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Report of the House of Delegates June 1 and 3, 1998

HENRI R. MANASSE, JR., SECRETARY

The 49th annual session of the ASHP House of Delegates was held at the Baltimore Convention Center, in conjunction with Annual Meeting '98.

First meeting

The first meeting was convened at 3 p.m., Monday, June 1, by Chair of the House of Delegates Steven L. Sheaffer. President-elect Bruce R. Canaday gave the invocation. The House observed a moment of silence in memory of Past President Paul F. Parker. Chair Sheaffer announced that Joy Myers would serve as parliamentarian.

Chair Sheaffer 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 health systems. He reviewed the general procedures and processes for the House of Delegates.

The roll of official delegates was called. A quorum was present, including 189 voting delegates representing 50 states, student delegates, officers and members of the Board of Directors, and past presidents of ASHP. Four fraternal delegates representing government services were also present. Chair Sheaffer pointed out that fraternal delegates have the privilege of the floor, which includes participating in discussion and debate, introducing amendments and motions, and making Recommendations. In addition, Chair Sheaffer introduced Celeste M. Lindley, Chair, ASHP Section of Clinical Specialists, and J. Scott Reid, Chair, ASHP Section of Home Care Practitioners. Chair Sheaffer explained that the section chairs sit in the House as observers and have the privilege of the floor but do not vote.

Chair Sheaffer reminded delegates that the report of the 48th annual session of the ASHP House of Delegates had been published in the August 15, 1997, issue of the *American Journal of Health-System Pharmacy* (*AJHP*). Delegates had been advised earlier to review this report. The proceedings of the 48th House of Delegates session were received without objection.

Board Chair John E. Murphy presented the preliminary report on Resolutions.[a] The report, which had been distributed to dele-

This report is an abstract of the proceedings of the House of Delegates session. An audiotape recording of the complete session is filed at ASHP headquarters.

Delegates to the 1998 Session of the House

Officers of the House
Steven L. Sheaffer, *Chair*
Sara J. White, *Vice Chair*
Henri R. Manasse, Jr., *Secretary*

Officers and Board of Directors
John E. Murphy, *President*
Bruce R. Canaday, *President-elect*
Henri R. Manasse, Jr., *Executive Vice President*
Sara J. White, *Immediate Past President*
David A. Zilz, *Treasurer*
Bruce E. Scott
Lois M. Nash
Marcia B. Gutfeld
Donald T. Kishi
Jane S. Henry
Michael E. Melby

Past Presidents
Paul W. Abramowitz
Roger W. Anderson
R. David Anderson
R. Paul Baumgartner
Joseph H. Beckerman
Donald F. Beste, Jr.
Herbert S. Carlin
Fred M. Eckel
Rebecca S. Finley
John A. Gans
Harold N. Godwin
Clifford E. Hynniman
Marianne F. Ivey[a]
Herman L. Lazarus
Carl D. Lyons
James C. McAllister III
Philip J. Schneider
Thomas S. Thielke

State Delegates[b]
Alabama (3)
- B. Tom Alford
- David E. Griffies
- Bill Stephenson

Alaska (2)
- Earl D. Ward, Jr.
- Robert P. Young

Arizona (3)
- Thomas Batik
- Victor A. Elsberry
- Steven R. Spravzoff

Arkansas (3)
- Jo Ellen Austin
- Teresa Hudson
- Don F. Johnson

California (8)
- Sian Carr-Lopez
- Fran Hopkins
- Jody Jacobson
- Steve Litsey
- Teresa Ann Miller
- Max D. Ray
- Kenneth H. Schell
- Sam Shimomura

Colorado (3)
- Larry C. Clark
- Martha T. Connell
- Paul N. Limberis

Connecticut (3)
- Steve Burke
- Richard Lisitano
- Kathleen Spooner

Delaware (2)
- Sandra Robinson
- Ann M. Rule

District of Columbia (2)
- Scott Mark
- Douglas J. Scheckelhoff

Florida (5)
- Deborah Brown
- John Clark
- Carsten Evans
- Sarah Hayes
- Phil Johnson

Georgia (4)
- Ray Maddox
- Marjorie Phillips
- Michael Schlesselman
- Mitch Wood

Hawaii (2)

Idaho (2)
- Shawna Kittridge
- Leo Nickasch

Illinois (5)
- Caryn Bing[c]
- Kevin J. Colgan
- Andrew J. Donnelly
- James V. Dorociak
- Steve Marx[a]
- Janet Teeters

Indiana (3)
- Jennifer S. McComb
- Eugene Pfiefer
- Michael Sievers

Iowa (3)
- Bill Baer
- Allen Fann
- John Placko

Kansas (3)
- Joe C. Choi
- Philip J. Schneider
- T. Mark Woods

Kentucky (3)
- Jacquelyn M. Burrell
- Max L. Hunt, Jr.
- Don Kuiper

Louisiana (3)
- Malcolm Broussard
- Helen Calmes
- Charles Jastram

Maine (2)
- Joe McVety
- Kathleen Rybarz

Maryland (4)
- Joseph Botticelli[a]
- Kathrin C. Kucharski
- David Moore
- Bonnie Pitt
- Deborah Thorn[c]

Massachusetts (4)
- Sylvia Bartel
- Frank Federico[a]
- Kathleen Gura
- Mark Kaplan

Michigan (4)
- Mary E. Burkhardt[c]
- Mark Isopi
- David Kalis[a]
- Mary Reed
- Randolph Schad

Minnesota (3)
- David W. Fuhs
- Bonnie Senst
- Richard Stambaugh

Mississippi (2)
- Kristie Gholson
- John A. McGowan

Missouri (3)
- Rebecca Coley
- Bonnie Grabowski
- Douglas Lang

Montana (2)
- Randy Kuiper
- Dean Mikes

Nebraska (3)
- Kurt E. Clyne
- James P. Goulet
- Donna Soflin

Nevada (2)
- William Duskin
- William Vanderpool

New Hampshire (2)
- Dennis J. Gerber[a]
- David Lacoste[c]
- Edward Rippe

New Jersey (4)
- Catherine L. Hansen
- Eric T. Hola
- Mark Kana
- Henry Lubinski

New Mexico (3)
- Amy Buesing
- Ernest J. Dole
- Michael Dutro

New York (5)
- Mary Andritz
- Nancy DiLiegro
- Thomas Lombardi[c]
- Harvey Maldow[a]
- Timothy Mirando
- Thomas E. O'Brien

North Carolina (4)
- William Lee Harris
- Julienne K. Kirk
- Stephen Novak
- Dennis M. Williams

North Dakota (2)
- Mary Lee Clarens
- Dorothy J. Sander

Ohio (5)
- Ann D. Abele
- Kathleen D. Donley
- Jill E. Martin
- Paul J. Mosko
- Robert M. Parsons

Oklahoma (3)
- Luke L. Nigliazzo, Jr.
- Barbara M. Poe
- Michele Splinter

Oregon (3)
- Mike Canton
- Charles McGinley
- Therese M. Wavrin

Pennsylvania (5)
- Ruth A. Brown
- Janice Dunsavage[c]
- Vicki Eliott[a]
- Patricia Kienle
- Gerald Meyer
- Terry Schwinghammer

Rhode Island (2)
- Christine M. Berard
- Marlene Ritualo

South Carolina (3)
- Jim Hammett
- Keith Linse
- Rhonda McManus

South Dakota (2)
- Debra Dees
- Tim Page

Tennessee (3)
- Robert A. Cates
- Paula Hinson
- Sheila Mitchell

Texas (5)
- Teri L. Bair
- Sharon A. Bronson
- Lourdes Cuellar[a]
- Diane B. Ginsburg
- Roland Patry
- William H. Puckett[c]

