



House of Delegates
Session—2009

June 14 and 16, 2009
Rosemont, Illinois

Proceedings of the 61st annual session
of the ASHP House of Delegates
June 14 and 16, 2009

Proceedings of the 61st annual session of the ASHP House of Delegates, June 14 and 16, 2009

HENRI R. MANASSE, JR., SECRETARY

The 61st annual session of the ASHP House of Delegates was held at the Donald E. Stephens Convention Center, in Rosemont, IL, in conjunction with the 2009 Summer Meeting.

First meeting

The first meeting was convened at 2:00 p.m. Sunday, June 14, by Chair of the House of Delegates Teresa Hudson. Lynnae Mahaney, Vice Chair of the Board of Directors, gave the invocation.

Chair Hudson introduced the persons seated at the head table: Janet Silvester, Immediate Past President of ASHP and Vice Chair of the House of Delegates; Kevin Colgan, President of ASHP and Chair of the Board of Directors; Henri R. Manasse, Jr., Executive Vice President and Chief Executive Officer of ASHP and Secretary of the House of Delegates; and Joy Myers, Parliamentarian.

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

The roll of official delegates was called. A quorum was present, including 175 delegates representing 49 states, the District of Columbia and Puerto Rico, delegates from the federal services, chairs of the sections and forums, ASHP officers, members of the Board of Directors, and ASHP past presidents.

Chair Hudson reminded delegates that the report of the 60th annual session of the ASHP House of Delegates had been published on the ASHP Web site and had been distributed to all delegates. Delegates had been advised earlier to review this report. The proceedings of the 60th House of Delegates session were received without objection.

Board Chair Kevin Colgan presented the preliminary report on the Resolution. The report, which had been distributed to delegates before the Summer Meeting, consisted of one Resolution from Dominick Caselnova (MT) and Randy Kuiper (SICP),

titled "To Amend ASHP Policy 0406 (Workload Monitoring and Reporting)."

Chair Hudson called on Raneë Runnebaum for the report of the Committee on Nominations.^a Nominees were presented as follows:

President-elect

Diane B. Ginsburg, M.S., R.Ph., FASHP, Clinical Professor, Division of Pharmacy Practice, Assistant Dean for Student Affairs, University of Texas at Austin, College of Pharmacy

Stanley S. Kent, M.S., FASHP, Assistant Vice President—Pharmacy Services, NorthShore University HealthSystem, Evanston, IL

Board of Directors (2010–2013)

Roy Guharoy, Pharm.D., MBA, FASHP, FCP, FCCP, Chief Pharmacy Officer, Professor, College of Medicine, University of Massachusetts Memorial Healthcare, Worcester, MA

Christene M. Jolowsky, M.S., R.Ph., IPPE Coordinator, University of Minnesota, College of Pharmacy, Minneapolis, MN

Deb Saine, M.S. R.Ph., Medication Safety Manager, Winchester Medical Center, Winchester, VA

Michael D. Sanborn, M.S., R.Ph, FASHP, Corporate Vice President, Cardiovascular Services, Baylor Health Care System, Dallas, TX

Chair, House of Delegates

Gerald E. Meyer, M.B.A., Pharm.D., FASHP, Director of Experiential Education, Thomas Jefferson University, Jefferson School of Pharmacy, Philadelphia, PA

Dennis M. Williams, Pharm.D., BCPS, FASHP, Associate Professor, University of North Carolina, School of Pharmacy, Chapel Hill, North Carolina

A “Meet the Candidates” session to be held on Monday, June 15, was announced.

Chair Hudson announced the candidates for the executive committees of the five sections of ASHP.

Report of President and Chair of the Board. President Colgan referred to the 2008 ASHP Annual Report, which had been distributed to delegates along with summaries of actions taken by the Board of Directors over the past year. He updated and elaborated upon various ASHP initiatives. There was no discussion, and the delegates voted to accept the report of the Chair of the Board.

Report of Treasurer. Paul W. Abramowitz presented the report of the Treasurer. There was no discussion, and the delegates voted to accept the Treasurer’s report.

Report of Executive Vice President. Henri R. Manasse, Jr., presented the report of the Executive Vice President. Dr. Manasse also made note of the retirement of William A. Zellmer, after 39 years of service.

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

Policy committee reports. Chair Hudson outlined the process used to generate policy committee reports. She announced that the recommended policies from each council would be introduced as a block. She further advised the House that any delegate could raise questions and discussion without having to “divide the question” and that a motion to divide the question is necessary only when a delegate desires to amend a specific proposal or to take an action on one proposal separate from the rest of the report; requests to divide the question are granted automatically unless another delegate objects.

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

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

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

Sheila L. Mitchell, Board Liaison to the **Council on Pharmacy Practice**, presented the Council’s Policy Recommendations A through E.

**A. Pharmacist’s Role in Providing Care for an Aging Population*

To encourage expansion of geriatric health care services; further,

To foster expanded roles for pharmacists in caring for geriatric patients; further,

To support successful innovative models of ~~team-based~~ *interdisciplinary* geriatric care; further,

To encourage expansion of the number of ASHP-accredited geriatric pharmacy residency programs:

To increase the focus on training of pharmacists in caring for geriatric patients within Doctor of Pharmacy curricula, in PGY1 residencies, and through the expansion of the number of ASHP-accredited PGY2 geriatric pharmacy residency programs.

**B. Pharmaceutical Waste*

To collaborate with regulatory bodies and appropriate organizations to develop standards for the disposal of pharmaceutical hazardous waste as defined in the Resource Conservation and Recovery Act (RCRA), for the purpose of simplifying the disposal of these substances by health systems; further,

To encourage pharmaceutical manufacturers and the Environmental Protection Agency (EPA) to provide guidance and assistance to hospitals and health systems in *proper* pharmaceutical waste *disposal and destruction and recycling* efforts; further,

To advocate that EPA update the list of hazardous substances under RCRA and establish a process for maintaining a current list; further,

To urge federal, state, and local governments to harmonize regulations regarding disposal of hazardous pharmaceutical waste; further,

To advocate that the Food and Drug Administration standardize labeling of drug products with information relating to appropriate disposal; further,

To promote awareness within hospitals and health systems of pharmaceutical waste regulations; further,

To encourage research on the environmental and public health impacts of drug products and metabolites excreted in human waste; further,

To encourage pharmaceutical manufacturers to streamline packaging of drug products to reduce waste materials.

(Note: This policy would supersede ASHP policy 0231.)

C. Automatic Stop Orders

To advocate that the Centers for Medicare & Medicaid Services (1) revise the requirement in the Hospital Conditions of Participation that all medication orders automatically stop after an arbitrarily assigned period to include other options to protect patients from indefinite, open-ended medication orders, and (2) revise the remainder of the medication management regulations and interpretive guidelines to be consistent with this practice.

D. ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control

To approve the ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control (Appendix A to the Board of Directors Report on the Council on Pharmacy Practice).

(Note: This statement would supersede the ASHP Statement on the Pharmacist's Role in Infection Control dated June 3, 1998.)

E. ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives

To approve the ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives (Appendix B to the Board of Directors Report on the Council on Pharmacy Practice).

Stanley S. Kent, Board Liaison to the **Council on Public Policy**, presented the Council's Policy Recommendations A through G.

**A. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management*

To advocate expansion of collaborative drug therapy management (CDTM) practices in which the prescriber and the licensed pharmacist agree upon the conditions under which the pharmacist *initiates*, monitors, and adjusts a patient's drug therapy; further,

To acknowledge that as a step toward the goal of universal recognition of and payment for pharmacist CDTM services, public

or private third-party payers may require licensed pharmacists to demonstrate their competence to provide CDTM, before the payers authorize them to engage in or be paid for such clinical services; further,

To support (1) the development (as a professional initiative by pharmacist associations rather than as a government activity) of national standards for determining a pharmacist's competence to provide CDTM and (2) the appropriate use of these standards by clinical privileging systems, government authorities, and public or third-party payers; further,

To support the use of clinical privileging by hospitals and health systems to assess a licensed pharmacist's competence to engage in CDTM within the hospital or health system; further,

To advocate that state boards of pharmacy apply the principles of continuous quality improvement in assessing the quality, safety, and outcomes of CDTM.

(Note: "Privileging" is the process by which an oversight body of a health care organization or other appropriate provider body, having reviewed an individual health care provider's credentials and performance and found them satisfactory, authorizes that individual to perform a specific scope of patient care services within that setting.)

(Note: This policy would supersede ASHP policy 0318.)

**B. Approval of Follow-on Biological Medications*

To encourage the development of safe and effective follow-on biological medications in order to make such medications more affordable and accessible; further,

To encourage research on the safety, effectiveness, and interchangeability of follow-on biological medications; further,

To support legislation and regulation to allow Food and Drug Administration approval of follow-on biological medications; further,

To require postmarketing surveillance for all follow-on biological medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biological medications that are deemed interchangeable; further

To promote education of pharmacists about follow-on biological medications and their appropriate use within hospitals and health systems; *further*,

To encourage pharmacist evaluation and the application of the formulary system before follow-on biological medications are used in hospitals and health systems.

(Note: Follow-on biological medications are also referred to as biosimilars, follow-on protein products, biogenerics, comparable biologicals, and generic biopharmaceuticals.)

(Note: This policy would supersede ASHP policy 0519.)

C. Pharmaceutical Product and Supply Chain Integrity

To encourage the Food and Drug Administration (FDA) and relevant state authorities to take the steps necessary to ensure that (1) all drug products entering the supply chain are thoroughly inspected and tested to establish that they have not been adulterated or misbranded and (2) patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, adulterated, or unapproved drug products; further,

To encourage FDA and relevant state authorities to develop and implement regulations to (1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers, and manufacturers) from purchasing legend drugs from unlicensed entities and (2) ensure accurate documentation at any point in the distribution chain of the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

To advocate the establishment of meaningful penalties for companies that violate current good manufacturing practices (cGMPs) intended to ensure the quality, identity, strength, and purity of their marketed drug product(s) and raw materials; further,

To urge Congress and state legislatures to provide adequate funding, or authority to impose user fees, to accomplish these objectives.

(Note: This policy would supersede ASHP policy 0722.)

D. Pharmacist Role in the Health Care (Medical) Home

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as a care provider within the health care (medical) home model; further,

To ensure that there are appropriate reimbursement mechanisms for the care that pharmacists provide (including care coordination services) within the health care home model; further,

To advocate to the Centers for Medicare & Medicaid Services that pharmacists be included in demonstration projects for the health care home model; further,

To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in the health care home model.

E. Regulation of Interstate Pharmacy Practice

To advocate that state governments, including legislatures and boards of pharmacy, adopt laws and regulations that harmonize

the practice of pharmacy across state lines in order to provide a consistent, transparent, safe, and accountable framework for pharmacy practice.

*F. Reporting Medication Errors

To encourage pharmacists to exert leadership in establishing a ~~nonthreatening, confidential atmosphere~~ culture in their workplaces *valuing behavioral choice and accountability and a nonpunitive systems approach to medication errors while supporting a nonthreatening reporting environment* to encourage pharmacy staff and others to report actual and *potential suspected* medication errors in a timely manner; further,

To provide leadership in supporting a single, comprehensive medication error reporting program that (1) fosters a confidential, nonthreatening, and nonpunitive environment for the submission of medication error reports; (2) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies; further,

To provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.

(Note: This policy would supersede ASHP policy 9918.)

G. Stable Funding for Office of Pharmacy Affairs

To advocate for adequate funding for the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs to support its public health mission; further,

To support initiatives of the Office of Pharmacy Affairs, including the 340B Drug Pricing Program and innovative pharmacy service models in HRSA-funded programs.

John A. Armitstead, Board Liaison to the **Council on Therapeutics**, presented the Council's Policy Recommendation A.

*A. Safe and Effective Use of Heparin in Neonatal Patients

To support the development and use of *nationally* standardized concentrations of heparin *when used* for maintenance and flush of peripheral and central venous lines in neonatal patients; further,

To advocate that hospitals and health systems use manufacturer-prepackaged heparin flush products to improve the safe use of heparin in neonatal patients

James G. Stevenson, Board Liaison to the **Council on Education and Workforce Development**, presented the Council's Policy Recommendations A through E.

A. Pharmacy Student Experiences in Medically Underserved Areas

To encourage colleges of pharmacy to require student learning experiences in traditionally medically underserved areas and with diverse patient populations.

**B. Medication Safety Related Education in U.S. Colleges of Pharmacy*

To encourage colleges of pharmacy to include medication safety instruction on patient safety throughout the medication management process in the didactic curriculum and during experiential education.

C. Pharmacy Expertise in the Preparation and Handling of Injectable Medications

To encourage colleges of pharmacy to include sterile compounding and aseptic technique instruction in the didactic curriculum and during experiential education; further,

To support the development of postgraduate, curriculum-based sterile compounding training programs to foster an increase in the number of pharmacists with sterile compounding expertise.

D. Continuing Professional Development

To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation; further,

To continue the development of a variety of mechanisms and tools that pharmacists can use to assess their CPD needs; further,

To encourage individual pharmacists to embrace CPD as a means of maintaining their own professional competence; further,

To encourage pharmacy managers to promote CPD as the model for ensuring the competence of their staff; further,

To collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods for implementing CPD; further,

To strongly support objective assessment of the impact of CPD on pharmacist competence; further,

To endorse the efforts of colleges of pharmacy and ASHP-accredited pharmacy residency programs to teach the principles, concepts, and skills of CPD.

(Note: This policy would supersede ASHP policy 0408.)

E. Pharmacy Residency Training

To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available.

(Note: This policy would supersede ASHP policy 9911.)

Kathryn R. Schultz, Board Liaison to the **Council on Pharmacy Management**, presented the Council's Policy Recommendations A through D.

**A. Pharmacist Leadership of the Pharmacy Department*

To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,

To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,

To recognize the emerging supporting role of nonpharmacists in leadership and management roles in within pharmacy departments.

(Note: This policy would supersede ASHP policy 0606.)

**B. Medication Errors Related to Intimidating and Disruptive Behaviors*

To affirm the professional responsibility of the pharmacist to ensure patient safety by communicating with other health professionals care personnel to clarify and improve medication orders management; further,

To advocate that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors; further,

To encourage hospitals and health systems to develop and implement education and training programs for all health professionals care personnel to encourage effective communication and discourage intimidating or disruptive behaviors; further,

To encourage colleges of pharmacy and residency training programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,

To collaborate with other organizations to advocate codes of conduct that minimize intimidating or disruptive behavior in hospitals and health systems.

C. Standardized Clinical Drug Nomenclature

To encourage federal agencies, the pharmaceutical industry,

pharmacy and medical software providers, and purveyors of clinical data repositories and drug databases to explore the potential benefits of supplementing or modifying the National Drug Code with a coding system that can be used effectively to support patient care, research, and financial management; further,

To encourage that such a coding system encompass prescription drug products, nonprescription medications, and dietary supplements and include both active and inactive ingredients.

(Note: This policy would supersede ASHP policy 0801.)

D. Pharmacist's Role in Health Care Information Systems

To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of pharmacy information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,

To advocate for incentives to hospitals and health systems for the adoption of patient care technologies.

(Note: This policy would supersede ASHP policy 0203.)

Candidates for the position of Chair of the House of Delegates made brief statements to the House of Delegates. The meeting adjourned at 4:30 p.m.

Second meeting

The second and final meeting of the House of Delegates session convened on Tuesday, June 16, at 4:30 p.m. A quorum was present.

Election of House Chair

Chair Hudson announced the appointment of alternate delegates as tellers to canvass the ballots for the election of Chair of the House of Delegates. Those appointed were Paul Barrett (ME), Scott Meyers (IL), and Robert Parsons (OH).

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

Resolution. President Colgan presented the Resolution from Dominick Caselnova (MT) and Randy Kuiper (SICP), titled "To Amend ASHP Policy 0406 (Workload Monitoring and Reporting)." Following discussion, the Resolution was adopted. It reads as follows:

To amend ASHP Policy 0406 (Workload Monitoring and Reporting) to read as follows:

To strongly discourage the use of pharmacy workload and productivity measurement systems ("pharmacy benchmarking systems") that are based solely upon dispensing functions (e.g., doses dispensed or billed) or a variant of patient days, because such measures do not accurately assess pharmacy workload, staffing effectiveness, clinical practice contributions to patient care, or impacts on costs of care, and therefore these measurement systems are not valid and should not be used; further,

To advocate the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care; further,

To define pharmacy workload as all activities related to providing pharmacy patient care services; further,

To continue communications with health-system administrators, consulting firms, and professional associations regarding the value of pharmacists' services and the importance of using valid, comprehensive, and evidence-based measures of pharmacy workload and productivity; further,

To encourage practitioners and vendors to develop and use a standard protocol for collecting and reporting pharmacy workload data and patient outcomes; further,

To advocate to health-system administrators, consulting firms, and vendors of performance-measurement services firms the development and implementation of pharmacy benchmarking systems that accurately assess the impact of pharmacy services on patient outcomes and total costs of care.

Board of Directors duly considered matters. The Board reported on 9 professional policies that were amended at the first House meeting. Pursuant to Bylaws section 7.3.1.1, the Board met on the morning of June 16, 2009, to "duly consider" the amended policies. The Board presented its recommendations as follows:

1. Council on Pharmacy Practice, Policy A, "Pharmacist's Role in Providing Care for an Aging Population": The Board encouraged delegates to reconsider the policy and adopt revised language. A motion was made to reconsider and the revised policy proposed by the Board was adopted. The policy reads as follows:

A. Pharmacist's Role in Providing Care for an Aging Population

To encourage expansion of geriatric health care services; further,

To foster expanded roles for pharmacists in caring for geriatric patients; further,

To support successful innovative models of team-based, interdisciplinary geriatric care; further,

To increase training of pharmacists in caring for geriatric patients within college of pharmacy curricula, in ASHP-accredited postgraduate-year-one residencies, and through the expansion of the number of ASHP-accredited postgraduate-year-two geriatric pharmacy residency programs.

2. Council on Pharmacy Practice, Policy B, “Pharmaceutical Waste”: The Board agreed that the amended language is acceptable.
3. Council on Public Policy, Policy A, “Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management”: The Board agreed that the amended language is acceptable.
4. Council on Public Policy, Policy B, “Approval of Follow-on Biological Medications”: The Board agreed that the amended language is acceptable.
5. Council on Public Policy, Policy F, “Reporting Medication Errors”: The Board encouraged delegates to reconsider the policy and adopt revised language. A motion was made to reconsider and the revised policy proposed by the Board was adopted. The policy reads as follows:

F. Reporting Medication Errors

To encourage pharmacists to exert leadership in establishing a just culture in their workplaces and a nonpunitive systems approach to addressing medication errors while supporting a nonthreatening reporting environment to encourage pharmacy staff and others to report actual and potential medication errors in a timely manner; further,

To provide leadership in supporting a single, comprehensive medication error reporting program that (1) fosters a confidential, nonthreatening, and nonpunitive environment for the submission of medication error reports; (2) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies; further,

To provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.

(Note: A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control, and that many individual or “active” errors represent predictable interactions between human operators and the systems in which they work. However, a just culture does not tolerate conscious disregard of clear risks to patients or gross misconduct.)

(Note: This policy would supersede ASHP policy 9918.)

6. Council on Therapeutics, Policy A, “Safe and Effective Use of Heparin in Neonatal Patients”: The Board agreed that the amended language is acceptable.
7. Council on Education and Workforce Development, Policy B, “Medication Safety Related Education in U.S. Colleges of Pharmacy”: The Board agreed that the amended language is acceptable with editorial changes. As edited, the policy reads as follows:

B. Patient and Medication Safety Related Education in U.S. Colleges of Pharmacy

To encourage colleges of pharmacy to include instruction on patient safety throughout the medication-use process in the didactic curriculum and during experiential education.

8. Council on Pharmacy Management, Policy A, “Pharmacist Leadership of the Pharmacy Department”: The Board agreed that the amended language is acceptable.
9. Council on Pharmacy Management, Policy B, “Medication Errors Related to Intimidating and Disruptive Behaviors”: The Board agreed that the amended language is acceptable.

New Business. Chair Hudson announced that, in accordance with Article 7 of the Bylaws, there was one item of New Business to be considered.

Chair Hudson called on John Poikonen (MA) to introduce the item of New Business, titled “Meaningful Use of Electronic Health Records.” Following discussion, the item was approved for referral. It reads as follows:

Meaningful Use of Electronic Health Records

Motion: ASHP should actively advocate directly to the Office of the National Coordinator for Health Information Technology to include the following elements of “Meaningful Use” focused on the medication use process:

Interoperability of Medication Orders and Prescriptions
Communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable with pharmacy information systems. A common medication vocabulary must be mandated to promote the semantic interoperability of medication use across the continuum of care. This will be essential for comparative research and for communicating medication information.

Medication Decision Support and Continuous Improvement
Medication decision support must include allergy, drug interac-

tion, duplicate therapy, and dose-range checking as a minimum. Such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers.

Quality Reporting

The ability to report and quantify improved patient safety, quality outcomes, and cost reductions in the medication use process particularly in nationally endorsed quality measures, antimicrobial and adverse drug event surveillance is essential.

Background: Under the American Recovery and Reinvestment Act (ARRA) of 2009, hospitals and physician practices beginning in 2011 are eligible for incentive payments by demonstrating “meaningful use of health information technology.” \$20 Billion has been allocated for hospitals and physician adoption.

To be eligible for the payments, hospitals must use the technology in a meaningful manner; to exchange electronic health information to improve the quality of care; and submit clinical quality measures – and other measures – as selected by the Secretary of Health & Human Services (HHS).

ASHP has repeatedly called for an improved and standardized drug nomenclature, as recently as the 2009 House of Delegates.

Suggested Outcome: That ASHP dedicate resources of the Section of Pharmacy Informatics and Technology and Government Affairs to monitor and insure that the priorities of the medication use process is addressed in the definition of meaningful use.

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

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

As a token of appreciation on behalf of the Board of Directors and members of ASHP, Chair Hudson presented Immediate Past President Colgan with an inscribed gavel commemorating his term of office. Dr. Colgan recognized the service of Chair

Hudson as Chair of the House of Delegates and a member of the Board of Directors.

Chair Hudson recognized Janet Silvester’s years of service as a member of the Board, in various presidential capacities, as Chair of the Board, and as Vice Chair of the House of Delegates.

Chair Hudson then installed the chairs of ASHP’s sections and forums: James Trovato, Chair of the Section of Clinical Specialists and Scientists; Tim Brown, Chair of the Section of Home, Ambulatory and Chronic Care Practitioners; Debra Cowan, Chair of the Section of Inpatient Care Practitioners; Chad Hardy, Chair of the Section of Pharmacy Informatics and Technology; Kathleen Pawlicki, Chair of the Section of Pharmacy Practice Managers; Daniel Crona, Chair of the Pharmacy Student Forum; and Michael De Coske, Chair of the New Practitioners Forum.

Dr. Hudson then recognized the remaining members of the executive committees of sections and forums.

Dr. Hudson called on Dr. Colgan for announcements at which time he disclosed that the Board of Directors had accepted the resignation of Board member-elect Wayne Bohenek. The Board is authorized to appoint a replacement for one year who will serve until the next election in August 2010. For this reason, the Board appointed Janet A. Silvester to fill this one-year appointment.

Installation. Dr. Hudson installed Lynnae Mahaney as President of ASHP, Janet A. Silvester and Lisa M. Gersema as members of the Board of Directors, and Gerald E. Meyer as Chair of the House of Delegates.

Parliamentarian. Dr. Hudson thanked Joy Myers for service to ASHP as parliamentarian.

Adjournment. The 61st annual session of the House of Delegates adjourned at 5:18 p.m.

*The Committee on Nominations consisted of Raneë Runnebaum (MO), Chair; Cynthia Brennan (WA), Vice Chair; Ernest R. Anderson (MA), Michael B. Cockerham (LA), Thomas J. Johnson (SD), Rosario J. Lazzaro (NJ), William P. Yee (CA)

2009 House of Delegate Recommendations

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

Recommendations by Delegates on Sunday, June 14:

1. *Michael Schlesselman (CT): ASHP Support of Small State Affiliate Chapters*

Recommendation: ASHP should continue to support smaller state affiliate chapters.

Background: (No background was provided.)

2. *Dennis Williams (NC): FDA and Regulation of Tobacco Products*

Recommendation: ASHP should be proactive in interacting with the FDA about development of policies related to the appropriate regulation of tobacco products.

Background: Areas that should be explored include the role of pharmacists in tobacco regulation, safety, and possible tobacco cessation messages, and the potential use of any funds generated through tobacco regulation for funding of health-related programs.

3. *Karen Kier (OH), Douglas Stillwell (OH), Peg Huwer, (OH), Dale English, (OH), and Kathy Donley (OH): Position Statement on the Role of the Pharmacist in Public Health*

Recommendation: ASHP should take the lead among pharmacy professional organizations in developing a position statement on the role of the pharmacist in public health and preventative medicine.

Background: An analysis of pharmacy professional organizations mission statements, policy statements, and position statements showed a paucity of information on the role of the pharmacist in public health. Of all the organizations evaluated by DiPietro, Davlin, and Kier, ASHP has the most information on public health but not one concise statement. The position statements focused mostly on immunizations and medication safety and lack many critical public health areas.

4. *New Practitioners Forum Executive Committee: Mike DeCoske (SC), Lindsay Garris (DC), John Hertig (OH), Monica Nayar, (MA), and Majid Tanas (WA): Practice Model Initiative and Summit Representation*

Recommendation: The ASHP Board of Directors should consider the views of all represented ASHP constituents, including new practitioners, in the practice model initiative and summit.

Background: The New Practitioners Forum is passionate about the upcoming practice model initiative and the questions that have been posed, because the responses and outcomes will greatly impact the future of our profession.

5. *Randy Kuiper (MT) and Paul Driver (ID): Accreditation of Residencies in Remote or Rural Areas*

Recommendation: The ASHP residency accreditation process should include a mechanism for accrediting residencies in which residents spend a significant amount of time in remote locations geographically separated from their preceptors during their residency experience.

Background: The Section of Inpatient Care Practitioners recognizes the need for pharmacists in remote practice sites. New graduates and residents rarely have the opportunity to get training in these types of sites. Currently, there is no mechanism to allow a resident to be placed in these types of sites due to geographic separation from the preceptor that is inevitable given their small size and remote location. Many of these potential locations are 30-100 miles from the nearest town or hospital and have no or little pharmacy input.

6. *Nancy Korman (CA): Duty Hours for Pharmacy Residents*

Recommendation: ASHP should advocate that pharmacy residents be exempt from labor laws that limit a resident's scheduling to 40 hours per five-day work week, and that residency training should not exceed the ASHP limit of an 80-hour work week, which is also a graduate medical education requirement.

Background: In states in which pharmacy residents are subject to labor laws, residents may be held to a work week limited to a five 8-hour days. While it is important that pharmacy residents should not work so long as to suffer fatigue and potentially compromise patient safety, duty hours should be sufficient to allow for adequate training experiences.

7. *Scott Takahashi (CA): Modernization of Medication Supply Chain Monitoring and Medication Recall Processes*

Recommendation: ASHP should take a leadership role in the modernization of the processes to monitor the medication supply chain from raw materials through manufacture, distribution, and ultimately receipt and use by the patient, thus enabling a more timely and efficient drug recall process.

Background: Recent notable medication recalls have made readily apparent the gaps in the current drug recall process. The need to track manufacturer, expiration and lot number information matched with doses administered to a patient, in a technology-driven database system in an efficient and uniform manner would provide the data necessary to alert the patient in the event of a medication recall.

8. *James R. Rinehart (NE): Insurance Coverage for Medications or Medication Administration Devices Supplied by a Hospital or Health-System Clinic*

Recommendation: ASHP should advocate that insurance payers not restrict coverage to patients for medications or medication administration devices supplied by hospitals and health system

clinics to patients, because lack of coverage may result in patients choosing, for financial considerations, to use their own medications or medication administration devices in hospitals or clinics.

Background: Patient insurance payers are selecting situations in which they will not cover the costs of medications or medication administration devices supplied to patients in hospitals or clinics. Patients then choose, for financial reasons, to use their own medications or medication administration devices, whose integrity cannot be validated. The result is that patients and healthcare providers must choose between product safety and patient financial impact. Such actions by insurers pose a risk to patient safety because they preclude pharmacist verification of storage conditions or the source of medications and may encourage the use of medication delivery devices that staff is not familiar with or whose integrity staff cannot assess.

9. Frank P. Sosnowski (NY): Enhancement of Pandemic Response

Recommendation: ASHP should continue to work with local, state, and federal agencies and pharmaceutical manufacturers and distributors to enhance communication and effective distribution of stockpile and future inventories of antiviral medications during pandemics.

Background: The experience in New York state in May and June 2009 created concerns about procurement and distribution of medications from the state department of health and manufacturers in response to the H1N1 pandemic.

10. Kimberly Tallian (CA): The Receipt of Medications in the Outpatient Setting

Recommendation: Recommend that ASHP promote the use of at least two patient identifiers upon receipt of a medication by a patient in the outpatient setting.

Background: Medication misadventures related to patients who have received another patient's medications are largely preventable. The Joint Commission's National Patient Safety Goal 1A requires the use of at least two patient identifiers when providing care within a hospital or health system, yet there are no standard requirements to correctly identify patients in the outpatient setting. The Institute for Safe Medication Practices has identified the lack of proper patient identification as a cause of wrong-patient errors.

11. Maria Serpa (CA): Evaluation of Vendors Supplying Intravenous (IV) Manufactured Products

Recommendation: ASHP should provide an article, paper, or guidelines on the process to evaluate vendors supplying IV manufactured products (similar to ASHP Guidelines on Outsourcing Pharmaceutical Services).

Background: Most sites are using outside vendors to prepare IV products. Does this require an FDA manufacturer license? One vendor has only an FDA repackaging license and a state pharmacy license, which may not be sufficient for interstate sale of IV preparations. Guidelines

to needed to ensure that federal and state laws and regulations are followed for IV and non-IV products.

Recommendations by Delegates on Tuesday, June 16:

1. *Randy Kuiper (MT): Just Culture and Reporting Medication Errors*

Recommendation: ASHP should further review the policy “Reporting Medication Errors” to improve clarity on the concept of “just culture.”

Background: In the note on just culture, “systems failings over which they have no control” is subject to interpretation, depending on the perspective of the practitioner. A statement or other document may be considered to further address the concept of just culture.

2. *Mike Rubino (CT): Prime-time Media Promotion of Hospital Pharmacists*

Recommendation: ASHP should develop a high-end media advertisement that promotes the value of hospital pharmacists and is ready for prime-time network television, similar to the nursing promotion supported by Johnson & Johnson.

Background: The public is clueless (still) on what we do.

3. *Helen Calmes (LA): Heparin Flush in All Populations*

Recommendation: ASHP should review current guidelines, policies, and recommendations regarding the use of heparin flush in all populations, and further, review alternatives to heparin flush in the pediatric population.

Background: Use of saline is recommended in adults, but the pediatric population is excluded. Although there are numerous devices and procedures available that may help eliminate heparin use in flushing lines in all patients, current manufactured products do not cover all the needed strengths and volumes of heparin.

4. *Dale English (OH), Peg Huwer (OH), Doug Stillwell (OH), Karen Kier (OH), Kathleen Donley, (OH), Lourdes Cuellar (TX), Brian Cohen (TX), Julie Nelson (TX), Diane Fox (TX), Jim Wilson (TX), and Joyce Tipton (TX): Continuing Professional Development for B.S. Pharmacists*

Recommendation: ASHP should develop an organized approach to ensure that B.S. graduates without residency training (who are the majority of health-system pharmacists) are able to develop, meet, and maintain the skills that are the basis of continuing professional development.

5. *Deb Saine (VA): Role of the Pharmacist in Safe Technology Implementation*

Recommendation: ASHP should define and advocate for the pharmacist’s role in safe implementation of technologies used in medication procurement, prescribing, preparation, dispensing, administration, and monitoring.

Background: The December 2008 *Joint Commission Sentinel Event Alert* outlined patient safety concerns specific to technology implementation and recommended actions to reduce error and patient harm. The Institute for Safe Medication Practices has published related information for specific technologies. Many of these technologies are involved in medication management, and the pharmacist should have a collaborative role in ensuring safe implementation.

6. *John Poikonen (MA) and Robert Moura (MA): Audio Content of the American Journal of Health-System Pharmacy (AJHP) and ASHP-related Items*

Recommendation: ASHP should produce an audio summary of each edition of *AJHP* and make audio podcasts on other timely topics available through electronic distribution.

Background: Several medical journals (*N Engl J Med.*, *J Am Med Assoc.*, *Annals* and *Archives of Internal Medicine*) are among the growing content producers that make summary information of their journals and other organizational issues available through an audio delivery mechanism. These low-cost production podcasts or netcasts increase the visibility and reach of the journal and organization’s content.

7. *Steven M. Riddle (WA): Proactive Exploration of Pharmacist Reimbursement Models*

Recommendation: ASHP should proactively explore reimbursement modalities for pharmacists, particularly in inpatient hospital settings and areas of practice where none exists, in preparation for designation of provider status by Medicare and/or other payers.

Background: ASHP has been active in the development of medication therapy management billing codes for pharmacists as well as refining “incident-to” billing methods. However, there are current areas of practice (hospital inpatient) and future areas of practice (i.e., medical home, “quick-care clinics”) that currently have no proposed reimbursement models. It would benefit the profession to proactively explore reimbursement models to ensure optimal implementation of clinical pharmacy services upon the granting of provider status.

8. *James M. Hoffman (TN): Evaluation and Monitoring of Pharmacogenomics*

Recommendation: ASHP should seek member input and engage the appropriate section (or sections) to evaluate and monitor scientific developments and practical applications of pharmacogenomics.

Background: Pharmacogenomics is a growing and maturing field that can now be applied to patient care in multiple areas. In a recent study, a large cohort of medication use indicated that 25% of medications dispensed to patients included genetic information in the FDA-approved label. As experts in medication use, pharmacists must understand pharmacogenomics and be

poised to facilitate its application to patient care and the medication-use system. ASHP should seek member advice as evidence for such use emerges.

9. Tina Aramaki (UT): Workload Monitoring and Reporting

Recommendation: The ASHP Council on Pharmacy Management should evaluate and identify a best practice standard metric and process for documentation of the financial benefit and productivity of clinical pharmacy practitioners in health systems that do not rely on self-reporting.

Background: Pharmacy productivity measurement must not be based solely upon dispensing functions, and we as pharmacists know we have a significant impact on the outcomes of our patients. But proving that to financial leadership, in a language that they support and understand, is problematic. It will be easier to support the resolution passed by the House of Delegates when a metric for the impact of clinical pharmacy services is identified.

10. Stephen R. Novak (NC): ASHP Provision of Educational Programs and Learning Opportunities on the ISO 9001 Quality Management Process

Recommendation: In response to the new Det Norske Veritas (DNV) accreditation organization, ASHP should provide educational programming and other learning opportunities on the ISO 9001 quality management process to better enable pharmacy managers to be more effective in implementing such systems as an alternative to The Joint Commission accreditation system.

Background: DNV was granted deeming status by the Center for Medicare & Medicaid Services (CMS) for accreditation of hospital and healthcare organizations starting in late 2008. DNV conducts surveys according to CMS standards and ISO 9001 quality management processes. Pharmacy managers are already knowledgeable about and held to CMS standards. ISO 9001 educational programs by ASHP would provide valuable training in this new and growing accreditation system.

11. Kevin Marvin (VT): Finalization of e-Prescribing Standards

Recommendation: ASHP should advocate for the finalization of e-prescribing standards of drug nomenclature and standardized SIG. Additionally, ASHP should advocate for Certification Commission for Health Information Technology (CCHIT) certification of ambulatory pharmacy systems with the goal of the standards reaching the patients.

Background: These are the only standards not yet finalized.

12. Pharmacy Student Forum Executive Committee: Emily Dotter (MD), Rachel Kruer (OH), Daniel Crona (CO), Amy Baker (NM), and Melissa Ortega (FL): Fostering Professional Networking and Communication Through Multimedia Outlets

Recommendation: ASHP should explore and implement a strategy to leverage multimedia outlets to expand professional networking and communication for ASHP members.

Background: Pharmacists and students increasingly turn to multimedia outlets for both social and professional networking and communication. If ASHP is to remain the main resource for the advancement and support of the professional practice of its members, it must be at the forefront of today's rapidly evolving modes of both social and professional communication.

13. Jennifer Thomas (MD): Pharmacist Provision of Point-of-Care Testing

Recommendation: ASHP should advocate for integration of pharmacist-provided point-of-care testing as part of collaborative drug therapy management (CDTM) programs.

Background: The ability of pharmacists to completely engage in CDTM by definition includes the authority to adjust medication therapy regimens, in many cases based upon a requirement of lab monitoring. The ability to perform Clinical Laboratory Improvement Amendments (CLIA)-waived testing is necessary for pharmacists to provide efficient, optimal care at the time of the patient-clinician encounter.

14. Larry Anderson (AZ): ASHP Role in Regulation of the Home Medical Equipment (HME) Industry

Recommendation: As Congress guides the restructuring of America's healthcare system, ASHP should advocate to Congress and suppliers of legend HME medications (e.g., oxygen, respiratory, and wound care) for regulations that will ensure patient safety and discourage fraud and abuse.

Background: The HME/oxygen industry, which has a vital role in the transition from acute to home care, has little oversight by regulatory agencies (e.g., The Joint Commission, state boards of pharmacy), which may compromise safety and lead to more re-admissions to hospitals. Lack of oversight may also encourage fraud and abuse of the CMS system.

