Organization and Delivery of Services

Patient Access to Pharmacist Care Within Provider Networks (1808)
Source: Council on Pharmacy Management
To advocate for laws and regulations that require healthcare payer provider networks to include pharmacists and pharmacies providing patient care services within their scope of practice when such services are covered benefits; further,

To advocate for laws and regulations that allow pharmacists and pharmacies to participate as a provider within a healthcare payer's network if the pharmacist or pharmacy meets the payer's criteria for providing those healthcare services; further,

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

To advocate that healthcare payers be required to disclose to pharmacists and pharmacies applying to participate in a provider network the criteria used to include, retain, or exclude pharmacists or pharmacies.

Health Insurance Policy Design (1809)
Source: Council on Pharmacy Management
To advocate that all health insurance policies be designed and coverage decisions made in a way that preserves the patient–practitioner relationship; further,

To advocate that health insurance payers and pharmacy benefit managers provide public transparency regarding and accept accountability for coverage decisions and policies; further,

To oppose provisions in health insurance policies that interfere with established drug distribution and clinical services designed to ensure patient safety, quality, and continuity of care; further,

To advocate for the inclusion of hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

This policy supersedes ASHP policy 1520.

Use of International System of Units for Patient- and Medication-related Measurements (1811)
Source: Council on Pharmacy Practice
To advocate that the U.S. healthcare system adopt and only use the International System of Units (SI units) for all patient- and medication-related measurements and calculations; further,

To advocate that healthcare organizations use clinical decision support systems, equipment, and devices that allow input and display of patient- and medication-related measurements and calculations in SI format only; further,

To advocate that health information technology manufacturers utilize only SI units in their product designs for patient- and medication-related measurements; further,

To promote education in the use of SI units and the importance of using SI units to prevent medical errors.

Rational Use of Medications (1822)
Source: Council on Therapeutics
To promote evidence-based prescribing and deprescribing for indication, efficacy, safety, duration, cost, and suitability for the patient; further,

To advocate that pharmacists lead interprofessional efforts to promote the rational use of medications, including engaging in strategies to monitor, detect, and address patterns of irrational medication use in patient populations.

This policy supersedes ASHP policy 1312.

Responsible Medication-related Clinical Testing and Monitoring (1823)
Source: Council on Therapeutics
To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage pharmacist accountability and engagement in interprofessional efforts to promote the judicious use of clinical testing and monitoring; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

Use of Biomarkers in Clinical Practice (1824)
Source: Council on Therapeutics
To promote appropriate, evidence-based use of biomarkers in clinical practice; further,

To encourage research that evaluates the clinical and safety implications of biomarkers in the care of patients and to guide clinical practice; further,

To promote Food and Drug Administration qualified biomarkers in drug development, regulation, and use in clinical practice; further,

To foster the development of timely and readily available resources about biomarkers and their evidence-based application in clinical practice.

Pharmacist's Leadership Role in Anticoagulation Therapy Management (1703)
Source: Council on Therapeutics
To advocate that pharmacists provide leadership in caring for patients receiving medications for anticoagulant therapy management; further,

To advocate that pharmacists be responsible for coordinating the individualized care of patients receiving medications for anticoagulation therapy management; further,

To encourage pharmacists who participate in anticoagulation therapy management to educate patients, caregivers, prescribers, and other members of the interprofessional healthcare team about anticoagulant medication uses, drug interactions, adverse effects, the importance of adhering to therapy, access to care, and recommended laboratory testing and other monitoring.

This policy supersedes ASHP policy 0816.

Clinical Significance of Accurate and Timely Height and Weight Measurements (1721)

Source: Council on Therapeutics

To encourage pharmacists to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,

To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,

To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing and dispensing of drugs most likely to be affected by extremes of weight and weight changes.

Patient Experience (1616)

Source: Council on Pharmacy Management

To encourage pharmacists to evaluate their practice settings for opportunities to improve the experience patients have with healthcare services and with the outcomes of their drug therapy; further,

To educate pharmacists and pharmacy personnel about the relationship between patient experience and outcomes; further,

To develop or adopt tools that will (1) provide a system for monitoring trends in the quality of pharmacy services to patients, (2) increase recognition of the value of pharmacy services, and (3) provide a basis for making improvements in the process and outcomes of pharmacy services in efforts to engage patients and improve their experience; further,

To facilitate a dialogue with and encourage education of patient experience database vendors to include the value of pharmacists and pharmacy services in the patient experience.

This policy supersedes ASHP policy 0104.

Integrated Approach for the Pharmacy Enterprise (1618)

Source: Council on Pharmacy Practice

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

To advocate a high level of coordination of all components of the pharmacy enterprise across the continuum of care for the purpose of optimizing (1) medication-use safety, (2) quality, (3) outcomes, and (4) drug therapy.

This policy supersedes ASHP policy 0619.

Preventing Exposure to Allergens (1619)

Source: Council on Pharmacy Practice

To advocate for pharmacy participation in the collection, assessment, and documentation of a complete list of allergens pertinent to medication therapy, including food, excipients, medications, devices, and supplies, for the purpose of clinical decision-making; further,

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

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

To encourage education of pharmacy personnel on medication-related allergens.

Patient Adherence Programs as Part of Health Insurance Coverage (1504)

Source: Council on Public Policy

To advocate for the pharmacist's role in patient medication adherence programs that are part of health insurance plans; further,

To advocate those programs that (1) maintain the direct patient pharmacist relationship; (2) are based on the pharmacist's knowledge of the patient's medical history, indication for the prescribed medication, and expected therapeutic outcome; (3) use a communication method desired by the patient; (4) are consistent with federal and state regulations for patient confidentiality; and (5) permit dispensing of partial fills or overfills of prescription medications in order to synchronize medication refills and aid in medication adherence.

This policy supersedes ASHP policy 0116.

Complementary and Alternative Medicine in Patient Care (1511)

Source: Council on Therapeutics

To promote awareness of the impacts of complementary and alternative (CAM) products on patient care, particularly drug interactions, medication safety concerns, and the risk of contamination and variability in active ingredient content; further,

To advocate for the documentation of CAM products in the health record to improve patient safety; further,

To advocate for the inclusion of information about CAM products and their characteristics in medication-related databases; further,

To provide education on the impacts of CAM products on patient care in healthcare organizations; further,

To foster the development of up-to-date and readily available resources about CAM products.

Pharmacist's Role in Population Health Management (1523)

Source: Council on Pharmacy Management

To recognize the importance of medication management in patient-care outcomes and the vital role of pharmacists in population health management; further,

To encourage healthcare organizations to engage pharmacists and pharmacy leaders in identifying appropriate patient cohorts, anticipating their healthcare needs, and implementing the models of care that optimize outcomes for patients and the healthcare organization; further,

To encourage the development of complexity index tools and resources to support the identification of high-risk, high-cost, and other patient cohorts to facilitate patient-care provider panel determinations and workload balancing; further,

To promote collaboration among members of the interprofessional healthcare team to develop meaningful measures of individual patient and population care outcomes; further,

To advocate for education to prepare pharmacists for their role in population health management.

Standardization of Doses (1525)
Source: Council on Pharmacy Practice
To recognize that standardization of medication doses reduces medication errors and improves information technology interoperability, operational efficiency, and transitions of care; further,

To encourage development of universal standardized doses for specific patient populations; further,

To encourage healthcare organizations to adopt standardized doses and to promote publication and education about best practices.

Standardization of Oral Liquid Medication Concentrations (1401)
Source: Council on Pharmacy Practice
To advocate for the development of nationally standardized drug concentrations for oral liquid medications; further,

To encourage all health care providers and organizations to standardize concentrations of oral liquid medications; further,

To promote effective instruction of patients and caregivers on how to properly measure and administer oral liquid medications.

Documentation of Patient-Care Services in the Permanent Health Record (1419)
Source: Council on Pharmacy Management
To advocate for public and organizational policies that support pharmacist documentation of patient-care services in the permanent patient health record to ensure accurate and complete documentation of the care provided to patients and to validate the impact of pharmacist patient care on patient outcomes and total cost of care; further,

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

This policy supersedes ASHP policy 0407.

Standardization of Intravenous Drug Concentrations (1306)
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.

This policy was reviewed in 2017 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Drug-Containing Devices (1313)
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.