Utah (2)
- Tina Aramaki
- Mark A. Balk

Vermont (2)
- Amy Yatsco

Virginia (4)
- Jody H. Allen
- Lee Brower
- Fred Chatelain
- Rawley Guerrero

Washington (3)
- Craig Biggs
- Susan Teil Boyer
- John P. Swenson

West Virginia (3)
- Dan Degnan
- Gwendolyn S. Gill
- Dan Hackett

Wisconsin (3)
- Lynnae Mahaney
- Pamela A. Ploetz
- Tom Woller

Wyoming (2)
- Kathryn Boname
- Linda Sutherland

Student Delegates
Kristine Khuc
Heather Kwitowski

Fraternal Delegates
Air Force
- Captain Mike Evans

Army
- Colonel Errol Moran

Department of Veterans Affairs
- Andrew Muniz

U.S. Public Health Service
- Rear Admiral Fred G. Paavola

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[a]Attended second meeting only.
[b]Number in parentheses
[c]Attended first meeting only.

gates before the Annual Meeting, consisted of two Resolutions. The first Resolution, from Dennis M. Williams and Stephen R. Novak, was titled "Collaborative Drug Therapy Management Activities." The second Resolution, from Kristine Marcus and Charles McGinley, was titled "Conscientious Objection by Pharmacists to Morally, Religiously, or Ethically Troubling Therapies."

Chair Sheaffer called on Douglas Lang for the report of the Committee on Nominations.[b] Nominees were presented as follows:

President-elect

Lois M. Nash, M.S., Houston, Texas, Pharmacy Services Director, Methodist Hospital and Community Health Centers

Bruce E. Scott, M.S., FASHP, St. Paul, Minnesota, Vice President of Pharmacy Operations, Allina Health System

Board of Directors (1999–2002)

Bonnie E. Kirschenbaum, M.S., FASHP, Santa Monica, California, Healthcare Consultant

Hetty A. Lima, FASHP, Mt. Prospect, Illinois, Regional Vice President, Coram Healthcare

Sam K. Shimomura, Pharm.D., FASHP, Pomona, California, Professor of Pharmacy Practice and Facilitative Officer for Professional Practice, College of Pharmacy, Western University of Health Sciences

T. Mark Woods, Pharm.D., Kansas City, Missouri, Interim Director of Pharmacy, Saint Luke's Hospital, Inc.

Chair, House of Delegates

Paul K. Mosko, M.S., Dayton Ohio, Director of Pharmacy, Good Samaritan Hospital

Steven L. Sheaffer, Pharm.D., FASHP, Philadelphia, Pennsylvania, Director of Pharmacy, Mercy Fitzgerald Hospital

A "Meet the Candidates" session to be held on Wednesday, June 3, was announced.

Chair Sheaffer called on Board Chair Murphy to present the Board's candidates for the office of Treasurer. Nominees were presented as follows: Jane S. Henry, M.B.A., FASHP, Director of Pharmacy Services, Olathe, Kansas, Olathe Medical Center, and David A. Zilz, M.S., Madison, Wisconsin, Senior Consultant, University of Wisconsin Health, Corporate Pharmacy Programs, and Emeritus Clinical Professor, UW College of Pharmacy.

Chair of the Board. President Murphy summarized his report to the House, which had previously been distributed to delegates. (The complete report presented to the House is included in these proceedings.) There was no discussion, and the delegates voted to accept the report of the President and Chair of the Board.

Treasurer. David A. Zilz presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer's report.

Executive Vice President. Henri R. Manasse, Jr., presented the report of the Executive Vice President. He supplemented his report with brief comments on some of its elements. He expressed his thanks to the Board of Directors and ASHP staff for making the past year a seamless transition. He especially acknowledged the role that Joseph A. Oddis played in making the change in leadership so successful. He discussed the July 1997 and February 1998 retreats with the Board of Directors, the development of an ASHP staff credo, his visits to a number of affiliated state societies, staff efforts for member services related to all aspects of the continuum of care, the development of "dashboard indicators" for monitoring organizational performance, plans for an enhanced public relations program, strong and aggressive advocacy for the skills of pharmacists as medication-use experts, ASHP's work on legislation that affects health-system pharmacy, enhancing strategic partnerships with nonpharmacy associations, continuing dialogue with the president of the Pharmaceutical Research and Manufacturers of America, and collaborative ties with the Pharmacy Technician Certification Board.

Recommendations. Chair Sheaffer called on members of the House of Delegates for Recommendations. (The name and state of the delegate who introduced the item and the subject of the item precede each Recommendation.)

Contribute to ASHP Policy

An overview of ASHP's policy-development process, including opportunities for member input, was published in the May 15, 1998, issue of *AJHP* (pages 1044–9).

Ray R. Maddox (GA): Preference for "pharmacist" versus "druggist"

Recommendation: The Georgia delegation recommends that ASHP, in conjunction with its fellow members of the Joint Commission of Pharmacy Practitioners (JCPP), develop a mechanism to inform and encourage the print and electronic media to use the preferred term "pharmacist" and refrain from use of the term "druggist" when referring to health care practitioners in the profession of pharmacy. We further recommend that ASHP independently pursue this objective if JCPP is unable to develop collaborative effort in this regard.

Background: We believe the title "druggist" is an outdated term that links pharmacists to a product-oriented image. For some pharmacists, the title "druggist" has a negative connotation. A recent search of the print media reveals that "pharmacist" is used more frequently but that "druggist" is still very commonly used. ASHP and JCPP can facilitate a change by actively suggesting the use of "pharmacist" when briefing reporters and providing material for the print media.

Rawley M. Guerrero (VA): Manufacturer-sponsored patient-assistance programs

Recommendation: That ASHP develop guidelines for appropriate administration by pharmacists of patient access to manufacturer-sponsored patient-assistance programs. Those guidelines should also help manufacturers develop appropriate criteria for patient eligibility.

Background: ASHP policy 9703 recommended that ASHP work with manufacturers to modify assistance programs to improve access on behalf of patients. Subsequently, a Wisconsin delegate to the 1997 House recommended that ASHP encourage manufacturers to standardize criteria and processes for patient-assistance programs. Manufacturers' eligibility requirements are often onerous and have the effects of limiting access to the programs and limiting the role of the pharmacist as a patient advocate and facilitator for obtaining medication. Presumably, manufacturers' eligibility requirements are designed to prevent misuse of medications obtained through assistance programs. But manufacturers' programs do not take into account federal and state programs that cover prescription drugs for indigent or uninsured patients. Manufacturers' criteria often include patients who are eligible for Medicaid and exclude those who are not covered by public programs but cannot afford the necessary medications.

ASHP development of appropriate guidelines for pharmacists to use to facilitate access on behalf of eligible patients could help streamline the process, procedures, and requirements. Such guidelines could also help manufacturers modify their eligibility requirements to ensure that the intent of their programs is more efficiently and effectively met.

Suggested outcome: Development of ASHP guidelines for use of manufacturer-sponsored patient-assistance programs.

Chair Sheaffer announced that Recommendations would be referred to the appropriate ASHP bodies and staff for study and appropriate action.

Council reports. (Note: The complete council reports were published in the April 1, 1998, issue of *AJHP* and are not duplicated in these proceedings. For background on the council policy recommendations approved by the House, and for information on other council activities, refer to pages 690–718 of the April 1 issue of *AJHP*.)

Chair Sheaffer announced that each council's recommended policies would be introduced as a block. He further advised the House that any delegate may raise questions and discussion without having to "divide the question," and that the need to "divide the question" is relevant only when a delegate desires to amend a specific proposal or to take an action on one proposal separately from the rest of the recommendations.

