, which works to ensure health-system pharmacy’s interests are addressed in the development of EHRs and the associated information exchanges necessary for transitions of care.

Council on Pharmacy Management E (1209): Value-Based Purchasing

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,
 To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

ASHP has engaged in continued advocacy with payers, most notably the Centers for Medicare & Medicaid Services (CMS), on the role of pharmacists in achieving value-based purchasing (VBP) goals. ASHP has presented educational sessions at meetings, and the *American Journal of Health-System Pharmacy (AJHP)* publications providing information on rules and best practices to achieve VBP targets.

Council on Pharmacy Management F (1210): Role of Corporate Pharmacist Leadership in Multifacility Organizations

To advocate that a pharmacist must be responsible for leadership and have responsibility for standardization and integration of pharmacy services in multiple business units across the entire pharmacy enterprise of multifacility health systems and integrated delivery networks; further,
 To educate health-system administrators about the importance of pharmacy leadership in setting system-wide policy regarding the safe and effective use of medications.

ASHP members presented at the American College of Healthcare Executives on pharmacy practice. The SPPM Advisory Group on Multi-Hospital Health System Pharmacy Executives provided peer networking and educational programs at the 2012 MCM and the [Leadership Conference](#).

Council on Pharmacy Management G (1211): Pharmacist’s Role in Health Care Information Systems

To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of medication-use information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,
 To advocate for incentives to hospitals and health systems for the adoption of patient-care technologies; further,
 To recognize that design and maintenance of medication-use information systems is an interdisciplinary process that requires ongoing collaboration among many disciplines; further,
 To advocate that pharmacists must have accountability for strategic planning and direct operational aspects of the medication-use process, including the successful deployment of medication-use information systems.

This policy has been utilized in comments to the Office of the National Coordinator for Health Information Technology (ONC) in ASHP’s comments on Meaningful Use of the EHR.

Council on Pharmacy Management H (1212): Clinical Decision Support Systems

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

The Section of Pharmacy Informatics and Technology (SOPIT) published a commentary, [The need for collaborative engagement in creating clinical decision-support alerts](#), in *AJHP*. SOPIT also brought EHR and knowledge vendors together at the MCM 2012 meeting to discuss opportunities for collaboration. SOPIT is in development of a mechanism for members to share CDS rules. Another commentary on managing Drug-Drug Interactions is awaiting publication in *AJHP*. The policy has been utilized in comments to the Office of the National Coordinator for Health Information Technology (ONC) in the Society’s comments on Meaningful Use of the EHR.

Council on Pharmacy Practice A (1213): Pharmacist Prescribing in Interprofessional Patient Care

To define pharmacist prescribing as follows: patient assessment and the selection, initiation, monitoring, adjustment, and discontinuation of medication therapy pursuant to diagnosis of a medical disease or condition; further,
To advocate that health care delivery organizations establish credentialing and privileging processes that delineate the scope of pharmacist prescribing within the hospital or health system and to ensure that pharmacists who prescribe are competent and qualified to do so.

This policy implements a working definition of pharmacist prescribing and recommends a means for ensuring competency in that role. The policy has been used to support ASHP’s ongoing advocacy efforts with credentialing, accreditation, regulatory, and legislative organizations.

Council on Pharmacy Practice B (1214): Pharmacist’s Role in Accountable Care Organizations

To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,
To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,
To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,
To advocate that pharmacists be included as health care providers in demonstration projects for ACOs; further,
To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,
To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.

ASHP convened Task Force on ACOs in June 2012. ASHP has provided members with ACO-related information and products in a variety of formats, including publications (e.g., articles in *AJHP*, a January 2011 ASHP [policy analysis](#) on the pharmacist’s role in ACOs); continuing education and networking sessions at meetings; and a one-hour, archived [webinar](#) on the Affordable Care Act and ACOs.

Council on Pharmacy Practice C (1215): Pharmacist’s Role in Team-Based Care

To recognize that pharmacist participation in interprofessional health care teams as the medication-use expert increases the capacity and efficiency of teams for delivering high-quality care; further,
To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care; further,
To assert that pharmacists are responsible for coordinating the care they provide with that provided by other members of the health care team and are accountable to the patient and to the health care team for the outcomes of that care; further,

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

Policy concepts included in “Common Principles of Team-Based Care,” a position document developed by the [Hospital Care Collaborative](#), an interprofessional group promoting team-based hospital care.

Council on Public Policy A (1216): Pharmacy Technicians

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

To advocate, with respect to certification, as an interim measure until the optimal model is fully implemented, that individuals be required either (1) to have completed an ASHP-accredited program of education and training or (2) to have at least one year of full-time equivalent experience as pharmacy technicians before they are eligible to become certified; further,

To advocate that all pharmacy functions be performed under the general supervision of a licensed pharmacist and that licensed pharmacists and technicians be held accountable for the quality of pharmacy services provided. (Note: Licensure is the process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.)