This policy was reviewed in 2017 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Qualifications and Competencies Required to Prescribe Medications (1202)
Source: Council on Education and Workforce Development
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 was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Transitions of Care (1208)
Source: Council on Pharmacy Management
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.

This policy was reviewed in 2016 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Pharmacist Prescribing in Interprofessional Patient Care (1213)

Source: Council on Pharmacy Practice

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 was reviewed in 2016 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Pharmacist's Role in Team-Based Care (1215)

Source: Council on Pharmacy Practice

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.

This policy was reviewed in 2016 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Medication Adherence (1222)

Source: Council on Therapeutics

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.

This policy was reviewed in 2016 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Patient-Reported Outcomes Tools (1107)

Source: Council on Therapeutics

To advocate for expanded use of validated patient-reported outcomes (PRO) tools in clinical research and direct patient care; further,

To support development of validated PRO tools that are sensitive to differences in cultural and health literacy; further,

To encourage additional research on PRO tools, including studies to assess their correlation to overall patient outcomes; further,

To educate clinicians and patients about the appropriate use of PRO tools.

This policy was reviewed in 2015 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Pharmacist Accountability for Patient Outcomes (1114)

Source: Council on Pharmacy Practice

To affirm that pharmacists are obligated by their covenantal relationship with patients to ensure that medication use is safe and effective; further,

To declare that pharmacists, pursuant to their authority over a specialized body of knowledge, are autonomous in exercising their professional judgment and accountable as professionals and health care team members for safe and effective medication therapy outcomes; further,

To encourage pharmacists to define practices and associated measures of effectiveness that support their accountability for patient outcomes; further,

To promote pharmacist accountability as a fundamental component of pharmacy practice to other health care professionals, standards-setting and regulatory organizations, and patients.

This policy was reviewed in 2015 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Pharmacists' Role in Medication Reconciliation (1117)

Source: Council on Pharmacy Practice

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

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in interdisciplinary efforts to develop, implement, monitor, and maintain effective medication reconciliation processes; further,

To encourage community-based providers, hospitals, and health systems to collaborate in organized medication reconciliation programs to promote overall continuity of patient care; further,

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

This policy was reviewed in 2015 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Medication Therapy Management (1005)

Source: Council on Public Policy

To support medication therapy management (MTM) services as defined in Section 3503 of the Patient Protection and Affordable Care Act (PL 111-148); further,

To affirm that MTM is a partnership between the patient (or a caregiver) and a pharmacist, in collaboration with other health care professionals, that promotes the safe and effective use of medications.

This policy was reviewed in 2014 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Patient Access to Pharmacy Services in Small and Rural Hospitals (1022)

Source: Council on Pharmacy Practice

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

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

This policy was reviewed in 2014 by the Council on Pharmacy Practice and was found to still be appropriate.

Scope and Hours of Pharmacy Services (1023)

Source: Council on Pharmacy Practice

To support the principle that all patients should have 24-hour access to a pharmacist responsible for their care, regardless of hospital size or location; further,

To advocate alternative methods of pharmacist review of medication orders (such as remote review) before drug administration when onsite pharmacist review is not available; further,

To support the use of remote medication order review systems that communicate pharmacist approval of orders electronically to the hospital's automated medication distribution system; further,

To promote the importance of pharmacist access to pertinent patient information, regardless of proximity to patient.

This policy was reviewed in 2014 by the Council on Pharmacy Practice and was found to still be appropriate.

Health-System Use of Medications and Administration Devices Supplied Directly to Patients (0806)

Source: Council on Pharmacy Management

To encourage hospitals and health systems not to permit administration of medications brought to the hospital or clinic by the patient or caregiver when storage conditions or the source cannot be verified unless it is determined that the risk of not using such a medication exceeds the risk of using it; further,

To support care models in which medications are prepared for patient administration by the pharmacy and are obtained from a licensed, verified source; further,

To encourage hospitals and health systems not to permit the use of medication administration devices with which the staff is unfamiliar (e.g., devices brought in by patients) unless it is determined that the risk of not using such a device exceeds the risk of using it; further,

To advocate adequate reimbursement for preparation, order review, and other costs associated with the safe provision and administration of medications and use of related devices.

This policy was reviewed in 2012 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Standard Drug Administration Schedules (0707)

Source: Council on Pharmacy Management

To support the principle that standard medication administration times should be based primarily on optimal pharmacotherapeutics, with secondary consideration of workload, caregiver preference, patient preference, and logistical issues; further,

To encourage the development of hospital-specific or health-system-specific standard administration times through an interdisciplinary process coordinated by the pharmacy; further,

To encourage information technology vendors to adopt these principles in system design while allowing flexibility to meet site-specific patient needs.

This policy was reviewed in 2016 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Universal Influenza Vaccination (0601)

Source: Commission on Therapeutics

To advocate universal administration of influenza vaccinations to the United States population.

This policy was reviewed in 2015 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Health Care Quality Standards and Pharmacy Services (0502)

Source: Council on Administrative Affairs

To advocate that health care quality improvement programs adopt standard quality measures that are developed with the involvement of pharmacists, are evidence-based, and promote the demonstrated role of pharmacists in improving patient outcomes.

This policy was reviewed in 2014 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Health-System Facility Design (0505)
Source: Council on Administrative Affairs
To advocate the development and the inclusion of contemporary pharmacy specifications in national and state health care design standards to ensure adequate space for safe provision of pharmacy products and patient care services; further,

To promote pharmacist involvement in the design-planning and space-allocation decisions of health care facilities.

This policy was reviewed in 2014 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Mandatory Tablet Splitting for Cost Containment (0525)
Source: Council on Professional Affairs
To oppose mandatory tablet splitting for cost containment in ambulatory care; further,

To encourage pharmacists, when voluntary tablet splitting is considered, to collaborate with patients, caregivers, and other health care professionals to determine whether tablet splitting is appropriate on the basis of the patient's ability to split tablets and the suitability of the medication (e.g., whether it is scored or is an extended-release product); further,

To urge pharmacists to promote dosing accuracy and patient safety by ensuring that patients are educated on how to properly split tablets; further,

To encourage further research by the United States Pharmacopeia and the Food and Drug Administration on the impact of tablet splitting on product quality.

This policy was reviewed in 2014 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Performance Improvement (0202)
Source: Council on Administrative Affairs
To encourage pharmacists to establish performance improvement processes within their practice settings that measure both operational and patient outcomes; further,

To encourage pharmacists to use contemporary performance improvement techniques and methods for ongoing improvement in their services; further,

To support pharmacists in their development and implementation of performance-improvement processes.

This policy was reviewed in 2016 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Pharmacy Benefits for the Uninsured (0101)
Source: Council on Administrative Affairs
To support the principle that all patients have the right to receive care from pharmacists; further,

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

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

This policy was reviewed in 2015 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Pharmacist Validation of Information Related to Medications (9921)
Source: Council on Professional Affairs
To support consultation with a pharmacist as a primary means for consumers to validate publicly available information related to medications.

This policy was reviewed in 2013 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Medication Administration by Pharmacists (9820)
Source: Council on Professional Affairs
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.

This policy was reviewed in 2017 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

ASHP Policy Positions 2009–2018 (with Rationales)
Medication Therapy and Patient Care:
Organization and Delivery of Services

1808

Patient Access to Pharmacist Care Within Provider Networks

Source: Council on Pharmacy Management

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

To advocate for laws and regulations that allow pharmacists and pharmacies to participate as a provider within a healthcare payer's network if the pharmacist or pharmacy meets the payer's criteria for providing those healthcare services; further,

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

To advocate that healthcare payers be required to disclose to pharmacists and pharmacies applying to participate in a provider network the criteria used to include, retain, or exclude pharmacists or pharmacies.

Rationale

As hospitals and healthcare organizations have become more engaged in developing ambulatory care services, pharmacists working in those settings increasingly find themselves excluded from healthcare payer networks. ASHP acknowledges that healthcare payers may develop and use criteria to determine provider access to its networks to ensure the quality of services and the financial viability of providers (i.e., ensuring sufficient patient volume to profitably operate), but when creating provider networks, payers should include pharmacists and pharmacies providing patient care services within their scope of practice when such services are covered benefits. To ensure equal treatment for healthcare providers, payers should be required to disclose to those applying to participate in a provider network the criteria used to include, retain, or exclude providers. When pharmacists obtain provider status, the infrastructure required to implement direct, independent patient care and billing for provider-based services needs to be in place and accessible. Ensuring pharmacists and pharmacies have the opportunity to engage and have access to payers and payer networks will improve patient access to pharmacists' care.