15. Michael DeCoske (SC): Residency Requirement by the Year 2020

Recommendation: ASHP should develop an initial strategic plan by 2010 that outlines how the residency requirement by 2020 will be accomplished.

Background: The need for the requirement is evident. Goals can be accomplished if strategic plans are designed and refined.

16. John Poikonen (MA): Blog Postings of ASHP Leadership

Recommendation: ASHP leaders should make their thoughts and perspectives on pharmacy issues available to the membership through the electronic publishing of personal blogs.

Background: Blogs are well-accepted electronic avenues of disseminating views, news, and personal commentary. ASHP leaders should make their opinions on a wide set of topics available to the membership on a more regular basis through this medium.

17. Randy Kuiper (MT): Patient Access to Pharmacists in Small and Rural Hospitals

Recommendation: ASHP should support access to a pharmacist to provide prospective medication review for hospitalized patients and other functions that improve the safe medication-use process in facilities regardless of hospital size or location.

Background: The recommendation was provided to the Section of Inpatient Care Practitioners Executive Committee by the Small and Rural Hospital Section Advisory Group. ASHP guidelines do state that pharmacists shall provide prospective review (ASHP Minimum Standard for Pharmacies in Hospitals; Standard III). These guidelines should be strengthened to make it clear that prospective review should be provided by pharmacists regardless of hospital size or location. Current legislation in some states may remove patient access to prospective review in rural and small hospitals.

18. John Poikonen (MA): Verification of Discontinued Orders in CPOE/CDS Systems

Recommendation: ASHP should support research and develop evidenced-based guidelines on when it is appropriate for pharmacist review of discontinued orders in a computerized provider order entry (CPOE)/clinical decision support (CDS) environment.

Background: State laws and The Joint Commission are unclear on the review of discontinued orders. There is a lack of evidence on when and under which circumstances pharmacist review can be most beneficial.

19. Randy Kuiper (MT) and Deb Saine (VA): Medication Safety Officer Education and Role

Recommendation: ASHP should define the role of the pharmacist as medication safety officer and provide increased educational opportunities and resources for medication safety officers and the development of such positions.

Background: Pharmacists are the best-prepared profession to serve as medication safety officers. Through networking sessions, listservers, and direct interactions, members have requested more educational opportunities and resources from ASHP to support pharmacists in medication safety officer roles. Methods of support for postgraduate year two medication safety residencies and student rotations should also be considered.

20. John Poikonen (MA): Standard Methodology for Determining Value of Pharmacist Near-Universal Prospective Order Review

Recommendation: Recommend that ASHP support and develop a standard methodology for determining where CPOE with decision support can safely and effectively replace pharmacist review of medication orders.

Background: The study of this comparative effectiveness has been endorsed by the Council of Pharmacy Management. A standard study methodology would help multiple organizations conduct and compare results of this research.

DELEGATES to the 2009 Session of the House

Officers of the House

Teresa J. Hudson, *Chair*
Janet A. Silvester, *Vice Chair*
Henri R. Manasse, Jr., *Secretary*

Officers And Board of Directors

Kevin J. Colgan, *President*
Lynnae M. Mahaney, *President-Elect*
Janet A. Silvester, *Immediate Past-President*

Teresa J. Hudson, *Chair House of Delegates*

Paul W. Abramowitz, *Treasurer*
Henri R. Manasse, Jr., *Executive Vice President and Chief Executive Officer*
John A. Armitstead
Stanley S. Kent
Janet L. Mighty
Sheila L. Mitchell
Kathryn R. Schultz
James G. Stevenson

Past Presidents

Roger W. Anderson
Debra S. Devereaux
Marianne F. Ivey
Thomas S. Thielke
Daniel M. Ashby
Fred M. Eckel
Herman L. Lazarus
Sara J. White
Robert C. Bogash
Rebecca S. Finley
James D. McAllister
T. Mark Woods
Cynthia Brennan
Harold N. Godwin
Philip J. Schneider²
David A. Zilz
Jannet M. Carmichael
Mick L. Hunt, Jr.²
Steven L. Sheaffer

STATE DELEGATES

Alabama (3)

Kim W. Benner
Marshall E. Cates
Lea S. Eiland

Alaska (2)

Thaddus Wilkerson

Arizona (3)

Larry Dean Anderson
Kristina R. De Los Santos
Eric Wade Weber

Arkansas (3)

Zhiva Kedesh Brown
Rob L. Christian
Jane Gault

California (8)

Sian Carr-Lopez
William C. Gong
Brian I. Kawahara
Nancy R. Korman
Maria D. Serpa
Kimberly Tallian
Scott Takahashi
Candy Tsourounis

Colorado (3)

Jennifer Davis
Erin Hendrick
Bonnie Kirchenbaum

Connecticut (3)

Michael Rubino
Michael D. Schlesselman
Fei Wang

Delaware (2)

Albert Helmecki
John P. McArtor

Florida (5)

Daniel E. Buffington
Thomas Burnakis
R. Peter Iafra Jr.
Mike McQuone
Richard Montgomery

Georgia (3)

Cynthia Scholl Pangburn
Sonny Rader
Andrea Gay Roberson

Idaho (2)

Patricia Killingsworth
Douglas H. Schoonover

Illinois (5)

Jered B. Bauer
Andrew J. Donnelly
James V. Dorociak¹
Ann M. Jankiewicz
Steve Marx²
William Michael McEvoy
Miriam Mobley-Smith²

Indiana (3)

Daniel D. Degnan¹
James Jorgenson²
Tina M. Love
Thomas J. Neyer

Iowa (3)

Diane Reist
James A. Wallace
David Weetman

Kansas (3)

Amber Lucas
Jennifer McKenna
Jim Rorstrom

Kentucky (3)

Lanny Adkins
Craig Martin
Stephanie Sutphin

Louisiana (3)

Christopher Betz
Helen M. Calmes
Michael B. Cockerham

Maine (2)

James A. Cattin
Bruce Daniels

Maryland (4)

Nakita Cropper
Vivian Rexroad
Lawrence P. Siegel
Jennifer K. Thomas

Massachusetts (4)

Ernest Anderson
Roy Guharoy
Robert Moura
John Poikonen

Michigan (4)

Jesse H. Hogue
Stephen T. Smith
Edward G. Szandzik
Paul C. Walker

Minnesota (3)

Kristi Gullickson
John Pastor
Judy Schneider

Mississippi (2)

Deborah S. King-Minor
Wesley Pitts

Missouri (3)

Nicole Allcock
Thomas G. Hall
Douglas Lang

Montana (2)

Dominick A. Caselnova III
Melanie Townsend

Nebraska (3)

Ken L. Saunders
Donna Soflin
Angela Ward

Nevada (2)

Kathryn Craven
Robert David Long

New Hampshire (2)

Linda Horton
Jane Rippe

New Jersey (4)

Robert T. Adamson
Eric Hola
Rosario Lazzaro
Mitch G. Sobel

New Mexico (2)

Joe R. Anderson
Melanie A. Dodd

New York (5)

Michael P. Blumenfeld
Leigh Briscoe-Dwyer
Debra B. Feinberg
Vickie Ferdinand-Powell
Frank P. Sosnowski

North Carolina (4)

Debra Cowan²
Stephen Dedrick
Stephen F. Eckel¹
Stephen Novak
Dennis Williams

North Dakota (2)

Dennis Delabarre
John Savageau

Ohio (5)

Kathleen D. Donley
Dale English II
Margaret A. Huwer
Karen L. Kier
Dou Stillwell

Oklahoma (3)

Edna Patatanian
Barbara Miles Poe
Darin L. Smith

Oregon (3)

Margaret E. McGuinness
Mihai Onofrei
Jennifer E. Tryon

Pennsylvania (5)

Patricia C. Kienle
Ronald Lay
Gerald E. Meyer
Rafael Saenz
Matthew Scola

Puerto Rico (2)

Dayna Quinones-Burgos

Rhode Island (2)

Martin E Killian
Martha J. Roberts

South Carolina (3)

David Brown
Gregory Nobles
Robert L. Spires

South Dakota (2)

Anne Morstad
Kelley Oehlke

Tennessee (3)

John D. Bridges
James M Hoffman
Kothanur Rajanna

Texas (6)

Brian A. Cohen
Lourdes M. Cuellar
Diane Lynn Fox
Julie A. Nelson
Joyce A Tipton
James Wilson

Utah (3)

Tina B Aramaki
Dallas Moore
Mark Munger

Vermont (2)

Michelle Havens
Kevin C. Marvin

Virginia (4)

Deborah R. Saine
Gayle J. Slifka¹
William Smith
Clara Y. Spencer
Rodney Stiltner²

Washington, D.C. (2)

John Quinn
Vaiyapuri Subramaniam

Washington State (3)

Susan Teil Boyer
Steven M. Riddle
Norman T. Suzuki

West Virginia (2)

Gwendolyn Gill
Carol Woodward

Wisconsin (4)

Joseph T. Botticelli
Dennis Brierton²
Arlene Iglar¹
James Klauck²
Steven S. Rough

Wyoming (2)

Linda Gore Martin

Sections and Forums Delegates

Clinical Specialists and Scientists

Kelly M. Smith

Home, Amb., and Chronic Care

Marc Stranz

Inpatient Care Practitioners

Randy Kuiper

Pharmacy Informatics & Tech.

Dennis A. Tribble

Pharmacy Practice Managers

James Rinehart

Pharmacy Student Forum

Daniel Crona

New Practitioners Forum

Michael De Coske

Fraternal Delegates

U.S. Air Force

John Michael Spilker

U.S. Army

John Spain

U.S. Navy

Susan Ann Sparks

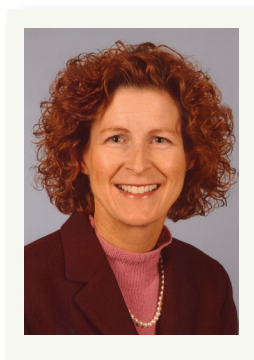
U.S. Public Health Service

Hollie J. Cook

¹ Sat in Sunday House Meeting only

² Sat in Tuesday House Meeting only

ASHP Board of Directors, 2009–2010



Lynnae M. Mahaney
President and Chair
of the Board



Kevin J. Colgan
Immediate Past-President



Paul W. Abramowitz
Treasurer



Gerald E. Meyer
Chair, House of Delegates



John A. Armitstead



Lisa M. Gersema



Janet L. Mighty



Kathryn R. Schultz



Janet A. Silvester



James G. Stevenson



Henri R. Manasse, Jr. Secretary

ASHP professional policy recommendations— Invitation to comment

Am J Health-Syst Pharm. 2009; 66:e14-8

All ASHP members are encouraged to review and comment on professional policy proposals scheduled for consideration by the House of Delegates in June 2009. By taking advantage of this opportunity, any member can influence the stance ASHP takes on issues of importance to the public and the profession.

The proposed policies were crafted by ASHP's policy committees and approved by the Board of Directors. Each group's proposed policies are published here.

Complete reports on policy issues considered by ASHP over the past year were made available via the ASHP Web site to each member of the House of Delegates and the presidents and chief executive officers of state affiliates. The Board of Directors Reports on Councils include background information on proposed policies and are available on ASHP's Web site (www.ashp.org/hod). All current ASHP professional policies may be found at www.ashp.org/policypositions.

How to comment. The best way to comment on specific policy proposals is through ASHP Connect on the Web site (www.ashp.org/ashpconnect), where members can also view comments by others. Members can also contact state delegates (listed on the House of Delegates Web site), the ASHP President, the Chair of the House of Delegates, or other members of the Board (telephone numbers are in each issue of *AJHP*).

Regional conferences for delegates to the House are scheduled for May 2–May 5, 2009, and comments received from members before then are especially useful in the policymaking process. The business scheduled for the House is reviewed in detail at the regional delegate

conferences (RDCs). Delegates who receive comments from members can share them with other state delegates at the RDCs.

ASHP policymaking process. The councils are the foundation of the ASHP process for developing professional policies. (The executive committees of sections and forums may also recommend professional policies.) In advance of the policy committee meetings that are held each September, ASHP issues a call for agenda items to be considered by any of the groups. Ideas for policy development come from ASHP members, members of the Board of Directors, policy committee members, and the ASHP staff. Further, the Board of Directors often refers Resolutions, Recommendations, and New Business items from the previous year's House of Delegates session to the appropriate policy-initiating group for con-

sideration. Each idea is researched by staff with respect to existing ASHP policy; appropriate background information on the issue is collected. The final agenda for the meeting is formulated by the chair and staff secretary of the group.

Actions taken during the two-day meeting of a policy committee are recorded in minutes. In January, the Board of Directors acts on policy recommendations, and the Board's decisions are reflected in the reports provided to delegates and published on the Web.

The ASHP policy-development process allows thorough exploration of an issue and careful crafting of language that expresses clearly the intent of ASHP members.

Policy recommendations

Council on Education and Workforce Development

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

A. Pharmacy Student Experiences in Medically Underserved Areas

To encourage colleges of pharmacy to require

student learning experiences in traditionally medically underserved areas and with diverse patient populations.

B. Medication Safety Related Education in U.S. Colleges of Pharmacy

To encourage colleges of pharmacy to include medication safety instruction in the didactic curriculum and during experiential education.

C. Pharmacy Expertise in the Preparation and Handling of Injectable Medications

To encourage colleges of pharmacy to include sterile compounding and aseptic technique instruction in the didactic

curriculum and during experiential education; further,

To support the development of postgraduate, curriculum-based sterile compounding training programs to foster an increase in the number of pharmacists with sterile compounding expertise.

D. Continuing Professional Development

To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation; further,

To continue the development of a variety of mechanisms and tools that pharmacists can use to assess their CPD needs; further,

To encourage individual pharmacists to embrace CPD as a means of maintaining their own professional competence; further,

To encourage pharmacy managers to promote CPD as the model for ensuring the competence of their staff; further,

To collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods for implementing CPD; further,

To strongly support objective assessment of the impact of CPD on pharmacist competence; further,

To endorse the efforts of colleges of pharmacy and ASHP-accredited pharmacy residency programs to teach the principles, concepts, and skills of CPD.

(Note: This policy would supersede ASHP policy 0408.)

E. Pharmacy Residency Training

To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available.

(Note: This policy would supersede ASHP policy 9911.)

Council on Pharmacy Management

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

A. Pharmacist Leadership of the Pharmacy Department

To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,

To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,

To recognize the emerging role of non-pharmacists in leadership and management roles in pharmacy departments.

(Note: This policy would supersede ASHP policy 0606.)

B. Medication Errors Related to Intimidating and Disruptive Behaviors

To affirm the professional responsibility of the pharmacist to ensure patient safety by communicating with other health professionals to clarify and improve medication orders; further,

To advocate that hospitals and health systems adopt zero-tolerance policies for intimidating or disruptive behaviors; further,

To encourage hospitals and health systems to develop and implement education and training programs for all health

professionals to encourage effective communication and discourage intimidating or disruptive behaviors; further,

To encourage colleges of pharmacy and residency training programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,

To collaborate with other organizations to advocate codes of conduct that minimize intimidating or disruptive behavior in hospitals and health systems.

C. Standardized Clinical Drug Nomenclature

To encourage federal agencies, the pharmaceutical industry, pharmacy and medical software providers, and purveyors of clinical data repositories and drug databases to explore the potential benefits of supplementing or modifying the National Drug Code with a coding system that can be used effectively to support patient care, research, and financial management; further,

To encourage that such a coding system encompass prescription drug products, nonprescription medications, and dietary supplements and include both active and inactive ingredients.

(Note: This policy would supersede ASHP policy 0801.)

D. Pharmacist's Role in Health Care Information Systems

To strongly advocate key decision-making roles for pharmacists in the planning, selection, design, implementation, and maintenance of pharmacy information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,

To advocate for incentives to hospitals and health systems for the adoption of patient care technologies.

(Note: This policy would supersede ASHP policy 0203.)

Council on Pharmacy Practice

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

A. Pharmacist's Role in Providing Care for an Aging Population

To encourage expansion of geriatric health care services; further,

To foster expanded roles for pharmacists in caring for geriatric patients; further,

To support successful innovative models of team-based geriatric care; further,

To encourage expansion of the number of ASHP-accredited geriatric pharmacy residency programs.

B. Pharmaceutical Waste

To collaborate with regulatory bodies and appropriate organizations to develop standards for the disposal of pharmaceutical hazardous waste as defined in the Resource Conservation and Recovery Act (RCRA), for the purpose of simplifying the disposal of these substances by health systems; further,

To encourage pharmaceutical manufacturers and the Environmental Protection Agency (EPA) to provide guidance and assistance to hospitals and health systems in pharmaceutical waste destruction and recycling efforts; further,

To advocate that EPA update the list of hazardous substances under RCRA and establish a process for maintaining a current list; further,

To urge federal, state, and local governments to harmonize regulations regarding disposal of hazardous pharmaceutical waste; further,

To advocate that the Food and Drug Administration standardize labeling of drug products with information relating to appropriate disposal; further,

To promote awareness within hospitals and health systems of pharmaceutical waste regulations; further,

To encourage research on the environmental and public health impacts of drug products and metabolites excreted in human waste; further,

To encourage pharmaceutical manufacturers to streamline packaging of drug products to reduce waste materials.

(Note: This policy would supersede ASHP policy 0231.)

C. Automatic Stop Orders

To advocate that the Centers for Medicare & Medicaid Services (1) revise the requirement in the Hospital Conditions of Participation that all medication orders automatically stop after an arbitrarily assigned period to include other options to protect patients from indefinite, open-ended medication orders, and (2) revise the remainder of the medication management regulations and interpretive guidelines to be consistent with this practice.

D. ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control

To approve the ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control.

(Note: This statement would supersede the ASHP Statement on the Pharmacist's Role in Infection Control, dated June 3, 1998.)

E. ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives

To approve the ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives.

Council on Public Policy

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

A. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management

To advocate expansion of collaborative drug therapy management (CDTM) practices in which the prescriber and the licensed pharmacist agree upon the conditions under which the pharmacist monitors and adjusts a patient's drug therapy; further,

To acknowledge that as a step toward the goal of universal recognition of and payment for pharmacist CDTM services, public or private third-party payers may require licensed pharmacists to demonstrate their competence to provide CDTM, before the payers authorize them to engage in or be paid for such clinical services; further,

To support (1) the development (as a professional initiative by pharmacist associations rather than as a government activity) of national standards for determining a pharmacist's competence to provide CDTM and (2) the appropriate use of these standards by clinical privileging systems, government authorities, and public or third-party payers; further,

To support the use of clinical privileging by hospitals and health systems to assess a licensed pharmacist's competence to engage in CDTM within the hospital or health system; further,

To advocate that state boards of pharmacy apply the principles of continuous quality improvement in assessing the quality, safety, and outcomes of CDTM.

(Note: *Privileging* is the process by which an oversight body of a health care organization or other appropriate provider body, having reviewed an individual health care provider's credentials and performance and found them satisfactory, authorizes that individual to perform a specific scope of patient care services within that setting.)

(Note: This policy would supersede ASHP policy 0318.)

B. Approval of Follow-on Biological Medications

To encourage the development of safe and effective follow-on biological medications in order to make such medications more affordable and accessible; further,

To encourage research on the safety, effectiveness, and interchangeability of follow-on biological medications; further,

To support legislation and regulation to allow Food and Drug Administration approval of follow-on biological medications; further,

To require post marketing surveillance for all follow-on biological medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biological medications that are deemed interchangeable.

(Note: Follow-on biological medications are also referred to as biosimilars, follow-on protein products, biogenerics,

comparable biologicals, and generic biopharmaceuticals.)

(Note: This policy would supersede ASHP policy 0519.)

C. Pharmaceutical Product and Supply Chain Integrity

To encourage the Food and Drug Administration (FDA) and relevant state authorities to take the steps necessary to ensure that (1) all drug products entering the supply chain are thoroughly inspected and tested to establish that they have not been adulterated or misbranded and (2) patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, adulterated, or unapproved drug products; further,

To encourage FDA and relevant state authorities to develop and implement regulations to (1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers, and manufacturers) from purchasing legend drugs from unlicensed entities and (2) ensure accurate documentation at any point in the distribution chain of the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

To advocate the establishment of meaningful penalties for companies that violate current good manufacturing practices (cGMPs) intended to ensure the quality, identity, strength, and purity of their marketed drug product(s) and raw materials; further,

To urge Congress and state legislatures to provide adequate funding, or authority to impose user fees, to accomplish these objectives.

(Note: This policy would supersede ASHP policy 0722.)

D. Pharmacist Role in the Health Care (Medical) Home

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as a care provider

within the health care (medical) home model; further,

To ensure that there are appropriate reimbursement mechanisms for the care that pharmacists provide (including care coordination services) within the health care home model; further,

To advocate to the Centers for Medicare & Medicaid Services (CMS) that pharmacists be included in demonstration projects for the health care home model; further,

To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in the health care home model.

E. Regulation of Interstate Pharmacy Practice

To advocate that state governments, including legislatures and boards of pharmacy, adopt laws and regulations that harmonize the practice of pharmacy across state lines in order to provide a consistent, transparent, safe, and accountable framework for pharmacy practice.

F. Reporting Medication Errors

To encourage pharmacists to exert leadership in establishing a nonthreatening, confidential atmosphere in their workplaces to encourage pharmacy staff and others to report actual and suspected medication errors in a timely manner; further,

To provide leadership in supporting a single, comprehensive medication error reporting program that (1) fosters a confidential, nonthreatening, and non-punitive environment for the submission of medication error reports; (2) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies; further,

To provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.

(Note: This policy would supersede ASHP policy 9918.)

G. Stable Funding for Office of Pharmacy Affairs

To advocate for adequate funding for the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs to support its public health mission; further,

To support initiatives of the Office of Pharmacy Affairs, including the 340B Drug Pricing Program and innovative pharmacy service models in HRSA-funded programs.

Council on Therapeutics

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

A. The Safe and Effective Use of Heparin in Neonatal Patients

To support the development and use of standardized concentrations of heparin for maintenance and flush of peripheral and central venous lines in neonatal patients; further,

To advocate that hospitals and health systems use manufacturer-prepackaged heparin flush products to improve the safe use of heparin in neonatal patients.

Inaugural address of the President-elect

Ignite your warrior within

LYNNAE M. MAHANEY

It truly is a humbling experience to be here with you today. I'm grateful for the faith you've placed in me as your president. What ASHP does every day is integral to our future and to the care of our patients.

We live in a difficult and perplexing time. We practice in a field that is full of challenges and obstacles. But I believe that this chaos also presents a unique opportunity for leadership and innovation.

Robert Kennedy captured this spirit during the chaotic 1960s when he said, "All of us might wish at times that we lived in a more tranquil world. But we don't. Our times are difficult and perplexing; so are they challenging and filled with opportunity."¹

And so my message today is one of hope and anticipation, one that shows how each of us can create the major changes that will transform health care in this country. All of us—everyone—can make patient care safer, more effective, and more economical.

Before I get to the heart of my remarks today, I'd like to take a moment to recognize some very important people in my life.

Over the years, there have been many special friends and colleagues

*All of us—everyone—
can make patient care safer,
more effective, and more
economical.*



who have supported me both professionally and personally: my mutual mentors and lifelong friends, Mark Woods and Jill Martin; Janet Silvester, Kevin Colgan, and Cindi Brennan, who have provided constant attention, friendship, and support; women leaders in ASHP and the Pharmacy Society of Wisconsin who have provided personal and professional direction early in my career, Cindy Raehl, Jan Carmichael, Patty Kienle, and Pam Ploetz; all my fellow Wisconsinites I've worked with over the years; Laura Stevenson and Mike Flagstad, very special friends and colleagues who introduced me to ASHP so many years ago; and my

Board buddy, Diane Ginsburg—you know how I feel about you.

And thank you to my wonderful family. I am truly blessed.

- My mother and best friend, Donna Jean Lind; you believed that I could do anything and taught me to believe that about myself,
- My very special father, Lloyd Lind; you have been loved since the day you entered this family,
- My two daughters, Theresa Kiedinger and Alaina Kiedinger, who put up with my long hours at work and my travel; you've become amazing young women and my closest friends,

LYNNAE M. MAHANEY, M.B.A., FASHP, is Chief, Pharmacy Service, William S. Middleton Memorial Veterans Affairs Hospital, Madison, WI.

Address correspondence to Ms. Mahaney c/o Executive Office, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814 (evp@ashp.org).

Presented at the ASHP Summer Meeting, Rosemont, IL, June 16, 2009.

Copyright © 2009, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/09/0802-1492\$06.00. DOI 10.2146/ajhp090004

- My two other fantastic children who came into my life when they were ages 10 and 13, Ryan and Tara Mahaney; I am proud that you call me Mom, and
- Last and most special, my husband, Kevin Mahaney. You are my companion, confidant, cheerleader, and the keeper of my heart and soul.

Being so close to home, I am fortunate to be joined today by several other family members. Thank you all for coming!

Finally, I work with some of the greatest pharmacists and staff in the world at the Madison Veterans Hospital. Many of them made the trip from Madison to be here today. You are part of a very special group of people who work in federal pharmacy, and I feel so privileged to count you as my colleagues.

Transformation at the Department of Veterans Affairs

For the past 10 years, I have had the great fortune to work for the Veterans Health Administration. The Department of Veterans Affairs (VA) is the nation's largest health network, treating approximately 5.5 million veterans.²

You know, a number of years ago, VA had a reputation for deteriorating facilities and mediocre care. But under the leadership of the then-Under Secretary of Health Dr. Kenneth Kizer, the VA system reengineered itself and made great strides. By focusing on information technologies, performance measurement, and integration of services, patient care improved tremendously.

And today's VA is an exciting place for pharmacists to work. The pharmacy alone is a \$1 billion-a-year operation that works from a single formulary. Extensive use of technology in our pharmacies reduces errors and frees up pharmacists to do more patient care activities.

Nearly every inpatient medication is bar coded, contributing to patient safety. And we have access to in-

The following ASHP Reports and information on 2009 ASHP award recipients appear in the online version of this issue (www.ajhp.org):

- “Hard at work on your behalf” and “Ensuring the future of health-system pharmacy practice”: remarks of outgoing ASHP president Kevin Colgan, M.A., FASHP
- “Finding success during tough times”: remarks of ASHP Executive Vice President and Chief Executive Officer Henri Manasse, Jr., Ph.D., Sc.D.
- “Leading the Way Through Troubled Times”: 2009 Report of the Treasurer by ASHP Treasurer Paul W. Abramowitz
- Professional Policies approved by the 2009 ASHP House of Delegates
- ASHP Board of Directors, 2009–2010
- ASHP Board of Directors Award of Honor
- ASHP Award of Excellence
- ASHP Honorary Membership

To read more about 2008 Society activities, go to www.ashp.org/s_ashp/docs/files/ASHP_AnnualReport07.pdf

depth electronic medical records that ensure continuity of care. VA pharmacists are able to prescribe as part of collaborative health care teams.

I'm sharing this with you because it illustrates—in a very real way—the power of people to change things for the better. Ken Kizer got the ball rolling, but practitioners at every level made it happen.

Working at VA has also provided me with a unique perspective on our military leaders, our soldiers, and our patients. In my work, I've come to realize that the complexities of war are very similar to the complexities of health care.

Recently, I read a book called *The Strongest Tribe* by Bing West. West found that the war in Iraq started to turn in America's favor when leaders began listening to the soldiers on the ground. Over the years, platoons forged strong relationships with local tribal leaders. These relationships were unconventional, to say the least, but they were effective. And they have helped turn the war around.

The military's philosophy has evolved. I believe it has embraced

Tolstoy's assertion in *War and Peace* that “battle is not decided by the orders of the commander in chief, but by the spirit of the army.”

So, what are we to do with a health care environment that was designed in the old “top-down” way? And how can we, as individual practitioners, create the change our patients need?

We must figure out how to reengineer our health systems, because they simply aren't flexible enough or innovative enough for today's complex environment. Top-down leadership models cannot withstand the demands of integrated care, because they minimize the input of staff who are the real “boots on the ground.”

We work in a profession that is highly regulated, legislated, and managed by outside groups. Many of us work in institutions that seem resistant to change. But I have a simple question for you today. Who will improve patient care if not you and me?

Today, I call on you to ignite your warrior within. My heartfelt belief is that the future of health care is in each of our hands. It will take a warrior's

passion, determination, and commitment to improve patient care.

Change is a personal decision. It is a choice we make every day: to call out processes that we know are unsafe, to speak up when we see things that aren't working well, to hold ourselves accountable for improving patient care.

Pharmacy warriors don't require special positions, titles, or credit for what they do. They seek continuous improvement and question the status quo. They are fearless defenders of what is right. And they can be found across the full spectrum of practice, from pharmacy technicians, to the decentralized pharmacist, right up to the chief pharmacy officer.

One warrior, big change

Let me tell you about a great pharmacy warrior I know. Cathy Johnson is an ambulatory care pharmacist who believed that she could improve the care of mental health patients at the VA hospital where she worked.

At her VA, more than 2,500 patients receive complex mental health care. But they did not have access to the direct medication management services that only pharmacists can provide. The physicians in the practice were simply overwhelmed by the sheer number of patients. Cathy saw an opportunity for change. She convinced her pharmacy director to give her just a half day per week to focus on medication management for these patients. She knew that she could improve patient care, save the physicians time, and manage costs better.

And, you know what? She was right!

Cathy Johnson now manages a panel of her own patients and supervises general and integrated mental health services for five clinics and over 14,000 patients.

Cathy did not set out on this personal mission because she had a special position or a special title. She was simply a pharmacist who saw an opportunity to transform patient care. Cathy listened to her "warrior within."

As pharmacists, we have a unique opportunity and a moral imperative to improve the quality and safety of medication management systems. Our patients deserve no less.

Unity of purpose

To create change, we must have a vision for what we want for our patients and for ourselves as practitioners. We must know what inspires us, what we are deeply passionate about, and what we do best.

In 1987, I attended my first ASHP Midyear Clinical Meeting. It was an amazing experience because, for the first time in my career, I was surrounded by thousands of pharmacists with a passion for their profession and patient care. For the first time, I got a sense of how many pharmacists were—and are—inspired by the opportunity to make patients feel better.

We are energized by the potential to find the most effective and cost-conscious medication solution for patients. We are excited to be members of interdisciplinary teams. And we strive for the day when our medical colleagues will see us as the medication experts.

But we are not in that perfect day yet. The numbers prove it. The Institute of Medicine found that, on average, a hospital patient can expect to experience more than one medication error each day.³

And the costs of errors to patients and their families, to employers, to hospitals, and to others is astonishing. One study found that each preventable adverse drug event in a hospital added over \$8,700 to the cost of a hospital stay.³

This clearly is unsatisfactory and unsustainable. So where do we go from here?

I believe that medication use can be improved only if we confront the twin imperatives of quality and safety. We have every opportunity to exert change and evolve our medication-use systems. We know the best practices. Technology is available. And

we have access to many, many lessons learned. Given all of that, why shouldn't zero-defect outcomes be our goal?

A pharmacy warrior

Yes, I know the challenges are daunting. Technology is expensive and complex. Technicians must be trained appropriately. Evidence-based information must be integrated into our decision-making.

But I ask you again, if the medication experts don't lead the way toward zero-defect outcomes, who will?

Let me tell you a story about the bold leadership of another pharmacist I know.

Kristin is a pharmacoeconomist. She and her interdisciplinary team developed criteria for the use of and a computerized ordering method for a high-risk drug. The criteria and method for ordering were approved, tested, and implemented. But seven months later, an inpatient went without this critical medication for three days and died.

Kristin and her colleagues didn't know whether the patient's severe heart condition or the medication omission caused his death. Obviously, Kristin was shaken to the core about potential faults in the ordering technique. Something was clearly wrong. That same interdisciplinary work group took immediate action to improve it. But Kristin was not convinced that even these changes would ensure safe use.

So she stood up against the wishes of her group and administration and refused to get behind the new system. Kristin's colleagues finally relented, and important new safeguards were created that are preventing patient harm to this day.

Kristin was a pharmacy warrior who wouldn't give in to pressure or prevailing wisdom. She demanded a foolproof, safe system.

But technology is only one piece of this very complex puzzle. We must use safety as our watchword for every

order, every patient interaction, every encounter with our colleagues.

I know that this is not without risk. I know that we are, by both nature and training, cautious and thorough people. But there are miles of difference between taking a chance on a medication order, which we can never do, and taking a risk on speaking out, loudly, when we know there is a problem.

Where to go from here

But there is more that we must do to lead the charge for change.

I believe that we need to change the very model by which we practice. Do you realize that the Hilton Head Conference on pharmacy happened almost 30 years ago? It is time for the next revolution.

ASHP has launched a Pharmacy Practice Model Initiative and is planning to hold a summit in 2010 to make that happen. Bill Zellmer, Whitney Award winner and my esteemed colleague and friend, best defined why this is so needed.

He said that “we need to develop sustainable and efficient practice models which support continuity of care for our patients. And this can only be accomplished through collaboration with other health care providers.”

Our models must be based on providing the best value to our patients. They must address how and where pharmacists practice. And they must finally answer the question about credentials: What are the training and credentials required for pharmacists to practice in hospitals and health systems and in specialty practice?

As the complexity of care increases, regulators, payers, and patients will expect us to be more accountable. This means that we will have to demonstrate a new level of credibility as patient care providers.

Roger Spear is a wonderful example of a pharmacist who has changed practice by collaborating with other health care providers. Roger is also here today.

A year ago, Roger was hired to fill a new position in our outpatient infusion clinic. This clinic serves outpatients receiving IV therapies for hematology, oncology, rheumatology, and a number of other conditions. Roger had more than five years of hospital experience, but he was not a specialist by any means.

Although Roger was tasked broadly with improving safety, efficiency, and patient satisfaction, he created his own set of specific objectives. At every point in each patient’s therapy, Roger works with pharmacists, nurses, social workers, doctors, formulary management specialists, and technicians to make improvements. In just one year, he has changed every aspect of the pharmacy care his patients receive.

Each day, Roger helps monitor the correct dosing, efficacy, and toxicity of prescribed therapies; monitors laboratory test values to ensure patients are good candidates for chemotherapy; manages inventory for these very-expensive infusions; trains and certifies technicians on sterile chemotherapy preparation standards; and participates on the hospital committee that develops the guided chemotherapy regimen templates.

Roger is a perfect example of an individual warrior pharmacist. He doesn’t have a special title, he received little guidance; yet, he made a very personal decision to become fully accountable for the patients under his care.

New practitioners like Roger expect to have more direct patient care and to be part of a team. Their collective enthusiasm, energy, and intolerance for the status quo are a great source of inspiration to the profession.

Young leaders like Elaine Huang, Dan Crona, Lindsey Kelley, Kristina De Los Santos, and Mike DeCoske have stepped up for leadership in ASHP’s Councils, Sections, and Forums. I can assure you that the future is in good hands!

Conclusion

As I conclude, I want to urge you to make the most of your membership in ASHP. Remember my reference earlier to the concept of “the strongest tribe”? Well, the strongest tribe in hospital and health-system pharmacy is right here. You. The members of ASHP.

We need our tribe more than ever if we are to manage the changes ahead. We need each other for support, for new ideas, for mentoring. I urge you to take advantage of the connections you have here. They are precious.

I hope you are as excited by the possibilities for the future as I am. At this point in time, we have a tremendous opportunity to lead and accelerate change. That’s because people want and need our services. But we have to be willing as a profession to say that we know medications best.

We have to be ready to manage medication use and be held accountable for outcomes. And we have to be willing, individually, to speak up every time we see something that can be improved, every time we see an opportunity to help a patient. We have to become pharmacy warriors.

I ask you, what is the one small thing that you can do today, tomorrow, and the day after that will improve the quality and safety of your patients?

I want to know what those small things are! I want to know what those big things are, too! E-mail me at prez@ashp.org about what you are doing.

Because once you and I begin to be bold, once we begin to always do what is right for our patients, only then will we truly have ignited our warrior within.

References

1. Kennedy R. Speech presented during lay day exercises of the University of Georgia Law School. 1961 May 6.
2. National Center for Veterans Analysis and Statistics. VA stats at a glance (April 2009). www1.va.gov/vetdata/docs/4x6_spring09_sharepoint.pdf (accessed 2009 Jul 13).
3. Aspolen P, Wolcott JA, Bootman JL et al, eds. Preventing medication errors. Washington, DC:National Academies Press; 2006.

Ensuring the future of health-system pharmacy practice

KEVIN COLGAN

As I conclude my term as president, I want to touch on important initiatives currently underway to ensure the future health of hospital and health-system pharmacy practice.

Work-force issues

As you know, ASHP has published a *Vision for the Pharmacy Workforce in Hospitals and Health Systems* that predicts pharmacists will be increasingly called on to manage and be held accountable for medication therapy. It also forecasts the need to build the capacity of the pharmacy work force to take on these additional responsibilities.

There are essentially two tracks of focus for ASHP right now in terms of workforce issues. One is our Pharmacy Technician Initiative, begun in 2008.

ASHP has always believed that safe, effective medication use can only happen if everyone on the pharmacy team works at the same level of excellence. If pharmacists hope to spend more time in direct patient care, we need to have confidence in the skills and knowledge base of our technicians. But it's very hard to have that full confidence now, because of the lack of nationally standardized technician train-

*We need
to rethink what
we do and how
we do it.*



ing. This is a real barrier to fulfilling pharmacists' potential as health care providers. I believe that this is the one issue that could potentially derail pharmacists from demonstrating the vital role we play in improving patients outcomes and making health care more efficient. If we don't have the support that we need on the pharmacy team, the evolution of pharmacy as a profession will be slowed considerably.