This policy is inherent to the ongoing work of ASHP’s Pharmacy Technician Initiative, which partners with state affiliates to achieve adoption of the policy’s elements. State affiliates have been surveyed about the prospect for legislative and regulatory changes to incorporate this policy. Assistance has been provided to select state affiliates as requested.

Council on Public Policy B (1217): Collaborative Drug Therapy Management

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

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

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

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

State legislative and regulatory initiatives have been supported by ASHP. Most initiatives involve expansion of existing collaborative drug therapy management authority to ambulatory and community settings.

Council on Public Policy C (1218): Approval of Biosimilar Medications

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

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

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

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

To require postmarketing surveillance for all biosimilar medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,
 To advocate for adequate reimbursement for biosimilar medications that are deemed interchangeable; further,
 To promote and develop ASHP-directed education of pharmacists about biosimilar medications and their appropriate use within hospitals and health systems; further,
 To advocate and encourage pharmacist evaluation and the application of the formulary system before biosimilar medications are used in hospitals and health systems.

State affiliates have been supported by ASHP in their advocacy on proposals that regulate the interchangeability of biosimilars. ASHP will use this policy in ongoing advocacy with FDA as it finalizes its guidance on implementation of the approval pathway for biosimilars. In addition, educational materials and programming have been developed for members.

Council on Public Policy D (1219): Stable Funding for HRSA Office of Pharmacy Affairs

To advocate for a sustainable level of funding, including appropriations, sufficient to support the public health mission of the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs; further,
 To support initiatives of the Office of Pharmacy Affairs, including the 340B Drug Pricing Program and innovative pharmacy service models in HRSA-funded programs; further,
 To encourage research on the potential impact of any proposed fees or alternative funding sources for the Office of Pharmacy Affairs.

This policy has been used in ongoing advocacy with Congress, HRSA, and other stakeholders as the program continues to be closely reviewed.

Council on Public Policy E (1220): Standardized Immunization Authority to Improve Public Health

To advocate that, to improve public health and patient access to immunizations, states grant pharmacists the authority to initiate and administer all adult and child immunizations through a universal protocol developed by state health authorities; further,
 To advocate that only pharmacists who have completed a training and certification program acceptable to state boards of pharmacy and meeting the standards established by the Centers for Disease Control and Prevention may provide such immunizations; further,
 To advocate that state health authorities establish a centralized database for documenting administration of immunizations that is accessible to all health care providers.

This policy is used in ongoing advocacy at the state level as pharmacists are granted the authority to provide immunizations.

Council on Therapeutics A (1221): Criteria for Medication Use in Geriatric Patients

To support medication therapy management, including assessment of physiologic and pharmacokinetic factors, as a central component of providing safe and effective drug therapy to geriatric patients; further,
 To oppose use of the Beers criteria or similar criteria by the Centers for Medicare & Medicaid Services and other accreditation and quality improvement entities as the sole indicator to assess the appropriateness of prescribing for geriatric patients based on known limitations in the evidence evaluating the association between use of medications listed in such criteria and subsequent adverse drug events; further,
 To advocate for the development, refinement, and validation of new criteria that consider drug-, disease-, and patient-specific factors and demonstrate the ability to decrease the occurrence of adverse drug events in geriatric patients; further,
 To support research to assess the clinical application of existing and proposed criteria, including assessment of their correlation to patient outcomes and strategies for implementation; further,
 To encourage inclusion of validated criteria in clinical decision support systems and other information technologies to facilitate prescribing for geriatric patients; further,
 To acknowledge that such criteria are intended as a guide and should not replace the clinical judgment of pharmacists and other clinicians.

This policy was communicated to staff at the American Geriatric Society (AGS), the Pharmacy Quality Alliance (PQA), and CMS. AGS and PQA were involved in developing the content and specific quality measures and CMS implements their assessments as part of their long-term care standards. The letters were tailored to the specific role each organization plays in developing and using the Beers criteria. ASHP staff participated in interview for cover story in the [August 2012 issue](#) of *Drug Topics*. Among other aspects, ASHP staff was quoted as opposing use of the Beers criteria as a sole indicator to assess quality of patient care. An educational session on geriatric care at the 2012 MCM provided a comparison of new Beers criteria and the version published in 2003.

Council on Therapeutics B (1222): Medication Adherence

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

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

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

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

To discourage practices that inhibit education of or lead patients to decline education and clinical information regarding their medication therapy; further,

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

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

An ASHP member was appointed to serve on a Pharmacy Quality Alliance adherence workgroup that is developing quality measure concepts for adherence. The [ASHP-APhA Medication Management in Care Transitions](#) project identified eight best practices for models of care to improve patient outcomes and prevent readmissions. Strategies to improving medication adherence and medication access were a central component of these programs.