Bruce E. Scott, Board Liaison to the Council on Administrative Affairs, presented the council's policy recommendations A through I. It was moved, seconded, and approved to divide the question for considering Policy Recommendation D. It was then moved and seconded to amend Policy Recommendation D by adding the words "or prescriptions" after the words "entry of medication orders." There was no discussion, and the amendment was approved. Policy Recommendation D, as amended, was then moved, seconded, and adopted. It now reads as follows:

D. Electronic entry of medication orders

To revise ASHP policy 9402 as follows (words to be added are italicized):

> To support, as the preferred method of prescribing, direct electronic entry of medication orders *or prescriptions* by the prescriber, with provisions for the pharmacist to review and verify the order's appropriateness *before medication administration, except in those instances when review would cause a medically unacceptable delay.*

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for considering Policy Recommendation E. It was then moved and seconded to amend Policy Recommendation E by adding the words "and enhancement" in the first paragraph after the words "maintenance" and deleting the word "and" before the word "maintenance." There was no discussion, and the amendment was approved. Policy Recommendation E, as amended, was then moved, seconded, and adopted. It now reads as follows (words to be added are italicized, words to be deleted are underscored):

E. Patient information systems

To affirm that, because of their unique expertise and value in patient care, pharmacists must have a leadership role in the planning, selection, implementation, and maintenance*, and enhancement* of electronic information systems used within a health system; further,

To affirm that pharmacists must contribute to the design of patient information systems, including involvement in decisions on the functions, logic, and rules related to medication use.

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation C. It was then moved and seconded to amend Policy Recommendation C by adding the words "in collaboration with other health care professionals" after the words "a leadership role," deleting the word "misadventures" after "medication," and adding the words "errors and adverse drug events" after "medication." After extensive discussion, the amendments were defeated. It was moved and seconded to amend the policy by adding the words "and collaborate with other health care professionals" after the words "leadership role." After discussion, the amendment was defeated. Policy Recommendation C was then moved, seconded, and adopted. It reads as follows:

C. Medication misadventures

To affirm that pharmacists must assume a leadership role in preventing, investigating, and eliminating medication misadventures across the continuum of care.

Policy Recommendations A, B, F, G, H, and I were then moved, seconded, and adopted. They read as follows:

A. Medication formulary system management

To revise ASHP policy 9501 as follows (words to be added are italicized; words to be deleted are underscored):

> To *declare* support the concept that *decisions on the* management of a *medication* drug formulary system *(a) should* must be based first and foremost on clinical principles, *quality-of-life, and pharmacoeconomic factors that result in optimal patient care* and *(b)* must include the active and direct involvement of physicians, pharmacists, and other appropriate health care professionals; *further,*

To declare that decisions on the management of a medication formulary system should not be based solely on economic factors.

B. Multidisciplinary action plans for patient care

To revise ASHP policy 9403 as follows (words to be added are italicized):

> 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.*

F. Defining and measuring the quality of clinical services.

To encourage pharmacists to establish a quality improvement process within their practice settings that measures both operational and patient outcomes.

G. Medicaid cost-containment options

To discontinue ASHP policy 8302, which reads:

> To establish the following broad guidelines for formulation of the ASHP position(s) on specific Medicaid cost-containment options:
>
> 1. The option under consideration for implementation should not be unduly complex or involve costly administration.
> 2. As a result of an option's implementation, pharmacy should not be placed in an adversarial relationship with patients, physicians, or other professionals (e.g., the determination of patient financial eligibility should not be the responsibility of pharmacists).
> 3. The option should recognize the distinct differences between inpatient and outpatient settings. Elements of control that may be implemented must acknowledge these differences (e.g., copayments or deductibles for inpatients should apply to the total cost of services rendered, not to discrete services or products).
> 4. The option should not impose any third-party restrictions on drug products or classes that compromise or preclude effective hospital formulary system management.

H. Health care financing: State (Medicare) waivers under Social Security Act Amendments of 1983

To discontinue ASHP policy 8401, which reads:

> To encourage ASHP's affiliated state chapters to involve themselves with state hospital associations, hospital financial management groups, other health professional organizations, and consumers to assure that state plans and hospital operations under state waiver plans authorized by the Social Security Act Amendments of 1983 reflect contemporary pharmaceutical services; further,
>
> To encourage ASHP's affiliated state chapters to educate public coalitions interested in controlling health care costs about the cost benefits of contemporary pharmacy practice.

I. Standardized protocol for information exchange between hospitals

To discontinue ASHP policy 9008, which reads:

> To support the adoption and use of a standardized protocol to facilitate information exchange within and between hospital data processing systems.

Lois M. Nash, Board Liaison to the Council on Educational Affairs, presented the Council's Policy Recommendations A, B, and C. It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation A. It was then moved and seconded, to amend Policy Recommendation A by deleting the word "and" before "continuing-education programs" in the last paragraph and adding the words "and the resulting applicant pool" at the end of the sentence. It was then moved and seconded to amend the amendment by adding the words "health-system pharmacist" before the words "applicant pool." This secondary amendment was approved. After discussion, the amendments were approved, and Policy Recommendation A, as

amended, was moved, seconded, and adopted. It reads as follows:

A. Declaration of Intent by American Council on Pharmaceutical Education

To revise ASHP policy 9101 as follows and to rename it Position on the Entry-Level Doctor of Pharmacy Degree (words to be added are italicized; words to be deleted are underscored).

To reaffirm the official policy of ASHP to support the Doctor of Pharmacy degree as the single entry-level degree for professional pharmacy practice; further,

To strongly encourage the development of viable and widely available external and nontraditional Doctor of Pharmacy Degree programs; further,

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

To provide the ACPE with appropriate documents and background materials in order to demonstrate the ASHP position and support for ACPE's intent on this important issue; further,

To actively *monitor* investigate 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.*

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

Policy Recommendations B and C were then moved, seconded, and adopted. They read as follows:

B. Relationship between practice sites and educational institutions

To revise ASHP policy 8505 as follows (words to be added are italicized; words to be deleted are underscored).

To reaffirm ASHP's commitment to practitioner input in undergraduate professional education and to restate the importance of the institutional *and health-system* environments as a site*s* for undergraduate training; further,

To *define and develop* continue discussions with the American Association of Colleges of Pharmacy (AACP) on defining and developing appropriate methods of organizational relationships between *health systems* hospitals and colleges of pharmacy that permit a balance of patient care and service, as well as educational and research objectives of both institutions in a mutually beneficial manner; further,

To include the administrative interests of both the *health system* hospital and the college in defining these organizational relationships to assure compatibility of institutional (i.e., *health system* hospital or university) and departmental (e.g., pharmacy department and department in the college) objectives; further,

To develop jointly with AACP model contracts, agreements, and memoranda of understanding for use by hospitals and schools; further,

To develop jointly with AACP appropriate support materials to assist pharmacists in developing cost analyses and other materials required to justify active participation of a *health system* hospital in undergraduate pharmacy education.

C. Model continuing-education regulations

To discontinue ASHP policy 9503, which reads:

To pursue with the National Association of Boards of Pharmacy the inclusion of model continuing-education regulations as part of the new model regulations for pharmacy practice.

Marcia B. Gutfeld, Board Liaison to the Council on Legal and Public Affairs, presented the council's Policy Recommendations A through I. There was no discussion, and the policy recommendations were moved, seconded, and adopted. They read as follows:

A. Graduate medical education

To revise ASHP policy 8605 as follows and to rename it Public Funding for Pharmacy Residency Training (words to be added are italicized; words to be deleted are underscored):

To support legislation and *regulation* that ensures *public* funding for hospital pharmacy residency programs consistent with the needs of the *public and* the profession; further,

To oppose legislation *or regulation* involving reimbursement levels for graduate medical education that adversely affects pharmacy residencies at a rate disproportionate to other residency programs.