So, ASHP has stepped into the gap. The Pharmacy Technician Initiative supports the need for all pharmacy technicians to complete accredited training programs, be certified by the Pharmacy Technician Certification Board, and be registered by state boards of pharmacy.

So far, 19 state affiliates have signed up for the initiative. And we're excited by the possibilities for change in these states. But we're also aware that 31 states have not joined.

There does seem to be a common thread of concern from some affiliates who have not yet joined the initiative. They tell us that they are worried about the long legislative and regulatory slog that is ahead to achieve success.

But we must think bigger than the current resources or capacity that exists. We must move beyond the myopia that makes the problem seem insurmountable. I assure you that it is not insurmountable. Let me remind you that the Pharmacy Technician Certification Board was

KEVIN COLGAN, M.A., FASHP, is Immediate Past-President, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814.

Remarks presented to the ASHP House of Delegates, Rosemont, IL, June 14, 2009.

Copyright © 2009, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/09/0802-0e59\$06.00.
DOI 10.2146/sp090007

formed in 1995 to a chorus of opposition from the commercial sector. Today, 329,000 technicians have been certified. So, we have the experience, and we've done it before. After all, technician training and certification is an important patient safety issue!

If your state hasn't signed on yet, I'd like to challenge you to consider what incremental steps it would take in your state to enact the ultimate goals of the initiative. It's being done in other states, like South Carolina and Florida, where our good friends Robert Spires and Mike McQuone have been forging ahead to make legislative changes.

I would ask you to do three things. First, find out where your state stands in terms of technician regulation and the initiative. Second, support them signing on. And third, see what your own institution can do to encourage technician-training requirements. Start where you work, and I'm convinced we'll see this movement grow by leaps and bounds through your grass-roots support.

Restoring funding for postgraduate year 2 residencies

ASHP's other big work-force initiative is our advocacy work to restore residency funding for postgraduate year 2 (PGY2) programs. Since 2004, when the Centers for Medicare and Medicaid Services (CMS) first eliminated pass-through funding for specialty pharmacy residency programs, ASHP has been advocating for its restoration.

This year, our grass-roots advocacy team has been working with ASHP members in Montana and Iowa to reach Senator Max Baucus, chair of the Senate Finance Committee, and Charles Grassley, the ranking minor-party member of the committee.

Our message is simple:

- We believe that PGY2 residency programs are vital to our nation's health care delivery system,
- We believe that the \$10 million–\$15

million in restored funding will be offset by the work that clinical pharmacy specialists do to ensure safe and effective medication use, and

- We believe that the long-term effect of CMS's decision will be a significant reduction in the number of qualified clinical pharmacists and pharmacy practice leaders needed to ensure appropriate management of high-risk medication therapy in hospitals.

We've also disseminated this message in a letter to Congress as a statement for the record, submitted testimony to the Senate Finance Committee, and met with leaders at the Health Resources and Services Administration to make the case.

This is a critical issue for hospital and health-system pharmacy's future, and we're going to keep knocking on doors until the funding is restored. This is a work-force training issue, and in this economy, hospitals need CMS funding support to offer specialty residencies.

Stay tuned as we continue to work on this issue over the coming months.

Centers for Education and Research on Therapeutics

One of the most exciting aspects of President Obama's new health care reform efforts is an enhanced focus on research-based medicine. The White House budget proposal included more than \$1 billion for comparative effectiveness research to be divided among the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health, and other organizations.

The funding will support research that evaluates and compares clinical outcomes of medical treatments and services that address a particular medical condition.

As you know, ASHP policy strongly supports the importance of comparative effectiveness research. As a member of the Alliance for Better Health Care—a coalition of

consumers, employers, health plans, providers, and other stakeholders—ASHP backed the inclusion of this provision in the budget proposal.

One of the components to this new national effort will be setting research priorities. And you'll be glad to know that ASHP will be front and center in that debate. Dr. Manasse is one of the few pharmacists to be appointed to AHRQ's Centers for Education and Research on Therapeutics (CERTs) steering committee.

The mission of CERTs is multifaceted: It conducts research and provides education to advance the optimal use of drugs, medical devices, and biological products. It works to increase awareness of the benefits and risks of therapeutics, and it is focused on improving quality while cutting the costs of care.

Specifically, the CERTs steering committee will be evaluating what's being learned through research in the field and then translating it into practice. This will help shorten the gap between what is discovered and how it applies to patient care.

With Dr. Manasse at the table, you can be sure that health-system pharmacy's perspective and priorities will be represented well.

Pharmacy practice model initiative

The future of hospital and health-system pharmacy is an ongoing point of focus for ASHP. Our councils, Board, and staff keep this issue at center stage. The complexity of medication use, advances in technology needs of our health care system, and the potential for health care reform is continuing to evolve at lightning speed. And pharmacists are being recognized for the value their broad knowledge brings to advancing patient care. I observe that we are asked more and more often to step outside of our traditional practice boundary and join teams of highly skilled clinicians, scientists, and even information technologists to improve health

care . . . to improve patient care. So, we need to rethink what we do and how we do it.

This isn't the first time our profession has faced such compelling circumstances. It's hard to believe that the Hilton Head Conference occurred almost 25 years ago. The conference was a sea change for our profession. Pharmacy leaders from across the country came together and achieved consensus that our profession is a clinical practice. They determined that if pharmacists saw themselves as practitioners of a clinical profession, then they would speak and behave accordingly, and others would perceive them as clinicians. Unequivocally, that has happened.

But here we are in 2009, and a lot has changed. More high-caliber, specialty-trained pharmacists are being produced than ever before due to the doctor of pharmacy degree and residency training. They are capable of both monitoring therapy and prescribing—innovations that we are seeing in team-based settings in our hospitals and clinics. Likewise, genetic science, nanotechnology, and bioscience are advancing tremendously and more therapy will be personalized through genetic testing.

This is a slow change in practice. The current practice model does not allow us to achieve our full potential as a profession, because it provides

roles that are inconsistent with contemporary pharmacy education. And it chokes the real value we can bring as a profession providing rational, evidence-based, efficient, and effective care.

As a result, ASHP is launching the Pharmacy Practice Model initiative, a joint project with the ASHP Research and Education Foundation. As part of this initiative, ASHP is planning an invitational high-level summit in 2010 to discuss what an optimal practice model should look like.

What do we want to achieve with the initiative and the summit? We hope to encourage pharmacists to take a critical look at whether they are using work-force and technology resources to optimize pharmacy's contributions to patient care. And we want to urge pharmacists to redeploy their resources to better align the pharmacy profession's capabilities with the patient care needs within their institutions.

This is a critical juncture for our profession. We stand at the crossroads of what we've always done and what we will be doing in the future. We have new practitioners who are coming out of residency training ready to provide direct patient care. They are ready, and we are ready. And the time is now to bring our superstars and creative thinkers together to create a new archetype of practice for the profession.

ASHP is currently seeking outside funding to support this summit. However, we are well aware of the limitations of corporations and foundations in this economy. We are considering any and all suggestions for financial support. If you have an idea, contact me, Dr. Manasse, the Foundation's Steve Allen, or other ASHP staff members and let us know your thoughts. Personally, I believe in this so much that I have already made a donation.

Conclusion

As I conclude, I hope you'll agree with me that ASHP is on track, with its legislative and regulatory advocacy and its focus on the future of the profession. Our mission is to fully support pharmacists who practice in hospitals and health systems. Every activity that we undertake and every resource that we offer is centered on that mission.

I believe our very future relies on ASHP and its membership constantly asking the question, "What can we do to stay credible and relevant in this evolving world of health care?"

At ASHP, we are always asking that question. As your president and chair of the Board, I would encourage you to consider that question as well. It is through your thoughtful input that we remain strong, credible, and relevant to you, our members.

2009 Report of the Executive Vice President and Chief Executive Officer

Finding success during tough times

HENRI R. MANASSE, JR.

Effects of the economy

Today, I'd like to talk about recent events as it relates to the economy, health-system pharmacy, and ASHP. We know that the general slowdown in the economy has affected departments of pharmacy in all hospitals and health systems across the United States. ASHP members are being asked to do more with less as they face a number of work-force and budget challenges.

In fact, as I survey what's going on in the present economy, I'm reminded of some correspondence between Thomas Jefferson and John Adams after the Declaration of Independence was announced and the United States had begun a war with Britain. Adams began his letter by saying, "These are terrible times."

I've just finished reading a biography of Harry Truman. When he addressed the Congress to announce he was not going to run for a second term, Truman began by recounting the engagement of the United States in the Korean War while simultaneously having to deal with the steelworkers strike. He called it a "terrible year."

To get a sense of how this year has gone for ASHP members, our Section of Pharmacy Practice Managers sur-

*ASHP members
are being asked to
do more with less as
they face a number of
work-force and budget
challenges.*



veyed 541 hospitals this past March and examined the economy's effects on payroll and employment, costs and capital investment, management, scope of pharmacy services, education, and professional development. The survey found that there have been real and potentially long-lasting negative effects due to the economic fallout. For example, 37% of respondents had their staffing budgets reduced in the past six months, 10% laid off personnel, 22% have frozen vacant positions, and 66% had to reduce their drug budgets. Among respondents with student rotations,

16% indicated that they will reduce the number of rotations.

Finally, among respondents that offer accredited first-year residency programs, 7% will reduce the number of residency positions.

Still, even with these realities, the news is not all bad. The survey also revealed that these economic difficulties have created some new opportunities for pharmacists within their institutions. For example, 23% of respondents indicated that they have expanded leadership opportunities resulting from leadership voids in other departments. And 60% of

Henri R. Manasse, Jr., Ph.D., Sc.D., is Executive Vice President and Chief Executive Officer, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814.

Presented to the ASHP House of Delegates at the ASHP Summer Meeting, Rosemont, IL, June 14, 2009.

Copyright © 2009, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/09/0802-0e62\$06.00.

DOI 10.2146/sp090006

respondents have been given oversight of organizational projects to identify and obtain cost reductions and enhance patient safety. That's very good news.

ASHP has used these survey results to help create educational programming at this meeting, and we've added topics to the ASHP Connect discussion board to help members share their experiences and solutions with each other as we weather these difficult storms. And, as you've heard from ASHP Treasurer Paul Abramowitz, ASHP has also been touched by these global and domestic economic events.

Adjustments at ASHP

On a personal note, this year has been the worst for me in all of the years that I have administered large organizations. I had to help lead some of the toughest decisions regarding staffing levels and other budgeting considerations that I've ever had to face. And ASHP staff members have stepped up to the plate. They have made very impressive and difficult personal financial sacrifices in terms of salary and benefits reductions. And they continue to exhibit teamwork and leadership in filling the spaces left by the personnel we had to lay off in March.

We are committed to staying lean and continuing to provide, within reason and with some strategic reductions, the high level of services and resources that members have come to expect. I can assure you that ASHP will get through this crisis and emerge on the other side as the fiscally strong organization that we always have been.

We're already starting to see some improvement. In fact, our vice president for finance recently told me that our investment portfolio went up \$1.9 million in May. We're hoping that that progression continues.

National Quality Forum triumph

I'm also happy to report that after

years of ASHP's tireless advocacy, the National Quality Forum (NQF) recently recognized pharmacists' leadership roles in ensuring medication-use safety in hospitals. This is an exciting and very real victory for hospital pharmacists everywhere. It's important to acknowledge that this victory did not happen in a vacuum. It resulted from many, many hours of work by staff, by a number of you who we brought in to discuss medication safety issues, and through my personal advocacy with Dr. Janet Corrigan, NQF's president and chief executive officer.

"Safe Practice 18" in the NQF's National Voluntary Consensus Standards for Safe Practices for Better Healthcare assert "that pharmacists should be included on administrative teams that oversee medication-use processes." That is a profound victory for pharmacists and patients alike.

The same document recommends "My Medication List," a tool developed by ASHP and the ASHP Foundation, as an excellent medication reconciliation resource. And it recognizes pharmacists as critical participants in efforts to prevent falls and contrast-media-induced renal failure.

Finally, the document notes the need to increase the use of pharmacy technicians and technology to improve patient care and recommends that pharmacists have more time to provide clinical services through the use of a qualified technician work force and automated technology.

We're very excited about these developments because we believe that these practices will reduce medication errors and enhance the quality of care and patient outcomes. We'll be using the safe practices to reach out to legislative and regulatory bodies, health care executives, and accrediting bodies, such as the Joint Commission, as we advocate on behalf of hospital and health-system pharmacists. My hope is that

members will start using NQF's Safe Practice 18 as part of their own departmental strategic planning.

National Health Care Reform and ASHP

As health care reform efforts gain momentum in the United States, it's important to understand the context of influence. In the United States, health care reform is marked by incredible social, political, cultural, and economic complexity. While the concept of reform may seem simple on its face, the task itself is really difficult. Personal values influence this issue at every level. How do we deal with the serious moral and ethical issues of providing health care for all of our citizens? How do we finance it? How do we deal with all of the special interests that are forming powerful blocks to any real movement toward health care reform?

ASHP has been very aggressive in our outreach during this national political debate, and we will continue until the final decisions are made by Congress.

As cochair of the Leadership for Medication Management coalition, ASHP has drafted legislative language to gain recognition for pharmacist services under Medicare Part B. We are simply trying to add that little word "pharmacist" into this piece of legislation, but you wouldn't believe how difficult it is.

As Kevin Colgan mentioned earlier, we've aggressively inserted ourselves in the national health care reform conversation, with representatives at most of the White House forums on health care reform and meeting with the White House health care reform team. And, it hasn't hurt us that ASHP's president is from Illinois! We're constantly meeting with Congress and its staff to educate them on the pharmacist's role in safe and effective medication use, and we've written a comment letter to the Senate Finance Committee that will provide a variety of options related

to rational medication use and its financial impact on America's health care budget.

It's important to understand the kinds of influence that an organization like ASHP can have in this debate. After all, we have a very specific focus on one core segment of one part of the health care professions. It's not an easy task to educate those at the top about the work that our members do. So, to increase our influence, we've teamed up with like-minded pharmacy organizations to get our message through, and we'll keep pounding the pavement on behalf of our members. Be assured that this hard work and focused advocacy will ultimately pay off. To see the latest activities we've undertaken to be heard in this important national debate, be sure to check out the Advocacy Resource Center on www.ashp.org.

Celebrating a special transition

Let me shift now to something totally different. As many of you know, we're celebrating a major milestone at ASHP this year. Our friend and colleague, William Zellmer, is approaching retirement at the end of 2009. I want to take a moment to acknowledge this historic transition for Bill and for ASHP.

Bill has worked as an executive with ASHP for nearly 40 years and has been an undeniable force in the advancement of our profession. Under his leadership, ASHP has truly flourished.

Bill first joined ASHP in 1970 in an editorial position. He became the editor of the *American Journal of Hospital Pharmacy*, as it was called at that time from 1974 to 1992, and then was named vice president for professional affairs, a position he

held from 1985 to 1991. Bill served as vice president of professional and public affairs from 1991 to 1997. And during my tenure, he was named deputy executive vice president. Bill has been both my right and left hands and brain.

Over the years, Bill and I have had the opportunity to work side by side to continue ASHP's growth as a formidable, relevant organization that promotes the cause of hospital and health-system pharmacy. He always forced us to answer the question, "So what?"

During the 13 years that Bill and I have worked together at ASHP, I've come to know what many people know about Bill—that he has an incredibly creative mind, that he is constantly focused on the future of health care and pharmacy, and that he is dedicated to improving the safety of patients under our care. He has been and continues to be the conscience of our profession. Our board actually calls him Yoda.

Bill has had a lifelong passion for promoting hospital and health-system pharmacy. In fact, he was an architect of the Hilton Head Conference. And he's been an effective leader and advocate for the profession, both nationally and internationally. Bill is also widely known for his thought-provoking ideas and his insightful writing. He dives deep into the issues of the day, asking the questions that need to be asked about pharmacy as a profession as well as our mission to care for patients.

During his tenure, Bill has received numerous honors, including the Harvey A. K. Whitney award in 1996 and the 2008 ASHP Board of Directors' honorary member award. This year, he was named the Donald E. Francke medalist, and he will

present his lecture at the 2009 Mid-year Clinical Meeting in Las Vegas.

Bill has been transitioning into his retirement by serving this year as ASHP's writer-in-residence, and I can't wait to read what he's writing right now. He will officially retire at the end of the year. Please join me, the Board of Directors, and our staff in acknowledging Bill's many years of service and his contributions to making ASHP a true success.

Conclusion

As I conclude, I want to express my personal gratitude for all the work that each of you do on a daily basis on behalf of ASHP, the profession as a whole, and, most importantly, America's patients. It's been a rough ride through the last half of this year, but there are still many exciting opportunities to create change.

I want to publicly thank the Board of Directors, all of ASHP's staff, and all of you for your commitment to sustain ASHP in the important work that we do here.

President Obama's chief of staff Rham Emanuel has a great saying: "Never let a good crisis go to waste." He's essentially highlighting the fact that uncertainty and chaos bring about huge opportunities for transformation. And we're seeing a new White House that is taking advantage of that chaos.

As our nation deals with the transformation of our health care services system and as we deal with the economic crisis that continues to challenge us to think and act creatively, I urge you to be proactive every day. If you see an opportunity to improve something, do it. If you perceive a chance to stand up for what's right, speak up. Let's not let a good crisis go to waste.

*2009 Report of the ASHP Treasurer***Leading the way through troubled times**

PAUL W. ABRAMOWITZ

Each year, the Treasurer of ASHP has the distinct pleasure of reporting to the membership the financial condition of the Society. Although I am happy to tell you we have a strong and vibrant organization, like many organizations in our country and around the world, the Society has been affected by the severe economic conditions of the past months. The Society's financial year is June 1 through May 31, coinciding with the Society's policy development year. Because the fiscal year ends May 31, the Treasurer has three financial periods to cover in the annual report: (1) final audited prior-year numbers (for the fiscal year 2008), (2) current year (2009) projected performance, and (3) the budget for the fiscal year ending May 31, 2010.

The audit of the May 31, 2008, financial statements of the Society and the Society's subsidiary, the 7272 Wisconsin Building Corp., resulted in an unqualified opinion. Copies of the audited statements are available by contacting the ASHP Executive Office.

Fiscal Year Ended May 31, 2008—Actual

Last year, I reported to you that the Society was expecting a loss

To ensure that the Society has the resources to continue serving the membership and the profession, changes had to be made. However, even with the changes, ASHP remains a strong and vibrant organization with a growing membership that we will continue to support and represent.



for the year due to the sagging performance in the stock market and from planned spending on programs funded from accumulated net worth. We did in fact end the year with a deficit; however, the loss was larger than expected due to the market falling faster than anticipated and a \$7.649 million entry to record a pension liability in accordance with new accounting standards. In total, the Society's year-end statements reflected a loss of \$11.948 million (Figure 1). On a positive note, the core operations produced a \$1.150 million surplus on revenues totaling

\$45.537 million. Net worth ended the year at \$35.403 million, 67% of total ASHP and 7272 Building Corp. expense, and 81% before the pension adjustment. Our policy is to maintain net worth at 75% of total ASHP and 7272 Building Corp. expense, with a range of 60–90%.

The Society's May 31, 2008 year-end balance sheet (Figure 2) reflects the impact of the 2008 fiscal year results. Assets decreased by \$5.304 million (8%), while liabilities increased \$6.645 million (36%). The asset-to-liability ratio, which had been \$4.18:\$1.00 at May 31, 2006 and

PAUL W. ABRAMOWITZ, PHARM.D., FASHP, is Interim Hospital Associate Director for Professional Services and Chief Pharmacy Officer, University of Iowa Hospitals and Clinics, Iowa City, and Professor and Assistant Dean, College of Pharmacy, University of Iowa, Iowa City.

Address correspondence to Dr. Abramowitz at the Department of Pharmaceutical Care, University of Iowa Hospitals and Clinics, 200

Hawkins Drive, Iowa City, IA 52242.

Presented at the ASHP Summer Meeting, Rosemont, IL, June 16, 2009.

Copyright © 2009, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/09/0802-0e65\$06.00. DOI 10.2146/sp090008

\$3.53:\$1.00 at May 31, 2007, fell to a still-respectable \$2.40:\$1.00 at May 31, 2008.

Fiscal Year Ended May 31, 2009–Projected

This year, falling market values in the Society’s reserve portfolio and falling core revenue will combine to produce a projected deficit (Figure 1). A projected \$2.953 million deficit in the core, coupled with a \$19.403 million deficit in the program development budget (funded by investment income, which is projected to lose \$17.125 million

this year) and \$718,827 spending from net worth will produce a loss of approximately \$23.398 million for the fiscal year ending May 31, 2009. The loss also includes a projected pension adjustment of \$322,744. Net worth is projected to decrease to \$12.005 million, 22% of total annual expense, and 37% of annual expense before the accumulated pension adjustments.

Fiscal Year Ending May 31, 2010–Budget

Like many for-profit, non-profit, and governmental entities, the

Society is struggling to maintain its core strategic operations in the face of declining revenues and falling asset values. Preparing the fiscal year 2010 budget was a challenge unlike anything we have ever faced before. Nevertheless, the 2010 budget is balanced and does not include any investment income or spending from net worth (Figure 1). Over \$3 million in expenses had to be removed from the 2010 budget. Expense reductions were implemented at all levels of the organization, including staff benefits, salaries, and programs.

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

	Actual Fiscal Year Ended May 31, 2007	Actual Fiscal Year Ended May 31, 2008	Budget Fiscal Year Ended May 31, 2009	Projected Fiscal Year Ended May 31, 2009	Budget Fiscal Year Ended May 31, 2010
CORE OPERATIONS					
Gross revenue	\$ 41,452	\$ 45,537	\$ 43,311	\$ 42,071	\$ 41,998
Operating expense	(42,116)	(44,605)	(45,602)	(45,554)	(40,664)
Operating Income	\$ (664)	\$ 932	\$ (2,291)	\$ (3,483)	\$ 1,334
Provision for income taxes	\$ (271)	\$ (428)	\$ (300)	\$ (275)	\$ (250)
Other expense	(437)	(348)	(291)	(356)	(291)
Earnings from subsidiary	1,401	994	1,161	1,161	750
Investment income subsidy	132	—	123	—	—
Core Net Income	\$ 161	\$ 1,150	\$ (1,598)	\$ (2,953)	\$ 1,543
PROGRAM DEVELOPMENT					
Investment income	\$ 7,688	\$ (1,866)	\$ 4,141	\$ (17,125)	\$ —
Program expenses	(2,124)	(2,634)	(2,543)	(2,278)	(1,543)
PD Net Income	\$ 5,564	\$ (4,500)	\$ 1,598	\$ (19,403)	\$ (1,543)
SPENDING FROM NET WORTH					
Net program spending	\$ (80)	\$ (949)	\$ —	\$ (719)	\$ —
ASHP Net Income	\$ 5,645	\$ (4,299)	\$ —	\$ (23,075)	\$ —
Pension plan adjustment	—	(7,649)	\$ —	(323)	—
ASHP Net Income	\$ 5,645	\$ (11,948)	\$ —	\$ (23,398)	\$ —
Net Worth Beginning of Year	\$ 41,706	\$ 47,351		\$ 35,403	\$ 12,005
ASHP Net Income	5,645	(11,948)		(23,398)	—
Net Worth End of Year	\$ 47,351	\$ 35,403		\$ 12,005	\$ 12,005
% of Total Expense	96%	67%		25%	25%

Unfortunately, the expense reduction also required a reduction in staff. In total, the 2010 budget reflects a 15% workforce reduction, implemented across all offices and divisions of the organization. Although the budget represents a smaller ASHP with less revenue and less spending, we believe it provides the resources necessary to maintain the services critically important to our members.

7272 Wisconsin Building Corporation

The Society’s subsidiary, the 7272 Wisconsin Building Corp., finished the 2008 fiscal year on a positive note, producing a \$994,066 net income before owner’s distribution (Figure 3). The subsidiary owns the headquarters building and derives income from leased commercial and office space.

Conclusion

No one is immune from the economic crisis facing our world. To ensure that the Society has the resources to continue serving the membership and the profession,

changes had to be made. However, even with the changes, ASHP remains a strong and vibrant organization with a growing membership that we will continue to support and

represent. The Society may be smaller this year than before, but the energy and the drive of the Board and staff to serve the membership has not wavered.

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

	Actual as of May 31, 2007	Actual as of May 31, 2008
ASSETS		
Current assets	\$ 7,060	\$ 8,040
Fixed assets	2,652	3,106
Long-term investments (at market)	49,563	46,861
Investment in subsidiary	2,853	2,460
Other assets	3,912	269
Total Assets	\$ 66,040	\$ 60,736
LIABILITIES		
Current liabilities	\$ 18,228	\$ 19,049
Long-term liabilities	460	6,284
Total Liabilities	\$ 18,688	\$ 25,333
NET ASSETS		
Net assets	\$ 47,352	\$ 35,403
Total Net Assets	\$ 47,352	\$ 35,403
Total Liabilities and Net Assets	\$ 66,040	\$ 60,736

Figure 3. 7272 Building Corp. (ASHP subsidiary) statement of financial position and statement of activities for fiscal year 2008 (in thousands).

	Actual as of May 31, 2008		Fiscal Year Ended May 31, 2008
ASSETS		REVENUE AND EXPENSE	
Current assets	\$ 1,328	Gross revenue	\$ 5,878
Property and plant (net)	18,208	Operating expense	(4,396)
Other assets	1,422	Operating Income	\$ 1,482
Total Assets	\$ 20,958	Provision for income taxes	\$ (488)
LIABILITIES		Increase in Net Assets	\$ 994
Current liabilities	\$ 661	Owner’s distribution and capital contributions	\$ (1,387)
Mortgage payable	17,508	Net increase in net assets	(393)
Other liabilities	329		
Total Liabilities	\$ 18,498		
NET ASSETS			
Net assets	\$ 2,460		
Total Net Assets	\$ 2,460		
Total Liabilities and Net Assets	\$ 20,958		



House of Delegates Session—2009

Board of Directors Reports on Councils

ASHP councils met in Bethesda, Maryland, September 23–24, 2008.

Each report has three sections:

Policy Recommendations: New policies initiated by the council, approved by the Board of Directors, and subject to ratification by the House of Delegates.

Board Actions: Board of Directors consideration of council recommendations that did not result in new policies, and actions by the Board in areas for which it has final authority.

Other Council Activity: Additional subjects the council discussed, including issues for which it has begun to develop policy recommendations.

Policy Recommendations

1 Council on Education and Workforce Development

- A. Pharmacy Student Experiences in Medically Underserved Areas
- B. Medication Safety Related Education in U.S. Colleges of Pharmacy
- C. Pharmacy Expertise in the Preparation and Handling of Injectable Medications
- D. Continuing Professional Development
- E. Pharmacy Residency Training

5 Council on Pharmacy Management

- A. Pharmacist Leadership of the Pharmacy Department
- B. Medication Errors Related to Intimidating and Disruptive Behaviors
- C. Standardized Clinical Drug Nomenclature
- D. Pharmacist's Role in Health Care Information Systems

10 Council on Pharmacy Practice

- A. Pharmacist's Role in Providing Care for an Aging Population
- B. Pharmaceutical Waste
- C. Automatic Stop Orders

- D. ASHP Statement on the Pharmacist's Role in Antimicrobial Stewardship and Infection Prevention and Control

- E. ASHP Statement on the Health-System Pharmacist's Role in National Health Care Quality Initiatives

17 Council on Public Policy

- A. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management
- B. Approval of Follow-on Biological Medications
- C. Pharmaceutical Product and Supply Chain Integrity
- D. Pharmacist Role in the Health Care (Medical) Home
- E. Regulation of Interstate Pharmacy Practice
- F. Reporting Medication Errors
- G. Stable Funding for Office of Pharmacy Affairs

22 Council on Therapeutics

- A. The Safe and Effective Use of Heparin in Neonatal Patients



House of Delegates Session—2009

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

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

James G. Stevenson, Board Liaison

Council Members

Rafael Saenz, Chair (Pennsylvania)
Miriam M. Smith, Vice-Chair (Illinois)
Kathleen H. Besinque (California)
Angela L. Bingham, Student (South Carolina)
Philip W. Brummond, New Practitioner (Wisconsin)
Kathryn M. Clark (Ohio)
Michael B. Cockerham (Louisiana)
Dianna L. Gatto (Washington)
William L. Greene (Tennessee)
Gerald E. Meyer (Pennsylvania)
Natasha C. Nicol (South Carolina)
Douglas J. Scheckelhoff, Secretary

Policy Recommendations

A. Pharmacy Student Experiences in Medically Underserved Areas

- 1 To encourage colleges of pharmacy to require student
- 2 learning experiences in traditionally medically under-
- 3 served areas and with diverse patient populations.

Background

The Council believed and the Board agreed that students would benefit from experiential rotations in rural and urban settings, especially in settings or areas classified as medically underserved. Numerous published reports have shown how such rotations provide value to both the site and the student. Students learn about the cultural, financial, language, and other challenges encountered in these settings, and these skills are often invaluable when they enter practice. In addition, it is not uncommon that a student's exposure to a new practice area results in great interest and ultimately in a career choice that might otherwise not have been considered.

The Council did not support the idea of a recommendation that would mandate rotations in these settings, since there are many ways to provide the interaction. Concern was also raised over how colleges develop an infrastructure for providing these experiences. The challenges of finding good teaching sites in these settings are formidable and include the limited number of sites, a lack of qualified preceptors, and geographic distances from the college that result in housing needs. Council members noted that the outcome of the educational experience is dependent on the quality of the preceptor, which is highly variable in these settings.

Current requirements of the Accreditation Council for Pharmacy Education (ACPE) call for colleges of pharmacy to ensure that graduates can provide patient-centered care that addresses cultural diversity. Although experiential rotations may be the most common way for students to be exposed to diverse patient populations,

the Council discussed many other creative ways in which this is being accomplished. Some colleges, for example, require students to perform service learning projects with a focus on underserved populations.

B. Medication Safety Related Education in U.S. Colleges of Pharmacy

- 1 To encourage colleges of pharmacy to include medication
- 2 safety instruction in the didactic curriculum and during
- 3 experiential education.

Background

The Council believed and the Board agreed that pharmacists play an important role in developing safe systems for medication use and in preventing medication errors. Unfortunately, most pharmacy curricula do not contain dedicated courses on medication safety. The Council believed this issue is so important that ASHP should recommend that all students receive this training while in pharmacy school. Students should learn about safety principles from a qualified instructor and should be encouraged to apply their learning about safe systems during their experiential rotations. Experiential preceptors should encourage students to identify flaws in the system and recommend changes.

Students often enter experiential rotations with limited knowledge about medication error prevention, a safety culture, or how to apply generally accepted safe practices. Council members noted that the need for medication safety awareness and error prevention touches every pharmacist, regardless of practice setting. Pharmacy students should learn of their professional obligation to provide medications in the safest possible manner before they enter practice. Pharmacy students often believe that they must work within the system of medication use they find themselves in and do not feel empowered

to identify safer processes. Council members noted that preceptors often do not teach safety or encourage students to look for potential improvements. One way to incorporate medication safety would be to give students projects that help develop their ability to analyze medication-use systems for error reduction potential.

The Council discussed existing ASHP policy 0608, Interdisciplinary Health Professions Education. Although policy 0608 was considered to still be relevant, its focus is on the importance of interdisciplinary education, with only a mention of patient safety. The Council concluded that a separate policy is needed to stress the importance of this educational focus.

Council members suggested that ASHP should develop materials (e.g., textbooks, video materials) for use in such a course, since teaching resources are limited. Council members believed a standard curriculum for a medication safety course is needed. It was noted that the American Association of Colleges of Pharmacy (AACCP) is developing a model curriculum in this area and there would be value in collaborating on that effort.

C. Pharmacy Expertise in the Preparation and Handling of Injectable Medications

- 1 To encourage colleges of pharmacy to include sterile
- 2 compounding and aseptic technique instruction in the
- 3 didactic curriculum and during experiential education;
- 4 further,

- 5 To support the development of postgraduate, curriculum-
- 6 based sterile compounding training programs to foster
- 7 an increase in the number of pharmacists with sterile
- 8 compounding expertise.

Background

The Council believed and the Board agreed that injectable medications and biologics will continue to be a significant aspect of treating patients. The Council agreed that there is a clear need for students to have a basic understanding of sterile compounding upon graduation. The Council also believed that the complexity of intravenous therapy, the risk of errors or patient harm, and new biologic therapies all demand a higher level of expertise in sterile compounding in the pharmacy.

USP Chapter 797 and other efforts have increased the focus on the quality of injectable medication preparation and have caused organizations to improve staff training, facilities, and procedures used. Some pharmacy departments give high priority to the quality of injectable medications, while others have reluctantly adopted USP 797 and ASHP guidelines. The Council discussed two needs related to pharmacy expertise in sterile product preparation: the baseline training and knowledge of the new pharmacy graduate and the need for pharmacists with an advanced body of knowledge on sterile product preparation, especially in pharmacy departments where complex sterile preparations are compounded.

Education in colleges of pharmacy on sterile compounding varies greatly. Some Council members noted that some students learn to compound intravenous admixtures proficiently by spending time working in a hospital pharmacy. Others cited examples in which students graduate without ever handling or touching an intravenous solution.

The Council also discussed the need for pharmacists who have additional training in sterile compounding beyond baseline knowledge. Many pharmacy departments, especially in larger hospitals, have a staff member who works in this capacity. Often these individuals have developed their expertise over time and will be retiring soon. Rarely is there anyone ready to step into this role, and training opportunities are limited.

The Council agreed that sterile product experts should receive more extensive training beyond simple aseptic technique. The Council suggested that ASHP seek ways to develop a model that combines classroom instruction with hands-on experience and exposure to facility design and equipment.

D. Continuing Professional Development

- 1 To endorse and promote the concept of continuing pro-
- 2 fessional development (CPD), which involves personal
- 3 self-appraisal, educational plan development, plan imple-
- 4 mentation, documentation, and evaluation; further,

- 5 To continue the development of a variety of mechanisms
- 6 and tools that pharmacists can use to assess their CPD
- 7 needs; further,

- 8 To encourage individual pharmacists to embrace CPD
- 9 as a means of maintaining their own professional com-
- 10 petence; further,

- 11 To encourage pharmacy managers to promote CPD as
- 12 the model for ensuring the competence of their staff;
- 13 further,

- 14 To collaborate with other pharmacy organizations, state
- 15 boards of pharmacy, accrediting bodies, and regulatory
- 16 bodies in the development of effective methods for
- 17 implementing CPD; further,

- 18 To strongly support objective assessment of the impact
- 19 of CPD on pharmacist competence; further,

- 20 To endorse the efforts of colleges of pharmacy and ASHP-
- 21 accredited pharmacy residency programs to teach the
- 22 principles, concepts, and skills of CPD.

(Note: This policy would supersede ASHP policy 0408.)

Background

During sunset policy review, the Council voted to recommend amending ASHP policy 0408 as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation; further,

To continue ~~strongly encourage~~ the development of a variety of mechanisms and tools that pharmacists can use to assess their CPD needs; further,

To encourage ~~support the efforts of~~ individual pharmacists to embrace CPD as a means of maintaining their own professional competence ~~understand CPD (including the fact that various options are available for self-assessment) and to implement CPD;~~ further,

To encourage pharmacy managers to promote CPD as the model for ensuring the competence of their staff; further,

To collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods strategies for implementing piloting the implementation of CPD; further,

To strongly support objective assessment of the impact outcomes of implementation of CPD on pharmacist competence; further,

To encourage ~~endorse the efforts of~~ colleges of pharmacy and ASHP-accredited pharmacy residency programs to teach the principles, concepts, and skills of CPD.

The Council supported and the Board agreed with the intent of policy 0408 but concluded that it should be revised to further emphasize the importance of CPD and personal responsibility in lifelong learning. The Council discussed establishing a target date (e.g., 2015) for full adoption of CPD principles. The Council also discussed whether CPD should be required by state licensing boards under another agenda topic (see Board Actions below).

E. Pharmacy Residency Training

- 1 To continue efforts to increase the number of ASHP-
- 2 accredited pharmacy residency training programs and
- 3 positions available.

(Note: This policy would supersede ASHP policy 9911.)

Background

The Council discussed existing ASHP policy 9911 regarding phar-

macy residency training. The Council considered the policy to be relevant but chose to amend it to recognize ASHP accreditation and broaden the scope of benefits that come from residency training. The promotion of residency training to pharmacy students, contained in the second paragraph of the policy, was reviewed and considered to be already addressed by existing ASHP policy 8507.

During sunset policy review, the Council voted to recommend revising ASHP policy 9911 as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available,; ~~further~~;

~~To expand efforts to make pharmacy students aware early in their education of the career choices available to them and the importance health-system employers attach to the completion of a residency.~~

Board Actions

Pharmacy Student Experiences in Medically Underserved Areas.

The Council recommended and the Board voted

To foster innovative models for involving pharmacy students in the provision of care to medically underserved populations; further,

To publish and promote best practices, tools, and resources supporting pharmacy student education and preceptor development in the provision of pharmacist services to underserved populations.