1809

Health Insurance Policy Design

Source: Council on Pharmacy Management

To advocate that all health insurance policies be designed and coverage decisions made in a way that preserves the patient–practitioner relationship; further,

To advocate that health insurance payers and pharmacy benefit managers provide public transparency regarding and accept accountability for coverage decisions and policies; further,

To oppose provisions in health insurance policies that interfere with established drug distribution and clinical services designed to ensure patient safety, quality, and continuity of care; further,

To advocate for the inclusion of hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

This policy supersedes ASHP policy 1520.

Rationale

Evolving practices by health insurers are negatively affecting patient care decisions and impacting the relationships between patients and their care providers. One common health insurance practice restricts management of and access to certain drugs to specialty suppliers. Another problematic practice is that certain drugs are not reimbursed by the insurer when used as part of the patient's hospital or health-system care. Medicare, for example, deems certain drugs as self-administered drugs, which are not reimbursed when provided to a patient because they are not considered integral to the reason for admission. These practices increase the number of patients that "brown bag" medications when they are admitted to a hospital to avoid being charged personally for the uncovered medications. ASHP has identified a number of concerns about these practices, including impact on continuity of care, integrity of the drug supply, patient satisfaction, and public perception of healthcare organizations.

It is the responsibility of the pharmacist to ensure the integrity of drugs used in the care of patients in the healthcare facility in which he or she practices. Having to verify products that patients bring with them from multiple suppliers disrupts the care process. Having patients go unreimbursed for a medication because it was administered in and supplied by the healthcare organization is confusing to the patient and damaging to the patient–provider relationship. More broadly, lack of understanding of the differing payment systems in different care settings leads to public relations challenges. In addition, the lack of transparency regarding how payers make certain coverage determinations and apply performance penalties (e.g., direct and indirect remuneration fees) creates a significant challenge for healthcare providers as they care for patients.

ASHP advocates reforming these insurance practices. Coverage of medications should not interfere with the safe and effective provision of care and should recognize the responsibility of pharmacists to ensure product integrity for care provided where they practice. In addition, ASHP advocates that the Centers for Medicare & Medicaid Services, commercial payers, and others include hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

1811

Use of International System of Units for Patient- and Medication-related Measurements

Source: Council on Pharmacy Practice

To advocate that the U.S. healthcare system adopt and only use the International System of Units (SI units) for all patient- and medication-related measurements and calculations; further,

To advocate that healthcare organizations use clinical decision support systems, equipment, and devices that allow input and display of patient- and medication-related measurements and calculations in SI format only; further,

To advocate that health information technology manufacturers utilize only SI units in their product designs for patient- and medication-related measurements; further,

To promote education in the use of SI units and the importance of using SI units to prevent medical errors.

Rationale

National healthcare, quality, and safety organizations have for years promoted the sole use of SI units for dosing and weight measurements. Errors in conversion from pounds to kilograms have caused two-fold overdosing and significant underdosing, particularly among pediatric patients, where even small dosing changes can have profound effects. Conversion to and from English units of volume (e.g., from milliliters to teaspoons) has long been identified as a source of dosing errors. These types of errors have been reported in all phases of the medication-use process (e.g., prescribing, preparation, dispensing, and administration) in all patient care settings.

Official labeling for U.S. drug products provides weight-based dosing only in SI units (e.g., mg/kg), so use of any other units introduces a risk of error. ASHP endorses national and institutional efforts to standardize the measurement and communication of patient weight using only SI units (i.e., grams and kilograms) but recognizes that other patient measures are sometimes used in dosing and other health-related calculations (e.g., body surface area, creatinine clearance, glomerular filtration rate, body mass index, or adjusted body weight). ASHP therefore advocates sole use of SI units by healthcare providers during prescribing, preparation, dispensing, and administration of medications in all patient care settings. To promote that practice, clinical decision support systems (e.g., electronic health record) and equipment (e.g., scales, stadiometers, infusion pumps) be structured to allow input and display of patient-related measurements and calculations in SI format only. Finally, education in how to use SI units, and about the importance of using SI units to prevent medical errors, will be required to overcome cultural resistance by healthcare providers, caregivers, and patients regarding SI unit use.

1822

Rational Use of Medications

Source: Council on Therapeutics

To promote evidence-based prescribing and deprescribing for indication, efficacy, safety, duration, cost, and suitability for the patient; further,

To advocate that pharmacists lead interprofessional efforts to promote the rational use of medications, including engaging in strategies to monitor, detect, and address patterns of irrational medication use in patient populations.

This policy supersedes ASHP policy 1312.

Rationale

The World Health Organization (WHO) identifies that rational use of medications requires that "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community." The overuse, underuse, or misuse of medicines results in wastage of scarce resources and widespread health hazards. Examples of irrational use of medicines include use of too many medicines per patient, inappropriate use of antimicrobials, inadequate dosage, overuse of injections when oral formulations would be more appropriate, failure to prescribe in accordance with clinical guidelines, inappropriate self-medication, decreased access to medicines, and nonadherence to dosing regimens. These actions can negatively affect the quality of patient care, raise healthcare costs, and increase the number of adverse reactions and events, and may cause adverse reactions or negative psychosocial effects.

Strategies to address irrational medication use can be characterized as educational, managerial, economic, or regulatory in nature. Furthermore, the WHO advocates 12 key interventions to promote more rational use of medications:

- establishment of a multidisciplinary national body to coordinate policies on medication use;
- use of clinical guidelines;
- development and use of national essential medications list;
- establishment of drug and therapeutics committees in districts and hospitals;
- inclusion of problem-based pharmacotherapy training in undergraduate curricula;
- continuing in-service medical education as a licensure requirement;
- supervision, audit, and feedback;
- use of independent information on medications;
- public education about medications;
- avoidance of perverse financial incentives;
- use of appropriate and enforced regulation; and
- sufficient government expenditure to ensure availability of medications and staff.

These recommendations are echoed by the Joint Commission of Pharmacy Practitioners, whose tenets of the pharmacists' patient care process include the collection of necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient; assessment of information

collected and analysis of the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care; development of an individualized patient-centered care plan, in collaboration with other healthcare professionals and the patient or caregiver that is evidence-based and cost-effective; implementation of the care plan in collaboration with other healthcare professionals and the patient or caregiver; and monitoring and evaluation of the effectiveness of the care plan and modification of the plan in collaboration with other healthcare professionals and the patient or caregiver as needed.

1823

Responsible Medication-related Clinical Testing and Monitoring

Source: Council on Therapeutics

To recognize that overuse of clinical testing leads to unnecessary costs, waste, and patient harm; further,

To encourage pharmacist accountability and engagement in interprofessional efforts to promote the judicious use of clinical testing and monitoring; further,

To promote research that evaluates pharmacists' contributions and identifies opportunities for the appropriate ordering of medication-related procedures and tests; further,

To promote the use of interoperable health information technology services and health information exchanges to decrease unnecessary testing.

Rationale

As the prevalence of collaborative practice grows and as pharmacist care expands into direct patient care services, so too do the responsibilities held by these practitioners. In many institutions, pharmacists' responsibilities now include ordering blood draws as a part of initiating a medication regimen, assessing drug levels, monitoring for adverse effects, or ordering imaging such as ultrasound for evaluating a deep vein thrombosis or an electrocardiogram to evaluate a QTc interval.

Overuse of medical care is a long-recognized problem in clinical medicine, and more spending and treatment do not translate into better patient outcomes and health. The number of articles on overuse nearly doubled from 2014 to 2015, indicating that awareness of overuse is increasing, despite little evidence of improved practice, which may mean that the overuse of diagnostic tests and lab monitoring is leading to patient harm and could outweigh benefits. Healthcare continues to be enthralled by high-technology innovation, including both therapies and tests. Once practice norms are established, clinicians are slow to de-implement services, even those that are found to be potentially dangerous. Reasons for excessive ordering of tests by healthcare providers include defensive behavior, fear, uncertainty, lack of experience, the use of protocols and guidelines, routine clinical practice, inadequate educational feedback, and clinician's lack of awareness about the cost of examinations. Inappropriate testing causes unnecessary patient discomfort, entails the risk of generating false-positive results, leads to overloading of diagnostic services, wastes valuable healthcare resources, and is associated with

other inefficiencies in healthcare delivery, undermining the quality of health services. One strategy for reducing unnecessary testing is use of interoperable health information technology services and health information exchanges.