B. Collaborative drug therapy management

To revise and combine ASHP policies 9404 and 9410 as follows (words to be added are italicized; words to be deleted are underscored):

To pursue the development of *federal and state* legislative and regulatory provisions that *authorize* allow for *collaborative drug therapy management* prescribing by the pharmacist as a component of pharmaceutical care; *further,*

To That ASHP actively support *affiliated* state societies in the *pursuit* development and use of state-level *collaborative drug therapy management* prescribing authority for pharmacists.

C. Controlled substances regulations

To revise policy 8515 as follows and to rename it Regulation of Automated Drug Distribution Systems (words to be added are italicized; words to be deleted are underscored):

To work with the Drug Enforcement Administration *and other agencies* to seek regulatory and policy changes to accommodate *automated drug distribution in health systems* automatic data processing systems in individual hospitals with multihospital systems.

D. Contingency plan to assist state chapters' adjustments to federal budget reforms

To discontinue ASHP policy 8210, which reads:

To develop, when appropriate, a contingency plan to commit existing ASHP resources to assist affiliated state chapters deal with new forms of Medicaid financing and the impact of budget constraints on hospitals if such constraints become too severe.

E. Patent term restoration

To discontinue ASHP policy 8211, which reads:

To support restoration of full patent term for pharmaceutical products to promote research and development, with consideration of the following:

1. That earnings attributable to such a restoration period are committed to research and development in new pharmaceutical products or prices that reflect the new monopoly period.
2. That regulatory barriers to market entry of pioneer and imitator drug products be eliminated to the extent they are not necessary to protect the public health.

(Note: Neither 1 nor 2 constitutes a specific legislative amendment, but is to be accomplished through ongoing evaluations; item 2 might necessarily imply some regulatory action.)

F. Pharmacy crime

To discontinue ASHP policy 8213, which reads:

To support making the theft or robbery of any controlled substance from any pharmacy, or from any area for which the pharmacist is responsible, a federal crime; further,

To encourage state societies to seek increased local vigilance by law enforcement to deter and punish such crimes when and as covered by state law.

G. Veterans Administration personnel legislation

To discontinue ASHP policy 8409, which reads:

To oppose elimination of the director of pharmacy position in

the Veterans Administration Central Office (as proposed in H.R. 2786).

H. Employee drug testing

To discontinue ASHP policy 8804, which reads:

To oppose the use of truth-verification testing (such as polygraphs and body tissue/fluid analyses) and all forms of integrity testing as routine employment practices because of the possible interference with the rights of individuals; further,

To recognize the limited use of such testing during employment in exceptional situations where such testing may protect the rights of individuals against false witness.

(Note: House of Delegates' approval of this recommendation would amend the following policy adopted by the House of Delegates in June 1986:

To oppose the use of truth-verification testing [such as polygraphs] and integrity testing as a routine employment practice because of the possible interference with the rights of individuals; further,

To recognize the limited use of such testing during employment in those exceptional situations where such testing may protect the rights of individuals against false witness.)

I. Political action committee

To discontinue ASHP policy 8903, which reads:

To establish a PAC [Political Action Committee] to assist ASHP in its federal legislative efforts.

Donald T. Kishi, Board Liaison to the Council on Organizational Affairs, presented the council's report. There were no policy recommendations. After discussion, the report was received without vote.

Jane S. Henry, Board Liaison to the Council on Professional Affairs, presented the council's Policy Recommendations A through M. It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation M. It was then moved and seconded, to amend Policy Recommendation M, on the ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance, by amending the Responsibilities section of the Statement. After discussion, the amendment was approved. The Statement, as revised, is included in this issue (pages 1721-4). It was then moved and seconded to amend the policy recommendation by omitting policy 9103 from the list of policies to be superseded by the Statement. The amendment was approved. Policy Recommendation M, as amended, was then moved, seconded, and adopted. It reads as follows (words to be deleted are underscored):

M. 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.

(Note: This Statement supersedes ASHP policies <u>9103,</u> 9120, 8908, 8713, 8611, 8502, 8404, and 8304.)

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1690 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation B. It was then moved and seconded to amend Policy Recommendation B by adding the words "and caregiver" after the words "informed patient" in paragraph one. The amendment was approved. Policy Recommendation B, as amended, was then moved, seconded, and adopted. It reads as follows (words to be added are italicized):

B. Pain management

To advocate for fully informed patient *and caregiver* participation in pain management decisions as an integral aspect of pharmaceutical care; further,

To support any advancements in treatment that result in improved control of pain, especially relief of chronic intractable pain; further,

To work with other health care organizations in fostering improved pain management; further,

To increase ASHP's efforts in offering educational programs on contemporary pain management therapies and techniques.

(Note: This policy supersedes ASHP policies 8309 and 8805.)

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation C. It was then moved and seconded to amend Policy Recommendation C by adding the words "caregivers" after the words "family members" in paragraph two. There was no discussion, and the amendment was approved. Policy Recommendation C, as amended, was moved, seconded, and adopted. It reads as follows (words to be added are italicized):

C. Appropriate pharmacy support for dying patients

To support the position that care for dying patients is part of the continuum of pharmaceutical care that pharmacists should provide to patients; further,

To support the position that pharmacists have a professional obligation to work in a collaborative and compassionate manner with patients, family members, *caregivers*, and other professionals to help fulfill the pharmaceutical care needs—especially the quality-of-life needs—of dying patients of all ages; further,

To support research on the needs of dying patients.

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for considering Policy Recommendation F. It was then moved and seconded to amend Policy Recommendation F by adding the words "pharmacists have the prerogative to formulate policies and" and deleting the words "business leaders should expect practicing pharmacists to formulate policies that affect the prerogative of pharmacists to" in the second paragraph. After discussion, the amendment was approved, and Policy Recommendation F, as amended, was moved, seconded, and adopted. It reads as follows (words to be added are italicized; words to be deleted are underscored):

F. Role of pharmacists and business leaders in health care services and policies

To support the principle that business leaders and health professionals must share responsibility and accountability for providing optimal health care services to patients; further,

To support the principle that <u>business leaders should expect practicing pharmacists to formulate policies that affect the prerogative of pharmacists to</u> *pharmacists have the prerogative to formulate policies and* make optimal care decisions on behalf of patients.

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for the purpose of considering Policy Recommendation E. It was then moved and seconded to amend Policy Recommendation E by adding the words "complementary and" before the words "alternative substances" in the title and throughout the document. It was then moved and seconded to further amend the policy recommendation by changing the word "substances" to the word "medicines." The second amendment was defeated. The original amendment was approved. After discussion, Policy Recommendation E, as amended, was moved, seconded, and adopted. It reads as follows (words to be added are italicized; words to be added to the title are in roman):

E. Regulation of complementary and *alternative substances*

To support Food and Drug Administration (FDA) regulatory authority over *complementary and* alternative substances for which claims—even indirect and general claims—are made by manufacturers or distributors about their usefulness in preventing and treating disease; further,

To support the principle that *complementary and* alternative substances not having proven efficacy but having no appreciable toxicity should be allowed to be marketed (but not as drugs or biologics) with labeling that clearly states their lack of proven efficacy; further,

To support the routine reporting and monitoring of product defects and adverse effects associated with *complementary and* alternative substances through the FDA MedWatch and United States Pharmacopeia reporting programs.