As part of the Council's discussion on student learning experiences in traditionally medically underserved areas and with diverse patient populations (Policy Recommendation A), ways to support development of teaching sites in underserved areas were also discussed, including preceptor development and finding ways to remove barriers to having students in these settings. Since these sites often have unique locations and limited resources, methods of placing and teaching students may also be non-traditional. The development of these types of experiences will be accelerated if new, innovative models can be developed and information about resources and best practices is made available to help remove barriers to these pharmacy student experiences.

Continuing Professional Competence.

The Council recommended and the Board voted

To explore the implications of requiring mandatory continuing professional development with periodic assessment to maintain pharmacist licensure.

The Council discussed the need for all health professionals to maintain professional competence throughout their careers. Nearly all health professions are developing a more rigorous means of ensuring continuing competence, usually through state licensing boards. Pharmacy continues to use initial licensure based on successful completion of the NAPLEX exam, supplemented by traditional continuing education, as a basis for establishing and maintaining competence. The Council discussed this model of "licensure for life," with its minimal requirements for continuing education, and did not consider it to be adequate for the future, especially with the growing complexity of medication use and the need for safe and effective patient care.

CPD was discussed as a way to provide structure to lifelong learning. If used as intended, CPD can be an effective model for maintaining competency. A needs assessment and individualized development plan using a portfolio subject to external review was viewed as a good model. Although CPD is endorsed by many in the profession, including ASHP, its voluntary nature has resulted in

minimal adoption by individual practitioners. The Council believed that unless state licensing boards set defined requirements, perceived issues related to a lack of accountability and consistency will only continue. The Council believed more information and analysis are needed before a specific policy recommendation can be made.

Competence of Pharmacists Re-entering Practice or Changing Practice Settings.

The Council recommended and the Board voted

To evaluate the feasibility of and need for establishing a requirement for re-entry training for pharmacists who have a time lapse in practice or change pharmacy practice settings.

The Council discussed the changing demographics of the pharmacy workforce and how a gender shift in the profession has resulted in a growing number of pharmacists leaving practice for a period of time during their career or working less than full-time. With the growing complexity of medication use, expanding body of literature, and release of new drug products, it is increasingly difficult for pharmacists to maintain their competence, much less re-enter practice after an extended absence. Currently, state boards of pharmacy require only that a pharmacist earn continuing education credits to maintain his or her license. The Council discussed how other health professions, such as nursing and medicine, have developed educational courses tailored to those re-entering practice. Many state licensing boards have also established requirements for an approved refresher course before professionals can re-enter practice after a defined period of time away.

There was strong Council support for requiring a structured educational program for those re-entering practice. However, the Council believed more information is needed to determine how long a practice lapse would require such a program; the depth, scope, and format of the re-entry program; and how the program might be managed. The Council also believed a better understanding of the number of individuals who would be eligible for such a program is needed.

The Council believed this is an extremely important issue because of the pharmacist's role in direct patient care and the need to ensure the safe provision of care. It was suggested that ASHP staff study the issue and bring it back to the Council for further consideration.

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

- Cultural Diversity Among Health Care Providers (0409)

Other Council Activity

ASHP Statement on Continuing Education. The Council voted

To revise the ASHP Statement on Continuing Education.

As part of sunset review, the Council discussed the ASHP Statement on Continuing Education. The Council believed that the statement includes many important components relevant to continuing education but that it should be revised to include current philosophies and policies related to continuing education, including active learning and continuing professional development.

Competence and Capacity of the Pharmacy Workforce to Care for an Aging Population. The Council discussed data projecting significant growth in the number of persons age 65 and older in the coming years. Currently, one third of all prescriptions are consumed by this population, and that proportion is expected to increase in the future. The Council discussed the need for pharmacists to have a broader knowledge of the health care issues and pharmaceutical needs of the elderly.

The Council discussed both the need for all pharmacists to have a greater understanding of issues related to caring for geriatric patients and the need for more pharmacy specialists who specifically care for elderly patients who are frail. The distinction is clear, since many aging baby-boomers are not frail but could still benefit from having a pharmacist who is competent in geriatric therapeutics.

ACPE curricular standards and guidelines for colleges of pharmacy include geriatrics as a special population area to be covered, but the guidelines do not specify the depth, breadth, or quantity of geriatrics-focused education and training.

It was suggested that ASHP work collaboratively with other pharmacy associations, especially the American Society of Consultant Pharmacists, on possible professionwide solutions, since pharmacists in all settings provide care for geriatric patients.

Models for Evaluating Professional Credentials for Pharmacists. The Council discussed the numerous credentials available for pharmacists beyond the academic pharmacy degree and state licensure, such as residency training and specialty certification. Many credentials are specific to pharmacy, but a growing number are multidisciplinary. Increasingly, pharmacy credentials are being used as part of a privileging process within hospitals and health systems to verify competencies and to define scope of practice. In addition, new models for payment for pharmacists' professional services are being developed, and some require the pharmacist to demonstrate competence by attaining certain credentials in order to become eligible for payment.

Council members described situations in which members of their staff had sought certificates or other credentials from unknown organizations. These credentials were not recognized by the profession and were of unknown quality. Council members found it very difficult to determine the value of these programs, and managers and others charged with ensuring competence of practitioners were left in a similarly difficult situation.

The need for a more structured way to evaluate the different credentials available was discussed. The Council reviewed the criteria developed by the Commission on Credentialing in Pharmacy (CCP) and published in *CCP Guiding Principles for Certification of Individuals in Pharmacy* and concluded that they were sound. However, publication of the criteria has not led to universal adoption and does not in itself provide the framework for a credible credentialing model. The Council strongly believed that the appropriate credentials for different levels of advanced practice and activities should be determined by the profession, not by the government or some outside body. The role CCP plays in that determination has not been clear.

The Council recommended that ASHP play an active role in developing a model for credentialing requirements that would be accepted professionwide.

Pharmacy Experiential Education. The Council discussed the results of a national survey conducted by ASHP and AACP related to experiential education. Much of the discussion focused on whether there will be adequate capacity for experiential education.

The Council discussed the role ASHP could play in helping enable health systems to establish an experiential site or expand an existing site. For example, guidance could be provided on how to establish an affiliation agreement and related logistical issues, how to prepare and promote resident involvement in teaching, and how to demonstrate to hospital administration the value of providing student rotations.

The Council agreed that the success of experiential rotations is often tied to how students are utilized. There must be a balance between the service students provide to the organization and the opportunity the organization offers students to learn about practice and build their knowledge. Successful sites find ways to serve both purposes simultaneously. The need for student schedules and college calendars to align with patient care needs was also noted. It is often difficult to establish a meaningful role for students when they are available on a very limited and sporadic basis. It was suggested that ASHP identify and promote examples of successful practice models that have integrated students into pharmacy services and patient care.

Expanding Access to Accredited Pharmacy Technician Training Programs. Current ASHP policy calls for standardized education and training of pharmacy technicians in ASHP-accredited training programs. However, the capacity of such programs is very limited and would need to be greatly increased for this vision to become a reality. The Council discussed what ASHP could do to encourage more hospitals to comply with training standards and seek accreditation of their training programs. Also discussed were whether colleges of pharmacy could be a source of training and education for pharmacy technicians and whether ASHP or state affiliates could offer a base curriculum to facilitate quality technician training.

The Council recommended that ASHP create and make available the modules and tools needed to develop a quality technician training program within hospitals that would meet ASHP-accreditation standards. This would help sites improve the training they offer and would help remove barriers to becoming accredited by ASHP.



House of Delegates Session—2009

Board of Directors Report on the Council on Pharmacy Management

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

Kathryn R. Schultz, Board Liaison

Council Members

Jennifer E. Tryon, Chair (Oregon)
Eugene A. Handza, Vice-Chair (Kansas)
Paul J. Barrett (Maine)
Robert DeChristoforo (Maryland)
Jennifer V. Kacmarcik, New Practitioner (Maryland)
Todd A. Karpinski (Texas)
Thomas E. Kirschling (Pennsylvania)
Nancy A. Konieczny (Missouri)
Donald H. Lynx (Texas)
Dawn M. Moore-Jefferson (Indiana)
Judith K. Schneider (Minnesota)
Mai-Chi N. Tran, Student (Pennsylvania)
Steven S. Rough, Section of Pharmacy Practice Managers Liaison (Wisconsin)
Kathryn R. Schultz, Board Liaison
David R. Witmer, Secretary

Policy Recommendations

A. Pharmacist Leadership of the Pharmacy Department

- 1 To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,
- 5 To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,
- 7 To recognize the emerging role of nonpharmacists in leadership and management roles in pharmacy departments.

(Note: This policy would supersede ASHP policy 0606.)

Background

The Council reviewed ASHP policy 0606 and voted to recommend amending the policy as follows (underline indicates new text):

To affirm the importance of an organizational structure in hospitals and health systems that places administrative, clinical, and operational responsibility for the pharmacy department under a pharmacist leader; further,

To affirm the role of the pharmacist leader in oversight and supervision of all pharmacy personnel; further,

To recognize the emerging role of nonpharmacists in leadership and management roles in pharmacy departments.

The Council believed and the Board agreed that ASHP's policy on leadership of the pharmacy department should be expanded to recognize the growth of leadership roles of nonpharmacists. The Council also saw the need to affirm the importance of a pharmacist as the leader of the pharmacy enterprise and the role of this pharmacist leader in the supervision and management of all pharmacy personnel.

The Council discussed the increasing complexity of managing medication use and the expanding roles for nonpharmacists in achieving the mission of the pharmacy department. The Council reviewed the ASHP Long Range Vision for the Pharmacy Work Force in Hospitals and Health Systems and ASHP Statement on the Roles and Responsibilities of the Pharmacy Executive. ASHP's Long Range Vision describes a growing role for nonpharmacists in management and leadership positions in hospitals and health systems. The Council and Board agreed that there will be expanded use of nonpharmacists in management and leadership roles in the future. Many factors will fuel this expansion, including a shortage of pharmacists, pharmacists' salaries, and the growing complexity of the pharmacy operation.

The Council believed and the Board agreed that there are many functions in the pharmacy department that can be led or managed by nonpharmacists. Some examples are supervision of technicians and management of technological, business, and financial matters. The Council distinguished between management, leadership, and supervision, noting that unique management roles do not necessarily imply a supervisory function. The Council also recognized that the use of such specialized nonpharmacist expertise will vary depending on the size and complexity of the pharmacy enterprise. These roles will be more prevalent in large facilities and less so in small or rural facilities, where there is likely to be less specialization in pharmacy functions. Therefore, the Council believed and the Board agreed that ASHP should not advocate that certain roles be

filled by nonpharmacists but instead should encourage members to share examples of innovative roles for nonpharmacists through education, publications, and networking forums.

The Council also discussed roles that should be filled by pharmacists. The Council emphasized the continuing need to utilize technology and well-trained technicians to allow pharmacists to become more fully engaged in patient care. The Council believed education and training as a pharmacist is critical for roles in the management of patient care functions. Since the director or the chief pharmacy officer is responsible for the management of all aspects of the pharmacy service, the Council also believed that the education and training of a pharmacist is essential for that position.

B. Medication Errors Related to Intimidating and Disruptive Behaviors

- 1 To affirm the professional responsibility of the pharmacist to ensure patient safety by communicating with
- 2 other health professionals to clarify and improve medication orders; further,
- 3
- 4
- 5 To advocate that hospitals and health systems adopt
- 6 zero-tolerance policies for intimidating or disruptive
- 7 behaviors; further,
- 8
- 9 To encourage hospitals and health systems to develop
- 10 and implement education and training programs for
- 11 all health professionals to encourage effective communication and discourage intimidating or disruptive
- 12 behaviors; further,
- 13
- 14 To encourage colleges of pharmacy and residency training
- 15 programs to incorporate training in communications and managing intimidating or disruptive behaviors; further,
- 16
- 17 To collaborate with other organizations to advocate
- 18 codes of conduct that minimize intimidating or disruptive behavior in hospitals and health systems.

Background

The Council discussed the role of intimidating and disruptive behaviors as contributing factors in medication errors. A July 9, 2008, sentinel event alert from The Joint Commission (TJC) titled "Behaviors That Undermine a Culture of Safety," summarizes the impact of these behaviors. Intimidating behavior can lead to medical errors, contribute to poor patient satisfaction, increase cost, and result in staff turnover. The alert notes that disruptive behaviors can range from passive behaviors such as refusal to answer questions or return pages and use of condescending language to overt actions such as verbal outbursts or physical threats. TJC has a new leadership standard (LD.03.01.01) that will become effective January 1, 2009. This new standard has two elements of performance (EP):

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive or inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

TJC also suggests education of all team members on appropriate professional behavior as defined by the organization's code of conduct, the creation of zero-tolerance policies for intimidating or disruptive behaviors, medical staff policies specifically addressing disruptive or intimidating behaviors, protections for those who report instances of intimidation, skills-based training, and an organizational process for addressing disruptive behaviors.

The Council also reviewed two medication safety alerts and a 2003 survey on workplace intimidation by the Institute for Safe Medication

Practices (ISMP). In ISMP's survey of 2095 hospital health care providers, 88% of respondents had encountered condescending language, 79% had encountered a reluctance or refusal to answer questions or phone calls, 48% had been subjected to strong verbal abuse, and 4% reported actual physical abuse. Intimidating behavior was not limited to physicians or prescribers. Nearly half (49%) of the respondents reported that experience with intimidation altered the approach to order clarifications or questions about medication orders, increasing the intimidated professional's reluctance to intervene.

There has been growing attention to this issue, especially by the nursing profession, with results such as the universal protocol and time-outs to prevent wrong site, wrong procedure, or wrong person surgery. However, pharmacy has given little attention to this issue. The Council believed and the Board agreed that it is important to encourage organizational efforts targeting all professionals and not just physicians. The Council also believed and the Board agreed that organizations should develop training programs to discourage disruptive behaviors and to train employees in handling disruptive situations, and it encouraged ASHP to address this through journal articles or the development of educational programs or products to assist in the provision of training in health care facilities. The Council believed and the Board agreed that it is important to encourage colleges of pharmacy and residency training programs to provide training in this area. The Council suggested that the issue of intimidation as a contributing factor in medication errors should be incorporated in the ASHP Guidelines on Preventing Medication Errors in Hospitals, and it encouraged the Council on Pharmacy Practice to modify the document accordingly.

C. Standardized Clinical Drug Nomenclature

- 1 To encourage federal agencies, the pharmaceutical industry,
- 2 pharmacy and medical software providers, and
- 3 purveyors of clinical data repositories and drug databases
- 4 to explore the potential benefits of supplementing or
- 5 modifying the National Drug Code with a coding system that can be used effectively to support patient care,
- 6 research, and financial management; further,
- 7
- 8 To encourage that such a coding system encompass pre-
- 9 scription drug products, nonprescription medications,
- 10 and dietary supplements and include both active and
- 11 inactive ingredients.

(Note: This policy would supersede ASHP policy 0801.)

Background

In response to a Recommendation from the ASHP House of Delegates, the Council assessed the need for expanding the concept of numerical classification or coding in ASHP's existing policies. The Council voted to recommend amending ASHP policy 0801 as follows (underline indicates new text):

To encourage federal agencies, the pharmaceutical industry, pharmacy and medical software providers, and purveyors of clinical data repositories and drug databases to explore the potential benefits of supplementing or modifying the National Drug Code with a coding system that can be effectively used to support patient care, research, and financial management across the medication use continuum; further,

To encourage that such a coding system encompass prescription drug products, nonprescription medications, and dietary supplements and include both active and inactive ingredients.

Clinical decision support systems (CDSS) in computerized provider order entry (CPOE) systems and pharmacy information systems have been widely used for screening drug interactions and patient allergies. For this screening to be effective, a baseline coding structure of the medications must be available. Discussion at the June 2008 session of

the ASHP House of Delegates suggested the need for expansion of this coding system to include drug excipients and herbal products.

The National Committee on Vital and Health Statistics (NCVHS) has recommended changes to give the Food and Drug Administration (FDA) full control over the National Drug Code (NDC). Currently, FDA controls only a portion and manufacturers control the remainder. FDA has made recommendations for uniform standards to enable electronic prescribing (e-prescribing) in ambulatory care. During the past several years, NCVHS has focused considerable attention on the feasibility and desirability of standards to support e-prescribing and the need for standard terminology for clinical drugs to facilitate automated drug-use review and decision support for patient safety. In previous reports, NCVHS documented NDC shortcomings, most notably concern about perceived weaknesses of the current NDC database and linkage of the NDC to RxNorm concepts. NCVHS expressed the need for harmonization of terminologies to eliminate incompatibilities that impair drug utilization studies and may negatively affect patient safety. RxNorm, a standardized nomenclature for clinical drugs, is produced by the National Library of Medicine. In RxNorm, the name of a clinical drug combines its ingredients, strengths, and form. RxNorm has limitations; it does not identify a product's excipients, and it does not include herbal products or nonprescription medications.

The Council noted that policy 0808 advocates the inclusion of excipients in the official product labeling for drugs and policy 0811 advocates disclosure of excipients in dietary supplement labeling. However, ASHP policy 0801 does not specifically identify excipients as critical elements of a coding system; that policy is limited to drug products. The Council amended policy 0801 to encompass prescription drug products, nonprescription medications, and dietary supplements and to include both active and inactive ingredients. The Council believed and the Board agreed that without the inclusion of these elements in a coding system, the effectiveness of CDSS for screening medication orders will be limited.

D. Pharmacist's Role in Health Care Information Systems

- 1 To strongly advocate key decision-making roles for
- 2 pharmacists in the planning, selection, design, imple-
- 3 mentation, and maintenance of pharmacy informa-
- 4 tion systems, electronic health records, computerized
- 5 provider order entry systems, and e-prescribing systems
- 6 to facilitate clinical decision support, data analysis, and
- 7 education of users for the purpose of ensuring the safe
- 8 and effective use of medications; further,
- 9 To advocate for incentives to hospitals and health sys-
- 10 tems for the adoption of patient care technologies.

(Note: This policy would supersede ASHP policy 0203.)

Background

The Council discussed ASHP policies related to e-prescribing and voted to recommend amending ASHP policy 0203 as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To strongly advocate key decision roles of pharmacists in the planning, selection, design, implementation, and maintenance of ~~electronic patient information systems (including computerized prescriber order entry systems)~~ pharmacy information systems, electronic health records, computerized provider order-entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications; further,

To advocate for incentives to hospitals and health systems for the adoption of patient-care technologies.

E-prescribing is similar in some respects to computerized provider order entry, but it is often less complicated and may stand alone from the electronic health record (EHR). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established a five-year program of incentive payments to eligible professionals who are "successful electronic prescribers." Successful prescribers are those who either report applicable electronic prescribing measures established under the Physician Quality Reporting Initiative or electronically submit prescriptions under Medicare Part D at a level determined by the Centers for Medicare & Medicaid Services (CMS). The incentive payment program begins in January 2009. A conference will be held to educate affected constituencies on the MIPPA program and CMS's plans for implementation. With the increased adoption of and government incentives for e-prescribing, hospitals and health systems may be involved in implementing a system in their ambulatory care areas.

The Council believed there would be many benefits to the widespread adoption of e-prescribing. Widespread use of e-prescribing could support the achievement of The Joint Commission's National Patient Safety Goals and could help to achieve more effective medication reconciliation. The Council noted, however, that standards for e-prescribing are still evolving and many pharmacies still are not equipped to effectively capitalize on the benefits of e-prescribing.

The Council reviewed ASHP policy 0203 and believed that use of the term "patient information systems" is not clear and that the policy does not adequately define the key elements of a prescribing system. The Council amended the policy to clarify that the policy applies to CPOE, EHRs, pharmacy information systems, and e-prescribing. The Council also believed that ASHP should advocate for incentives for hospitals and health systems to implement e-prescribing. The Council also noted that the U.S. Drug Enforcement Administration needs to address the regulation of electronic prescriptions for controlled substances, and it encouraged the Council on Public Policy to address this issue.

Board Actions

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

- Scope and Hours of Pharmacy Services (0403)
- Standardization, Automation, and Expansion of Manufacturer-Sponsored Patient-Assistance Programs (0404)
- Workload Monitoring and Reporting (0406)
- Documentation of Pharmacist Patient Care Services (0407)
- Fostering Pharmacy Leadership (9901)
- Compliance with Governmental Payment Policies (9902)
- Optimizing the Medication-Use Process (9903)

Other Council Activity

Pharmacy Perioperative Services. At the request of the Section of Pharmacy Practice Managers, the Council discussed the desirability of efforts to expand pharmacy services in the perioperative area. The Council believed expansion of the pharmacist's role in the perioperative area would provide significant opportunities for education, improving cost capture, control of waste, management of controlled substances, and clinical consultation. The Council believed that the perioperative area presents opportunities for pharmacists to improve patient care, but it also believed that pharmacy services to the perioperative area are highly variable and that pharmacy leaders should be encouraged to assess pharmacy practice in their institutions to identify high-risk areas where expansion of pharmacists' services could improve patient care.

The Council reviewed the ASHP Guidelines on Surgery and Anesthesiology Pharmaceutical Services. The guidelines were developed in 1998. The Council believed the guidelines should be updated, and it encouraged the Council on Pharmacy Practice to revise the document. The focus of the current guidelines is on operating room satellite pharmacies. The Council believed that the document should be updated with a focus on the role of the pharmacist in improving patient safety and should increase its focus on pharmacy services to the perioperative area rather than describing a satellite pharmacy structure. The Council also encouraged ASHP to identify and showcase new models of pharmacy service to the perioperative area and to provide education and training to assist pharmacy leaders in cost justification of perioperative pharmacy services.

Telepharmacy as Equivalent to Pharmacists' Order/Medication Review. In response to a Recommendation from the ASHP House of Delegates, the Council discussed the desirability of promoting telepharmacy as an alternative to pharmacists' on-site review and evaluation of medication orders. The Council strongly believed that, when feasible, it is desirable for pharmacists to be present in a practice setting in physical proximity to patients, physicians, nurses, and other health care personnel. The Council believed that this enhances effective communication and that working directly with patients and other caregivers encourages the development of professional relationships that help facilitate practice. However, the Council also noted that telepharmacy is an effective tool that can be used to provide access to the services of pharmacists when 24-hour on-site pharmacist services are not practical.

The Council discussed a variety of potential applications of telepharmacy to support medication order review, including supporting 24-hour access, providing access to pharmacists in rural and underserved areas, supporting work-from-home arrangements for pharmacists, and providing access to specialist pharmacist services. The Council supported the use of telepharmacy to increase the provision of pharmacist services when on-site service is not feasible, but it did not support expanding the use of telepharmacy to accommodate telework preferences.

The Council reviewed ASHP policies 0712, 0716, and 0403 and did not suggest changes to these policies. ASHP policy 0403 supports the use of remote review of medication orders when on-site pharmacist review is not available. The Council also reviewed draft ASHP Guidelines on Remote Medication Order Processing and believed that this document will provide useful guidance to ASHP members when completed. The Council suggested broadening the description of the areas of current use of telepharmacy in the document. The Council believed that standards should not be compromised to accommodate telepharmacy and that standards of care should apply equally to on-site and telepharmacy practice.

Use of Clinical Decision Support to Limit Near-Universal Pharmacist Order Review. In response to a Recommendation from the ASHP House of Delegates, the Council discussed the desirability of using clinical decision support systems (CDSS) to limit universal pharmacist order review. The Council discussed the current status of CDSS. According to a 2007 ASHP survey only 12% of US Hospitals have implemented CPOE with a robust CDSS. Up to 90% of hospitals are looking at this technology in the next three

years. While every CPOE computer system includes commercially developed CDSS, extensive local customization is required to achieve optimal performance and patient outcomes. When implemented and properly customized with dedicated pharmacist resources there is substantial evidence that CDSS can have positive patient outcomes. However, the extensive customization required by these systems has limited the widespread use of CDSS, especially for the purpose of limiting pharmacists' review of medication orders.

The Council supported further research and pilot projects to demonstrate the value of CDSS. Research validating CDSS algorithms, as well as human factors research in the application of CDSS, would be valuable. The impact of CDSS on the pharmacist review of orders should be aggressively evaluated. The Council did not support the use of CDSS to replace pharmacist review of medication orders at this time. The Council did not believe that the technology has evolved to a point where it could replace the pharmacist's role in medication review. The Council also did not think it would be wise to create policy that conflicted with Joint Commission requirements for pharmacist medication order review. The Council did support the use of CDSS to improve medication use, believing that there may be more value in focusing efforts on the use of CDSS in improving the use of high-risk medications.

Centralized Distribution Services. In response to a Recommendation from the ASHP House of Delegates, the Council discussed the desirability of promoting increased centralization of distributive pharmacy functions to improve the efficiency of logistical functions and expand patient care opportunities for pharmacists. The Council discussed advantages and potential disadvantages of centralizing pharmacy distribution services. A centralized approach has the potential to increase efficiency of the distribution process, but there are risks associated with placing all pharmacy distribution in one facility. The Council noted that natural disasters such as hurricanes and earthquakes can damage infrastructure and disrupt delivery channels. Recent hurricanes and bridge collapses were noted as examples of events that can have a negative impact on centralized distribution. It is important to plan for contingencies and build redundancy into distribution models to ensure that patient care can still be delivered in an emergency. The U.S. Department of Veterans Affairs (VA) Centralized Mail Order Pharmacies (CMOPs) model was described. CMOPs process 70–80% of the entire VA outpatient national prescription workload, filling 100 million prescriptions annually. In the design of the CMOPs, redundancy was a very important feature; all operations can be transferred to another CMOP in the event that one facility can no longer function.

The Council believed that well-designed centralized distribution models with appropriate control measures could generate efficiencies, especially in corporately related hospitals. The Council believed that the most significant barrier to the implementation of centralized distribution models is state laws and regulations. Even corporately related hospitals face challenges when distribution crosses state lines. The Council reviewed ASHP policy 0522 and concluded that it generally addresses the issue but does not specifically describe centralized distribution models. The Council believed that the Council on Public Policy should review this issue and assess whether ASHP policy sufficiently addresses state regulation of centralized distribution models.

Compromises in Medication-Use Standards Due to Manpower Shortages. The Council discussed the impact of pharmacist shortages on the implementation of medication-use standards. The Council believed that manpower shortages are only one factor affecting the implementation of standards. An additional challenge is keeping pace with the expansion of standards by various groups, including The Joint Commission, CMS, the United States Pharmacopeia (USP), payers, and ASHP. The growing number of pharmacy schools and increasing enrollments in pharmacy schools are also placing greater demands on limited pharmacy manpower. Overall, the Council believed that the demand for pharmacists' services is exceeding the capacity to deliver them. The Council expressed

concern that as pharmacy leaders try to manage to meet standards, they may be losing sight of the desired outcome of improved quality that underlies the standards.

The Council noted that resource requirements are often not considered in the development of new standards. It was noted that *USP* Chapter 797 requires significant resources to implement. Council members questioned whether the increase in quality achieved through implementation of *USP* 797 is commensurate with the resources that are required. It was noted that the application of resources in other areas may have greater impact on patient outcomes. The Council believed ASHP should encourage analysis of the resource requirements (including manpower implications) when new standards are proposed by regulators and accrediting bodies.

Pharmacy managers are constantly challenged to prioritize the available resources to achieve medication-use standards. Specific demands vary by organization. Directors need assistance in deciding where to apply limited resources to achieve the greatest impact on patient care. Council members were complimentary of ASHP's many tools and resources to assist pharmacy directors with implementation of standards. The Council suggested a variety of specific ideas for tools and resources to assist pharmacy managers in implementing standards.

Bar-Code Verification upon Compounding and Dispensing. The Council discussed ASHP policies related to the use of bar-code verification in the medication-use process. Current ASHP policy advocates the use of machine-readable coding prior to administration of medications but does not address the use of machine-readable coding in the preparation and dispensing process. There is evidence that the use of bar-code-enabled machine-readable coding can reduce dispensing and medication errors. The Council discussed various potential applications of machine-readable coding within the medication use process, including inventory control, managing recalls, compounding intravenous admixtures, and dispensing medications.

The Council believed that the Section of Pharmacy Informatics and Technology would be the most knowledgeable about the specific applications of machine-readable coding and suggested that the Section review this matter and develop a policy proposal for review by the Board of Directors and the House of Delegates.

Credentialing Vendors. The Council discussed the changing nature of credentialing health care industry representatives (HCIRs) in hospitals and health systems. The Association of periOperative

Registered Nurses and the American College of Surgeons have developed policy statements on this topic. The Joint Commission's proposed 2009 standard LD.3.40 requires hospitals to provide information regarding quality and safety to staff, independent licensed practitioners, patients, families, and external interested parties. Concerns about patient confidentiality, the Health Insurance Portability and Accountability Act (HIPAA), HCIR access to patient care areas, and infection control requirements are among the factors that have led to increased interest in credentialing HCIRs.

A number of companies offering credentialing services have emerged in the marketplace, including RepTrax, StatusBlue, Vendor Clear, and Vendor Mate. These companies charge fees of \$100 to \$700, which are generally paid by HCIRs or their employers. The companies' services include compiling data about HCIRs, verifying credentials, and conducting criminal background checks on HCIRs and financial background checks on vendor companies. As individual institutions contract with credentialing companies, HCIRs must complete the credentialing process through multiple companies with varying requirements. These include proof of liability insurance, verification of training, vaccination or immunization records, criminal background checks, code of conduct training, proof of HIPAA training, and fingerprinting. In some cases these requirements do not distinguish between HCIRs whose role involves support in medical procedure areas and those who only meet with buyers or other staff outside patient care areas. These new requirements are often hospitalwide and are altering the role of pharmacists in managing vendor representatives.

The Council reviewed the ASHP Guidelines for Pharmacists on the Activities of Vendors' Representatives in Organized Health Care Systems. The current guidelines were written in 1993 and were last reviewed in 1998. The guidelines focus on sales representatives of pharmaceutical companies, but today pharmacists interact with an array of vendors, including various computer, technology, and equipment vendors. The Council believed the guidelines should be updated to reflect the changing environment in which the pharmacy department interacts with various vendors. The Council also encouraged ASHP to investigate opportunities to collaborate with others to establish more uniform requirements for vendor credentialing.

ASHP Guidelines on Managing Drug Product Shortages. The Board also approved revisions to the ASHP Guidelines on Managing Drug Product Shortages that were recommended by the Council.



House of Delegates Session—2009

Board of Directors Report on the Council on Pharmacy Practice

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

Sheila A. Mitchell, Board Liaison

Council Members

Edward M. Jai, Chair (California)
Stephen F. Eckel, Vice-Chair (North Carolina)
Jennifer Chan, Student (Illinois)
Curtis D. Collins (Michigan)
Kristina R. De Los Santos (Arizona)
Lori J. Golterman (Washington, DC)
Roy K. Guharoy (Massachusetts)
James M. Hoffman (Tennessee)
Kathleen A. Rottman, New Practitioner (Florida)
Deborah R. Saine (Virginia)
Jamie S. Sinclair (Minnesota)
Jeffrey T. Thiel (Illinois)
Bona E. Benjamin, Secretary

Policy Recommendations

A. Pharmacist's Role in Providing Care for an Aging Population

- 1 To encourage expansion of geriatric health care services;
- 2 further,
- 3 To foster expanded roles for pharmacists in caring for
- 4 geriatric patients; further,
- 5 To support successful innovative models of team-based
- 6 geriatric care; further,
- 7 To encourage expansion of the number of ASHP-accred-
- 8 ited geriatric pharmacy residency programs.

Background

The Council believed and the Board agreed that the 2008 report from the Institute of Medicine (IOM), *Retooling for an Aging America: Building the Health Care Workforce*, which predicts a pending crisis caused by an inadequate workforce for a rapidly increasing elderly patient population, highlights issues significant for pharmacy. According to the report, older adults make up only about 12% of the U.S. population, but they account for approximately 26% of all physician office visits, 35% of all hospital stays, 34% of all prescriptions, 38% of all emergency medical service responses, and 90% of all nursing-home use. By 2030, the number of adults age 65 and older will have doubled to 70 million, or 20% of the total population, which will place even more demands on an already undermanned workforce.

The report recommends three major immediate actions to retool the workforce: enhancing the competence of all individuals in geriatric care, increasing the recruitment and retention of geriatric special-

ists and caregivers, and redesigning models of care, with broadened provider and patient roles to achieve greater flexibility.

The report discusses the significant role of pharmacists in counseling, monitoring of medication-related problems, and support of medication adherence. The pharmacist role on patient care teams and in medication therapy management becomes more important with the increasing numbers of frail or chronically ill patients treated with medication.

Many elderly people have a number of drug-related issues as well as cognitive impairment and complex needs. These factors increase the amount of expertise, time, and attention required to deliver appropriate care, which has implications for staffing. In addition, pharmacists may not have received sufficient training to assume this role. While professional education provides basic competence for medication management in the elderly, there are comparatively few geriatric pharmacy specialists. Professional education for pharmacists in geriatrics may vary widely, and only 10 programs offer ASHP-accredited geriatric pharmacy residency training.

The Council noted that ASHP does not have guidance that specifically addresses pharmacy services for geriatric patients, other than the ASHP Statement on the Pharmacist's Role in Primary Care, developed in 1999. The Council recommended placing high priority on the ASHP Guidelines on Geriatric Pharmaceutical Services currently in development.

B. Pharmaceutical Waste

- 1 To collaborate with regulatory bodies and appropriate
- 2 organizations to develop standards for the disposal of
- 3 pharmaceutical hazardous waste as defined in the Re-
- 4 source Conservation and Recovery Act (RCRA), for the
- 5 purpose of simplifying the disposal of these substances
- 6 by health systems; further,

- 7 To encourage pharmaceutical manufacturers and the
 8 Environmental Protection Agency (EPA) to provide guid-
 9 ance and assistance to hospitals and health systems in
 10 pharmaceutical waste destruction and recycling efforts;
 11 further,
- 12 To advocate that EPA update the list of hazardous sub-
 13 stances under RCRA and establish a process for maintain-
 14 ing a current list; further,
- 15 To urge federal, state, and local governments to har-
 16 monize regulations regarding disposal of hazardous
 17 pharmaceutical waste; further,
- 18 To advocate that the Food and Drug Administration
 19 standardize labeling of drug products with information
 20 relating to appropriate disposal; further,
- 21 To promote awareness within hospitals and health sys-
 22 tems of pharmaceutical waste regulations; further,
- 23 To encourage research on the environmental and public
 24 health impacts of drug products and metabolites excreted
 25 in human waste; further,
- 26 To encourage pharmaceutical manufacturers to streamline
 27 packaging of drug products to reduce waste materials.

(Note: This policy would supersede ASHP policy 0231.)

Background

The Council voted to revise ASHP policy 0231 as follows (under-
~~score~~ indicates new text; ~~strike through~~ indicates deletions):

To collaborate ~~work closely~~ with regulatory bodies and appropriate organizations to develop standards for the disposal of that address pharmaceutical hazardous waste as defined in the Resource Conservation and Recovery Act (RCRA), for the purpose of simplifying the disposal of these substances by ~~in~~ health systems; further,

To encourage pharmaceutical manufacturers and the Environmental Protection Agency (EPA) to provide guidance and assistance to health systems in ~~their~~ pharmaceutical waste-destruction and ~~waste-~~recycling efforts; further,

To advocate that EPA update the list of hazardous substances under RCRA and establish a process for maintaining a current list; further,

To urge federal, state, and local governments to harmonize regulations regarding disposal of hazardous pharmaceutical waste; further,

To advocate that the Food and Drug Administration standardize labeling of drug products with information relating to appropriate disposal; further,

To promote awareness within hospitals and health systems of pharmaceutical waste regulations ~~within health systems~~; further,

To encourage research on the environmental and public health impacts of drug products and metabolites excreted in human waste; further,

To encourage pharmaceutical manufacturers to streamline packaging of drug products to reduce waste materials.

The Council discussed how ASHP might help define pharmacists' responsibility to the public for safe disposal of hazardous pharmaceutical waste, outside their responsibility to be compliant with applicable regulations. The Council noted that current policy focuses on compliance with RCRA. A number of other issues that the revised ASHP policy should address include obsolete lists, variability in requirements, labeling, and research.

Obsolete lists. The waste stream is in part determined by the list to which a drug is assigned. However, these lists do not include all medications, especially newer products. If a drug is not listed, individual organizations either follow the method of disposal listed for similar drugs or drug classes or use no special disposal method at all. Minimally hazardous drugs are included on lists, creating needlessly burdensome disposal requirements.

Variability in requirements. Regulations vary from state to state and even from county to county. Large hospital systems are forced to create site-specific policies, which complicate communication and education about the appropriate management of waste.

Labeling. Ensuring that products for disposal are directed into the proper waste stream is left up to health care organizations. Many apply auxiliary labeling on-site to communicate this information. It would be more logical and efficient for the manufacturer to include this information in product labeling. The Council recommended that labeling immediate containers with disposal directions would ensure that this information reached the end user of the product. An example of how this might be done is the method used by the National Fire Protection Agency, which identifies hazards with specific symbols.

Research. Little research or guidance is available on the environmental effect of hazardous metabolites excreted in human waste. The Council believed more research is needed in this area.

C. Automatic Stop Orders

- 1 To advocate that the Centers for Medicare & Medicaid
- 2 Services (1) revise the requirement in the Hospital Condi-
- 3 tions of Participation that all medication orders automati-
- 4 cally stop after an arbitrarily assigned period to include
- 5 other options to protect patients from indefinite, open-
- 6 ended medication orders, and (2) revise the remainder of
- 7 the medication management regulations and interpretive
- 8 guidelines to be consistent with this practice.