Choosing Wisely is a national program designed to help raise provider and public awareness and garner support for appropriate test utilization, with the goal of promoting conversations between providers and patients about choosing appropriate care in order to reduce both harm and waste. In 2016, ASHP announced its partnership with the ABIM Foundation on the Choosing Wisely campaign, and in 2017 became the first pharmacy organization to contribute recommendations to the campaign.

1824

Use of Biomarkers in Clinical Practice

Source: Council on Therapeutics

To promote appropriate, evidence-based use of biomarkers in clinical practice; further,

To encourage research that evaluates the clinical and safety implications of biomarkers in the care of patients and to guide clinical practice; further,

To promote Food and Drug Administration qualified biomarkers in drug development, regulation, and use in clinical practice; further,

To foster the development of timely and readily available resources about biomarkers and their evidence-based application in clinical practice.

Rationale

The National Institutes of Health Biomarkers Definitions Working Group defined a biomarker as "a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention." In comparison to a clinical endpoint, a biomarker is strictly objective and quantifiable, whereas a clinical endpoint reflects the subject's well-being and health status from the subject's perspective. As defined by the FDA, a biomarker is "a defined characteristic that is measured as an indicator of normal biological processes, or responses to an exposure or intervention, including therapeutic interventions." The FDA classifies biomarkers in the following categories: susceptibility/risk biomarker, diagnostic biomarker, monitoring biomarker, prognostic biomarker, predictive biomarker, pharmacodynamic/response biomarker, and safety biomarker.

Further, the FDA and its Center for Drug Evaluation and Research are involved in regulating biomarkers in drug development, regulation, and use in clinical practice. Under the FDA Biomarker Qualification Program, researchers can request qualification of a biomarker in the use of drug development. The FDA's involvement in biomarker qualifications allows for the development of a regulatory process to investigate the safety and efficacy of biomarkers. Innovative and newly discovered biomarkers are investigated or found unexpectedly in clinical research. Recently published articles demonstrate newly discovered biomarkers that potentially

show clinical efficacy; however, there is debate about how to conduct further research to establish a biomarker's clinical efficacy.

This growth in discovery and application of established biomarkers in practice presents several practice issues, including use of recognized biomarkers, collaborating with practitioners concerning newly discovered or rising biomarkers, conducting research on the outcomes of the use of various biomarkers, and integrating use of biomarkers into practice.

1703

Pharmacist's Leadership Role in Anticoagulation Therapy Management

Source: Council on Therapeutics

To advocate that pharmacists provide leadership in caring for patients receiving medications for anticoagulant therapy management; further,

To advocate that pharmacists be responsible for coordinating the individualized care of patients receiving medications for anticoagulation therapy management; further,

To encourage pharmacists who participate in anticoagulation therapy management to educate patients, caregivers, prescribers, and other members of the interprofessional healthcare team about anticoagulant medication uses, drug interactions, adverse effects, the importance of adhering to therapy, access to care, and recommended laboratory testing and other monitoring.

This policy supersedes ASHP policy 0816.

Rationale

As medication experts, pharmacists are well poised to play a key role in implementation, maintenance, monitoring, management of complications, risk assessment, and assurance of continuity of care for patients receiving medications for management of anticoagulation therapy. Inappropriate medication-related management of anticoagulants creates unnecessary preventable harm.

The Joint Commission 2008 National Patient Safety Goals for hospitals include a requirement for reducing the likelihood of harm associated with anticoagulant therapy. Healthcare facilities are instructed to assign leadership for ensuring compliance with this requirement, standardize therapeutic practices and protocols, establish monitoring procedures and a drug–food interaction program, individualize care for each patient receiving these treatments, and provide education on the appropriate management of these patients.

1721

Clinical Significance of Accurate and Timely Height and Weight Measurements

Source: Council on Therapeutics

To encourage pharmacists to participate in interprofessional efforts to ensure accurate and timely patient height and weight measurements are recorded in the patient medical record to provide safe and effective drug therapy; further,

To encourage drug product manufacturers to conduct and publicly report pharmacokinetic and pharmacodynamic research in pediatric, adult, and geriatric patients at the extremes of weight and weight changes to facilitate safe and effective dosing of drugs in these patient populations, especially for drugs most likely to be affected by weight; further,

To encourage independent research on the clinical significance of extremes of weight and weight changes on drug use, as well as the reporting and dissemination of this information via published literature, patient registries, and other mechanisms; further,

To advocate that clinical decision support systems and other information technologies be structured to facilitate prescribing and dispensing of drugs most likely to be affected by extremes of weight and weight changes.

Rationale

Patients who have clinically significant changes in weight during an admission or between physician visits, or who are at an extreme high or low weight, have a higher risk of medication dosing errors that depend on weight body surface area. Accurate heights and weights in SI units (i.e., kilograms, grams, meters, and centimeters) are an integral part of a physical examination for pharmacists to ensure proper dosing of medications. Certain medications require dosing based on body surface area, and there is a need for healthcare organizations to consistently record patients' height, as estimation of height or weight can contribute to potential over- or underdosing.

Factors such as clinically significant changes in weight due to fluid overload and subsequent diuresis, patient growth, and weight changes due to changes in caloric consumption complicate the picture of an appropriate weight to record for dosing certain medications. Some healthcare organizations default to a dosing weight that is used for dosing medications alone, while other weight fluctuations recorded on a daily basis are not used to dose medications, whereas other organizations alert pharmacists to a clinically significant change in weight. Leveraging technology to ensure such safeguards are in place is essential, and providing interoperability between the patient's recorded dosing weight and smart pumps is ideal.

Pharmacists are also seeing an increase in the number of patients at both extremes of weight, and there is a lack of information regarding dosing medications for these populations. ASHP advocates that the Food and Drug Administration (FDA) develop guidance for voluntary drug dosing studies in these populations, as the need for this guidance is supported by the complexity of drug dosing that can vary based on drug and patient characteristics. Drug product manufacturers should be encouraged to complete pharmacokinetic and pharmacodynamic dosing studies, and to publicly report the results, especially for drugs for which significant weight extremes may have clinical impact.

1616

Patient Experience

Source: Council on Pharmacy Management

To encourage pharmacists to evaluate their practice settings for opportunities to improve the experience patients have with healthcare services and with the outcomes of their drug therapy; further,

To educate pharmacists and pharmacy personnel about the relationship between patient experience and outcomes; further,

To develop or adopt tools that will (1) provide a system for monitoring trends in the quality of pharmacy services to patients, (2) increase recognition of the value of pharmacy services, and (3) provide a basis for making improvements in the process and outcomes of pharmacy services in efforts to engage patients and improve their experience; further,

To facilitate a dialogue with and encourage education of patient experience database vendors to include the value of pharmacists and pharmacy services in the patient experience.

This policy supersedes ASHP policy 0104.

Rationale

A major component of quality of healthcare is patient satisfaction (often referred to as "the patient experience"), which is critical to how well patients respond and adhere to healthcare. Research has identified a clear link between patient outcomes and a positive patient experience. Additionally, the patient experience is a key determinant of quality of care and an important component of pay-for-performance metrics. Pharmacy leaders need to continually assess how pharmacists and pharmacy services support an improved patient experience with their care across the continuum of practice sites, including how pharmacists contribute to team-based care.

1618

Integrated Approach for the Pharmacy Enterprise

Source: Council on Pharmacy Practice

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

To advocate a high level of coordination of all components of the pharmacy enterprise across the continuum of care for the purpose of optimizing (1) medication-use safety, (2) quality, (3) outcomes, and (4) drug therapy.

This policy supersedes ASHP policy 0619.

Rationale

In November 2004 the Joint Commission of Pharmacy Practitioners adopted a vision for pharmacy practice that states that "pharmacists will be the healthcare professionals responsible for providing patient care that ensures optimal medication therapy outcomes." At the time, ASHP envisioned the pharmacy department as an integrated entity serving as the

nucleus for direct and team-based engagement of all pharmacists who work in the institution in an open feedback loop among various areas that support the overall pharmacy enterprise, including drug-use policy, product acquisition and inventory control, frontline and specialized clinical practice, product preparation and distribution, and medication-use safety and quality.