Council on Therapeutics C (1223): Globalization of Clinical Trials

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

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

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

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

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

This policy was communicated to FDA in an official comment letter regarding reauthorization of the Prescription Drug User Fee Act (PDUFA).

Council on Therapeutics D (1224): Tobacco and Tobacco Products

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

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

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

To promote the role of pharmacists in tobacco-cessation counseling and medication therapy management; further, To join with other interested organizations in statements and expressions of opposition to the use of tobacco and tobacco products.

This was a revision of existing ASHP policy with a minor alternation to acknowledge the pharmacist's role in medication therapy management in addition to counseling. The policy will be used in ongoing ASHP advocacy.

Section of Clinical Specialists and Scientists (1225): Board Certification for Pharmacists

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

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

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

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

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

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

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

The Section of Clinical Specialists and Scientists (SCSS) coordinated an open hearing at the 2012 MCM for members to provide comments to BPS regarding recognition of pediatrics and critical care as Board-certified specialties, and section members participated in writing the petitions to BPS for recognition of those two specialties, which were [recognized by BPS](#) in April. SCSS members were also involved in the BPS practice analysis task force that conducted role delineation studies in cardiology and infectious diseases. SCSS members helped develop ASHP educational offerings, review courses, and core therapeutic modules to help pharmacists prepare for the BCPS, BCACP, and BCOP specialty examinations and recertification programs. SCSS is also hosting a networking session on credentialing and privileging at the 2013 Summer Meeting and has proposed educational programming on the topic at the 2013 MCM.

Council on Education and Workforce Development E (1226): ASHP Statement on the Role of the Medication Safety Leader

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

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy with The Joint Commission, the National Quality Forum (NQF), and CMS.

Council on Pharmacy Practice D (1227): ASHP Statement on the Pharmacist's Role in Medication Reconciliation

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

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy with The Joint Commission in support of National Patient Safety Goal (NPSG).03.06.01 on medication reconciliation.

Pharmacy Student Forum and Section of Pharmacy Informatics and Technology (1228): ASHP Statement on Use of Social Media by Pharmacy Professionals

To approve the ASHP Statement on Use of Social Media by Pharmacy Professionals.

The statement was published in *AJHP* and *Best Practices for Hospital and Health-System Pharmacy* and has been used in ongoing advocacy.

Recommendation: Vickie Powell (on behalf of NY delegation)

ASHP should create a certification program on financial management skills to provide baseline and ongoing competency that is consistent across the health system.

ASHP has not considered a certification or certificate program for financial management skills but has devoted resources to regular education, advocacy, publications, news reports, and web resources to addressing this critical area for pharmacy leaders. The Section of Pharmacy Practice Managers (SPPM) has two advisory groups specifically on the business management of pharmacy and the associated quality and compliance aspects. The 2012 House of Delegates approved changes to ASHP’s policy on Financial Management Skills (see Council on Pharmacy Management Policy Recommendation C, above) to include metrics for clinical and distributive services and revenue cycle compliance and management. Examples of useful ASHP references include:

- 1) The [SPPM website](#) has a number of resources and a financial self-assessment tool.
- 2) Each year the [Conference for Leaders in Health-System Pharmacy](#) has components based on financial management.
- 3) The ASHP publication, [Financial Management for Health-System Pharmacists](#).

This timely recommendation is reflective of the increasing demands on pharmacy leaders to more effectively manage all aspects of the pharmacy enterprise and the complexities of the business of pharmacy. Section leadership will continue to identify the products and services to be developed for our members.

Recommendation: Melanie Dodd (NM)

ASHP should replace terms such as “multidisciplinary” and “interdisciplinary” with “interprofessional” in ASHP policies.

ASHP has started replacing these terms, when appropriate, with "interprofessional" and will do so in a stepwise fashion as policies and documents are developed or revised.

Recommendation: Casey White (TN)

ASHP should develop clear, delineated, and implementable guidelines for transition of pharmacists traditionally involved in primarily operational activities to direct patient care roles.

This topic was included on the agenda of the Council on Pharmacy Education and Workforce Development when they met in September as part of a broader discussion of how to ensure that both new graduates and existing pharmacists are prepared for the needs of the future pharmacy workforce (see the “Other Council Activity” section of the Board Report).

Recommendation: Allen Flynn (SOPIT)

The Section on Pharmacy Informatics and Technology recommends that ASHP establish by consensus a medication-use process model with a set of measurable patient-focused criteria for use by ASHP to certify or accredit the medication-use process within hospitals and health systems.

This topic is a subject of ongoing discussion and exploration by ASHP staff and members. ASHP recently joined the governing body of the Center for Pharmacy Practice Accreditation (CPPA). CPPA oversees the development and implementation of voluntary accreditation standards for pharmacy practice sites. Although CPPA's initial focus will be community pharmacy settings, CPPA anticipates the development of accreditation standards for other pharmacy practice settings. In addition, the Section of Inpatient Care Practitioners (SICP) is exploring the development of essential medication safety measures, and ASHP Foundation is developing a patient complexity index.