Background

The Council reviewed current policy on limiting duration of therapy contained in the ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control. It also reviewed the Centers for Medicare & Medicaid Services (CMS) Hospital Conditions of Participation requirement that hospitals assign automatic stop dates to orders if not specified by the prescriber, which reads:

A-0257 482.25(b)(5) Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is predetermined by the medical staff.

Council members noted that automatic discontinuation of all medication orders with no clinical justification is problematic and has caused omitted doses and interruption of treatment. The CMS regulation does not specify what duration is appropriate, and some states have taken the requirement one step further and imposed specific durations in state regulations. The CMS regulation is outdated in light of The Joint Commission requirement for medication reconciliation and review of orders by a pharmacist.

After being informed that the ASHP Technical Assistance Bulletin on Drug Distribution and Control is slated for revision, the Council recommended that the revision should reflect the risks inherent in automatic cancellation of all medication orders and that the document should include recommendations for protecting patients from indefinite, open-ended medication orders. The Council expressed its support, with appropriate changes in federal statutes and regula-

tions, for drug-, class-, or indication-specific automatic stop-order policies based on monitoring requirements or other organizational policies.

D. ASHP Statement on the Pharmacist’s Role in Antimicrobial Stewardship and Infection Prevention and Control

- 1 To approve the ASHP Statement on the Pharmacist’s Role
- 2 in Antimicrobial Stewardship and Infection Prevention
- 3 and Control (Appendix A).

(Note: This statement would supersede the ASHP Statement on the Pharmacist’s Role in Infection Control, dated June 3, 1998.)

Background

The Council and Board requested that the ASHP Statement on the Pharmacist’s Role in Infection Control be updated to reflect more current thinking on antimicrobial stewardship and infection prevention and control, as reflected in the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship, which ASHP has endorsed.

E. ASHP Statement on the Health-System Pharmacist’s Role in National Health Care Quality Initiatives

- 1 To approve the ASHP Statement on the Health-System
- 2 Pharmacist’s Role in National Health Care Quality Initia-
- 3 tives (Appendix B).

Background

The Council and the Board voted to develop an ASHP statement that provides recommendations on how pharmacists can integrate leadership on quality initiatives into their day-to-day practice. The Council and the Board agreed that there are unique opportunities for pharmacists to contribute more of their professional resources to quality measure development; data collection, analysis, and dissemination; and development, implementation, and evaluation of evidence-based practices. The Council and the Board believed that pharmacists could be more involved in hospital and health-system efforts aimed at achieving and exceeding national quality indicators, including those indicators that directly address medication use. The Council and Board suggested that pharmacy departments should integrate health-system quality improvement initiatives into their strategic plans and that health-system administrators need to become more knowledgeable about the roles pharmacists can play in improving quality.

Board Actions

Ethical Issues Associated with Pharmacist Dispensing of an Intermediate Category of Drugs. The Council recommended and the Board did not support seeking revision of the *Code of Ethics for Pharmacists* to address potential conflicts of interest that might arise from dispensing medications under an intermediate category model. Board members commented that this action may be premature and should be deferred until pharmacist dispensing of the intermediate drug class is an established practice. However, the Board recommended that, when such a statement is developed collaboratively, a documentation system should be included as a key component. The Board suggested that the Council review this concept in the context of the ASHP Statement on Intermediate Drug Category at their next meeting.

Resources on Pharmaceutical Waste Disposal for Pharmacists. The Council recommended and the Board did not support development of a Web resource center on pharmaceutical waste disposal. The Board commented that the utility of such a resource is unknown, as pharmacists must consult applicable regulations at national, state, and local levels to ensure compliance. The Board also expressed concern that this project has the potential to be labor-intensive at a time when resources should be conserved for high-priority projects. Further, the Board noted that implementing the related proposed policy on pharmaceutical waste should be a priority.

Pharmacist’s Role in Drug Safety. The Council recommended and the Board voted

To develop resources for pharmacists on how to handle Food and Drug Administration (FDA) drug safety alerts, including a decision tool for interpreting alerts, determining the appropriate response, and communicating the appropriate actions to individuals or groups within the hospital or health system; further,

To provide educational programming on pharmacovigilance and pharmacoepidemiology that focuses on the pharmacist’s role in managing drug safety alerts, including evaluating, interpreting, and responding to alerts; further,

To provide regular updates to ASHP members on the progress of the FDA Sentinel Initiative, with analysis of implications for pharmacists, including effects on day-to-day practice.

The Council noted that managing FDA drug safety alerts presents a number of challenges and recommended that ASHP study the following implications for pharmacists: protecting the privacy of health information, developing standards and interface tools for interoperability, identifying and managing risk (Council members all reported that their organizations have difficulty interpreting the significance of many of the FDA alerts they currently receive), and the role of the individual pharmacist (the Council recommended that ASHP study and delineate the pharmacist’s role in drug safety by monitoring and analyzing developments in the implementation of the Sentinel System). The Council suggested that the Section of Clinical Specialists and Scientists be consulted for additional recommendations on interpretation of FDA alerts.

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

- Pharmaceutical Counterfeiting (0401)
- Ready-to-Use Packaging for Ambulatory Patients (0402)
- Telepharmacy (9920)
- Pharmacist Validation of Information Related to Medications (9921)
- Role of Pharmacists and Business Leaders in Health Care Services and Policies (9819)
- Use of Color to Identify Drug Products (9608)
- Therapeutic Interchange (8708)
- International System of Units (8612)
- ASHP Position on Assisted Suicide (9915)
- Use of Drugs in Capital Punishment (8410)
- ASHP Statement on the Pharmacist’s Role in Clinical Pharmacokinetic Monitoring
- ASHP Statement on the Pharmacist’s Role in Substance Abuse Prevention, Education, and Assistance

- ASHP Statement on the Pharmacist's Role in the Care of Patients with HIV Infection
- ASHP Statement on the Role of Health-System Pharmacists in Emergency Preparedness
- ASHP Statement on Pharmacist's Decision-making on Assisted Suicide
- ASHP Guidelines on Documenting Pharmaceutical Care in Patient Medical Records
- ASHP Guidelines on Pharmaceutical Services in Correctional Facilities. (The Council reaffirmed this document, and noted that it

has not been revised in 13 years. The Council recommended that it be reviewed by pharmacists who practice in prisons to ensure its currency and then be reconsidered in 2009 in light of results of the review.)

- ASHP Guidelines on the Pharmacist's Role in Immunization
- ASHP Guidelines on Pharmacy-Prepared Ophthalmic Products. (The Council reaffirmed this document while awaiting clarification of specific concerns expressed by the group revising the ASHP Guidelines on Quality Assurance for Pharmacy-Prepared Sterile Products.)

Other Council Activity

Pharmacist's Role in the Health Care (Medical) Home.

The Council voted to develop policy that fosters and supports the participation of the pharmacist in the health care (medical) home model and aligns with the policy on payment structure developed by the Council on Public Policy. The policy should also be consistent with the current ASHP Statement on the Pharmacist's Role in Primary Care, but avoid redundancy.

Practice Models in Hospital and Health-System Pharmacy. The Council was asked to provide insight and direction for ASHP's Pharmacy Practice Model Project. Council members agreed that there is not one universal ideal practice model. The Council recommended that members of the project steering committee first establish a vision for the practice model and then identify guiding principles, rather than defining a specific structure for the model. Once the model is developed, barriers and opportunities should also be analyzed by the steering committee. The guiding principles should be broad enough to be applicable to all organizations.

The Council proposed the following concepts that could be developed into guiding principles: patient-centeredness; continuous, 24-hour per day, 7-day per week care, as provided by physicians and nurses; broad expertise integrated with specialization, to ensure a consistent level of care; accountability for patient outcomes; and seamless care. The Council stressed the importance of agreed-upon definitions for the practice model concept (e.g., "clinical pharmacy") to avoid the lack of common vision and understanding that has impeded work on this issue, and they hoped that one of the questions addressed would be how best to integrate generalists, whose expertise has broad applicability, with highly trained specialists who see far fewer but more acutely ill patients. Council members cautioned that this issue requires careful thought if specialists will be expected to take on broader responsibilities. A new expectation will have to be set for postgraduate year 2 (PGY2) residencies; practitioners in these residencies consider their practice model to be defined by postgraduate training (e.g., a critical care residency). The Council also thought it was important to consider PGY2 residents' expectation for better hours and higher salaries consistent with or in light of their advanced training. The Council recommended considering how the practice model can avoid giving the impression that advanced training is not valued if clinical specialists work 24-7 and share generalist functions. The Council also believed that pharmacists who prefer or who are expert in distributive or dispensing roles need to be considered in the model as well. A well-run operation is important, and individuals in these roles allow others more time for research and publishing.

ASHP Guidelines on Clinical Drug Research. The Council discussed merging these guidelines with the ASHP Statement on Pharmaceutical Research in Organized Health Care Systems and updating the document, as it has not been revised since approval in 1997. An updated guideline would set a standard of practice that would assist practitioners in changing unrealistic and burdensome sponsor requirements, such as return of empty vials, paper distribu-

tion records, and other impediments to efficient handling of study drugs. The document should emphasize stronger pharmacy oversight for the entire process of investigational medication use, including application of decision support, the electronic record, safe conduct of clinical trials, and safe use of investigational drugs. The Council recommended that the appropriate section advisory group revise the guidelines.

ASHP Guidelines on Surgery and Anesthesiology Pharmaceutical Services. The Council considered a recommendation from the Council on Pharmacy Management to expand the guidelines to include perioperative areas. The "Purpose" section of that document states that the guidelines apply to any area where surgical or anesthesia procedures take place, and the Council believed that this includes perioperative areas. However, the Council noted that the guidelines have not been revised since 1997 and recommended review and updating to reflect contemporary practice.

ASHP Guidelines on the Safe Use of Automated Compounding Devices for the Preparation of Parenteral Nutrition Admixtures. The Council recommended that the ASHP Guidelines on the Safe Use of Automated Compounding Devices for the Preparation of Parenteral Nutrition Admixtures be retained. The American Society of Parenteral and Enteral Nutrition (ASPEN) has established guidance on compounders in its document *Safe Practices for Parenteral Nutrition*. The Council has the option of recommending that ASHP endorse this policy. The Council decided to compare ASPEN's document with ASHP's to ensure that ASHP's positions are adequately covered by ASPEN before a decision is made about recommending endorsement.

Clinical Pharmacist's Role in the Emergency Department. The Council considered a suggestion that ASHP develop guidelines on the clinical role of the emergency department pharmacist and deferred development of such guidelines to the Section of Clinical Specialists and Scientists Advisory Group on Emergency Medicine, which was instrumental in developing the ASHP Statement on Pharmacy Services to the Emergency Department.

Use of the Terms "Transcribe" and "Transcribing." After review of background material, Council members commented that they appreciate the issues raised by the Recommendation from the House of Delegates on this topic. The Council noted that there is a lack of common understanding of definitions of many terms associated with order entry and that a more appropriate term is needed to describe the evaluation, interpretation, and implementation of a medication order. The Council believed that the cognitive functions implied by the term "order perfection" are addressed in the definition of dispensing contained in the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy. The Council encouraged ASHP to avoid the use of the terms "transcribe" and "transcribing" when referring to the dispensing process.

Council Review and Recommendations for Guidance Documents Currently in Development. The Council voted to discontinue development of the following ASHP statements and guidelines:

- Statement on team-based care. (The Council agreed that this topic is addressed in other ASHP policy.)
- Statement on the pharmacist’s role in computerized prescriber order entry (CPOE). (The Council noted that ASHP guidelines on CPOE are currently in development.)
- Statement on telepharmacy patient–pharmacist relationship. (The Council agreed to discontinue the document but urged that guidance on pharmaceutical care via telepharmacy be included in the guidelines on remote order entry currently in development.)
- Guidelines on measuring preventable medication misadventures. (The Council urged that measurement and cost implications of preventable medication errors and the issue of intimidation and resultant process breakdowns be addressed in the revision of the ASHP Guidelines on Preventing Medication Errors in Hospitals.)
- ASHP Statement on Pharmaceutical Research in Organized Health Care Systems. (The Council agreed that this guidance should be

included in the previously recommended revision of the ASHP Guidelines on Clinical Drug Research.)

- ASHP Statement on Unit-Dose Drug Distribution. (The Council agreed that this statement should be combined into the ASHP Guidelines on Hospital Drug Distribution and Control currently under development.)

The Council believed there is merit in ongoing monitoring of documents in development for best practices, how best practices are being used, and how they could be used better. The Council voted to include this review as a standing agenda item, beginning in 2009.

Update of Best Practices Indexing System. The Council recommended the use of more contemporary keywords and a greater number of keywords for indexing *Best Practices for Hospital and Health-System Pharmacy*.

Therapeutic Use of Alcohol. The Council recommended that the Council on Therapeutics evaluate the use of alcohol as a medication and provide recommendations for an ASHP position statement.

**1 Appendix A—ASHP Statement on the Pharmacist’s
2 Role in Antimicrobial Stewardship and Infection
3 Prevention and Control**

4 Position

5 The American Society of Health-System Pharmacists (ASHP)
6 believes that pharmacists have a responsibility to take prominent
7 roles in antimicrobial stewardship programs and participate in the
8 infection prevention and control programs of health systems. This
9 responsibility arises, in part, from pharmacists’ understanding of and
10 influence over antimicrobial use within the health system. Further,
11 ASHP believes that the pharmacist’s ability to effectively participate
12 in antimicrobial stewardship and infection prevention and control
13 efforts can be realized through clinical endeavors focused on proper
14 antimicrobial utilization and membership on multidisciplinary
15 work groups and committees within the health system. These ef-
16 forts should contribute to the appropriate use of antimicrobials,
17 ultimately resulting in successful therapeutic outcomes for patients
18 with infectious diseases, and reduce the risk of infections for other
19 patients and health care workers.

20 Background

21 Antimicrobial stewardship is utilized in practice settings of health
22 systems to improve patient outcomes while minimizing the unin-
23 tended consequences of antimicrobial use. The goals of antimicrobial
24 stewardship programs include attenuating or reversing antimicrobial
25 resistance, preventing antimicrobial-related toxicity, and reducing
26 the costs of inappropriate antimicrobial use and health care-
27 associated infections. Guidelines published by the Infectious Dis-
28 eases Society of America and the Society for Healthcare Epidemi-
29 ology of America and endorsed by ASHP and other organizations
30 describe an evidence-based approach to antimicrobial stewardship
31 in health systems and the important role pharmacists with infec-
32 tious diseases training have in leading stewardship efforts.¹

33 Identifying and reducing the risks of developing, acquiring, and
34 transmitting infections among patients, health care workers, and
35 others is an important part of improving patient outcomes. In
36 order to maximize outcomes, antimicrobial stewardship should
37 be used in combination with infection prevention and control
38 practices.¹ Most health systems maintain an infection prevention
39 and control program directed by a multidisciplinary committee.
40 The specific program and responsibilities of the infection preven-
41 tion and control committee (or its equivalent) may differ among
42 health systems.

Typically, the infection prevention and control committee devel- 43
ops organizational policies and procedures addressing 44

1. The management and provision of patient care and employee 45
health services regarding infection or infection prevention and 46
control. 47
2. The education of staff, patients, family members, and other care- 48
givers in the prevention and control of infections. 49
3. Surveillance systems to track the occurrence and transmission of 50
infections. 51
4. Surveillance systems to track the use of antimicrobials and the 52
development of antimicrobial resistance. 53
5. Promotion of evidence-based practices and interventions to 54
prevent the development of infections. 55

Responsibilities of Pharmacists 56

Pharmacists’ responsibilities for antimicrobial stewardship and 57
infection prevention and control include promoting the optimal use 58
of antimicrobial agents, reducing the transmission of infections, and 59
educating health professionals, patients, and the public. 60

Promoting optimal use of antimicrobial agents. An 61
important clinical responsibility of the pharmacist is to ensure the 62
optimal use of antimicrobial agents throughout the health system. 63
Functions related to this responsibility may include 64

1. Encouraging multidisciplinary collaboration within the health 65
system to ensure that the prophylactic, empirical, and therapeutic 66
uses of antimicrobial agents result in optimal patient outcomes. 67
These activities may include antimicrobial-related patient care 68
(e.g., aiding in appropriate selection, optimal dosing, rapid initia- 69
tion, and proper monitoring and de-escalation of antimicrobial 70
therapies) as well as the development of restricted antimicrobial- 71
use procedures, therapeutic interchange, treatment guidelines, 72
and clinical care plans.² 73
2. Working within the pharmacy and therapeutics committee (or 74
equivalent) structure, which may include infectious disease- 75
related subcommittees, to ensure that the number and types of 76
antimicrobial agents available are appropriate for the patient 77
population served. Such decisions should be based on the needs 78
of special patient populations and microbiological trends within 79
the health system. High priority should be given to developing 80
antimicrobial-use policies that result in optimal therapeutic out- 81
comes while minimizing the risk of the emergence of resistant 82
strains of microorganisms. 83
3. Operating a multidisciplinary, concurrent antimicrobial steward- 84
ship program that uses patient outcomes to assess the effectiveness 85
of antimicrobial-use policies throughout the health system. 86

- 1 4. Generating and analyzing quantitative data on antimicrobial drug
2 use to perform clinical and economic outcome analyses.
- 3 5. Working with the microbiology laboratory personnel to ensure
4 that appropriate microbial susceptibility tests are reported on
5 individual patients in a timely manner, and collaborating with
6 the laboratory, infectious diseases specialists, and infection pre-
7 ventionists in compiling susceptibility reports (at least annually)
8 for distribution to prescribers within the health system to guide
9 empirical therapy.
- 10 6. Utilizing information technology to enhance antimicrobial stew-
11 ardsnip through surveillance, utilization and outcome reporting,
12 and the development of clinical decision support tools.
- 13 7. Facilitating safe medication management practices for antimicro-
14 bial agents by utilizing efficient and effective systems to reduce
15 potential errors and adverse drug events.

16 **Reducing the transmission of infections.** Pharmacists
17 should participate in efforts to prevent or reduce the transmission
18 of infections among patients, health care workers, and others within
19 all of the health system's applicable practice settings. This may be
20 accomplished through

- 21 1. Participating in the infection prevention and control committee
22 (or its equivalent).
- 23 2. Establishing internal pharmacy policies, procedures, and quality
24 control programs to prevent contamination of drug products
25 prepared in or dispensed by the pharmacy department. This is
26 of paramount importance in the preparation and handling of
27 sterile products.³ Other considerations include (but are not lim-
28 ited to) provisions for cleaning pharmaceutical equipment (e.g.,
29 laminar-airflow hoods and bulk-compounding equipment) and
30 establishment of appropriate personnel policies (e.g., limiting
31 the activities of staff members who exhibit symptoms of a viral
32 respiratory illness or other infectious condition).
- 33 3. Encouraging the use of single-dose packages of sterile drug
34 products rather than multiple-dose containers, except in sterile
35 environments.
- 36 4. Recommending proper labeling, dating, and storage of sterile
37 products and multiple-dose sterile-product containers (if used).
- 38 5. Encouraging routine immunization (e.g., influenza vaccination)
39 of hospital staff and others who impact the patient care environ-
40 ment, and promoting periodic screening for selected transmissible
41 diseases (e.g., tuberculosis) in accordance with health-system
42 policy and federal, state, or local regulations.
- 43 6. Promoting adherence to standard precautions by health care
44 workers, patients, and others who impact the patient care
45 environment.⁴
- 46 7. Collaborating in the development of guidelines for risk assess-
47 ment, treatment, and monitoring of patients and health care
48 workers who have been in contact with persons with a transmis-
49 sible infectious disease.
- 50 8. Striving for zero tolerance of health care-associated infections,
51 including surgical site infections, catheter-associated bloodstream
52 infections, catheter-associated urinary tract infections, and
53 ventilator-associated pneumonia.

54 **Educational activities.** The pharmacist's role includes provid-
55 ing education and information about antimicrobial stewardship and
56 infection prevention and control to health professionals, patients,
57 and members of the public who come in contact with the health
58 system's practice settings. Incorporating active intervention tech-
59 niques, such as formulary restriction and preauthorization, enhance
60 the effectiveness of educational activities in the patient care setting.¹
61 Specific activities may include

- 62 1. Providing clinical conferences, newsletters, and other types
63 of educational forums for health professionals on topics such
64 as antimicrobial use and resistance, decontaminating agents
65 (disinfectants, antiseptics, and sterilants), aseptic technique and
66 procedures, and sterilization methods.
- 67 2. Educating and counseling inpatients, ambulatory care patients,
68 home care patients, and their families and caregivers in the fol-
69 lowing areas: adherence to prescribed directions for antimicrobial
70 use, storage and handling of medications and administration
71 devices, and other infection prevention and control procedures
72 (e.g., medical waste disposal).

- 3. Participating in public health education and awareness programs
aimed at controlling the spread of infectious diseases by:
 - a. Promoting prudent use of antimicrobials, 75
 - b. Providing immunization access for children and adults, and 76
 - c. Promoting appropriate infection prevention and control 77
measures (e.g., proper hand hygiene techniques). 78
- 4. Providing exposure to antimicrobial stewardship and infection 79
prevention and control practices through experiential and didac- 80
tic training for practicing health-system pharmacists, students, 81
residents, and research fellows. 82

Education and Training of Pharmacists 83

ASHP recognizes that the current shortage of pharmacists with
advanced training in infectious diseases and the limited number of
training opportunities may require pharmacists without such training
to assume some of the responsibilities described above. ASHP supports
the expansion of pharmacy education and postgraduate residency
training on infectious diseases in order to develop an adequate supply
of pharmacists trained to deliver these essential services. 90

Conclusion 91

ASHP believes that pharmacists have a responsibility to take
prominent roles in antimicrobial stewardship and infection preven-
tion and control programs in health systems. Pharmacists should
participate in antimicrobial stewardship and infection prevention
and control efforts through clinical endeavors focused on proper an-
timicrobial utilization and membership on relevant multidisciplinary
work groups and committees within the health system. 98

References 99

- 1. Dellit TH, Owens RC, McGowan JE, et al. Infectious Diseases Society of America and
the Society for Healthcare Epidemiology of America Guidelines for Developing an
Institutional Program to Enhance Antimicrobial Stewardship. *Clin Infect Dis*. 2007;
44:159-77. 100-103
- 2. American Society of Health-System Pharmacists. ASHP guidelines on the pharmacist's
role in the development, implementation, and assessment of critical pathways. *Am J
Health-Syst Pharm*. 2004; 61:939-45. 104-106
- 3. American Society of Health-System Pharmacists. ASHP guidelines on quality assurance
for pharmacy-prepared sterile products. *Am J Health-Syst Pharm*. 2000; 57:1150-69. 107-108
- 4. Siegel JD, Rhinehart E, Jackson M, et al. 2007 Guideline for Isolation Precautions:
Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007. Available
at: <http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf> (accessed
February 18, 2009). 109-112

Suggested Readings 113

- Centers for Disease Control and Prevention. Guideline for disinfection and sterilization
in healthcare facilities, 2008. Accessed 15 December 2008. [http://www.cdc.gov/ncidod/dhqp/
pdf/guidelines/Disinfection_Nov_2008.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf) 114-116
- Centers for Disease Control and Prevention [CDC]. Guidelines for environmental infec-
tion control in health-care facilities: recommendations of CDC and the Healthcare Infection
Control Practices Advisory Committee (HICPAC). *MMWR*. 2003; 52 (No. RR-10): 1-48. 117-119
- Diekema DJ, Doebbeling BN. Employee health and infection control. *Infect Control Hosp
Epidemiol*. 1995; 16:292-301. 120-121
- Gardner P, Schaffner W. Immunization of adults. *N Engl J Med*. 1993; 328:1252-8. 122
- Goldmann DA, Weinstein RA, Wenzel RP, et al. Strategies to prevent and control the
emergence and spread of antimicrobial-resistant microorganisms in hospitals. A challenge
to hospital leadership. *JAMA*. 1996; 275:234-40. 123-124
- Kollef M, Shapiro S, Fraser V, et al. A randomized trial of ventilator circuit changes. *Ann
Intern Med*. 1995; 123:168-74. 125-126
- MacDougall C, Polk RE. Antimicrobial stewardship programs in health care systems. *Clin
Microbiol Rev*. 2005 Oct; 18(4):638-56. 127-129
- Shlaes DM, Gerding DN, John JF Jr, et al. SHEA and IDSA Joint Committee on the
Prevention of Antimicrobial Resistance: guidelines for the prevention of antimicrobial
resistance in hospitals. *Clin Infect Dis*. 1997; 25:584-99. 130-132
- Sepkowitz KA. Occupationally acquired infections in health care workers. *Ann Intern
Med*. 1996; 125:826-34, 917-28. 133-134

Curtis Collins, Pharm.D., M.S. is gratefully acknowledged for
drafting the revisions to this statement. 135-136

Approved by the ASHP Board of Directors on April 15, 2009. 137
Approval by the ASHP House of Delegates is pending. Developed 138
through the ASHP Council on Pharmacy Practice. 139

Copyright © 2009 American Society of Health-System Pharmacists, 140
Inc. All rights reserved. 141

**1 Appendix B—ASHP Statement on the Health-
2 System Pharmacist’s Role in National Health Care
3 Quality Initiatives**

4 Position

5 The American Society of Health-System Pharmacists (ASHP) be-
6 lieves that pharmacists who practice in hospitals and health systems
7 (“health-system pharmacists”) have a critical leadership role in
8 national health care quality improvement initiatives. Health-system
9 pharmacists possess the knowledge of drug therapy and medication-
10 use systems required to successfully implement quality assurance
11 and improvement programs. These pharmacists should use their
12 authority over and accountability for medication management sys-
13 tems to align medication use in hospitals and health systems with
14 the national health care quality agenda.

15 Background

16 Major reports from the Institute of Medicine (IOM) have demon-
17 strated that the quality and safety environment across the health
18 care industry needs significant transformation. *The Urgent Need to*
19 *Improve Health Care Quality* suggested that the quality of the health
20 care system in the United States could be accurately measured and
21 that the quality of care was being compromised by the underuse,
22 overuse, and misuse of health care entities.¹ *Crossing the Quality*
23 *Chasm* built a compelling case that the American health care delivery
24 system requires major restructuring and proposed goals for improv-
25 ing six key dimensions of health care quality: safety, timeliness, ef-
26 fectiveness, efficiency, equity, and patient-centeredness (the “STEEP”
27 framework).² To achieve these aims, IOM called for fundamental
28 reforms, including new payment methodologies, public reporting,
29 and transparency of quality improvement data.

30 Since the release of these reports, health care policymakers, pro-
31 viders, purchasers, payers, consumers, and others have responded
32 in ways that are beginning to change the U.S. health care delivery
33 system. These changes are influenced by a growing number of private
34 and public organizations, including The Joint Commission, Centers
35 for Medicare and Medicaid Services (CMS), National Quality Forum,
36 National Priorities Partnership, Agency for Healthcare Research
37 and Quality, Institute for Healthcare Improvement, and American
38 Health Quality Association, among others. These organizations,
39 alone or in collaboration, identify health care quality measures to
40 set the national health care quality agenda. These quality measures
41 are collected and reported through both mandatory and voluntary
42 reporting systems, and the outcome measurements of a health
43 system may be linked to reimbursement (e.g., through CMS pay-
44 for-performance programs).

45 Responsibilities of Health-System Pharmacists

46 Many national health care quality measures are related to medi-
47 cation use.³ Health-system pharmacists are strategically positioned
48 to integrate practices and procedures that support these quality
49 measures into the medication-use system. To help align medication
50 use in hospitals and health systems with the national health care
51 quality agenda, health-system pharmacists should

- 52 • Become familiar with the organizations that influence the national
- 53 health care quality agenda and monitor those organizations for
- 54 changes in medication-use-related quality measures.

- Participate in the development, implementation, and evaluation 55
of national and state health care quality improvement initiatives 56
related to medication use. 57
- Collaborate with other health care professionals to evaluate 58
medication-use practices in their organizations and develop and 59
implement programs that optimize patient outcomes, improve 60
medication use, and align with the national health care quality 61
agenda, including expanding the scope and reach of pharmacists’ 62
services when appropriate. 63
- Collect, analyze, and report data that measure health care quality 64
related to medication use, and support the public availability of 65
those data. 66
- Integrate and align information systems in their organizations 67
with the national health care quality agenda. 68
- Educate other health care practitioners, health care executives, 69
and the public about medication-related health care quality 70
improvement initiatives and the critical role pharmacists have 71
in those initiatives (e.g., by publishing articles about innovative 72
pharmacy services that improve patient outcomes or medication 73
use). 74
- Encourage national pharmacy organizations to support, guide, 75
and provide education related to the national health care quality 76
agenda. 77

Conclusion

78 The number of mandatory and voluntary health care quality 79
measures related to the use of medications is large and growing. 80
As medication-use experts, health-system pharmacists have a re- 81
sponsibility to become knowledgeable about national health care 82
quality improvement initiatives and to align their practices accord- 83
ingly. Because health-system pharmacists possess knowledge of drug 84
therapy and medication-use systems and have authority over and 85
accountability for medication management systems, they have a 86
fundamental leadership role in the development, implementation, 87
and evaluation of health care quality improvement initiatives. 88

References

89
1. Chassin MR, Galvin RW. The urgent need to improve health care quality. Institute of 90
Medicine National Roundtable on Health Care Quality. *JAMA*. 1998; 280:1000-5. 91
2. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the* 92
quality chasm: a new health system for the 21st century. Washington, DC: National 93
Academy Press; 2001: 43-56. 94
3. Bohenek WS, Grossbart SR. Pharmacists’ role in improving quality of care. *Am J Health* 95
Syst Pharm. 2008; 65:1566-70. 96

Wayne S. Bohenek, Pharm.D., M.S., FASHP and Jamie S. Sinclair, 97
M.S. are gratefully acknowledged for their contributions to this 98
statement. 99

Approved by the ASHP Board of Directors on April 15, 2009. 100
Approval by the ASHP House of Delegates is pending. Developed 101
through the ASHP Council on Pharmacy Practice. 102

Copyright © 2009 American Society of Health-System Pharmacists, 103
Inc. All rights reserved. 104



House of Delegates Session—2009

Board of Directors Report on the Council on Public Policy

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

Stanley S. Kent, Board Liaison

Council Members

Robert T. Adamson, Chair (New Jersey)
Jillian James Foster, Vice-Chair (Mississippi)
Rachel Brewer, Student (Kentucky)
Mark A. Chamberlain (Virginia)
Lisa L. Deal, New Practitioner (Virginia)
Melanie A. Dodd (New Mexico)
David A. Ehlert (Minnesota)
Amber J. Lucas (Kansas)
Teresa A. Miller (California)
Robert L. Spires (South Carolina)
Vaiyapuri Subramaniam (Maryland)
Donna S. Wall (Indiana)
Brian M. Meyer, Secretary

Policy Recommendations

A. Credentialing and Privileging by Regulators, Payers, and Providers for Collaborative Drug Therapy Management

1 To advocate expansion of collaborative drug therapy
2 management (CDTM) practices in which the prescriber
3 and the licensed pharmacist agree upon the conditions
4 under which the pharmacist monitors and adjusts a
5 patient's drug therapy; further,

6 To acknowledge that as a step toward the goal of univer-
7 sal recognition of and payment for pharmacist CDTM
8 services, public or private third-party payers may require
9 licensed pharmacists to demonstrate their competence
10 to provide CDTM, before the payers authorize them to
11 engage in or be paid for such clinical services; further,

12 To support (1) the development (as a professional
13 initiative by pharmacist associations rather than as a
14 government activity) of national standards for deter-
15 mining a pharmacist's competence to provide CDTM
16 and (2) the appropriate use of these standards by clini-
17 cal privileging systems, government authorities, and
18 public or third-party payers; further,

19 To support the use of clinical privileging by hospitals
20 and health systems to assess a licensed pharmacist's
21 competence to engage in CDTM within the hospital or
22 health system; further,

23 To advocate that state boards of pharmacy apply the
24 principles of continuous quality improvement in assess-
25 ing the quality, safety, and outcomes of CDTM.

26 (Note: *Privileging* is the process by which an oversight
27 body of a health care organization or other appropriate
28 provider body, having reviewed an individual health care
29 provider's credentials and performance and found them
30 satisfactory, authorizes that individual to perform a spe-
31 cific scope of patient care services within that setting.)

(Note: This policy would supersede ASHP policy 0318.)

Background

The Council voted to recommend completely revising policy 0318. For ease of comparison, policy 0318 reads as follows:

To recognize licensure of pharmacists as the only state-imposed legal requirement necessary for pharmacists engaged in providing collaborative drug therapy management services; further,

To support the current practice of pharmacists and prescribers negotiating and establishing collaborative drug therapy management agreements in which the pharmacist receives delegated authority; further,

To support the use of privileging processes in those practice environments where explicit privileging is required to receive delegated authority; any additional training or credentials required of pharmacists engaging in these practices should be determined by the local practice site; further,

To stipulate that privileging should be conducted by an oversight body of the practice site.

(Note: *Privileging* is the process by which an oversight body of a health care organization or other appropriate provider body, having reviewed an individual health care provider's credentials and performance and found them satisfactory, authorizes that individual to perform a specific scope of patient care services within that setting.)

The Council revised policy 0318 in response to a New Business item passed by the House of Delegates in June 2008. The New Business item noted the need to revise policy 0318 in order to provide more flexibility for ASHP to achieve its goal of attaining recognition of pharmacist collaborative drug therapy management (CDTM) services by Medicare. Over 45 states have enacted CDTM. In addition, federal legislation (H.R. 5780) was introduced that would allow for Medicare payment for CDTM for pharmacists that are designated by state law as a "clinical pharmacist practitioner" or "pharmacist clinician" (currently North Carolina and New Mexico, respectively). These two designations are conferred upon licensed pharmacists who also complete physical assessment training and experiential hours. Since policy 0318 was explicit in stating that licensure was the only state requirement, ASHP was unable to support H.R. 5780.

The Council determined that a new policy would best serve this purpose while maintaining certain elements of policy 0318. In developing the newly proposed policy, the Council recognized and the Board concurred that licensure may not be the only state-imposed legal requirement to provide CDTM. The proposed policy not only supports CDTM but advocates for its expansion. It continues to support and apply the clinical privileging process to CDTM as practiced within hospitals and health systems. Also, it recognizes that payers may require pharmacists to demonstrate competence to provide CDTM as a step toward universal recognition of pharmacist-provided CDTM. Finally, it supports a professional initiative to develop national standards for determining pharmacist competence and the appropriate use of these standards by clinical privileging systems, governments, and public or third-party payers.

The Council acknowledged that proposals similar to H.R. 5780 would serve to move the profession forward in its goal of recognizing and paying pharmacists for CDTM services. In developing the proposed policy, the Council and Board wanted to enable ASHP to support these proposals as a step toward universal recognition of pharmacists as providers. The Council and Board acknowledged that this initial step would demonstrate to payers and the public that pharmacists providing these services have attained a required level of competence. In addition, the Council and Board noted the need for the profession itself to develop national standards for credentials that are used to determine a pharmacist's competence to provide CDTM. Council and Board members also noted the need for state boards of pharmacy to establish quality improvement processes with respect to patient safety and outcomes of CDTM services.

B. Approval of Follow-on Biological Medications

- 1 To encourage the development of safe and effective
- 2 follow-on biological medications in order to make such
- 3 medications more affordable and accessible; further,

- 4 To encourage research on the safety, effectiveness, and
- 5 interchangeability of follow-on biological medications;
- 6 further,

- 7 To support legislation and regulation to allow Food and
- 8 Drug Administration approval of follow-on biological
- 9 medications; further,

- 10 To require postmarketing surveillance for all follow-on
- 11 biological medications to ensure their continued safety,

12 effectiveness, purity, quality, identity, and strength;

13 further,

14 To advocate for adequate reimbursement for biological

15 medications that are deemed interchangeable; further,

16 To promote education of pharmacists about follow-on

17 biological medications and their appropriate use within

18 hospitals and health systems.

19 (Note: Follow-on biological medications are also referred

20 to as biosimilars, follow-on protein products, biogenics,

21 comparable biologicals, and generic biopharmaceuticals.)

(Note: This policy would supersede ASHP policy 0519.)

Background

The Council voted to recommend amending policy 0519 as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To encourage the development of safe and effective follow-on biological generic versions of biologic medications in order to make such medications more affordable and accessible; further,

To encourage research on ~~scientific methods to ensure~~ the safety, effectiveness, and interchangeability therapeutic equivalence of follow-on biological generic biologic medications; further,

To support legislation and regulation to allow Food and Drug Administration approval of follow-on biological generic versions of biologic medications; ~~;~~ further,

To require postmarketing surveillance for all follow-on biological medications to ensure their continued safety, effectiveness, purity, quality, identity, and strength; further,

To advocate for adequate reimbursement for biological medications that are deemed interchangeable; further,

To promote education of pharmacists about follow-on biological medications and their appropriate use within hospitals and health systems.

(Note: Follow-on biological medications are also referred to as biosimilars, follow-on protein products, biogenics, comparable biologicals, and generic biopharmaceuticals.)

There has been renewed interest in legislative proposals to establish a regulatory pathway for these medications. In response, the Council made changes to the existing policy by using a standard term, "follow-on biological medications," and parenthetically referring to other terms used to describe biological products that are in need of a regulatory pathway in order to be marketed. The Council also replaced the term "therapeutic equivalence" with "interchangeability," since that is a term that will be considered in legislative proposals to establish a regulatory pathway for these medications. The Council also added three new clauses at the end of the policy. The Council and Board believed that a requirement for postmarketing surveillance to ensure patient safety as well as product effectiveness is an important component of a regulatory pathway. The Council and Board also noted that reimbursement for follow-on biological medications deemed interchangeable should be adequate in order to positively affect patient access. The Council and Board noted the continuing need for pharmacist education about follow-on biological medications and their appropriate use within hospitals and health systems. This is particularly important as a regulatory pathway is established and follow-on biological medications are approved for marketing.