Support for such an integrated approach is based on recognition that the medication-use process is a tightly linked continuum in which the activities of one area affect other upstream and downstream processes.

In the decade since, the healthcare enterprise has continued its evolution from single hospitals to integrated systems and networks. These systems have become even more complex as they expand into new businesses, such as physician practices and outpatient care sites. As these organizations seek to standardize operations and gain economies of scale, pharmacy leaders have recognized that the evolving pharmacy enterprise is more far-reaching and sophisticated than in the past, and pharmacy leaders at all levels have to manage their pharmacy services in the context of the overall goals and needs of the organization across a wide array of business units, care settings, and organizations. ASHP continues to believe that the integrated approach will optimize drug therapy (i.e., obtaining the most benefit from the resources invested in drug products, taking into account both the cost of drug products and appropriate use of the products); medication-use safety (i.e., avoiding preventable adverse drug events, including medication errors); patient and economic outcomes, and healthcare quality.

Management of pharmacy services is no longer confined to drug distribution and clinical pharmacy but also includes human resources management, integrity of the electronic health record and related patient-care information, and oversight of various business partners. Pharmacy leaders within these evolving health systems confront many new challenges, ranging from communication among the pharmacy management team, decisions on pharmacy infrastructure purchases and contracting, identification of critical services and standardization, succession planning and workforce development, supply chain management, human resource coordination, and strategic planning across diverse healthcare sites within the system. Further challenging health system pharmacy leaders are coordinating pharmacy services across larger geographical regions and organizational boundaries. To cope with these new challenges, pharmacy department leaders need to integrate into a team all pharmacy personnel engaged in the medication-use process of their organizations, including general and specialized clinical practice, drug-use policy, product acquisition and inventory control, product preparation and distribution, and medication-use safety and other quality initiatives.

1619

Preventing Exposure to Allergens

Source: Council on Pharmacy Practice

To advocate for pharmacy participation in the collection, assessment, and documentation of a complete list of allergens pertinent to medication therapy, including food, excipients, medications, devices, and supplies, for the purpose of clinical decision-making; further,

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

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

To encourage education of pharmacy personnel on medication-related allergens.

Rationale

In 2005, ASHP adopted policy 0501, Mandatory Labeling of the Presence of Latex, and in 2008 adopted policy 0808, Excipients in Drug Products (now ASHP policy 1528). The common theme in these policies is that patients may be exposed to potentially life-threatening allergens in items encountered in the medication-use process (i.e., natural rubber latex, drugs, drug product excipients, devices, and supplies). Pharmacy involvement in collection, assessment, and documentation of a complete list of allergens pertinent to the medication-use process, including food, excipients, medications, devices, and supplies, would assist in clinical decision-making. Pharmacists should also minimize patient and healthcare worker exposure to known allergens, for example by limiting or banning the use of latex gloves in pharmacies and striving for latex-safe medication formularies. Although allergy information is becoming more readily accessible though the electronic health record and clinical decision support systems, some well-known cross-sensitivities are good candidates to be included in medication-related databases.

1504

PATIENT ADHERENCE PROGRAMS AS PART OF HEALTH INSURANCE COVERAGE

Source: Council on Public Policy

To advocate for the pharmacist's role in patient medication adherence programs that are part of health insurance plans; further,

To advocate those programs that (1) maintain the direct patient pharmacist relationship; (2) are based on the pharmacist's knowledge of the patient's medical history, indication for the prescribed medication, and expected therapeutic outcome; (3) use a communication method desired by the patient; (4) are consistent with federal and state regulations for patient confidentiality; and (5) permit dispensing of partial fills or overfills of prescription medications in order to synchronize medication refills and aid in medication adherence.

This policy supersedes ASHP policy 0116.

Rationale

Current payment rules for Medicare Part D plans require a prorated cost-sharing rate for prescriptions dispensed with less than a 30-day supply. This is allowed to avoid waste in the event that a prescription is modified in response to an adverse reaction. Aligning or synchronizing a medication to all of a patient’s chronic medications has been proven to improve adherence. Although Medicare has adopted a policy allowing for a daily cost-sharing rate, other payers have not followed suit. ASHP advocates for similar changes in state law and regulation,

since such a change would allow for broader synchronization and improved adherence for patients covered by Medicaid and private third-party payers.

1511
COMPLEMENTARY AND ALTERNATIVE MEDICINE IN PATIENT CARE
Source: Council on Therapeutics

To promote awareness of the impacts of complementary and alternative (CAM) products on patient care, particularly drug interactions, medication safety concerns, and the risk of contamination and variability in active ingredient content; further,

To advocate for the documentation of CAM products in the health record to improve patient safety; further,

To advocate for the inclusion of information about CAM products and their characteristics in medication-related databases; further,

To provide education on the impacts of CAM products on patient care in healthcare organizations; further,

To foster the development of up-to-date and readily available resources about CAM products.

Rationale

Complementary and alternative medicine (CAM) may be broadly defined to include biologically based practices, such as dietary supplements, proteins, amino acids, and functional foods; energy therapies; manipulative body-based methods; and mind-body medicine. It is estimated that 38% of adults and 12% of children use some form of CAM. In 2007, $15 billion was spent on CAM in the U.S., and the worldwide market for dietary supplements alone is estimated to be $68 billion.

In the ASHP Statement on the Use of Dietary Supplements, ASHP expressed its concern that the widespread, indiscriminate use of dietary supplements presents substantial risks to public health and detailed the basis of those concerns. Some dietary supplements are inherently unsafe, to all people or special populations. Lax regulation of dietary supplement manufacturing presents the risk of contamination or adulteration with harmful substances, including prescription medications. Some dietary supplements interact with medications and may therefore compromise, complicate, or delay effective treatment. Some patients, particularly those who cannot afford expensive medication regimens, may substitute ineffective alternatives for well-proven medical therapies. Product content (both active ingredient and excipients) is not standardized, therapeutic goals are vague, and evidence of efficacy and safety is absent or ambiguous. Although the National Center for Complementary and Alternative Medicine (NCCAM) is taking steps to address the gaps in information regarding CAM products, pharmacists (like other healthcare providers) are frustrated in fulfilling their professional responsibility to provide patients with sound advice by the lack of reliable information about

the safety and efficacy of CAM products.

Healthcare organizations take varying approaches to addressing CAM use. Some actively counsel patients against CAM use, others take a more integrative approach and accept the practice, and some even have clinics for referrals. There is, however, a gap in information about CAM use in healthcare organizations. A recent survey of 109 children's hospitals revealed that 44% report having written policies on dietary supplements, with 46% requiring that interactions be documented in the medical record. Another survey of 302 pharmacy directors found that 38% had no policy on dietary supplements. ASHP has long encouraged healthcare organizations to develop an institutional policy regarding the use of dietary supplements that would allow pharmacists and other healthcare practitioners to exercise their professional judgment while balancing patient autonomy and institutional concerns. Such policies should include promoting healthcare practitioner awareness of the potential impacts of CAM use and should encourage documentation of CAM use in the patient's health record so that pharmacists and other healthcare practitioners have the knowledge and information they need to treat and advise patients.

1523

PHARMACIST'S ROLE IN POPULATION HEALTH MANAGEMENT

Source: Council on Pharmacy Management

To recognize the importance of medication management in patient-care outcomes and the vital role of pharmacists in population health management; further,

To encourage healthcare organizations to engage pharmacists and pharmacy leaders in identifying appropriate patient cohorts, anticipating their healthcare needs, and implementing the models of care that optimize outcomes for patients and the healthcare organization; further,

To encourage the development of complexity index tools and resources to support the identification of high-risk, high-cost, and other patient cohorts to facilitate patient-care provider panel determinations and workload balancing; further,

To promote collaboration among members of the interprofessional healthcare team to develop meaningful measures of individual patient and population care outcomes; further,

To advocate for education to prepare pharmacists for their role in population health management.