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

It was moved, seconded, and approved to divide the question for considering Policy Recommendation D. It was then moved, seconded, and approved to amend Policy Recommendation D by deleting the words "alternative substances" in all paragraphs and replacing them with the words "dietary supplements and other integrated or complementary therapies." It was then moved and seconded to amend the amendment by replacing the words "other integrated" with "alternative." The second amendment was approved, and the amendment now read "dietary supplements and alternative or complementary therapies." It was then moved, seconded, and approved to change the word "therapies" in the amendment to "substances." The amendment now read "dietary supplements and alternative or complementary substances." It was moved and seconded to strike the third paragraph of Policy Recommendation D. This motion was defeated. Policy Recommendation D, as amended, was moved, seconded, and adopted. It reads as follows (words added are italicized; words added to the title are in roman):

D. Pharmacists as a source of information about dietary supplements and *alternative or* complementary *substances*

To support the principle that pharmacists should be informed about *dietary supplements and* alternative *or complementary* substances, and capable of providing sound advice to patients about their use; further,

To support the principle that pharmacists and pharmacies should foster public confidence that they are accessible sources of available authoritative information about *dietary supplements and* alternative *or complementary* substances; further,

To support the principle that pharmacists' recommendations about the use of *dietary supplements and* alternative *or complementary* substances should be based on scientific evidence of safety and efficacy.

(Note: When the House of Delegates amends a professional policy recommendation submitted to it by the Board, the ASHP Bylaws (Section 7.3.1.1) require the Board to review the amended action and make a recommendation to the House on final disposition of the issue. See page 1689 for the final action on the above issue.)

Policy Recommendations A, G, H, I, J, K, and L were then moved, seconded, and adopted. They read as follows:

A. Educating pharmacists to provide appropriate support for dying patients

To provide education to pharmacists on caring for dying patients, including education on clinical, managerial, professional, and legal issues; further,

To urge the inclusion of such topics in the curricula of colleges of pharmacy.

G. Medication administration by pharmacists

To support the position that the administration of medicines is part of the routine scope of pharmacy practice; further,

To support the position that pharmacists who administer medicines should be skilled to do so; further,

To support the position that pharmacists should be participants in establishing procedures in their own work settings with respect to the administration of medicines (by anyone) and monitoring the outcomes of medication administration.

(Note: This policy supersedes ASHP policy 9112.)

H. ASHP Statement on the Pharmacist's Role in Clinical Pharmacokinetic Monitoring

To approve the ASHP Statement on the Pharmacist's Role in Clinical Pharmacokinetic Monitoring.

(Note: This document supersedes the ASHP Statement on the Pharmacist's Role in Clinical Pharmacokinetic Services, dated June 5, 1989.)

I. ASHP Statement on the Pharmacist's Role in Infection Control

To approve the ASHP Statement on the Pharmacist's Role in Infection Control.

(Note: This document supersedes a document of the same title dated June 4, 1986.)

J. Aversive flavoring

To discontinue policy 9207, which reads:

To endorse the March 24, 1991, resolution of the American Association of Poison Control Centers concerning the addition of aversive flavoring to potentially toxic products.

K. ASHP Statement on the Pharmacist's Role in Patient Education Programs

To discontinue the ASHP Statement on the Pharmacist's Role in Patient Education Programs, dated June 3, 1991.

L. Patient Education

To discontinue policy 8406, which reads:

To reaffirm existing ASHP policy on patient education as summarized below.

The Society believes that efforts to provide patient information and educational services are maximized only when the multidisciplinary health-care team approach is used. A willingness to share pertinent patient information by all members of the team is the fundamental principle on which the success of these services is based. In discussions of patient drug education in institutions, it is important to have an appreciation of the institutional environment and an understanding of the philosophical framework in which education and information are provided in hospitals. While the *objectives* of health education are uniform among hospitals, the *method of executing* programs varies according to the requirements of each facility. Some hospitals may rely on multidisciplinary teams to deliver educational services; others may employ educational specialists. Programs use various media; some are developed in-house and other media are provided commercially. No *one* method is best for integrating medication instruction into patient education programs.

Patient education is important from the perspectives of hospital accreditation, informed consent, consumer rights, and professional responsibility. An overview of pertinent legal and professional documents shows that patient education is a recognized component of high quality care, an integral part of professional services, a legitimate and growing demand of the consumer, and a mechanism to help prevent legal action that can result from medical procedures provided without a clear understanding of these procedures by the patient.

The needs of practitioners are reflected in the Society's official policies, statements, budgetary allotments, publications, and continuing-education activities. With the expressed commitment to patient education on the part of its members in mind, ASHP plans to use all means available in its long-term efforts to alleviate deficiencies in the provision of drug information to patients and health-care professionals.

After announcements and a comment from Delegate Nickasch concerning the length of the first meeting of the House, the meeting adjourned at 5:55 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Wednesday, June 3, at 3:00 p.m. A quorum was present.

Chair Sheaffer announced the appointment of tellers to canvass the ballots for the election of Chair of the House of Delegates and Treasurer of ASHP. Those appointed were Robert Parsons (OH), Chair; Shawna Kittridge (ID); and John Swenson (WA).

Resolutions. President Murphy presented the report on Resolutions. He presented the Resolution from Dennis M. Williams and Stephen R. Novak on "Collaborative Drug Therapy Management Activities." After discussion, the Resolution was adopted. It reads as follows:

Collaborative drug therapy management activities

Motion: To support the participation of pharmacists in collaborative drug therapy management, which is defined as a multidisciplinary process for selecting appropriate drug therapies, educating patients, monitoring patients, and continually assessing outcomes of therapy; further,

To recognize that pharmacists participate in collaborative drug therapy management for a patient who has a confirmed diagnosis by an authorized prescriber; further,

To recognize that the activities of a pharmacist in collaborative drug therapy management may include, but not be limited to, initiating, modifying, and monitoring a patient's drug therapy; ordering and performing laboratory and related tests; assessing patient response to therapy; counseling and educating a patient on medications; and administering medications.

Background: ASHP has a position statement about collaborative drug therapy management and reimbursement for pharmaceutical care that was apparently developed for use by the government affairs group. The practice standards of ASHP do not include adequate information in this area. Action by the House of Delegates would strengthen this position. The proposed policy is purposely general, since the nature of pharmacist activities varies among different states (e.g., dependent versus independent authority, written versus oral agreements, individual patient versus populations).

Related policies:

9404: To pursue the development of legislative and regulatory provisions that allow for prescribing by the pharmacist as a component of pharmaceutical care.

9410: That ASHP actively support state societies in the development and use of state-level prescribing authority for pharmacists.

Suggested outcome: An official policy from the ASHP House of Delegates for pharmacists to use when addressing this issue in individual states.

The second Resolution, from Kristine Marcus and Charles McGinley, was on "Conscientious Objection by Pharmacists to Morally, Religiously, or Ethically Troubling Therapies." It was moved and seconded to submit a substitute Resolution, which reads as follows: "ASHP supports the establishment of systems that protect the patient's right to obtain legally prescribed and medically indicated treatments while reasonably accommodating the pharmacist's right of conscientious objection to morally, religiously, or ethically troubling therapies." After extensive discussion, the substitute Resolution was defeated. A motion for referral was moved and seconded. This motion was defeated. It was then moved and seconded that the Resolution be adopted. The motion was approved. The Resolution reads as follows:

Conscientious objection by pharmacists to morally, religiously, or ethically troubling therapies

Motion: ASHP recognizes a pharmacist's right to conscientious objection to morally, religiously, or ethically troubling therapies and supports the establishment of systems that protect the patient's right to obtain legally prescribed and medically indicated treatments while reasonably accommodating the pharmacist's right of conscientious objection.

Background: There is a need for the pharmacy profession to discuss, debate, and gain professional consensus on resolving the potential conflict between pharmacists' duty to provide legal and medically indicated medications and their right to refuse to participate in something they find morally, religiously, or ethically objectionable. ASHP's only policy addressing conscientious objection (policy 8410) is related to the use of drugs in capital punishment.

Since many uses of drugs (e.g., birth control, capital punishment, cloning, gene therapy, physician-assisted suicide, termination of pregnancy, and termination of life support) may be morally, religiously, or ethically objectionable to a given pharmacist, a policy that is broader in scope than the current ASHP policy is needed.