C. Pharmaceutical Product and Supply Chain Integrity

1 To encourage the Food and Drug Administration (FDA)
 2 and relevant state authorities to take the steps necessary
 3 to ensure that (1) all drug products entering the supply
 4 chain are thoroughly inspected and tested to establish
 5 that they have not been adulterated or misbranded and
 6 (2) patients will not receive improperly labeled and pack-
 7 aged, deteriorated, outdated, counterfeit, adulterated, or
 8 unapproved drug products; further,

9 To encourage FDA and relevant state authorities to
 10 develop and implement regulations to (1) restrict or
 11 prohibit licensed drug distributors (drug wholesalers,
 12 repackagers, and manufacturers) from purchasing legend
 13 drugs from unlicensed entities and (2) ensure accurate
 14 documentation at any point in the distribution chain of
 15 the original source of drug products and chain of custody
 16 from the manufacturer to the pharmacy; further,

17 To advocate the establishment of meaningful penalties
 18 for companies that violate current good manufactur-
 19 ing practices (cGMPs) intended to ensure the quality,
 20 identity, strength, and purity of their marketed drug
 21 product(s) and raw materials; further,

22 To urge Congress and state legislatures to provide ad-
 23 equate funding, or authority to impose user fees, to
 24 accomplish these objectives.

(Note: This policy would supersede ASHP policy 0722.)

Background

The Council voted to recommend amending policy 0722 as follows (underline indicates new text; ~~strikethrough~~ indicates deletions):

To encourage the Food and Drug Administration (FDA) and relevant state authorities to take the steps necessary to ensure that (1) all drug products entering the supply chain are thoroughly inspected and tested to establish that they have not been adulterated or misbranded and (2) patients will not receive improperly labeled and packaged, deteriorated, outdated, counterfeit, adulterated, or unapproved drug products; further,

To encourage FDA and relevant state authorities to develop and implement regulations to (1) restrict or prohibit licensed drug distributors (drug wholesalers, repackagers, and manufacturers) from purchasing legend drugs from unlicensed entities and (2) ensure accurate documentation ~~accurately document~~ at any point in the distribution chain of the original source of drug products and chain of custody from the manufacturer to the pharmacy; further,

To advocate the establishment of meaningful penalties for companies that violate current good manufacturing practices (cGMPs) intended to ensure the quality, identity, strength, and purity of their marketed drug product(s) and raw materials; further,

To urge Congress and state legislatures to provide adequate funding, or authority to impose user fees, to accomplish these objectives.

The Council’s discussion of the need for additional authority and stronger enforcement by FDA addressed a delegate Recommendation concerning the recent contamination of heparin products manufactured with raw materials from China. The Council revised

policy 0722 to emphasize the need for FDA resources and authority to enforce adherence to cGMPs by all suppliers in the supply chain. The Council and Board noted that since foreign facilities are notified of most FDA inspections in advance, they have little incentive to maintain cGMPs. The Council and Board believed that holding the manufacturer of the finished product responsible for the compliance of all its suppliers would provide that incentive. To further enhance enforcement, the Council and Board believed that meaningful penalties for violations of cGMPs should be available to FDA. Finally, the Council and Board believed that to ensure supply chain integrity, the manufacturer should maintain ongoing surveillance of its products as well as its manufacturing processes.

D. Pharmacist Role in the Health Care (Medical) Home

1 To advocate to health policymakers, payers, and other
 2 stakeholders for the inclusion of pharmacists as a care
 3 provider within the health care (medical) home model;
 4 further,

5 To ensure that there are appropriate reimbursement
 6 mechanisms for the care that pharmacists provide (in-
 7 cluding care coordination services) within the health
 8 care home model; further,

9 To advocate to the Centers for Medicare & Medicaid Ser-
 10 vices (CMS) that pharmacists be included in demonstra-
 11 tion projects for the health care home model; further,

12 To encourage comparative effectiveness research and
 13 measurement of key outcomes (e.g., clinical, economic,
 14 quality, access) for pharmacist services in the health care
 15 home model.

Background

The Council voted to recommend policy addressing the emerging concept of a “health care home,” also referred to as a “medical home.” Medical home is the term developed and used by medical organizations and health care home is used by others including health policymakers. The model, first described by the American Academy of Pediatrics in 1992 and soon to be the subject of demonstration projects by the Centers for Medicare & Medicaid Services (CMS), emphasizes care coordination from a medical practice and uses an interdisciplinary health care team approach to managing a patient’s overall health. Council members noted the recent Medicare Payment Advisory Commission (MedPAC) report that discussed a health care home program in Medicare. The report stated that, ideally, medication reviews conducted by a health care home should be coordinated by a pharmacist. The Council also noted that CMS will begin health care (medical) home demonstration projects in 2009. The Council and Board believed it is important to advocate that a pharmacist be included in the health care (medical) home model and that pharmacists be factored into the compensation for services provided. The Council and Board also believed that research and measurement of key outcomes are important to include in any demonstration and permanent delivery model, in order to determine the effectiveness of the care that is delivered.

E. Regulation of Interstate Pharmacy Practice

1 To advocate that state governments, including legislatures
 2 and boards of pharmacy, adopt laws and regulations that
 3 harmonize the practice of pharmacy across state lines in
 4 order to provide a consistent, transparent, safe, and ac-
 5 countable framework for pharmacy practice.

Background

The Council reviewed existing policies (0716, 0507, 0523, 9813, 9205) dealing with automation, information technology, and

telepharmacy and their increasing application and implementation across state borders. Council and Board members believed that an overarching policy is needed to express the notion that state regulatory bodies need to work more closely together and provide a more consistent and transparent regulatory framework in order to achieve a high level of patient safety. It was noted that with the emergence of new technology, borders are becoming more artificial and coordination between states is needed. The Council and Board observed that through dialogue with the National Association of Boards of Pharmacy (NABP) and individual state boards, model language dealing with these issues can be developed and adopted by individual states.

F. Reporting Medication Errors

- 1 To encourage pharmacists to exert leadership in estab-
- 2 lishing a nonthreatening, confidential atmosphere in
- 3 their workplaces to encourage pharmacy staff and oth-
- 4 ers to report actual and suspected medication errors in
- 5 a timely manner; further,

- 6 To provide leadership in supporting a single, compre-
- 7 hensive medication error reporting program that (1)
- 8 fosters a confidential, nonthreatening, and nonpunitive
- 9 environment for the submission of medication error re-
- 10 ports; (2) receives and analyzes these confidential reports
- 11 to identify system-based causes of medication errors or
- 12 potential errors; and (3) recommends and disseminates
- 13 error prevention strategies; further,

- 14 To provide leadership in encouraging the participation
- 15 of all stakeholders in the reporting of medication errors
- 16 to this program.

(Note: This policy would supersede ASHP policy 9918.)

Background

As part of sunset review, the Council voted to recommend amending policy 9918 as follows (~~strikethrough~~ indicates deletions):

To encourage pharmacists to exert leadership in establishing a nonthreatening, confidential atmosphere in their workplaces to encourage pharmacy staff and others to report actual and suspected medication errors ~~and adverse drug reactions~~ in a timely manner; further,

To provide leadership in supporting a single, comprehensive medication error reporting program that:

- (a) fosters a confidential, nonthreatening, and non-punitive environment for the submission of medication error reports;
- (b) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and
- (c) recommends and disseminates error prevention strategies; further,

To provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.

The Council and Board believed any reference to adverse drug reactions should be deleted, since the policy deals almost exclusively with reporting medication errors. The Council noted that ASHP's Guidelines on Adverse Drug Reaction Monitoring and Reporting address that topic extensively.

G. Stable Funding for Office of Pharmacy Affairs

- 1 To advocate for adequate funding for the Health Re-
- 2 sources and Services Administration (HRSA) Office of
- 3 Pharmacy Affairs to support its public health mission;
- 4 further,

- 5 To support initiatives of the Office of Pharmacy Affairs,
- 6 including the 340B Drug Pricing Program and innovative
- 7 pharmacy service models in HRSA-funded programs.

Background

The Council and Board discussed the need to support the mission of HRSA and its component Office of Pharmacy Affairs (OPA). Council and Board members reviewed the recent history of funding for OPA. OPA administers the 340B Drug Pricing Program, which requires drug manufacturers to give covered entities (including eligible disproportionate-share hospitals) a discount below average manufacturer prices for brand and generic drugs. OPA also helps administer innovative pharmacy models, such as the Patient Safety and Clinical Pharmacy Services Collaborative. OPA funding since 1992 has come from program management funds and other agencywide funding sources available to the HRSA Administrator. There has not been a dedicated line item in the HRSA budget for OPA. In fiscal year 2008, OPA requested a budget of nearly \$3 million to administer these programs. The Council and Board believed it was important to support the need for a dedicated and stable source of funding to maintain the 340B Drug Pricing Program, clinical pharmacy services, and other patient safety initiatives in order to maintain program integrity and affordable access by indigent patients.

Board Actions

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

- Compounding by Health Professionals (0411)
- Importation of Pharmaceuticals (0413)
- Home Intravenous Therapy Benefit (0414)
- Management of Blood Products and Derivatives (9919)
- Drug Nomenclature (9011)

Other Council Activity

Method-of-Use Patents. The Council discussed some manufacturers' practice of patenting the procedure associated with the use of a product in an attempt to prohibit generic competition. The Council noted that policy 0814 addressed the need for federal oversight of anticompetitive practices by manufacturers. Furthermore, the Council noted that this area of patent law is unfamiliar to most members and suggested that more research be conducted as to the frequency of this type of method-of-use patents. Council members also noted that it would be timely to provide information to members concerning the role of patent law and the federal Patent and Trademark Office, FDA, and the Federal Trade Commission. All three federal agencies play a role in the marketing and use of medications.

Cost Benefit as a Factor in Coverage for Unlabeled Use. The Council discussed the process used to determine coverage for unlabeled use and the various perspectives of patients and family members, employers, government agencies, and payers. The Council noted that payer policies vary in coverage decisions, ranging from step therapy to the use of a medical claim versus a pharmacy claim for expensive unlabeled uses. Council members noted that it is important for compendia to be evidence based and for payers to use the best available evidence in making coverage decisions. Members noted that as revisions are made to the ASHP Statement on the Use of Medications for Unlabeled Uses, the issue of how to deal with cost benefit as a factor in coverage decisions should be considered. Finally, the Council suggested that perspectives of other organizations such as the Academy of Managed Care Pharmacy and the International Society for Pharmacoeconomics and Outcomes Research should be reviewed.

Interstate Compacts Recognizing Licensure. The Council discussed the concept of state boards of pharmacy mutually recognizing another state's licensure and allowing a pharmacist to practice in either state. The experience of state nursing boards was examined. The National Council of State Boards of Nursing began a process for mutual recognition of registered nurses and licensed practical or vocational nurses in 1996. Currently, 23 states participate in this mutual recognition model for nursing regulation. A similar process was begun for advanced practice nurse licensure in 2002. In addition, the State Alliance for E-Health (created by the National Governors Association) recommended that NABP gain consensus on a cross-state cooperative pharmacist licensure system to enable a pharmacist to practice across state or territorial lines.

The Council recognized that funding such a mutual recognition system would be an issue for individual state boards. However, the

Council also noted that mutual recognition could help address workforce issues and the need to recognize residents who practice in states outside their state of original licensure. The Council also suggested that mutual recognition could be phased in as the current process of licensure reciprocity is phased out. The Council noted that it would be timely to enter into a dialogue with NABP to further discuss this issue and provide input in the development of model legislation and regulation.

State Labor Law Classification of Pharmacists. The Council discussed a delegate Recommendation concerning state law in California that does not consider pharmacists as exempt professional employees unless they are considered executive or administrative employees. The Council acknowledged that this classification affects the training schedule and educational opportunities for residency programs as well as overall flexibility in departmental workload scheduling. The Council expressed concern about the lack of flexibility created by this state law and suggested that this issue be monitored in other states. The Council did note that ASHP policy and philosophy would support the concept that pharmacists are professionals. The Council suggested that ASHP support state affiliates in their advocacy to classify pharmacists as professionals.

Impact of Government Programs on Drug Costs. In its discussion regarding funding for the OPA, the Council discussed how various prescription drug coverage and discount programs at the state and federal level influence drug costs. The Council suggested that this topic be an agenda item for a future meeting. In addition, it suggested that ways to educate and inform the membership be explored. Also, coordination with appropriate Sections should be considered.

Motivation for Patient Referral. In its discussion on cost benefit as a factor in determining coverage for unlabeled uses, the Council observed the practice of physician referral of patients to hospital outpatient departments. The Council suggested that more information be collected to assess the magnitude of the issue and that members be educated (possibly through a case history) on how hospitals deal with an influx of patients who are referred because of coverage considerations. In addition, the Council noted that some patients request hospitals to administer medications brought from home that may have been provided by another pharmacy. The Council noted that the proceedings of a newly formed Task Force on Caring for Patients Served by Specialty Suppliers would spotlight this issue.



House of Delegates Session—2009

Board of Directors Report on the Council on Therapeutics

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

John A. Armitstead, Board Liaison

Council Members

Lynette R. Moser, Chair (Michigan)
Douglas Slain, Vice-Chair (West Virginia)
Jill S. Bates (Illinois)
Kimberley W. Benner (Alabama)
Ronald J. Campbell, Jr. (Pennsylvania)
Kathleen L. Deering (Illinois)
Steven B. Levy (New York)
Leslie D. Jagers (Georgia)
Thomas J. Johnson (South Dakota)
Patrick J. McDonnell (Pennsylvania)
Mark J. Sinnott (New York)
David D. Stenehjem, Student (Minnesota)
Michael W. Kelly, Section of Clinical Specialists and Scientists Liaison (Iowa)
Cynthia Reilly, Secretary

Policy Recommendations

A. The Safe and Effective Use of Heparin in Neonatal Patients

- 1 To support the development and use of standardized
- 2 concentrations of heparin for maintenance and flush of
- 3 peripheral and central venous lines in neonatal patients;
- 4 further,
- 5 To advocate that hospitals and health systems use
- 6 manufacturer-prepackaged heparin flush products to
- 7 improve the safe use of heparin in neonatal patients.

Background

The preferential use of saline to maintain peripheral lines and devices in adult patients has largely become the standard of care, but use of heparin in neonates continues because of a lack of consensus and perceived and actual limitations in the evidence in published literature. However, fatal medication errors caused by the use of heparin in this patient population have brought to the forefront concern that the risks of using heparin for this purpose may outweigh the potential benefits.

The ASHP Therapeutic Position Statement on the Institutional Use of 0.9% Sodium Chloride Injection to Maintain Patency of Peripheral Indwelling Intermittent Infusion Devices, which was published in 1994 and reviewed and revised in 1997 and 2006, respectively, provides evidence for the use of sodium chloride as the preferred solution for maintaining peripheral lines in adult

patients. However, the existing therapeutic position statement (TPS) does not address the use of sodium chloride versus heparin in patients younger than 12 years of age, because at the time of publication there was a lack of sufficient evidence regarding the effectiveness of sodium chloride solution for flushing peripheral lines or maintaining their patency in neonatal and pediatric patient populations.

The Council reviewed evidence from evaluations of the use of 0.9% sodium chloride and heparin to maintain and flush arterial and central lines in neonatal patients and reports of medication errors that involved heparin. The advantages of saline include greater compatibility than heparin with concurrently administered drug therapies, reduced product costs, avoidance of adverse drug events such as heparin-induced thrombocytopenia (a rare but potentially fatal event in this patient population), and the potential to avoid errors caused by improper selection or dilution of heparin products. Advantages of heparin use include extended line patency and a beneficial antithrombotic effect at the insertion site. The Council concluded and the Board agreed that the data are conflicting and insufficient to support the recommendation of a preferred solution for line maintenance in neonatal patients at this time. Confounding factors in this patient population include the type of intravenous access, catheter lumen size, duration of access, and patient variables (e.g., age, weight). The Council believed and the Board agreed that the development of standardized concentrations of heparin to decrease practice variation and the use of manufacturer-prepackaged products are the best ways to improve the safe use of heparin in neonatal patients.

Board Actions

Use of Clinical Decision Support to Identify and Manage Drug Interactions. The Council recommended and the Board voted

To establish, in conjunction with the ASHP Section of Pharmacy Informatics and Technology, a multidisciplinary group or meeting that includes representatives of professional associations, drug information publishers, and software companies to develop consistent standards for the development and inclusion of drug interaction information in clinical decision support systems.

Computerized drug interaction alerts are intended to improve the safe use of drugs, but they often fall short of expectations because of software limitations (e.g., incomplete or incorrect information, improper assignment of severity levels) or user factors (e.g., alert fatigue, overrides). Existing software systems base interaction alerts on information contained in variable drug information databases that use different approaches to assigning severity ratings and clinical significance. In 2001, a study evaluating four drug information compendia found that of the more than 400 drug interactions described in at least one compendium as having major clinical significance, only 2.2% were described similarly in all four compendia. In fact, more than 70% of interactions identified as having major clinical significance in one compendium were not identified as such in the other compendia. The evidence supporting drug interactions is often based on case reports or extrapolated from underpowered studies—situations that do not accurately represent real use conditions and patient-specific variables that affect drug use. Facilities' modifications of software to address the needs of the individual practice site, as well as frequent updates by software vendors that override these modifications, further contribute to the suboptimal results achieved with these software programs. In combination, these factors present significant challenges for health systems, which must balance patient safety, workflow, and productivity.

The Council recommended that ASHP seek collaboration among entities that develop and use drug interaction information in clinical decision support systems to address current limitations in the development and use of these software programs. The collaboration will seek to standardize processes and develop criteria for determining clinically significant drug interactions that can be validated and replicated.

Therapeutic Position Statement on Strict Glycemic Control in Patients with Diabetes. The Council recommended and the Board voted

To discontinue the ASHP Therapeutic Position Statement (TPS) on Strict Glycemic Control in Patients with Diabetes.

Tight glycemic control has been demonstrated to reduce morbidity and mortality associated with complications of diabetes, including nephropathy, neuropathy, and retinopathy. This TPS was developed through the Commission on Therapeutics and approved by the Board on July 28, 2003, to address practice variation in managing blood glucose in patients with type 1 and type 2 diabetes and to evaluate patient- and setting-specific factors that should be considered in targeting mean glycosylated hemoglobin (HbA1c) levels recommended by the American Diabetes Association and the American College of Endocrinology (ACE).

The Council recommended that the TPS be discontinued because the current document is outdated. Recent evidence from the Action to Control Cardiovascular Risk in Diabetes (ACCORD) and Action in Diabetes and Vascular Disease: Preterax and Diamicon MR Controlled Evaluation (ADVANCE) trials have the potential to alter best practices for glycemic control, especially in the primary care setting. Substantial practice changes have also occurred in the inpatient setting, including adoption of the ACE recommendation to use correctional insulin therapy in conjunction with monitoring to prevent significant hypoglycemia and increased availability and use of long-acting insulin therapies to meet basal insulin needs. In addition, recent evidence demonstrates that the target level of glycemic control may be less important than controlling the extent of variability in glucose levels in some patient populations in the intensive care unit setting. New devices, including implantable insulin devices that allow for more accurate and continuous monitoring of blood glucose, may also have an impact on practice recommendations. While this information evolves, the Council recommended education as a mechanism to inform clinicians about practice implications of the ACCORD and ADVANCE trials and ACE's policy position discouraging use of sliding-scale insulin.

Other Council Activity

Pharmacogenetics and Personalized Medicine. One of the earliest known genetic variations to affect drug therapy, glucose-6-phosphate dehydrogenase deficiency, results in the breakdown of red blood cells when a person is exposed to certain drugs (e.g., antimalarial drugs, aspirin, nonsteroidal anti-inflammatory drugs, quinidine, quinine, and sulfonamide antibiotics). More recent discoveries include genetic variations that result in variable response to warfarin dosing, use of the CYP 2D6 gene to predict tamoxifen effectiveness, and the establishment of causality for adverse drug reactions that had previously been described as idiosyncratic (e.g., variants in SLCO1B1 associated with an increased risk for statin-related myopathy).

While pharmacogenetic information is growing at an unprecedented pace, the practical application of this evidence to clinical practice is still in its infancy. The extent of genetic biomarker information available in labeling approved by the Food and Drug Administration (FDA) has also increased in recent years, but only a handful of drugs (e.g., abacavir) describe the clinical application of these tests in their prescribing information. The FDA has no requirement that drug product manufacturers complete genetic studies. The Council believed that this field would be greatly enhanced if drug product manufacturers conducted more research (including

practical clinical trials) and if collection and analysis of data on the use of these tests were improved.

The Council recognized that genetics play a significant role in response to drug therapy, but that uncertainties remain about the extent to which genetics affect response and the interplay of genetics with other variables, including concomitant therapies, diet, and other patient-specific factors. There is also limited information about the cost-effectiveness, clinical impact, and implementation of genetic testing and, most important, whether testing improves patient outcomes or avoids adverse drug reactions. Current study design, which includes small populations, also limits the ability to identify the impact of genetic variation, including the strength of correlation between the genotype and perceived effect.

The Council encouraged pharmacists to take a leadership role in determining how pharmacogenetic tests will be applied in the management of drug therapy. The Council suggested that ASHP continue and enhance current efforts to educate members, including information about how genetic tests are developed and approved by the FDA and the benefits and limitations of their use. The need for counter-detailing was recommended because the use of some tests is aggressively promoted to physicians and patients.

Standardization of Creatinine Assays and Its Impact on Drug Dosing. The National Kidney Disease Education Program (NKDEP) laboratory working group has implemented two changes that are expected to have a significant impact on pharmacy practice: calibration of serum creatinine assays and automatic laboratory reporting of estimated glomerular filtration rate (eGFR) calculated by the Modification of Diet in Renal Disease (MDRD) equation.

Assay calibration increases the accuracy of laboratory assessments but also results in reported creatinine levels that can be decreased as much as 5–20% from previously reported values. Therefore, it is important that pharmacists and other clinicians know when their laboratory has started using the new assay, which is being phased in with full implementation expected by late 2009.

eGFR is believed to be superior for staging renal function. Its automatic reporting is expected to improve early detection and management of patients with chronic kidney disease, and NKDEP has encouraged practitioners to use this method for estimating GFR instead of the Cockcroft-Gault (C-G) equation. However, application of eGFR to drug dosing is limited because existing pharmacokinetic formulas and dosing information from FDA-approved labeling are based on creatinine clearance calculated by the C-G equation.

While noting the limitations of both equations, the Council believed that, with additional research, clarification, and education, transition to the MDRD equation and eGFR would improve patient care. Information needs were suggested, including identification of high-risk drugs for which the change in dose could be clinically significant and validation of the MDRD equation in different patient populations (e.g., elderly or obese patients). The Council supported the suggestion by NKDEP and others that the FDA issue new guidance directing drug product manufacturers to submit renal dosing information for new drugs using the MDRD equation. ASHP was encouraged to educate pharmacists about the implications of these changes.

Evaluating and Communicating the Risk of Drug Therapies. Assessing the potential risk of drug therapies and communicating that risk to patients and other clinicians is a core responsibility of pharmacists, but this responsibility is often complicated by extensive and sometimes competing messages that are presented to health care professionals and patients. Findings reported in the media and elsewhere need to be evaluated in terms of risk versus benefit for the individual patient, including the potential for harm that arises from stopping a therapy prematurely or unnecessarily. Clinicians should also be aware of the potential for liability.

The Council encouraged ASHP to continue current efforts to increase awareness about the need for critical assessment and to provide clinicians with education on assessing and communicating the risk:benefit ratio of therapies. Patient education via www.safemedication.com, media interviews, and other mechanisms was also recommended.

Benefits and Limitations of Using Data from Clinical Trials to Improve Drug Safety. Clinical trials for drug approval are intended to demonstrate efficacy and safety of marketed products. However, inherent limitations of preapproval studies (e.g., small sample size and narrowly defined patient populations) frequently necessitate safety-related regulatory actions (e.g., black box warnings, market withdrawals) following FDA approval. Other factors that limit preapproval drug safety efforts include difficulty identifying a cause-and-effect relationship for unanticipated adverse effects and the use of surrogate endpoints that shorten the time to approval and limit the extent of data available. The critical importance of pharmacovigilance, or postmarketing safety surveillance, is highlighted by the Food and Drug Administration Amendment Acts of 2007, which include additional authority for FDA to require postapproval safety studies.

The Council believed this enhanced regulatory authority would improve drug safety, but noted that lack of standardization in reporting adverse events or side effects in clinical trials also contributes to limitations in the current system. Vague terminology (e.g., “the drug was well tolerated”), failure to disclose all study inclusion and exclusion criteria, failure to explain reasons for study withdrawal,

and lack of analysis of data for subpopulations that may be at greater risk are shortcomings in current reporting that limit individual and system-based decision-making. The lack of consistent reporting also makes it difficult to compare results of different trials. Publication bias and lack of data representing negative trial results further limit clinician access to information. The Council reviewed with favor recommendations offered in the 2004 extension of the Consolidated Standards of Reporting Trials (CONSORT) statement (*Ann Intern Med.* 2004; 141:781–8) and suggested that ASHP review and consider endorsing the recommendations.

MedWatch and other spontaneous reporting systems were also noted as cornerstones of improving drug safety. The Council suggested that ASHP continue work with MedWatch and members to standardize reporting and increase the already high rates of pharmacist reporting.

Therapeutic Position Statement on the Institutional Use of 0.9% Sodium Chloride Injection to Maintain Patency of Peripheral Indwelling Intermittent Infusion Devices. The Council voted to revise the ASHP TPS on the Institutional Use of 0.9% Sodium Chloride Injection to Maintain Patency of Peripheral Indwelling Intermittent Infusion Devices.

The ASHP Therapeutic Position Statement on the Institutional Use of 0.9% Sodium Chloride Injection to Maintain Patency of Peripheral Indwelling Intermittent Infusion Devices was published in 1994 and subsequently reviewed and revised in 1997 and 2006, respectively. The document recommends the preferential use of sodium chloride in adult patients. It does not offer a recommendation for patients younger than 12 years of age, because at the time of publication there was a lack of sufficient evidence on the effectiveness of using sodium chloride in that patient population for flushing peripheral lines or maintaining their patency.

The Council reviewed studies evaluating the use of saline and heparin flush in patients 12 years of age and younger that have been published since the last revision of this TPS in 2006. The Council believed that the availability of new evidence, including data from higher-quality studies, warrants revision of the TPS to recommend preferential use of 0.9% sodium chloride in pediatric patients.

Use of Drug Interaction Information to Guide Drug Therapy Decisions. The Council voted to develop guidelines on best practices for the assessment and management of potential drug interactions identified by clinical decision support software and other drug information sources.

Significant variation exists in the implementation and use of drug interaction software in clinical decision support systems. In many health systems, this function is disabled for the prescribing interface in order to address frustration expressed by physicians but is maintained for pharmacy order verification. Some software systems do not permit selective disabling, and some facilities have fully disabled this function for all users.

Prescribers and pharmacists frequently report “alert fatigue” that can lead to the assumption that most alerts are not clinically significant. However, significant liability can result for the prescriber, pharmacy, and pharmacist if failure to recognize and respond appropriately to alerts results in patient harm. Abbreviated references that provide point-of-care drug information (e.g., handbooks, applications for hand-held devices) also contribute to practice variation by providing less complete information.

Although criteria can be developed to identify clinically significant and life threatening interactions, the ultimate decision to use a therapy is based on the patient-specific assessment of risk versus benefit and the availability of alternative treatments. Pharmacists and pharmacy students require education about appropriate strategies for using this information to guide drug therapy for individual patients. The Council recommended that ASHP develop a statement or guideline on best practices for the clinical assessment and management of potential drug interactions that would include strategies for assessing the significance of interactions, including consideration of unique patient characteristics and appropriate documentation of the rationale for how the clinician handled the alert.

Statement on Evaluating the Quality of Drug Information. The Council reaffirmed its 2006 recommendation to develop this statement to describe essential components of quality print and electronic drug information resources, including those contained in clinical decision support systems and other technologies. The Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council believed that development of this statement in collaboration with other organizations should be pursued and given highest priority.

Therapeutic Position Statement on the Preferential Use of Metronidazole for the Treatment of Clostridium difficile-Associated Disease. The ASHP TPS on the Preferential Use of Metronidazole for the Treatment of *Clostridium difficile*-Associated Disease was approved by the Board on April 22, 1998, and reviewed by the Commission on Therapeutics and the Board in 2002 and found to still be appropriate. In 2007, the Council recommended revision of this document, noting that it continues to be an important resource for clinicians, especially in light of the emergence of more virulent strains of *C. difficile* and the addition of fluoroquinolones as major contributors to the development of *C. difficile*-associated disease. The 2008 Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council noted that the Infectious Diseases Society of America is nearing completion of a guidance document on this topic and recommended that ASHP review that guideline, when available, to determine if there is a continued need for ASHP's document.

Therapeutic Position Statement on the Safe Use of Oral Nonprescription Analgesics. The ASHP Therapeutic Position Statement on the Safe Use of Oral Nonprescription Analgesics was approved by the Board on November 14, 1998. In 2003, the Commission on Therapeutics recommended that the document remain active while a revision was developed. The Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development and recommended that development of this guidance document be continued because of the significant safety risk posed by inappropriate use of these therapies.

Therapeutic Position Statement on the Use of Perioperative Antibiotic Irrigations. In 2005, the Commission on Therapeutics recommended development of this document to address the lack of consensus about the effectiveness of using perioperative antibiotic irrigations to prevent surgical site infections. The Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council believed that the use of antibiotic irrigations continues; therefore there would be benefit in developing an official ASHP guidance document to provide support to pharmacy staff who receive requests to compound antibiotic irrigations.

Therapeutic Position Statement on the Safe Use of Pharmacotherapy for Obesity Management in Adults. The Board approved this guidance document on April 23, 2001; in 2006, the Council reviewed the document and recommended that it remain active while a revision was developed. The Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council noted an ongoing need for this document but recommended that its development be assigned lower priority than other documents scheduled for development or revision.

Therapeutic Position Statement on the Use of Corticosteroids for Pediatric Patients with Asthma. In 2007, the Council reviewed a draft outline for this document and provided recommendations for revision. The 2008 Council re-examined the need for this TPS as part of its evaluation and prioritization

of guidance documents scheduled for development. The Council recommended that development of this document be discontinued in light of the increased awareness that inhaled corticosteroids are the standard of care for treatment of asthma in this patient population and the recent publication of the National Asthma Education and Prevention Program guidelines that meet the information need intended for this TPS.

Statement on the Use of Antidepressants in Children and Adolescents. In 2007, the Council reviewed the controversy surrounding the use of antidepressants in pediatric and adolescent patients, including conflicting evidence on the potential for these therapies to increase suicidality in these patient populations, and recommended that ASHP develop a statement describing appropriate management of these drug therapies, including monitoring and adjuvant therapies (e.g., counseling). The 2008 Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council determined that a commentary in *AJHP* or educational programming would better meet the need for information this statement was intended to address.

Therapeutic Position Statement on the Recognition and Treatment of Depression in Older Adults. In 2002, the Commission on Therapeutics recommended revision of the ASHP Therapeutic Position Statement on Recognition and Treatment of Depression in Older Adults, which was approved by the Board on September 18, 1998. The Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council recommended that development of this document not be pursued because awareness of depression in the elderly has increased dramatically and there are numerous guidelines available on detection and treatment of this condition.

Therapeutic Position Statement on the Treatment of Tuberculosis. The ASHP Therapeutic Position Statement on Strategies for Preventing and Treating Multidrug-Resistant Tuberculosis was first approved by the Board of Directors on November 16, 1996. In 2000, the Commission on Therapeutics completed a sunset review of this guidance document and recommended revision; in 2007, the Council reviewed a draft manuscript and recommended strategies to uniquely position the document in light of recent guidance available from the Centers for Disease Control and Prevention (CDC). The 2008 Council re-examined the need for this guidance document as part of its assessment and prioritization of therapeutic guidance documents scheduled for development. The Council recommended that development of this document not be pursued based on the availability of quality and comprehensive guidelines from other sources, including the CDC. A commentary in *AJHP* or educational programming was suggested as mechanisms that would meet the need for information this statement was intended to address.

Recommendations for Development of ASHP Therapeutic Guidance Documents. The Council recommended strategies for improving the timeliness and usefulness of ASHP's therapeutic guidance documents, based on a review of the Society's Best Practices Improvement Initiative, excerpts from the Institute of Medicine report, *Knowing What Works in Health Care*, and other resources. The Council recommended continued collaboration with other guideline developers (including the establishment of multidisciplinary expert panels) and use of a consistent system for grading evidence and strength of recommendations. Inclusion of comparative effectiveness information is desirable, but often limited by the quality of available evidence and the perspective (i.e., payor, provider, or the payer) selected by the study authors. The Council suggested that cost-effectiveness information should be included in ASHP guidelines when information is available and valid. Strategies for including this information could be based on recommendations that appear in the chapter "Strategies for Including Resource Allocation and Economic Considerations" in *Antithrombotics and Thrombolytic*

Therapy: American College of Chest Physicians (ACCP) Evidence-Based Clinical Practice Guidelines, 8th ed.

Other Council suggestions included increasing the transparency of the guideline development process, promoting opportunities for member participation in guideline development and review, and providing readily accessible information about the status of guidelines in development. An evaluation of the optimal time frame for sunset review of therapeutic guidelines was also recommended.

Recommendations for Comparative Effectiveness Research. The Council discussed potential clinical research topics for submission to the Agency for Healthcare Research and Quality (AHRQ) Effective Health Care (EHC) program, which conducts comprehensive reviews of existing evidence on the relative benefits and risks of alternative interventions or generates new scientific evidence in situations in which the existing evidence is not sufficient to respond to a specific research question. A Council subcommittee will work with ASHP and AHRQ staff to prepare one or more formal submissions to the EHC program.



House of Delegates Session—2009

Reports on Sections and Forums

ASHP sections consist of members within five well-defined areas of health-system pharmacy who collaborate to advance professional practice in their respective areas. ASHP members may enroll in as many sections as they wish; practitioner members are asked to select one section as their primary “home,” which allows them to vote for the chair and members of the executive committee of that section.

The ASHP Student Forum consists of all student members. The New Practitioners Forum consists of all practitioner members who are within five years of graduation from a college of pharmacy.

Each section and forum is led by an Executive Committee elected (sections) or appointed (forums) from the ASHP membership. Each Executive Committee met face to face June 6 and 7, 2008, to review the past year’s activities and plan for the coming year. The committees met again on January 14, 2009, and by telephone periodically during the year to assess progress on initiatives and discuss new trends or events that warrant section or forum activity. Each section and forum has its own mission, vision, goals, and objectives.

-
- 1 ASHP Section of Clinical Specialists and Scientists**
 - 3 ASHP Section of Home, Ambulatory, and Chronic Care Practitioners**
 - 5 ASHP Section of Inpatient Care Practitioners**
 - 7 ASHP Section of Pharmacy Informatics and Technology**
 - 9 ASHP Section of Pharmacy Practice Managers**
 - 11 ASHP New Practitioners Forum**
 - 14 ASHP Pharmacy Student Forum**

ASHP Section of Clinical Specialists and Scientists

The mission of the Section of Clinical Specialists and Scientists is to improve patient care by serving as a conduit for translating scientific advances in drug therapy and clinical therapeutics into the practice of pharmacy and advocating practice development and advancement. The Section Executive Committee has developed a strategic plan linked to the Section's mission and goals. These goals are (1) effectively communicating the value members receive from their membership in the Section and ASHP, (2) enhancing efforts to encourage networking among Section members, (3) supporting the professional development of specialists and scientists, (4) promoting pharmacist implementation of evidence-based medicine, (5) facilitating the development of strategic internal and external partnerships, and (6) actively participating in ASHP's policy and advocacy initiatives. The Section offers members a sense of identity within ASHP and an organizational home dedicated to meeting their specialized practice, scientific, and research needs. The Section will continue to grow and expand its activities largely because of the efforts of its enthusiastic members and dedicated leaders.

2008–2009 Section Highlights. Section membership declined by 0.5% during 2008, to almost 11,500 members. Approximately 48% of the Section's members have selected the Section as their primary membership group. There still is strong interest with the Section among students and new practitioners. Section members elected Dr. Trovato as Chair and Dr. Eiland as a Director-at-Large; both will be installed at the June 2009 ASHP Summer Meeting.

The Section selected Kimberly A. Galt as the winner of the Section of Clinical Specialists and Scientists Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the section's mission and helped advance the profession. The award was presented at the 2008 Midyear Clinical Meeting (MCM).

Educational and Networking Opportunities. The Section's Programming Committee is charged with developing programming at an advanced level that will be of interest to clinical specialists and scientists. The 2007–2008 Programming Committee developed more than 14 hours of educational programming on current issues in infectious diseases, perinatology, pediatrics, psychiatry, and internal medicine. In addition to developing two highly successful educational sessions ("In Case You Missed It: Top Ten Papers in Medicine 2008" and "Meta-Analysis: Principles and Practice"), the committee planned a session devoted to debates in areas of therapeutic controversy and coordinated the Clinical Pearls session.