Rationale

As hospital and health systems become larger and adjust to new payment models (e.g., readmissions penalties and reduced Medicare payments), the need for health-system and pharmacy leaders to determine the safest, most efficient, and most economical way to care for identified patient populations has become a significant challenge. Pharmacists have an important role in managing medication therapies for individual patients as well as participating

in the development of care models for patient populations with the interprofessional teams they work within. The utilization of "big data" by health systems is a growing domain of research, and it will be important for pharmacists and pharmacy leaders to make use of this information when developing strategic plans and resource allocations. Similar to the workload and productivity issues traditionally facing hospital leaders, the need to stratify total patient populations, anticipate their healthcare resource needs, and then assign the best site and model of care to obtain the ideal return on investment for both the patient and organization has become of paramount importance. The need for identifying the ideal patient panel sizes and the demographics of these panels will be important for patients and pharmacists as pharmacists practice more in the ambulatory care environment. To accomplish these goals, pharmacists will require education to prepare for their role in population health management.

1525
STANDARDIZATION OF DOSES
Source: Council on Pharmacy Practice

To recognize that standardization of medication doses reduces medication errors and improves information technology interoperability, operational efficiency, and transitions of care; further,

To encourage development of universal standardized doses for specific patient populations; further,

To encourage healthcare organizations to adopt standardized doses and to promote publication and education about best practices.

Rationale

Standardization and simplification are widely accepted methods for reducing variability in processes with risk for error. Standardization of medication doses reduces waste and improves efficiency. Computer databases could be constructed with standard dosage forms, facilitating information technology interoperability. Simplified instruction for patients and caregivers improves administration in the home as well as patient adherence.

The standardization of liquid doses has been successfully accomplished in hospitals, but standardization of doses is also applicable to parenteral nutrition solutions and other injectable dosage forms. Standardization of doses within a hospital or health system would reduce waste and the potential for errors in those settings. The strict application of pediatric weight-based dosing, for example, leads to a large number of different doses being used, and many of those doses must then be prepackaged dose-by-dose due to limited stability of liquid and injectable dosage forms.

Standardization of doses within organizations would be made easier by the development of universal standardized doses for specific patient populations, which will require substantial research. Additional studies to determine best practices for standardization of medication doses and education of healthcare practitioners are also needed to facilitate broad adoption of this practice.

1401

STANDARDIZATION OF ORAL LIQUID MEDICATION CONCENTRATIONS

Source: Council on Pharmacy Practice

To advocate for the development of nationally standardized drug concentrations for oral liquid medications; further,

To encourage all health care providers and organizations to standardize concentrations of oral liquid medications; further,

To promote effective instruction of patients and caregivers on how to properly measure and administer oral liquid medications.

Rationale

Standardization and simplification are widely accepted methods for reducing variability in processes with risk for error. Many oral liquid medications are available in more than one concentration from manufacturers, and unique pharmacy-compounded formulations also result in a wide variety of concentrations. Standardization at a national level would reduce variability when patients are discharged and have prescriptions filled at pharmacies in the community. Standardization of concentrations within a hospital or health system would reduce the potential for errors in those settings. Standard doses would reduce the potential for error, reduce waste, and improve efficiency. Improved instruction of patients and caregivers would improve proper administration in the home, safely delivering the prescribed dosage of medication.

1419

DOCUMENTATION OF PATIENT-CARE SERVICES IN THE PERMANENT HEALTH RECORD

Source: Council on Pharmacy Management

To advocate for public and organizational policies that support pharmacist documentation of patient-care services in the permanent patient health record to ensure accurate and complete documentation of the care provided to patients and to validate the impact of pharmacist patient care on patient outcomes and total cost of care; further,

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

This policy supersedes ASHP policy 0407.

Rationale

Documentation in the patient record is a critical for a complete record for patient care and communication among members of the health care team. Documentation should be done within an electronic health record (EHR) or on paper. When documenting electronically, use of standardized and coded formats will allow for improved patient outcome measurements.

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.

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, Board, and House clarified that the intent of this 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, and the Board and House agreed.

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.

Rationale

The Council, Board, and House of Delegates 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 and House agreed. For these reasons, the Council, Board, and House 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, Board, and House 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, and the Board and House agreed. In addition, it was noted that even when these studies are completed, information from these studies is not widely available or easily accessible. Finally, 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, Board, and House to improve the transparency of the approval process and access to information.

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, Board, and House encouraged research that could inform product manufacturers during the development process and provide information to clinicians about use of these products in patient care.

1202

QUALIFICATIONS AND COMPETENCIES REQUIRED TO PRESCRIBE MEDICATIONS

Source: Council on Education and Workforce Development

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.

Rationale

Debate about health care providers' evolving scopes of practice, focused primarily on prescribing privileges, has raised the question of what training and competencies should be required of current or potential prescribers. The increasing complexity of medication use, growing diversity of professionals authorized to prescribe, and continuing high incidence of adverse drug events call for the development of standards for prescribing and further development of associated competencies and training requirements.

1208

TRANSITIONS OF CARE

Source: Council on Pharmacy Management

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.

This policy supersedes ASHP policy 0301.

Rationale

Health care reform will have a significant impact on the implementation of new pharmacy practice models. Changes in health care reimbursement will likely result in an increasing focus on the role of pharmacists at the transition of care from the acute care environment to other settings. ASHP policy 0301 will be increasingly important as health systems increase their focus on reducing readmissions, improving patient satisfaction, and effectively educating patients about their medications. It is important that ASHP advocate for improvements in information systems that facilitate sharing of patient information across various care settings. Further alignment of financial incentives and resources that encourage and support patient-care roles of pharmacists in the transition of care are also required.

1213

PHARMACIST PRESCRIBING IN INTERPROFESSIONAL PATIENT CARE

Source: Council on Pharmacy Practice

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.

Rationale

The Pharmacy Practice Model Initiative (PPMI) Summit recommended that "[t]hrough credentialing and privileging processes, pharmacists should include in their scope of practice prescribing as part of the collaborative practice team." (Recommendation B14) With the demand for health care growing as the nation ages and increasing concern about the shortage

of primary care providers, expanding the pharmacist's role will contribute to the overall capacity of the health care workforce to meet patients' primary health care needs.

As pharmacist prescribing is an innovative concept, a clear, concise definition of what it means and does not mean has yet to be established. Unlike physician prescribing, which is commonly understood to be the diagnosis and treatment of diseases and conditions, various terms are currently used to describe pharmacists' medication ordering activities, such as prescriptive authority, collaborative practice, and collaborative drug therapy management (CDTM). These differ in definition and interpretation, depending on state scope of practice laws and other factors. A standard definition of pharmacist prescribing will facilitate future discussions on the role of pharmacists in interdisciplinary health care, help delineate health care team roles, enhance collaborative patient care, and clarify the meaning of pharmacist prescribing for other health care providers.

In the proposed definition, pharmacist prescribing differs from that by other authorized prescribers and from medication therapy management (MTM) and CDTM in three significant aspects. First, prescribing by pharmacists requires active participation in the patient's health care team or active engagement and coordination with other individual practitioners responsible for the patient's care. Second, pharmacist prescribing must take place in concert with assessment, diagnosis, and other clinical findings contributed by the patient's other care providers, and changes in the patient's medication therapy must be communicated to these individuals in a readily available and timely manner. Third, pharmacists who prescribe are accountable to patients and to the health care team for exercising professional judgment in pharmacotherapy and medication-use decision-making according to their defined scope of services, as well as for the outcomes of those services. While many pharmacists may currently order medications under protocols for MTM or CDTM, prescribing entails a higher degree of autonomy and is a role for advanced practitioners with demonstrated competency and expertise.

Although clinical pharmacy specialists practicing in highly focused clinical areas such as oncology and transplant often become skilled at diagnosing and treating symptoms in their respective patient populations, and pharmacists are prepared and qualified to interpret medication-related clinical laboratory results, the education and training pharmacists receive in physical assessment does not prepare or qualify them to be diagnosticians. Pharmacist prescribing may therefore be described as interdependent, but under this interdependent model, review, approval, and co-signature of pharmacist-prescribed medications by a licensed independent prescriber should be unnecessary, if pharmacists are in fact accountable for medication therapy outcomes. ASHP policy supports pharmacist authority in matters of medication therapy, autonomy in exercising professional judgment, and accountability for medication therapy outcomes. Patients are best served, however, when the expertise of pharmacists is applied to therapeutic use of medicines after definitive diagnosis indicates that medicines are the appropriate therapy.