Recommendation: Jennifer Tryon, Ian Doyle, and Kate Farthing (OR)

ASHP should develop a statement on the roles of pharmacy team members (technicians, students, interns, etc.) in medication reconciliation.

In 2012, the ASHP House of Delegates approved the ASHP Statement on the Pharmacist’s Role in Medication Reconciliation. Although the statement mainly addresses the pharmacist's role in medication reconciliation, roles of technicians and others are also included. The Council on Pharmacy practice considered the statement and the recommendation at its September meeting and, in light of evidence supporting the recommendation, voted to develop a separate statement that focuses specifically on a standardized approach to including pharmacy technicians, students, and residents in the medication reconciliation process. The Council referred development of the document to the Pharmacy Student Forum and New Practitioners Forum, and requested follow-up at the 2013–2014 Council Meeting. ASHP is also engaged in a number of activities that promote optimal deployment of other qualified pharmacy staff, including technicians, students, and residents in transitions of care, including medication reconciliation roles.

Recommendation: Dale English II (OH)

ASHP should work with all other interested stakeholders to provide appropriate and accurate information to the general public about their specific rights as patients and the professional obligation of pharmacists to provide them with education about their medications.

ASHP policy supports the recommender’s views on this topic. ASHP will continue to advocate these policies when opportunities present themselves, through media outreach and other outreach to consumers and consumer groups. In addition, this policy is often a subject in meetings with community and chain pharmacy organizations.

Recommendation: Jennifer Schultz (SICP)

ASHP should pursue the creation of grants to support nontraditional residency programs and provide a toolkit that demonstrates components of successful nontraditional programs.

Although ASHP would like to see grants created to help nontraditional residency programs, ASHP is the accrediting body and therefore cannot directly seek grants to help ASHP-accredited programs. The recommendation has been shared with the ASHP Foundation, as only they can seek and award grants related to residencies. Regarding the request for toolkits for successful nontraditional programs, ASHP is exploring whether some of the programs can provide input for creating such a toolkit. Because each of these programs is usually uniquely suited to its site and particular situation, there is not necessarily a one-size-fits-all template for nontraditional programs. These programs are also often short-lived for many organizations, yet they cannot see what works until after 2–3 years of running the programs, making the suggestion even more challenging. ASHP has included nontraditional programs in educational sessions at the [National Residency Preceptors Conferences](#) and the 2012 Summer Meeting, as well as with articles in *AJHP* to share the variety of ways individuals have approached nontraditional residencies. More programming is being planned around this topic at future ASHP meetings. Programs have been encouraged to submit proposals and management case studies on the topic.

Recommendation: Jennifer Schultz (SICP), Steve Rough (WI), and Lynn Eschenbacher (NC)

ASHP should develop a strategy in the form of a toolkit to assist pharmacy leaders in achieving pharmacist credentialing as providers within the medical staff as allowed by the new CMS language.

This recommendation is very timely, as ASHP and its members implement the opportunity to make full use of expanded allowance for practitioner credentialing under the Medicare and Medicaid Programs Reform of Hospital and Critical Access Hospital Conditions of Participation. The Council on Education and Workforce Development discussed the idea for ASHP guidelines on pharmacist privileging and credentialing at its September meeting. They noted that the Council on Credentialing in Pharmacy (CCP) is developing a document on the topic and concluded that ASHP, being a founding member of CCP, will likely endorse the new guidance document. The Council concluded that two very similar documents are not needed, and that resources could be better spent on education and other ways to implement these systems. They recommended that ASHP not initiate development of its own guidelines at this time but were willing to reconsider after reviewing the CCP document. In addition, the ASHP Foundation has a grant to develop tools for health-system pharmacy leaders in working with the C-suite and they have agreed to include this recommendation as part of the charge to expert panel.

Recommendation: Jennifer Schultz (SICP), Steve Rough (WI), and Lynn Eschenbacher (NC)

ASHP should assist state affiliates with strategies for improving relationships and influence with state boards of pharmacy to support practice advancement initiatives.

ASHP has a close liaison relationship with the leadership of the National Association of Boards of Pharmacy (NABP). In addition, ASHP sponsors a meeting of health-system pharmacists who serve on individual state boards of pharmacy during the MCM. Moreover, ASHP staff attend the annual NABP meeting and will be making presentations at a number of upcoming NABP District meetings. ASHP has existing policy 0518 (below) that addresses the funding, expertise, and oversight of state Boards of Pharmacy. As recently adopted policies will require advocacy before state boards, policy 0518 provides the overall direction to ASHP to support state affiliates to advocate for these practice advancement initiatives. ASHP also provides ongoing support and strategic direction to state affiliates on legislative and regulatory matters under consideration in a particular state.