The Section's electronic NewsLink is distributed once a month to more than 13,000 ASHP members, providing news and current information on medical research, regulatory and health policy issues, health care, and therapeutics. The Section Chair's message is also distributed once a month to NewsLink subscribers and provides news on Section and ASHP programs and initiatives. The Section's electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to clinical practice; currently, more than 2700 members participate. The discussion group is also used to communicate urgent information on clinical specialty practice.

The Section has 17 specialty networks encompassing most areas of specialty pharmacy practice. The networks meet regularly at the MCM, with approximately 750 meeting attendees participating. Facilitators are appointed for each network by the Section's Chair. The network facilitators monitor developments and trends in their therapeutic area and advise ASHP and the Section's membership of these developments through the Section's electronic discussion group, NewsLink, networking meetings, the Virtual Journal Club, and other venues. The facilitators also serve ASHP and its members as therapeutic experts and contribute to ASHP advocacy and educational efforts.

Executive Committee

Kelly M. Smith, Chair (Kentucky)
James A. Trovato, Chair-elect (Maryland)
Michael W. Kelly, Immediate Past Chair (Iowa)
Marie A. Chisholm-Burns, Director-at-Large (Arizona)
Erin R. Fox, Director-at-Large (Utah)
Lea S. Eiland, Director-at-Large-elect (Alabama)
Kathryn R. Schultz, Board Liaison (Minnesota)
Sandra Oh Clarke, Secretary

Resources for Clinical Specialists and Scientists. The Section continues to enhance its resources for pharmacy practitioners in different specialty areas and to use multiple communication pathways to notify Section members of new resources. The Section hosted a Virtual Journal Club on the ASHP Web site to enhance communication and participation among members with different specialties. This program is on hold due to a revamping of the program and an ASHP software upgrade. The Clinical Consultation column in the *American Journal of Health-System Pharmacy (AJHP)*, created by the Section, continues to be a popular resource for members. This column covers therapeutic controversies and provides recommendations for handling specific pharmacotherapeutic problems. The Section planned two Webinars on the pharmacist's role in the implementation of The Joint Commission National Patient Safety Goal 3E. Other Section initiatives in this area included the development of the anticoagulation resource center, entitled "ASHP's Anticoagulation Initiative: Promoting Patient Safety Through Education, Practice, Policy, and Advocacy," on the ASHP Web site. This site is a compilation of educational materials, policies, best practices, and links to other organizations for practitioners looking for resources in the area of anticoagulation management.

Task Force on Science. The Section was involved with planning the ASHP Task Force on Science, held at ASHP headquarters on September 17, 2008 with participation from national experts in informatics/technology, pharmacogenomics, personalized medicine, gene therapy, and nanomedicine. The task force made 12 recommendations, which can be categorized into three areas: education and research, practice and policy development, and advocacy efforts. The recommendations from this meeting will help guide future activities of the Section and ASHP in the emerging sciences and the incorporation of informatics/technology into pharmacy practice. The full report will be published in the June 15, 2009 issue of *AJHP*.

Advisory Group on Emergency Care. In 2007, the Section Advisory Group (SAG) on Emergency Care developed the ASHP Statement on Pharmacy Services to the Emergency Department to address this growing practice area. As a follow-up to this document, the group is drafting guidelines on the pharmacist's role in the emergency department. In addition to two emergency-care-related programs at the 2008 MCM, a successful emergency medicine networking session at the meeting drew more than 70 participants. Practitioners in this field also network through the ASHP Emergency Care electronic discussion group, which has close to 1100 subscribers.

Advisory Group on Gene Therapy. The SAG on Gene Therapy was established in 2008. The group has been reviewing the *European Association of Hospital Pharmacists Guidance on the Pharmacy Handling of Gene Medicines* for its application to U.S. practice. A gene therapy survey was developed and launched in November 2008. The purpose of the survey is to identify educational and practice gaps in gene therapy. Survey results identified a number of practitioner needs in this area. As a first step, the SAG will develop a template policy and procedure on the safe handling of gene therapy agents. The group also planned a two-hour educational program at the 2008 MCM that was well received by meeting attendees.

Advisory Group on Investigational Pharmacy Services.

The Section continues to recognize and support the needs of pharmacists working in the areas of investigational drugs and clinical research. The SAG on Investigational Pharmacy Services is currently developing an investigational pharmacy services resource center and reviewing and updating the ASHP Statement on Clinical Drug Research and ASHP Statement and Guidelines on Pharmaceutical Research in Organized Health-Care Settings. In addition to the educational session on investigational drugs held at the 2008 MCM, the SAG led a successful networking session in this practice area. This group and practitioners in this area network through the ASHP Investigational Drug Services electronic discussion group, which has over 675 subscribers.

Residency Preceptor Skills Development. The Executive Committee is collaborating with the Accreditation Services Division to develop educational initiatives on residency preceptor skills development. Committee members will lead a networking session at the 2009 Summer Meeting on this topic. Other educational initiatives are planned, including programming at the 2009 MCM and a series of articles in *AJHP*.

Advocacy. The Section has been heavily involved in emphasizing the evidence-based nature of pharmacy practice and has worked to incorporate evidence-based medicine concepts into the ASHP Health-System Pharmacy 2015 Initiative. The Section will continue to stress that the responsibility for incorporating evidence-based therapeutic guidelines and medication use into patient care is a responsibility of all pharmacists and pharmacy departments.

Committee on Nominations

Michael W. Kelly, Chair (Iowa); Curtis D. Collins (Michigan); Rita K. Jew (California); Edward Li (Pennsylvania); Alan H. Mutnick (Ohio); Melinda Neuhauser (Illinois); Jean M. Scholtz (Pennsylvania)

Programming Committee

Kevin Garey, Chair (Texas); Cherry W. Jackson, Vice-Chair (Alabama); Ericka L. Breden (Virginia); Curtis D. Collins (Michigan); Michelle D. Wiest (Ohio); Daniel P. Hays (Arizona); Karla Miller (Tennessee); Kamakshi V. Rao (North Carolina); Lori Reisner (California); Susan M. Stein (Oregon); Paul M. Szumita (Massachusetts); Alan J. Zillich (Indiana); James A. Trovato, Executive Committee Liaison (Maryland)

Advisory Group on Emergency Care

Umbreen Murtaza, Chair (Maryland); Renee M. Petzel, Vice-Chair (Illinois); Roshanak Aazami (California); Tony Casanova (Washington); Toby L. Cooper (Texas); Heather Draper Eppert (Tennessee); Alison Jennett (Michigan); Ted L. Rice (Pennsylvania); Kevin O. Rynn (New Jersey); Joanne Witsil (Illinois); Marie Chisholm-Burns, Executive Committee Liaison (Arizona)

Advisory Group on Gene Therapy

Susan Goodin, Chair (New Jersey); Gail Bernstein (Illinois); Susan Johnston (Wisconsin); Stephen C. Kay (Massachusetts); Theresa Mays (Texas); John Petrich (Ohio); Kim Powell (Texas); Lynette Moser (Michigan); Michael W. Kelly, Executive Committee Liaison (Iowa)

Advisory Group on Investigational Pharmacy Services

Kathleen Truelove, Chair (Maryland); Darlette G. Luke, Vice-Chair (Minnesota); Anastasia Lialios-Ramfos (Virginia); Tricia Meyer (Texas); Ronald Seto (Canada); Erin R. Fox, Executive Committee Liaison (Utah)

Network Facilitators

Anticoagulation: Snehal Bhatt (Massachusetts)
Cardiology: James C. Coon (Pennsylvania)
Critical Care: Lance J. Oyen (Minnesota)
Drug Information/Pharmacoeconomics: Karen P. Norris (Kansas)
Emergency Medicine: Roshanak Aazami (California)
Geriatrics: Rosina M. Stamati (New York)
Hematology/Oncology: Leila R. Mohassel (Virginia)
Immunology/Transplant: Nicole Weimert (South Carolina)
Infectious Diseases: Curtis Collins (Michigan)
Investigational Drugs/Critical Research: Darlette G. Luke (Minnesota)
Nutrition Support: Vivian Zhao (Georgia)
Pain Management: Christopher M. Herndon (Illinois)
Pediatrics/Obstetrics-Gynecology/Neonatal: Cathy Y. Poon (Pennsylvania)
Pharmacokinetics: Rosa Yeh (Texas)
Primary Care/Pharmacotherapy: Steven T. Boyd (Louisiana)
Psychopharmacy/Neurology: Eric C. Kutscher (South Dakota)
Surgery/Operating Room/Anesthesiology: Peggy Bickham (Illinois)

ASHP Section of Home, Ambulatory, and Chronic Care Practitioners

The mission of the ASHP Section of Home, Ambulatory, and Chronic Care Practitioners is to improve patient care and patient health outcomes by advancing and supporting the professional practice of pharmacists who are medication-use specialists, patient care providers, and operational specialists in home, ambulatory, and chronic care settings. To achieve this mission, the Section will provide guidance that improves both the use of medications by patients and the medication-use process in ways that enhance patients' health-related quality of life and patient outcomes.

Goals. The Section will promote the clinical and administrative roles of pharmacists and contribute to the advancement of care across the health-care continuum. It will serve as the voice of and a resource for the Section's practitioners within ASHP, especially in ASHP governance and policy development. The Section will engage those who want to improve their professional knowledge and skills with leaders and experts in their practice settings. It will recruit and cultivate members who are active within the profession, providing a mechanism to develop the future leaders of ASHP. It will develop a membership that is actively involved in ASHP, that is widely utilized as a resource throughout the profession, and whose contributions are clearly recognized by the Section, ASHP, and other professional organizations. The Section will communicate effectively with Section members to ensure that they understand, support, and contribute to the direction and role of the Section in representing their interests. It will promote collaboration, including networking and services, among the Section's members. It will create or foster the creation of ASHP products, educational programs, and services that meet the unique needs of the Section's membership, including products, educational programs, and services that utilize advanced technologies for delivery via the Internet or the World-Wide Web and will work with other professional organizations to develop products, educational programs, and services that meet the unique needs of the Section's membership.

2008–2009 Section Highlights. The Section of Home, Ambulatory, and Chronic Care Practitioners focused in 2008 on reimbursement for cognitive services, ambulatory care services, pain management and palliative care, home infusion guidelines, and criteria for postgraduate year 2 (PGY2) residencies in pain and palliative care. At the end of 2008 the Section had a total primary and secondary membership of 6919.

Dr. Stranz served as Chair of the Section. Dr. Brown served as Chair-elect and will begin his service as Chair in June 2009. Section members also elected Dr. Nowobilski-Vasilios to a two-year term as Director-at-Large. The Committee on Nominations for 2009 will present a slate of candidates for Chair-elect and Director-at-Large-elect.

The Section of Home, Ambulatory, and Chronic Care Practitioners had a very productive year as it fulfilled members' needs and continued striving to provide leadership and value for its members through its members.

Distinguished Service Award. The Section selected Mary Ann Kliethermes as the recipient of the 2008 Home, Ambulatory, and Chronic Care Practitioners Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member from each Section whose volunteer activities have supported the Section's mission and helped advance the profession. The award was presented at the 2008 Midyear Clinical Meeting (MCM).

Executive Committee

Marc H. Stranz, Chair (Colorado)
 Timothy R. Brown, Chair-elect (Ohio)
 Ernest J. Dole, Immediate Past Chair (New Mexico)
 Barbara J. Petroff, Director-at-Large (Michigan)
 Richard L. Stambaugh, Director-at-Large (Minnesota)
 Anna Nowobilski-Vasilios, Director-at-Large-elect (Illinois)
 Janet L. Mighty, Board Liaison (Maryland)
 Deborah G. Peretto, Secretary

Educational Programming. The Section Programming Committee planned 11 hours of educational programming specifically for ambulatory and chronic care practitioners at the 2008 MCM. Topics included medication adherence and patient outcomes, drug resistant infections, managing chronic pain, practical solutions in patient care, and polypharmacy and the elderly. There were also two Section networking sections at the 2008 MCM focusing on home care essentials and modern ambulatory care.

Advisory Group on Reimbursement for Cognitive Services. The Section Advisory Group (SAG) on Reimbursement for Cognitive Services organized the Ambulatory Care Workshop at the 2008 MCM. This workshop focused on establishing a pharmacist managed ambulatory clinic. A similar workshop is being planned for 2009. The SAG also produced two Webinars on reimbursement for cognitive services. In addition, the SAG plans to publish the third article in a series of articles on reimbursement in the *American Journal of Health-System Pharmacy (AJHP)*.

Advisory Group on Pain Management and Palliative Care. This SAG created a 2008 MCM workshop on the clinical and administrative responsibilities of caring for pain and palliative care patients. A similar workshop is being planned for the 2009 MCM. This SAG also is finalizing proposed criteria for a PGY2 specialty residency in pain management and palliative care. The group is continuing to support activities with the Mayday Pain Project, an international educational resource that provides information about pain care issues.

Advisory Group on Home Infusion. The new SAG is working to update the ASHP guidelines for home care pharmacies. They are also planning a new workshop for the 2009 MCM focusing on creating policies and procedures for USP Chapter 797 compliance, establishing working relationships with infectious disease specialists to provide dosage and monitoring services, and guidelines for monitoring total parenteral nutrition patients. Additionally, the SAG sponsored a successful home infusion-focused track at the 2008 MCM.

Ambulatory Care Specialty Credential. ASHP, along with the American College of Clinical Pharmacy and the American Pharmacists Association, continues to support the process for establishing an ambulatory care specialty credential. Public comment is currently being solicited.

Advocacy. Many Section members represent ASHP on various coalitions and committees. The Section has provided member experts to the Pharmacy Quality Alliance, the National Quality Forum, The Joint Commission Professional and Technical Advisory Committees on ambulatory care and home care, and the National Asthma Education and Prevention Program. These members provide the pharmacist's perspective in discussions that have an impact on patient care nationwide. Section members continue to support ASHP's efforts in advocacy for the expansion and payment of pharmacists and medication management services.

Committee on Nominations

Ernest Dole, Chair (New Mexico); Caryn Bing (Nevada); Mary Ann Kliethermes (Illinois); Steven Riddle (Washington); Cathy L. Sasser (Georgia)

Programming Committee

Pamela L. Stamm, Chair (Alabama); Jennifer P. Askew (North Carolina); Sandra L. Chase (Michigan); Michelle Cudnik (Ohio); Michelle A. Fritsch (Maryland); Katie V. Lai (Washington); Jeannie Kim Lee (Arizona); Kimberly Braxton Lloyd (Alabama); Tracy A. Martinez (Michigan); Michelle L. Matthews (Massachusetts); Edward P. Sheridan (Indiana); Marc Stranz, Executive Committee Liaison (Colorado)

**Advisory Group on Reimbursement
for Cognitive Services**

Seena Haines, Chair (Florida); Amy L. Stump, Vice-Chair (Wyoming); Kristy Butler (Oregon); Kelly T. Epplen (Ohio); Roger S. Klotz (California); Sandra Leal (Arizona); John R. Miller (Ohio); Edith Nutescu

(Illinois); Laura D. Roller (Utah); Laura Traynor (Minnesota); Richard L. Stambaugh, Executive Committee Liaison (Minnesota)

**Advisory Group on Pain Management
and Palliative Care**

Sondra Adkinson, Co-Chair (Florida), Suzanne A. Nesbit, Co-Chair (Maryland), David Craig (Florida), Victoria Ferraresi (California), Virginia Ghafoor (Minnesota), Christopher Herndon (Illinois), Lee Kral (Iowa), Mary Lynn McPherson (Maryland), Douglas Nee (California), Lori Reisner (California), Scott Strassels (Texas), Jennifer Strickland (Florida), Ernest Dole, Executive Committee Liaison (New Mexico).

Advisory Group on Home Infusion

Donald J. Filibeck, Chair (Ohio); Jeannie Barkett (Oregon); Michael P. Corrol (Vermont); Daniel B. Dobson (Washington); Kim Ebert (Minnesota); Douglas R. Lang (Missouri); Taeho Oh (Florida); Steven M. Pate (Tennessee); Kathleen Pawlikowski (New Jersey); Barbara J. Petroff, Executive Committee Liaison (Michigan)

ASHP Section of Inpatient Care Practitioners

The Section of Inpatient Care Practitioners was launched in September 2003 to meet the needs of the frontline pharmacist. The Section dedicates itself to achieving a vision of pharmacy practice in which pharmacists practicing in an inpatient setting safely integrate clinical (direct patient care or indirect patient care), distributive, and operational functions and are focused on improving inpatient care. To achieve this vision, the Section will:

- Serve as a voice for inpatient care practitioners and members of the Section within ASHP, including ASHP governance and integration of Section policy development within ASHP;
- Facilitate the integration of drug distribution and clinical practice for inpatient care practitioners and members of the Section;
- Promote the professional development of inpatient care practitioners and members of the Section through education and skills development;
- Increase communication with Section members on key issues for the profession and the Section;
- Encourage, facilitate, and educate on the application of ASHP best practices and evidence-based guidelines at the inpatient care practitioner level; and
- Identify and promote the development of leaders within the Section.

2008–2009 Section Highlights. Now in its fifth year, the Section of Inpatient Care Practitioners has grown to more than 9000 members. Through educational programming, networking, advocacy, and volunteer opportunities, the Section Executive Committee has worked to develop member services that support the needs of the frontline pharmacist.

Educational Programming. The Section conducted more than 17 hours of successful educational sessions at the 2008 Midyear Clinical Meeting (MCM). For the third consecutive year, a day of programming for pharmacists working in small and rural hospitals was offered. This programming, dubbed the Sunday Rural Track, commenced with remarks by Paul Moore, President of the National Rural Health Association (NRHA). Topics included the Health Resources and Services Administration's Patient Safety Pharmacy Collaborative (PSPC) and pediatrics and technology safety issues in rural hospitals. Also aimed at these practitioners were two highly attended networking sessions, including one on remote order entry. Other MCM programming of interest to Section members addressed pediatric updates for the non-pediatric specialist, expanded use of antineoplastic agents, medication safety tips for frontline pharmacists, and strategies for anticoagulation safety related to The Joint Commission's (TJC's) National Patient Safety Goal. The Section's Educational Steering Committee (formerly the Programming Committee), chaired by Laura Wachter, met at the 2008 MCM to discuss and select topics for Section programming for the 2009 MCM. The committee members utilized the Section's Need Assessment Survey, electronic discussion group reports, networking session discussions, and conversations with peers to guide them in the topic selections. The new charge for this committee has been expanded to also include content for Summer Meeting programming, Section-relevant Webinars, and publications.

Committee on Nominations. This committee works to develop a slate of candidates to serve as officers to fulfill Section initiatives and began its work in January.

Resources for Inpatient Care Practitioners. The Section's page on the ASHP Web site features information pertinent to the needs of frontline pharmacists. The information includes recent news, practical tools, and member spotlights. All Section members receive a monthly electronic NewsLink containing information of interest to staff pharmacists and notifying members of opportuni-

Executive Committee

Randy L. Kuiper, Chair (Montana)
 Debby Lynn Painter Cowan, Chair-elect (North Carolina)
 Helen M. Calmes, Immediate Past Chair (Louisiana)
 Brian D. Benson (Iowa)
 Jennifer M. Edwards (Montana)
 Richard J. Pacitti, Jr. (Pennsylvania)
 Teresa J. Hudson, Board Liaison (Arkansas)
 Anthea V. Francis, Secretary

ties within the Section and ASHP. The Section electronic discussion group continues to be an effective networking mechanism. A similar discussion group for small and rural hospitals continues to be active and serves as a resource center on the ASHP Web site to provide pertinent information for this component group.

Section Advisory Groups. Section advisory groups (SAGs) advise the Section and ASHP at large on specific issues or areas of practice. There are four such groups within the Section of Inpatient Care Practitioners.

Advisory Group on Small and Rural Hospitals. As mentioned earlier, the SAG on Small and Rural Hospitals maintains an active electronic discussion group and planned a successful educational track and networking sessions for the 2008 MCM. The group is serving as a pilot for ASHP's Webinar-on-demand series. The SAG will continue to provide input on proposed ASHP policies dealing with issues facing small and rural hospitals. The group has suggested that ASHP seek continued collaborative efforts with NRHA and other rural health agencies/offices.

Advisory Group on Publications. The SAG on Publications continues its contribution to the Frontline Pharmacist column in the *American Journal of Health-System Pharmacy (AJHP)* and is working with the Executive Committee to finalize a manuscript summarizing the Section's Quality of Life Survey, which when completed will be submitted to *AJHP* with an accompanying editorial. The SAG has also contributed to the recently relaunched ASHP consumer drug information Web site, SafeMedication.com. At the 2008 MCM, the SAG conducted a networking session that addressed publication tips for frontline pharmacists. A panel of experts that included ASHP staff, SAG members, and a SAG student representative offered advice on overcoming writing fears, handling editorial criticism, and mentoring students through the publication process.

Advisory Group on Medication Safety. This SAG, formed in August 2006, is charged with providing tools and resources for medication safety officers or pharmacists who have medication safety responsibility as a component of their positions. The group has provided educational content for the 2008 MCM, which included the Safety and Quality Pearls Session for the second consecutive year. In response to TJC's April 2008 Pediatric Sentinel Alert, the SAG sponsored a Webinar entitled "Sentinel Alert: Pediatric Medication Errors and The Joint Commission." The speakers, from Johns Hopkins Hospital in Baltimore, were a neonatologist/ informatics professor and a pediatric medication safety officer. The Webinar drew more than 200 participants and is posted on the Section's Web site. Additionally, the group conducted a successful networking session at the 2008 Summer Meeting and two networking sessions at the 2008 MCM.

Advisory Group on Pharmacy Practice Experiences. This SAG was formed to provide tools and resources for preceptors and potential preceptors that foster favorable student experiences as students matriculate through their pharmacy rotations. A tool kit the SAG developed is posted on the Section's Web site. This group presented a poster for the annual American Association of Colleges of Pharmacy meeting in Chicago. The SAG also held a successful networking session at the 2008 MCM and has submitted a proposal for the 2009 MCM.

Advocacy. At the recommendation of the SAG on Small and Rural Hospitals, the Executive Committee suggested that ASHP seek ways to work with external organizations dealing with small and rural hospitals. To that end, ASHP has worked to strengthen its relationship with NRHA, Office of Pharmacy Affairs (OPA), Office of Rural Health Policy, Institute of Healthcare Initiatives (IHI), and Institute of Safe Medication Practices (ISMP). The SAG on Small and Rural Hospitals has used its Sunday Rural Track to give voice to HRSA/OPA's PSPC and IHI's 5 Million Lives Campaign. Partnership with ISMP has been in the form of two ISMP personnel being represented on the SAG. ASHP was a major sponsor for NRHA's first National Conference on Medication Access, Use and Safety in Rural America, which convened in June 2008. For the second conference, in Kansas City, Missouri in September 2009, ASHP has entered a co-sponsorship agreement to provide pharmacist continuing education credits.

Educational Steering Committee

Laura Wachter, Chair (Maryland); Lois F. Parker (Massachusetts); Linda Spooner (Massachusetts); Trish Wegner (Illinois); Angela Turner Cassano (Virginia); Greg Lukaszczyk (Texas); Debra L. Cowan, SRH SAG Liaison (North Carolina); Brian Benson, Executive Committee Liaison (Iowa); Michelle Abalos, ASHP Staff (Maryland)

Advisory Group on Medication Safety

Deb Saine, Chair (Virginia); Paul F. Davern (Connecticut); Lynn Eschenbacher (North Carolina); Nancy Granger (Tennessee); Chris Hartman (Massachusetts); Janice Hoyt (Washington); Joanne Kowiatek (Pennsylvania); Nicole L. Mollenkopf (Maryland); Kathryn Montanya (North Carolina); Victoria Tamis (Washington); Linda Tyler (Utah); Richard Pacitti, Executive Committee Liaison (Pennsylvania)

Advisory Group on Publications

Tammy Cohen, Chair (Texas); Catherine Christen (Michigan); Sandra C. Hennessy (Massachusetts); Bonnie A. Labdi (Texas); Matthew Levanda (New Jersey); Melanie Nicol, Student Representa-

tive (Nova Southeastern University, Florida); Melissa Ortega, Student Representative (Ohio Northern University); Jacqueline L. Olin (North Carolina); Gina Ryan (Georgia); Suzanne Ryan (Georgia); Susan Jean Skledar (Pennsylvania); Janine Stewart (Maryland); Randy Kuiper, Executive Committee Liaison (Montana); Sharon Park, ASHP Staff (Maryland)

Advisory Group on Small and Rural Hospitals

Paul Driver, Chair (Idaho); Emily Alexander (Texas); Jessica Bannon, Student Representative (University of Houston, Texas); Debra L. Cowan, SRH SAG/Programming Liaison (North Carolina); Matthew P. Fricker, ISMP Liaison (Pennsylvania); Todd Lemke (Minnesota); Paul K. Moore, NRHA Liaison (Oklahoma); Ann Marie B. Prazak, Student Representative (University of Colorado Health Sciences Center); Timothy P. Stratton (Minnesota); Allen J. Vaida, ISMP Liaison (Pennsylvania); Helen M. Calmes, Executive Committee Liaison (Louisiana)

Advisory Group on Pharmacy Practice Experiences

Debbie Sisson, Chair (Minnesota); Michele Biggs (Texas); Delia Charest, Student Representative (Samford University, Alabama); Dale E. English II (Ohio); Beth D. Ferguson (Minnesota); T. Kristopher Harrell (Mississippi); Emily Knapp, Student Representative (University of Maryland); Sevan Kolejian, New Practitioner (Maryland); Pamela Leal (Texas); Gerald S. Meyer (Pennsylvania)

Committee on Nominations

Dale English, Chair (Ohio); Helen Calmes, Vice-Chair (Louisiana); Megan McMurray, Immediate Past Chair (Illinois); Ronald Barnes (Georgia); Shahira Ghobrial (Maryland)

Networking Session Facilitators

Tammy Cohen (Texas); Debra Cowan (North Carolina); Lynn Eschenbacher (North Carolina); Janice Hoyt (Washington); Joanne Kowiatek (Pennsylvania); Paul Moore (Oklahoma); Deb Saine (Virginia); Debbie Sission (Minnesota); Tim Stratton (Minnesota); Bruce Thompson (Minnesota)

ASHP Section of Pharmacy Informatics and Technology

The mission of the Section of Pharmacy Informatics and Technology (SOPIT) is to improve health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. In that role, the Section continually seeks to define and promote the optimal synergy between technology and the pharmacy professional in an effort to enhance and support practice models that bring the full benefit of the pharmacist's training and experience to the medication-use process. The Section is dedicated to achieving a vision in which members will (1) be enabled by technology to focus on providing optimal pharmaceutical care to each patient, (2) participate in all aspects of medical informatics that support the medication-use process through multidisciplinary collaboration across the entire health care system, (3) collaborate domestically and internationally with other organizations and governmental agencies to promote the use of medical informatics in the provision of quality health care, (4) take a leadership role in medical informatics, at all levels of health care, to ensure that health information technology (IT) supports safe medication use, (5) promote the development of a set of practical medical informatics competencies to manage medication-related data and information challenges across the continuum of care, and (6) stimulate an environment that focuses on setting the agenda for designing and conducting research to expand medical informatics knowledge and its use in supporting patient care. The Section is dedicated to improving health outcomes through the use and integration of data, information, knowledge, technology, and automation in the medication-use process. This Section is excited to carry its mission forward in an area that is quickly changing the face of health care.

2008–2009 Section Highlights. During 2008, the Section added more than 3100 members. About 19% of the Section's members have selected this group as their primary membership group. In the 2008 elections, the Section's membership elected Dr. Hardy as Chair-elect. Ms. Bobb was elected as a Director-at-Large; both will be installed at the June 2009 ASHP Summer Meeting.

The Section also selected Kevin Marvin as the winner of the Section of Pharmacy Informatics and Technology Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of the Section whose volunteer activities have supported the mission of their Section and helped advance the profession. The award was presented at the 2008 Midyear Clinical Meeting (MCM).

Mr. Siska was appointed as the Section representative to the advisory committee that is charged with helping to plan the ASHP/ASHP Foundation Practice Model Summit. The Section Executive Committee has also developed a commentary on technology-enabled practice for publication in 2009.

Educational Programming. The Section's programming for the 2008 MCM consisted of over 14 hours of continuing education. Topics that were presented included bar-code medication administration (BCMA), lessons learned from the Veterans Administration, clinical decision support, intelligent infusion devices, role of the pharmacist in computerized provider order entry (CPOE), and IT collaboration. Beth Fields of the Section's Programming Committee coordinated the Informatics Bytes: Pearls Session. Michael Schlesselman was the Chair of the Section's 2007–2008 Programming Committee.

Planning for the 2009 MCM is currently in progress. The Programming Committee is developing programming on the following topics: BCMA and CPOE deployment in unique patient care settings, complex order sets and protocol management, informatics education in the Pharm.D. curriculum, informatics research, managing vendor relations, switching vendors, and technology solutions in the emergency department. Maritza Lew of the Section's Program-

Executive Committee

Dennis A. Tribble, Chair (Florida)
 J. Chad Hardy, Chair-elect (Texas)
 Mark H. Siska, Immediate Past Chair (Minnesota)
 Anne M. Bobb (Illinois)
 Brent I. Fox (Alabama)
 John C. Poikonen (Massachusetts)
 Stanley S. Kent, Board Liaison (Illinois)
 Karl F. Gumpfer, Secretary

ming Committee will coordinate the Informatics Bytes: Pearls Session. Michael Schlesselman is the Chair of the Section's 2008–2009 Programming Committee.

Dr. Fox, working with ASHP Educational Services Division, planned an informatics series at the 2008 Summer Meeting. An informatics session was scheduled during all six of the meeting's educational opportunities. Topics that were presented included the Section's IT survey, robotic IV automation, CPOE implementation, managing clinical decision support, bar coding, and formulary management.

Dr. Fox and Dr. Fortier planned an Informatics Series for the 2009 Summer Meeting, whose topics include: quality improvement through CPOE, implementation of new technology, telepharmacy, medication reconciliation and electronic prescribing, closed-loop medication management systems, and clinical surveillance systems.

The Section also planned and implemented four networking sessions at the 2008 MCM. The networking sessions were on bar-coding, CPOE, and pharmacy informatics residencies, with one general session that engaged members to discuss a vision of the technology-enabled pharmacy practice model of the future. A networking session is planned for the 2009 Summer Meeting.

Electronic Networking Opportunities. The Section's electronic NewsLink is distributed monthly to more than 3000 ASHP members. The NewsLink provides current issues relating to informatics and technology, research, legislative and regulatory facts, and health policy and health care news. The Section's electronic discussion group, which includes 2300 participants, provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy informatics and technology. The participant list is also used to communicate urgent information from the Centers for Medicare & Medicaid Services, the Food and Drug Administration, and The Joint Commission that may have an impact on the Section's membership.

Advisory Group on Clinical Information Systems. Activities of the Section Advisory Group (SAG) on Clinical Information Systems included the development of CPOE guidelines and resources on the electronic medication reconciliation process and clinical decision support systems (CDSS). Draft guidelines on planning for and implementing CPOE are being developed by the SAG and should be completed in 2009. The SAG will be developing member resources on CDSS involving allergy processing and drug interactions and investigating areas of collaboration with existing ASHP committees and external groups.

Advisory Group on Automation and Documentation. Activities of the SAG on Automation and Documentation include management of the medication supply chain process, preparation of medications and dispensing of medications with robotics, medication administration with bar-code medication technologies and smart pumps, formulary management with multiple applications within multiple hospital settings, and clinical documentation. The SAG is currently revising the ASHP Guidelines on Safe Use of Automated Medication Storage and Distribution Devices and developing guidelines for the appropriate labeling and repackaging of unit-dose medications. The Executive Committee and the SAG are developing a statement on bar-code-assisted dispensing

as a result of a recommendation from the Council on Pharmacy Management.

Advisory Group on Ambulatory Care Informatics. The SAG on Ambulatory Care Informatics was formed by the Section's Executive Committee in June 2008. The activities of this SAG include electronic prescribing, documentation of medication therapy management, and radio frequency identification integration/epedigree compliance. The Executive Committee will further define the SAG's charge as the group meets more regularly and defines the scope of its work.

Advisory Group on Pharmacy Informatics Education. The Section's Executive Committee approved changing the Task Force on Education and Publications to the SAG on Pharmacy Informatics Education to better meet the needs of the Section's members. There are many issues related to education of practitioners, residents, and students that this new SAG will address. This SAG will work with the Section's Programming Committee on educational offerings at the Summer Meeting and MCM. The SAG will work with the other groups and committees of the Section to develop Webinars and continue to be responsible for updating the Section's Web site and resource areas. The SAG has been busy with the following activities: updating and maintaining the Section's Web site and resource centers; supporting the development of informatics residency programs and other educational opportunities for pharmacists, students, technicians, and vendors; and establishing a column in the *American Journal of Health-System Pharmacy (AJHP)*. The column was launched in June 2008, and *AJHP* staff has had success in receiving manuscripts for publication. The Informatics Interchange column was changed from an every-other-month publication to a monthly publication starting January 2009. The SAG was also involved in updating and providing new content for the Section's Web site. This task was accomplished in November 2008. The SAG was responsible for planning the November 2008 Webinar on Innovations in Chemotherapy Preparation Safety: Telepharmacy and Barcode.

Task Force on Standards and Regulations. The Section Task Force on Standards and Regulations has been productive, making comments to governmental agencies over the past year on topics involving health IT. The task force is charged with the following: (1) establishing a process to make comments to aid ASHP staff on upcoming governmental regulations and other standards groups, (2) providing examples of best practices for members to meet regulations and standards, and (3) working with standards organizations to develop standards that affect the medication-use process. The task force has made recommendations to ASHP for comments on the Certification Commission for Healthcare Information Technology's draft criteria for inpatient electronic health records and ambulatory care health records. The task force has also made recommendations to ASHP staff on e-prescribing to the Centers for Medicare & Medicaid Services and to the Drug Enforcement Agency on the use of e-prescribing for controlled substances.

ASHP Survey of Pharmacy Informatics, Technology, and Automation in Health Systems. Findings of the IT National Survey were published in the December 1, 2008 issue of *AJHP*. Hospitals appear to be moving toward an enterprise approach to IT adoption and away from a best-of-breed approach. Although nearly half of hospitals have components of an electronic medical record (EMR), a complete digital hospital with a fully implemented EMR is far in the future, with only 5.9% of hospitals being fully digital (without paper records). An estimated 12% of hospitals use CPOE systems with decision support, 24.1% use BCMA, and 44% use intelligent infusion devices (smart pumps). The Section is determining the feasibility of repeating the survey in 2009.

Committee on Nominations

Kevin C. Marvin, Chair (Vermont); Denny C. Briley (Illinois); Kevin A. Scheckelhoff (Ohio); Scott R. McCreadie (Michigan); Mark H. Siska (Minnesota)

Programming Committee

Michael D. Schlesselman, Chair (Connecticut); Robert Christiansen, Vice-Chair (Pennsylvania); Maryam Behta (New York); Alan Chung (Virginia); Elizabeth A. Fields (Tennessee); Maritza Lew (California); John Manzo (New York); Dallas Moore (Utah); Ian Orensky (Virginia); Lynn C. Sanders (District of Columbia); Armen I. Simonian (California); Lolita G. White (Maryland)

Advisory Group on Clinical Information Systems

Tommy J. Mannino, Chair (Louisiana); Denis J. (Jeff) Ramirez, Vice-Chair (Virginia); Matthew D. Balla (Indiana); Anne M. Bobb (Illinois); Jennifer Boehne (Minnesota); Denny C. Briley (Illinois); James D. Carpenter (Oregon); Charles R. Downs (Maryland); W. Lynn Ethridge (South Carolina); Randy Herring (Alabama); John R. Horn (Washington); Bonnie Levin (District of Columbia); Rane M. Runnebaum (Missouri); Andrew C. Seger (Massachusetts); Sylvia Thomley (Wisconsin); David L. Troiano (Texas); Kevin B. Waite (Kansas); Lori Wright (Tennessee); Jayson J. Przybyła, New Practitioner Member (Virginia); Jason Kinyon, Student Member (Maryland); J. Chad Hardy, Executive Committee Liaison (Texas)

Advisory Group on Automation and Documentation

Christopher J. Urbanski, Chair (Indiana); Arash T. Dabestani, Vice-Chair (California); James L. Besier (Ohio); Leslie H. Brookins (Missouri); Ron Burnette (Florida); Thomas W. Cooley (Massachusetts); Charles De la Torre (Florida); Kimberly Dove (California); Craig P. Frost (Texas); Rick K. Glabach (Maryland); Gary L. Johnson, Jr. (Washington); Brad Rognrud (Minnesota); Paul M. Seelinger (California); Gwen R. Volpe (Illinois); Ray Vrabel (California); Denise H. Mckenzie, Technician Member (Missouri); Matthew Marshall, New Practitioner Member (Tennessee); Marvin H. Choi, Student Member (Maryland); Dennis A. Tribble, Executive Committee Liaison (Florida)

Advisory Group on Ambulatory Care Informatics

Marc T. Young, Chair (Maryland); Jennifer Boehne (Minnesota); Tim R. Brown (Ohio); Janet Crawford (Missouri); Doina Dumitru (Texas); Sharon L. Ellison (North Carolina); Barbara Lane Giacomelli (New Jersey); Sarah Glamm (Wisconsin); Anne Johnston (Florida); Kevin C. Marvin (Vermont); Teresa (Teri) Ann Miller (California); Sandra Mitchell (Maryland); Kirby K. Stiening (Virginia); Ronald Schneider (Maryland); Abraham Gilbert, Technician Member (Georgia); Co Lai, New Practitioner Member (Florida); Ed Chin, Student Member (Ohio); John C. Poikonen, Executive Committee Liaison (Massachusetts)

Advisory Group on Pharmacy Informatics Education

Helen L. Figge, Chair (New York); Kevin Clauson, Vice-Chair (Florida); Louis D. Barone (Ohio); Carol Hope (Utah); Patrice S. Johnson (District of Columbia); Douglas B. Kent (Pennsylvania); Ingrid K. Lewis (Colorado); Terry L. Seaton (Missouri); David A. Tjhio (Illinois); Ross Edward Vanderbush (Arkansas); Mai-Chi Tran, Student Member (Pennsylvania); Brent I. Fox, Executive Committee Liaison (Alabama)

Task Force on Standards and Regulations

Michael E. McGregory, Chair (Michigan); Michael A. Jones, Vice-Chair (Colorado); Brian W. Dennis (Michigan); Susan M. Gugliotta (New Jersey); Joan E. Kapusnik-Uner (California); Timothy W. Lynch (Washington); Edward D. Millikan (Maryland); Alan M. Portnoy (Pennsylvania); James A. Russell (Wisconsin); Suzanne B. Shea (Texas); Douglas R. Smith (Texas); Mark H. Siska, Executive Committee Liaison (Minnesota)

ASHP Section of Pharmacy Practice Managers

The mission of the Section of Pharmacy Practice Managers is to help members manage pharmacy resources, maximize the safety of medication-use systems, develop future leaders, and promote the pharmacist's role in patient care. The Section Executive Committee has developed a strategic plan linked to the mission and goals of the Section. These goals are (1) maximizing communications and interactions with and among Section members, (2) fostering education, training, and development opportunities for managers and leaders, (3) recommending professional policy and advocacy on issues of importance to Section members, (4) supporting members in developing and managing staff and in the advancement of pharmacy practice, and (5) helping members improve adherence to ASHP practice standards and other best practices. The ASHP Section of Pharmacy Practice Managers represents ASHP's continued commitment to meeting the needs of pharmacists who lead and manage departments of pharmacy. The Section provides pharmacy directors and managers with a sense of identity within ASHP and an organizational home dedicated to meeting their special needs.