The American Medical Association and the American Academy of Family Physicians have publicly and staunchly opposed any expansion of pharmacist scope of practice perceived to encroach on the practice of medicine. Pharmacist prescribing is implicit to interdisciplinary care delivery, however. Independent drug therapy decision-making by pharmacists in hospitals is already common. It is often accepted and even expected by physicians. Physicians participating

in multidisciplinary teams with pharmacists come to rely on their knowledge and see an opportunity to free themselves from tasks that can be done by another professional with demonstrated competency and expertise. Pharmacists in specialty practices such as anticoagulation management, solid organ transplant, and nutrition support have long functioned in roles in which near-independent authority to manage drug therapy has resulted in improved outcomes. In settings such as the Indian Health Service and Veterans Affairs health systems, where access to a primary care provider is limited, care provided by pharmacists with prescribing authority has demonstrated the benefits of this model.

Most hospitals authorize pharmacists to manage drug therapy by enacting Pharmacy and Therapeutics Committee policies that require use of an approved medical staff protocol and physician oversight for pharmacist-initiated orders. In practice, however, pharmacists often manage patients' clinical needs that cannot be appropriately treated per protocol with minimal physician oversight. Depending on the patient, medication, and degree of trust, physicians may co-sign such orders with only cursory review. To the extent allowed by hospital policy, physicians often delegate therapeutic decision-making to pharmacists, secure in the trust developed through established professional relationships and shared experiences in successfully dealing with challenging clinical situations, rather than through formal collaborative practice agreements. Common examples of de facto pharmacist prescribing include independently managing symptoms and side effects in oncology patients, identifying and resolving drug-induced disease or problems, managing anticoagulant therapy for patients whose clinical status falls outside protocol-specified parameters, and responding to general directives to simply "fix the problem" when medication therapy is indicated.

Credentialing by individual health care organizations is a natural selection process for determining who is authorized to prescribe that avoids distinguishing pharmacists by practice setting and allows more latitude in scope of practice. The credentialing procedures to establish pharmacists' competency to prescribe must ensure that patients receive treatment from highly qualified caregivers. In addition to verifying appropriate education, licensure, and certification, the process should include

- the same transparency and rigor applied to other prescribers,
- criteria used to measure patient care quality, and
- peer review by pharmacists and others who are authorized to prescribe.

Health care organizations should use privileging methods that establish the scope of practice and clinical services that pharmacists are authorized to provide commensurate with their demonstrated competency within an area or areas of clinical expertise. Pharmacists practicing in hospitals and health systems do not have or need privileges, such as admitting, that are not related to medication use.

Finally, interdisciplinary health professional training programs should incorporate the concept of pharmacist prescribing in a standard way.

1215

PHARMACIST'S ROLE IN TEAM-BASED CARE

Source: Council on Pharmacy Practice

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.

Rationale

The PPMI Summit recommendations are based on a growing consensus among health care providers and payers that patient-centered care by a collaborative team is the optimal model of care. A collaborative care model provides pharmacists with an opportunity to contribute their expertise in medication use to improving patient outcomes.

The pharmacy profession appears to be struggling, however, with implementation of this care model. Not unexpectedly, states appear to vary widely in the way the "team-based care" PPMI recommendations are interpreted and applied. Therefore, states currently in the process of rewriting practice acts have been challenged to find guidance on the fundamental roles and responsibilities of pharmacists in various care settings. This policy recommendation builds on concepts in ASHP policy 1114, Pharmacist Accountability for Patient Outcomes; sets the expectation for other providers that teams with pharmacists will improve the quality, safety, and efficiency of care; and supports advocacy to the broader health care community on the value of care delivery by teams that include pharmacists.

1217

COLLABORATIVE DRUG THERAPY MANAGEMENT

Source: Council on Public Policy

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.

This policy supersedes ASHP policy 9812.

Rationale

ASHP policy 9812 was revised to (1) explicitly include in the second clause the need to expand a pharmacist's scope of practice to allow them to practice to the fullest extent of their expertise, and (2) acknowledge in the third clause that pharmacists are part of the interdisciplinary team and are accountable to the patient and the team for all medication-related outcomes. With these changes, the policy expresses the concept of pharmacists' professional identity and autonomy while providing their unique expertise and practice as part of an interdependent and interdisciplinary health care team focused on achieving the best patient outcomes.

Although more than 43 states permit collaborative drug therapy management (CDTM), there is great variability in the authority granted to pharmacists engaged in CDTM. With this policy, ASHP reiterates its support for CDTM and advocates for its expansion to all states, in a variety of diverse practice settings, and at the highest level of pharmacy practice. As new practice models emerge as recommended by the PPMI, CDTM should be a part of those innovations. The addition of these clauses in policy 9812 will aid in moving the profession forward to the highest level of practice and enable pharmacists to practice at the top of their licenses.

1222

MEDICATION ADHERENCE

Source: Council on Therapeutics

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.

Rationale

The need to improve medication adherence as a cornerstone of efforts to improve patient care outcomes is widely recognized. A 2010 *New England Journal of Medicine* editorial issued a call to action to improve adherence based on estimates that 50 percent of all patients are non-adherent, resulting in an estimated $100 billion spent annually on avoidable hospitalizations. ASHP supports programs to improve adherence, but such efforts are not useful, and are perhaps harmful, if they fail to (1) assess the appropriateness of therapy, (2) provide patient education, and (3) ensure patient comprehension of information necessary to support safe and appropriate use of prescribed therapies. Pharmacists are the ideal clinician to lead multidisciplinary efforts to improve medication adherence based on their distinct knowledge, skills, and abilities related to drug therapy management. Other members of the multidisciplinary team could include physicians, nurses, health psychologists, and social workers. Patients and their caregivers must share accountability with clinicians for medication outcomes, including the responsibility for following instructions for safe and effective medication use. Otherwise, the results from efforts of pharmacists and other clinicians would be negligible. Some interventions to improve medication adherence have shown favorable results, but the greatest success is achieved by models that incorporate multiple strategies reinforced over time. Therefore, the development, evaluation, and dissemination of models that use multimodal approaches are encouraged. The development of information technology solutions and other mechanisms to document interventions intended to improve medication adherence are also recommended. Further, payment models that support an expanded role for pharmacists in medication adherence efforts should be pursued.

1107

PATIENT-REPORTED OUTCOMES TOOLS

Source: Council on Therapeutics

To advocate for expanded use of validated patient-reported outcomes (PRO) tools in clinical research and direct patient care; further,

To support development of validated PRO tools that are sensitive to differences in cultural and health literacy; further,

To encourage additional research on PRO tools, including studies to assess their correlation to overall patient outcomes; further,

To educate clinicians and patients about the appropriate use of PRO tools.

Rationale

The Council supported expanded use of validated patient-reported outcomes (PRO) tools—assessments of patient satisfaction, health-related quality of life, or health status—in clinical research and direct patient care, and the Board and House agreed. Although PRO tools are most often applied in the research setting, the Council, Board, and House believed that their increased application in direct patient care was warranted as a mechanism to integrate the patient perspective into the assessment and management of disease. Use of PRO tools was noted as consistent with the emphasis on patient-centered care advocated by the Institute of Medicine and other quality improvement initiatives. The Council, Board, and House supported the development of validated PRO tools that account for variability in patient cultural and health literacy and encouraged research to better define the relationship between PRO measures and overall patient outcomes. The need for clinician and patient education on the appropriate use of PRO tools was noted, including the importance of instructing clinicians to select PRO tools that are validated in patient populations that are similar to the populations in which they will be used.

1114

PHARMACIST ACCOUNTABILITY FOR PATIENT OUTCOMES

Source: Council on Pharmacy Practice

To affirm that pharmacists are obligated by their covenantal relationship with patients to ensure that medication use is safe and effective; further,

To declare that pharmacists, pursuant to their authority over a specialized body of knowledge, are autonomous in exercising their professional judgment and accountable as professionals and health care team members for safe and effective medication therapy outcomes; further,

To encourage pharmacists to define practices and associated measures of effectiveness that support their accountability for patient outcomes; further,

To promote pharmacist accountability as a fundamental component of pharmacy practice to other health care professionals, standards-setting and regulatory organizations, and patients.