Evidence that this is a professionwide concern is supported by the approval of a Pharmacist Conscience Clause by the 1998 American Pharmaceutical Association house of delegates, which reads:

1. APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.
2. APhA shall appoint a council to serve as a resource for the profession in addressing and understanding ethical issues.

Although the Joint Commission on Accreditation of Healthcare Organizations currently requires accredited institutions to develop a policy allowing for conscientious objection by all health care employees, some of these policies are vague and do not address the specific concerns of pharmacists. ASHP has an opportunity to take a leadership role by researching and recommending standard policy language and suggesting a workable system that will accommodate conscientious objection while continuing to meet the needs of all involved parties.

Suggested outcome: This is a complex matter that requires discussion and evaluation of how to balance the issues of patients' rights, pharmacists' rights and duties, employers' interests, and employment law. ASHP should develop final policy language and a practice standard on this topic.

Recommendations. Dr. Sheaffer called on members of the House of Delegates for Recommendations. (The name and state of the delegate who introduced the item and the subject of the item precede each Recommendation.)

Michael D. Schlesselman (GA): Guidelines for management of blood products and derivatives

Recommendation: That ASHP develop guidelines to assist pharmacists in identifying which FDA regulations and requirements apply to blood products or blood derivatives. The guidelines should include recommendations for developing and managing distribution systems for these products. Content should include documentation requirements and a recall mechanism to protect the patient.

Background: FDA regulations address blood, blood products, and blood derivatives as biologics. The FDA regulations for blood and some blood products require records of receipt and distribution, including lot number and expiration date of the product and patient information. Distribution of blood products and blood derivatives in the health care organization may or may not include the pharmacist.

The incidence of recalls of blood products and blood derivatives has increased. These products may have the potential for transmission of serious viral and other diseases. Patients exposed to these products may need to be identified for monitoring. Pharmacists need guidance in identifying required regulations for these products and in establishing distribution systems that protect patients.

Dennis Gerber (NH): Manufacturers' telephone numbers

Recommendation: To enhance the provision of pharmaceutical care, we would like ASHP to encourage FDA to request all manufacturers of legend drugs to place within the package labeling a telephone number that will allow health care providers direct access to an appropriate medical representative for product-specific information.

Background: The process as it exists now is to find a reference book containing a list of the manufacturers and their telephone numbers. Every company handles telephone calls differently; the current process is multitiered and cumbersome. At a time when access to drug information is more important than ever, having a direct avenue to a medical representative of the manufacturer would facilitate the process of obtaining vital product information.

Philip Schneider (KS): Dialogue with NABP

Recommendation: That ASHP pursue dialogue with the National Association of Boards of Pharmacy (NABP) for the purpose of educating NABP and its state boards on the practice of pharmacy in modern health systems; further, to focus these educational efforts on modern drug distribution services in health systems.

Background: Aspects of modern drug distribution services (automated dispensing systems, robotics, tech-check-tech programs) may be in conflict with current or proposed state regulations or practice acts. Many state boards of pharmacy have little or no representation from health-system practice. Changes in pharmacy practice acts being implemented by boards of pharmacy without an understanding of the potential effects on health-system practice are a significant issue in many states. Efforts by ASHP to educate NABP could minimize the risk of unanticipated negative effects on health-system practice. ASHP could advise affiliated state societies on ways of establishing similar efforts to address specific concerns in their states.

Suggested outcome: Establishment of an ongoing dialogue between ASHP and NABP regarding modern practice environments in health systems, as well as advice to affiliated state societies on suggested mechanisms for educating individual state boards.

Mike Canton (OR): Affiliated state society relationships with other organizations

Recommendation: ASHP should develop a model for working relationships between affiliated state societies and other pharmacy organizations for the purpose of building consensus and representing pharmacy issues before government, public, and industry groups in order to define and advance the scope of care that pharmacy provides.

Background: The Council on Organizational Affairs discussed this topic at length. State societies have done everything from forming umbrella organizations to merging with pharmacy associations, and ASHP needs to help direct this process to improve pharmacy representation without compromising state health-system pharmacy societies.

Suggested outcome: A technical assistance bulletin outlining the preferred working relationships between state societies and other pharmacy organizations.

Steven E. Marx (IL): Alternate delegates

Recommendation: That ASHP support both delegates and alternate delegates by inviting alternate delegates to the ASHP delegate reception and providing delegate binders to alternate delegates. The number of alternate delegates should not exceed the number of seated delegates.

Background: Alternate delegates participate in regional delegate conferences and are often called upon on short notice to participate as delegates. Usually, alternate delegates participate by attending and observing the house of delegates.

Suggested outcome: That ASHP increase and facilitate the grooming of future seated delegates.

Rhonda B. McManus (SC): Definition of medication misadventures

Recommendation: That ASHP clearly define the term "medication misadventure" and renew efforts to work with other disciplines to standardize terminology and increase awareness of the term among ASHP members and other disciplines; further, that ASHP work with the media through the public relations network to increase the public's familiarity with such terminology.

Background: ASHP has published a paper that defines "medication misadventure" as a phrase to describe myriad medication-use problems. However, the term is not routinely used by all disciplines or the media.

Suggested outcome: Define and encourage the use of "medication misadventure" among all disciplines, and inform the public of such terminology—or discontinue the use of the term in ASHP policies.

Sandra Robinson (DE): Multiple-dose containers of sterile products

Recommendation: That the Council on Professional Affairs review the ASHP Statement on the Pharmacist's Role in Infection Control and any other related policy statements, guidelines, or technical assistance bulletins that address the use of multiple-dose containers of sterile products, and that the Council address the issue of the appropriate use of multiple-dose containers.

Background: The ASHP Statement on the Pharmacist's Role in Infection Control was recommended for adoption by the Council on Professional Affairs and approved during Monday's session of the House. Much discussion during the caucuses concerned the use of single- versus multiple-dose packages of sterile products. While the use of single-dose packages of sterile products may be ideal, there are circumstances in which the use of multiple-dose vials is appropriate. For example, in the home care setting, patients are often taught to draw up their heparin and saline flushes from multiple-dose vials. In this situation, the multiple-dose vials are patient specific and the patients are trained in the proper use of multiple-dose containers.

In attempting to revise the Statement, it became obvious that this issue needed more discussion than could be accomplished at this session of the House. Therefore, I recommend that the Council on Professional Affairs review this Statement and consider including language on the appropriate use of multiple-dose containers.

Robert M. Parsons (OH): Term of office of the Chair of the House of Delegates

Recommendation: The Ohio delegation recommends the development of a proposed amendment to Article 7 of the ASHP Bylaws that would provide for a two-year term for the Chair for the House of Delegates, with the provision to serve up to two successive terms.

Background: A term of more than one year would be consistent with other elected offices of the society. Currently the Chair, if interested in serving for more than one year, must seek reelection before ever having chaired a session of the House. While the current one-year term helps to ensure that an ineffective Chair not be retained in office for more than one year, the rigors of the nominating process make it unlikely that a potentially ineffective Chair would ever become a candidate.

Douglas Lang (MO): Reimbursement for the provision of medications and pharmaceutical care services in alternate care sites

Recommendation: ASHP should develop and implement strategies for addressing the policies and practices of payers on the reimbursement of pharmaceutical services in alternate care sites.

Background: Health care payers are changing the methods used to determine reimbursement for alternate-site pharmaceutical care services. Among the most distressing trends is the rapid transition from a method based on average wholesale price plus per diem to one based on medication acquisition cost, neither of which provides adequate economic incentives to organizations for providing optimal pharmaceutical care services. The consequences may include shifting the site of care back to the costly inpatient setting and even limiting patient access to alternate-site pharmaceutical care. This may occur, since payments based on acquisition cost will not cover the provision of pharmaceutical care services. ASHP should assist its members in alternate care sites in addressing the operational and economic impact of changing reimbursement methods and should be an advocate for appropriate pharmaceutical care services in alternate care sites.