0518, Funding, Expertise, and Oversight of State Boards of Pharmacy

To advocate appropriate oversight of pharmacy practice (including nontraditional practice) and the pharmaceutical supply chain by state boards of pharmacy and other state agencies whose mission it is to

protect the public health; further,

To advocate adequate representation on state boards of pharmacy and related agencies by pharmacists who are knowledgeable about hospitals and health systems to ensure appropriate oversight of hospital and health-system pharmacy practice; further,

To advocate adequate funding for state boards of pharmacy and related agencies to ensure the effective oversight and regulation of pharmacy practice and the pharmaceutical supply chain.

Recommendation: Ken Jozefczyk, Pat Knowles, and Megan Freeman (GA)

ASHP should oppose displacement of regulatory and enforcement authority away from state boards of pharmacy.

ASHP's existing policy 0518 (see above) addresses the importance of state boards of pharmacy and representation of health-system pharmacists on these boards to ensure appropriate oversight of the profession. ASHP has used policy 0518 and its predecessors to assist state affiliates in advocating for the autonomy of state pharmacy boards and opposing its consolidation into a "super board" that regulates other health professions and will continue to do so.

Recommendation: James Hoffman (TN)

ASHP should implement a strategy to communicate and collaborate with national and state hospital associations to increase hospital leaders' understanding of contemporary pharmacy services.

ASHP has well-established relationships with national hospital associations, including AHA, NRHA, HIMSS, and ACHE. ASHP routinely works with these organizations on professional and advocacy issues. For example, ASHP and AHA regularly discuss proposed and final rules as well as guidance documents to align positions before commenting. In addition, ASHP recently worked with AHA very closely on the drug shortages issue with Congress, with numerous joint Capitol Hill and FDA visits, as well as a joint press conference and several joint ads in local DC press. ASHP also has a representative on the AHA Committee on Health Professions. In addition, each year we have ASHP representation at HIMSS and NRHA meetings. More recently, ASHP and Section leaders have worked to provide presentations at the annual ACHE conference on pharmacy-related issues and the value of pharmacy and pharmacists. The Section of Pharmacy Practice Managers has as a primary goal to present at this meeting each year, with this past year being the third time. Part of this goal is to develop guidance and template tools the Section can share with ASHP and ASHP affiliate leaders to use at the state level with these national organizations' affiliates. In addition, communications and efforts of education and outreach to organizations such as AHA, ACHE, and NRHA are included and tracked for report to the ASHP Board as a tactic for promoting health system pharmacy.

Recommendation: Katherine Palmer (NPF)

ASHP should encourage and facilitate new practitioners to consider practice in small and rural hospitals to help ensure access to direct pharmacist patient care.

The New Practitioners Forum and Section of Inpatient Care Practitioners executive committees have initiated discussion on ways to get new practitioners engaged in small and rural practice settings. ASHP will begin promotion of existing federally funded programs that offer repayment programs as incentives for pharmacy practitioners to go to rural settings as well as Section-generated resources such as *AJHP* articles and a web-based resource center.

Recommendation: Carrie Sincak (on behalf of IL delegation)

ASHP should establish a turnkey training program that all pharmacy practice settings can purchase and implement to achieve accreditation at their own practice sites, when technician training accreditation transition to the Accreditation Council for Pharmacy Education (ACPE) has occurred.

Because ASHP is the accrediting body for pharmacy technician training programs, we are not permitted to develop and market an accredited training program that would compete with those we accredit. Should ASHP not be the accrediting body for technician training programs in the future, it is likely that we would evaluate developing such a program and consider offering it to practice sites.

Recommendation: Dale English II (OH)

ASHP should continue to identify areas of inefficiency and to maximize efficiencies in the current structure, process, function and execution of the ASHP House of Delegates and its associated activities.

The ASHP Task Force on Organizational Structure will be reviewing and making recommendations on improvements to the entire ASHP policy development process, including the House of Delegates. The recommendation has been shared with the Task Force.

Recommendation: Lisa Scherkenbach (PSF)

In consideration of the significant growth in ASHP student membership, ASHP should ensure sufficient representation on any and all existing and future decision-making entities within ASHP as appropriate.

ASHP views involving students as vital to our success, and we are constantly looking for new ways to involve students in key activities. The vast majority of ASHP's committees, for example, include a student representative, as do many of our ad hoc committees. Although the new Task Force on Organizational Structure does not include a student representative, it does include a number of new practitioners, some of whom were recent student leaders within ASHP. The Task Force's work will continue for 17 months, and we were concerned that most third- and fourth-year students would not have the time to participate in such an intensive, 17-month-long activity, and many would have graduated before the Task Force concluded its work. In addition, we felt that the charge of this particular task force lent itself to including members who could reflect on a few years of experience as participants in ASHP's organizational structure, governance, and policy development process, which is why recent Pharmacy Student Forum Executive Committee members (now new practitioners) were included. There will be many opportunities for ASHP members to make suggestions to and review the work of the Task Force, and we will especially be reaching out to ASHP sections and forums. The Chair of the Task Force recognizes that input from students will be vital to the success of the Task Force, and that input will be given every consideration.