2008–2009 Section Highlights. The Section has 7721 members, with approximately 45% of the Section's members having selected the Section as their primary membership group. Section members elected Ms. Pawlicki as Chair and Ms. Killingsworth as a Director-at-Large; both will be installed at the June 2009 ASHP Summer Meeting.

Distinguished Service Awards. The Section recognized Paul Bush as the winner of the Section of Pharmacy Practice Managers Distinguished Service Award. Established in 2007, the ASHP Pharmacy Practice Sections Distinguished Service Award recognizes a member of each section whose volunteer activities have supported the Section's mission and helped advance the profession. The award was presented at the 2008 Midyear Clinical Meeting (MCM).

Conference for Leaders in Health-System Pharmacy. The Section, in collaboration with ASHP Advantage, planned and implemented another successful leadership conference. This event, which attracted approximately 400 participants, included key programs in areas such as increasing the leadership impact of pharmacists in quality initiatives, innovative staffing models, improving quality in health systems, and the future of pharmacy practice and evolving models. In addition, a pre-conference Managers' Boot Camp was introduced focusing on leadership and leveraging the national quality agenda for the expansion of pharmacy services. As part of the conference proceedings the John W. Webb Lecture Award was presented to Thomas Thielke.

Educational and Networking Opportunities. Under the leadership of Lance Swearingen, the 2007–2008 Programming Committee designed educational sessions for pharmacy managers and directors that were presented at the 2008 MCM. The topics included advancing technician careers, making the transition from clinician to manager, tools for upselling pharmacy services, and management pearls. All of these sessions were recorded and synchronized with the presentation slides so that they can be made available to members. For the 2009 MCM, the committee is planning sessions on human resource management, hazardous waste management, inpatient and outpatient prospective payment system rules and regulations, retention strategies, and the national quality agenda. The Section also planned and implemented networking sessions at the 2008 MCM on leadership with the C-suite, administrative residences, impact on managing the pharmacy enterprise and electronic health records, patient assistance programs, and the 340B program.

The Section continues to distribute a monthly electronic NewsLink that serves over 7000 ASHP members. The NewsLink

Executive Committee

James R. Rinehart, Chair (Nebraska)
 Kathleen S. Pawlicki, Chair-elect (Michigan)
 Steve S. Rough, Immediate Past Chair (Wisconsin)
 Scott J. Knoer (Minnesota)
 Paul J. Mosko (Ohio)
 Patricia J. Killingsworth (Idaho)
 James G. Stevenson, Board Liaison (Michigan)
 David Chen, Secretary

provides management paradigms, business information, relevant research, legislative updates, regulatory alerts, and health policy/health care news. The Section also continues to facilitate an electronic discussion group with approximately 1500 participants. The electronic discussion group provides a forum for Section members to exchange information and ideas on a wide variety of topics related to pharmacy management and leadership. The participant list is also used to communicate urgent information from the Centers for Medicare & Medicaid Services, the Food and Drug Administration, and The Joint Commission.

Advisory Group Reorganization. The Section reorganized its section advisory groups (SAGs) in 2008 around the following five areas: Pharmacy Business Management, Management Development, Quality and Compliance, Leadership Development, and Communication and Publications. The SAGs were successful in initiating and completing a number of projects to support the Section's members. Publications that were completed during 2008 included three Management Consultation columns for the *American Journal of Health-System Pharmacy* on leadership, self assessment, and charge master management. The completion of a comprehensive paper on workload and productivity was finalized for publication in 2009. The Section also coordinated a Webinar on the use of technicians in accomplishing medication reconciliation goals.

A significant accomplishment of the Section was the introduction of the Student Leadership Development Workshop. This workshop is a three-hour program to introduce students to leadership opportunities and network with other students interested in leadership. The program was piloted in four states in conjunction with state affiliate meetings and at one college of pharmacy. It will also be integrated into the ASHP 2009 Summer Meeting student education track. It is expected that four more states will utilize the workshop during 2009, and the Section is working with the ASHP Foundation to provide further opportunities for state affiliates to implement the program.

The SAGs are also engaged with the Center for Health-System Pharmacy Leadership on activities related to student leadership development, the Center's advisory committee, and the expansion of the Student Leadership Development Workshop. The Section's Coaches Corner was continued in 2008 with career tips for practitioners. These tips were authored by successful Section members, disseminated on the Section's and the New Practitioners Newslink services, and posted on the Section's Web page. Additional projects in process include the development of a continuing professional development curriculum for managers that is a compilation of key domains of skills required for pharmacy managers cross-walked to key readings in selected ASHP publications. This resource will be ideal for leaders who would like educational materials for staff development and succession planning. The SAGs were also instrumental in organizing networking sessions during the 2008 MCM.

Committee on Nominations

Steve S. Rough, Chair (Wisconsin); Paul W. Bush (South Carolina); David A. Kvacz (Ohio); Scott Mark (Pennsylvania); Andrew L. Wilson (Virginia); David Chen, ASHP Staff

Programming Committee

Rafael Saenz, Chair (Pennsylvania); John Pastor (Minnesota); Lance Swearingen, Immediate Past Chair (Minnesota); Lynn Belcher (Oregon); Michael Benedict (Colorado); Stephen F. Eckel (North Carolina); Ryan Forrey (Ohio); Staci Hermann (Wisconsin); Thomas E. Kirschling (Pennsylvania); Kathleen S. Pawlicki, Executive Committee Liaison (Michigan)

Advisory Group on Pharmacy Business Management

Heather Kokko, Chair (South Carolina); Dave A. Ehlert, Vice-Chair (Minnesota); Anne T. Jarrett (North Carolina); Tammy Cohen (Texas); Karl H. Kappeler (Ohio); Laura Mark (Pennsylvania); Fred J. Payne (North Carolina); Jack Temple (North Carolina); Adam Nicholas Bauman (Florida); Howard S. Glazier (California); Paul Krogh (Minnesota); Shane Madsen (Minnesota); Chad Stashek (Oregon); Michael R. McDaniel (Alabama); Charles Cooper (Minnesota); Kathleen Moorman (Florida); Kathleen S. Pawlicki, Executive Committee Liaison (Michigan)

Advisory Group on Leadership Development

Tad Gomez, Chair (Georgia); Cyndy Clegg, Vice-Chair (Washington); Christopher Fortier, Immediate Past Chair (South Carolina); Phil W. Brummond (Minnesota); Jennifer Cimoch (Ohio); Lisa Gersema (Minnesota); Samaneh T. Wilkinson (Kansas); Karol Woltenburg (New York); Carol Woodward (West Virginia); Nannette M. Berensen (Utah); Joe Vargas (Illinois); Edward Nold (Florida); J. Sue Arnold (Oklahoma); Steve S. Rough, Executive Committee Liaison (Wisconsin)

Advisory Group on Manager Development

John E. Clark, Chair (Florida); Jennifer Tryon, Vice-Chair (Oregon); Burnis D. Breland (Georgia); Amanda Hafford (Ohio); Lindsey R. Kelley (Pennsylvania); Ross Thompson (Massachusetts); John Worden (Kansas); Michael C. Nnadi (North Carolina); Garret Newkirk (Wisconsin); Jamie S. Sinclair (Minnesota); Adam Dean Orsborn (North Carolina); Jennifer Austin (Florida); Jason A. Christensen (Wisconsin); Ronda K. Lehman (Ohio); Rick Couldry (Kansas); Robert P. Granko (North Carolina); Scott Knoer, Executive Committee Liaison (Minnesota)

Advisory Group on Quality and Compliance

Christene Jolowsky, Chair (Minnesota); Greg Polk, Vice-Chair (Michigan); Fred Massoomi (Nebraska); Bonnie E. Kirschenbaum (Colorado); Janinah Barreto-Hernandez (Ohio); Mark Thomas (Texas); Jennifer Burges (North Carolina); Kate Schaafsma (Wisconsin); Teri Wooton (North Carolina); Kevin B. Waite (Kansas); Vincent A. Lacroce (Pennsylvania); Jenny Jastrzembski (Tennessee); Carol Birk (Indiana); Brian M. Cotter (Maryland); Christian Aaron Hartman (Massachusetts); Katie McMillen (Pennsylvania); Patricia Killingsworth, Executive Committee Liaison (Colorado)

Advisory Group on Communications and Publications

Michael D. Sanborn, Chair (Texas); John S. Clark, Vice-Chair (Michigan); Scott M. Mark, Immediate Past Chair (Pennsylvania); Erin C. Hendrick (Colorado); Michael McGregory (Michigan); Sylvia M. Thomley (Wisconsin); Michael Todaro (Mississippi); Steven H. Dzierba (Texas); James E. Smeeding (Texas); Audrey Nakamura (California); Matthew Eberts (Pennsylvania); Barbara T. Irby (Massachusetts); Trinh Le (District of Columbia); Paul J. Mosko, Executive Committee Liaison (Ohio)

ASHP New Practitioners Forum

The New Practitioners Forum is led by a five-member Executive Committee appointed each year by the ASHP President-elect and approved by the Board of Directors. The Executive Committee is responsible for advising the Board and ASHP staff on the overall direction of the Forum, including member services, programs, and resources. The Executive Committee Chair participates in ASHP's strategic planning process and serves as a voting new practitioner member in the ASHP House of Delegates. Each Executive Committee member serves as a liaison to one of the Forum's five advisory groups.

Strategic Goals and Objectives. The Executive Committee established five strategic goals, with accompanying objectives, to direct the Forum's operations:

1. **Serve the unique and evolving educational and informational needs of new practitioner members.** Objectives: (1) Conduct continual assessment and analysis of evolving professional needs and the effectiveness of Forum programs to meet these needs. (2) Provide programs and publications that meet the educational and informational needs of Forum members.
2. **Cultivate professionalism in new practitioners.** Objectives: (1) Expand collaboration between Forum members and others in ASHP, including section and Pharmacy Student Forum members. (2) Provide career development tools for new practitioners. (3) Promote initiatives and accomplishments of new practitioner members. (4) Encourage new practitioner involvement on the state affiliate level.
3. **Foster leadership skills in members of the New Practitioners Forum.** Objectives: (1) Promote leadership opportunities for New Practitioners Forum members within the Forum and ASHP. (2) Provide programs and resources that promote leadership skill development.
4. **Promote membership and active involvement in the ASHP New Practitioners Forum.** Objectives: (1) Recruit, retain and promote active involvement in the Forum. (2) Enhance visibility and awareness of Forum membership benefits.
5. **Cultivate awareness and engagement of new practitioners in practice advancement initiatives and advocacy.** Objectives: (1) Create awareness and support involvement of new practitioners in legislative and professional advocacy. (2) Promote involvement in public relations initiatives. (3) Foster awareness and engagement in professional teamwork and collaborative approaches to practice.

2008–2009 Forum Highlights. Landmark achievements consistent with these goals and objectives in 2008–2009 included hosting the third Great eXpectations conference for new practitioners, awarding the second New Practitioners Forum Distinguished Service award, offering a series of Webinars addressing new practitioners' unique career development needs, launching ASHP Connect, and enhancing the New Practitioners Forum Web page with a redesigned image and enhanced content. These activities demonstrate the commitment of ASHP and the Forum to meeting the unique needs of over 4000 new practitioner members. The continual creation and provision of career development tools, leadership opportunities, practice resources, and the identification of opportunities for collaboration with the ASHP practice sections also show support for this membership group. By meeting new practitioner needs, ASHP hopes to foster professional development in new practitioners that extends into greater involvement in ASHP and state and local health-system pharmacy organizations.

Distinguished Service Award. The Forum selected Christopher Fortier as the winner of the New Practitioners Forum Distinguished Service Award. Established in 2007, the ASHP New Practitioners Forum Distinguished Service Award recognizes a member of the Forum whose volunteer activities have supported

Executive Committee

Lindsey R. Kelley, Chair (Pennsylvania)
 Michael A. DeCoske, Vice-Chair (South Carolina)
 Teresa M. Cavanaugh (Kentucky)
 Ashley M. Garrett (Kansas)
 Elaine M. Ladd (Idaho)
 John A. Armitstead, Board Liaison (Kentucky)
 Jill L. Haug, Secretary

the Forum's mission and helped advance the profession. The award was presented at the 2008 Midyear Clinical Meeting (MCM).

Advisory Group Reorganization. The Chair of the New Practitioners Forum Executive Committee appoints Forum members to advisory groups in June each year, placing 60 new practitioners in leadership positions. The advisory groups are charged with providing feedback, guidance, and assistance in achieving the Forum's strategic goals. This year, the Executive Committee re-engineered the structure of the groups by appointing a returning advisory group member to the chair position and Executive Committee members to liaison roles in each advisory group.

Advisory Group on Membership and Outreach. This group is charged with advancing the objectives set forth in strategic goal 4. This year the group concentrated on identifying new potential member audiences and increasing the awareness of membership benefits that can assist new practitioners with their career development and daily practice needs through targeted communication strategies.

Advisory Group on Communications and Public Affairs. This group is charged with advancing the objectives set forth in goal 5. Priorities this year included increasing new practitioner involvement in ASHP grassroots advocacy efforts through collaboration with the ASHP Government Affairs Division and working with the ASHP Public Relations Division to promote ASHP initiatives.

Advisory Group on Leadership and Career Development. This group is charged with advancing the objectives set forth in goals 2 and 3. Its priorities in the past year included identification of topics addressing career and leadership development for the Forum's Webinar series, exploring collaborative opportunities with the ASHP Research and Education Foundation's Center for Health-System Pharmacy Leadership, and creating a series of succinct articles focusing on leadership and career development issues for the Forum's Web page.

Advisory Group on Professional Practice. This group is charged with advancing the objectives set forth in goal 1, specific to professional practice issues. Its priorities this year have been identifying Web content pertinent to new practitioners' practice needs and highlighting new practitioners who have demonstrated practice success.

Advisory Group on Science and Research. This group is charged with advancing the objectives set forth in goal 1, specific to science and research issues. Priorities this year included identifying science and research topics for Web site enhancement, including the development of specific resources to assist new practitioners in research endeavors. The advisory group is exploring opportunities to collaborate with the ASHP Research and Education Foundation.

Meetings and Programming. The third conference specifically for new practitioners, Great eXpectations, was held August 22–24 in New York City and was enormously successful. High-tech, interactive, fresh, and fun, the conference allowed new practitioners to learn, network, and move forward in their careers. It offered

skill-building sessions in three learning tracks: Fine Tuning Your Clinical Skills, Mentoring and Leadership, and Advancing Your Career. Attendees also had many opportunities to mix and mingle with fellow new practitioners from across the country.

The 2008 MCM offered a variety of programs and opportunities for new practitioners. New practitioners participated in the residency showcase and CareerPharm's Personnel Placement Service (PPS). For the third consecutive year, a one-day educational track for new practitioners was offered. The highly attended sessions, planned in cooperation with the Forum, included: "Making the Transition from Clinician to Manager," "Developing a Rigorous Medication-Use Evaluation Program: Applying the Principles of Descriptive Research," and "Achieving Excellence in Your Clinical Practice." A reception just for new practitioners was held immediately following the programming. The New Practitioner Lounge was available throughout the meeting, giving new practitioners a place to meet with peers in an informal setting. The Forum's Executive Committee and advisory group members were in the Lounge throughout the week, providing members an opportunity to talk with these leaders about the Forum. Executive Committee and advisory group members also represented the Forum in the ASHP Experience Membership booth and in PPS.

The Forum hosted several live Webinars throughout the year, including: "New Practitioner Leadership: The Challenges and the Triumphs," "Going the Distance: Pointers on Preparing for the BCPS Exam," "Preceptors: Making Music with our Students," and "The Amazing Race: Successfully Navigating the Midyear as a New Practitioner." The Forum recognizes that practitioners early in their careers cannot always attend national meetings, and these Webinar programs allow new practitioner members to take advantage of ASHP educational programs from a distance.

Communications. In February, the Forum launched its own electronic discussion group with the new ASHP Connect electronic communication tool. This technology allows new practitioner members the ability to self-select discussion areas of interest. The Forum created the following seven group discussion areas: Post-graduate Year 1 (PGY1), Postgraduate Year 2 (PGY2), Fellows and Other Post-Graduates, Science and Research, Professional Practice, Career Development, and Open Discussion. ASHP Connect provides members the convenience of only participating in discussions of interest and will assist in reducing the volume of e-mails members receive from ASHP.

The Forum's existing listserver continues to be used by new practitioners posting inquiries and responses on clinical practice issues and career development topics directly from their e-mail boxes. In addition, twice a month all members of the Forum receive the ASHP New Practitioners Forum NewsLink, which provides information relevant to recent graduates, communicates deadlines, and helps recruit members for greater involvement in the Forum. The NewsLink has enabled the Forum to recruit new practitioner authors, advisory group members, and volunteers for various outreach efforts and to identify new practitioners to highlight on the Web page.

The Forum has its own area on the ASHP Web site where new practitioners can find information pertinent to their needs, such as updates on Forum activities, career development resources, leadership opportunities, and a personal message from the Forum Executive Committee. Efforts have focused on making the site a clearinghouse for career development, clinical, precepting, and administrative and management resources to meet new practitioners' varying informational needs. This section of the Web site also highlights each member of the Executive Committee and allows Forum members to communicate directly with these leaders.

New Practitioners Forum Column. Members of the Forum are contributing authors to the New Practitioners Forum column in the *American Journal of Health-System Pharmacy*. The topics, pertinent to the needs of practitioners just starting their careers, have included a variety of career and professional development topics, such as residency training, legislative advocacy, and developing clinical practices. The column offers new graduates the chance to

learn about writing for a professional journal and increases their awareness of opportunities for new practitioners in ASHP.

Outreach. Forum members desire to mentor students and share experiences with peers. To this end, Forum leaders participated in various student outreach initiatives throughout the year to promote ASHP membership, provide information on pursuing residencies, promote the value of involvement in professional organizations, and explain how to become more engaged in professional endeavors on the local, state, and national level. Forum leaders also represented the Forum at each of the six regional residency conferences during the Spring, promoting the Forum and encouraging peers to become involved in the many opportunities ASHP offers exclusively for new practitioners.

Section Collaboration. Forum members share common professional and career development needs, but their varied practice needs are addressed through involvement in the ASHP pharmacy practice sections. Many new practitioners hold positions on section committees and advisory groups.

Mentor Exchange. This program provides the opportunity for new practitioners to seek guidance and professional development advice from more experienced practitioners. Use of this members-only benefit from ASHP continues to grow, with several hundred mentors and mentees participating.

Membership Video. The Forum developed and continues to distribute a membership video, *Get Connected!*, that demonstrates the numerous ways one can get involved with ASHP, depending on one's interests. The video is available on the Forum's Web page, is shown at numerous events, and is distributed through multiple channels throughout the year.

ASHP Resident Visit Program. For many years ASHP has invited residents in accredited programs to visit ASHP headquarters. These all-day visits give residents an inside glimpse of ASHP operations and an opportunity to learn about the many ways to get involved in ASHP and the resources available to them as new practitioner members. Multiple visits are held each year, with more than 100 residents participating. ASHP has redesigned this program in recent years. Now, participants not only learn but actively participate and provide feedback to ASHP on issues of importance.

Advisory Group on Membership and Outreach

Rebecca Nick-Dart, Chair (Pennsylvania); Ashley Garrett (Kansas); Benjamin Anderson (Pennsylvania); Andy Laegeler (Texas); Ashley Dalton (California); Ashley Tyler (South Carolina); Daisy Dai (Wisconsin); Brandon Trollinger (Maryland); Veronica Moore (Ohio); Lakesha Butler (Illinois); David Jarnot (Washington); Danielle Patrick (Ohio)

Advisory Group on Communications and Public Affairs

Sarah Elliott, Chair (Washington); Michael DeCoske (South Carolina); Sarah Bush (South Carolina); Nicole Cerussi (Pennsylvania); Christine Corsberg (Tennessee); Davina Dell-Steinbeck (Missouri); Lindsay Garris (District of Columbia); Jack Iskander (Wisconsin); Annalise Jenson (Maryland); Jeff Little (Pennsylvania); April Puhl (Virginia); Morgan Roberts (Maryland)

Advisory Group on Leadership and Career Development

Joel Marrs, Chair (Oregon); Elaine Ladd (Idaho); Leslie Hamilton (Tennessee); Kavish Choudhary (Oregon); Amy Hyduk (Indiana); Raenna Nerpel (New Jersey); Justin Konkol (Oregon); Brandon Ordway (Wisconsin); Majid Tanas (Washington); Mahsa Sharifi (Florida); Abbie Williamson (North Carolina); Helen Marshall (Washington)

Advisory Group on Professional Practice

Scott Bergman, Chair (Illinois); Lindsey Kelley (Pennsylvania); Allison King (Missouri); Angelina Sagarsee (Indiana); Joshua Howell (Texas); Meredith Toma (Oklahoma); Julie King (Virginia); Joseph LaRochelle (Maryland); John Hertig (Ohio); Mark Triboletti (Illinois); Melissa Meekins (Ohio); Stephanie Thune (Arizona)

Advisory Group on Science and Research

Sacha Pollard, Chair (Michigan); Teresa M. Cavanaugh (Kentucky); Kimberly Day (Missouri); Amy Dill (Ohio); Amy Kendrick (North Carolina); Olga Hilas (New York); Marantha Short (Kentucky); Ali McBride (Florida); Rima A. Mohammad (New York); Erin Bedard (Tennessee); Jillene Beuke (Minnesota); Manouchkathe Cassagnol (New York); Anne Sutherland (New York)

ASHP Pharmacy Student Forum

The mission of the Pharmacy Student Forum is to prepare the next generation of health-system pharmacists to be leaders in their schools and communities to advance the future of the pharmacy profession. Leading the charge are five student members of the ASHP Pharmacy Student Forum Executive Committee who were appointed by the ASHP President in 2008. The Executive Committee is responsible for advising the ASHP Board of Directors and staff on the overall direction of the Forum, including member benefits and services. The Chair of the Executive Committee serves as the voting student representative to the ASHP House of Delegates. Each Executive Committee member serves as chair of one of the five Forum advisory groups: Membership, Meetings and Programming, Student Society and Leadership Development, Policy and Legislative Affairs, and Communications. The Executive Committee also assists in building relationships between ASHP and the 106 U.S. colleges of pharmacy by serving as regional liaisons, providing information to student society leaders, and helping to strengthen the Student Society of Health-System Pharmacy (SSHP) activities and programs on each campus.

Strategic Goals. The 2008–2009 Executive Committee established a strategic plan with three core goals to direct the Forum's operations: (1) to provide pharmacy students with access to resources that foster the development of a comprehensive understanding of health-system pharmacy to ensure confident and prepared career decisions upon graduation, (2) to establish ASHP as a key resource to provide professional and leadership development for students at all levels of pharmacy education who are considering a career in health-system pharmacy, and (3) to cultivate a community of actively engaged and involved students who value and maintain life-long ASHP membership.

2008–2009 Forum Highlights. This year was successful for the Pharmacy Student Forum, marked by continued growth in membership and student involvement and the expansion of a program to strengthen the relationship between ASHP, state affiliates, and SSHPs across the nation. The ASHP Pharmacy Student Forum continually strives to meet the needs and exceed expectations of student members. This goal was accomplished through increasing awareness of career opportunities within health-system practice; providing information regarding postgraduate education programs, including residency training programs; enhancing student involvement in the development of ASHP policies; and encouraging professional development by fostering student involvement in ASHP, state, and local health-system pharmacy organizations.

The Forum Executive Committee and advisory groups focused efforts on its strategic goals and made progress on numerous initiatives. Highlights included the launch of a discussion board to connect members, a new student leadership program planned in conjunction with the Section of Pharmacy Practice Managers for the 2009 ASHP Summer Meeting, and concentrated efforts to increase participation in the recently implemented ASHP/SSHP Recognition program.

Forum membership exceeds 10,000 and includes students from schools of pharmacy across the nation. The consistent growth trend in the Forum is attributed to the growing number and expansion of pharmacy programs, as well as the wealth of valuable member benefits that help students achieve their professional needs.

Advisory Group Appointments. The five advisory groups of the Forum serve to offer guidance to ASHP on areas of specific interest to pharmacy students, while expanding the opportunity for student leadership at the national level. For the 2008–2009 academic year, 55 students from the first through fourth professional years were appointed to these advisory groups. The groups completed their work via frequent e-mail communications, periodic conference calls, and one in-person meeting preceding the Midyear Clinical Meeting (MCM) in December 2008.

Executive Committee

Elaine Y. Huang, Chair (Washington)
 Dan J. Crona, Vice-Chair (Colorado)
 Megan V. Davlin (Ohio)
 Carrie M. Jacobs (Indiana)
 Kate A. Palmer (Illinois)
 Sheila L. Mitchell, Board Liaison (Tennessee)
 Marni D. Williams, Secretary

Meetings and Programming Advisory Group. This group evaluated and made recommendations for the student programming offered at the 2008 MCM and aided in the concept development for the new Pharmacy Student Leadership Development Program at the 2009 ASHP Summer Meeting. The advisory group also advised ASHP on the exploration of a Webinar series to supplement the educational programming offered at the national meetings and to make the sessions available to students who are unable to attend such meetings.

Membership Advisory Group. This group evaluated and provided guidance to improve membership recruitment materials and communications from ASHP and between SSHPs. The advisory group worked to assist SSHPs to meet the criteria for official ASHP/SSHP Recognition and leveraged the structure of the recognition program to increase student membership in ASHP, state affiliates, and SSHPs. The advisory group also sought to better understand and meet the unique needs of students in their earlier years of pharmacy school.

Student Society and Leadership Development Advisory Group. This group planned and implemented the student leadership session at the MCM. As a result of this session, a report was generated and provided to the ASHP Foundation outlining feedback from students across the nation on the recommendations put forth by the Student-New Practitioner Task Force on Leadership Development. The advisory group also offered guidance to ASHP on meeting specific needs of SSHPs and recommended strategies for retaining student members during their transition to new practitioners. The advisory group also helped SSHPs gain more awareness of opportunities for students provided by ASHP through the implementation of an online calendar of events.

Communications Advisory Group. This group provided recommendations to enhance the vehicles used to share information with Forum members by standardizing official communications and employing consistent and distinct branding. The group also piloted a tool to facilitate communication and information sharing among students across the nation through the ASHP Connect discussion board technology.

Policy and Legislative Affairs Advisory Group. This group sought to get more students actively engaged in advocacy. The group developed a policy primer for use at national meeting student programming and participated in state legislative conference calls. The group also formulated a list of resources for ASHP to include in the creation of a toolkit designed to increase student participation in grassroots advocacy.

ASHP/SSHP Relationship Model and Recognition Program. In 2007, the Forum devoted resources to advance the development of strong SSHPs. This was accomplished through the launch of a new model to help define and strengthen the relationship between ASHP, state affiliates, and student societies. As a result of the efforts invested in this initiative, the ASHP/SSHP Recognition program was developed. Student societies nationwide have the opportunity to earn this official annual recognition from ASHP based on programming and activities completed each year. Criteria for recognition encourage SSHP activities that promote

membership in local, state, and national health-system organizations; stimulate interest in health-system pharmacy careers; and encourage career development and professionalism among students aspiring to careers in health-system pharmacy. In 2008, 50 SSHPs met the criteria for recognition and received benefits, including a complimentary registration for one student to attend the MCM, awards for incoming and outgoing officers, a certificate of recognition, and an ASHP publication.

Outreach and Connection. The Pharmacy Student Forum strives to reach out to and connect with pharmacy students who have an interest in hospital and health-system pharmacy careers. The Forum aims to reach every school of pharmacy and SSHP every year; this is partly achieved through both live and virtual campus visits by ASHP staff and volunteer leaders. The Forum also connects with students by encouraging the utilization of a wide variety of student benefits from ASHP. Examples include student-relevant educational programming, professional development resources, and career preparation tools. A key resource promoted by the Forum Executive Committee this year was the MentorExchange program. This Web-based tool provides the opportunity for student members to seek guidance and career connections from more experienced practitioners. Use of this members-only benefit from ASHP continues to grow, with several hundred mentors and mentees participating.

With so much activity in the Forum, communication is critical. The Forum facilitates connections with and between students by leveraging communication vehicles such as the student pages of the ASHP Web site, the ASHP Student NewsLink, and the ASHP Connect discussion board. The Web site remains a vital source of information to help students navigate the multitude of resources provided by ASHP. To keep student members up-to-date, the twice-monthly NewsLink e-mail service provides deadline reminders and highlights of student-relevant topics of interest. The ASHP Connect discussion board technology, launched in February 2009, allows student members across the nation to connect with each other in real time to pose inquiries and share information. This technology allows student members the ability to self-select discussion areas of interest.

Meetings and Programming. More than 3300 pharmacy students from around the world attended the 43rd annual ASHP MCM in Orlando, Florida. Students took advantage of the residency showcase, career development opportunities such as the ASHP CareerPharm Personnel Placement Service, and two days of student educational programming. Programming topics included sessions on residencies, resume writing and interviewing, e-professionalism, and financial management. A record number of SSHPs participated in the Student Society Showcase, putting the spotlight on student leaders from across the nation. Other highlights from the MCM included a workshop for student leaders, the student research poster session, a career roundtable open house, and a student reception.

Clinical Skills Competition. The 13th annual ASHP Clinical Skills Competition, supported by the ASHP Research and Education Foundation, was held at the 2008 MCM. Teams from 97 schools of pharmacy throughout the nation competed. This two-day competition offered students the opportunity to analyze patient cases; demonstrate their skills in assessing a patient's medical history; identify drug therapy problems and treatment goals; and recommend a pharmacist's care plan, including monitoring desired patient outcomes. The national title was awarded to Lindsey Elmore and Evan Clemens of the University of California, San Francisco College of Pharmacy.

ASHP Student Leadership Award Program. The ASHP Student Leadership Award program prominently recognizes and celebrates the contributions of students who represent the very best attributes and accomplishments of ASHP student members. The highly competitive program consists of 12 annual awards to four student members in each professional year of pharmacy school, beginning with the second professional year. Award recipients receive a plaque, an ASHP drug information reference library, and a cash

award provided by the ASHP Research and Education Foundation and funded through the Walter Jones Memorial Student Financial Aid Fund. The objective of the program is to encourage personal and professional development through a formal program providing well-deserved recognition to student leader role models who have demonstrated an interest in health-system practice and displayed exemplary student involvement in professional organizations.

The 2007–2008 ASHP Student Leadership Award recipients were as follows:

- Class of 2008: Jeffrey Little, University of Kansas; Christina Phan, University of Southern California; Linda Wylie, Oregon State University; Ellen Yang, Ohio State University.
- Class of 2009: Todd Okamoto, University of Southern California; Andrea Pallotta, University of Toledo; Carolyn Ragsdale, Mercer University; Megan Sheehan, University of Wisconsin.
- Class of 2010: Jennifer Barker, Drake University; Travis Garrett, Texas Tech; Beju Shah, South Carolina College of Pharmacy; Brittany Warrick, University of Kentucky.

Experiential Education Program. ASHP offers an elective rotation in national association management. The purpose of the experiential education program is to provide students with an understanding of the importance of pharmacy associations to the profession and the value of participation in local, state, and national pharmacy organizations. The rotation also provides an opportunity for pharmacy students with an interest in association management to experience a professional association's practices and procedures in furthering its mission, vision, and goals. The program also identifies potential leaders in the pharmacy profession. In the 2008–2009 academic year, ASHP hosted Nick Rogers from North Dakota State University, Allie Woods from the University of North Carolina, and Martin Yoon from Howard University.

ASHP Summer Internship Program. The summer internship is a 10-week training program for a pharmacy student, with one week conducted at the ASHP Summer Meeting and nine weeks at ASHP headquarters. The purpose is to provide pharmacy students with an opportunity to gain experience at the national headquarters of a pharmacy association to provide an understanding of the importance of associations to the profession. The 2008 ASHP summer intern was Emily Dotter from the University of Maryland.

Student Society Development Grant Program. ASHP offers grants to aid in the development of SSHPs. The grants are intended for use by the ASHP state affiliate and college of pharmacy partners to establish a new SSHP or to strengthen an existing SSHP, ultimately aiding the SSHP to achieve official ASHP Recognition. In 2008, grants were awarded to the following pharmacy programs:

- University of Florida (Orlando)
- Nova Southeastern University
- Sullivan University
- University of Cincinnati
- University of Minnesota
- University of California, San Diego
- South University
- Temple University
- University of Louisiana
- Lake Erie College of Osteopathic Medicine (Bradenton)

Student Research Award. Through the ASHP Foundation's annual Literature Awards Program, a Student Research Award is presented to a pharmacy student for a published or unpublished paper or report of a completed research project related to pharmacy practice in a health system. The Foundation provides a plaque and an honorarium to the award recipient, as well as an expense allowance to attend the MCM to receive the award. The 2008 recipient was Deborah A. Cios, Pharm.D., the second leading author of a paper titled "Evaluating the impact of study-level factors on warfarin control in United States-based clinical trials: a meta-analysis." The report concluded that over the past two decades in the United States there has been an improvement in the percentage of time that patients stay within the therapeutic international normalized ratio (INR) range

and that the use of anticoagulation services is superior to standard community care in this regard. However, even among patients who received care in an anticoagulation clinic, the amount of time spent within the therapeutic INR range was less than 66.6%.

Meetings and Programming Advisory Group

Carrie Jacobs, Chair (Indiana); Ellen Smith (Washington); Iona Alabado (California); Kunal Patel (Texas); Leena Amine (Georgia); Leanne Svoboda (Oregon); Mychieala Cooper (Virginia); Patricia Pitts (Oregon); Stacy Coffee (Ohio); Ingrid Larson (Washington); Pamela Dyer (Texas); Stephanie Weightman (Texas)

Membership Advisory Group

Kate Palmer, Chair (Illinois); Allison Palmer (Texas); Tami Houser (Florida); Amy Bean (Kentucky); Carla Veronese (Alabama); Daniel Ortiz (Texas); Kajua Lor (Wisconsin); Lamar Quinn (Illinois); Stacy Livingston (Iowa); Paulin Heng (California); Tanea Chane (Georgia)

**Student Society and Leadership Development
Advisory Group**

Elaine Huang, Chair (Washington); Adora Obiechina (Texas); Amy Baker (New Mexico); James Lee (Texas); Erik Borg (Oregon); Jessica Baker (Georgia); Natalie Hunley (Alabama); Peter Weber (Oregon); Seth Storby (Washington); Christine Vi-Dang (Colorado); Tri Minh Nguyen (Texas)

Communications Advisory Group

Meghan Davlin, Chair (Ohio); Beju Shah (South Carolina); Brandon Shank (Pennsylvania); Candice Wiggins (Texas); Carolyn Ragsdale (Georgia); Christine Parker (Texas); Ian Alcancia (North Carolina); Negin Soufi (Ohio); Scott Anderson (Illinois); Yen Phung (California); Thu Pham (Texas)

Policy and Legislative Affairs Advisory Group

Dan Crona, Chair (Colorado); Ashley Garcia (Colorado); Brooke Ade (Virginia); Lorraine Sam (California); Nick Rogers (North Dakota); Shirley Lee (Maryland); Teresa Dai-Zovi (Oregon); Teena Sam (New York); Rebecca Lalani (Michigan); Travis Garrett (Texas); Yuli Chang (California)