The 1998–1999 leadership agenda states that ASHP should "increase awareness among the public in general and among health-system decision-makers specifically about the vital patient care role of pharmacists." The rationale behind this statement is that "decision-makers in health systems do not fully appreciate the value of pharmacists in patient care and in the continuity of care." Another point on the leadership agenda is to "foster executive pharmacy leadership in health systems"; the key element in the rationale for this item is "consolidation of health care delivery suggests that there will be a strong demand for pharmacists who combine clinical expertise, business acumen, management know-how, and leadership ability." We strongly believe that ASHP action to address this subject will meet the mandate of the leadership agenda.

Suggested outcome: ASHP should (1) identify key organizations for development of coalitions that can address the policies and practices of payers on the provision of pharmaceutical care services in alternate-site care and across the continuum of care, (2) develop tools for evaluating the cost of providing appropriate and optimal pharmaceutical care services in alternate care sites, (3) identify or add resources within ASHP for focusing on current issues and trends in reimbursement policies and practices of payers in alternate-site care and across

the continuum of care, (4) develop tools and strategies for enhancing the skills of pharmacy practitioners and managers in addressing payers' policies and practices regarding reimbursement for pharmaceutical care services in alternate care sites, (5) and update ASHP policies on reimbursement for pharmaceutical care services (the ASHP Statement on Third-Party Compensation for Clinical Services by Pharmacists, the ASHP Statement on Principles for Including Medications and Pharmaceutical Care in Health Care Systems, the ASHP Guidelines for Implementing and Obtaining Compensation for Clinical Services by Pharmacists, and the ASHP Technical Assistance Bulletin on Assessing Cost-Containment Strategies for Pharmacies in Organized Health Care Settings) to be more reflective of current trends.

James V. Dorociak (IL): Attire for Annual Meeting

Recommendation: That ASHP promote and encourage business casual attire at the Annual Meeting with the exception of the Whitney Award dinner.

Background: The Annual Meeting occurs during the summer, and business casual attire may be more comfortable. Other professional meetings and organizations are adopting business casual attire. Business casual attire is more conducive to informal interactive networking.

Suggested outcome: That ASHP encourage and promote business casual attire for members and exhibitors at the Annual Meeting.

Dennis Williams (NC): Health-system pharmacists as vaccine advocates

Recommendation: ASHP should promote the role of health-system pharmacists as vaccine advocates and encourage active participation in immunization activities.

Background: ASHP policy 9113 is related; however, a mobilization of effort would be useful in addressing this unmet public health need.

Suggested outcome: Educational and public awareness activities about the pharmacist as an immunization resource, and educational sessions and journal articles about pharmacist involvement and opportunities.

Leo Nickasch (ID): House of Delegates (HOD) ad hoc committee

Recommendation: That the HOD form an ad hoc committee to look at the internal functions and rules of procedure for the HOD and the relevant sections of the ASHP Bylaws.

Background: Items considered should include but not be limited to the following: moving the President's speech to the opening session; electronic voting and roll call; two-year term for the speaker; changing the open hearing format; the caucus process; possibly reforming the HOD into sections; and reviewing when HOD sessions are held and their length.

Suggested outcome: That a committee consisting of a cross-section of the House be appointed by the speaker, to include the speaker and one staff member, for the purpose of looking at how the HOD can become more proactive in forming ASHP policy in an expeditious manner.

Leo Nickasch (ID): Unification of two or more professional pharmacy organizations

Recommendation: That ASHP provide for distribution to all interested state societies the template of organization that the Pharmacy Society of Wisconsin (PSW) developed.

Background: The unification of the two former professional pharmacy organizations into the PSW is a tremendous accomplishment. The pharmacists of Wisconsin have created a plan to maximize the thin resources within the profession in the state and dedicate them toward the advancement of pharmacy practice in the state's health systems. The leadership of PSW is to be congratulated, encouraged, and supported for the vision articulated and the plans constructed.

Suggested outcome: That we consider how ASHP can extend the Wisconsin example to other states and initiate a process for greater collaboration among pharmacy's national organizations.

Rhonda B. McManus (SC): Herbal and alternative therapies

Recommendation: The South Carolina delegation applauds ASHP's efforts to provide continuing education on herbal remedies. We recommend that ASHP continue to provide continuing education on this subject and that ASHP encourage colleges of pharmacy to incorporate courses about alternative therapies into their curricula; further, that ASHP encourage the National Association of Boards of Pharmacy to include questions about herbal and alternative therapies on the NABLEX.

Background: Herbal remedies and other alternative therapies have moved from the fringe to mainstream America. Pharmacists must be prepared to assess and monitor outcomes of patients who use alternative therapies alone or in conjunction with allopathic medicines.

Mitch Wood (GA): Bar codes for labeling with medication lot number and expiration date

Recommendation: To encourage the pharmaceutical industry to develop standardized bar coding for product packages that will include product lot numbers and expiration dates. The bar code would enhance the pharmacist's management of medications throughout the health care system.

Background: The pharmacy must control medications throughout the health care system. Out-of-date medications must be tracked and removed from stock. Monthly checks of drug storage areas to review the dating of the stock require personnel time. Floor stock has increased with the growth of decentralized automated dispensing units. Lot numbers and expiration dates must be manually entered during restocking of the units to use the automated devices' tracking of products.

Industry-provided bar codes that include lot numbers and expiration dates would enhance both manual and automated floor stock systems. If nurse documentation of medications via an online system is used, the bar code will allow capture of lot numbers and expiration dates of the medication administered.

Suggested outcome: That ASHP lobby the industry on the benefits of such bar coding.

Chair Sheaffer announced that Recommendations would be referred to the appropriate ASHP bodies and staff for study and appropriate action.

Board of Directors duly considered matters. The Board reported on nine items of business that were amended at the first House meeting. Pursuant to Bylaws Section 7.3.1.1, the Board met on Wednesday morning to "duly consider" the amended policy recommendations. The Board presented its recommendations as follows.

Regarding the first item, from the Council on Administrative Affairs, titled "Electronic entry of medication orders," the Board agreed that the amendment was acceptable. (See report of the Council on Administrative Affairs, first meeting of the House, page 1683.)

Regarding the second item, from the Council on Administrative Affairs, titled "Patient information systems," the Board agreed that the amendment was acceptable. (See Council on Administrative Affairs, first meeting of the House, page 1683.)

Regarding the third item, from the Council on Educational Affairs, titled "Declaration of intent by American Council on Pharmaceutical Education," the Board agreed that the amendment was acceptable. (See Council on Educational Affairs, first meeting of the House, page 1684.)

Regarding the fourth item, from the Council on Professional Affairs, titled "Pain management," the Board agreed that the amendment was acceptable. (See Council on Professional Affairs, first meeting of the House, page 1685.)

Regarding the fifth item, from the Council on Professional Affairs, titled "Appropriate pharmacy support for dying patients," the Board agreed that the amendment was acceptable. (See Council on Professional Affairs, first meeting of the House, page 1685.)

Regarding the sixth item, from the Council on Professional Affairs, titled "Pharmacists as a source of information about dietary supplements and alternative or complementary substances," the Board agreed that the amendments were acceptable. (See Council on Professional Affairs, first meeting of the House, page 1685.)

Regarding the seventh item, from the Council on Professional Affairs, titled "Regulation of complementary and alternative substances," the Board agreed that the amendments were acceptable. (See Council on Professional Affairs, first meeting of the House, page 1685.)