Recommendation: John Pastor, Paul Krogh, and Shane Madsen (MN)

ASHP should, as part of the Pharmacy Practice Model Initiative (PPMI), develop and provide specific tools for pharmacists to improve their ability to effectively supervise technicians.

This topic was discussed by the Council on Education and Workforce Development at its September meeting (see the "Other Council Activity" section of the Council's Board report).

Recommendation: Diane Fox (TX)

ASHP should develop an application for tablet computers containing all information for the House of Delegates so that it is easily downloaded and updated.

ASHP will continue to provide House of Delegates-related information via the House of Delegates section of the ASHP website, ASHP Connect, and the Summer Meeting application. In addition, we will also share this recommendation with the ASHP Task Force on Organizational Structure, which will be reviewing and making recommendations on ASHP's membership structure and the ASHP policy development process.

Recommendation: Paul Driver (ID)

ASHP should review existing ASHP policies on immunization and vaccination (policies 0213, 0601, 0615) for consolidation into the new policy (Council on Public Policy: G. Standardized Immunization Authority to Improve Public Health).

The Council on Public Policy reviewed the four policies ([0601](#), [0615](#), [1220](#), and [0213](#)) at its September meeting to consider consolidating them. The Council believed and the Board concurred that combining all four would dilute the impact of the policies. Instead, the Council identified two policies (1220 and 0213) that related to promotion and administration of vaccines, and two others (0601 and 0615) that related to the importance of the influenza vaccine. The Council combined ASHP policies 1220 and 0213 (see Policy Recommendation C in the Council's Board report) and suggested that the Council on Therapeutics and the Council on Pharmacy Practice combine policies 0601 and 0615 and consider specific revisions; those councils will consider those suggestions at their meetings in September 2013.

Recommendation: Kerry Haney and Melanie Townsend (MT)

ASHP should support regulations to limit PBM auditing practices in outpatient pharmacies, as have other national pharmacy organizations (APhA, NCPA) and several state associations.

The Council on Public Policy discussed this issue at its September meeting (see the "Other Council Activity" section of the Council's Board report). The Council concluded that more discussion with other pharmacy organizations is needed to determine the proper role and interests of ASHP in advocacy on the issue.

Recommendation: Brian Marden (ME)

ASHP should consider a change in its name, with resulting changes in scope of mission and vision, from the American Society of Health-System Pharmacists to the American Society of Health-System Pharmacy.

This recommendation was shared with the ASHP Task Force on Organizational Structure, which will be reviewing ASHP's membership structure, governance, and policy process.

Recommendation: Brian Marden (ME)

ASHP should consider revisions to [policy 0305](#) with the intent of advocating for mandatory inclusion of therapeutic purpose with all medication orders and prescriptions.

The Council on Pharmacy Practice considered this recommendation at its September meeting (see the “Other Council Activity” section of the Council’s Board report). Although the Council agreed that inclusion of indication would facilitate counseling in outpatient settings and improve patient safety, they concluded that mandating this practice would not be likely to achieve the intent of the policy. The Council also noted that there is no standard for information systems for translation of medical terms to layman’s terms for labeling prescription containers, although the Section of Pharmacy Informatics and Technology is advocating for such standards. The Council therefore recommended that the current policy be reaffirmed, and the Board agreed.

Recommendation: Melinda Thom Burnworth and Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID)

ASHP should develop policy to actively pursue legislative changes in the Social Security Act to require CMS to recognize pharmacists as nonphysician practitioners (providers of patient care) with authority to bill Medicare directly for compensation of clinical services in any health-system setting. Further, ASHP should pursue changes in other federal, state, and third-party payment programs to achieve similar recognition.

The Council on Public Policy discussed this recommendation at its meeting in September and developed policy (see Policy Recommendation A in the Council’s Board report). Provider status will be ASHP’s top advocacy priority for the foreseeable future.

Recommendation: Christina Rivers (on behalf of IL delegation)

ASHP should continue and accelerate discussions with ACPE to move the Technician Training Accreditation program to ACPE so that all pharmacy-related education accreditation is housed within ACPE.

ASHP recognizes the importance of accreditation of pharmacy technician training programs and the role we play in that process. ASHP will continue to engage in constructive dialogue with the Accreditation Council for Pharmacy Education (ACPE) on pharmacy technician training, among other vital issues. Although it is not possible to predict which organization will ultimately have primary authority over and responsibility for pharmacy technician accreditation, we understand and appreciate the intent of this recommendation and will take it into consideration as we work with ACPE.

Recommendation: Lynn Eschenbacher (NC, SICP)

ASHP should re-examine the 2002 Summit on Measuring Medication Safety with recent technological advances and just culture to develop a consensus statement of two or three national medication safety metrics to demonstrate safety in hospitals.