Rationale

The Council, Board, and House agreed that a clear, succinct policy communicating the interrelationship of authority and autonomy with accountability for outcomes, good or bad, is needed. The policy should distill and define ASHP's stance on accountability and draw on concepts implicit in current ASHP policy documents. The Council, Board, and House recognized that authority, autonomy, and accountability are inseparable components of professional practice. Without accountability, the pharmacy profession cedes the ultimate authority for decision-making in matters of medication therapy to prescribers, calling into question whether pharmacy is, in fact, a profession.

The pharmacist's covenantal relationship with patients is described in the *Pharmacist's Oath*, to which all pharmacy students profess, and which states in part:

- I will consider the welfare of humanity and relief of suffering my primary concerns.
- I will apply my knowledge, experience, and skills to the best of my ability to assure optimal outcomes for my patients.
- I will embrace and advocate changes that improve patient care.

The attributes of professional status are defined by sociological, ethical, and legal expectations in literature on this subject. Those commonly cited include:

- Work is based upon the mastery of a complex body of knowledge and skills; a practice founded upon this knowledge is used in the service of others.
- Members are governed by codes of ethics and profess a commitment to competence, integrity, and … promotion of the public good within their domain.
- A social contract exists in which, in exchange for these commitments, society recognizes the profession's authority over the knowledge base, autonomy in practice, and the privilege of self-regulation.
- The profession's members are accountable to those served and society.

Despite strong advocacy by pharmacy thought leaders and a wealth of evidence in its support, the precept that pharmacists are accountable for medication therapy outcomes is not widely accepted by other health care disciplines, nor is it broadly integrated into pharmacy practice. Moreover, many pharmacists may be ambivalent about assuming a role that holds them to high standards of practice and makes them answerable for the welfare of patients.

Accountability is implicit in many ASHP policy documents, most notably in the *ASHP Statement on Pharmaceutical Care*:

> Pharmaceutical care is not a matter of formal credentials or place of work. Rather, it is a matter of a direct personal, professional, responsible relationship with a patient to ensure that the patient's use of medication is optimal and leads to improvements in the patient's quality of life.

The pharmacist's authority over and expertise in use of medications are supported by the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation Interpretive Guidelines, which establish a definition and expectation for pharmaceutical care:

Pharmaceutical care is defined as the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient's quality of life while minimizing patient risk.

The *Statement on the Future Vision of Pharmacy Practice* from the Joint Commission of Pharmacy Practitioners (JCPP) is explicit in its expectation for pharmacist autonomy and accountability and states in part:

> How Pharmacists Will Practice. Pharmacists will have the authority and autonomy to manage medication therapy and will be accountable for patients' therapeutic outcomes.

> In doing so, they will communicate and collaborate with patients, care givers, health care professionals, and qualified support personnel. As experts regarding medication use, pharmacists will be responsible for rational use of medications, including the measurement and assurance of medication therapy outcomes…. Working cooperatively with practitioners of other disciplines to care for patients, pharmacists will be … valued patient care providers whom health care systems and payers recognize as having responsibility for assuring the desired outcomes of medication use.

The JCPP vision statement encompasses these attributes and clearly illustrates the direction that the pharmacy profession must take. In particular, the Council, Board, and House confirmed that pharmacist accountability is a profession-defining issue that must be urgently addressed, recognizing that the policy is at most a starting point for the transformation that needs to take place in order to realize the JCPP vision.

The Council stated that unless the pharmacy profession commits to actions that translate the policy into practice, pharmacists are at risk of becoming irrelevant. As changes brought about by health care reform are implemented to add value to health care and reduce costs, the extensive training and high salaries of pharmacists cannot be justified if, as noted by the 2007 Council, "pharmacists are responsible and held accountable only for the acquisition, storage, and dispensing of medications."

The Council called on ASHP to be fearless and persistent in promoting and establishing the JCPP vision within the profession. The Council also recommended that ASHP use its influence to create the "pull" for accountability in pharmacy practice by establishing an expectation of pharmacist accountability by other health care providers, standards-setting and regulatory organizations, and payers.

1117

PHARMACISTS' ROLE IN MEDICATION RECONCILIATION

Source: Council on Pharmacy Practice

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

To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should take a leadership role in interdisciplinary efforts to develop, implement, monitor, and maintain effective medication reconciliation processes; further,

To encourage community-based providers, hospitals, and health systems to collaborate in organized medication reconciliation programs to promote overall continuity of patient care; further,

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

This policy supersedes ASHP policy 0620.

Rationale

The Council reviewed proposed changes to The Joint Commission (TJC) national patient safety goal requiring medication reconciliation. The Council expressed support for TJC's intent to make the goal more achievable while continuing to support patient safety and recommended policy changes where indicated in order to align with TJC standards.

The Council noted that ASHP policy did not include an affirmation of the value of medication reconciliation in both patient care and patient safety and recommended a revision in support of the medication reconciliation process. The Council also noted that the revised goal no longer requires a list of medications, only "information on the medications the patient is taking." The Council recommended changes in policy language that delete references to a list as an essential component of medication reconciliation and emphasize the pharmacist's role.

Council members expressed concern that current policy language could be misinterpreted as placing sole responsibility for implementation of medication reconciliation on the pharmacy department and believed the policy should acknowledge other equally invested stakeholders in the medication-use process. The Council emphasized, however, that pharmacists are the health care professionals who should promote medication reconciliation practices that ensure good patient outcomes. They stated that pharmacy leadership in developing and guiding an organizational approach to medication reconciliation is more important than ever.

1005

MEDICATION THERAPY MANAGEMENT

Source: Council on Public Policy

To support medication therapy management (MTM) services as defined in Section 3503 of the Patient Protection and Affordable Care Act (PL 111-148); further,

To affirm that MTM is a partnership between the patient (or a caregiver) and a pharmacist, in collaboration with other health care professionals, that promotes the safe and effective use of medications.

Rationale

The term "medication therapy management" (MTM) has received widespread use within the pharmacy profession and among health policymakers. The definition of MTM under Part D of the Medicare program is significantly different from the consensus definition developed by national pharmacy organizations, including ASHP, in 2004. Provisions dealing with MTM grant programs contained in Section 3503 of the Patient Protection and Affordable Care Act (PL 111-148) (PPACA) broaden and enhance MTM beyond the Part D definition. Those provisions also refer to collaborative practice agreements as allowed by state practice acts, referred to in ASHP policy and elsewhere as "collaborative drug therapy management" (CDTM). As health care reform evolves and is implemented, it is important to recognize the distinction that state and federal laws and regulations and ASHP policy make between those two terms and to affirm

ASHP's support for the broader definition of MTM in PPACA and the central role of pharmacists in MTM.

1022
PATIENT ACCESS TO PHARMACY SERVICES IN SMALL AND RURAL HOSPITALS
Source: Council on Pharmacy Practice

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

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

This policy supersedes ASHP policy 0503.

Rationale
Recent legislation in Texas exempts hospitals with fifty or fewer beds in remote locations from requiring prospective medication order review by a pharmacist. Pharmacist prospective order review is a well-supported safety practice that is required by the Centers for Medicare & Medicaid Services Conditions of Participation, Joint Commission accreditation standards for hospitals, and in state practice acts. Current ASHP policy supports pharmacist prospective order review and a consistent standard of care for all patients regardless of where that care is provided.

1023
SCOPE AND HOURS OF PHARMACY SERVICES
Source: Council on Pharmacy Practice

To support the principle that all patients should have 24-hour access to a pharmacist responsible for their care, regardless of hospital size or location; further,

To advocate alternative methods of pharmacist review of medication orders (such as remote review) before drug administration when onsite pharmacist review is not available; further,

To support the use of remote medication order review systems that communicate pharmacist approval of orders electronically to the hospital's automated medication distribution system; further,

To promote the importance of pharmacist access to pertinent patient information, regardless of proximity to patient.

This policy supersedes ASHP policy 0403.

Rationale

Recent legislation in Texas exempts hospitals with fifty or fewer beds in remote locations from requiring prospective medication order review by a pharmacist. Pharmacist prospective order review is a well-supported safety practice that is required by the Centers for Medicare & Medicaid Services Conditions of Participation, Joint Commission accreditation standards for hospitals, and in state practice acts. Current ASHP policy supports pharmacist prospective order review and a consistent standard of care for all patients regardless of where that care is provided.