Regarding the eighth item, from the Council on Professional

Affairs, titled "Role of pharmacists and business leaders in health care services and policies," the Board agreed that the amendments were acceptable. However, the Board noted that the changes made at the first meeting altered the intention of the originally proposed policy. It was moved and seconded to reconsider the previously adopted policy. (See Council on Professional Affairs, first meeting of the House, page 1685.) After discussion, the House approved reconsideration. Policy Recommendation F, as originally written, was then moved, seconded, and adopted. It now reads as follows:

F. Role of pharmacists and business leaders in health care services and policies

To support the principle that business leaders and health professionals must share responsibility and accountability for providing optimal health care services to patients; further,

To support the principle that business leaders should expect practicing pharmacists to formulate policies that affect the prerogative of pharmacists to make optimal care decisions on behalf of patients.

Regarding the ninth item, from the Council on Professional Affairs, titled "ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance," the Board agreed that the amendments were acceptable. (See Council on Professional Affairs, first meeting of the House, page 1685.)

New Business. Chair Sheaffer announced that, in accordance with Article 11 of the Bylaws, there were four items of New Business to be considered. He noted that if an item of New Business is approved for referral to the Board the delegates' discussion, ideas, and comments on the item become a part of the referral.

Chair Sheaffer called on New Jersey delegate Eric T. Hola to introduce the first item of New Business, titled "ASHP Practice Site Accreditation." After extensive discussion, the item was defeated.

The second item of New Business, "Collaboration with Health Care and Consumer Associations," was introduced by Past President R. Paul Baumgartner. After discussion, the item was approved for referral to the Board of Directors. It reads as follows:

Collaboration with health care and consumer associations

Motion: That ASHP place a high priority on (1) further developing a meaningful and ongoing relationship and dialogue with national associations representing medicine, nursing, nurse practitioners, physician assistants, administration, insurance, and consumers for the specific purpose of gaining public endorsement by other health care groups for ASHP practice standards as a means of advancing our legislative and reimbursement initiatives and (2) providing resources and assistance to affiliated state societies to achieve the same results at the state level with such health care and consumer associations.

Background: Health care is a multidisciplinary effort that requires cooperation and understanding among various disciplines, payers, insurers, and consumers to be successful. The cost containment strategy adopted by managed care has resulted in escalation of friction and misunderstanding as a result of competition for health care dollars. Isolated efforts to update laws and regulations to be consistent with evolving pharmacy practice (e.g., pharmaceutical care and collaborative care) have been largely unsuccessful because of opposition from the pharmaceutical industry and certain health care professions. In like manner, pharmacy has yet to achieve widespread support for reimbursement for nondispensing functions. In order to be successful in these critical activities, it is essential that we gain the support of these influential groups. We cannot do it alone. By better understanding these groups, we may also identify other issues critical to our health care colleagues that merit our support.

Suggested outcome: Within the next year, ASHP will have established a formal, ongoing dialogue with these associations that involves, as appropriate, the officers, Board, staff, and appointed members in order to create an understanding and advocacy for ASHP statements with respect to practice standards and public policy. Periodic reports should be made to the membership on the results of these collaborative efforts and on the provision of guidance and support to affiliated state societies that results in complementary activities at the state level.

The third item of New Business, "Patient Confidentiality and Protection," was introduced by Jody Allen (VA). After discussion, the item was approved for referral to the Board of Directors. It reads as follows:

Patient confidentiality and protection

Motion: The ASHP Board of Directors should establish a uniform statement that supports the responsible integration and exchange of patient health information among providers for the purpose of optimizing patient care and protecting patient health. This statement should support safeguarding patient confidentiality and patient identifiable health information but recognize the need for appropriate use of such information to protect the patient against adverse drug events and inappropriate medication use and to ensure the best medical outcomes for the patient.

Background: A variety of federal and state legislative bills have been introduced recently addressing the issue of patient confidentiality and privacy. As part of the Health Insurance Portability and Accountability Act (HIPPA or Kennedy-Kassebaum Act), the federal government must enact legislation concerning patient confidentiality by August 1999 or the Secretary of Health and Human Services will be required by law to promulgate federal regulations in 2000. Currently there are at least six federal legislative proposals addressing the issue of access to medical information, prescription information, and patient confidentiality. Many of the proposed bills would impede the appropriate use of patient health information for optimizing outcomes across all providers of health care.

The current health care system works best as a fully integrated system with fully informed providers whose function is to achieve optimal patient outcomes. Pharmacists depend on this information to protect the patient from drug misadventures and to assess and monitor outcomes of pharmaceutical therapy. Much of this current legislation would impede the appropriate use of patient health information for quality measurements (identification of diabetics without eye screenings), disease management programs, patient satisfaction surveys, outcomes research, and referrals of high-risk patients.

ASHP has several practice standards that include language about protecting or safeguarding patients' rights to privacy and confidentiality of data. The current policy language varies among the different documents. Adopting a uniform statement for use in all applicable documents that clearly articulates the importance of safeguarding patient confidentiality but recognizes the importance of the responsible exchange of patient medical and pharmaceutical information across providers for the purpose of achieving optimum patient care and protection of patient health is timely and important. Legislation that impedes the exchange of this information for patient safety and health should be opposed.

Suggested outcome: By ASHP Legislative Day 1998, the ASHP Board of Directors should establish a uniform statement that supports the responsible exchange of patient health information among health providers.

The fourth item of New Business, "President's inaugural address," was introduced by John Swenson (WA). After discussion, it was approved for referral to the Board of Directors. It reads as follows:

President's inaugural address

Motion: That the ASHP President's inaugural address be moved to be the first presentation at the Opening General Session of the ASHP Annual Meeting.

Suggested outcome: Moving the President's inaugural address should allow (1) a greater proportion of those attending the Annual Meeting to see and hear our newly elected President's ideas and goals, (2) other Opening General Session speakers to make reference to the President's ideas and goals in their presentations, and (3) more time in the second meeting of the House of Delegates for conducting the business of the House.

President's inauguration. Chair Sheaffer installed Bruce R. Canaday as President of ASHP. President Canaday presented his inaugural address, titled "Bold in Our C.A.R.E (Commitment, Advocacy, Relations, Education)." Chair Sheaffer introduced President Canaday's wife, Kathy; his children, John Canaday and Jaime Baldwin; and his father, Joe Canaday.

Election of House Chair and Treasurer of ASHP. Chair Sheaffer conducted the election for Chair of the House of Delegates and Treasurer. He called delegates to present completed official ballots to tellers, who certified the eligibility of delegates to vote. After the balloting, the tellers counted the ballots.

Recognition. Chair Sheaffer recognized members of the Board who were continuing in office. He 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 Sheaffer presented Immediate Past President Murphy with an inscribed gavel commemorating his term of office. Immediate Past President Murphy recognized the service of Chair Sheaffer as Chair of the House of Delegates and a member of the Board of Directors.

Chair Sheaffer recognized Sara J. White'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.

Installation. Vice Chair White received the tellers' certified report and announced that Steven L. Sheaffer was the newly elected Chair of the House of Delegates and David A. Zilz was the newly elected Treasurer. She installed Board members Daniel M. Ashby and Debra S. Devereaux, Treasurer David A. Zilz, and Chair of the House of Delegates Steven L. Sheaffer. She introduced the families of Board members Ashby and Devereaux.

Parliamentarian. Vice Chair White thanked Joy Myers for service to ASHP as parliamentarian.

Adjournment. The 49th annual session of the House of Delegates adjourned at 5:06 p.m.

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[a]In accordance with the Bylaws, the Board of Directors acts as a referral committee for Resolutions.

[b]The Committee on Nominations included Douglas Lang, Chair; Cynthia Raehl, vice chair; and Steve Litsey, Leslie Mackowiak, Jill Martin, Leo Nickasch, and William Puckett.