The development of meaningful metrics for medication safety has been a challenge for the various initiatives on this topic. The Council on Pharmacy Practice reviewed several proposed measures at its September meeting (see the “Other Council Activity” section of the Council’s Board report) but could not develop a proposed consensus statement within the constraints of its meeting.

Recommendation: Jason Strow (WV)

ASHP should consider updating its policies concerning controlled substances to reflect the availability and appropriate use of controlled-substance prescription databases.

In 2011, the House adopted policy 1122, State Prescription Drug Monitoring Programs, which reads:

- To advocate for uniform state prescription drug monitoring programs that collect standard information about controlled substances prescriptions; further,
- To advocate that the design of these programs should balance the need for appropriate therapeutic management with safeguards against fraud, misuse, abuse, and diversion; further,
- To advocate that such programs be structured as part of electronic health records and exchanges to allow prescribers, pharmacists, and other practitioners to proactively monitor data for appropriate assessment; further,
- To advocate for interstate integration to allow for access by prescribers, pharmacists, and other practitioners across state lines; further,
- To advocate for federal and state funding to establish and administer these programs.

This policy will be sunset-reviewed by the Council on Public Policy in 2015, or earlier if circumstances warrant.

Recommendation: Jason Strow (WV)

ASHP should create a Section Advisory Group for Inpatient Rehabilitation Facilities (IRFs) to facilitate best practice development and advocacy for pharmacists practicing in this setting.

Section advisory groups fall under the purview of the executive committees of ASHP sections. These groups are typically created when a critical mass of members demonstrate they are representative of an emerging practice area or a practice-related issue surfaces that has a major impact on a particular group of practitioners. The recommendation was submitted to the Section of Inpatient Care Practitioner's Executive Committee, which considered the suggestion at its December meeting and declined to form such a group at this time.

Recommendation: Melinda Throm Burnworth and Carol Rollins (AZ, with CA, NM, MI, NC, NE, and ID)

ASHP should investigate opportunities to further strengthen available literature that supports the proven value of pharmacists as providers and to educate and assist pharmacists in their efforts to continue to strengthen available literature to receive compensation for patient-care services.

ASHP is actively advocating for changes in the Social Security Act to recognize pharmacists as nonphysician practitioners. That advocacy requires ASHP to educate policymakers about the value that pharmacists provide to improving patient outcomes. In 2013 alone, the ASHP Research and Education Foundation will offer \$350,000 to support research that focuses on advancing patient care and pharmacy practice. In addition, the Foundation provides extensive web-based and live programs to support new investigators striving to undertake practice-based research.

Recommendation: John Hertig and Daniel Degnan (IN)

ASHP should further explore and endorse a credential that deems a pharmacist an expert in the field of medication safety.

The Council on Education and Workforce Development discussed this topic at its meeting in September (see the "Other Council Activity" section of the Council's Board report). The Council concluded that medication safety is too new and evolving to have a specialty credential at this time.

Recommendation: Steve Novak (NC)

ASHP should expand, update, and improve accessibility of its current website resource offerings under the Pharmacy Practice Managers Section, and then formalize and maintain those as an ASHP resource center for revenue cycle compliance and financial management.

Financial management education and resources are important areas of focus for ASHP and the Section of Pharmacy Practice Managers (SPPM). SPPM has two advisory groups specifically on the business management of pharmacy and the associated quality and compliance aspects. ASHP's web resource center on reimbursement and financial management did not receive much traffic and was difficult to maintain. ASHP and SPPM have continued to provide a portfolio of regular education, advocacy, publications, news reports, and web resources related to this critical area for pharmacy leaders, including:

- 1) The [SPPM website](#) has a number of resources and a financial self-assessment tool.
- 2) Each year the [Conference for Leaders in Health-System Pharmacy](#) has components based on financial management.
- 3) The ASHP publication, [Financial Management for Health-System Pharmacists](#).
- 4) One of SPPM's advisory group members created a podcast: [JW Modifiers: A model for automating compliance documentation](#).
- 5) For the past 3 years at the MCM, ASHP has conducted an IPPS/HOPPS update session.
- 6) SPPM will continue to identify products and services to be developed by and for our members and seek to provide more streamlined methods to routinely share those with ASHP members.

Recommendation: Steve Novak (NC)

ASHP should work with the Drug Enforcement Administration (DEA) to seek revisions in the Controlled Substance Act to develop regulations for health-system central-fill pharmacies that enable centralized repackaging, dispensing, or distribution of all controlled substances to hospitals within a system and do not require registration of hospital or health-system pharmacies as manufacturers.

ASHP's existing policy 9813, [Regulation of Automated Drug Distribution Systems](#), provides sufficient direction to ASHP to approach the DEA to seek the agency's assistance in more fully utilizing central fill pharmacies within a health system without registering as a manufacturer. ASHP will continue to advocate this policy to the DEA.

Recommendation: Brian O’Neal (KN)

ASHP should create ASHP guidelines for controlled substance diversion prevention and detection.

The Council on Pharmacy Practice voted to develop guidelines on detecting and preventing controlled substance diversion in hospitals and health systems at its September meeting (see the “Other Council Activity” section of the Board Report).

Recommendation: Julie Lenhart (CA)

ASHP should review policy 0710 for its continued relevance, and, to specifically expand the section on education to include medications (e.g., over-the-counter [OTC] medications and dietary supplements) that may impact doping control results.

The Council on Pharmacy Practice discussed this recommendation at its September meeting and incorporated this recommendation into a revised policy recommendation (see Policy Recommendation A in the Council’s Board report).

Recommendation: Ernest Dole (NM)

ASHP should develop policy that advocates for accountability by third-party payers for delay in therapy.

The Council on Public Policy discussed this recommendation at its September meeting and concluded that policy 1206, [Payment Authorization and Verification Processes](#), adequately addresses the issue. The Council recommended that the impact of policy 1206 be monitored by ASHP staff and that ASHP consider collaboration with other stakeholders (e.g., Academy of Managed Care Pharmacy) to improve processes and decrease or avoid delays in therapy.

Recommendation: Jeanne Ezell (TN)

ASHP should develop a model technician training program curriculum to provide easier access to affordable training throughout the country.

ASHP developed a [Model Curriculum for Pharmacy Technician Training](#) in 1996 and published a second edition published in 2001. ASHP is currently revising both the accreditation standards for pharmacy technician training programs and the model curriculum. The current format for the model curriculum is a list of learning objectives for the training program. We are evaluating other formats for the revision, and these changes might address the suggestions made in the recommendation.

Recommendation: Jeanne Ezell (TN)

ASHP should implement a leadership development program for technicians focused on management skills needed to fulfill the role of pharmacy operations manager.

This recommendation is consistent with a number of activities ASHP and the ASHP Foundation have in motion. The future of health-system pharmacy practice is dependent on the continued development and expansion of roles of well-educated and trained technicians. ASHP has a number of efforts supporting this vision through the [Pharmacy Practice Model Initiative](#) (PPMI) and the [Pharmacy Technician Initiative](#). For example, one of the PPMI National Dashboard objectives measures the percentage of hospitals and health systems utilizing pharmacy technicians in three or more nontraditional or advanced responsibilities or activities.

In addition, both the Section of Inpatient Care Practitioners and the Section of Pharmacy Practice Managers have advisory groups that have technicians’ development and role advancement as part of their activities. A joint project of the two groups is publishing *AJHP Management Consultation* columns on leadership development of technicians, which is running parallel to efforts to share regular case studies on how pharmacies have expanded the roles of technicians. The first of these columns, addressing developing pharmacy technicians across the leadership spectrum, was published in the December 1, 2012 edition of *AJHP* (Thompson J, Swarthout MD. Developing pharmacy technicians across the leadership spectrum. *Am J Health-Syst Pharm.* 2012;69:2040-2. [doi:10.2146/ajhp120124]). In August ASHP presented a [webinar](#) on tech-check-tech case studies and other technician-related topics. The section executive committees and the ASHP Foundation will continue to develop tools and resources to support pharmacy leaders and technicians in their efforts to advance technician practice and leadership skills.

Recommendation: James Rinehart (IN) and Kathy Donley (OH)

ASHP should expand upon the Council on Pharmacy Management’s support of uniform workload and productivity measures and establish a minimum of three such measures by the time of the 2014 ASHP Summer Meeting.

Since a two-part white paper on the topic was published in *AJHP* (2010; 67:300-11 and 380-8), more resources have been made available on the Section of Pharmacy Practice Managers (SPPM) [Practices Resources web page](#). ASHP and SPPM continue to address this issue through resource development and advocacy.

Recommendation: Patricia Kienle (PA) and Natasha Nicole (SC)

ASHP should develop an appropriate component group to represent health-system medication safety leaders of all disciplines.

This recommendation was shared with the ASHP Task Force on Organizational Structure, which is charged with reviewing and making recommendations on ASHP's membership structure, governance, and policy process.

Recommendation: Bonnie Kirschenbaum (CO)

ASHP should continue to fund its REMS Resource Center and keep it updated at least on a monthly basis.

In January 2012, ASHP staff and member volunteers refreshed and updated the [REMS Resource Center](#) to ensure that each drug with a REMS appeared on the website with accurate information about each drug's REMS requirements. ASHP staff continues to maintain the REMS Resource Center by ensuring that drugs that are taken off REMS are removed. ASHP is considering hiring an outside contractor to help keep the Resource Center up to date. In addition, ASHP staff is developing a database to simplify the manner in which the updates are applied to the Resource Center. ASHP staff also regularly communicates with FDA staff on REMS-related requirements.